UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al,	)	
	)	
Plaintiffs,	)	Case No.
	)	1:23-cv-00595-JHP-KMB
-vs-	)	
	)	
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,	)	
	)	
Defendants.	)	

DEPOSITION OF DANIEL WEISS, M.D.

The deposition upon oral examination of DANIEL WEISS, M.D., a witness produced and sworn before Wendi Kramer Sulkoske, Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiff via videoconference in Santa Clara, Washington County, Utah on May 26, 2023, pursuant to the Federal Rules of Civil Procedure.

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(Via Video Conference)

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ALSO PRESENT: Zoom Moderator, Erica Harriman

EXAMINATION INDEX

EXHIBIT INDEX

DANIEL WEISS, M.D.

the witness herein, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION,

QUESTIONS BY MR. SELDIN:

Q Dr. Weiss, good morning.

A Good morning.

Q My name is Harper Seldin. I'm an attorney for the plaintiffs. You and I will be doing this deposition today.

Just a couple table setting things, have you ever been deposed before?

A I have.

Q How many times?

A Two times.

Q When was that?

A That is mentioned in my C.V. The last time was 2021. The time before that I believe was 1993, but the C.V. will indicate with certainty.

Q Great. So when you are referring to your C.V., you are referring to the two prior times you served as an expert witness in other matters?

A Yes.

Q Great. Okay. So some of this will be familiar to

you, but we will go over it anyway just so we are on the same page.

Today I will be asking you questions. You will provide answers. Those answers must be verbal. Head shakes will not come through. Uh-huh, huh-uh will not come through.

If you answer a question, I will assume that means that you understood my question. If you don't understand my question, let me know and we will try again.

Does that sound good to you?

A It does. I understand.

Q Now, is there any reason today, medication or otherwise, that you would not be able to understand me, understand my questions, and provide truthful responses?

A No.

Q Okay. The only other thing I will say is let's just try not to talk over each other. Even if you anticipate where I'm going, let me finish my question. I will try to let you finish your answer. That way Wendy will not yell at us, which is always my goal.

The other thing is if you need to take a break at any time, let me know. I just ask if

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there is a question pending that you answer the question and then we can take a break.
A I understand.
Q Great. Do you have anyone in the room with you today?
A No.
Q Do you have any notes with you today?
A No.
Q Do you have a copy of your declaration in this matter with you?
A I do.
Q Great. That will make it easy.
MR. SELDIN: Just for purposes of making sure we have the exhibits right, Erica, would you pull up what is marked as Weiss Exhibit 1. Great.
Q Does this appear to be the expert declaration that you submitted in this case, or the first page of it?
A It does.
Q You can see this PDF has about 113 pages on it. Does that sound about right?
A It does.
Q Is this the same document as the one you have in front of you?
A Yes.

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Q Does this declaration contain all of the opinions that you intend to offer in this case?
A No.
Q What other opinions do you intend to offer in this case?
A Other opinions might arise during the deposition.
Q Okay. So as of right now, these are all of the opinions that you intend to offer in this case?
A They are.
Q Okay. So there are no additional opinions in your mind or elsewhere that you intend to offer. As we talk you may have further opinions?
A That is correct.
Q Okay.
MR. SELDIN: Could you pull up Exhibit 2.
Q Dr. Weiss, I'm showing you Exhibit 2. You will see it has the case caption and notice of deposition and request for production of documents.
Have you seen this document before?
A I don't recall receiving this document, seeing this document, no.
Q I will represent to you that it's the notice of deposition and request for production of documents that we gave to the State Attorney General's

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office in connection with this deposition.
If you look midway down the page it says Request for Production of Documents. This is a request from the plaintiff that you produce in connection with this deposition your current C.V. first.
Starting there, do you see that request?
A I do.
Q You included a C.V. with your declaration. Is that your current C.V.?
A Yes.
Q Okay. I believe if you scroll all of the way to the back of your C.V., Page 75 it's dated May 10, 2023.
A That is correct.
Q I take it there have been no changes to this in the last sixteen days?
A Correct.
Q Great. Then, in addition, you will see back to Exhibit 2 at the bottom of the page it asks that you provide, "The declaration report, and rebuttal report the deponent has most recently submitted as an expert witness in any litigation related to the provision of gender-affirming care to minors, if such a declaration, report or rebuttal report has

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ever been submitted; if no such declaration report or rebuttal report has ever been submitted, produce any prior reports that have been submitted on the provision of gender-affirming care generally."
Do you see where that is?
A Yes, I do.
Q So I'm just wanting to confirm, have you ever issued another declaration or report or rebuttal report in a case involving gender-affirming care?
A Not an expert declaration, no.
Q Have you provided a fact witness declaration of any kind in a case?
A I provided written testimony in support of legislation, but not expert declarations.
Q Okay. Thank you for clarifying. So we will talk about that a little bit later. Thanks so much. All right.
Dr. Weiss, how did you prepare for today's deposition?
A I read the literature. I read the materials provided from the plaintiffs and I read the information available on, actually all of the plaintiffs, the four children, adolescents. And basically that's it.

And my expertise in this area comes from my experience in treating adults with gender dysphoria and reading in this area.
Q Have you treated minors for gender dysphoria before?
A I've not.
Q Okay. So I guess I will ask you two separate questions. You said you reviewed the literature and the material provided by the plaintiffs.
I take it that that is what you reviewed to prepare your declaration, is that correct?
A Well, all of the scientific literature. Also, the cases and the details with regard to the medical history of the four plaintiffs and all that material. Yes.
Q Did you review any other documents to prepare for today's deposition?
A What did I state here? Let me look.
Q Dr. Weiss, just to make sure we are understanding each other, I'm asking, like, in terms of preparing for today?
A Oh, today.
Q We will talk about your declaration in a minute. I'm asking -- let's start here. This is just a yes or no question.

To prepare for today's deposition did you speak to Ms. Youngs or any of the other attorneys at the Attorney General's office?
A Yes.
Q Okay. When did you talk to them?
A Yesterday.
Q And for about how long?
A Oh, about two hours.
Q And do you recall which attorneys were present?
A Ms. Youngs and Mr. Fisher.
Q Was there anyone else present during your preparation?
A No, there was not.
Q Other than that two hour conversation yesterday with Mr. Fisher and Ms. Youngs, did you speak to anyone else to prepare for today's deposition?
A No.
Q Okay. Did you speak with any of the other defense experts in this case to prepare for today's deposition?
A No.
Q Okay. Did you review the, to prepare for today's deposition did you review any of the expert declarations from the plaintiff experts. Dr. Shumer, Dr. Karasic, Dr. Turban?

A Yes, all three of them.
Q And have you reviewed the transcripts of their depositions in this case?
A Only Dr. Turban's.
Q Do you recall when you reviewed Dr. Turban's deposition?
A About a week ago.
Q Any other materials you can think of that you read to prepare for today's deposition?
A No.
Q Have you spoken with any of the defense experts in this case in any context at all?
A No.
Q Okay. So we know we are talking about the same folks, have you ever had a conversation with Dianna Kenny?
A No.
Q Kristopher Kaliebe?
A No.
Q Paul Hruz?
A No.
Q James Cantor?
A No.
Q I want to talk a little bit about your professional background.

Your C.V. indicates that you have several board certifications. What are your board certifications in?
A Internal medicine. Diabetes and endocrinology metabolism. There is a board for physician nutrition specialists. I'm board certified in that. I am a diplomat in the American Board of Obesity Medicine. I'm a certified diabetes education and care specialist.
Some of those boards require in order to get, in order to maintain the certification you have to pay a fee on a regular basis so some of them I've not renewed. I'm also a certified physician investigator.
Q What is a certified physician investigator?
A Someone who has expertise in the conduct of clinical trials. So they have expert knowledge in conduct and performance of clinical research in children and adults.
Q What is the process for obtaining that certification?
A There is experience and a lengthy exam.
Q When did you take that exam?
A I don't recall. It might be mentioned in my curriculum vitae.

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Q Was that towards the beginning of your career?
A Probably something like five or six years ago.
Q Okay. So within the last five or six years you obtained that certification.
Did you have to take any classes to prepare for this?
A No.
Q Any other certifications or board certifications that you have other than the ones we have just discussed?
A I might have forgotten something. If I can refer to my C.V., is that okay?
Q If it's fair to say it would be in your C.V., that is fine.
A Yes. It probably would be in my C.V. I think that is all of them.
Q Great. Who first contacted you about being an expert in this case?
A Ms. Youngs.
Q About when was that?
A Perhaps roughly, I'm not certain, maybe six weeks ago.
Q Thank you for that. If you would turn to, I guess Exhibit 1, please.
MR. SELDIN: Would you bring that up,

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Erica?
Q We will be at Page 39 of this PDF. That is the start of the C.V.
Dr. Weiss, you have your copy in front of you. We will end up on Page 2 of your C.V.
A Page 2.
Q You will see underneath Section V, Appointments: Academic and Clinical --
A Yes.
Q -- I'm looking at the portion about being a clinical assistant professor at Case Western Reserve University. Do you see that?
A Not yet. I see it now.
Q It says here that you "resigned after lengthy training was demanded for new in-hospital computer software."
Is that why you resigned?
A Yes.
Q Were there any other reasons why you resigned?
A None whatsoever.
Q What kind of software was it?
A I don't know. But I was, at that point I was an independent practitioner. I refused to use electronic medical records and I was not doing inpatient care. I saw that requirement for

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training as an unnecessary burden and completely unrelated to my management of patients.
Q Why did you not want to use electronic medical records?
A They are detrimental to patient care.
Q How so?
A They are basically a billing software. Most people don't know that.
Q Is it fair to say you had an ethical objection to being trained on the software?
A No, it's not ethical. It's not, it is not, the software was not pertinent to my management of patients.
In fact, we can get into a tangential discussion on the management, on the etiology or origin, I should say, of electronic medical records.
Basically they are a method to optimize billing. They are not good for patient care.
Q Were you seeing patients at this time?
A Of course.
Q Okay. So were you keeping paper records?
A I was keeping paper records, yes.
Q Okay. In your current practice how do you keep medical records?

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A They are electronic medical records. They are a requirement of my employment.
Q Looking lower on your C.V. on that same page you have several prior positions listed. The first one is as chief of endocrinology at University Mednet. It looks like you ended your employment there in April 2003, is that correct?
A That is correct.
Q What were the circumstances of your departure?
A This big group was disintegrated. There was poor management. There was embezzlement of funds by a physician manager. There was not optimal patient care.
Q Was there a criminal investigation related to the embezzlement?
A I think University Hospitals dropped the -- this particular physician administrator went to New York City. They left the area. They only discovered the embezzlement later. He was not a good actor.
The whole group disintegrated basically. I left a lot later than many other physicians and I just set up practice in the same area and patients followed me. I was one of 110 doctors in that group. I was the sole endocrinologist managing

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patients with endocrine disorders in that group before it deteriorated.
Q So after April 2003 that is when you set up an independent practice in Ohio?
A That is correct. I was running my own practice with a staff of thirteen people doing clinical research. I employed other endocrinologists. Then I could not maintain that financially after seventeen years of independent practice.
That is when I sold to the group Lake Health System. They were eventually bought by University Hospitals and that is when I decided to look elsewhere because then I was, I would then be employed by the same group I had originally left.
Q Looking lower on your C.V., just below that it says that until June 2007 you were the medical director at the Joslin Diabetes Center.
A That is correct.
Q What were the circumstances of your departure from that role?
A I was the first director of that diabetes center which was in another area of Cleveland, Ohio. I did that along with my role as the director of Your Diabetes Endocrine Nutrition Group, which was my independent practice.

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And the administrator of the Joslin Diabetes Center basically thought I was being paid too much and a bunch of us left at the same time.
Q And so you referred just now to Your Diabetes Endocrine Nutrition Group. That was the name of your independent practice?
A Yes.
Q I see that at Page 3, from April 2003 to December 2019. December 2019, is that when you were acquired by Lake Health?
A I sold to Lake Health, yes.
Q So it was not so much a departure so much as you sold your practice?
A Correct. I sold the practice.
Q Is that the point at which you became an employee of Lake Health Physician Group?
A That is correct.
Q Okay. I see a little lower on your C.V. it says that you were employed there from January of 2020 to January 2022, is that correct?
A That is correct.
Q Okay. What led to you leaving Lake Health?
A Well, as I said, it was principally that they were going to be purchased, they were purchased by University Hospitals. Then I looked at other

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opportunities when that became apparent that I was, that I would then be an employee of University Hospitals, which was the group I had left in 2003.
Q You say that was principally the reason you left. Were there any other reasons that you left?
A That was the reason really. And I think, I was a little bit fatigued of the thirty-six years of winters in Cleveland, you know, six months of winters. So a warmer, sunny climate was enticing.
Q So where did you go after that then?
A Now I'm in St. George, Utah. I live in Santa Clara, which is a suburb of St. George. It is a desert environment with no need for a snow shovel.
Q Makes a lot of sense to me. Is that when you became an employee of Intermountain?
A Correct.
Q I see here that also in 2022 lower on your C.V. on Page 3 that that is when you stopped being adjunct clinical faculty both at Kent State and Ohio University Heritage College of Osteopathic Medicine.
Was that because you moved to Utah?
A Yes, that was the reason.

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Q Is it a sunny day in Utah, dare I ask?
A Almost every day is sunny.
Q Good for you. So I'm looking now still on your C.V. on Page 5. You will see that there is a Section VII, Major Courses and Meetings; Continuing Medical Education.
Do you see where I am?
A Yes.
Q So this Page 5, VII. We will get to a point where I don't know what the Roman numerals stand for.
Dr. Weiss, do you see where I am?
A I do.
Q So this list of courses and meetings for continuing medical education, are these classes that you have taken or classes that you have taught?
A These are classes that I have, courses that I have taken or meetings I have attended.
Q Got it. Okay. And it looks like the first entry begins with "Review of Endocrinology" that took place in October of 1985, is that correct?
A Yes. I have been in practice many years.
Q Then by my count, if you flip to Page 10 of your C.V. you will see that the last number is 64 with Annals of Internal Medicine review from May 2021,

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is that correct?
A Yes.
Q Is it fair to say then that this has been a running list of your continuing medical education participation from 1985 to 2021?
A It's not complete because there will be continuing medical education I will do but from reading journal articles or from going online, going to an online reference called Up To Date.
So this extensive number of so-called category one credits I would obtain from that. I don't list that on the C.V.
Q So then is this list of sixty-four classes just ones that you have physically attended as opposed to done online?
A That is correct. Basically meetings that might be online meetings or more often in-person meetings.
Q Okay. So you may have done additional continuing medical education independently online --
A Correct.
Q -- but that might not be covered here?
A Correct. And you will notice it says 2021. That is the time when we happened to have a worldwide pandemic.
Q Roundabout then, yes.

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A Yeah.
Q It seems that these seem to be mostly about diabetes and metabolic disorders.
Is that about right?
A The broad area of diabetes endocrinology, yes. There are other internal medicine related topics. Correct.
Q Is any of this continuing medical education pertaining to assessing gender dysphoria?
A No.
Q Does any of it pertain to diagnosing gender dysphoria?
A No.
Q Does any of this pertain to treating gender dysphoria?
A No.
Q Does any of it pertain to providing gender-affirming care?
A I don't use that term. But treating gender dysphoria does not relate to that.
Q And why don't you use the term gender-affirming care?
A Perhaps we can defer that to later on in the discussion because it's not -- I think it's gender harming care. It's person harming care. It is a

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euphemistic term that is not appropriate to the interventions that are, that some practitioners apply to these minors. I think it's harmful. So I don't call it gender-affirming.
Q So as part of your explanation you said it's harmful to minors.
Do you also believe it's harmful to adults?
A Yes.
Q So you would not use the term gender-affirming care for a person of any age?
A Correct.
Q So when I use the term gender-affirming care I'm referring to in some part the medical procedures that are listed in Senate Enrolled Act 480 in this case.
If I refer to that broadly as treating gender dysphoria, would we understand each other?
A I think it is a better term to use the term treating gender dysphoria with hormones, puberty blockers, surgery.
I would not call it gender-affirming care. I think it is euphemistic and misleading language.
Q So just to make sure that we continue to understand each other in this deposition, I will likely use the terms gender-affirming care and

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treating gender dysphoria interchangeably.
You and I will understand that we are talking about the same kind of care. You just have a different view about whether gender-affirming care is the appropriate way to characterize it, is that fair?
A That is a fair statement.
MS. YOUNGS: And if necessary, can we specify as to what aspect because it is kind of a large umbrella and it might be confusing.
MR. SELDIN: I think we can figure it out as we go along in the context.
Q It's fair to say then that you have had no continuing medical education about treating gender dysphoria since 1985?
A No, I don't think that is fair. Because continuing medical education includes studying the scientific literature. It may not be category one credit based upon the AME designation of what category one is.
But it would be category two credit. I have had extensive category two credits, but I don't list category two credits on this C.V.
Q What is the difference between category one and category two credits?

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A It is a designation that the AMA comes up with. If you are studying a publication, analyzing it carefully and reading it, that is considered category two.

But if you are attending a meeting and they have certified it as category one, then you get category one credit. You can click on some sites and get category one credit pretty easily.

But category two credit is still very meaningful. Reading journal articles. Reading the scientific literature. I have done extensive reading on gender dysphoria that would be, that would achieve many, many credits in category two.

Q And in terms of maintaining your medical license, do category two credits count towards that?

A They do, but they are not as important. You have to have a minimum of category one for maintaining your license.

Q Is there a minimum number for category two?

A No.

Q So is it fair to say then that you could not maintain your medical license merely by using category two credits?

A That is correct.

Q Okay. I take it then when you have category one

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credits you receive some kind of a certificate or acknowledgment so when the licensing board asks if you are current you can demonstrate you have attended the requisite number. Is that fair?

A That is correct.

Q Lawyers have something similar so I'm assuming there are so many ways to track continuing education of any kind.

Do you receive similar acknowledgments for category two credits?

A No.

Q So pardon my ignorance. Is there such a thing as category three?

A I have never heard of it.

Q Is it fair to say then that you have independently researched and read about the treatment of gender dysphoria which you characterize as category two credits, but you don't have a running list of that?

A Correct.

Q Do you recall the first time that you pursued any continuing medical education about the treatment of gender dysphoria?

A I was doing some reading during a period of time when I was treating adults, which was

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approximately 2003 to 2013. So I read the literature during that period of time.

Q So you have been in practice since about 1985, is that right?

A Practice outside of Iowa since 1986.

Q Right. So from 1986 to 2002, let's say, you did not have any continuing, any medical education about the treatment of gender dysphoria. That all began in 2003?

A I don't think that is accurate to state that because there was some treatment of gender dysphoria during my training in Iowa at the University of Iowa.

There was a physician who was probably the only doctor in the state treating adults with gender dysphoria. I learned aspects of treatment from him. That would have been during my fellowship at the University of Iowa in the 1980s.

Q Who was that doctor?

A Dr. John MacIndoe.

Q I'll claim this is for the court report, but it's for me, can you spell that?

A M-A-C-I-N-D-O-E.

Q Tell me a little bit about this training that you received at the University of Iowa with

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Dr. MacIndoe?

A So he would see an occasional adult patient with gender dysphoria. I would go into the exam room and assess the patient along with Dr. MacIndoe and talk about hormonal interventions.

Q About how many of those patients do you think you encountered with Dr. MacIndoe?

A Maybe twelve.

Q Over what period of time?

A Years.

Q Two years? Four years?

A Two years.

Q Two years. Was that the length of your fellowship at the University of Iowa?

A Yes.

Q Was your fellowship in a particular specialty?

A Yes. So the training, you know, there's four years of medical school after college. And then there is residency, which is three years. And then two years of fellowship.

So the fellowship, my expertise, my fellowship is in that subspecialty of internal medicine called endocrinology metabolism.

Q So over the course of your two year endocrinology fellowship with Dr. MacIndoe you believe you

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encountered about twelve adult patients being treated for gender dysphoria?
A Yes. And keep in mind this is the early 1980s. So this was before any of the Dutch studies or any -- there was really no Endocrine Society guidelines at that point.
There were only occasional patients who expressed what was then called gender identity disorder.
Q So with these twelve patients that you saw with Dr. MacIndoe, what was your role in those consultations?
A Well, I was a fellow. So I would learn his approach and his management of the patient and discuss providing consent to the patient, discuss pros and cons of the treatment and see how he evaluated and treated these adults.
Q Did you make any treatment decisions for these adults?
A I was primarily learning at that point.
Q Is it fair to say then that you did not assess whether or not these individuals had at that time a gender identity diagnosis?
A I don't recall. I would say it's probably accurate.

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Q So you would not have been diagnosing them with --
A No, I was not.
Q And do you recall what treatments these approximately twelve adults were provided as a result of Dr. MacIndoe's care?
A It was opposite sex hormone treatment.
Q When you say opposite sex hormone treatment, what do you mean?
A So biologic males were given estrogen or androgen blockers. Biologic females were given testosterone.
Q And for these twelve patients do you recall how many times you would have seen them?
A Maybe three times for each of the twelve patients.
Q Did Dr. MacIndoe in your presence speak to these patients about how their treatments were working?
A Yes.
Q And what did they tell you and Dr. MacIndoe?
A That was a long time ago so I can't recall specifics on that.
Q Do you recall generally how these twelve adults faired on this treatment?
A My recollection from forty years ago is that they valued the physical changes that they were experiencing.

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Q Did you keep in touch with Dr. MacIndoe?
A No.
Q During your two year fellowship you would see these patients as part of learning as a fellow with Dr. MacIndoe.
Did you have any experience treating gender dysphoria between the end of your fellowship and 2003?
A I don't recall treating when I was with University Mednet, no. I think I only was treating when I was an independent practice from 2003 on. There were relatively few patients until the last decade or so. Ten, fifteen years.
Q Between the end of your fellowship and 2003 did you advertise any clinical expertise in treating gender dysphoria?
A I did not advertise at all. I didn't need to. Patients would come to me with their endocrine disorders. I was not promoting myself. I didn't need to. I was a sole endocrinologist in this group of 110 doctors. I didn't speak up or talk about my expertise in that area because there was no need to. There were patients sent to me for that.
Q So you didn't treat any patients' gender dysphoria

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from the end of your fellowship until 2003?
A Correct. They were not sent to me. I was not asked to treat them.
Q Did you have any patients who were transgender between the end of your fellowship and 2003?
A I don't recall.
Q Looking at your C.V. if you look at Page 16, Roman Numeral XII, do you see your bibliography?
A Yes.
Q You will see that this runs through Page 18. There is a Number 26 for the last publication.
Do you see that as well?
A I do.
Q Do any of these publications in your bibliography pertain to the treatment of gender dysphoria?
A None.
Q Do any of them pertain to the assessment or diagnosis of gender dysphoria?
A No.
Q Have you ever conducted any original research about gender dysphoria?
A No.
Q Have you ever conducted any original research about gender identity or transgender people?
A No.

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Q Have you published any peer reviewed articles about the treatment of gender dysphoria?
A No.
Q Have you published any not peer reviewed articles about gender dysphoria?
A No.
Q Thank you, Dr. Weiss. I'm now going to turn to Page 20 of your C.V. This is Roman Numeral XIII, Presentations to Medical Professionals.
A Yes.
Q You will see that first presentation is dated March 31, 1981, correct?
A Correct.
Q Then if we go to Page 62 of your C.V., you will see that the last entry is 564 and is dated November 9, 2022.
Do you see that?
A Say that again.
Q I'm saying do you see the last entry in this section?
A 564?
Q Yes.
A Yes, I see it.
Q Is it fair to say then this is a complete list of your presentations from 1981 to 2022?

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A That is correct. This is to medical professionals, yes.
Q Are any of these presentations regarding gender dysphoria or its treatment?
A No.
Q On Page 63 of your C.V. it says, "Note, Dr. Weiss continues to be a speaker presenting at programs across the United States. However, as of June 2007 only programs that were non-promotional in nature are listed above."
Did I read that correctly?
A You did.
Q What does that mean?
A So I have been a speaker for pharmaceutical companies and those presentations relate to their medications and teaching doctors about these new medications.
So I listed some of those. Many of those were listed early on among those presentations to medical professionals.
As of June 2007 only the programs that were not promotional, that were not pharmaceutical related were listed. So those were just didactic in nature without a sponsor by a pharmaceutical company.

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Q So why did you stop listing -- why did you change how you listed after June 2007?
A It makes the C.V. too long and it's unnecessary.
Q So can you give me an example of a promotional program that you would not have included?
A For example, there is a medication called Mounjaro. That is a one weekly injection for Type II diabetes. It is excellent for glucose control.
Most people when they are on it they also tend to lose weight. I'm currently a speaker for one pharmaceutical company that makes Mounjaro, but I don't list all those presentations. It would be too long.
Q Who makes Mounjaro?
A Lilly. Eli Lilly.
Q Are you compensated for those presentations?
A I am.
Q About how many of them do you do a year?
A It varies. It may be thirty. It may be fifty.
Q What was that first number?
A It may be thirty. It may be fifty. If the product is new they need to -- they want to promote it. They want to teach health care providers about what is available, how good it is.

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They are not familiar with it so they like to hear from an expert and so I talk to them about it.
Q And for those thirty to fifty presentations that you do a year, how much are you compensated?
A It depends if there is travel involved. If it's a web-based or just a remote, so-called remote live through the computer, then it is $1,100.
At this point for travel programs in the area it is about $3,025.
Q And so about how much money per year do you think you make doing the promotional presentations all in?
A It really varies a lot from year to year. It may be $50,000. There are some years over the last fifteen years or so it was $100,000.
Q How much do you make as part of your role at Intermountain currently?
A My current salary I think is $220,000.
Q So would it be fair to say then that the compensation for these promotional presentations has been a significant part of your income for the last five to fifteen years?
A For the last probably twenty years it has been, yes. They are all done outside of the workday. They are evening programs or maybe a lunch hour or

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morning programs so they don't interfere with patient care.
Q And you listed Mounjaro as one of the medications that you do promotional presentations for.
Are there other medications that you have done presentations for? That was a bad question.
I'm trying to ask you of the medications that you have made promotional presentations about, have they all related to the treatment of diabetes?
A No. So there have been medications for treating cholesterol. There have been medications for treating osteoporosis. There have been medications for treating diabetes. Medications related to obesity.
There are so many over the years because I have been in practice for over thirty-five years. I have been doing promotional programs since the 1980s.
Q Of the medications that you have done these promotional presentations for, have any of them been for the treatment of gender dysphoria?
A No.
Q Okay.
A Let me also spell Mounjaro for the court reporter.

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Q Thank you.
A M-O-U-N-J-A-R-O.
Q I'm turning now -- we are still on Page 63 of your C.V.
Outpatient Teaching Of Health Professionals in Training, do you see where I am?
A I do.
Q Great. And it continues onto the next page briefly.
Is any of this outpatient teaching pertaining to the treatment of gender dysphoria?
A Yes.
Q Which of these pertains to the treatment of gender dysphoria?
A So whenever I would teach a medical student or a nurse practitioner or an endocrine fellow in training or internal medicine or a family practice resident or a medical student, I would have them accompany me in my care of patients with gender dysphoria in the office so I would teach them about it.
Q So fair to say then that the teaching that you were providing on the treatment of gender dysphoria would have been the education of medical professionals in the ordinary course of treating

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patients?
A Correct. I think that is accurate.
Q As opposed to like a special seminar where there are no patients, this would be taking folks on rounds with you?
A Correct.
Q Would this have taken place from 2003 to 2013?
A That is correct. I did teaching before 2003, but I don't recall seeing patients with gender dysphoria before I, when I was in practice with University Mednet. It was only when I was in independent practice.
Q What would you tell these medical students or practitioners about treating gender dysphoria?
A I would discuss the, that particular patient and their feelings about their gender and the intervention I was offering to them. Why I was giving the hormonal treatments I was providing.
I was using opposite sex hormones or blockers. Not puberty blockers for a variety of reasons. And I talked to them about seeing the people.
The endocrinology fellows I taught often expressed an unwillingness to be, to take care of those patients when they went into practice.

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Q Why was that?
A Most endocrinologists that I have interacted with are not on board with, are not convinced that the evidence is good or they are uncomfortable treating with opposite sex hormones for those people with gender dysphoria so they don't see those people.
Q When you say uncomfortable, do you mean because of their perception of the evidence base or some other reason?
A I think it's their perception of the evidence base, yes.
Q What would you say in response to that?
A Now I would support them. I can understand their feeling that the evidence is very weak because it is both for adults and for children.
Back then when I was treating, obviously, I was not aware of how weak the evidence was.
I was offering treatment. I was the principal person in northern Ohio treating people with gender dysphoria during that ten years of time I was treating.
Q But at the time you were providing treatment to adults?
A Correct.

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Q And was your perception that the treatment was effective for them?
A I was not sure. There was an evolutionary process there with me. I felt, I evolved to the point where I saw that people were really not improving.
They had lots of other, lots of other problems. Lots of psychiatric problems. Discord in the family. There were other unresolved issues, anxiety, depression. And I thought they were inadequately evaluated when they were sent to me because they were sent to me having seen a therapist, but often those visits were one or two visits and then they were told that they were good to go. They met the criteria for hormonal interventions.
But I didn't -- so, yes, they had physical changes. But I don't think from a psychological standpoint they really improved. Eventually I, then I started to see more and more and my other patients were not getting care. I could not see new people because my practice is very busy. I declined seeing new patients.
I continued to provide care for those established patients. But as I stated in my declaration, probably seventy percent discontinued

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their care. Or I should say more specifically, they didn't follow up with me so I suspect they discontinued their care because there was no one else who could offer that care in the area.
Q When you say that you stopped seeing new patients, what year did you stop seeing new patients for the treatment of gender dysphoria?
A 2013.
Q Have you seen any patient for the treatment of gender dysphoria since 2013?
A For the treatment of gender dysphoria, no.
Q Okay. So I want to make sure I have the timeline correct. From 2003 to 2013 you saw patients for the treatment of gender dysphoria.
In 2013 you stopped seeing new patients for the treatment of gender dysphoria.
A Correct.
Q So for the existing patients that you had with gender dysphoria, the last one of those people that you saw would have also been in 2013?
A No. No. I continued seeing them until I left Ohio.
Q What year was that?
A I left Ohio in December of last year, 2022.
Q So when was the last time you saw a patient that

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you were treating for gender dysphoria?
A Around that time. December of 2022.
Q Okay. So in your declaration I think you said that you treated approximately one hundred patients for gender dysphoria, is that correct?
A Yes.
Q Does that hundred patients include the twelve you saw during your fellowship?
A No.
Q Okay. Of the hundred patients that you saw, that was from 2003 to really 2020, right?
A 2022.
Q 2022. I apologize. Well, from when you left Ohio?
A Yes.
Q Okay. So how many of those patients do you think you treated continually over that period of time?
A Well, if seventy percent left that would leave thirty.
Q So when you left Ohio in 2022 you still had thirty patients you were treating for gender dysphoria?
A Correct.
Q Okay. And what did you tell them about why you would be discontinuing care with them?
A Moving to Utah.

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Q Did you transfer their care to another practitioner?
A I discussed options with them because I felt bad about leaving. That was not just the patients with gender dysphoria, but all my patients because they had seen me for many years. Some of them thirty years.
So I offered options and asked the endocrinologist whom I hired years ago if he would continue to manage them. They were on stable hormonal treatment.
Even though he would not see people, new patients, he was willing to continue their care in most cases. I should say in all cases he was willing to continue to manage those people.
Q Okay. You believe those thirty people were appropriately continuing to receive care for gender dysphoria at the time that you transferred them to another endocrinologist?
A If I were to see them again I would not offer them opposite sex hormones and all of that treatment that I did then because I learned a lot more than I knew back then.
They are on stable regimens. They are doing as best as they can. They are getting

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psychotherapy and counseling. They are on antidepressants. Some of them have had surgical reassignment and they need their hormones. They will be maintained on those hormones by Dr. Burtch in my practice.
Q Fair to say you think your patients would have done poorly from a medical perspective if they had not been able to continue receiving the treatment for the gender dysphoria upon your departure?
A These people who had surgical reassignment certainly. They don't have their gonads. They need hormones. These are adults, of course, all of them in their thirties and forties and fifties.
Q Of those thirty patients, do you recall about how many of them had surgery to remove their gonads?
A I'm thinking here now. I don't recall.
Q Not all of them, fair to say?
A Correct.
Q Even for those who had not had a surgical intervention related to their gonads you believed it was appropriate for them to continue to receive hormones as part of the treatment for their gender dysphoria?
A I think all those patients that the endocrinologist that I hired who was going to

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assume their care, all of them have had surgical reassignment. I'm just thinking back. Yeah. All of them did.
Q They would not be producing endogenous hormones?
A That is correct.
Q I take it from a medical perspective it's not healthy to not have endogenous hormones and also not to receive them --
A Correct.
Q Okay. Now of the seventy -- so we are talking about the hundred folks that you saw between 2003 and 2022.
You say by the time you ended your practice there you were only seeing thirty of the hundred?
A Yes.
Q Do you know what happened to the other seventy folks in terms of their care?
A All I know is that they did not return for office visits. So I assume that they no longer, they discontinued treatment. They were not getting their opposite sex hormones or their blockers at all because no one else would be providing it around that time.
Q When you say blockers, you mean testosterone blockers?

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A That is right.
Q Earlier you said you don't prescribe GnRH agonists, right?
A Right. Those are not covered by insurance. They are very costly. Insurance would not tend to provide those even if we wanted to.
Q Since these patients were, had already gone through puberty they would not be candidates for puberty blockers?
A Correct.
Q But of the seventy patients, it is possible they moved away from the area, right?
A That is possible, yes.
Q It's possible that they found another provider to continue prescribing that care?
A Very unlikely. Back in 2013 there were no other providers except the Cleveland Metro General Hospital that had a clinic back then and patients preferred not to go there. It was hard to get into there.
That was the only other provider in the area. It was fairly far from where I was offering care.
Q So you suspect that, but you are not certain. Someone could have made the drive, right?
A Correct.

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Q Okay. And in 2013 when you stopped seeing new patients did you tell your existing patients that you were no longer treating new patients for gender dysphoria?
A No.
Q Okay. Do you think any of them knew that?
A I don't know. When people would call for a visit, my office would say he is not seeing new patients at this time.
Q Would they specify that you were not seeing new patients for gender dysphoria, or would they say he is not seeing any new patients, period?
A No. It was for gender related issues. I was seeing other new patients.
Q What I'm saying is if someone called you in 2014 and said I would like to make an appointment with Dr. Weiss and they didn't say why, you would take them because you were seeing new patients?
A Correct. The office would ask what it was for. Then they would clarify. If it was a gender related issue they would say I was not seeing new patients at this point. You can go down to Cleveland Metro.
Q Did you notice a drop off in your existing patients after 2013 when you stopped seeing new

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ones?
A No. I was booked out months and months. There was a great demand for our services. We had excellent reviews. Patients loved us. There were lots of referrals from other patients.
Q So there were lots of referrals from other patients?
A Yes.
Q So it's possible some of your existing patients learned you were not seeing new ones because they would refer a friend and your office would not be able to schedule them?
A Possible.
Q Okay. And in any given year, I would say in any given year about how many active patients would you have for gender dysphoria?
A It's hard to estimate.
Q It's a hundred over that 2003 to 2022 period. I am trying to figure out how many of those you saw over what period of time.
Do you have a sense?
A I would see those patients usually every three to four months. So you can do the math. I don't know.
Q I mean, do you think there was ever a point in

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time where you were actively seeing a hundred patients for the treatment of gender dysphoria all at once?
A Well, they would be spread out through the year. So I think there was a drop off over time. So maybe it was a hundred overall, but then among those hundred then there would still be those patients who would no longer follow up.
They might be initiated on hormonal therapy and then I would see them for a year or two. Then I might not see them after that. So there was attrition.
Q Okay.
A Attrition presumably from discontinuation of treatment.
Q You are not actually sure about whether they were discontinuing their treatment all together or just with you?
A That is correct. But it's highly unlikely. When I mentioned the one patient about where he could go for care, it would be, oh, I don't want to go down to the Pride Clinic. That was -- because a lot of these patients had been there. They didn't want to go back. It was a different approach that we took. It's not like that was a desired

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location for people to go to.
Q Again, you have some suppositions about what might have happened. You didn't follow up? You didn't call and say you have not come in for an appointment, what's happening?
A I did not do any systematic follow up of all hundred patients like doing clinical research, no.
Q We have been going for about an hour. Is now a good time for a five minute break?
A I can keep going if you want to. If you want a five minute break, I'm fine with that.
Q Not to put too fine a point on it, I would like a five minute break.
(OFF RECORD AT 10:36 A.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 10:42 A.M.)
BY MR. SELDIN:
Q Dr. Weiss, we are still in your C.V. on Page 64. This section is called Legal Experience.
Do you see that?
A Yes.
Q So you listed two cases in which you were an expert witness.

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A Yes.
Q Did either of these cases involve the treatment of gender dysphoria?
A No.
Q Did either case involve anyone who was transgender to the best of your knowledge?
A No.
Q Are there any other cases that you were a testifying expert that you didn't include here?
A No.
Q Are there any cases where you were a consulting expert that you didn't include here?
A No.
Q Are there any other cases where you have been retained as an expert, but have not yet testified?
A Not that I recall.
Q There are several other states that have passed laws similar to Senate Enrolled Act 480.
You are not an expert in any of those, are you.
A No. I have submitted written testimony in multiple states for legislation similar to the Indiana bill, but I've not provided any expert declarations in any other states.
Q And you have not been retained as part of

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litigation?
A No.
Q Is that something that you are interested in doing?
A I think it's important to provide the science and the facts and provide balance in this because I think a lot of harm is being done to minors.
Q On Page 64 of your C.V. it has Participation in Clinical Trials and then it goes to the next page.
For these trials what has your role been? Are you the principal investigator for all of these?
A Yes.
Q Okay. So in your declaration you talk about having been the principal investigator in about a hundred clinical trials.
Those are the ones listed here, is that correct?
A Yes.
Q Do any of these pertain to the treatment of gender dysphoria?
A No. It would be great if one did because there are no randomized clinical trials with comparator control groups for the treatment of gender dysphoria in adults or minors.

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Q And were all these trials sponsored by pharmaceutical companies?
A No.
Q Which ones were not sponsored by pharmaceutical companies?
A The second one, the efficacy of fluoxetine. That was an investigator initiated trial. I did that one without funding. There was the ACCORD trial in which I was a principal investigator. That was analogous to a health sponsored trial. That should be listed here. That is listed on Page 65. That is Action to Control Cardiovascular Risk in Diabetes. That was a National Institute of Health sponsored trial. So that was also not a pharmaceutical trial.
All of the others were pharmaceutical sponsored trials except for Page 72, 2011 to 2012 Trial-Net was an NIH sponsored trial.
Q So with the exception of those, the rest of those indicate at the end there has been a sponsor. So I take it the rest of them were sponsored by pharmaceutical companies?
A Correct.
Q Have you supervised any clinical research about the treatment of gender dysphoria?

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A No.
Q Okay. Now on Page 75 of your C.V. you will see there's a section midway through called Speakers Bureaus and Advisory Boards. Then you have Lilly on there.
Earlier you were talking about your promotional presentations for Mounjaro. Is this the same thing?
A Yes.
Q Okay. Are there any other -- other than Lilly, are there any other Speakers Bureaus or Advisory Boards that you are on currently?
A I'm a senior fellow with Do No Harm. That is not listed on my C.V. Many people view it as a politically motivated organization. It's not.
Are you familiar with Do No Harm?
Q Why don't you tell me about it?
A So basically it's an organization that attempts to eliminate ideology out of the practice of medicine to try to optimize patient care, what is best for the patient, and leave ideology, politics, religion out of practicing medicine.
So I'm a senior fellow with that organization. I do occasional, I write occasional testimony. I guess it's testimonies that I write

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in support of legislation related to gender ideology.
Q When did you first become a senior fellow in Do No Harm?
A It was something like March or so of this year. Early this year.
Q March of 2023?
A Correct.
Q And how did you learn about them?
A It's a long -- how did I learn about them? That is a short story. I just saw the, I think I saw something online with regard to what their efforts were.
The head of the organization is the former dean of the University of Pennsylvania School of Medicine. He is a nephrologist. He is just brilliant and articulate. I think his goals are wonderful. They are well -- just the motivation and the goals are really noble.
Q And do you remember where online you learned about them or what you were doing online when they popped up?
A I do not remember.
Q And so that is how you learned about them. What happened next?

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A Well, what happened was -- can you clarify that question? What happened next?
Q So you first learned about them. Then suddenly you were a senior fellow. What happened in between?
A I will explain. So there was an email sent out to request support for Florida's legislation related to treatment of minors with gender dysphoria.
I sent an email to the Florida, I think legislature's medical board or someone to support Florida's legislation. Then there was a follow-up email from Do No Harm to please send us any communication you wrote in support of the Florida legislation.
I sent them a copy of my supportive testimony. They contacted me. I think that was partly because I'm an endocrinologist who has had a lot of experience treating gender dysphoria and they were interested in my viewpoint.
Q And so thank you for that.
MR. SELDIN: Erica, if you could please pull up Exhibit 11.
Q Dr. Weiss, you will see this is an email from a DW, but it's signed by you to the Board of Medicine Public Comment.

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It's an email dated October 24, 2022. Do you see this email?
A Yes, I do.
Q And it says, "Please see my attached comments. I strongly support Florida's efforts to protect minors from experimental medical interventions such as cross sex hormones, puberty blockers, and surgery to remove normal body parts. Thank you."
Did I read that correctly?
A You did.
Q So is this the email that you sent with respect to that Florida comment we were just talking about?
A Well, no. There was probably a two-page commentary with references sent to Florida. So this is -- the attached comments are not shown here.
MR. SELDIN: Erica, if you could scroll down for us.
A Very good.
Q Is this the cover email and then the attachments that you sent that we were just talking about?
A It looks familiar, yes.
Q Okay. So in October of 2022 you send this Florida comment.
When you sent this comment did you know about

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Do No Harm?
A I don't think so.
Q Okay.
A I don't think so.
Q So --
A Wait. Excuse me.
Q Yeah.
A Yes, I must have known about Do No Harm because, as I said earlier, Do No Harm said to please send comments to Florida if you support this legislation.
That is when I sent this email to Florida. And it was only because of the Do No Harm email sent to their members, most of them who are physicians I think.
Q And when did you become a member of Do No Harm separate from being a senior fellow if those are different things?
A They are different things. I think I became a member sometime last year. I do not recall when. It may be mentioned on my C.V. I don't think so though.
Q Just so I understand the timeline, sometime in 2022 you are online. You learn about Do No Harm. Is that when you became a member?

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A Yes, when I saw the work they were doing. Yes.
Q And then you start getting Do No Harm's emails. One of them was sometime before October 24, 2022 that solicits folks to send comments into Florida.
And that is what prompted this email from you with the attached comments. Is that an accurate sort of summary of what we have been talking about?
A Yes.
Q Okay. And then did you send a copy of this to Do No Harm?
A Only when asked after.
Q Okay. So Do No Harm said to send comments. They say then thank you for sending comments. Please send us a copy of what you sent?
A Correct.
Q Then you heard back?
A Yes.
Q Do you remember about when between October 24, 2022 and becoming a senior fellow that you heard back?
A I don't remember.
Q Okay. And when you did hear back who reached out to you?
A Kristina Rasmussen, who is their kind of chief

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administrator.
Q What did she say to you?
A She said something like Dr. Goldfarb and I would be interested in speaking with you about your joining Do No Harm or something along those lines.
Q Did you then meet with Dr. Goldfarb?
A Yes. It was just online like a Zoom meeting.
Q What was that conversation like?
A They discussed their goals and how I might work with them in achieving their goals specifically with focusing on the gender dysphoria issue.
They work on other matters, too. That was not the pursuit at that point.
Q So specifically on gender dysphoria what did they say their goals were?
A Well, I think the goal is to protect minors. To protect really only minors from these harmful and experimental interventions.
Q And is a goal of Do No Harm to end the treatment of gender dysphoria for adults?
A No, not at all.
Q Is it your goal to end the treatment of gender dysphoria for adults?
A I think if adults want to undergo those treatments if they have really clear informed consent by the

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prescribing physician, I mean, they are welcome to do that. Adults are adults. It's a different story.
I don't think it's the best treatment for them if they have gender dysphoria. I think there are better approaches to their dysphoria. But if they seek to have modification in their appearance to resolve their dysphoria and the prescribing doctor thinks that's the way to go, as long as there is clear and complete consent then that's fine for adults.
Q This particular testimony that you wrote, did you write it yourself?
A Yes.
Q In the legal world it's not nearly as offensive to ask if you wrote it yourself. This was what you wrote before your involvement with Do No Harm?
A What are you referring to?
Q The Florida testimony that we are looking at right now that you submitted to the Board of Medicine, did you write this yourself?
A Yes.
Q Did you have any assistance writing it?
A No.
Q Did anyone review it before you sent it in?

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A I think I may have shown it to my wife. She is a retired physician. She is really good with grammar and clarity.
Q Good to have a copy editor in the house. What kind of physician was your wife?
A Nephrology.
Q How long did she practice?
A Oh, she is seven years older than I. She just stopped practicing about five years ago.
Q Does she also enjoy Utah and the sunshine?
A She is.
Q Okay. Glad to hear it.
Has she ever treated anyone with gender dysphoria as far as you know?
A No.
Q I want to talk more about your testimony before some state legislatures that you talked about.
Do you recall what states you offered testimony in either written or oral?
A I can check my folders and tell you. From my memory it would be Indiana, Ohio, Montana, Utah. I think that is all. That is all that I can remember. There are probably some I left out.
Q Is it possible you testified in North Dakota?
A Wyoming is in there. I think North Dakota also,

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yes. I think that is right.
Q Other than the legislative testimony that you referred to, and you listed some states just now, have you ever provided legislative testimony on another topic other than the treatment of gender dysphoria in minors?
A Another topic outside of gender dysphoria?
Q Correct.
A Yes. I have submitted video testimony in Ohio about not requiring vaccine mandates to people before -- it had to do with vaccine mandates. It was that topic.
Let's see what else. That was about two years ago I think. I can't recall any other testimony.
Q Would that have been vaccine mandates in Ohio?
A Yes.
Q What was your position on vaccine mandates?
A They should not be required by the state.
Q Why was that your position?
MS. YOUNGS: Objection. What is the relevance to the vaccines?
Q Dr. Weiss, what was your position on the vaccines? Why was that your position?
A My position at that point was that there was, it

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was a privacy issue. People's health status should not be the reason they should be excluded from businesses or governmental positions or -- basically that was it. It was a health privacy stance.
Q Is it fair to say you thought this was an inappropriate use of state power?
A Correct.
Q Have you ever lobbied?
A I'm sorry. Have I lobbied?
Q Yes.
A No.
Q You have never met with state legislators to talk about medical issues, vaccines, or treatment of gender dysphoria, nothing like that?
A No.
Q Okay.
MR. SELDIN: Erica, if you could pull up Exhibit 8.
Q Dr. Weiss, we were talking earlier about your testimony.
Do you recognize this document?
A Yes.
Q What is it?
A It's a statement I presented to Ohio's members of

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the House, Families, Aging and Human Services Committee to support the Save Adolescents From Experimentation Act.
Q Would that have been -- do you recall was that HV 454?
A That sounds familiar.
Q Was this testimony May 19, 2022, does that sound about right?
A It does.
Q Okay.
MR. SELDIN: Erica, can you pull up Exhibit 32.
Q While Erica finds that, Dr. Weiss, I have a link to the recording of that testimony.
My question will be is that you, is that the testimony?
A If it looks like me it probably is.
Q Famous last words in the court of law. We will make sure it's you.
MR. SELDIN: Erica, if you could get us to 32.
Q While that comes up, Dr. Weiss, so in May of 2022 you were not a member of Do No Harm yet?
A No.
Q You were not a senior fellow yet?

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A That is correct. I might have been a member. I don't know. But I was certainly not a senior fellow. That was just early this year.
Q So you were not a senior fellow. You are not sure if you had signed up to be a member?
A Correct.
Q When you signed up to be a member did you make a donation, or it was to join the email list?
A I think it was to join the email list. I don't think there was any monetary requirement.
Q This testimony that you provided which we just talked about as Exhibit 8, did you write that yourself?
A Yes, sir.
Q Did anyone help you write it?
A No. Again, I may have shown it to my wife for grammar and clarity.
Q Did anyone compensate you for providing that testimony?
A No.
Q What prompted you to go to that hearing?
A It is a rather long story but I will make it brief. So I was contacted by a physician who is a member of the, of SEGM, Society for Evidence Based Gender Medicine. I had joined that group probably

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two or three years ago. He, that physician, is a member of that group and he is in Ohio. He said, hey, there's this legislation coming up. Would you be willing to write testimony in support for it?
And he got me in contact with an organization that was supporting the legislation.
Q Do you recall what that organization was that was supporting that?
A CCV, I think. Center for Christian Values or something like that. I think they changed their name. But it's something along those lines.
Q You mentioned SEGM. What is that?
A SEGM. Society for Evidence Based Gender Medicine.
Q When did you join that organization? Was it maybe two or three years ago?
A Something like that, yes.
Q What prompted you to join that organization?
A So I had written a letter in support, well, actually praising an editorial or an article that Dr. Malone, an endocrinologist and founding member of the organization, had written.
And in response to my commending him on how well balanced and clear and well written that article was that he wrote about gender dysphoria

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he contacted me. He said would I be interested in just joining the organization. You know, it's basically a non-political organization that tries to provide the best science and the best evidence for taking care of people with gender dysphoria. So I joined.

There's, they have discussions online and so on. They have several physician members that are -- I'm just, I'm just connected to them. I'm really not a member of the group in that sense. They allow me to access their kind of interactive site.

Q Do you have to be a member to access the -- are you talking about -- you are on their website?

A Yes, that is all. I'm not even listed. You will not find me, if you go to SEGM you won't see my name there because I'm just -- I know about them. They have their resources basically.

Q Who was the doctor from SEGM who reached out to you about testifying in Ohio?

A Dr. William Malone. M-A-L-O-N-E. He is an endocrinologist.

Sorry. What was that question? Now repeat the question.

Q You said a doctor had reached out to connect to

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you from SEGM, the organization CCV, is that right?

A I misspoke. Okay. Right. The doctor who asked me about Ohio is Dr. Beck.

Q Who is Dr. Beck?

A He is actually one of the founding members of SEGM.

Q You found SEGM because Dr. Malone. Once you were part of SEGM Dr. Beck got in touch and asked you about supporting this bill in Ohio?

A Correct.

Q Okay. And then the organization that was supporting the bill in Ohio that you were involved with related to your testimony was CCV, is that right?

A I think that is what it's called. There are many organizations supporting the bill. CCV was the one that reached out to me and gave me a copy of the bill. They communicated with me.

Q You will see actually we have up on the screen the Exhibit 32-C which is from CCV.org.

A Okay.

Q I take it that was the organization you are talking about there. I think they have a recording of your testimony online.

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A Okay. Good.

Q Okay.

A So my recollection was accurate.

Q We love to hear that in a deposition. So during that testimony you talked about how you estimated that seventy-five percent of your patients failed to persist in their treatment with you.

Does that sound about right?

A I think I modified that to seventy percent in my statements to you earlier and in my declaration.

Q But the word "persist" is the word that you used.

A Okay.

Q I guess my question will be what does persistence mean? Like we were speaking earlier about your patients didn't return to treatment with you.

When you say didn't persist, is that what you meant?

A Yes. So when they discontinued their care with me I would equate that to lack of persistence in their treatment. Although, accurately as you stated, I can't be sure what happened to those people.

Q We have talked about other reasons that people might not have returned to you for care. It could have been that they lost their insurance perhaps?

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A Correct. Many of those people were on Medicaid. That is possible. Sure.

Q It could have been possible they were happy with the results they got and didn't feel the need for further treatment?

A That would be, that would be desistance if they stopped. They would not have discontinued hormonal, you know, to say -- well, then they would basically desist. They would say I don't really need this any more and they would stop hormonal treatments.

Q Well, I think I'm asking a different question. There are some treatments that, I mean, someone might say I want to take testosterone because I want my voice to be lower. Once their voice achieved that pitch, they might say I have achieved what I desired and I don't need more.

A That would not be the case in these people because they are all adults who have their voices. Their vocal cords will not change after the treatment. They are all post puberty.

Q As part of your testimony you have talked about a patient who had regretted the removal of their testicles.

Does that sound familiar?

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A Yes. Before I left Ohio I had two men who had bilateral orchidectomy, that is, testicular removal who regretted it within one year of treatment.
Q Were they adults when they had this surgery?
A They were.
Q Do you recall approximately how old they were?
A One was in his thirties. The other was about forty-five.
Q And were those surgeries as part of their treatment for gender dysphoria or for some other reason?
A The man in his thirties was treatment of gender dysphoria. Surgery was done in Philadelphia. He came to me for care after that.
The man in his forties was -- he should never have had that done. I was treating him for gender dysphoria. He was -- it's a complicated story. He was really autogynephilic. He basically wanted some feminine characteristics. He was married to a biologic female and sexually active with his wife. He was living as a man with long hair.
And he went -- I was seeing him for years. And he was, he seemed happy with his hair on low dose estrogen. And then I didn't see him for

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several months. He ended up going to a urologist for orchiectomy. He was evaluated by a psychologist that cleared him for surgery. He came back to see me saying I'm having problems with erections since my surgery. I said, What surgery? Because they never contacted me for his, they never contacted me before his surgery.
Then he wanted testosterone for his erections. I called the urologist. I said, How come you didn't contact me? What happened there? They said, We had a psychologist. He thought he was fine to have surgery. This just shows if two adult men can have regret it would not be surprising there would be many minors who would regret having interventions if two adult men who obviously failed to understand what they were having done to them.
That is the story on those.
Q Have you had other patients who regretted surgeries they have gotten, any kind of patient for any treatment?
A Yes. I have had patients who had complications after breast surgery. Patients who had complications after knee and hip surgeries. Yes.
Q This was not the first time you had patients come

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to you and have some regret or complications from surgeries?
A Right. But the distinction is hardly analogous because these are people who have healthy body parts and then they are being removed. They clearly don't -- they don't clearly have informed consent. When people have knee and hip and shoulder surgery they have severe pain. They have deranged, abnormal joints or breasts. They might have breast cancer.
So all these people have a disease state that can only be corrected by surgery. There is no other intervention that would be appropriate. It's quite different from people with gender dysphoria.
Q So I take it then your concern is not the regret. It is the surgery operated on what you think is healthy tissue?
A That the surgery was not the best intervention for these people's distress. There was, you know, there were interventions that they could have been offered that might have resolved their distress and they actually did not get resolution of their distress and they had worsening with the surgery in these cases of gender dysphoria.

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Q So based on those anecdotal experiences with those two patients, that is why you support laws like Senate Enrolled Act 480 which bans this care for minors, right?
A No. No. That is a terrible oversimplification. I think the evidence base is pitiful to support these interventions. It's not just my experience. It's the experience that the people didn't improve from a dysphoric standpoint, even those who did not regret their surgery.
But also the evidence base is very poor. It is really low quality. And even those -- the Endocrine Society -- that's why four, five countries have said this is not, this is not the way to go. They really should have psychological support.
And some countries have said they should only be offered -- medical interventions should only be offered in a research setting because the evidence is so poor to support it. It is not just simply my experience.
Q We will talk about the countries in a minute. I think I was asking a different question.
A Sorry.
Q Even though you had two adult patients who

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regretted their surgeries, you do not support a ban on the treatment of gender dysphoria for adults? You just support bans on the treatment of gender dysphoria for children, for minors?
A That is correct.
Q Okay. That is what I was getting at.
A I'm sorry if I misunderstood.
Q Not at all. Do you support bans on orthopaedic surgeries for minors?
A I think there needs to be informed consent for all surgeries on children. That means that informed consent involves the pros and cons, risks and benefits, alternative treatment and the parents need to be involved in the decision making process and sign off on that.
Q There are circumstances in which minors you believe can provide assent to certain types of medical care with the consent of their parents and that kind of care should be provided?
A Absolutely.
Q Okay.
MR. SELDIN: I saw a note from Erica about the video. Thank you. Can you pop that up real quick. All this for one question. Would you play the first thirty seconds or so.

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(Video Playing.)
MR. SELDIN: You can pause it.
A That is me.
Q Not the other Dr. Daniel Weiss, M.D. testifying in Ohio. Great. Thank you. Thank you for confirming that.
So during that testimony you criticized some doctors as delegating diagnosis to a minor.
Do you recall that part of your testimony?
A I don't recall the exact words, but I think there's, I think that approach is accurate.
Q Do you have any examples of a doctor failing to independently diagnose a minor with gender dysphoria before providing care?
A I think it happens all of the time in gender clinics.
Q Why do you think that?
A Well, I have heard that from parents who attended gender clinics in Ohio with their child and they are -- basically the child will just say I was born in the wrong body or I don't like my breasts and they will diagnose them with gender dysphoria and not explore any other issues.
So the person, the child comes in with this sense of what they have and that is accepted by

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the treating physicians. I think if you see what others have said in other clinics, the affidavit of Jamie Reed at the Gender Clinic in Washington, the stories of what happened at the Gender Identity Center in the U.K. and experiences from other parents of children with gender dysphoria, they will also describe the lack of exploration, investigation and psychological counseling that their children go through basically, or fail to have when they are treated.
I mean, if you just look at M.R., one of the plaintiffs, in the hospital with suicidal ideation, I think this is correct. Then a week later gets testosterone. Where is the, where is the biopsychosocial evaluation over months?
Q So based on reports from parents and other news articles, that is your basis for believing that there are minors who are being provided treatment for gender dysphoria without a gender dysphoria diagnosis?
A Well, I think, I think it's more accurate to say that there is inadequate exploration of other co-morbidities and the family dynamics and their social situation and why that child has come to reject their natal sex.

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And that is what happens in many of these clinics. And it's not just, it's not news articles. I mean, the affidavit of Jamie Reed is not a news article. The book Time to Think, which is an exploration of the very thorough evaluation of the Gender Identity Center in the U.K., that is not a news article. Also, reports from parents who, that is very powerful, very meaningful. Some of that was presented in Ohio. We hear that repeatedly.
Why are all these D tran sites coming up? There are many of them. Those people have had experiences where they were basically affirmed with minimal evaluation under two visits.
Q So it's not that you think there is not an evaluation taking place that is leading to an independent diagnosis of gender dysphoria.
It is that you believe that they should be exploring other co-morbidities?
A I think for many cases there is virtually no evaluation.
Q You said that, you know, you found compelling some of the testimony of parents.
Do you find the testimony of the parents in this case about how their children have improved

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to be compelling?
A I didn't see clear evidence that the children were improving.
Q Do you have any firsthand knowledge of a minor being provided with treatment for gender dysphoria without parental consent?
A What do you mean by firsthand knowledge?
Q Well, we talked earlier about how there are circumstances you believe where children can assent to medical treatment and their parents can consent and the provision of that treatment is appropriate based on that informed consent process.
Are you personally aware of a minor receiving treatment for their gender dysphoria where that didn't happen? Are you personally aware of that?
A I know of circumstances in which minors have gotten hormones through Planned Parenthood without parental consent.
Personally knowing them as someone I've taken care of or in my, that lives in Ohio nearby, a neighbor, no. I don't have that kind of personal awareness.
Q You said during your testimony in Ohio that it was immaterial that you had not visited any

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multi-disciplinary clinics in Ohio that were treating pediatric patients.
Do you recall saying that?
A I think so.
Q Do you still believe that to be true that it's immaterial?
A Yeah, I think it does not matter.
Q Okay. So you are comfortable relying on secondhand reports to describe what you believe is happening in that --
A They are very powerful statements by parents who attend with their child at the clinic. So when people say they have a very thorough evaluation, they do not do any of that. They don't do this. They will evaluate the child from a psychological standpoint over months and really address all of their other problems, that does not happen.
I don't believe it happens. I never hear that it happens. With my experience with adults it didn't happen. The parents don't say that it happens. The comments from the extensive evaluation, extensive interviews in Time to Think that I've referenced in my bibliography at the Gender Identity Development Center in the U.K. that has decades more experience than we do in the

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United States, and the affidavit of Jamie Reed.
And I think there will be many coming out along with many, many parental testimonies that describe how minimal the evaluation is.
And we just see the plaintiffs. We don't see extensive evaluation of these children. I mean, look at these sad stories of these children who felt terribly traumatized and they are treating them with hormones.
There was one that was physically and sexually abused by the father. Another one who has two biologic male parents. One of whom is transgender.
You wonder how much of this is pressure on the child to have hormonal treatment. That all needs to be explored. It's just not being done.
Q Dr. Weiss, I'm sorry to cut you off.
MR. SELDIN: Ms. Youngs, we will designate parts of this testimony regarding the medical records of the minor plaintiffs as confidential.
MS. YOUNGS: Certainly.
MR. SELDIN: Ms. Youngs, I believe in Dr. Weiss' declaration he has several paragraphs that we would like those designated as confidential and redacted. I just wanted to flag

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those for the court reporter and for you that that is how we would like to proceed. I assume that is not going to be a problem?
MS. YOUNGS: No.
Q Sorry for that little bit of housekeeping.
Do you think that there are any minors who are properly evaluated for gender dysphoria?
A I hope so.
Q For those minors who are properly evaluated, do you still oppose the treatment for gender dysphoria?
A The hormonal, or what you might call gender-affirming care, yes, because I think it is personally harmful and it does not help. There are safer less harmful interventions like supportive exploratory psychotherapy.
Q So it's not just the evaluations, because even if a minor were appropriately evaluated, thoroughly had a diagnosis of gender dysphoria and you agreed with that, you would still oppose the provision of the treatment of their gender dysphoria either through puberty blockers or hormones, is that correct?
A I would be more clear in stating that a thorough proper evaluation would very, very likely reveal

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factors in the family dynamics, history, sexual abuse, physical trauma, bullying, social isolation, autism spectrum disorder or depression, anxiety.

That all could be addressed and there would be no need for hormonal interventions that would be not helpful and likely harmful.

Q Do you think it's possible that there are minors who do not have any history of trauma, do not have any co-morbid conditions, do not have any social or familial pressure and, nonetheless, had gender dysphoria that would benefit from treatment?

A I think they may benefit from treatment. But the treatment is best hormonal or hormonal interventions.

So even if such children did exist and, of course, in the Dutch study they found not very many of them. They had no other significant psyhosocial issues, they treat them with these hormonal interventions and I don't think they helped them as we will discuss.

Q So you don't believe that there are any minors who had gender dysphoria period, or who have gender dysphoria?

Well, first question, do you believe there

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are any minors who have gender dysphoria?

A Sure.

Q And just gender dysphoria, no co-morbid conditions?

A Well, I think there is an explanation. They may not have obvious co-morbidities. I think with supportive therapy, one would be able to identify reasons why they have rejected their natal sex.

And those children, their dysphoria would likely resolve with that therapy. Because really what the goal is, the goal of treatment for gender dysphoria is not to make the person look like another sex. That is not the goal.

The goal is to resolve the dysphoria, the distress. Right? So if you can resolve the distress with really safe reversible interventions to addressing the biopsychosocial issues, that is what should be done.

Q So you believe there is no way to resolve gender dysphoria through physical changes, is that what I'm hearing you say?

A I don't think physical changes are helpful. This would be the only disorder listed in the DSM for which there is an intervention to modify appearance to fix the mental disorder. It's the

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only one.

Q Let's say I have a three year old child who has no history of trauma, no co-morbid conditions, nothing else going on except for gender dysphoria.

Do you believe that that child is a candidate for medical treatment of their gender dysphoria as they get older?

A So I think the diagnosis of gender dysphoria in a three year old is extraordinarily difficult. What is a three year old's understanding of gender?

If you have had kids you know that boys like to put on mommy's shoes. Girls like to wear, you know, daddy's glasses. I mean, boys have, there is just exploration and children do these things.

They might say they -- are they going to say they don't like their penis. They don't know what gender is at the age of three or four. I think that is frankly absurd, most of that.

And we know, we talk about this later, those kids, that resolves over time in most of those children. If it does not, then they need supportive therapy to help them out.

Q You can't imagine a circumstance in which a child could be accurately diagnosed with gender dysphoria?

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A In the absence of all other psychiatric or family dynamics, social causes, bullying, social isolation, influences of other children, no, I think there are other factors that explain it.

It's a symptom of something else that is going on.

Q You said they should receive supportive therapy.

What do you think the goal of that therapy should be?

A I think to resolve their dysphoria and to address their anxiety, depression. How they feel about themselves. Because it's not -- the child might come and say I really want to be a girl. Okay. Tell me more about that.

This is not conversion therapy. We are talking about just helping them out to feel less distress, less anxiety. What is going on in your life? What's happening at home? Does your dad beat your mom up? Is there alcoholism?

I mean, in the four plaintiffs we see a lot of that going on. None of these four children would have qualified for treatment based upon the only solid evidence that's claimed to be solid, it's really weak, which is the Dutch protocol.

Because the Dutch excluded those people with

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any significant psychosocial issues. All four of the plaintiffs have major psychosocial issues. They would never have been treated per the evidence that we have, which is the Dutch protocol.

Q So earlier you said that, you know, the resolution of the gender dysphoria was not going to come from changing physical characteristics.

So the goal of that supportive exploratory therapy would be to be at peace with one's assigned sex, is that right?

A Correct. I think that being at peace would come not with a focus on you have to accept your sex. Not with something that might be called conversion therapy. But really with exploring everything that is going on in the child's life.

What has happened here? What happened? How were they raised? What is going on? Have you been abused? Have you been -- how safe are you at home? What is going on at school? Do you feel isolated? Do you have friends?

All of those issues. We know that social media for all these girls has a powerful impact on their reasons for all of a sudden now when they are adolescents deciding they want to be boys.

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Q You believe that once all those issues have been fully explored and addressed if they exist, nonetheless, it's not appropriate to provide gender-affirming, to provide treatment of gender dysphoria to minors?

A To provide -- nonetheless, it would not be appropriate to provide hormonal treatment, either puberty blockers, opposite sex hormones, surgical reassignment to minors, correct. That would not be appropriate.

Q If you believe it or not, we started by talking about your testimony in Ohio. I will now turn back to that.

During that testimony in May of 2022 you were still seeing patients, adult patients who you were treating for gender dysphoria, is that right?

A Correct. Those would have been follow-up patients, but not new ones.

Q Was your provision of treatment for gender dysphoria to adults particularly lucrative?

A No.

Q During your testimony in Ohio you compared gender-affirming care to providing weight affirming care with an eating disorder.

Do you recall that part of your testimony in

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Ohio?

A Yes.

Q The term weight affirming care, does that come from somewhere or did you make it up for your testimony?

A I made it up.

Q Okay. You talked about how you provide promotional presentations for Mounjaro. That's, is that Tirzepatide?

A Yes, it is. Does Wendy know how to spell that? It's T-I-R-Z-E-P-A-T-I-D-E.

Q So my understanding is that Mounjaro has some profound weight loss side effects, is that correct?

A Yes.

Q What about a patient who came to you in your practice and said, I'm very overweight. I don't want to go outside because I'm so overweight. I don't want to see my friends because I'm so overweight. I feel like this body is preventing me from participating in society.

Do you think it would be appropriate to treat that person with weight loss drugs?

A So I, as I said, I'm a diplomatic of the American Board of Obesity Medicine. I'm very knowledgeable

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about treating obesity.

Obesity has many adverse consequences. We want to help people as best we can to help them lose weight. There are medications approved for the obesity. Yes, I treat those people.

Most of them are not dissatisfied with their, well, their appearance, but they are really struggling with knee pain, with sleep apnea and other adverse consequences, medical consequences, that derive from their weight. There is medications approved for treating weight.

Mounjaro has been studied. It works really well, but it's not yet approved for weight loss. I would not give Mounjaro to those people. I would offer them other medications which are approved for weight loss by the FDA.

Q I'm not surprised. But you could imagine a patient who said in addition to my knee pain and my sleep apnea, I want to lose weight for that, but I want to look thinner because I want to be thinner in society.

Would that be an okay reason to provide someone with a weight loss drug?

A It would depend on their body mass index.

Q Assuming it was not unsafe for them to lose

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weight?
A If their body mass index is above thirty and that is one of their concerns, sure, I would do that.
My example with the weight affirming intervention was related to a minor, a seventeen year old, who came in and said I'm too fat. And she has anorexia nervosa. Okay? That is a condition which children eat very little. It's usually females. They eat very little. They have no, their menstrual periods stop. They are really underweight, but they still see them, they see themselves as too fat.
They want to have a, they feel bad about their body. They feel they are too fat and so they want to lose weight.
So if they came to a physician and said I'm really fat. I feel bloated. I am really fat. We don't give them medication to lose weight when we as physicians judge them to be underweight.
So we would not do that. We would not affirm their self-diagnosis. Which is what is happening with gender-affirming care. The child says I want hormones. Oh, okay. I want to be the opposite sex. We will take care of that.
You just basically affirm them instead of

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having the physician make the diagnosis. In the case of anorexia you are underweight. You have a psychiatric disorder -- this may not be the way we say it -- but we will try to help you out. Let's talk about it. What's going on? What's going on at home? I will send you to a therapist.
Q So in your weight loss example, the reason that you think that that would be problematic, this prescribing a weight loss medication to a minor who was underweight and also had anorexia would be one, primarily, because it would be unsafe for that person physically to lose weight?
A There are a few reasons. One is that it's not appropriate. The person, the patient made the wrong diagnosis. I make the right diagnosis. I'm the physician. You are underweight. Your problem is not your weight problem. It's something else going on. That is why you are not eating.
The best treatment for you is not a change in your body appearance. It is therapy. We need to figure out what is going on here. Why are you not eating?
Q But to go to the other side, there are circumstances in which someone who had a BMI that was higher than it should be who wanted to lose

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weight and, therefore, change their body and it was not medically contraindicated for them to lose weight. So if their primary reason for wanting a drug was they wanted to lose weight, you could see that that would be acceptable medical practice?
A Yes. Weight loss in people who are obese is medically beneficial. No question.
Q So in your testimony in Ohio you had some criticism for advocacy groups and activist positions.
I believe you said "Most of these societies are heavily influenced and swayed by activists and by physicians who run transgender clinics who have a profit motive."
Does that sound like something you said in your testimony?
A It does.
Q Okay. I think you also said that medical societies have been co-opted by these activists.
Does that sound like something that you said in your testimony?
A It does.
Q Do you think that physicians who treat patients at clinics in academic institutions are profit motivated?

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A Some of them might be. I think the academic centers make money off certainly the surgeries and the patients. I think the physicians themselves who are treating are probably uninformed about the evidence base and how weak it is.
If they really would honestly and objectively look at the evidence base, they would see that they are really harming these children rather than helping them and they would not treat.
Q But it was your experience in providing treatment for gender dysphoria to adults in your private practice that was not particularly lucrative?
A No. I had not many patients. I think there is more -- I was not running a transgender clinic like some physicians. I think there is more money in the surgeries than there is in just prescribing medications.
But I'm not sure I -- if you have a gender clinic and that is mostly what you do, you do not want to lose those patients.
Q So when we were talking earlier about Do No Harm, you said that you didn't include it on your C.V. attached to your declaration because some people think it's a politically motivated organization.
Do you remember that we were talking about

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that?
A Yes.
Q So do you think that being involved in a politically motivated organization is detrimental to credibility?
A I don't think it is politically motivated. I think this organization is really for quality care of patients and to remove ideology from the practice of medicine.
Just do what is best for the patient in front of you. So I don't view it that way. People, you know, unfortunately this whole area of transgender has gotten, outside of medicine and science it has become like a right and left thing and Republican and Democrat.
It should be what is best for the patient. We are talking about children here. It distresses me to see that it's, you know, there's politics in there. There should not be. You can't, you can't stop people from, I mean, from their perceptions. I leave that out because I don't want to have that as a factor. I don't know if I answered your question.
Q No. You said you leave it out. Just to make sure I heard you correctly, you said you leave it off

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your C.V. because you don't want your position as a senior fellow in the organization Do No Harm to be a factor in evaluating your opinions?
A Right. Yeah. I think because of people's perception of Do No Harm. Because their perception would be, I don't know, they might perceive it as a right wing or something like that. It's really what is best for patients.
MR. SELDIN: So Erica, if you could bring up Exhibit 1, please.
Q In Paragraph 40 of your declaration you talk about -- I will wait for it to come up. You probably have it in front of you as well.
A This is in my declaration.
Q Yes. Paragraph 40. I think is on Page 9. You will see that you talk about WPATH as a U.S. based advocacy group.
Do you see that, Dr. Weiss?
A Yes.
Q Then do you see where it says that?
A Yes.
Q Okay. Then if you go to Paragraph 42 -- I'm sorry. Go back to 40.
In Paragraph 40 you say that the WPATH "guidelines have been adopted and endorsed by many

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in the health care field."
Do you see that?
A Yes.
Q So later on in your declaration in Paragraph 70, you say that doctors, like all groups, are susceptible to group think and social contagion.
Do you see that?
A I do.
Q Okay. So there is a list of organizations that have endorsed or approved the treatment of gender dysphoria for minors.
One of them is the American Medical Association which, I assume, you are familiar with?
A Sure. There are about thirty, twenty-five or thirty percent of doctors who are members of that. So the vast majority of doctors are not a member.
Q Do you think that the AMA, the American Medical Association, do you think of that as a politically motivated organization?
A Yes.
Q Do you think that that is an organization that has been overtaken by group think and social contagion?
A Yes.

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Q For the American Academy of Pediatrics, are you familiar with them?
A Yes.
Q Is that an organization that you think is a political advocacy organization?
A Not entirely. It has many political advocacy positions. I think they have adopted viewpoints that are not based upon good evidence in many respects. And gender is one of them.
Q So you think that that, in that respect that is subject, it has been overtaken by group think and social contagion?
A Absolutely.
Q I am going to ask similar questions for another couple organizations.
The American Psychiatric Association, do you consider that a political advocacy organization?
A So I would not use -- I think that it's not a political advocacy organization, but they failed to carefully look at the evidence in the treatment of gender dysphoria.
And so they have been swayed by the position that the transgender activists take in that regard. I think that is a clear way of stating it. So it's not entirely a political advocacy

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group. They have been affected by these activists and their positions fail to address the science and the evidence.
Q Do you feel the same about the American Psychological Association?
A Yes.
Q Do you feel the same way about the American Academy of Family Physicians?
A Yes.
Q And in that same regard, do you consider them as having been overtaken by group think and social contagion?
A Yes.
Q So that I understand, the organization Do No Harm that you belong to, you do not think of that as a political advocacy organization?
A No. It is very difficult for people to be outspoken and take positions that are not so popular especially when there is -- I think one can be labeled a transphobe. And, you know, you can be accused and there is a tendency of threats and violence from the other side.
So I think there are complex reasons why people might take a stance in this regard. Many of these people that are thinking the same are

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coming out and saying the same viewpoint. But group think and social contagion, fear, many people are not members of these groups. They do not want to get involved.
The Endocrine Society, which you will ask me about, a lot of the endocrinologists are not members. My group, most of them don't treat gender. They don't want to treat them. That is, you know, they just are not, they don't buy into the WPATH approach.
Q I take it then that you also think that Do No Harm has not been subjected to the same kind of group think and social contagion as these other groups?
A Correct.
Q Okay.
MR. SELDIN: So I see that it's 12:01 East Coast time. I know it's bright and early in Utah.
Ms. Youngs, how do you feel about taking a break now? Do you want to take a short break and then go another hour before lunch. What would you like to do?
THE WITNESS: We can take a short break and then take another break in other hour.
(OFF RECORD AT 12:01 P.M.)

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(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 12:07 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I want to talk a little bit about your time in independent practice between 2003 and when you left in 2022.
During that time about how many patients did you see per year for all conditions?
A I have to do the math on that. That's -- I don't know the answer. I had thousands and thousands of patients I was seeing over the years, of course. I would see, let's see, I would see fifteen patients a day roughly five days a week.
So that is seventy-five times probably about, including vacation, forty-five weeks. Seventy-five times forty-five.
Q I will get my calculator out. So 3,375 a year. I assume some of these were repeat customers?
A Yes.
Q You would call them something different. Patients that had continuing care with you?
A Yes.
Q So thousands, if not tens of thousands, over the

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course of your almost twenty years in Ohio?
A I was in Ohio since --
Q I asked that poorly. From 2003 to 2022 during your independent practice, you saw thousands of patients?
A Okay. To clarify, my independent practice was stopped when I was employed by Lake Health. That was the end of 2019.
Q Okay.
A So 2003 to 2019 I was independent. Then I was employed. You know, if you do multiply those years times the 3,000 you will get that. That is a lot of patients.
Q And so of that large number, about one hundred during that whole time you treated for gender dysphoria?
A Correct.
Q So a very small part of your overall practice?
A Correct.
Q And I believe in your declaration you describe yourself as the principal physician in northern Ohio offering hormonal treatment for adults with gender dysphoria, is that correct?
A Correct.
Q And that was based on those patients during that

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time?
A It was, that statement derives from not the number of patients I was treating, but that during that period of time up until 2013 the patients who came to me indicated, and the website that was available as a resource as to what physician they could go to for their gender-affirming care, as you put it, was me.
So I was the principal physician on that Be All website. Essentially that is what it was called. That website indicated that I was the doctor in northern Ohio to see for hormonal treatment.
Q That was the basis of that statement, was your inclusion and description?
A Correct.
Q Not the number you were seeing?
A Correct.
MR. SELDIN: Erica, could you pull up Exhibit 3, please.
Q Doctor, Exhibit 3 is a printout from the website called TransFamily. I know you said the website was called Be All, but does this bear any resemblance to the website?
A This is along the same lines. So the doctor there

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that is mentioned, Thomas Murphy, that was the site that, that was the other location that was doing hormonal treatment during that period of time that I was treating.
Q If you look down it says the LGBT Pride Clinic. That was the Pride Clinic that some of your patients didn't want to go to?
A Correct.
Q Why didn't they want to go there?
A I don't know the specifics. That particular patient or a couple of patients who expressed that, they didn't like the way they were treated there. I can't give you details on that.
Q For those hundred people that you treated did you treat other conditions for them other than their gender dysphoria?
A Occasionally. I might do, I might have treated on a few of them high blood pressure. Most of them they were just seeing their primary care provider for their other care.
Q When patients would come to you for treatment for their gender dysphoria, did you ask them to provide a diagnosis prior to you providing care?
A Yes.
Q What did you require?

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A A letter from a therapist.
Q Did you require the therapist to have any particular kind of background or licensure?
A Well, they had to be a licensed therapist.
Q Okay. You didn't require a psychiatrist, for example?
A No.
Q A letter from a therapist. What would you look for in that letter?
A I would look for a statement that that person met criteria for gender identity disorder, which was a DSM criterion or term at that point. And that they were an appropriate candidate for hormonal intervention.
Q You would require a letter from a therapist saying that they had been diagnosed with gender identity disorder in the DSM 4?
A Right.
Q And that they were an appropriate candidate for treatment for their gender dysphoria using hormones, correct?
A Yes.
Q Okay. And did you require anything else in the letter?
A No.

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Q Did someone ever give you a letter and you said this is not enough, I need something different?
A Some patients came without a letter. I asked them for a letter. But they would, all those patients I treated did have some confirmation by a therapist that they were appropriate candidates for treatment.
Q You stopped seeing new patients in 2013, is that correct?
You stopped seeing new patients for the treatment of gender dysphoria in 2013, is that correct?
A Correct.
Q I believe that is right when the DSM 5 came out about that time, is that your recollection?
A Yes.
Q Did you ever treat anyone who had come to you with a letter with gender dysphoria?
A Oh. Based upon the DSM 5, no.
Q Okay.
A You know, they are basically, I mean, the distinction between the two is really not a major distinction. One is they have to have dysphoria. They would like -- the goal has been to demythologize this disorder.

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So there is movement towards changing the terminology. But in gender dysphoria they have to have significant distress associated with the gender identity.

In either case, the people who would come to me wanted hormonal treatment. Whatever you called it, gender identity, gender dysphoria, they wanted hormonal treatment to modify their appearance so they would feel better.

Q Did the move from the DSM 4 to the DSM 5 have any bearing on your decision to stop seeing new patients?

A No, it did not.

Q Did you do any independent evaluation of the diagnosis for, at the time, gender identity disorder in your patients?

A Yes, I would question what their story was on their feelings about their gender. When did it start? What else was going on?

I was not treating depression, anxiety. I did not address, you know, their childhood upbringing and whether they were abused sexually and those kinds of things, you know.

My hope was that the therapist would be providing that.

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Q Did you have a particular evaluation or set of questions or was this more general patient history?

A There would be questions. I would ask about the onset of their symptoms. I would go through the whole history of when they started to reject their natal sex.

It kind of went -- it was open with no, you know, it was with open-ended questions so they can talk to me about that like a therapist might but, you know, in a forty-five minute session. I would explore again on the next visit how they were doing emotionally.

Q So someone comes to your office. They have a letter. You have an initial appointment of forty-five minutes.

At the end of that appointment would you prescribe any medical treatment or would you require them to come back?

A In most cases I would prescribe in these adults. Occasionally I would ask them to come back. One person who was eighteen who had a letter, but I was really uncomfortable, there was a lot of stuff going on with her. She was going off to college. She wanted to have -- and I would not, I would not have been able to evaluate her for quite some time after.

So I said I don't feel comfortable giving you hormones at this time. I think you need to come back. She was one I declined to prescribe. I didn't really feel that she was adequately evaluated.

Q Did that patient come back to you for treatment or did you see that patient?

A I did not see her again. That was around probably 2012, 2013.

Q So right when you were going to stop seeing new patients anyway?

A Yes.

Q And were there any other patients who you did not treat in a similar way based on your assessment?

A There were a few people that I wanted to have come back and discuss further. But most people I would initiate therapy on the first or second visit in these adults.

Q Were there any patients -- what was the youngest patient who you prescribed hormones or other medication to?

A Probably twenty-one, twenty-two.

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Q So you saw one potential patient who was eighteen and you ended up not providing treatment.

Then the next youngest patient you actually prescribed to you believe was twenty-one or twenty-two, is that accurate?

A Yes.

Q For the folks that came to you with a letter, were most of them just starting hormones or had they been getting hormones from someone else?

A Most of them had not been on any hormones at all.

Q So you would have been starting them on hormonal treatment?

A Yes.

Q Of the hundred patients that you saw, what percentage do you think you were starting new as opposed to continuing someone else's prescriptions?

A Probably ninety-five percent.

Q Typically what medications would you prescribe?

A So I would give testosterone to females. I would give spironolactone, which blocks androgen action. I would give estrogen along with that to those males, biologic males. So biologic males would get spironolactone and estrogen. It was Estradiol usually.

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And biologic females would get testosterone --
Q Did you ever refer patients for surgery?
A I had patients that had surgery. I did not direct them to a surgeon. In the patients that sought out surgeons on their own some went to Thailand. Some went to a surgeon at Metro. Some went elsewhere for surgery for mastectomy, genital reconstruction.
In terms of referring a person, directing them to a particular surgeon, patients would often seek those surgeons out on their own.
Q Did you ever write letters for them to bring to their surgeons?
A I probably did. I have been seeing this person for so long and they have been on this therapy. Yes.
Q Do you recall of the hundred patients about how many of those letters you may have written?
A Maybe five. Something like that.
Q Earlier we talked about which of your patients had had a hysterectomy or had gonads removed.
In terms of the timeline of care, do you think most, maybe ninety-five percent of the people who came to you had not been on hormones

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before, right?
A Correct.
Q So had any of your patients when they started care with you already had some kind of surgery to treat their gender dysphoria?
A No. No one.
Q Okay. They would have had those surgeries while you were treating them, right?
A Let me clarify that. There was one person who had the orchidectomy who I saw last year who had had his treatment, all of his treatment, hormonal and other stuff, before he came to me.
I saw him because the office didn't know what he was coming from. He was one who had the orchidectomy in Philadelphia after being evaluated there.
When he came to me as a new patient, he wanted testosterone. He was one of the two who had an orchidectomy that regretted it. Otherwise, no one else had had surgery before they came to me.
Q So then I guess of the ninety-nine remaining patients, how many of them during the course of your treatment of them do you think had surgery of any kind? Then we will talk about which kind.

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A Probably about maybe fifteen or so. Fifteen to twenty. Something like that.
Q Had had surgery of any kind?
A Yes.
Q Of those fifteen to twenty do you recall which surgeries they had?
A Most of them had mastectomies. Bilateral mastectomies.
Q You said most of those fifteen to twenty. Do you have an estimate of --
A So I would say -- yeah. So maybe five or so had other surgeries besides mastectomies. So general reconstruction or augmentation, mammaplasty. That kind of thing. Breast implants.
Q Did you follow any guidelines or standards of care in your practice regarding the treatment of gender dysphoria?
A During that period of time I was following Endocrine Society guidelines.
Q Do you recall which ones?
A Well, it would not have been 2017 because I stopped in 2013. So it was 2009.
Q Okay. And then did you use the WPATH guidelines at all?
A No.

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Q So we talked earlier about your fellowship with those twelve patients that you had seen with the supervising physician.
Then after that you think the next patient that you saw would have been in 2003 when you started your independent practice.
How did it come to be that you were providing treatment for gender dysphoria in 2003?
A Well, I wanted to help people. People called my office. I wanted to relieve their distress and do what is best.
I mean, the goal, the reason I went into medicine, I like to help patients. So they would call my office. And I thought -- and there was no one else treating in the area during that time or they chose not to go to Metro. There were closer to my office or they were unhappy with Cleveland Metro.
And so I said okay. I will treat you. I looked at the Endocrine Society guidelines. I did what I thought was best for them at the time.
Q In terms of how you then went from no patients to one hundred over the course of your time in independent practice, was that primarily through word of mouth and your presence on that website?

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A Yes.
Q Okay. Did you independently advertise that you provided these services? Or no?
A No.
Q What prompted you to stop seeing new patients in 2013 for the treatment of gender dysphoria?
A Well, I had a gradual realization that I was really not helping people. Yes, they had these physical changes, but they still had a lot of psychiatric stuff going on.
Lots of them had anxiety and distress and depression and sleep problems. They felt bad. They were -- I was urging them to follow up more regularly with a therapist. And there was an increasing number coming out. I should not say -- I should say calling the office to be seen.
I would give priority over the years to get those people in promptly to the practice even though there was a delay, you know, my next opening might be three months and I would try to find a spot for the people with gender dysphoria. I felt then that my other patients were suffering.
So the combination of that and what I was doing was not helpful and my other patients were losing out. I said that's okay. I'm not going to

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be seeing new people. I will take care of the patients that I have. Those other patients can go down to Metro.
Eventually other centers emerged. University Hospitals started providing care. Cleveland Clinic opened up a transgender clinic. They promote theirs. Both of them are promoting their practices.
Q So I think in your declaration you said you realized the lack of benefits and the potential harm these treatments caused, is that correct?
MS. YOUNGS: Can you point to where that is?
Q Yes.
MR. SELDIN: Erica, can you bring up Exhibit 1.
Q In Paragraph 8 you will see in the last two or three lines, "I stopped seeing new patients with gender incongruence when I realized the lack of benefit and the potential harm these treatments caused."
Did I read that correctly?
A Yes.
Q Okay. Great. And how were you measuring or observing this lack of benefit?

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A It was really just from an open dialogue discussion with the patients when they come back. How are they doing? Asking what their emotional state is. Mood. Are they feeling down or sad? Have they lost pleasure in things? You know, are they nervous or anxious a lot? How is their sleep? So on.
Q Did you encourage those folks to seek other additional medical treatment when you were here about this?
A Yes. Therapists.
Q In the same paragraph you talk about the potential harm.
What do you mean by potential harm?
A Well, I think I detail that in my declaration.
Q I mean, specifically with the adult patients that you were treating from 2003 to 2013, what potential harm were you talking about?
A Well, so given that the lack of long-term evidence of benefit, even in adults, and the potential harm with these opposite sex hormone treatments, I didn't -- and I was not apparently achieving the goal of relieving their distress, and potentially these were -- giving estrogen to a man might be harmful.

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There is thrombotic risk with it. You know, clots in the veins and arteries. What harm am I doing by giving testosterone to a female? So there were a lot of unknowns and potential harms.
Q You said potential harms. Did anything bad happen to one of your patients in that regard, or were you concerned it might in the future?
A There were some concerns with some treatment. There is some evidence that there is worsening in a condition called sleep apnea.
There was a person I was giving -- a biologic female I was giving testosterone to. That person's sleep apnea got worse. That was a potential harm. That is one that comes to mind.
The others might have been apparent with longer follow-up. Not that I saw.
Q Did you treat any patients from 2003 to 2022? Did you have any that you saw that whole time?
A With gender dysphoria?
Q Yes.
A From 2003 to 2013 was a period of ten years of when I was treating the hundred patients.
Q I'm asking you a different question. Is there any patient who you treated for gender dysphoria that you saw in the first, you know, one or two years

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of your practice who you then treated for the next twenty years?
A Oh, yes. There is one that comes to mind. There may have been others.
Q So you think you had one patient that you treated for possibly that whole range of time?
A Yes.
Q Okay.
A Probably longer actually. Maybe I treated him even before. Well, at least during that period of time.
Q Over those twenty years did you see any of these potential harms come to fruition?
A Yes. That person with the perhaps worsening sleep apnea given testosterone, yes.
Q So that sleep apnea person is the same person?
A No. That is a different person. That was not twenty years. That person I treated for probably, actually I was seeing that person even in 2022. That person, that was a follow-up person. That person I probably treated for ten years.
Q What I'm trying to get at is you had at least one patient that you saw for twenty years and other patients that you saw for ten or more.
Did you see any of these sort of long-term

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potential harms come to fruition in those patients?
MS. YOUNGS: For clarity, that's gender dysphoria?
Q Yes. Just for gender dysphoria treatment.
A I would say no.
Q You also said in Paragraph 8, the last sentence, "I also found that these persons had minimal psychological evaluation for their psychic distress."
Did I read that correctly?
A You did.
Q So when you say that do you mean -- what do you mean?
Do you mean prior to them initiating treatment with you?
A Prior and even after.
Q But at the time that you provided treatment you thought their evaluation had been sufficient for you to start them on hormones?
A That is what I thought at the time. In retrospect I would say no, that it was inaccurate.
Q Today what would you consider an appropriate psychological evaluation for an adult prior to providing treatment for gender dysphoria?

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A I would say long-term exploratory supportive psychotherapy.
Q How long-term?
A As long as necessary to really sort out and help the person with their psychic distress. It varies with the individual. No time limit.
Q I want to talk about your current role at Intermountain Health.
What do you do there?
A I'm an endocrinologist seeing adults and adolescents with endocrine, diabetes, metabolic disorders.
And because I'm board certified in internal medicine I will address internal medicine related issues outside of the purview of an endocrinologist.
Q What are those things that you see that are outside of the purview of an endocrinologist?
A It might be hypertension. It might be high blood pressure. It might be fungal infections. It might be kidney stone prevention. Things like that.
Q Is that because folks come to you for that? Or is it, hey, Doctor, I know I'm here for my diabetes, but I've also got this foot thing?

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A Yes. It's usually the latter.
Q Not to put too fine a point on it. I'm not saying that's what I say to my doctor, but it has been known to happen?
A Absolutely. No. I like to look at the whole picture. Oh, what's going on? Okay. You're having problems with hives. Has your doctor tried this? You might consider that. Here, I will send him a note.
How about your high cholesterol? Well, I know I am asked to address your thyroid, but here is a medication for your cholesterol you might try because these others didn't work.
Q You said you treat adolescents. Do you see anyone under eighteen?
A Yes.
Q What percent is your practice of people under eighteen?
A About five percent.
Q How old are they generally?
A Sixteen. Seventeen.
Q Do you see anyone fifteen or younger?
A Sure. I'm open to that. So my practice is open. I only really started seeing people February 1. So but the office knows I will see those people.

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Q Okay. So you will see -- do you see anyone who has not gone through puberty?
A Yes. In my practice in Ohio I was seeing five years Olds.
Q Okay.
A Not for gender dysphoria.
Q Okay. So in Ohio your overall practice where we talked about the several thousand patients, what percentage of that was people under eighteen?
A Less than one percent during the time I was independent and after. When I saw children it was before 2003.
Now in Utah I'm seeing children again because there is really no practitioners who are seeing minors in the area so I'm providing that care.
Q You are not a pediatric endocrinologist?
A No. I had training in pediatric endocrinology as part of my fellowship. I have knowledge in that area.
I will treat not all disorders that pediatric endocrinologists treat, but many of them for those people who I'm seeing now in Utah.
Q Would it be fair to say then that your practice includes people under eighteen largely because of an insufficient number of pediatric

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endocrinologists in the area?
A Correct.
Q Okay. So rather than them having no care they see you?
A Or they have to travel far.
Q Just to be clear, none of your patients are treating for gender dysphoria?
A Correct.
Q Do you have any patients who are transgender?
A I have a couple of questioning patients. They are non-binary or they are questioning.
Q And have they come to you for any kind of hormonal treatment for gender dysphoria?
A No.
Q How many of those patients do you think you have?
A Two.
Q Okay. Out of how many total patients?
A I have to do the math again.
Q I know you have been seeing patients since February.
A February. Yes.
Q Is it a couple hundred? Is it dozens? How many people --
A A few hundred.
Q Do you prescribe puberty blockers in your current

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role?
A No.
Q Do you prescribe testosterone or estrogen in your current role for anything?
A Testosterone, yes. Estrogen I leave to the OB/GYN doctors.
Q What do you prescribe testosterone for in your current role?
A People who have low testosterone. Men, biologic males who are low on testosterone.
Q So I understand, you provide testosterone prescriptions to patients who were assigned male at birth?
A Yes. Biologic males and they have -- their testosterone was found to be low at some point. So I am replacing their deficiency in testosterone.
Q The two non-binary or questioning patients that you have, have you told them about your perspective on the treatment of gender dysphoria?
A No. Because it was not appropriate for what I was seeing them for.
Q What were you seeing them for?
A A thyroid problem.
Q Are those adults or are they under eighteen, those

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two patients?
A I think one of them was seventeen. The other one was twenty or twenty-one.
Q Does Intermountain have a pediatric endocrinology practice?
A They do.
Q At the location where you work or is it somewhere else?
A No. Up north. It's three or four hours away.
Q So I should take a step back. Your employer Intermountain has multiple locations in Utah?
A Yes. They are in multiple states, too.
Q Which location do you work at?
A I'm in St. George, Utah. It's the southwest part of the state.
Q What is the nearest -- what is the next closest office for Intermountain?
A Gee, I don't know. I think probably in Ogden or Logan. That's something, like, four hours away.
Q All right. So Intermountain has a pediatric endocrinology practice, but it's not in st. George. It's some distance from you?
A Correct.
Q And in the pediatric endocrinology practice at Intermountain's other locations, do you know if

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they treat early onset puberty?
A Central precocious puberty, it's very likely I'm sure.
Q Delayed puberty, would they treat that?
A Very likely.
Q Turner Syndrome?
A Sure.
Q And how about growth hormone deficiency or short stature?
A Yes.
Q Would you agree that those are conditions that should be treated by a pediatric endocrinologist when available?
A Yes.
Q Dr. Weiss, this is a page from Exhibit 17. This is from Intermountain called Additional Resources.
MR. SELDIN: Erica, could you scroll down a little bit for the text.
Q Have you seen this website page before?
A I don't recall.
Q You will see -- in the Transgender Care Section do you see where I am in the middle of the page?
A Yes.
Q Do you see that it links to the UCSF Primary Care Guidelines for Transgender Individuals?

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A Yes.
Q Do you see a little bit down it links to WPATH? Do you see that?
A Yes.
Q It also links to the Endocrine Society guidelines?
A Yes.
Q As well as the Report for the U.S. Transgender Survey in 2015?
A Yes.
Q Have you spoken to your employer about their link to these resources?
A No.
Q Do you think it is a mistake they link to these resources?
A Yes.
Q Do you think it's ill advised?
A Yes.
Q If you scroll all of the way down you will see under Referrals it says, "Please direct any questions or comments to Associate Medical Director of LGBTQ Health, Matt Bryan." Then there is an email.
Do you see that?
A Yes.
Q Have you ever reached out to Matt Bryan?

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A No.
Q Have you spoken to him? Do you know who he is?
A I'm not sure whether he is -- there's a social worker who was hired to run some of their things. That may be him. I've not spoken to him. I see no reason to.
Q Do you think it would be relevant to tell him that you think it's a mistake to link to these resources?
A Absolutely not.
Q Why not?
A Because I think most people have a viewpoint that is fairly -- in this area they are not open minded. They are not interested in seeing the evidence.
They made their -- they have confirmation bias. So by confirmation bias I mean that anything that they see that challenges their strongly held belief, they are not interested in seeing or they dismiss.
And if I brought this up, they would call me transphobic. They are not interested in seeing what is best for them based upon the evidence because they made their decision. They hire people based on their viewpoint in promoting the

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WPATH approach.
All these resources are affected by activists and it's not scientifically based. It's not based upon really good evidence. It's based upon their conviction that this is the way to go.
As I have stated in my declaration, I think the evidence and the science does not support hormonal interventions for minors, nor does it support it for adults.
They give you these resources that this is the way to go.
Q Just to circle back to something we talked about earlier. Not withstanding your feelings about the evidence, you don't support banning care for gender dysphoria in adults?
A No, not at all. If adults want to do it, that is up to them. They are free to do so.
MR. SELDIN: Can you pull up Exhibit 18, please, Erica.
Q You will see this is another page from Intermountain on the telehealth services offered to LGBTQ+ Patient Care.
Do you see that?
A Yes.
Q Have you seen this page before?

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A I don't think so.
Q Okay. You will see on this page there are several sessions on various topics that are offered.
Did you attend any of these?
A No.
Q Okay. And I take it you didn't present at any of these?
A That would not be taken well if I did.
Q And I take it that is because of your position on this care?
A Because of what I previously stated, I think this is not people -- they throw out science and thinking when they have their strongly held beliefs and they fail to see the evidence that kind of challenges that belief.
Q There is an expert clinical panel listed here at the bottom. There are several various names of practitioners.
Have you spoken to any of these practitioners?
A No. This is -- the second person, Ejay Jack, he is the social worker who I think runs the transgender program. You know, I have not spoken to him.
Q You don't know any of the other providers that are

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there either?
A No.
MR. SELDIN: Can you scroll up to the top again, Erica.
Q Dr. Weiss, you will see under LGBTQ+ Patient Care a block of text. I'm going to skip straight to the acronym. It says, "LGBTQ individuals often experience disparities in health care access and outcomes due to several factors, including social issues such as bias and prejudice, marginalizing laws and policies, and a lack of LGBTQ+ friendly practices in all areas of care."
Did I read that correctly?
A Yes.
Q Do you agree with that statement?
A I think we are talking mostly about T here now. Not all of the other stuff, all of the other letters or the plus. I'm not sure what the plus is.
But I think there is truth to that statement. But I think we are focusing on transgender dysphoria issues right now.
Q You would generally agree with that statement?
A Yes.
Q You would generally agree with that statement as

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to lesbian, gay, bisexual and transgender people?
A Yes.
Q Would you consider Senate Enrolled Act 480 to be such a marginalizing law or policy?
A Not at all.
Q Why not?
A I think it's a policy that aims to protect minors from harmful interventions, such as one might have laws to protect or exclude minors from, you know, we don't let thirteen year olds drive.
We don't want them to smoke, to use tobacco. We don't want them to use alcohol. It's along the same lines, but it's protecting them.
The medical community has failed to do so and has continued to promote harmful interventions. And they are not stopping. It's just increasing for whatever reason even though in our countries they have realized these are harmful interventions. We need to hold off here. We need to stop. Let's go back. Let's see what is the best approach to treating minors with gender dysphoria.
So it's really the state trying to protect minors because these other institutions, which ought to have done that, are not. They are just

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increasing their number of children they are harming.
Q Dr. Weiss, you have referred to other countries and what they are doing.
MR. SELDIN: Erica, can you pull up Exhibit 26, please.
A Florida is not another country.
Q We will get there.
A Okay.
Q Dr. Weiss, this is an Amicus brief that Do No Harm, your organization, filed in a case called Dekker v. Weida.
Do you see the document that I'm looking at?
A I do.
Q Have you seen this brief before?
A No.
Q Did you work on this brief?
A No.
Q Were you asked about this brief?
A No.
Q And were you aware that Do No Harm filed this brief?
A No.
Q Okay.
MR. SELDIN: So Erica, if you can scroll

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to Page 4, please, Page 4 of the text.
Q Dr. Weiss, I'm in the middle of the page. You will see, "Florida is not alone."
A Yes.
Q It says, "Just last year, Sweden's public-health body barred puberty blockers for adolescents in all but 'exceptional cases' because 'the efficacy and safety, benefits and risks of treatment are not proven'."
Did I read that correctly?
A You did.
Q So in Sweden it's not that the puberty blockers are banned entirely. It's that they are restricted, is that right?
A I would like to look at the Swedish statement so that I don't quote it out of context. That is one of the references in my bibliography.
Q Do you have a reason to believe that Do No Harm would mischaracterize Sweden's approach here?
A No.
Q Okay. And so to the best of your recollection, puberty blockers are still being provided in Sweden under specific requirements, right?
A I think I would still want to look at the wording of the Swedish document.

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MS. YOUNGS: Can we pull up the originals as exhibits?
MR. SELDIN: We will do a little more on this first. I think we will probably get there.
MS. YOUNGS: Okay.
A Sweden is 102.
Q Let's look at 102 in your declaration.
MR. SELDIN: Erica, can you pull up Exhibit 1, Paragraph 102.
Q We will probably come back to this exhibit as well.
A I have it.
Q Great. Are you looking at Paragraph 132?
MS. YOUNGS: 132?
Q Dr. Weiss, where are you?
A I am sorry. I pulled up the original hard copy of the reference 102 in my declaration. I do have that.
Q Dr. Weiss, do you have other documents in front of you other than your declaration?
A I just have all my references. That's all. They are all on my declaration.
Q You have the full text of all of the items that are listed in your bibliography?
A Yes.

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MR. SELDIN: Ms. Youngs, could we get copies of all those?
MS. YOUNGS: Yes.
MR. SELDIN: The witness is relying on them in front of him in his deposition. I think we are entitled to see them.
MS. YOUNGS: Okay. I don't think he is using them right now. I think he has them printed out in a pile.
MR. SELDIN: He had them printed out and he pulled up the original.
A I have it for the paper copy because that is easier to look at that for the reference.
MR. SELDIN: We will have to take a housekeeping pause here. If the witness has hard copy documents and he is using them in the deposition I believe that we are entitled to receive them. Is that a problem?
MS. YOUNGS: It's not a problem. It will take a while.
A This is the first document I've used a hard copy with since we have spoken.
Q Do you have other hard copies on your desk?
A On my desk, but I've not referred to them at all. They are just in a pile in the corner.

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MR. SELDIN: Maybe at a break we can sort this out, Ms. Youngs. We might need copies of those.
MS. YOUNGS: I presume it's just everything that is in the bibliography.
A It is.
MR. SELDIN: I have no reason to doubt that. I think we are entitled to see them.
MS. YOUNGS: Well, I don't know that we can produce them at this moment.
MR. SELDIN: I don't need them today. I will need them eventually.
MS. YOUNGS: Okay.
MR. SELDIN: I suspect with FedEx from Utah to here we will get them next week or the doctor can scan them.
Q Let's start from the beginning. Dr. Weiss, at the beginning of your deposition I asked you what you had in front of you. You confirmed you had your declaration, which included your C.V., is that right?
A Right.
Q Okay. And you also have hard copies of the references in your bibliography on your desk, is that right?

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A Well, it is on my desk. It would be in front of me. It's there.
Q Are there any other documents related to this case that are on your desk whether you have touched them or not?
A There is this book.
Q Okay. Have you referred to that book?
A During this deposition, no.
Q Okay. All right. Anything else on your desk related to this case or this subject matter that we have not discussed?
A No.
Q Okay.
MR. SELDIN: So Ms. Youngs, I would like to request that we have the -- we don't need the book, but the title of the book, and then copies of whatever is in front of him as they sit on his desk. We don't need them today, but we will need them.
A The title of the book is in one of my references.
Q Great.
MS. YOUNGS: Okay.
MR. SELDIN: We have been going about an hour. I'm just going to finish up this line. Then we will go for lunch if that works for you?

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MS. YOUNGS: That would be great. Do you have any indication on how long we will be going today?
MR. SELDIN: I think we might go the full seven hours.
MS. YOUNGS: Okay.
MR. SELDIN: I will know more after the break for lunch. Let's finish this line real quick. Actually, you know what, now is probably a good time to break.
Does that work for you?
MS. YOUNGS: Yes.
(OFF RECORD AT 1:05 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 1:45 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I want to ask you about your position as a senior fellow at Do No Harm. We were talking about that a little earlier today.
Do you receive any compensation as part of being a senior fellow?
A Yes.
Q What is that compensation?

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A An hourly rate.
Q What is that hourly rate?
A I think $325.
Q What activities are you compensated for?
A For my efforts to prepare expert testimony for those legislative bodies.
Q You became a senior fellow in March 2023, this year?
A Approximately early this year.
Q So we will talk through the testimonies since then. But fair to say you believe Do No Harm would have compensated you for your time involved in some of that?
A Yes.
Q Do you receive compensation from Do No Harm for any other activities?
A No.
Q Do you know who provides the funding for Do No Harm?
A No.
Q Have you discussed this case with anyone at Do No Harm?
A No.
Q Have you discussed your declaration with anyone at Do No Harm?

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A No.
Q Is Do No Harm aware that you are an expert in this case?
A Part of my knowledge has been what has accrued over the years and more recently, which was writing testimony for my statement in Ohio and subsequently for the statements in affiliation with Do No Harm.
Q I'm sorry. I must have misspoken.
Is Do No Harm aware that the state of Indiana has employed you as an expert in this particular case?
A I do not think so.
Q All right. We talked earlier about your testimony in Ohio. That was before you became a senior fellow at Do No Harm, correct?
A Correct.
Q I think earlier you said that you testified in Utah, is that correct?
A Yes.
Q Dr. Weiss, this Exhibit 10 is the minutes of the House Health and Human Services Standing Committee. It is a long agenda for Tuesday, January 4, 2023.
Is that the date that you testified in Utah?

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A I don't remember.
Q On Page 2 you will see midway through there is an Agenda Item 3.1st Sub S.B. 16, Transgender Medical Treatments and Procedures Amendments. Do you see that, Dr. Weiss?
A I do.
Q Do you see the second name is "Dr. Daniel Weiss, M.D., Do No Harm, spoke in favor to the bill"?
A Yes.
Q Based on this agenda, is it fair to say you spoke on or about January 24.
A Yes. My recollection of when I became a senior fellow with Do No Harm was off a bit. My recollection of when I started with Do No Harm, I could not recall with certainty and it was obviously before this date of January of this year.
Q So you would think then that sometime in 2022 you became affiliated with Do No Harm?
A Must have been. Yeah.
Q And who asked you to testify at that hearing in Utah?
A I don't recall.
Q Were you compensated for your testimony at that hearing?

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A If I was with Do No Harm, yes.
Q And did you have to travel to testify at that hearing?
A No.
Q Who wrote your remarks for that hearing?
A Daniel Weiss. Me.
Q Did anyone review them other than your wife maybe for grammar?
A No.
Q And would anyone at Do No Harm ever have read them?
A Only after they were submitted.
Q I think you mentioned earlier that you testified in Montana, is that correct?
A I believe that is correct.
MR. SELDIN: Erica, could you pull up Exhibit 22.
Q These are minutes from the Montana Senate. If you will scroll down to Page 3, the third from the bottom you will see your name, Dr. Daniel Weiss, Do No Harm. Do you see that?
A Yes.
Q Would this have been the January 27, 2023 hearing that you testified at in Montana?

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A Correct.
Q Who asked you to testify at that hearing?
A Likely Do No Harm.
Q Were you compensated for your testimony at that hearing?
A Yes.
Q Did you have to travel?
A No.
Q Did you testify live or was it just written remarks?
A I don't remember.
Q Did you write your remarks?
A I did.
Q Did anyone other than your wife review them?
A No.
Q Would Do No Harm have read them before you gave them?
A No.
Q Would they have read them after?
A I'm sure after they were submitted.
Q Then we will pull up Exhibit 21. Dr. Weiss, in addition to your testimony in 2022 did you testify again this year in support of a bill to ban care?
A For minors with gender dysphoria?

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Q Yes.
A Can you clarify your question?
Q Sure. I have up here remarks that appear to be from you. We will scroll down to the end and it ends with, "Please help protect the children of Ohio" on Page 4 of the PDF. You will see right above your signature, Dr. Weiss, it says "Please protect the children of Ohio" and your name and the date.
A Yes.
Q Was this written testimony in support of House Bill 68 in Ohio?
A I don't recall the number of the House bill. There was the Safe Act Save Adolescents from Experimentation Act this year. I submitted written testimony in support of that.
Q Did you testify live or provide oral remarks?
A No. It was only written testimony.
Q Were you compensated for providing that written testimony?
A I don't recall.
Q If you had been, would anyone other than Do No Harm have compensated you?
A No.
Q Then did you write these remarks yourself?

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A I did.
Q Would anyone have reviewed them other than your wife?
A No.
MR. SELDIN: Erica, take us to Exhibit 24, please.
Q Do you recognize this document?
A Yes.
Q Is this your testimony in North Dakota in support of House Bill 1254?
A Yes.
Q Do you recall whether you provided these remarks live or just submitted them in written form?
A I believe it was just submitted in written form.
MR. SELDIN: Erica, could you pull up Exhibit 25, please.
Q Dr. Weiss, on Page 6 of this document all of the way at the bottom you will see there is a line that says 3/28, 11:30 a.m. and then Daniel Weiss.
A It must have been live.
Q Okay. I will represent the link is to your written testimony. I was not sure if you testified or not.
A I don't remember. To my surprise, if you have a video then it was live.

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Q This was not a gotcha. I was really asking for the answer on this one. It was not a trap.
You provided testimony in support of this bill in North Dakota, right?
A Yes.
Q And were you compensated for providing this testimony?
A I believe so, yes.
Q Would that have been by Do No Harm?
A Yes.
Q And then, again, did you write these remarks?
A I did.
Q Yourself?
A Yes.
Q Okay. I believe that we have talked about your testimony in Ohio twice.
Dr. Weiss, when I say testimony, I mean live or written remarks. You have provided testimony in some form in support of bills that would ban the treatment of gender dysphoria in minors in Ohio, Utah, North Dakota, Montana, and earlier we spoke about your letter to the Florida Board of Medicine.
Does that all sound correct to you?
A That treatment we are talking about is -- sorry.

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I think Ms. Youngs is trying to jump in.
MS. YOUNGS: Dr. Weiss was just trying to clarify that by treatment you mean certain, what procedure -- can you say what you mean? Dr. Weiss is not against treatment.
Q For all of these bills, Dr. Weiss, that we have been talking about, these are all bills that would ban medical care that treated gender dysphoria in minors. Is that your understanding as well?
A These bills would ban interventions that were medications, hormonal interventions and surgery as proposed treatment for gender dysphoria.
Not any treatment. Not medical care. But only treatment that was intended to improve the dysphoria and that treatment that would be banned would be hormonal interventions and surgery.
Q In the states in which you provided such testimony were Ohio, Utah, North Dakota and Montana, is that correct?
A Sounds correct.
Q You also submitted the letter we spoke about to the Florida Board of Medicine, is that correct?
A That was correct. That was an email.
Q Right. And earlier when we were chatting I think you had mentioned that you thought you had

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testified in Indiana and Wyoming.
Did you testify in those places?
A I believe so.
Q Okay. Do you recall anything about your testimony in Wyoming?
A Just it was similar written testimony. I think that was live in Wyoming. I'm pretty sure it was live. I'm pretty sure.
Q Do you recall when?
A Sometime this year. This spring.
Q Did Do No Harm compensate you for that testimony?
A I believe so.
Q Did you testify in support of Senate Enrolled Act 480 in Indiana?
A There was a bill in Indiana that I did support. I submitted written testimony. It was not in person. I don't remember the bill number. It had to do with gender dysphoria care in minors.
Q Do you recall when that was?
A I think it was sometime this spring.
Q You don't think it was Senate Enrolled Act 480?
A I don't know. I don't recall.
Q Are there any other states where you provided testimony on this or a similar topic that we have not talked about?

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A Not that I recall.
Q Dr. Weiss, do you keep a running list anywhere of the places in which you have provided this kind of testimony?
A Yeah. I have a list of folders that have testimony that I submitted. I have one for the different states.
Q That would be the list that you would refer to in trying to determine where all you have testified?
A That would be the closest to a list, correct.
Q Roughly do you know how much in total Do No Harm has compensated you for all of your legislative testimony?
A Maybe about $8,000.
Q Earlier we talked about why you don't include Do No Harm on your C.V. as one of your affiliations.
I'm curious why you don't include any of your legislative testimony on there either?
MS. YOUNGS: Can you clarify? Don't include what where?
A I don't understand.
Q The legislative testimony that we just spoke about, that does not appear on your C.V., is that

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correct?
A Correct. I don't see any reason to mention that on a C.V.
MR. SELDIN: Erica, could you pull up Exhibit 26.
Q We will look at Page 2 of the document or Page 8 of the PDF. If you go to 8 of 25, that is where it is.
Dr. Weiss, do you see that?
A Yes.
Q Do you see where I am at the top? I will just read this.
"Amicus Do No Harm is a diverse group of physicians, health care professionals, medical students, patients, and policymakers whose goal is to protect health care from a radical, divisive, and discriminatory ideology."
A Yes.
Q Did I read it correctly?
A Yes.
Q And what is that ideology, do you know?
A Well, I would consult the Do No Harm website in that regard. My focus is on gender dysphoria.
MR. SELDIN: Erica, could you please pull up Exhibit 28.

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Q This is from the Do No Harm website. It says, "Protecting Minors from Gender Ideology."
Is that the ideology that you believe is being referenced there?
A Yes.
MR. SELDIN: Erica, can you please pull up Exhibit 27.
Q Dr. Weiss, these are the FAQs from Do No Harm's website. You will see that the first two are "What is Critical Race Theory?" and "What is anti-racism?"
Do you see those two?
A Yes.
Q Do you do any work for Do No Harm regarding critical race theory and anti-racism?
A No.
Q So your sole focus in your work with Do No Harm is gender ideology?
A Yes.
Q Are you on social media?
A No.
Q No Twitter? No Facebook?
A None at all. In fact, I eliminated a Facebook account about a decade ago. Never used Twitter. They are dangerous.

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Q Have you given any media interviews of any kind regarding your work with Do No Harm?
A No.
Q Have you spoken at any conferences?
A No. On this topic?
Q On this topic?
A No.
MR. SELDIN: Erica, can you pull up Exhibit 1.
Q I'm going to look at Paragraph 6 of your declaration on Page 2.
Let me know if you can see that?
A Yes.
Q Do you see you say, "I have been a member of the Endocrine Society since 1990 but I canceled my membership in 2022 after the repeated failure to respond to my concerns about its promotion of hormonal interventions in children with possible gender-related distress."
Did I read that correctly?
A Yes.
Q When you say "repeated failure to respond to my concerns," how did you indicate your concerns to the Endocrine Society?
A Emails.

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Q About how many emails did you send?
A Four.
Q Do you remember to whom you sent them?
A I sent them to the president of the Endocrine Society, a couple of committee people, and someone else that I don't remember.
Q Did you do that in your personal capacity or as part of your membership in Do No Harm?
A This was well before Do No Harm. It was in my personal capacity.
Q When about do you think you sent these emails?
A Well, probably early 2022.
Q Did you ever hear back?
A No.
Q The substance of these emails, would they have been similar to your legislative testimony?
A It was really more brief and focused on my concerns about their promoting this practice with little evidence.
It was not as extensive with references. I also directed it to a person who was in a fellowship with me, a year behind me at the University of Iowa so I knew her. I still know her. And there was no response.
Q Do you still use the Endocrine Society Clinical

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Practice Guidelines in your practice?
A On what particular disorder?
Q Any disorder?
A Some of them.
Q Okay.
MR. SELDIN: Erica, could you pull up Exhibit 12.
Q Dr. Weiss, what I'm about to show you is from the Endocrine Society website. It's a list of their clinic guides by topic area. I'm going to ask you for these topics that are listed, whether you practice in this space and whether you use any guidelines.
So going from the top, do you treat adrenal conditions?
A Yes.
Q Do you use the Endocrine Society guidelines to treat those?
A Some of them.
Q How about for hypoglycemia?
A Yes.
Q Do you treat that condition?
A Yes.
Q Do you use the Endocrine Society guidelines for those conditions?

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A Yes.
Q Okay. Then just looking through the rest of this, you will see there are several other conditions listed.
How about for bone health and osteoporosis?
A I treat that.
Q Do you use these guidelines?
A Some of them.
Q And then for male reproductive endocrinology?
A Yes.
Q Are you a reproductive endocrinologist?
A No.
Q How about for diabetes, mellitus and glucose metabolism, do you use the guidelines?
A I don't know what they are. I don't tend to refer to them because I'm an expert. They are probably outdated by the time they are written. I see so much diabetes and I'm very current on the literature on that.
I treat many people with diabetes. I don't care about the Endocrine Society guidelines for that.
MR. SELDIN: Erica, could you pull up Exhibit 31?
Q Dr. Weiss, this is clinical guidelines from the

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Endocrine Society on the Management of Individuals With Diabetes at High Risk for Hypoglycemia: An Endocrine Society Clinical Practice Guideline.
Do you see what I'm referring to?
A Yes.
Q Is this a clinical practice guideline that you have used?
A I don't refer to it because I'm so knowledgeable in this area. By the time it's written -- it was published in 2022. We have actually enhanced knowledge from that time.
So it's, these are often outdated by the time they were written. These are usually fairly well evidence based when they do come out. They get outdated shortly thereafter.
But I follow, when I do check these guidelines I'm doing -- my care is consistent with them.
Q And so we will scroll down to the section that says Methods on Page 1.
Do you see where I am, Methods?
A Yes.
Q You will see it says, "Methods. A multidisciplinary panel of clinician experts, together with a patient representative, and

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methodologists with expertise in evidence synthesis and guideline development, identified and prioritized 10 clinical questions related to hypoglycemia in people living with diabetes."
Do you see that?
A Yes.
Q Do you think a multidisciplinary panel with a patient representative is a good way to develop a guideline?
A Those are a couple of elements. There's much more than that though.
Q Then at the bottom of Methods it says, "The Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology was used to assess the certainty of evidence and make recommendations."
Do you see that?
A I do.
Q Do you agree with the use of GRADE?
A Yes.
MR. SELDIN: Take us to Page 9, please.
Q Dr. Weiss, Recommendation 1, do you see where I am?
A I do.
Q It says, "We recommend continuos glucose

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monitoring (CGM) rather than self-monitoring of blood (SMBG) glucose by fingerstick for patients with type I diabetes receiving multiple daily injections (MDIs)."
Do you see that?
A I do.
Q Do you agree with that recommendation?
A Yes.
Q Is that something that you use in your practice?
A Absolutely.
MR. SELDIN: Erica, can you take us to Page 11.
Q You will see where it says Justification For The Recommendation.
Do you see that?
A Yes.
Q It says there, "The panel justified a strong recommendation despite the low quality of evidence, based on recognition that iatrogenic hypoglycemia is the limiting factor in the glycemic managment of diabetes and is a major concern for individuals with diabetes and for their family members."
Do you see that?
A I do.

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Q You see that they use low quality of evidence here.
Does that give you any concern about this particular guideline?
A No. Because I think it's true. No concern.
MR. SELDIN: Erica, can you take us back to Page 2.
Q At the top of Page 2, Dr. Weiss, it says Conclusion and there it says -- do you see where I am?
A Yes.
Q Then it says, "The recommendations are based on the consideration of critical outcomes as well as implementation factors such as feasibility and values and preferences of people with diabetes."
Did I read that correctly?
A Yes.
Q Do you generally agree with that statement?
A Yes.
MR. SELDIN: Erica, can you take us back to Exhibit 1?
Q I'm going to Paragraph 9 of your declaration. That is on Page 2.
You say at the end, "Unlike most pediatricians, my care and follow up of patients

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does not stop when the person turns 18."
Do you see where you said that?
A Yes.
Q I take it that is because you generally treat patients that are over eighteen so they don't age out of your practice, right?
A Pediatricians stop care for people when they are eighteen. For example, people with Type I diabetes who might have hypoglycemia related to that guideline, the pediatrician stops seeing them when they are eighteen and they turn them over to me.
Q Do you know pediatricians who will see patients after they turn eighteen?
A Very few.
Q Generally or in pediatric endocrinology?
A Both. There are a few disorders where they might see them beyond eighteen like cystic fibrosis. Like most disorders, chronic conditions, they turn them over to a person who is board certified in internal medicine.
And in the case of endocrine disorders, an endocrinologist.
Q And that is because pediatric medicine is different from adult medicine, right?

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A I think it's, a lot of it is tradition. I think there are a number of reasons.
Q Well, they are different specialities, though, right?
A They are.
Q So there are differences in how to treat pediatric patients versus adult patients?
A True.
Q And how do you know that most pediatricians stop care at eighteen?
A Thirty-six years of practice.
Q Then, Dr. Weiss, in Paragraph 10 of your declaration you say that you have training in diagnosis and treating patients with some mental health disorders including depression.
Do you see that?
A Yes.
Q What training have you received in diagnosing and treating patients with some mental health disorders?
A Some of it is from during residency in internal medicine. Some of it is from reading. Some of it is from online conferences. Some of it is from in-person conferences.
Q And depression is a DSM 5 diagnosis, is that

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right?
A Yes.
Q Is that a diagnosis that you make in your practice?
A Yes. Depression is common with diabetes, for example.
Q Why is that?
A It's not known.
Q Do you have a theory?
A No.
Q So endocrinologists can sometimes be qualified to make a mental health diagnosis then?
A Absolutely.
Q So not just psychiatrists can make these kind of diagnoses, but other clinicians can?
A Most people who treat depression are primary care people.
Q Have you ever received any training in diagnosing gender dysphoria using the DSM 5?
A The DSM 5 came out in 2013 and that's when I stopped treating.
Q So you would not have received training in specifically how to use those criteria to diagnose?
A It does not take a lot of training. That is why

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WPATH recommends that primary care people do it. WPATH even excludes, does not, it states that you don't even need dysphoria now.
Q Dr. Weiss, in Paragraph 17 of your declaration you say, "Any well-trained" -- let me know when you are there.
A I am.
Q You say, "Any well-trained practicing physician must be able to analyze evidence with a careful reading of published literature. Doctors who are unable to do so cannot provide good care for their patients."
Did I read that correctly?
A You did.
Q What is a well-trained practicing physician?
A That is a good question. One of the criterion are to be able to analyze evidence with a careful reading of the published literature.
And many physicians don't have that. They just look at guidelines. They say okay. They don't critically think about it. They don't look and do literature searches. They don't analyze the methodology of studies.
They say I will follow the guidelines. That is why there are now more and more physician

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assistants and nurse practitioners doing care. They can just simply follow the guidelines without much thought or critical analysis.
Q Do you consider yourself to have expertise above that of a well-trained practicing physician?
A It depends on the area you are referring to.
Q With respect to the treatment of gender dysphoria in minors?
A Yes, I do think I am more knowledgeable in that area. Most physicians have actually not, have studied the literature in this regard. They are not knowledgeable and they are not interested in treating.
Q So you believe that your expertise in that regard comes from your ability to read the studies that are used behind the guidelines, is that accurate?
A That is part of it, yes.
Q Dr. Weiss, go to Paragraph 21 of your declaration on Page 4.
You say, "While hormonal and surgical procedures may enable some individuals to appear to others as the opposite sex during some of their lives, no procedures can enable an individual to perform the reproductive role of the opposite sex."

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Did I read that correctly?
A Yes.
Q So if someone cannot perform the reproductive role of being male you would consider them not to be male?
A There might be exceptions with intrasex -- disorders of sexual differentiation, which are exceedingly rare.
Q But you believe there could be some males who cannot perform their reproductive role because of an intrasex condition, but are nonetheless male?
A Right. If someone was born without testes, but is XY and otherwise a male, he is still a male, but he is born without testes.
There are women that are born without uteruses. They have disorders where that is how they are born.
So those are really rare exceptions and that would be a person that would still be that same biologic sex. Otherwise, no. I'm not talking about these people here though.
Q Would you consider chromosomes to be definitive in determining sex?
A Examine the external genitalia. And then if there is a question, chromosomes.

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Q So you agree that a visual inspection of an infant's external genitalia does not provide information about the reproductive capacity as an adult, right?
A It does in almost all instances. There are very few instances in which it does not. So we don't have to assign sex at birth. You examine the child and you can determine what their sex is in all likelihood.
Unless they have some unusual disorder, they will be -- they might be infertile. Yes, there are some infertile people, but otherwise they would have the potential for reproductive capacity. But that is not all it is.
I think you are kind of changing the wording of this because we are changing the topic because what I have said here was that those changes, those hormonal changes to a person with gender dysphoria do not enable them to have reproductive capacity.
And now you are asking what is a boy or a girl? What is a male or female? That is a different question.
Q And so using your definition of men and women or boys and girls, you believe that there are some

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men who are born infertile, but are nonetheless still men, right?
A Correct.
Q There are some women who are born infertile, but are nonetheless still women, correct?
A Correct.
Q In Paragraph 24 you have a quote from Dr. Levine about twelve year olds. Then you make some reference to the plaintiffs in this age when they were four.
My question is just, have you ever done a biopsychosocial assessment of a child of any age?
A No.
Q So for that statement about four year olds and twelve year olds are you just relying on your common sense there?
A Common sense and being a father.
Q Then in Paragraph 25 you say, in the second sentence you are talking about adolescents. You say, "One series of 1,655 youth, mean age of 15.7 years, reported that 55% had friends who also 'came out' as transgender around the same time."
Do you see that?
A Yes.
Q As a general matter does it surprise you that

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adolescents would go online and find people with whom they had common traits or interests?
A This is not speaking to that. It's not that they, they said they were gender dysphoric or transgender and then they found the people.
It's that they found these people online and then they came out. Or they found these, they had these friends and they all came out and said that they were transgender at the same time.
That should raise concerns that that might be some element of social contagion or peer influence.
Q So imagine an adolescent who has never been on the internet. They have parents that keep them away from screens entirely. They come to believe or realize that they are transgender. would it surprise you when they went online and they would look for other people who were transgender?
A That would not surprise me at all. But there are no adolescents that don't go online.
Q Dr. Weiss, in Paragraph 26 of your declaration in the third sentence, second line, you say, "There are no standards of care accepted by most practitioners, either internationally or within the United States."

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Do you see where you said that?
A I do.
Q What do you mean when you say "most 'practitioners"?
A That is what I said. Most practitioners.
Q How do you know that most practitioners don't accept those guidelines?
A During my thirty-five years of experience of teaching many of those in the health care field and interacting with hundreds and hundreds of physicians, I know that most are not supportive of the so-called WPATH or Endocrine Society guidelines. And for that reason they chose not to treat.
From seeing the statements and evaluation by other countries they don't endorse the treatment that we are doing in the U.S. These other countries have had many years of experience above and beyond the United States.
So it's not, it's kind of -- it is a fiction that it's some kind of universal, you know, or that it's endorsed around the world, this particular approach to care. There's a lot of disagreement.
Q You believe that based on your conversations over

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your career with folks about this topic that you have accurately ascertained that most of them do not agree, not withstanding what the major medical associations have said?
A Some of those organizations have made those statements and many physicians are not members of those organizations.
And it's not just my conversations with physicians. It is also what is seen and what other countries have concluded, as we will talk about I'm sure.
Q Then, Dr. Weiss, in Paragraph 26 you say, "The goal of treating children with gender dysphoria is to resolve their gender related distress."
Do you see that, the first sentence of Paragraph 26?
A Yes.
Q When you say that, do you mean pre-puberty children?
A All children.
Q How are you defining children?
A Anyone under eighteen.
Q So you mean both children who have not hit puberty and children who have hit puberty?
A Correct.

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Q What is that statement based on?
A Well, it would be based upon the approach of most physicians including Dr. Shumer and Dr. DeVries and Dr. Cohen-Kettenis, the people who started the Dutch protocol, and other treating physicians.
The goal is not to modify the appearance of the body. The goal is to relieve the psychic distress related to the gender incongruence. That is what they say. That is what -- the Dutch protocol initially started with that goal in mind.
Q So when you say that the goal is of relieving, resolving gender related distress, you are referring to resolution through non-hormonal interventions?
A No. That should be the goal. That should be the goal of all treatments. The goal, the reason that hormonal treatments have been implemented is not because they want to create these people who are looking like the opposite sex, but really to help the child's psychic distress.
That is the initial reason for the whole Dutch protocol. That is the basis -- that is the best evidence that the Endocrine Society invoked for the management of children and adolescents

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with gender dysphoria, is the Dutch protocol.
The Dutch said the reason to treat these children and to treat early is to relieve their gender related distress.
Q You believe that relief should not come in the form of bodily changes?
A That is correct, because it does not work.
Q In paragraph, that same Paragraph 26, you say at the very end, "Psychotherapy can be very beneficial in patients with gender dysphoria and lead to their desistance."
Do you see where you said that?
A I do.
Q Based on your prior statement do you mean patients of all ages?
A Yes.
Q What is desistance?
A Desistance would be, could be defined -- people define it differently.
I would define it as no longer rejecting your natal sex.
Q Is that a term that you would use for both children who have not hit puberty and also adolescents?
A Yes.

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Q Okay. Is detransition a term that you are familiar with?
A Yes.
Q What does that term mean to you?
A That term relates to those who took therapies, hormonal therapies, blockers, or opposite sex hormonal therapies, to appear as the opposite sex and after a period of time decide -- or maybe even surgery, underwent surgery -- then changed their mind and wanted to return to their natal sex.
Q What is the difference then between desistance and detransition?
A Desistance is just discontinuing the efforts to appear as the opposite sex. Detransition is already, those children or adolescents or adults who made the change to the opposite sex, the change in the appearance, took those therapies or interventions and now they want to return to their natal sex.
Q So when you say desistance, do you mean the resolution of gender dysphoria, or an identification to the sex assigned at birth?
A It would be the identification with the sex assigned at birth. What their psychic state is, that does not speak to that other than they are

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returning to their, accepting their natal sex.
They might have depression, anxiety, who knows.
Q So in your mind, desistence then is the resolution of gender dysphoria by identification with the sex assigned at birth, is that what you mean by desistence?
A There is more work that needs to be done in this area to study this. Unfortunately, little has been done.
Desistence would be defined as no longer having dysphoria related to your gender.
Q Okay. And is that different from identifying with your sex assigned at birth?
A No, I would say it was the same. You are now returning and identifying with your natal sex.
Q If a patient is receiving psychotherapy but continues to have severe gender dysphoria, do you think medical intervention is ever appropriate?
A No. By medical intervention you are talking about to change the appearance of the child and giving them opposite sex hormones? Is that what you are referring to?
Q We have been talking about treatment with hormones --

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A I think it's never appropriate.
Q Is that true, it's never appropriate for a person of any age?
A We are talking about children and adolescents right now. I don't think it is appropriate for any age because I don't think any evidence supports those hormonal interventions as being beneficial.
Q So, Dr. Weiss, say that you have a patient who has gender dysphoria and receives the interventions that we have been talking about to treat that in the form of hormones and that fully resolves their gender dysphoria.
They are back to zero gender dysphoria. Would you consider that a successful outcome?
A I think that hypothetical case is merely hypothetical. It just does not happen. You are implying causation from the intervention. I think there is no convincing evidence that those hormonal interventions are the key to, or are causal in improving any gender dysphoria.
I think it is very unclear and it actually may worsen it. And, remember, so are you going to -- are you telling me that that child has no psychotherapeutic intervention during that period

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of time?
You are just applying hormonal intervention and then they get better? I think that is very interesting. I've not seen any reports of that. And I don't think that exists. I would wonder whether the child would have desisted otherwise without your harmful interventions.
Q So let's say you have two patients. One who receives both psychotherapy and the medical interventions that we have been talking about in the form of hormones. That completely resolves their gender dysphoria.
Then you have another patient who only receives psychotherapy and their gender dysphoria resolves because they desist and begin to identify with their sex assigned at birth.
Do you think one outcome is better than the other?
A Yeah. I think the intervention that is least invasive, least potentially harmful is always the best intervention.
So not giving hormonal treatments to these children with normal bodies that might lead to irreversible effects is always best to minimize harm. The harm is minimized if it's just a

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supportive psychotherapeutic intervention.
Q So you think that desistance is the better outcome?
A Oh, sure. Because that means the child is no longer dysphoric and that is the goal. The goal is not to modify their body. We want to help them so they are no longer in distress.
So the goal should be relieving their distress with the least harmful intervention.
Q Is there any point at which you would agree that medical intervention would be warranted?
A For?
Q Well, for an adolescent. Let's say we have an adolescent who has been in therapy since they were three and their gender dysphoria has not improved. It's now thirteen years later. They are sixteen.
Do you think that that person is a candidate for hormonal treatment?
A If that hormonal treatment is intended to improve their gender dysphoria, absolutely not. It would likely worsen.
That child has been gender dysphoric since the age of three. What else is going on with that child? Do they have autism spectrum disorder? Are they feeling -- do they have a family

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environment that is really in chaos?
There are other things going on. Hormones will not help that child with gender dysphoria.
Q Let's say you have someone who is forty years old. They have been in some kind of psychotherapy for twelve years for their gender dysphoria. It has not abated.
Do you think that person at forty or -- I can't do math -- let's say they are thirty. So it's eighteen plus twenty-two. Do you think that person is a good candidate for a medical intervention like hormones?
A I don't think any person is a good candidate. And if they had not improved with psychotherapy, maybe they need to find a different therapist.
You know, there are good mechanics and bad mechanics. The same thing with therapists. There are different therapeutic approaches, you know. And some people have serious psychiatric problems that may not be remedied with therapy.
But you can make them much worse if you start giving them hormones that are not going to help them. There may be doctors who will be willing to treat that person, that adult, but it would not be me because I don't want to hurt them.

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Q In Paragraph 27 of your declaration you say in the second sentence, "But Clinicians who without question 'affirm' the child's self-diagnosis will fail to address psychiatric co-morbidities that may underlie the rejection of their sex."
Do you see where you say that?
A Yes.
Q Do you have any examples of a clinician failing to use the DSM 5 criteria to diagnose gender dysphoria?
A How is that related to that statement? I don't know why you are asking me that in reference to this statement.
Q Regardless of that statement, do you have an example of that?
MS. YOUNGS: Does he have an example of? State that again.
Q I'm asking, Dr. Weiss, do you have an example of a clinician who failed to use the DSM 5 criteria to diagnose gender dysphoria in a minor?
A Let me give that some thought. No.
Q Do you have an example where a clinician declined to treat a co-morbidity once they found a gender dysphoria diagnosis?
A I think there are examples in these plaintiffs,

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yes.
Q Other than the plaintiffs, do you have an example?
A Yes. The patients I was seeing, I think some of those adults had co-morbidities that I was not treating. I was giving them these opposite sex hormonal interventions that were not helpful. They needed really primarily psychotherapy. I would say also if you read Jamie Reed's affidavit from the Washington University Gender Center it seemed to be the pattern, the consistent pattern that they ignored all other co-morbidities and just focused on gender.
Q Let's go to Paragraph 28 of your declaration.
MR. SELDIN: Ms. Youngs, I know we talked about this earlier, but I want to confirm about designating the portions of the deposition pertaining to the plaintiffs' medical records, we will treat those as confidential?
MS. YOUNGS: Yes.
Q So in that respect, Dr. Weiss, in Paragraph 28 you said that, "I reviewed the records of A.M., K.C. and M.W., all plaintiffs in this case. All had multiple serious psychiatric co-morbidities including anxiety, depression, and self-harm behavior. The health care providers did not

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address these problems. All care has been focused on gender affirmation."
Do you see that?
A Yes.
Q What do you mean by gender affirmation here?
A Hormonal interventions, either puberty blockers or opposite sex hormones.
Q What do you base that definition on?
A So-called gender-affirming care is hormone interventions, either blockers or opposite sex hormones. Some people call them cross hormones.
Then surgery after that as so-called gender-affirming care or gender affirmation.
Q So I'm showing you a document, Exhibit 13, with the caption to this case. It says Plaintiff's Responses and Objections to Defendant's First Requests for Production to Plaintiffs.
Do you see that?
A Yes.
Q Have you seen this document before?
A I don't remember. Scroll further. That looks familiar. That came along with the records. Right? Is that correct that it came with the records?
Q I will represent this was a document provided by

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plaintiff's counsel to counsel for Indiana in connection with the discovery in this case. I don't want to hear what your counsel gave you. We will represent that is what the document is.
A Understood. I believe I saw this, yes.
Q Okay. I will head that problem off at the pass. You believe you may have reviewed this document in connection with that?
A Yes.
Q On Page 5, Dr. Weiss, do you see there is Request 1 and the response. At the end it says, "Moreover, this request is vague, overbroad, and unduly burdensome to the extent it requests records for 'a related condition' because there are no conditions inherently related to gender dysphoria."
Do you see that?
A No. I don't see it yet. Where?
Q So do you see Request Number 1?
A Yes.
Q Then you see Response?
MS. YOUNGS: Can you zoom in? Do you see it?
A Okay.
Q That is four lines down.

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A Yes.
Q So you see where it says, "Moreover, this request is vague, overboard, and unduly burdensome to the extent it requests records for 'a related condition' because there are no conditions inherently related to gender dysphoria."
Did I read that correctly?
A Yes.
Q Would it surprise you to learn that the medical records that have been produced in this case all pertain to the treatment of gender dysphoria?
A I think that statement that there are no conditions inherently related to gender dysphoria is ridiculous. It's absurd.
The whole patient psychiatric psychosocial status is related to gender dysphoria. Their family situation. Whether they were sexually abused. That is related to gender dysphoria. Whether they are physically abused. Were they bullied. All those.
So there are no conditions related to gender dysphoria, that is a ridiculous remark. It's antithetical to any psychological care that that person might require.
Q Earlier we were talking about diabetes. You said

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a lot of your patients with diabetes also have depression, correct?
A Yes.
Q Do you consider depression and diabetes to be related conditions?
A There is more depression in people with diabetes and that is perhaps in part because of the burden of the diabetes care. But that is just an association.
Q Other than that case, have you ever evaluated the medical records of a minor?
A Yes.
Q When?
A Over my thirty-five years of practice I have. I took care of children down to the age of five.
Q We talked about you thought that was less than one percent of your practice overall, correct?
A Maybe a little more earlier then and then it became less later. Yes.
Q You have interacted with the records of your minor patients, correct?
A What is the question?
Q I'm asking, we are talking about when you treated minor patients as a small part of your practice you interacted with their medical records as their

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physician?
A Yes. I also would have reviewed previous records when I was assuming care for that child.
Q How long did your review of the medical records take in this case?
A I don't remember. Hours.
Q Can you estimate approximately how many hours you spent reviewing the medical records in this case?
A The medical records of the four plaintiffs, maybe five hours.
Q Who did you discuss your review with, if anyone?
A I just reviewed them on my own.
Q Did you discuss, this is a yes or no question, did you discuss your review with the attorneys for the state of Indiana?
A Yes.
Q Did you discuss your review of the medical records with any other physician?
A No.
Q Did you discuss them with your wife?
A No.
Q Then I assume I know the answer to this, have you shared those medical records with anyone else?
A Absolutely not.
Q In Paragraph 29 you say one of the plaintiffs had

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been abused and that "Puberty blockers are not a treatment for post-traumatic stress disorder."
Do you see that?
A Yes.
Q Do you recall a physician prescribing blockers to treat PTSD in that plaintiff's medical records?
A I recall puberty blockers being prescribed. The prescription was for gender dysphoria, but the gender dysphoria diagnosis was made in the context of major psychosocial factors that ought to have been addressed.
And per the Dutch protocol guidelines or the Endocrine Society guidelines, those should have been addressed. Failing to address those is not optimal care if you just jump to treating and introducing a new problem like treating with puberty blockers.
Q In Paragraph 30 you are talking about a different plaintiff here.
You say that another child was socially transitioned at age four by the parents, both of whom are biologic males and one who identifies as transgender.
Do you see that?
A Yes.

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Q What was your basis for saying that that plaintiff's parents are biological males, one of whom identifies as transgender?
A It was in the records.
MR. SELDIN: Erica, can you pull up Exhibit 19.
Ms. Youngs, this is a medical record. Again, we will talk about how to designate this as confidential. I took the one page as opposed to a whole set so we don't have a larger number of documents to deal with.
MS. YOUNGS: Okay.
MR. SELDIN: Can you scroll down to the bottom of this document, please. It is IUH821. I didn't think it was necessary or appropriate to bring in the entire medical record from IU Health given what we are dealing with.
MS. YOUNGS: We will reserve the ability to object if there is more information that we need to review to answer the question.
MR. SELDIN: Of course.
Q So, Dr. Weiss, I want to direct you to the bottom. Or rather I'm sorry. Scroll up. You will see at the top right there is a name which I will not say so we don't have to redact it from the record from

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the persons whose medical record this is.
The first initial is K and the last is a C.
Do you see that?
A Yes.
Q That is the K.C. you are referring to in Paragraph 30?
A Yes.
Q We will scroll down to the bottom. Dr. Weiss, in the bottom left do you see under Social History where I am?
A Yes.
Q Then Home/Environment. Lives with parents. And I will skip the names and ages of the siblings. It says, "Mom had menarche at 11 and Dad was shaving in the sixth grade."
Do you see that?
A I do.
Q Is that consistent with your statement that both K.C.'s parents are biologic males?
A That is not consistent. There is elsewhere in the record that I derived that statement from.
Q Do you recall where in the record?
A No. Also, I believe this was K.C. who there was a restraining order from the biologic father to stay -- I believe that is correct -- to stay away

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from the -- I believe I'm not confusing. No. No. That is A.M. I'm sorry.

With K.C. there is somewhere in the record where that was apparent about a transgender parent. I don't recall.

Q If it's not K.C.'s parents would you need to revise your declaration?

A It's possible I am mistaken with regard to that. That is what I saw, that there was a parent who identified as transgender and was a biologic male.

Q And why was the sex of the parents notable to you?

A How they identify is notable because I would be curious as to whether there was pressure on the child from the age of four to socially transition.

That is unusual. So that ought to have been explored by any biopsychosocial evaluation in this child who has multiple medical problems.

Q In Paragraph 31 of your declaration you say, "The mother of M.W. questioned the rapid onset of gender dysphoria in her," you use the term "daughter."

You said, "However, after a telephone call with a health care provider, she no longer expressed concern, though the file does not explain."

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Do you see that?

A Yes.

Q Why was it notable to you that the clinicians addressed the mother's concerns?

A That is not what was notable. What was notable was the mother had those concerns. What happened to those concerns? How were they addressed?

Q I mean, in general it's a good thing when clinicians express concerns of parents in the care of their children, right?

A Yes.

Q Doesn't that mean there was not immediate affirmation here if, in fact, the mother had questions that were strong enough that she followed up with the clinician?

A They rate parents on their degree to which they affirm. You know, so they are really evaluating parents on an ongoing basis if they do any questioning of them, of the gender issues that the child has.

So I would wonder what happened here. We don't know what the conversation was and whether was the parent told if you don't affirm M.W. she will kill herself. Was it that kind of a threat which we often hear occurs in these kind of

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settings. I don't know. I wonder about that because this later onset expression of gender dysphoria in this sixteen year old suggests it has not been an ongoing gender issue for years with the child.

Q So it raises concerns in your mind when gender dysphoria begins to appear in a later adolescent, is that what I'm hearing you say?

A Yes.

Q You also don't believe that a three year old can accurately express gender dysphoria, is that right?

A Yes.

Q So there is no age between three and sixteen where you think a child can accurately report gender dysphoria?

A Well, they can mistakenly report it, but that does not mean there are not co-morbidities or reasons why they are feeling dysphoria that could be addressed without hormonal interventions.

They can be dysphoric and attribute it to their gender. But especially for a new, rapid onset in this setting there is usually factors. Like I think she had just broken, she had a relationship that just broke up. She had a bad

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experience in school. Yes, that was M.W.

So there was a stabbing at the school. So that needed to have been explored. This feeling of gender incongruence, why did it come up all of a sudden? But it is not clear to me from the records that there was any exploration of that and they moved right onto testosterone at the second visit with the first visit being a video visit.

Q In your practice do you do telehealth visits?

A Yes. That is with established patients.

Q During the pandemic did you have any new patients that started with telehealth?

A No.

Q Were there doctors in your practice who did?

A Not new patients, no. We only did televisits for a short period of time. Then we were seeing them in the office.

Q In Paragraph 32 of your declaration you are discussing an informed consent sheet. In the last two lines you said, "Among the potential undisclosed harms are infertility, baldness, and an increased risk of heart attacks and stroke."

Do you see that?

A I do.

Q This was for M.R.

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MR. SELDIN: Erica, can you please pull up Exhibit 20.
Q This is another medical record where I have the one page.
Dr. Weiss, do you see this says, "Informed Consent for balancing hormones in Gender Diverse people" with the Mosaic logo in the top right and the plaintiff's name in the top left?
A Yes.
Q Is this the informed consent sheet that you are talking about in Paragraph 32 of your declaration?
A Yes.
Q Okay. And your question about this form is that there are undisclosed harms of infertility, baldness, and increased risk of heart attacks and strokes, is that right?
A Yes. Undisclosed or minimized.
Q To read back the sentence from your declaration you said, "Unknowns and potential harms were minimized on this form. Among the potential undisclosed harms are infertility, baldness, and an increased risk of heart attacks and strokes."
Do you see that?
A Yes.
Q So do you see on this form the part where it says

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midway through, "People whose bodies are at higher concentration of testosterone have higher risk of heart disease, high cholesterol and high blood pressure."
Do you see that?
A Yes. It's followed by the sentence, "These are all modifiable by diet, exercise and medications."
Q It would be fair to say this was a risk that was disclosed, but you believe minimized?
A Correct.
Q So it is not an undisclosed harm?
A I agree.
Q And then if you move up a little bit you will see under Not Permanent changes it says, "Hair loss on head (sometimes permanent)."
Do you see that?
A I will follow up on the statement I said, increased risk of strokes. She does not mention and this form does not mention strokes. So that is not disclosed.
Q Heart disease, high cholesterol, and high blood pressure are?
A Yes.
Q Now, do you see the part on this form where it discloses, "Hair loss on head (sometimes

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permanent)" as a potential side effect?
A Yes.
Q And so that would be a disclosed harm, is that right?
A It is expressed hair loss on head. I call it baldness. It's a different way of expressing it. Yes.
Q And then do you see at the bottom of this sheet it says "What we don't know."
The second bullet point is, "What testosterone does to fertility."
Do you see that part?
A Yes.
Q So, in fact, concerns about fertility are disclosed on this form.
MS. YOUNGS: Was there a question?
Q Potential fertility issues is a disclosed potential risk on this form, is that correct?
A Maybe. What we don't know is what testosterone does to fertility.
Q Well, then it says, "Some trans men come off T and get pregnant and birth babies, have no long-term data on these humans."
All together would you agree that is a disclosure of some risk to fertility?

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A Yes, I would agree.
MR. SELDIN: We have been going for a little bit. Is now a good time for a five minute break?
MS. YOUNGS: Thank you.
(OFF RECORD AT 3:12 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 3:17 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I'm on Exhibit 1, your declaration. Paragraph 34.
Do you see that?
A Yes.
Q In Paragraph 34 you say, "With gender identity issues, open, exploratory supportive psychotherapy or talk therapy is too often dispensed with entirely."
Do you see that?
A Yes.
Q There is no citation for that, is that correct?
A Correct.
Q Do you have any examples of children or adolescents who were not offered therapy as part

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of their treatment for gender dysphoria?
A Just in speaking with parents and hearing of cases. Not patients under my care. I was not treating minors.
Q Dr. Weiss, what do you mean when you say open exploratory supportive psychotherapy?
A It's talk therapy without the goal of changing the child's view on their gender. It's really exploring their whole family dynamics. What's going on. How is school. Just trying to understand what, how the child feels overall. Their mood. Their outlook. Their interest in things. That kind of approach.
Q How is that different from a gender-affirming approach?
A A gender-affirming approach would be an approach that says, okay, your problem is you are not the right -- you don't appear the right gender. We are going to give you hormones and we will give you -- or puberty blockers -- and we will fix your appearance and you will feel better.
Q So you would agree that pre-pubertal children who have not yet hit puberty are not offered medical interventions in forms of blockers or hormones, correct?

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A What is the question?
Q For the treatment of gender dysphoria that we have been discussing in minors, that treatment is not even on the table until a minor hits puberty and the -- right? Because puberty blocker, by definition you have to be going through puberty?
A Right. They would initiate a puberty blocker at stage two, which is early onset puberty.
Q When you say stage two you mean Tanner Stage Two, is that correct?
A Yes.
Q So for a child who has not yet hit puberty, what is the difference between the open exploratory supportive psychotherapy that you just described and the gender-affirming that you just described since there is no medicine on the table?
A Well, gender-affirming therapy might be, okay, your main problem is your gender dysphoria. They might institute social transition at that point, which is a treatment.
Q So your open exploratory supportive psychotherapy would not include social transition?
A Correct. Because there is evidence that social transition is a powerful intervention that may change outcomes.

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Q And what does institutional social transition mean?
A It means that the child adopts a different name and pronoun and lives as the opposite gender.
Q So you don't think that is an appropriate intervention?
A Correct.
Q And in your view of gender-affirming therapy, is the therapist pushing that or just merely not opposing it?
A The therapist would push it.
Q What about a therapist that does not push it, but says this is an option. How do you feel about it?
A I think that hypothetical situation is not one that is realistic or meaningful.
Q So in your open exploratory supportive psychotherapy would social transition be discussed at all?
A It might come up.
Q What do you think the therapist's response should be when it comes up?
A It really depends on the situation and the child. It's so complex. It is an interplay of so many factors.
Q Do you think there is ever a situation where the

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therapist and patient might come to the conclusion that that would be helpful to socially transition?
A Not a therapist who knows the evidence base.
Q And so in your mind, open exploratory supportive psychotherapy, is the goal of that therapy identification with the sex assigned at birth?
A The goal is to help the child's distress.
Q How do you believe that that distress can be ameliorated using that kind of psychotherapy?
A That is how therapy often works. There is no age below which you can't have that kind of therapy for children. So five year olds, six year olds, four year olds can all benefit from those kinds of therapies without drugs.
Q So the goal of that open exploratory supportive psychotherapy that you feel is not being provided is resolving the gender dysphoria because the patient comes to identify or be at peace with their sex assigned at birth, is that right?
A I think the goal is to really relieve their anxiety and depressed co-morbidities. And if gender dysphoria is part of that, that hopefully will resolve, too.
Q Is there any evidence for the open explorative supportive psychotherapy that you are talking

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about?
A Yes. I referenced some papers.
Q Is there anything other than the papers that you reference in your complaint -- I'm sorry -- in your declaration?
A Yes. Yes. There are therapists who use it all of the time and children and adolescents benefit from it.
Q Which therapists do you know that are providing the kind of open explorative supportive psychotherapy that you are talking about?
A What do you mean by "know"?
Q You said you know there are therapists that provide this kind of therapy. I am asking who is it?
A Someone like Dr. Kenneth Zucker. Dr. Steven Levine. Dr. Cantor. James Cantor. Dr. Marcus Evans. There are others.
Q The same Dr. James Cantor who is a witness for Indiana in this case?
A Yes.
Q Were you aware that both Dr. Zucker and Dr. Levine have treated adolescent patients with gender-affirming care?
A I'm not aware that they prescribed hormonal

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therapy for those people.
Q Are you aware of whether or not they recommended hormone therapy for those people?
A No.
Q Would your view of their practice change if you learned they had, in fact, prescribed gender-affirming care in the form of hormones for these patients?
A What was the question again?
Q Well, you told me that you think Dr. Cantor and Dr. Zucker were providing the kind of open exploratory supportive psychotherapy that you think should be happening. Right?
A Right.
Q And I asked were you aware that they prescribe or have recommended the prescription of hormones for their patients with gender dysphoria. You said you were not sure. Is that correct?
A I'm not aware that they, themselves, prescribed it or that they recommended it.
If they did recommend it or prescribed it I think they were doing, that recommendation was inappropriate and not based upon good evidence. Maybe they were not aware of the evidence at that point when they prescribed it.

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Q So I will represent to you that Dr. Zucker's clinic did treat adolescents with hormones.
Does that give you pause as to the psychotherapy that he is providing?
A No.
Q So you think it's possible to provide the kind of psychotherapy you think is appropriate while also prescribing hormones to adolescents?
A I don't think it's appropriate to prescribe the hormones.
Q In Paragraph 39 of your declaration, I believe that takes us to Page 9, you say, "No other mental disorders listed in the DSM are treated with medication or surgery with the goal of altering body appearance or function."
Do you see that?
A I do.
Q There is no citation for that, correct?
A Correct.
Q Would you agree the brain is part of the body?
A Yes.
Q So psychotropic meds do change bodily function to the extent that they change brain function. Would you agree with that?
A I agree that they do change brain function. Yes.

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Psychotropic medications are not intended to change body appearance.
Q Would you want to revise that statement to say that the goal is altering body appearance then as opposed to function?
A That might be better.
Q Dr. Weiss, in Paragraph 58 of your declaration, which takes us to Page 13 -- the heading is Gender Dysphoria and Associated Psychosocial Conditions.
Do you see where that is?
A Yes.
Q What is a psychosocial condition?
A What is the question?
Q What is a psychosocial condition?
A Social conditions would be the environment the child is living in. So that is the family, friends, school.
The psychological status has to do with their mood, their interest in things, their sleep. Are they anxious. All those factors.
Q So in Paragraph 58 say, "Most current data show that 70% of children with gender dysphoria have had recent trauma, history of abuse, autism spectrum disorder, homosexual orientation, depression, anxiety, or bullying."

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Do you see where you said that?
A I do.
Q Why is homosexual orientation worth remarking on here?
A It is really important. If a parent has expressed or discussed an objection to be homosexual and the child has some homosexual orientation, that child might find it more acceptable to identify as transgender than to express their homosexual sexual orientation. That would be one example.
Q Are there other examples where homosexual orientation would be notable?
A Well, there might be some so-called internalized homophobia if the child feels bad about being gay or lesbian. But it's more acceptable and it is kind of considered cool to be transgender. They come out as transgender, but they really have a homosexual orientation, gay or lesbian.
That is apparent with some of those people who end up detransitioning. They really realize they were gay or lesbian and that it was a mistake for them to transition.
Q Do you think as a general matter it's more socially acceptable to be transgender than it is to be gay currently?

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A Yes.
Q Why?
A I don't know. Mores and cultural. Things change.
Q So it's your belief that currently in the United States it is more socially acceptable to express being transgender than to express being gay, lesbian, or bisexual?
A In many environments, yes, I do believe that. And really, it's really the child's perception. It's not what I think. It's what the child perceives. If the child perceives that it's more, that it's more acceptable in his or her environment to be trans rather than to be gay or lesbian, they may kind of reject their homosexual sexual orientation and express a transgender identity.
Q I guess we are talking about two different things.
One is your perception and then a child's perception. So it's your perception that it's more socially acceptable to be transgender than it is to be gay, is that correct?
A Yes. But I don't think that is important. What is important is the child's. We need to evaluate each child to see what is going on from an intrapsychic standpoint that leads them to feel dysphoric, have gender dysphoria.

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And for some of these children it's a homosexual orientation that needs to be explored. They need to be accepted and affirmed that if they are gay or lesbian that that is okay. That is good. We don't have to give you hormones and blockers and all this stuff.
It is not for them. We can be treating their condition with the wrong intervention if we give them gender-affirming care.
Q So from your perspective, it is preferable for an individual to be gay or lesbian as opposed to transgender?
MS. YOUNGS: I think that is a mischaracterization of his testimony.
A I would agree with that. I'm not placing any judgment on it. I'm saying that from the standpoint of what we are talking about here, which is treatment of gender dysphoria, that it's important to understand the basis for that child's feelings.
And for some of those children it's a homosexual orientation. They need to be affirmed from that standpoint and that will help them. It will be really -- that will come out with open exploratory supportive psychotherapy and you don't

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need to give them hormones.
Q So in your view then after a period of open exploratory supportive psychotherapy, as you have defined it in your declaration, you think as a medical outcome it would be better if the patient subjected to that therapy concluded that they were, in fact, gay or lesbian as opposed to suffering from gender dysphoria that required treatment through hormones?
A Well, hormones are not required. And I would not use the word "subjected." It is not a harmful intervention, talk therapy. It is kind and caring and supportive and open. And, you know, it's everything that children should be getting that they might not get from mom or dad. It depends on the household.
The outcome would be wonderful if they could avoid irreversible harm from hormonal interventions or even surgical reassignment.
Q You expressed concern earlier that co-morbid conditions were not being adequately addressed in minors with gender dysphoria.
Is that a fair characterization of what we have been talking about?
A Yes.

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Q Are there other medical treatments that you think are inappropriate for adolescents who are currently experiencing depression or anxiety?
A Not that I can think of.
Q Are there other medical treatments that you think should not be provided to adolescents because they have been bullied or have experienced trauma or abuse?
A Medical treatments other than hormonal interventions for gender dysphoria?
Q Other than that?
A No.
Q Would you agree that someone can have more than one condition that might require two different kinds of treatment?
A Yes.
Q But it is your position that even if an adolescent has no other diagnosis other than gender dysphoria they are still not a candidate for hormonal intervention or puberty blockers?
A That is my view because there, because the evidence does not support benefit from those interventions.
Q So in that case it would not be the existence of co-morbidities. It would be your view of the

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evidence base that would cause you to believe that?
A Right. The evidence does not support benefit from hormonal interventions for gender dysphoria even in the absence of major co-morbidities.
Q In Paragraph 60 of your declaration you say at the end, "When the GRADE score is 'low,' the true effect is likely to be markedly different from the estimated effect."
Do you see that?
A I do.
Q Can you give me an example of that?
A Can you be a little more specific in what you are asking?
Q Sure. You say when the GRADE score is low that the true effect is likely to be markedly different from the estimated effect.
And there is no citation there, right?
A Well, the citation relates to GRADE. That is what GRADE, that is what -- the citation still relates to citation 42, which is on GRADE.
Q Okay. So that is how you believe GRADE characterizes low in terms of quality?
A Yes. That is right out of the GRADE criteria.
Q All right. And can you give me an example of

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that?
A An example of what?
Q A place where the GRADE score on research is low and so the true effect is likely to be markedly different from the estimated effect?
A The hormonal treatment for gender dysphoria.
Q Any other treatment other than that where you believe that applies?
A The GRADE score.
Q Okay.
A I don't -- not that comes to mind.
Q So earlier today we were talking glycemia and we were looking at the Endocrine Society guideline. It talked about the recommendation for continuous monitoring versus fingerstick.
It said we recommend this even though it's low quality GRADE score.
Do you recall that?
A Oh, yes.
Q So do you have the same concerns about that intervention as you do with gender-affirming care?
A Oh, my goodness. Absolutely not. It is so different. We see immediate real time ongoing clear-cut evidence of benefit with continuous

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glucose monitoring daily, multiple times a day. We see evidence for that even though there might not be a study, you see that the patient has -- you are preventing a serious outcome every day, which is hypoglycemia. That is easily measurable and people get alerts from their continuous glucose monitoring system.
There is no parallel. There is no comparison to an intervention for hormone therapy for gender dysphoria.
Q So I will represent to you in this case and in other places there have been self-reports from minors with gender dysphoria that have received gender-affirming care that they on a daily basis feel better psychologically. They are more comfortable in their bodies. They are better able to participate in society.
You would not consider that self-report to be credible in this instance?
A It's worthless. It means that there are so many confounders. That is an anecdote from one or two people. But what else is going on in that patient's life? Have they had psychotherapy? You know, it could be the placebo affect.
It's nothing like continuous glucose

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monitoring in patients with diabetes. There's just no comparison whatsoever.
Q Is that because you don't believe we should give credence to the self-report of the minors who receive this care who say this is making me feel better on a daily basis?
A I think the patients can't diagnose themselves. Glucose measurements on a continuous glucose monitoring reader or an iPhone app, glucose measurements are very different from, I feel better and I think it's from that shot. There is no comparison.
Q You have patients with diabetes.
A Yes.
Q Are they able to tell based on how they feel in their body that maybe their blood sugar is getting low?
A Often no.
Q Is there a point at which they can?
A Sometimes. But often no. They need a measurement tool.
Q If you had a patient who came in and said I just, I'm not feeling particularly well. Would that be something that you would want to explore further in your treatment of them with diabetes?

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A Sure. Why are they not feeling well?
Q So you do believe that patient's self-report has some role in medical diagnosis?
A Oh, of course. Part of that, the most important part of the engagement is the history, what is going on. The patient can't diagnose their own condition. They can't -- they will come in and say I think that pill is giving me this problem, but they are on twelve pills.
Well, how do we know which pill? We can't rely on the patient to make the diagnosis.
Q In Paragraph 64 of your declaration you talk about, you know, essentially what would be a randomized control study.
Is that a fair summary of what you are talking about in Paragraph 64?
A Yes.
Q Is there any evidence that supportive psychotherapy alone can treat gender dysphoria?
A Yes. It's low quality evidence, but there is.
Q Would you expect people to sign up for a study where the intervention only had low quality evidence?
A It depends.
Q What does it depend on?

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A How well the informed consent process is. And I think if people were clearly informed of the weakness of the evidence for hormonal interventions and the potential harm, they might sign up for it. It might be difficult to do the study.
Q You think that the low quality evidence for the supportive psychotherapy that you are talking about, there is a form of informed consent that could be sufficient that you could ethnically sign people up for that group?
A For that group and the comparative group, it might be this would be an experiment, a clinical research trial where people were fully informed.
As you know, I'm an expert in clinical research. They would be fully informed from the outset with what is called equipoise. Not the doctor convinced that the best approach is hormones. But the doctor unsure of what the best approach is.
And then be able to convey that to the person who signed up and say these are your two options. We can see how you do. Then they randomly are assigned to one group or the other.
Q So the other group in your study, they would be

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receiving hormones, is that right?
A That is part of clinical research.
Q So you think this kind of study would be a good idea?
A Well, if the physicians in the United States continue to push these interventions which are so, I think, unhelpful and potentially harmful, perhaps this would get them to back down and say, look, this is what needs to be done and this is what is recommended.
Some other countries have said we need to put a stop to this right now. We need to evaluate it further. This would be a means to evaluate it.
Q You are aware that Senate Enrolled Act 480 bans care all together even in a research setting, correct?
A No, I was not aware of that.
Q Are you in favor of a law that bans care entirely without a research exception?
A I think I would have to see how -- what the research would be. You can call it research and have no control group. We are doing research.
There are publications where they call it research and I don't think it adds meaningfully to the evidence base. So it has to be a really well

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designed study prospective, randomized with a good comparator group.
Q So that kind of study then, the one you just described, you would be in favor of that kind of study taking place?
A I would.
Q In Paragraph 69 of your declaration, it says in the second sentence, "A Cochrane Review was performed of hormonal interventions in females with gender dysphoria. They found 'insufficient evidence to determine the efficacy or safety of hormonal treatment approaches in transgender women in transition.'"
Do you see where that is?
A Yes.
Q I'm a little confused. Is this review that you are talking about, was it addressing transgender men or transgender women?
MS. YOUNGS: Can he refresh his memory by looking at the study? Do you have the review of the study?
Q Before we get there, Dr. Weiss, do you know just from reading this whether the study was about being assigned male at birth or people assigned female at birth?

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A Let me look at the reference. This was biologic males.
Q Thank you. Then in Paragraph 70 in the second sentence you say, "Doctors, like all groups, are susceptible to group think and social contagion."
Do you see that?
A Yes.
Q Other than the treatments for gender dysphoria that we have been discussing can you give me another example of that?
A The treatment of post-menopausal women with estrogen and progestin in the hope that it would reduce heart attacks. The treatment of primary aldosteronism with surgical intervention. The treatment of high blood pressure in persons with Type II diabetes. I can go on and on.
Q And for all of those you believe that is group think and social contagion that were at fault?
A I think much of that is group think and doctors not thinking for themselves and not critically questioning the evidence.
Q In those cases was it further research that turned the tide?
A Yes.
Q So it was not debate. It was new research

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studies, is that fair to say?
A Yes.
Q Okay. In Paragraph 78 of your declaration you say, "At a minimum, one must conclude from these studies that persons with gender dysphoria continue to have significant psychiatric issues despite hormonal and surgical interventions."
Do you see that?
A Yes.
Q For people who have gender dysphoria, if they have other co-morbidities, why not treat all of the conditions as opposed to stopping the treatment for gender dysphoria?
A So one of the principles of treatment is to initiate treatment that is least harmful. And so the least harmful interventions would -- a harmful intervention, potentially irreversible, or definitely irreversible if surgery is involved, would be hormonal interventions for those persons.
So you could treat depression through various approaches and maybe the gender dysphoria would resolve. But if you are doing multiple interventions at one time you will not know what is helping.
Clearly in these citations in these reports

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focusing on treatment of gender dysphoria, it didn't seem to really help much in terms of the suicide and depression and so on.
Q Okay. So if someone has both diabetes and a heart condition and you are treating their diabetes and it is being effectively treated but their heart condition does not improve, do you stop treating the diabetes?
A So we are talking about mental disorders when we talk about gender dysphoria. So not chronic medical conditions that are outside of the brain.
So people can have multiple sclerosis and depression and you can treat both. You can treat both of those. But multiple sclerosis is not thought to be a psychiatric disorder.
So you are mixing apples and oranges, I think.
Q What if someone has depression and ADHD and you are effectively treating their ADHD but they continue to be depressed, would you stop treating the ADHD because the depression did not resolve?
A So I don't know that much about ADHD, but it may be that when you are treating the depression they will have less in the way of ADHD.
But, no. I think the psychiatrist who is

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treating needs to know the interaction between those two and treat both of them and maybe taper off on one of those medications. Your depression is much better. Maybe we can drop back on your meds for your ADHD or vice versa.

You can't do that if you were doing hormonal interventions and you have already transitioned the person. That is not something that you can go up and down on.

Q In Paragraph 80 of your declaration you are talking about a quote and then you say at the end, "Elsewhere this author writes that there are 'numerous gaps in knowledge' in transgender medicine."

Do you see that?

A Yes.

Q Are there gaps in knowledge in other areas of medicine?

A Not as much as in transgender medicine. And the gaps are so large in transgender medicine that practitioners are inclined to treat with these interventions that I think are harmful.

Q So when there are gaps in knowledge in medicine do you believe that we should withhold care?

A No. The care just continues to improve and change

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over time. But we always want to have the care be the least harmful possible.

Q And so you would agree then that the way you close those gaps to get to a place of care that is more effective and less harmful is through research?

A Correct.

Q In Paragraph 86 of your declaration you say that GnRH analogs are approved for use in children with a relatively rare disorder called central precocious puberty.

Do you see that?

A Yes.

Q So would you agree that for children experiencing that condition GnRH analogs are safe to use?

A They appear to be. And there is no other treatment for those children.

Q What about a child who has both precocious puberty and gender dysphoria, would you consider GnRH analogs to be an appropriate treatment?

A Yes, for the precocious puberty. Not for the gender dysphoria.

Q But if they had both, you would still find it appropriate to use the GnRH analog to treat them?

A For the precocious puberty. I've not seen a single report of a child who has both though.

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Q In Paragraph 90 of your declaration you say, "Seizures have been reported in children receiving puberty blockers."

There is no citation to that sentence. Do you see that?

A The citation comes in the next sentence.

Q Okay. So you believe that footnote 60 applies to both those sentences?

A I think so. Let me check. Yes, it does apply to both sentences.

Q So is that the Bangalore Krishna study?

A Yes.

Q Okay. Was that study in children who are being treated for precocious puberty?

A Yes. There is very little data on children treated with puberty blockers for gender dysphoria. Very little published data.

Q So because central precocious puberty can only be treated with GnRH agonists or puberty blockers, even though there are some rare side effects it's still an appropriate treatment in your mind?

A Yes.

Q So you would agree that medical interventions can always have rare side effects?

A They can always have side effects. We don't know

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how rare these are in their use with children with gender dysphoria because the data are not there. These children -- there is no reporting. There is no collection of data. They are just being treated.

Q I'm asking you a broader question. Generally speaking, medical interventions can have side effects and some are more common, some are more rare?

A Correct.

Q And even for medications or treatments where there are those side effects, if the treatment on balance benefits the majority of patients they will continue to be prescribed, is that fair to say?

A Yes, as long as the person knows the risk versus benefit and gets full informed consent.

Q In Paragraph 96 of your declaration you say: "Children who fail to progress through puberty are infertile."

Do you see that?

A Yes.

Q Okay. So puberty blockers themselves don't cause infertility though, right?

A They should not if we look at the data on

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precocious puberty. There is no good published data in the treatment of children with gender dysphoria.
Q Would you agree once the puberty blockers stop and the child progresses through endogenous puberty we have no reason to believe that blockers have a negative effect on fertility?
A They should not. Although, there is not data published for those with gender dysphoria.
Q You would agree with that statement when it is used for precocious puberty?
A Yes, it appears that it does not impair fertility. But the data that is published in the children with precocious puberty is primarily biologic females usually.
We have very, very little data on biologic boys and their ability to conceive when puberty blockers are stopped in them.
Q And that is something that you probably would want more data on, right?
A Yes.
Q Can you think of other medical treatments that can cause infertility in children that are minors?
A Chemotherapy.
Q You believe there are circumstances in which

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children and their parents can consent to the receipt of that treatment, correct?
A Well, that is pretty clear. If they have cancer they might be infertile, but they won't die of their cancer hopefully.
Q You would agree that there are medical outcomes that are more important than fertility, or parents and their minor children can weigh whether fertility is important to them relative to the other potential conditions or side effects?
A That is the importance of the full informed consent by the parents and the assent by the child. Children have, they don't have long-term perspective often. But, yes.
Q We may have covered this. Have you ever prescribed puberty blockers for any condition?
A Not that I recall.
Q In Paragraph 106 of your declaration you are talking about hormones.
You say in the third sentence, "Pediatricians and pediatric endocrinologists would fail to recognize any of these long-term harms because they usually do not provide care to persons after the age of 18."
Is that what you said there?

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A Yes.
Q Is that statement generally true of all pediatric interventions?
A Yes.
Q So it's not specific to the provision to treating gender dysphoria in minors?
A Correct.
Q So you were talking earlier about the treatment of Type I diabetes in minors and their transition to adult endocrinologists.
A Yes.
Q Do you believe that, generally speaking, pediatric endocrinologists do understand the long-term effects of treating Type I diabetes in children?
A Yes.
Q Then in Paragraph 109 of your declaration you say, "Short-term effects of testosterone given to natal females include acne, baldness, facial hair, clitoral enlargement and pelvic pain. There may be deepening of the voice."
Do you see that?
A Yes.
Q And so for a person whose goal it is is to reduce their gender dysphoria, would you agree that some of those side effects are actually intended

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results?
A No.
Q You don't believe facial hair is an intended result of the testosterone to treat gender dysphoria?
A Well, acne is not. Pelvic pain is not. Clitoral enlargement may be painful. That is not really the goal. Maybe facial hair.
Q So at least one of those might be an intended result?
A People don't usually want to go bald.
Q Would you agree if your goal was to appear more masculine then being bald might, in fact, help you in that effort?
A It might. I agree.
Q Not to put too fine a point on it.
A Correct.
Q In Paragraph 110 you talk about infertility or rather you say, "Infertility is frequent in those females treated with testosterone even if not given puberty blockers."
Do you see where you wrote that?
A Yes.
Q Have you ever treated a transgender man for infertility?

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A Not for their infertility.
Q And you are not a reproductive endocrinologist, correct?
A No.
Q Or by practice, I guess?
A No. Reproductive endocrinologists are trained initially as obstetricians gynecologists. They really just mostly focus on infertility in biologic females.
Q In Paragraph 126 you talk in the second sentence, "Bilateral mastectomy has been euphemistically called 'top surgery' and 'chest contouring'."
Do you see that?
A I do.
Q Do you think that anyone who gets that medical procedure fails to understand that breast tissue will be removed?
A I think actually they don't, a lot of them don't understand it. So there are instances in which young women have had their breasts removed and then they regret it and they want to have them put back on.
Q Well, I'm asking a different question. The question is not about that, but do you think that the fact that a surgery is called top surgery or

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chest contouring obscures the fact to the patient that what is going to happen is they are going to have breast tissue removed bilaterally?
A I think it's inappropriate and it is obscuring. I think it is misleading and it minimizes what they are doing.
Q Would you be more supportive of that as a medical intervention if everyone agreed we will only call it bilateral mastectomy? We will not use the terms top surgery and chest contouring.
A Yes. Call it what it is.
Q Okay.
MR. SELDIN: So we have been going for a little under an hour. Is now a good time to take maybe a five minute break?
MS. YOUNGS: Sure.
(OFF RECORD AT 4:09 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:15 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, in Paragraph 131 of your declaration, which is Exhibit 1, you talk about clinics in the U.K.

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Is it your understanding that the treatment of gender dysphoria using blockers and hormones is still being provided in the U.K. in some form?
A That is still an option.
Q Then in Paragraph 132 you discuss Sweden. In the second sentence you talk about, "Its new guidelines stated that the risks of hormonal interventions outweighed benefits and that hormonal interventions in minors can only be used as part of a research protocol."
Did I read that correctly?
A Yes.
Q So in Sweden they are still providing care, but limited to research studies?
A They are providing care, but it's hormonal interventions that are limited to research protocols.
Q Yes. So you would agree then that hormonal care is still being provided to adolescents in Sweden in the context of research protocols?
A Yes.
Q Okay. Which in your view might be beneficial in the United States as well in the context of a randomized control trial?
A Right. Carefully designed randomized control

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trial. Yes.
Q In Paragraph 133 of your declaration you talk about France.
Is it your understanding that care is being provided in France under some restrictions related to research?
A Specifically what do you mean by "care"?
Q Hormonal treatments for the gender dysphoria in adolescents?
A "They advised 'the greatest reserve' in the use of hormonal treatments."
That should be not an initial treatment. It's an option, but only after extended psychological support.
Q Which in your view, that would be if you were going to provide hormonal care to adolescents for gender dysphoria, that would be the correct protocol after an extended period of therapy?
A To evaluate all co-morbidities, evaluate the child very thoroughly and only in the setting of the research protocol.
Q Is it your understanding then with respect to Paragraphs 134 and 135 that similarly Norway and Finland are also providing hormonal treatment for gender dysphoria to adolescents in some form?

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A In Norway, this statement there in Norway was that there was insufficient evidence for the use of puberty blockers and opposite sex hormones in young people.
The approach that the Norwegians are taking has not been finalized. That was the guidance from their Health Care Investigation Board.
In Finland, let me refresh my memory. They recommended psychosocial support as a first line of treatment. Hormonal interventions may be considered with a great deal of caution and no irreversible treatment should be initiated.
Q But in neither place is care banned -- is the provision of hormonal treatment to adolescents for gender dysphoria banned entirely at this stage?
A To my understanding that is correct.
Q Okay. Earlier today we were talking about your employer Intermountain Health --
A Yes.
Q -- and their linking to certain resources for care of transgender people and LGBTQ health generally.
Do you remember that discussion?
A Yes.
Q Do you believe that Intermountain has been subjected to sort of group thinking and social

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contagion in the same way as the AMA and other organizations?
A Yes.
Q Do you think that there are any large medical systems in the United States that have not been subjected to that kind of group think and social contagion?
A No.
Q We were talking about your prior experience as an expert in two cases. I believe that is in your declaration in Paragraph 13.
Do you have that portion of your declaration up?
MS. YOUNGS: Paragraph 13?
MR. SELDIN: Yes.
MS. YOUNGS: Okay.
Q Okay.
A Yes.
Q For Suzanne Platz did you write a report?
A Yes.
Q Were you deposed?
A Yes.
Q Did you testify at trial?
A No.
Q Did the case go to trial?

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A No.
Q Was your expert opinion in that case challenged in the form of a Daubert motion or a state equivalent?
A No.
Q For the second case, William Blair, did you do a report?
A Yes.
Q Were you deposed?
A Yes.
Q Did you testify at trial?
A Yes.
Q Did any party file a Daubert motion as to your testimony or try to limit it in some way?
A Not that I'm aware of.
Q In either case was your testimony limited or excluded by the court in any way?
A No.
Q Have you ever had to detract a research paper?
A No.
Q Have you ever had to issue a correction for a research paper?
A No.
Q Have you ever been sued for medical malpractice?
A No.

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Q Have you ever been the subject of professional discipline?
A No.
Q Or sanctioned by the licensing board?
A No.
Q Have you ever had a professional complaint filed against you?
A No, not that I'm aware of.
Q Have you ever been arrested or charged with a crime?
A No.
Q Have you ever been the subject of a Title Nine complaint?
A No. What is Title Nine?
Q Have you ever worked at an academic research institution?
A No. The answer is no, I've not been the subject to a Title Nine complaint.
Q Have you ever been accused of any other form of discrimination or harassment?
A No.
Q Recalling earlier we were talking about your senior fellowship with Do No Harm. You also mentioned being a member of, I believe, SEGM, S-E-G-M, is that correct?

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A Yes.
Q Are there any other organizations like that that you belong to?
A Like what?
Q Like Do No Harm or SEGM?
A How are you characterizing them?
Q Are you a member of any other organizations that take a position on the provision of treatment for gender dysphoria?
A No.
Q Are you a member of any other organization that takes the position on gender ideology as to how Do No Harm uses that term?
A I will correct that statement. The answer is yes, there is one other organization. They take a position on treatment of gender dysphoria. That organization is AAPS, American Association of Physicians and Surgeons.
They have been around since the 1950s. They also have a view that is similar to Do No Harm's view.
Q And what was the extent of your involvement with AAPS?
A I'm just a member.
Q Do they have a newsletter that you read? Do you

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go on their website? What is the nature of your belonging to that organization?
A I just pay dues. I get a regular mailing and newsletter. They have, they have been involved in -- I think they filed some Amicus briefs in various cases. I don't know about gender cases. And my membership there is in my C.V.
Q So other than Do No Harm, SEGM and AAPS, are there any other organizations of which you are a member that are similar in their beliefs regarding gender ideology or the treatment of gender dysphoria?
A No.
MR. SELDIN: If we could take another break. It's possible I'm done.
MS. YOUNGS: Okay.
MR. SELDIN: Would you be amenable to ten minutes? Let's come back at 4:37 Eastern.
MS. YOUNGS: Okay.
(OFF RECORD AT 4:27 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:37 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, thank you. Unless I have some

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follow-up questions from any questions Ms. Youngs might ask, I have nothing further for you today. Thank you for your time.
MS. YOUNGS: I have no rebuttal questions.
(OFF RECORD AT 4:41 P.M.)

AND FURTHER THE DEPONENT SAITH NOT.

(Signature waived.)

_____
DANIEL WEISS, M.D.

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STATE OF INDIANA)
) SS:
COUNTY OF BOONE)

I, Wendi Kramer Sulkoske, Notary Public in said county and state, do hereby certify that the deponent DANIEL WEISS, M.D. was sworn to tell the truth in the aforementioned matter:
That the deposition was taken on behalf of the Plaintiffs at the time and place heretofore mentioned, with counsel present as noted;
That said deposition was taken down in Stenograph notes, reduced to typewriting under my direction, is a true record of the testimony given by said deponent; and that the reading and signing by the deponent were waived, the witness being present and consenting thereto.
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties or otherwise interested in the event of this action, and am not in the employ of the attorneys for the respective parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 2023.

_____
Wendi Kramer Sulkoske, Notary Public

Commission Number NP0661030

My commission expires December 1, 2030
My county of residence is Boone

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Daniel Weiss MD CDECES PNS CPI FAPCR

Chair □anchester□□ice Chair C□trona□Ranking □em□er □enson□and mem□ers of the Ho□se □amilies□□ging□and H□man □ervices Committee

I am here to support the *Save Adolescents from Experimentation Act*, the SAFE Act.

My testimony is strictly my own and does not represent any health care organization in the State of Ohio.

I am a board-certified internist and endocrinologist. I have practiced in northern Ohio since 1986. I am also a Certified Physician Investigator. I have been the principal investigator for over 100 clinical trials involving both adults and children.

Physicians have 3 fundamental responsibilities: we must use our expertise to **diagnose** and to **care** for our patients. And we must be certain that our patients understand and fully **consent**.

Diagnosis of a medical condition is <u>not</u> delegated to the patient, because it requires expert medical evaluation. Physicians who see a child with distress, possibly related to gender, should not agree to the child's diagnosis any more than they would agree with a child who thinks he or she has diabetes or cancer.

Once the physician is confident in the diagnosis, he or she can weigh the best **care** or treatment for that patient. A cardinal principle is: "first do not harm".

Finally, physicians must obtain informed **consent**, especially for any experimental intervention. Ethical practice prohibits children from providing consent. Children cannot fully comprehend risks versus benefit, and at most can provide assent to a parental decision. Children must obtain consent from their legal guardian or parent for any medical treatment or surgery. Treatment for gender dysphoria should not be an exception to this requirement.

I stopped accepting new patients with gender dysphoria because I discovered that most had stories of traumatic childhoods and co-morbid depression. Most had inadequate psychologic

evaluation before they were “cleared” for treatment. Hormonal treatment did not resolve those underlying psychologic issues.

Parents are often told if they fail to go along with hormonal interventions for their child with gender dysphoria, he or she will commit suicide. However, the best evidence proves this to be completely false. A long-term study of adults in Sweden found that despite cross sex hormones and surgical reassignment surgery, there was a 19-fold higher suicide rate and a 3-fold higher overall mortality in transgender persons as compared to the control population.

The only study on hormonal treatment of gender dysphoria in minors is the so called the Dutch study. That study found no improvement in depression, anxiety or anger after treatment in a small group of 55 children.

To summarize, there are NO studies that demonstrate clear benefit with hormonal or surgical treatment for children with gender dysphoria.There is increasing evidence of harm with puberty blockers and cross sex hormones—damaging bone health, cardiovascular health and fertility. A paper published this year in the Endocrine Society’s key journal described the evidence on hormonal interventions for “gender diverse adolescents” as sparse, of low quality and with potentially irreversible side effects.

And GnRH analogues, so called puberty blockers, are not FDA approved for treating gender dysphoria. All these facts mean that puberty blockers and cross sex hormones are experimental interventions for gender dysphoria. The SAFE Act aims to protect children from these experimental therapies.

There are an increasing number of people who were given hormonal or surgical treatment for gender dysphoria who later regret such treatment. I estimate that 75% of my adult patients failed to persist in their treatment with me. Recently, I saw a man who regretted having his testicles removed within one year of that surgery.

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I strongly support the SAFE Act. The SAFE act is an act of harm reduction for children.

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Reference List

1. Kaltiala R, Heino E, Tyolajarvi M, Suomalainen L. Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. Apr 2020;74(3):213-219. doi:10.1080/08039488.2019.1691260

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From: D W
To: BOM Public Comment
Subject: Gender dysphoria comments from an endocrinologist who has treated many
Date: Monday, October 24, 2022 9:21:21 PM
Attachments: Dr Daniel Weiss .pdf

Please see my attached comments.
I strongly support Florida's efforts to protect minors from experimental medical interventions such as cross sex hormones, puberty blockers and surgery to remove normal body parts.
Thank you.

Daniel Weiss MD CDCES
Physician Nutrition Specialist
Board Certified: Diabetes/Endocrinology/Metabolism
Diplomate: American Board of Obesity Medicine

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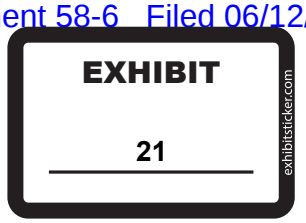

Daniel Weiss MD

My name is Dr. Daniel Weiss.

I am a board-certified internist and endocrinologist. I am also a senior fellow with the non-profit organization called Do No Harm. My commentary is mine alone and does not represent the views of any medical practice.

I practiced endocrinology in northeastern Ohio for 36 years. In December 2022, I moved to Utah and joined a medical practice there. I believe my clinical experience is meaningful in part because for 10 years I provided hormonal treatments for persons with gender dysphoria .

I no longer provide this care.

Why not? Because I discovered that most of these patients had stories of traumatic childhoods and co-morbid depression. Their psychologic evaluation was inadequate before they were "cleared" for treatment. Furthermore, opposite sex treatment did not resolve any of their underlying psychologic issues.

I later learned that there is no good scientific or clinical evidence to support hormonal or surgical interventions for minors with gender dysphoria. Instead, there is increasing evidence to show that such treatments for gender dysphoria cause harm. I will briefly summarize key data in the medical literature .

The most-cited studies of hormonal treatment in minors report the outcomes using the so-called Dutch protocol. I encourage you to look at the references I have provided.

Multiple papers detail the many scientific flaws in the Dutch studies. Here are a few. There was no comparison group. The study subjects were highly selected. The study started with 111 children but only 55 were analyzed at its conclusion. Nonetheless the small group of children showed no improvement in gender distress, anxiety, or anger after opposite sex hormone treatment. The researchers used an unvalidated measurement tool and manipulated its results.

It is little known that the series included a death as a complication of surgery. Importantly, independent UK researchers could not replicate the findings of the Dutch group.

A paper published last year in the Endocrine Society's key journal summarized the evidence on hormonal interventions for "gender diverse adolescents" as sparse and of low quality. In the key authoritative endocrinology textbook, just published in 2023, the chapter on Transgender Healthcare, written by a WPATH member, states that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

And gender dysphoria resolves in the vast majority of children without any interventions.

I have touched on the lack of data showing benefit. So, what about harm? Many studies show that puberty blockers and opposite sex hormones damage bone health, cardiovascular health, and fertility. There is emerging evidence of increased rates of breast cancer and other adverse effects.

Those who state that puberty blockers are readily reversible and harmlessly "pause" puberty can cite no published data on the reversibility of these drugs in this setting. The FDA has not approved any drug for treatment of gender dysphoria.

How about suicide? The largest study documented 4 suicides out of 15,000 adolescents being treated for gender dysphoria in the UK. It is not known whether this rate is any different than that seen in adolescents undergoing mental health treatment who do not have gender dysphoria.

The best data suggest that hormonal and surgical interventions increase the risk of suicide. The Dutch study provided no data on suicide. In contrast, a long-term study of transgender persons in Sweden found a 19-fold overall higher suicide rate, 40-fold higher in females and a

3-fold higher overall mortality despite treatment with opposite sex hormones and surgery as compared to the control population. In a study of over 8000 transgender person,two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. In an article this year in the NEJM there was a 45-fold increase in suicide with opposite sex hormonal therapy.

For more than a decade, long before opposite sex therapies became popular in the United States, European centers offered these treatments for gender confusion. Now, as increasing data show substantial harm, Finland, Sweden, Norway, France and the United Kingdom have discouraged or terminated opposite sex treatments for minors. Instead, they advise supportive psychotherapy for minors with gender confusion.

The United Kingdom's Gender Identity Development Service, started in 1989, is now closed. Hormonal interventions will only be provided as part of formal research program. They recognize the experimental nature of these treatments in those who have normal puberty.

Why haven't US physicians and surgeons learned from their European colleagues? I am uncertain but I ask how many doctors who justify this harm to minors have financial conflicts of interest? How many are employed at transgender clinics and how many perform lucrative surgeries ?

Finally, it should be noted that strict international principles prohibit children from providing consent because children cannot fully comprehend risk versus benefit. The United States is a signatory to the United Nations Convention on the Rights of the Child. The *Declaration of the Rights of the Child* states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care." These safeguards are uniquely important when it comes to an experimental intervention. The Declaration of Helsinki allows individual parents to consent to an experimental treatment for their child. Usually, this choice is made in an extraordinary

circumstance, to save that child's life, and with the child's assent. Experimental treatments to change gender appearance should not be an exception to these requirements.

Please help protect the children of Ohio.

Thank you.

Daniel Weiss MD

April 24, 2023

Key References:

Lack of efficacy

de Vries A. L. *et al.* Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J. Sexual Medicine 2011; 8: 2276-2283.

"Dutch Study." There was no change in anxiety, depression or gender distress following GnRH therapy (puberty blockers) and opposite sex therapy in children. There was no comparator control group and all received psychologic support.

de Vries A.L. *et al.* Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014; 134: 696-704.

"Dutch Study." A non-validated assessment tool was used to assess dysphoria, there was no control group and the 55 patients were tested in such a way that improvements in scores would be seen even without treatment.

Carmichael P. *et. al*. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLOS One 2021; 16 (2)

These researchers could not confirm any of the claims of DeVries et al in young people treated with the Dutch protocol in the U.K.

Kaltiala R, *et. al.* Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. 2020;74(3):213-219.

This retrospective chart review showed no improvement in psychiatric status in 52 adolescents after opposite sex hormone treatments.

Abbruzzese E. *et. al*. The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed, Journal of Sex & Marital Therapy. January 2023.

This paper is a comprehensive and critical review of De Vries' studies identifying the many flaws and biases in the methodology.

Levine S. *et. al*. Reconsidering informed consent for trans-identified children, adolescents and young adults. J. Sex and Marital Therapy 2022; 48: 706-727.

This paper describes the challenges in providing full and proper informed consent to children with gender dysphoria and their parents in light of the flaws in the Dutch protocol and limitations in our knowledge base.

O'Connell MA, *et al*. Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. 2022;107(1):241-257.

This review stresses the need for improvement in the "evidence base" emphasizing that the "evidence relating to hormonal therapies in youth is low" and that "data on wellbeing in transgender persons is sparse".

Levine SB, et. al. What are we doing to these children? Response to Drescher, Clayton, and Balon commentaries on Levine et. al. 2022. J Sex and Marital Therapy 2023; 49:115-125.

In a response to comments, the authors discuss the benefits of psychotherapeutic interventions and the frequent conflicts of interest in those clinicians who promote hormonal and surgical interventions.

Deutsch, MB. Transgender Healthcare. p 1752-1757 *in* Degroot's Endocrinology. Basic science and clinical practice. 8th edition. 2023.

Dr. Madeline Deutsch, a member of the World Professional Association for Transgender Health (WPATH) writes that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

Role of psychotherapy or non-intervention

Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20.

85% of children with gender dysphoria show spontaneous resolution of their symptoms and distress without any intervention.

Clayton, A. Gender-affirming treatment of gender dysphoria in youth: a perfect storm environment for the placebo effect-the implications for research and clinical practice. Arch Sex Behavior 2023; 52:483-494.

This paper provides an overview of the poor data in support of opposite sex hormone treatment, of the harms caused by opposite sex treatment and improvement in response to placebo. For perspective, it describes historical treatments which once were popular, but eventually proved harmful to children.

Costa R. *et. al.* Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015: 12: 2206-2214.

This UK study found that psychological support alone lead to significant improvement in psychological function in adolescents with gender dysphoria, mean age of 15.5.

Psychiatric co-morbidities in youth with gender dysphoria

Becerra-Culquie TA *et. al.* Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 2018: 141: e20173845.

Over 60 % of transgender adolescents were diagnosed with depression, autism spectrum disorders, psychoses, substance abuse, anxiety or eating disorders

Kozlowska, K. *et. al.* Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments 2021; 1: 70-95

88% of these youth had comorbid mental health diagnoses and other indicators of psychological distress and adverse childhood events. 19% had a history of sexual abuse.54% were bullyed. What is the best approach to treating these youth?

Devor, H. Transexualism, dissociation and child abuse: an initial discussion based on nonclinical data. J Psychology and Human Sexuality 1994; 6: 49-72.

In depth interviews disclosed that sixty percent of the natal females disclosed one or more types of child abuse; more than 50% of that abuse was sexual.

Harm:

Mortality:

Dhejne C, *et al.* Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.

This long-term study found an overall 19-fold higher suicide rate (40 fold in female to male) and a 3-fold higher overall mortality in 324 transgender persons at 11 years after full transition, compared to the control population.

de Blok CJM. *et al.* Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670.

This study documented increased rates of mortality in all persons receiving opposite sex hormone therapy.

Bone:

Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27 2021;34(7):937-939.

Children treated with puberty blockers showed a marked reduction in bone density in those treated with GnRH analogues (puberty blockers); this change would be expected to increase the risk of fractures.

Cardiovascular:

Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019;139(11):1461-1462.

This study found increased rates of heart attacks, strokes and blood clots in those treated with opposite sex hormone therapy.

Getahun D. *et. al.* Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21 2018;169(4):205-213.

This study documents increased rates of blood clots as well as strokes and heart attacks in males given opposite sex hormone treatment

Fertility:

Baram S, *et al*. Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5 2019;25(6):694-716.

The authors raise concerns that opposite sex hormone therapies cause infertility, but offer no solutions to this problem.

Rodriguez-Wallberg K, *et. al.* Reproductive health in transgender and gender diverse individuals: a narrative review to guide clinical care and international guidelines. International J of Transgender Health. 2023; 24: 7-25

This paper details the likelihood of infertility "inherent in these interventions". They stress the many challenges and unknowns in fertility preservation in those receiving opposite sex therapy, especially in children. They note that many transgender persons "regret missed opportunities for fertility preservation".

Cancer:

de Blok CJM, *et. al.* Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. BMJ 2019; 365: l1652.

Males given opposite sex hormones experience a 46 fold increase in the occurrence of breast cancer.

Corso, G, *et. al.* Risk and incidence of breast cancer in transgender individuals: a systematic review and meta-analysis. European J of Cancer Preventioln 2023;

Reports a 22 fold increase in breast cancer in male to female transgender persons as compared to biolologic males.

Gurrala RR, *et. al.* The impact of exogenous testosterone on breast cancer risk in transmasculine individuals. Ann Plastic Surg 2023; 90: 96-105.

Breast cancer occurred 20 yrs earlier than expected in this population of females even though most had mastectomies before the diagnosis.

Wang, JC et. al. Factors associated with unsatisfactory Pap tests among sexually active trans masculine adults. LGBT Health 2023;

Those females who had received 1 year or more of testosterone were three and half times more likely to have an unsatisfactory Pap test, making early detection of cervical cancer much more difficult.

Breastfeeding:

Gribble, K. *et al.* Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm. Frontiers in Global Women's Health 2023; Feb.

This case report describes the challenges faced by a woman who detranstions and who grieves over being unable to breastfeed her infant. Detransition is discussed and the importance of including in the informed consents before mastectomy the inability to breastfeed.

Brain:

Schneider MA, e*t. al.* Brain maturation, cognition, voice pattern in a gender dysphoria case under pubertal suppression. Frontiers in Human Neuroscience Nov 2017; 11.

This patient showed an abnormal failure to increase brain white matter. In addition the patient experienced a reduction in IQ and memory during 22 months of puberty blockers.

Gutkind NE, *et. al.* Idiopathic intracranial hypertension in female-to-male transgender patients on exogenous testosterone therapy. Ophthalmic Plast Reconst Surg 2023.

Describes 4 patients, the youngest 19, with visual impairment, headaches and other symptoms caused by increased intracranial pressure. They postulate male hormone therapy as a cause.

Post-surgical complications

Van der Sluis WB, *et. al.* Genital gender-affirming surgery for transgender women. Best Practice and Research Clinical Obstetrics and Gynecology Dec 2022.

The surgical procedures vulvoplasty and vaginoplasty typically require a 5 day hospital stay. The authors describe the risk of severe complications, the possibility of repeat surgeries and the fact that there is no accepted validated questionnaire to assess postoperative satisfaction.

Ortengren, C. et. al. Urethral outcomes in metoidoplasty and phalloplasty gender affirming surgery and vaginectomy: a systematic review. Translational Andrology and Urology 2022; 11: 1762-1770.

The authors review reports of surgical outcomes including the ability to urinate while standing after surgery. Of those reporting this result, 25% of patients were unable to urinate while standing. Up to 63% had complications including urethral strictures and infections. No description was provided of patient satisfaction after surgery.

Kamal K, *et.al.* Addressing the physical and mental impacts of postsurgical scarring among transgender and gender diverse people. LGBT Health 2023

The authors describe the "dearth of peer-reviewed research" on the "repurcussions" of postsurgical scarring and the lack of coverage by insurance for "scar treatment".

Potter, E. *et. al*. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic Neurourol Urodyn 2023; 42: 523-529

Pain, bleeding, sexual dysfunction and urinary symptoms were common (> 50%) in this series of 80 biologic males who had undergone surgery to create a vagina.

Wang, AMQ, *et. al*. Outcomes following gender affirming phalloplasty: a systematic review and meta-analysis. Sexual Medicine Reviews 2022; 10: 499-512.

The authors describe a 76% complication rate after attempts to create a penis in biologic females. Goals of surgery include being able to urinate with standing, having sensation, and aesthetics, i.e being similar in appearance to biologic male genitalia. The objective the authors considered did not include having a penis that can function for intromission. Only 6% of those centers reporting results aesthetic results.

Suicide risk

Wiepjes CM, *et. al.* Trends in suicide death risk in transgender people; results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). Act Psychiatr Scand 2020; 141: 486-491.

This long-term study of 8263 transgender adults, (mean age of 25 at first visit to gender dysphoria center) showed that suicide deaths occur during every stage of gender transitioning. There were 49 suicides out of 8263 persons with average follow-up of 7.5 years. This number is a rate of 40/100,000 which may be compared to 11/100,000 in the general population. Two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. The average age at the time of suicide was 41. This study provided no additional psychiatric information.

Biggs, M. Suicide by clinic-referred transgender adolescents in the United Kingdom. Arch Sexual Behavior 2021; 51: 685-90.

In this study, of the Gender identity Development Service in the UK, 4 patients commited suicide out of 15,000. This rate was 5.5 times higher than the overall adolescent population without psychiatric diagnoses. The study reached no conclusion as to the best approach to prevent these suicides.

Chen, D. *et. al.* Psychosocial functioning in transgender youth after 2 years of hormones. N Engl J Med 2023; 388: 240-250.

There was no control group in this study of children, aged 12-20 (mean age 16) treated with opposite sex hormones over 2 years in 4 US transgender clinics. Psychiatric care was not described. The biologic males showed no improvement in depression, anxiety or life satisfaction. There were no reports of adverse physical events but 2 children, on treatment, committed suicide during this short term study. The rate of suicide in this group translates into a 45 fold higher rate than CDC reported suicide rates for those of comparable age in the general population.

Jackson, D. Suicide-related outcomes following gender-affirming treatment: a review. Cureus March 20, 2023. Vol 15.

The author reviews those 23 studies that examine suicidal ideation and suicide attempts in persons before and after surgical and/or hormonal interventions. He finds various flaws in most of these studies. He points to the need for more research and informed consent for those considering these treatments.

Regret and Detransition

Littman L. Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch. Sex Behavior. 2021; 50: 3353-3369.

This study recruited subjects with gender dysphoria and offered them a 115-question anonymous survey on several social media sites. The responses showed that 48% of the natal females had trauma within 1 year before onset of gender dysphoria. 55% felt they did not receive adequate evaluation from a doctor or mental health professional before opposite sex therapy 76 % did not tell their treating physician that they had chosen to detransition. In 23%, the desire to "transition" was a response to difficulty in accepting themselves as gay, lesbian, or bisexual. Gender dysphoria started on average at age 11 and transition occurred on average at age 22. On average, detransition occurred 4 years later.

Roberts CM, *et. al.* Continuation of gender-affirming hormones among transgender adolescents and adults. J Clin Endocrinol Metab 2022; 107: e3937-e3943.

This study used the US Military Healthcare System database to determine the adherence rates for opposite sex hormone treatment in 952 persons with a mean age 19. 66% of this cohort were natal females. Over 4 years, 36% of the natal females discontinued treatment. Of those who started opposite sex treatment below the age of 18, 26% discontinued within 4 years.

Ethics

https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-50/subpart-D/section-50.52

Code of federal regulations relating to institutional review board requirements for clinical investigations involving children. There must be anticipated benefit that is as favorable as other available treatments and there must be assent of the children and permission of the parents or guardians.

Declaration of Helsinki (1964) BMJ 313, 1448-1449, 1996

Gender Service Providers

Barnes, Hannah. Time to Think. The Inside Story of the Collapse of the Tavistock's Gender Service for Children. 2023.

This BBC journalist details the history of the poor care provided to over 10,000 children seen over the course of 30 years in the United Kingdom's Gender Identity Development Service. Pressure from transgender activists, concrete thinking by distressed youth hoping for a quick fix and financial issues were some of the reasons why staff failed to address important psychologic

factors in their patients. In doing so, they directed these children into medical therapies that harmed and did not help.

Cass Review Interim Report (Feb 2022)
https://cass.independent-review.uk/publications/interim-report/

This is the commissioned report written by Dr Hillary Cass, a highly respected pediatrician in the United Kingdom. She describes the failings of the Gender Identity Development Service. Dr. Cass recommends many changes to the treatment of minors with gender dysphoria. She stresses psychosocial interventions as the principal focus.

Affidavit of Jamie Reed.
https://ago.mo.gov/docs/default-source/press-releases/2-07-2023-reed-affidavit---signed.pdf?sfvrsn=6a64d339_2

The writer is a whistleblower who describes the treatment of (over 600) children at the Washington University Pediatric Transgender Center. Children were railroaded into opposite sex medical interventions without addressing adverse effects and without treating underlying psychiatric conditions.

Do No Harm

EXHIBIT

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exhibitsticker.com

North Dakota Senate

Senate Committee on Human Services

HB 1254

Daniel Weiss MD

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is Dr. Daniel Weiss.

I am a board-certified internist and endocrinologist. I am also a senior fellow with the non-profit organization, Do No Harm. My commentary is mine alone and does not represent the views of any medical practice.

I believe my clinical experience is meaningful, in part, because I have provided hormonal treatments for persons with gender dysphoria in the past.

I do not do so now.

Why not? Because I discovered that most of these patients carried stories of traumatic childhoods and co-morbid depression. Their psychologic evaluation was inadequate before they were “cleared” for treatment. Furthermore, opposite sex treatment did not resolve any of their underlying psychologic issues.

I later learned that there is no good scientific or clinical evidence to support hormonal or surgical interventions for minors with gender dysphoria. Instead, there is increasing evidence to show that such treatments for gender dysphoria cause harm. I will briefly summarize key data in the medical literature.

The most-cited studies of hormonal treatment in minors report outcomes using the so-called Dutch protocol. I encourage you to review the references I have provided.

Multiple papers detail the many scientific flaws in the Dutch studies: There was no comparison group. The study subjects were highly selected. The study started with 111 children but only 55 were analyzed at its conclusion. Nonetheless, the small group of children showed no improvement in gender distress, anxiety, or anger after opposite sex hormone treatment. The researchers used an unvalidated measurement tool and manipulated its results. It is also little known that the series included, as a complication of surgery, a patient death. Independent researchers in the United Kingdom attempted to replicate the findings of the Dutch group, but, revealingly, were unsuccessful.

A paper published last year in the Endocrine Society's key journal summarized the evidence on hormonal interventions for "gender diverse adolescents" as sparse and of low quality. In the key authoritative endocrinology textbook, just published in 2023, the chapter on Transgender Healthcare, written by a WPATH member, states that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

And gender dysphoria resolves in the vast majority of children without any interventions.

I have touched on the lack of data showing benefit. So, what about harm? Many studies show that puberty blockers and opposite sex hormones damage bone health, cardiovascular health, and fertility. There is emerging evidence of increased rates of breast cancer and other adverse effects.

Those who state that puberty blockers are readily reversible and harmlessly "pause" puberty can cite no published data on the reversibility of these drugs in this setting. The FDA has not approved any drug for treatment of gender dysphoria.

How about suicide? The largest study documented 4 suicides out of 15,000 adolescents being treated for gender dysphoria in the United Kingdom. It is not known whether this rate is any different than that seen in adolescents undergoing mental health treatment who do not have gender dysphoria.

The best data suggest that hormonal and surgical interventions increase the risk of suicide. The Dutch study provided no data on suicide. In contrast, a long-term study of transgender persons in Sweden found a 19-fold overall higher suicide rate.

The rate was 40-fold higher in females and a 3-fold higher overall mortality, despite treatment with opposite sex hormones and surgery as compared to the control population. *In a study of over 8000 transgender person, two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center*. In a New England Journal of Medicine article this year, suicide reportedly increased 45-fold with opposite sex hormonal therapy.

For more than a decade, long before opposite sex therapies became popular in the United States, European centers offered these treatments for gender confusion. Now, as increasing data show substantial harm, Finland, Sweden, France, and the United Kingdom have discouraged or terminated opposite sex treatments for minors. Instead, they advise supportive psychotherapy for minors with gender confusion.

Why have physicians and surgeons in the United States resisted the shift occurring among their European counterparts? I do not know the answer. However, I caution legislators to avoid all individual and institutional financial conflicts of interest while finalizing this bill.

In closing, it should be noted that strict international principles prohibit children from providing consent. This is because children cannot fully comprehend risk versus benefit. The United States is a signatory to the United Nations Convention on the Rights of the Child. The *Declaration of the Rights of the Child* states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care." These safeguards are uniquely important when it comes to an experimental medical intervention. The Declaration of Helsinki allows individual parents to consent to experimental treatment for their child. Usually, this choice is made in an extraordinary circumstance, to save that child's life, and with the child's assent. Experimental treatments to change gender appearance should not be an exception to these requirements.

Please help protect the children of North Dakota.

Thank you.

Daniel Weiss MD

Key References:

Lack of efficacy

de Vries A. L. *et al.* Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J. Sexual Medicine 2011; 8: 2276-2283.

"Dutch Study." There was no change in anxiety, depression or gender distress following GnRH therapy (puberty blockers) and opposite sex therapy in children. There was no comparator control group, and all received psychologic support.

de Vries A.L. *et al.* Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014; 134: 696-704.

"Dutch Study." A non-validated assessment tool was used to assess dysphoria, there was no control group, and the 55 patients were tested in such a way that improvements in scores would be seen even without treatment. There was one post-surgical death. Only 55 of the original 111 children were included in the analysis.

Carmichael P. *et. al.* Short-term outcomes of pubertal suppression in a selected cohort of 12- to 15-year-old young people with persistent gender dysphoria in the UK. PLOS One 2021; 16 (2) *These researchers could not confirm any of the claims of DeVries et al in young people treated with the Dutch protocol in the U.K.*

Kaltiala R, *et. al.* Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. 2020;74(3):213-219.

This retrospective chart review showed no improvement in psychiatric status in 52 adolescents after opposite sex hormone treatments.

Abbruzzese E. *et. al.* The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed, Journal of Sex & Marital Therapy. January 2023.

This paper is a comprehensive and critical review of De Vries' studies identifying the many flaws and biases in the methodology.

Levine S. *et. al.* Reconsidering informed consent for trans-identified children, adolescents, and young adults. J. Sex and Marital Therapy 2022; 48: 706-727.

This paper describes the challenges in providing full and proper informed consent to children with gender dysphoria and their parents in light of the flaws in the Dutch protocol and limitations in our knowledge base.

O'Connell MA, *et al.* Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. 2022;107(1):241-

257. *This review stresses the need for improvement in the "evidence base" emphasizing that the "evidence relating to hormonal therapies in youth is low" and that "data on wellbeing in transgender persons is sparse".*

Levine SB, *et. al.* What are we doing to these children? Response to Drescher, Clayton, and Balon commentaries on Levine et. al. 2022. J Sex and Marital Therapy 2023; 49:115-125. *In a response to comments, the authors discuss the benefits of psychotherapeutic interventions and the frequent conflicts of interest of those clinicians who solely promote hormonal and surgical interventions.*

Deutsch, MB. Transgender Healthcare. p 1752-1757 *in* Degroot's Endocrinology. Basic science and clinical practice. 8th edition. 2023.

In this authoritative textbook on endocrinology, *Dr. Madeline Deutsch, a member of the World Professional Association for Transgender Health* (WPATH) *writes that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."*

Role of psychotherapy or non-intervention

Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry.* 2016;28(1):13-20. *85% of children with gender dysphoria show spontaneous resolution of their symptoms and distress without any intervention.*

Clayton, A. Gender-affirming treatment of gender dysphoria in youth: a perfect storm environment for the placebo effect-the implications for research and clinical practice. Arch Sex Behavior Nov. 2022.

This paper provides an overview of the poor data in support of opposite sex hormone treatment, of the harms caused by opposite sex treatment and improvement in response to placebo. For perspective, it describes historical treatments which once were popular, but eventually proved harmful to children.

Costa R. *et. al.* Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015: 12: 2206-2214.

This UK study found that psychological support alone lead to significant improvement in psychological function in adolescents with gender dysphoria, mean age of 15.5.

Psychiatric co-morbidities in youth with gender dysphoria

Becerra-Culquie TA *et. al.* Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 2018: 141: e20173845.

Over 60 % of transgender adolescents were diagnosed with depression, autism spectrum disorders, psychoses, substance abuse, anxiety or eating disorders.

Kozlowska, K. et. al. Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments 2021; 1: 70-95

88% of these youth had comorbid mental health diagnoses and other indicators of psychological distress and adverse childhood events. 19% had a history of sexual abuse. 54% were bullied. What is the best approach to treating these youth?

Devor, H. Transexualism, dissociation and child abuse: an initial discussion based on nonclinical data. J Psychology and Human Sexuality 1994; 6: 49-72.

In depth interviews disclosed that sixty percent of the natal females disclosed one or more types of child abuse; more than 50% of that abuse was sexual.

Harm

Mortality:

Dhejne C, *et al.* Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.

This long-term study found an overall 19-fold higher suicide rate (40 fold in female to male) and a 3-fold higher overall mortality in 324 transgender persons at 11 years after full transition, compared to the control population.

de Blok CJM. *et al.* Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670.

This study documented increased rates of mortality in all persons receiving opposite sex hormone therapy.

Bone:

Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27, 2021;34(7):937-939. *Children treated with puberty blockers showed a marked reduction in bone density in those treated with GnRH analogues (puberty blockers); this change would be expected to increase the risk of fractures.*

Cardiovascular:

Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019;139(11):1461-1462.

This study found increased rates of heart attacks, strokes, and blood clots in those treated with opposite sex hormone therapy.

Getahun D. *et. al.* Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21, 2018;169(4):205-213.

This study documents increased rates of blood clots as well as strokes and heart attacks in males given opposite sex hormone treatment.

Fertility:

Baram S, *et al.* Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5, 2019;25(6):694-716.

The authors raise concerns that opposite sex hormone therapies cause infertility, but offer no solutions to this problem.

Cancer:

de Blok, *et. al.* Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. BMJ 2019; 365: l1652.

Males given opposite sex hormones experience a 46-fold increase in the occurrence of breast cancer.

Gurrala RR, *et. al.* The impact of exogenous testosterone on breast cancer risk in transmasculine individuals. Ann Plastic Surg 2023; 90: 96-105.

Breast cancer occurred 20 yrs earlier than expected in this population of females even though most had mastectomies before the diagnosis. Despite mastectomy, they retained some breast tissue.

Wang, JC et. al. Factors associated with unsatisfactory Pap tests among sexually active trans masculine adults. LGBT Health 2023;

Those females who had received 1 year or more of testosterone were three and half times more likely to have an unsatisfactory Pap test, making early detection of cervical cancer much more difficult.

Breastfeeding:

Gribble, K. *et al.* Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm. Frontiers in Global Women's Health 2023; Feb.

This case report describes the challenges faced by a woman who detranstions and who grieves over being unable to breastfeed her infant. Detransition is discussed and the importance of including in the informed consents before mastectomy the inability to breastfeed.

Brain:

Schneider MA, et. *al.* Brain maturation, cognition, voice pattern in a gender dysphoria case under pubertal suppression. Frontiers in Human Neuroscience Nov 2017; 11. *This patient showed an abnormal failure to increase brain white matter. In addition the patient experienced a reduction in IQ and memory during 22 months of puberty blockers.*

Post-surgical complications

Van der Sluis WB, *et. al.* Genital gender-affirming surgery for transgender women. Best Practice and Research Clinical Obstetrics and Gynecology Dec 2022.

The surgical procedures of vulvoplasty and vaginoplasty typically require 5 day hospital stay. The authors describe the risk of severe complications, the possibility of repeat surgeries and the fact that there is no accepted validated questionnaire to assess postoperative satisfaction.

Ortengren, C. et. al. Urethral outcomes in metoidioplasty and phalloplasty gender affirming surgery and vaginectomy: a systematic review. Translational Andrology and Urology 2022; 11: 1762-1770.

The authors review reports of surgical outcomes including the ability to urinate while standing after surgery. Of those reporting this result, 25% of patients were unable to urinate while standing. Up to 63% had complications including urethral strictures and infections. No description was provided of patient satisfaction after surgery.

Kamal K, *et.al.* Addressing the physical and mental impacts of postsurgical scarring among transgender and gender diverse people. LGBT Health 2023

The authors describe the "dearth of peer-reviewed research" on the "repercussions" of postsurgical scarring and the lack of coverage by insurance for "scar treatment".

Potter, E. et. al. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic Neurourol Urodyn 2023; 42: 523-529

Pain, bleeding, sexual dysfunction, and urinary symptoms were common (> 50%) in this series of 80 biologic males who had undergone surgery to create a vagina.

Wang, AMQ, et. al. Outcomes following gender affirming phalloplasty: a systematic review and meta-analysis. Sexual Medicine Reviews 2022; 10: 499-512.

The authors describe a 76% complication rate after attempts to create a penis in biologic females. Goals of surgery include being able to urinate with standing, having sensation, and aesthetics, i.e being similar in appearance to biologic male genitalia. The objective the authors considered did not include having a penis that can function for intromission. Only 6% of those centers reporting results aesthetic results.

Suicide risk

Wiepjes CM, *et. al.* Trends in suicide death risk in transgender people; results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). Act Psychiatr Scand 2020; 141: 486-491.

This long-term study of 8263 transgender adults, (mean age of 25 at first visit to gender dysphoria center) showed that suicide deaths occur during every stage of gender transitioning. There were 49 suicides out of 8263 persons with average follow-up of 7.5 years. This number is a rate of 40/100,000 which may be compared to 11/100,000 in the general population. Two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. The average age at the time of suicide was 41. This study provided no additional psychiatric information.

Biggs, M. Suicide by clinic-referred transgender adolescents in the United Kingdom. Arch Sexual Behavior 2021; 51: 685-90.

In this study, of the Gender identity Development Service in the UK, 4 patients committed suicide out of 15,000. This rate was 5.5 times higher than the overall adolescent population without psychiatric diagnoses. The study reached no conclusion as to the best approach to prevent these suicides.

Chen, D. *et. al.* Psychosocial functioning in transgender youth after 2 years of hormones. N Engl J Med 2023; 388: 240-250.

There was no control group in this study of children, aged 12-20 (mean age 16) treated with opposite sex hormones over 2 years in 4 US transgender clinics. Psychiatric care was not described. The biologic males showed no improvement in depression, anxiety, or life satisfaction. There were no reports of adverse physical events but 2 children, on treatment, committed suicide during this short-term study.

The rate of suicide in this group translates into a 45-fold higher rate than the CDC reported suicide rates for those of comparable age in the general population.

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https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-50/subpart-D/section 50.52

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Declaration of Helsinki (1964) BMJ 313, 1448-1449, 1996

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al,	)	
	)	
Plaintiffs,	)	Case No.
	)	1:23-cv-00595-JHP-KMB
-vs-	)	
	)	
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,	)	
	)	
Defendants.	)	

DEPOSITION OF KRISTOPHER KALIEBE, M.D.

The deposition upon oral examination of KRISTOPHER KALIEBE, M.D., a witness produced and sworn before Wendi Kramer Sulkoske, Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiff via videoconference in Tampa, Hillsborough County, Florida on June 1, 2023, pursuant to the Federal Rules of Civil Procedure.

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Bailey Steinhauer, Andrew Shaw
Charles Ferguson

EXAMINATION INDEX

EXHIBIT INDEX

KRISTOPHER KALIEBE, M.D.
the witness herein, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:
EXAMINATION,
QUESTIONS BY MR. SELDIN:

Q Dr. Kaliebe, good morning.
A Good morning.
Q My name is Harper Seldin. I'm an attorney with the ACLU for the plaintiffs on this matter. Joining me is Stevie Pactor, along with Gavin Rose, along with some interns as well as an intern from the national office.
How are you this morning?
A I'm good.
Q So just to do a little bit of table setting and some housekeeping and then we will get right to it.
MR. SELDIN: Mr. Patterson, I don't know if you want to enter an appearance for the record?
MR. PATTERSON: I'm appearing on behalf of the defendants and to defend this deposition.
Q Dr. Kaliebe, have you had your deposition taken before?

A Yes.
Q About how many times?
A Fifteen.
Q Okay. So this will all be familiar to you, but I will say it again.
A Yes.
Q I'm sure fourteen times you have heard lawyers say you know this, but we will go over it anyway.
First, are you on any medications today that would prevent you from hearing and understanding me and providing truthful responses?
A No.
Q Any other reason today that you could not testify truthfully or understand what I'm asking you?
A No.
Q Great. So today we will be having a discussion. I just ask that with the Zoom lag that we let each other finish. Please let me finish my question even if you think you know where I'm going. I will endeavor to let you finish your answer.
If you answer my question I will assume that means you understood it. Is that fair?
A Yes.
Q Great. And your responses need to be verbal. Uh-huh and huh-uh look pretty much the same on the

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record. We ask that you verbalize your response. If at any time you need a break, let me know. I will try to break us around the hour mark. I ask if there is a question pending that you answer the question before you take a break.
Does that sound like a good plan?
A Yes.
Q Great. Then, Doctor, do you have any notes with you today or anything on your desk?
A I only have a blank piece of paper and a pen, so, no, I have no notes or anything like that.
Q Okay. Great. So the first thing that I would like to show you is an exhibit that has been marked Exhibit 1.
I think Joel will pull that up for us.
A Okay.
Q My question when we see Exhibit 1 is just going to be do you recognize this document?
A Yes, I recognize that document.
Q And is this the declaration that you submitted in this case?
A It does appear to be so.
Q Does this contain all of the opinions that you intend to offer in this case?
A Yes. Unless I'm asked about other matters.

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Q As of this moment it contains all of the opinions that you intend to offer?
A Yes.
MR. SELDIN: Joel, could you scroll us down toward the end.
Q Dr. Kaliebe, I don't believe there was a C.V. attached to this declaration. I just want to go to the end. I believe it just includes a list of publications. I just want you to confirm that that is the case.
A Correct.
Q Okay.
MR. SELDIN: Joel, can you pull up Exhibit 3 for us.
Q My question, Dr. Kaliebe, is just going to be do you recognize this document?
A Yes.
Q What is this?
A This is another report, expert report for the state of Alabama.
Q And I believe there was a C.V. attached to the end of this.
MR. SELDIN: Joel, if you can scroll down for us, please. I believe it starts at about Page 87 of the PDF.

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Q Is this a copy of your C.V?
A It does appear to be so.
Q Were there any changes from when you submitted this report and when you submitted the declaration in this case?
A Nothing major. I'm not sure the C.V. has my promotion to full professor on it. That occurred as of a couple months ago.
Q Other than your promotion to full professor, congratulations, would there be any material changes?
A If they are, they are quite minor.
Q Dr. Kaliebe, do you still hold the opinions that you provided in the report that you submitted in Boe v. Marshall?
A Yes.
Q Were you aware that the state of Indiana provided this report to plaintiffs as an example of a report that you might offer in this case?
A Yes.
MR. SELDIN: Joel, if you can pull up Exhibit 4 for us.
Q Dr. Kaliebe, do you recognize this document?
A Yes.
Q What is it?

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A It's a report for the state of Florida.
Q The case caption is Decker v. Weida, is that correct?
A Yes.
Q Do you still hold the opinions contained in this report?
A Yes, I think perhaps some minor opinions have evolved somewhat. But I would say for the most part, yes.
Q How would they have evolved?
A You have to be specific. I have continued to -- the report was filed, you know, months ago.
Q Looking at the date at the top of this -- you were fading out.
A No. I just continue to read. I continue to amass more information. So, you know, opinions that I had a couple months ago may be more nuanced if I have additional data to substantiate or slightly alter opinions.
I don't have any direct, I don't have any particular things that I know of in the report that I feel differently on. Although, I'm guessing there are probably some things that have slightly changed.
Q Just to make sure I understand, the report in

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Decker was filed on April 7, correct?
A Correct. Yes.
Q So it's your belief that in less than the two months that have elapsed between this report and today your opinions may have been refined or evolved, but are materially the same?
A Correct.
MR. SELDIN: Joel, can you pull up Exhibit 5?
Q Dr. Kaliebe, I'm showing you what we marked as Exhibit 5.
Do you recall being deposed in the Decker matter we were just discussing?
A Yes, I do.
Q Does this appear to be a copy of your deposition in that case?
A Yes, it is.
Q Were you truthful in that deposition?
A Yes. Although, as I read the deposition transcript, I feel like there are a couple times where the answer that I gave, as I read it, seemed to be somewhat -- the question asked seemed to be somewhat different than as I understood it at the time.
So I was truthful, however, now that I look

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at some of the answers I might have answered them with some different nuance.
Q Is there a particular question you have in mind when you are explaining that to me?
A Well, yes. There were some questions about treatment of gender dysphoria that were framed in a manner that seemed to me as I read them that were sort of, that indicated that it must be treated. Where I believe at the time the questioner was, you know, is this a valid thing to treat? Would this be a good thing to treat? You know, just a slight nuance there.
I also noted that the questioner asked, they had a comment that I had to ask my wife, who is an endocrinologist, about the endocrinological patients. I didn't note it at the time that that was how the questioner framed it.
Of course, I know plenty about those things and have done my own research. I just thought it was nice to add on top of that, you know, she is a board certified endocrinologist.
As I read it, there are some minor things like that that I think were in the moment I didn't hear the question the way reflected as I read it. I would refine my answer.

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Q Did you have an opportunity to review your deposition transcript in Decker to submit an errata?
A Yes.
Q Did you submit any errata?
A Yes.
Q Did your errata address your different understanding of those questions or --
A My errata contained what I thought were misquotes of myself. I didn't see the errata as a time to change my answer on things. I just saw it as a time to correct any errors in the transcript. So that is what is in the errata.
Q When did it become apparent to you that perhaps you would have changed some of your answers in this deposition if you had understood the question differently?
A When I read the transcript.
Q Okay. So is it fair to say -- so you read the transcript for errata. You changed what you believed were misquotes, but you did not seek to address to change your answers when you had a new understanding of the questions?
A Correct.
Q Okay. So for purposes of this deposition let's

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just make sure that you understand my questions and so if there is any ambiguity we sort that out. How about that?
A Yes.
Q Okay.
MR. SELDIN: Joel, could you pull up Exhibit 7.
Q Dr. Kaliebe, in the Decker matter do you recall testifying at trial?
A Yes.
Q That was very recently, is that right?
A May 18.
Q And is this, you will see this is a transcript of the fifth day of the trial in Decker.
MR. SELDIN: Joel, can you take us to Page 1058.
MR. PATTERSON: It looks like it is Page 95 if I'm doing that math correctly.
MR. SELDIN: Mr. Patterson is much braver than I to do math in the middle of a deposition.
MR. PATTERSON: I was off by one page.
Q Dr. Kaliebe, you will see on Page 1058 --
MR. SELDIN: Joel, if you can scroll down one more.
Q It starts afternoon session. I might have the

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wrong page on this one. Give me a second.
A I was the second witness in the afternoon.
Q Let me find the right page. I apologize.
MR. SELDIN: Joel, I think it's 1095 or try Page 133.
Q Dr. Kaliebe, do you see where it says Direct Examination and then --
A Yes.
Q Is this a copy of your trial testimony in Decker?
A Yes.
Q Were you truthful during that testimony?
A Yes.
Q Did you do your best to answer honestly?
A Yes.
Q Was that true when the state of Florida was asking you questions?
A Yes.
Q Was that also true when plaintiffs in that case were asking you questions?
A Yes.
Q I believe that the court in that case also asked you some questions while you were on the stand. Do you recall that?
A Yes.
Q Did you do your best to be truthful when answering

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the judge in that case?
A Yes.
MR. SELDIN: Joel, can you pull up Exhibit 6 for us.
Q Dr. Kaliebe, have you ever seen this document before?
A Yes.
Q What is this document?
A It's a Plaintiff's Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Kristopher Kaliebe.
Q Is it your understanding then that the plaintiffs in Decker tried to exclude your testimony in that case?
A Yeah. I just found that out the other day.
Q I'm sorry. You said --
A Yes. I guess so. I just found out.
Q Do you know whether the court has resolved this motion yet?
A No.
Q Were you aware prior to testifying for Decker that this motion had been filed?
A No.
Q Thank you so much.
MR. SELDIN: Joel, we can take that down

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for now. Thank you.
Q Dr. Kaliebe, I will ask you some questions about how you prepared for today's deposition.
Just to head trouble off at the pass, I'm not asking you what you talked about with your lawyers. I'm asking you questions about the where and who, but not the what.
I'm sure Mr. Patterson will cut you off if you try. I just want to be clear about that ahead of time.
So my question is just going to be how did you prepare for today's deposition?
A Well, I did have a meeting, I think it was Sunday, with the lawyer for about forty-five minutes. So I had one meeting with the lawyer. The other prep was I read my report. I read the deposition that I gave. I read my trial testimony.
Q When you say you read the deposition that you gave, are you referring to the deposition in Decker that we were just talking about?
A Yes.
Q When you say your trial testimony, are you referring to the trial testimony in Decker that we were just discussing?
A Correct.

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Q Do you recall which lawyer you met with for about forty-five minutes this past Sunday?
A Yeah. I hate to -- I do not remember Brian's last name. There has been a lot of switching of the lawyers.
Q Any part of their name will do.
A Brian.
Q Did you say Brian?
A Yes.
Q Is that Brian Barnes with Cooper and Kirk?
A I believe it is.
Q Any other attorneys that you spoke with?
A No.
Q Okay. Any other meetings other than that forty-five minute meeting?
A No.
Q Did you speak with anyone else at all in preparation for today's deposition?
A No.
Q Okay. Other than your report or your declaration in this case, your deposition testimony in Decker, and your trial testimony in Decker, did you review any other documents to prepare for today's deposition?
A Well, I continually am educating myself and

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reading more reports, articles, and such. None of them were in preparation for this deposition though.
Q Did you review the expert declarations from Dr. Shumer, Dr. Karasic, or Dr. Turban?
A I did.
Q Did you review the transcription of their depositions?
A I did.
Q Did you review any of the declarations submitted by Indiana's other experts?
A No, I did not.
Q I'm sorry?
A No. I don't believe so. Just those three.
Q In the process of preparing for today's deposition, did you review any of the medical records of the plaintiffs in this case?
A I reviewed medical records, but not regarding, you know, it was a while back. It was not regarding this deposition.
Q So did you review the plaintiffs' medical records in your declaration?
A I did review them. But I decided, it was decided to not, you know, include anything regarding those records in my report.

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So if that answers your question, I reviewed the records. I did not, you know, formulate opinions or, you know, add anything into my report related to that. So I did review them, but I didn't comment on them.
Q Have you spoken to Diana Kenny, who is one of the experts in this case that Indiana has proffered?
A No.
Q Have you spoken with Daniel Weiss, who is another of the Indiana experts in this case?
A No.
Q Have you spoken with Paul Hruz?
A No.
Q Have you spoken with James Cantor?
A No.
Q When we were talking earlier about your deposition in Decker you referred to part of the transcript where you discussed speaking with your wife, Dr. Olga Kaliebe, who is a board certified endocrinologist, is that correct?
A Yes.
Q Have you spoken with your wife, Dr. Kaliebe, about this case?
A No.
Q Did she assist in any way in your declaration in this case?
A No.
Q Thank you, Dr. Kaliebe.
Anything else that you did to prepare for today's deposition that we have not covered?
A No.
Q Then Dr. Kaliebe, I want to talk a little about your background. You are board certified in psychiatry, is that correct?
A Yes.
Q You are also board certified in child and adolescent psychiatry, is that correct?
A Yes.
Q And forensic psychiatry as well?
A Correct.
Q Do you have any other board certifications?
A No.
Q Do you have any formal training in sociology?
A Well, I believe during medical school and residency, yeah, training in the broad range of the field, which sociology is somewhat included within psychiatry. So psychiatry has some sociology included.
Q Was there a specific course in sociology that you took as part of your medical training?

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A Well, since psychiatry deals with biopsychosocial phenomenon in people, sociology is a component of how you are trained. So the social part is quite important.
As I said, what people think about how you approach the patient is biopsychosocial. So social is a major component. In psychiatry we frame our approach to patients as biopsychosocial. So social matters are essential and a large part of psychiatry. So there's a lot of psychiatric training and medical school training.
So, yes, it is quite important to be up on social matters and understand social interactions. That is a large component of our training.
Q And how are you defining sociology?
A Well, how am I defining sociology? In psychiatry social matters are very important. Social interactions are the basis of sociology is my understanding. So that is how I was applying them.
Q Fair to say that in psychiatry you are treating individual patients, correct?
A Well, you do. You treat families. You treat them within a context. You are also asked for input regarding matters that are more broad. So, you

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know, it depends. Yes. Typically our model is individual patients or families.

COURT REPORTER: Doctor, I'm sorry. you are cutting out and I am having a hard time hearing you.

MR. SELDIN: Let's go off the record.

(OFF RECORD AT 10:00 A.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 10:01 A.M.)

BY MR. SELDIN:

Q Thank you, Dr. Kaliebe. Do you treat families in your psychiatry practice currently?

A When you practice child psychiatry you typically do see the family. Right? You have to see the family. So you are doing family work.

Q I'm not asking typically. I'm asking do you specifically treat families currently in your psychiatry practice?

A Yes. I mean, when you work in child psychiatry you work with the family, yes.

Q And when you say you work with the family, you mean providing psychiatric treatment to the family and consulting with the family about the child?

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A Well, neither of those is the right way to frame it. You work with a child and family together. The child may be the assigned patient, but you are working with the entire family.

Q Do you prescribe medication as part of your psychiatry practice?

A Yes.

Q Are you prescribing medication to any of the parents or the family members of your child patients as part of your practice?

A No.

Q Do you provide psychotherapy as part of your psychiatric practice?

A You would provide parent training. So, yes, you are providing -- it's not, it's family work so you do some family therapy. Even when you are in a room with a parent and the child together that is a therapeutic interaction with both members.

Q Then other than the training in sociology that you talked about as part of your medical training, do you have any other training in group dynamics or organizational dynamics?

A We receive some of that training as, you know, in medical school and during your residency and because I was the program director and was

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involved in training when I was at LSU you do learn about a lot of organizational stuff because you do the trainings that the universities do to help understand how to run a residency and work with trainees.

There is some organizational work, some organizational training that I received as part of that. Each medical school has a medical education department. They do trainings about other work systems.

Q Anything other than that?

A Not that I recall.

Q And then in your declaration you said that gender dysphoria and its treatment were part of your professional training.

Do you recall that part of your declaration?

A Yes.

Q Okay. And what professional training did you receive on gender dysphoria or its treatment?

A Well, at the time it would have been called gender identity disorder. I use the modern term. But when you are doing a general psychiatry residency your section of the training in medical school includes a section of training or learning that includes those disorders.

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In child psychiatry residency, you have training that includes those disorders. So at every level of training you get some education regarding, you know, at that point it was gender identity disorder, but now it's called gender dysphoria.

Q Did you take any specialized or targeted classes that dealt with gender identity disorder or gender dysphoria as part of your medical school training?

A No.

Q Okay. Have you done any continuing education on gender identity disorder or as it was previously called or gender dysphoria?

A Yes.

Q What continuing education have you done?

A Okay. So I attend meetings at the American Academy of Child and Adolescent Psychiatry, they have CME meetings at every annual meeting. And I attended in the last four years, five years, I would guess about half a dozen, maybe more, of the presentations, or I bought the, you know, you get the audio package later.

With COVID it kind of got messed up so it was not the usual conference. We were doing online

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not real time so you could watch later. Because of that I would not say that all of the ones I watched every single minute of, you know, during that online period.

When you are in person you know that you sit there through the whole presentation. So I would estimate at least six presentations which are CME presentations from the American Academy of Child and Adolescent through the annual meeting.

Most of them were at the time of the annual meeting, but some of them were later because I get the package where you can watch them later so if you miss something you can go back and watch.

I was at the American Psychiatric Association meeting last year and attended a CME meeting related to gender dysphoria and adolescents. And I downloaded, or I also participated in one of the American Psychiatric Association trainings related to gender dysphoria this year.

Q So it sounds like those first six CME credits that you were talking about, were those all related to gender dysphoria or its treatment?

A Yes.

Q Okay. So the past four or five years about how many hours of CME training do you think you have

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had on gender dysphoria or its treatment?

A About ten.

Q Okay. And so six years ago and later about how many hours of CME credit do you think you had related specifically to gender dysphoria or gender identity disorder?

A Only to the degree it was included in larger programs. So at that point I had not sought out any. So one answer to that question is none.

Or only as it was included in course reviews or other classes. Because when you do, when you go to the annual conference there's a performance and practice feedback that you do, which is asking and answering questions about different topics in child psychiatry. That includes topics related to gender dysphoria.

Then also when you do board review there are sections of board review that are also related to gender dysphoria and gender dysphoria treatments. That is a general review of all topics, but it includes those.

So I did retake my boards, I'm guessing in 2005. Then in 2015 would have been my redo for my child psychiatry boards. So I would have to study. But you do get CME for taking the board.

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That is considered continued medical education, taking the board review.

Q Doctors have a better deal than lawyers when it comes to CLEs.

A It's expensive.

Q Other than the ten hours we talked about and the education that you would have gotten in the ordinary course as part of your board certifications and continuing training, anything else since 2005?

A I do not believe anything else that was CME.

Q Okay. How did you come to be an expert in this case?

MR. PATTERSON: I will object to the extent it calls for attorney/client privilege communication.

Q Let me break it down a little more in smaller chunks to see if we can avoid the problem. This is a yes or no question.

Did the state of Indiana reach out to you about becoming an expert in this case?

A Yes.

Q So you did not affirmatively reach out to them, is that correct?

A Correct.

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Q When was the first case -- excuse me.

Prior to Decker, were you an expert in any case involving gender dysphoria or its treatment?

A No.

Q Other than Decker and Boe v. Marshall, have you been involved in any case involving gender dysphoria or its treatment?

A No.

Q In your C.V. and in Boe and in your declaration you listed your prior expert engagements.

Fair to say other than Decker, Boe, and this matter, none of the rest would pertain to gender dysphoria or its treatment?

A Correct.

Q In which case did you become an expert first, Decker or Boe?

A Decker.

Q Okay. In the Decker matter in Florida, did the state of Florida reach out to you about becoming an expert?

A Yes.

Q Were any third parties involved in making that connection between you and the state of Florida?

A I actually don't know.

Q Prior to Decker had you ever held yourself out as

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an expert in gender dysphoria or its treatment?
A No.
Q Have you ever lobbied before a state legislature?
A No.
Q Have you ever testified before a state legislature?
A No.
Q The same question at the federal level, have you ever lobbied for federal legislature?
A No.
Q Have you ever testified before Congress?
A No.
Q You are aware this case involves Senate Enrolled Act 480 in Indiana, correct?
A Correct.
Q Have you made any public statements for or against Senate Enrolled Act 480?
A No.
Q Have you ever made any public statements for or against any other laws pertaining to the treatment of gender dysphoria in minors in other states?
A No.
Q No op eds or letters to the editor? Nothing like that?
A Correct.

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Q Dr. Kaliebe, I will ask you some questions about your background. They come from the portions of your declaration and when we talk about it if you would like to refer to those, let me know and we will pull up Exhibit 1.
My questions will be what were the circumstances of starting or stopping various jobs. I'm not trying to trick you. If you want to refer to that for dates, just let me know.
According to your declaration you stopped being the assistant professor at LSU Health Science Center in 2016, is that correct?
A Yes.
Q What prompted the end of your employment there?
A I moved to Tampa, Florida. It did not totally end my employment with LSU. I'm not exactly sure how long I remained with some contracts in Louisiana. I retained my medical license in Louisiana and still had an LSU collaborative care contract when I moved to Florida. I can't exactly say that it ended.
I mostly became a University of South Florida employee and had moved to Tampa. I had a collaborative care contract, I believe it was for one more year at LSU, you know, doing psychiatry

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and collaborative care back to Louisiana. But I mostly moved from Louisiana to Florida, thereby changing my work from mostly LSU to mostly the University of South Florida.
Q Did your role at LSU involve clinical treatment?
A Yes.
Q Did it involve clinical supervision?
A Yes.
Q Did you teach?
A Yes.
Q Did you perform research?
A Yes.
Q Okay. Did you have any administrative responsibilities?
A Yes.
Q Here is the tough question, what percentage of your job do you think was clinical treatment versus the other things we just talked about?
A So when I was at LSU my job involved, it changed over time. That is not a question that I can answer easily because there were different times with different roles.
Mostly I would do clinical work. So, you know, I was mostly a clinician. But I would say I was heavily a clinician educator. So I was always

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very involved with the training programs and teaching. So I always had a large teaching role.
In my clinical sites I would have students or residents come with me where I was working a lot of the time and people would, you know, sit in with me. So I had a clinical role, which included some resident supervision. Then if you want me to breakdown the numbers --
Q I think that is a good answer. Thank you.
A Okay.
Q In your current role at USF do you have roughly the same mix of responsibilities in terms of being a clinician and teaching?
A Well, yes and no. When I moved to Florida I was offered a number of contracts in corrections which was actually a little bit more time in juvenile corrections than I was spending in Louisiana. So I do more correctional work in Florida than I was doing in Louisiana hours-wise.
Recently I'm doing more forensic cases so I'm doing more forensic work. My clinical role in Florida was significantly decreased in terms of, like, having an individual patient clinic. Right? So I have two resident clinics right now.
But that is, you know, a lot less sort of

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direct patient care and, you know, very little independent patient care compared to what I was doing in Louisiana.
Q Dr. Kaliebe, how long have you been practicing psychiatry?
A Well, I finished my first residency in, which would be the general psychiatry residency as I transferred into child psychiatry, that would be in 2004.
At that point, because I was already moonlighting, which was an independent practice, you know, I would say my first independent practice was 2001 or 2002. So during your residency sometimes you are also independent practicing. So I would have to say 2001 would probably be my first year of independent practice. I graduated medical school in 1999.
I know during your first year of residency no one does any independent practice. That is one way to answer the question.
Another way to answer is when I finished all my fellowships and residencies, that would be July 2005 because I did general psychiatry. Then I did child and adolescent psychiatry.
So general for three years. Child psychiatry

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for three years. Forensic psychiatry for one year. And finished in July of 2005.
Q Fair to say then you have seen patients in some capacity for about twenty-two years?
A Correct. You could say my residency started on July 1 of 1999.
Q Round numbers, is it fair to say you have treated thousands of patients in that twenty plus year period?
A Correct.
Q Of those thousands of patients how many of them have you treated that have had gender dysphoria or gender identity disorder?
A As you have probably seen in my deposition, there is a -- it is probably around sixteen or seventeen patients right now.
Q I believe you had a colloquy with the court in Decker that led you to that number about sixteen or seventeen.
Do you recall that part of your testimony?
A Yes.
Q Okay. Of those sixteen or seventeen patients with gender identity disorder or gender dysphoria, how many of them were under eighteen?
A I would guess twelve or thirteen of them.

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Q So twelve to thirteen were under eighteen? Then we will call it --
A I'm not sure how you count the people that you saw and they were below eighteen and now they are over eighteen in that question.
Q When you started seeing those people under eighteen, if we use that definition, does the twelve to thirteen still stand?
A We will make it thirteen if it's when I started to see them. You know, that is my, I'm, that is the best estimate that I can give you.
Q I will spot you the one. We will call it thirteen.
Of those thirteen did you diagnose any of them with gender dysphoria?
A Yes.
Q How many of them did you diagnose with gender dysphoria?
A There are different ways to answer that question. All of them are diagnosed with gender dysphoria and had come to me with that diagnosis or some question regarding that diagnosis.
Now, are you asking am I the first person to diagnose gender dysphoria for that patient? Or are you asking me did I continue a diagnosis of

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gender dysphoria?
Q We will break it down into small chunks to get exactly at that question. Of those thirteen patients how many of them when they arrived in your office already had a diagnosis of gender dysphoria?
A I would guess maybe ten.
Q Okay. Of those ten who arrived in your office already with a diagnosis of gender dysphoria, how many of those did you also diagnose with gender dysphoria?
A I'm trying to think back if there was any. I believe there was a continuation of a diagnosis in all patients.
Q So of those ten who showed up with a diagnosis of gender dysphoria, in none of them you said, I don't think that is correct. You don't have gender dysphoria.
A Well, you are asking me questions about when they present for treatment. You know, you see people over time. So it may be a different answer at the end of the day did they always leave the practice also with a gender dysphoria diagnosis, you know, that is a slightly different question.
I believe there was continuation of the

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incoming diagnosis in all ten.
Q When the ten, when those ten who showed up with a diagnosis of gender dysphoria at least at the beginning you thought all ten of these have, I agree with that diagnosis of gender dysphoria. Is that fair to say then?
A Yes.
Q At the end of treatment for those ten, were there any of them where you did not continue the diagnosis of gender dysphoria?
A I would say no. That is a difficult question sometimes because you get people for, you know, at the clinics for a certain amount of time. Then they roll off of your clinic or they leave and you often don't know what happens next with them.
But I don't remember taking away that diagnosis in any particular patient.
Q We talked about the ten of the thirteen who showed up with a diagnosis of gender dysphoria.
Of the three additional folks who were minors when you began seeing them, did you diagnosis all three of those people with gender dysphoria?
A Yes.
Q Were you using the DSM-5-TR criteria to make that diagnosis?

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A Yes.
Q I believe that leaves four adults who you have seen or treated who had gender dysphoria.
The same set of questions. When they showed up in your office did all of those four adults already have a diagnosis of gender dysphoria?
A Yes.
Q Did you continue the diagnosis for all four adults?
A Yes.
Q I'm sort of zooming out to the sixteen or seventeen people who you have seen with gender dysphoria.
Did any of them have a gender identity disorder diagnosis, or were they all post DSM-5?
A Post DSM-5, correct.
Q Did you recommend or prescribe any treatment for the gender dysphoria that you diagnosed in these individuals?
A Yes.
Q What treatment did you prescribe?
A Well, I recommend when a child presents with gender dysphoria that they enter psychotherapy.
Q Anything other than psychotherapy?
A No. I mean, if you are talking about treating --

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people come in with co-morbidities. So there's treatment for matters other than gender dysphoria, which could include medications or other therapies.
Let me qualify, also, that I have a practice of always recommending certain things for patients when they show up in my clinic. It includes a number of matters that all patients get. So I would recommend these things also for a patient who presents with gender dysphoria. So I don't just recommend people for psychotherapy and leave it at that.
Would you like me to tell you about what I recommend for all of the patients that I interact with?
Q Well, so I want to ask a clarifying question. Of the general suite of things that you recommend to all of your patients, is that fair to say that is part of general wellness? It is not specific to any diagnosis?
A I don't think wellness is the correct word. I am talking about things that do promote wellness, but they also have an impact on mental health.
So, you know, when I am, when I have someone present to me with a mental health condition, the

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fact that I want them to get involved with physical activity, exercise, you know, perhaps sports. Perhaps, you know, yoga. Perhaps, you know, time in nature. Perhaps taking walks. I mean, all that physical activity and movement stuff has very good evidence base and is important. I emphasize it with all my patients. So it is true with a patient with gender dysphoria.
I would talk about changing how people eat, food related issues. Once again, that is pretty strong evidence base, great risk and benefit profile. It does treat and help with mental disorders.
Then the other component is managing what I call honoring silence. That is a general frame for having some mediative or calming practice that you do all of the time.
And then, also, mindfully managing your exposure, especially for children these days, to electronics. When I say honor silence, that includes, you know, turning, coming to some conclusion as a family about, you know, what is the relationship that this person is going to have with electronics? Where do they go? How much

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time do they spend on the different devices? What other activities, you know, might be better than the extra time online? Are there any things that are good or positive they are doing online? Those could be increased or the important part of it.

But that is advice that I do think is pertinent and I give to all patients. So that would include, you know, that would include patients with gender dysphoria. They would get the advice to, you know, basically eat food to improve their diet. Move their body, physical activity. Mixed in with mindfulness. Hopefully a mindful practice of moving their body and properly managing, because today's kids are so heavily involved in electronics and it's so much of their social world. So managing those things.

That is not everything that I tell people, but that is a standard, you know, speech that I give or discussion that I have with every single patient. It would be applicable in this case in addition to my referral for, you know, psychotherapy.

Q And is it fair to say that you didn't say to any of those patients that I think if you do more yoga or are more mindful you will no longer have gender

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dysphoria?

It was just part of your general suite of all your patients you see, you think that is a good plan for everyone to do yoga and limit screen time and be --

A No. I would not say it like that. I would say there is a significant possibility that people can help with their distress about their body through the practices that I'm recommending and by managing, you know, what is coming into their brain through, you know, media.

So, yes, I do think particularly in these cases this would be a part of the treatment plan. I think it is something that is important to communicate to the patients.

Q Are there any randomized controlled trials, studies, regarding yoga as a treatment for gender dysphoria?

A No.

Q In your declaration you said that you were consulted about providing a second opinion and coordinating care regarding a patient with gender dysphoria in the Louisiana Juvenile Correctional System.

Do you recall that part of your declaration?

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A Correct.

Q Is that patient included in your sixteen or seventeen, or is that a separate person?

A Actually it was not included.

Q Who asked you for a second opinion?

A Well, at the time when I moved to Florida I still had a relationship with the clinic with the correctional system in Louisiana. If you remember what I said, I moved here. I kept the Louisiana license. I was still doing work in Louisiana.

As the most senior clinician within the company that has all of the contracts for the juvenile justice in Louisiana, whenever they have challenging cases I was likely to get consulted.

That was a patient who was moving facilities and so they asked my opinion. They asked, you know, basically what approach should they have. So that was actually working for the company at that time and they consulted me.

Q I take it that was because it was a juvenile correctional system that that person was under eighteen?

A That person -- well, I don't want to speak too much about individual patients because, you know, especially when we get into specifics about where

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they are and how they move.

Q Well, we can designate this portion of your deposition transcript as confidential.

A Can we?

Q Yes.

MR. SELDIN: Mr. Patterson, I don't know if you are aware of the confidentiality order that we have in this case. We have been using that to designate portions in other expert testimony pertaining to the plaintiffs.

If it's appropriate here, we can designate this portion as confidential so I can inquire into his expertise.

MR. PATTERSON: Yes. We can designate it confidential, but I would say to the extent he is under any obligations not to disclose any information even in a confidential setting he has to abide by those. I'm okay with this being made confidential.

MR. SELDIN: Great.

Q The particular individual about whom you provided a second opinion, was that person a minor?

A They, since this is not -- I mean, I don't believe that in this context that this would be too, that I'm revealing too much. I do want to not speak

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too specifically because, obviously, we are, when you talk about individual patients, any of this could be trackable. I do not want to say anything that would reveal anything about any patient that I'm treating. Right?

So I'm trying to keep it as general as possible. Redacted

Redacted

Q Redacted

Redacted

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A Redacted

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Q Redacted

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A Redacted

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Page 47

Redacted

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Q Redacted

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A Redacted

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Q Also, in your declaration you said that you provided an opinion about whether a pediatric patient was competent to assent to the administration of puberty blockers.

Doctor, do you recall that part of your declaration?

A Yes.

Q In what capacity were you consulted on that? I guess which contract was that a part of?

A It was within the USF, you know, child psychiatry realm.

Q Okay. When you provided that opinion, was that to someone you were supervising or a lateral colleague?

A Lateral colleague.

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Q What was your opinion on their competence to assent?

A Well, my opinion was that at the age they were that it seems unlikely that they would have full knowledge or capacity to fully assent, you know, or if you want to say consent to the procedure.

It seemed -- the particular wording of the question was not can they assent or not. It was more do they have the, you know, capacity to fully understand what they are agreeing to.

Q Do you recall how old that person was?

A I don't, I don't remember for sure. But I do think it was twelve or thirteen.

Q And were you asked to provide an opinion on that child's parents' ability to consent to the treatment?

A No.

Q Did you have any concerns based on what you heard in that consultation about the parents' ability to consent?

A No.

Q You also said that you have been consulted regarding psychotherapeutic approaches to young adult patients who detransition.

Do you recall that part of your declaration?

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A Correct.

Q When you say young adult, I take it you mean those people were over eighteen?

A Correct.

Q You also said you collaborate in the care of patients with gender dysphoria as part of your work with the Florida Medicaid psychiatric hotline.

Do you recall that part?

A Yes.

Q And about how many patients have you collaborated in the care with for those hotline calls?

A That also had gender dysphoria?

Q Yes.

A I'm trying to think if it was two or one. Only one that I remember. So one time.

Q Did your involvement in that care go beyond that phone call?

A No.

Q How many patients have you consulted about in connection with your work on the Florida Medicaid psychiatric hotline?

A Good question. Twenty. Thirty.

Q Dr. Kaliebe, have you conducted any research about gender dysphoria?

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A No.
Q Any research on gender identity generally?
A No.
Q Any research focusing on the treatment of transgender people?
A No.
Q Have you published any papers on those topics?
A No.
Q Have you supervised any research on those topics?
A No.
Q Have you ever had to retract a research paper?
A No.
Q Or issue a correction to a research paper?
A No.
Q Have you ever been sued for medical malpractice?
A No.
Q Have you ever been the subject of professional discipline?
A No.
Q Have you ever been sanctioned by a licensing board?
A No.
Q Have you ever had a professional complaint filed against you?

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A No.
Q Have you ever been the subject of a Title Nine complaint?
A Not that I know of.
Q Have you ever been arrested or charged with a crime?
A No.
Q Are you on social media?
A Yes.
Q What social media do you use?
A Use would probably be a strong word because I'm on social media, but I do not use social media generally. I have a Facebook account. I believe I have an Instagram account that links to my Facebook. I never actually go on Instagram. So it's very rare that I'm on Facebook. That would be the only social media that I'm on.
I will, I occasionally have gone on Twitter. I don't make it a practice to go on Twitter. But I have gone on Twitter. I don't have a presence. I don't post. I don't do any of those things. Sometimes to access things I'm occasionally linked to Twitter. I would not say I really have a Twitter account, but I've gone on Twitter.
Q I think the youth call people like us lurkers.

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That is the technical term. I don't know if you have encountered that in the practice with your youth?
A Yes, I have used that term.
Q Fair to say you fall more on that side of the continuum?
A That is fair to say, yes.
Q Have you given any interviews in either traditional media or elsewhere on the topic of gender dysphoria?
A Given any interviews? Yes.
Q What interviews have you given on the topic of gender dysphoria?
A Well, I haven't, I was contacted by someone to do an interview. I talked briefly with the person. I don't have their name in front of me. This was quite recently. So I was contacted by someone to do an interview regarding some of the stuff I guess that has gone on, you know, in this case or with professional organizations.
Q Do you recall the name of who --
A I don't. I don't.
Q Do you recall what publication they were with?
A I don't.
Q Do you recall --

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A I can tell you it was not a publication or place that I had heard of. So, hence, maybe that is part of why I don't remember actually who they are. Yeah.
Q I take it you said no?
A We briefly spoke. I said yes.
Q I'm sorry. What did you speak about?
A Well, they asked about things that are going on with the professional organizations that I have written about in my report.
So they asked for details regarding those things and what is going on and I said that I would talk a little bit about it, but not, you know, not at length.
I said that it is accurate what I wrote in my reports that we have attempted to submit proposals that seem to have been squashed based on ideological grounds. I said that that is, you know, accurate. And basically, you know, I left it at that.
I was, I had mixed emotions, of course, about getting myself involved. I've not previously and I'm trying to not be involved with press related stuff. So I didn't want to talk at length. Yeah.
Q Was this on background with this person, or do you

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anticipate there will be an article?
A I don't know if there will be an article or not. I asked to, you know, to not be named or, you know, so, yeah.
Q When you said your reports, were you talking about your reports in Decker and Boe?
A Yes. You know, I guess those are public. I don't know what is publicly available and what is not. I have already made statements in these cases regarding my opinion regarding what is going on within the academia and our professional organizations.
Q Fair to say, did you speak specifically about this case in that interview?
A No.
Q How did that person get in touch with you?
A I got an email.
Q Did you keep that email?
A Yes.
Q Why do you try not to get involved with press around this?
A Well, I guess there are a number of things. For one, it seems like if you are an honest broker of information and try to work for more cautious care and for people to be careful about transitioning

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minors, then you get painted as a right wing extremist and hateful and transphobic. I would prefer myself and my family not to go through that.
So I'm trying to, you know, be honest with the courts. I was asked for an opinion so I feel like I have to give my honest opinion. I feel like the safeguarding of children is very important. I feel like I have a duty to my patients to testify.
Yet, you know, as I wrote in my report, there are a lot of thought levels and tribalism in our society. People are using this issue to attack other people. And I don't want to be involved with attacking other people.
I also would prefer for, I would prefer to remain within respectful academic-type dialogue. That is hard to get to happen in these things, as I've written in my report. But I feel like the dialogue of ideas would go best through medical either journals and professional organizations and that is a, you know, the more ideal way to work these things out rather than going through, you know, the media.
Although, I do think that, you know, once

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again, considering the stakes that I'm getting asked, I mean, it's a tough discussion. But, yes, those are some of the factors that I thought about.
Q In your answer you said you thought you had a duty to your patients in this regard.
Were you referring to the sixteen or seventeen patients with gender dysphoria that you have treated?
A Yes. And to all patients, yes.
Q And of the sixteen or seventeen patients with gender dysphoria, you believed as a psychiatrist that they all, in fact, had gender dysphoria, correct?
A Yes, that they had that diagnosis. Correct.
Q You said you thought there, that you wanted to participate in more academic dialogue about this topic.
Do you believe that Senate Enrolled Act 480 furthers academic dialogue on this topic?
A I think just, like anything else in life, there are trade offs. So it might. It might not. I guess we would have to see what the results of it are.
Q You said trade offs. Do you believe that the

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trade off of banning medical treatment for gender dysphoria in minors in Indiana is an acceptable trade off to possibly further academic dialogue on this topic?
MR. PATTERSON: Object. This is outside of the scope of his testimony.
You can answer.
A Well, I don't think, I think that is only one of the implications of the law. So, no, that is not the primary implication of the law. It is an implication of it.
Q I'm sorry. What is not a primary implication of the law?
A The law's effect on the academic or scholarly or public dialogue is a secondary effect and not a primary effect.
Q Do you agree with the primary -- I take it then that you are supportive, however, of the primary effect of Senate Enrolled Act 480, which is to prohibit gender-affirming care for minors in the state of Indiana?
MR. PATTERSON: Object. The law speaks for itself.
You can answer the question if you understand it.

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A I will answer in that I was asked to give my opinion about matters related to the treatment of gender dysphoria, what is going on in professional organizations, what is going on in the academia. That is where my realm, you know, is that I'm providing expertise.
So the effects of the laws, both good and bad, is not something that I've given, that is sort of a secondary effect.
But, yes, I'm, I do believe that in all it's better to stop these gender-affirming treatments which in total I believe cause more harm than they ameliorate.
Q When you say in total cause more harm than they ameliorate, do you mean at the individual level or population level?
A Both.
Q Do you believe there are any individual patients for whom gender-affirming care as a minor is a net positive?
A I'm not sure.
Q Of the thirteen patients who you have seen with gender dysphoria, were any of them receiving care that would otherwise be banned by the state of Indiana?

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A If we are going to ask me about my patients I would like to go off the record again.
MR. PATTERSON: You mean confidential?
A Confidential, yes.
Q I think the way we have been doing this is that when we remember during the deposition we say it and then when we get the transcripts we mark it.
A Okay. So you would like me to answer? As long as its confidential then I will answer.
Q Redacted
Redacted
Redacted
A Redacted
Q Redacted
A Redacted
Redacted
Redacted
Q Redacted
Redacted
Redacted
A Redacted
Q Of the thirteen, how many of those patients were receiving care that would otherwise be banned by the state of Indiana?
A Well, I mean, one at one time would have been.

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Q Redacted
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A Redacted
Q Redacted
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A Redacted
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Q Redacted
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A Redacted
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Q Dr. Kaliebe, you are testifying on behalf of the state of Indiana, right?
A Yes.
Q They are defending a law that bans gender-affirming care for minors.
Part of your expertise is predicated in your representation to the court that you have treated

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some number of patients with gender dysphoria.
A Correct.
Q You told me that you believe that at the individual level the provision of the kind of care that is banned by Indiana now for minors is more harmful than it is beneficial.
So I'm trying to ask so the court, when it sees the transcript, can assess what is it that you have observed as a clinician that makes you think this care is more harmful than it is beneficial?
So it would be helpful then to know -- let me ask you small questions to see how far we get.
Were these long-term risks you were concerned about or short-term?
A Once, again, I would prefer not to talk about individual patients.
Q Let's talk generally. What are the general risks you believe outweigh the benefits for this kind of treatment?
A Well, so first off, there are risks related to mental health that are, especially long-term mental health, that seem apparent based on long-term data. And especially would be apparent in someone who has not gone through a proper

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process of actually developing as an individual before they moved on to consider such things. And in such cases, they should have a period of time where they are able to interact with mental health professionals and explore their identity, explore how they got to the place where they are, explore what possibly might be other things that could be involved that would lead them, you know, to have this gender dysphoria. So that should all be worked up prior to initiation of these treatments. And as someone who is a growing, developing adolescent, they should finish their development or very close to finishing it before they make permanent changes in their bodies. Those are some of the psychological. The physical risks is risk of surgery, hormones, cancers. Any kind of medical problems that could come.

Q Do you believe that there are any patients at the end of this process that you propose, that the provision of gender-affirming care, the benefits will outweigh the risks?

A Yes. Could I qualify since we have not gone on yet? I think you are asking me to opine on an

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unknown that I would not say that I have a -- I'm saying yes based on that I think those who have gone through, you know, a proper process and are adults, you know, I think that that is a, that it's unknown, it's unknown still overall about the risks and benefits of these transitions. I think we do need more evidence on it. But that is my qualified answer. Go ahead.

Q Would you support a ban on this kind of care for adults?

A You would have to tell me what you mean by ban.

Q Well, you are familiar with Senate Enrolled Act 480, which we are talking about in this case as pertains to minors.

A Yes.

Q Would you support a law like Senate Enrolled Act 480 if it applied to adults?

A You are saying starting at what age?

Q Let's start with for anybody of any age, would you support a ban on this kind of care?

A I mean, I think you can reasonably say there must be some, there could be an age limit. There could be a process that people have to go through. Yes. I mean, it may be in the current climate that you need some legislative safeguards

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in order to ensure that there is a proper process.

Q I am asking two questions then. The first question is so you believe that after some kind of proper evaluation process the provision of this care may be appropriate in adults, correct?

A Correct.

Q Setting aside what that process is, do you believe that there is any age limit that should exist for folks who are even eligible to go through that process to then receive this kind of care?

A Well, I don't have a formulated opinion on what would be the pluses and minuses of a particular age limit. But I do think, in general, we understand that people are growing and developing and, you know, in other circumstances people are often, oh, the brain develops until twenty-five or until twenty-one. You know, there is an active debate about the age where someone sort of becomes, you know, a fully developed complete person and, you know, when their identity of any type, you know, would have solidified. I think you can have -- I don't think we have

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had enough quality discussion and debate in the literature regarding those things to give me a sense of what would be a, you know, how to approach that.

Q In the interim while this debate is continuing or not, do you believe that there should be a ban on this kind of care for folks who are over eighteen?

A A blanket ban for over eighteen? Well, as I was saying, I just think my belief would be with some process and with some age bar which might be more than eighteen could be appropriate.

Q Okay. Well, I guess, earlier when we were talking about how you think that there is not sufficient research or there has not been sufficient debate with respect to folks under eighteen so you support a ban in the interim. I am asking the same question for over eighteen. Do you think there should be an age ban above eighteen in the interim?

A I have not given it -- I think that it could be reasonable to have an age ban over eighteen, correct. I don't know what exactly, I've not given it a lot of thought, nor have I seen in the

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literature what would be a proper way to approach this. What process would people have to go through. I mean, whenever you make an age limit like sixteen for driving, or twenty-one for drinking, there are always problems with those strict age limits. There are those trade offs. There is a lot of complex calculation that would go into any such trade off.

And so I've not really seen any analysis of exactly what would be the best trade off in these situations.

MR. SELDIN: We have been going for a little bit at this point. How would a five minute break sound?

(OFF RECORD AT 11:09 A.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 11:15 A.M.)

BY MR. SELDIN:

Q Dr. Kaliebe, welcome back.

MR. SELDIN: Joel, will you pull up Exhibit 1 for us?

Q Dr. Kaliebe, I would like to talk a little about your declaration.

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A Okay.

Q Dr. Kaliebe, in your declaration in Paragraph 25 you say, "Current discussions regarding transgender care take place in the context of an unexplained and remarkable rise in minor patients reporting gender dysphoria."

Do you see where you wrote that?

A Yes.

Q Would you agree that gender dysphoria is a real condition that requires treatment?

A Well, that is one of the things I was talking about before in my preamble about things I was asked before.

So is it is a real disorder? Correct. But the "requires treatment" part is a complicated matter. So I would say, no. Even though before I sort of automatically said yes, that sounds reasonable. Lots of times in our business there are problems people have that they mostly work through on their own and do not get treatment for.

So that is the standard, you know, mental health, most of the things that people have that might meet criteria for a disorder or a problem do not usually get solved by therapy or the medical community.

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So, no. I would not say that I would agree with that statement in that it does not, it seems to reflect a it must be treated part. So I can't agree with that.

MR. SELDIN: Joel, will you pull up Exhibit 7? We will be at Page 157 of the PDF.

Q Dr. Kaliebe, earlier I showed you Exhibit 7, which was your testimony at trial in Decker.

Do you recall us talking about that?

A Yes.

Q Okay. You will see on this Page 1119 of the transcript starting at Line 11 you are asked questions.

"Q. Dr. Kaliebe, you would agree that gender dysphoria is a real condition that requires treatment?

A. Correct."

Do you see that?

A Yes, I do.

Q Was the testimony that you provided at trial in Decker that I just read truthful?

A Yes. In that I -- if you remember at the beginning when you asked about did I make any changes, as I looked at it and saw the wording of this in both my previous, you know, as I was

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questioned, this is exactly what I was talking about that now that I see how that was worded, that I, in some ways, misunderstood about "requires treatment" because you can talk about that in different ways.

Is it, do we normally -- would we like to treatment something? Is it good if something is treated? Sometimes that is what you mean by requires treatment.

I just want to clarify there are lots of disorders and problems that do not require treatment that for most people most of the time they solve their problems without medical or psychiatric treatment.

Now that I have had time to think about it and looked at it in print, that is what I was mentioning that I think I was, you know, I believe that "requires" is a word that I was misreading.

And now I can see that if that is the, if that is how you are asking it, "must be treated", no, I don't, I want to add some nuance to that question.

Q So, Dr. Kaliebe, earlier you were talking about your deposition in Decker, which was like this, just lawyers, no court.

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We talked about how you reviewed your transcript for errata. In that case you pointed out misquotes, but not sot of substantive changes that you were thinking about after reflecting upon the testimony.
What we just read was testimony that you provided live in court from Decker a few weeks ago. Are you saying the testimony I just read that you provided to the court in Florida is, in fact, not true?
A I'm saying that I would add nuance to it because the word "requires" can be seen in different ways. I don't want to be boxed into a corner of saying something that I didn't.
Now that I read it, as I said about the deposition, I am now reflecting an opinion that the word "requires" can mean different things in different contexts. So I'm just clarifying.
Q Do you feel like given what you have just told me you will need to correct your testimony in Decker?
A I don't know what you mean by correct my testimony.
Q Well, in Decker you said in court in front of a judge, just like the judge that we have in our case in Indiana, you were asked "You would agree

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that gender dysphoria is a real condition that requires treatment?"
You said, "Correct."
Then you moved on being questioned. So the judge in that case heard you say that it's correct.
Do you think that judge needs to know that, in fact, you want to add nuance to that because it's not the answer that you wanted to give?
MR. PATTERSON: Objection.
You can answer.
A I think the judge is plenty intelligent to siphon out these things himself. He saw the rest of my testimony. I'm pretty sure that he was capable of coming to conclusions about what I felt and how I approached treatment.
So I think, I don't think it's necessary for me to go and, you know, try to have something amended. I don't see it as a matter that would reach that level of importance.
But, once again, since I noticed it and I have evolved or became more mindful of exactly how the words are asked to me to, you know, and could be perhaps used to twist or change what my opinion is, I wanted to make sure here I'm on the record

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accurately with what my opinion is.
Q So you believe that your views have evolved since May 18 when you provided this testimony?
MR. PATTERSON: Objection.
Mischaracterizes his testimony.
You can answer.
A I don't think, I think, you know, my views have not changed on it. I just, the word "requires" is an overly strong word that now I'm realizing I had agreed to and now would be, I would add nuance. I should have at that time added the nuance to my answer.
Q All right. Further down on this page, you know, right after this question I will read you part of this testimony.
On Line 14 you were asked the question, "You provided some testimony just earlier about the number of people presenting for care. Do you recall that?"
You said, "Correct."
Then you were asked, "You previously testified that the fact that more people have been showing up in clinics could be, could be explained by, (a), that the care is more available; and, (b), that more people feel comfortable seeking

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care; is that correct?"
And you said, "Yes."
A Correct.
Q Do you have any nuance that you want to add to that testimony?
A Well, I would assume if you have specific questions, you could ask me. So I think that that speaks for itself.
Q So when I asked you correct -- when we were talking earlier you said you had some nuance to add to your answer in Line 16 of "Correct."
So I'm asking the same question here, which is, did you understand the question then and answer truthfully, I guess? Then, is there anything that you need to change now to make that the case?
A No. I mean, I think that those are factors which are involved. So I still would believe -- I believed at the time and I still believe the -- no, that's -- I will stick with that.
Q In your report or your declaration you talk about how you had not seen any patients for gender dysphoria between 2005 and 2016.
Do you recall that?
A Yes.

Q Okay. And you are aware that there was at least one clinic in the United States as early as 2007, correct?
A Yes.
Q Is there a particular reason you didn't include that fact in this declaration?
A I don't understand the question.
Q Okay.
MR. SELDIN: Joel, will you pull up Exhibit 4?
Q Look at Paragraph 102. We were earlier talking about the report that you provided in Decker. This was filed with the court on April 7.
In Paragraph 102 if you read maybe two-thirds of the way down the paragraph you said, "The first gender clinic in the United States just opened in 2007."
Do you see that?
A Correct.
Q So is there a particular reason that you did not include that fact in your declaration in this matter?
A No.
Q Earlier we talked about how Decker was the first case you had been an expert in that involved

gender dysphoria, correct?
A Yes.
Q You said you had not held yourself out as having any particular expertise in gender dysphoria prior thereto, correct?
A Well, other than I have obviously testified on, in many cases being a forensic psychiatrist. I have repeatedly held myself out as an expert in psychiatry and in child psychiatry.
So my expertise is as a psychiatrist and as a child psychiatrist.
Q But you did not specifically hold yourself out as having an expertise in gender dysphoria, is that correct?
A Correct.
Q Okay. So turning back to Exhibit 1, Paragraph 26, you will see in Paragraph 26 that you talk about how from 2005 to 2016, that eleven year period, none of the medical students or residents you supervised presented you with cases involving gender dysphoria.
Do you see where you wrote that?
A Yes.
Q It would not be surprising if no one came to specifically ask you about gender dysphoria if you

were not holding yourself out as having a particular expertise on that topic, right?
A No. Because I work with residents and medical students and primary care doctors on all sorts of patients. So if we were seeing those patients they would have brought them to me because I was working with them as a supervisor under many circumstances.
So, no, it would not have to be that I was an expert. I was the expert as the attending clinician or the person who ran the clinic or the person doing the consultative service.
So I would disagree with that characterization.
Q You would agree then that from 2005 to 2016 just because you were not encountering patients with gender dysphoria, that does not mean that no one was encountering patients with gender dysphoria, right?
A Well, I think I was very clear that it was just nobody in my sphere that I worked in at all and my personal interaction.
So I didn't ever claim that no one anywhere ever saw a patient with gender dysphoria.
Q Okay.

MR. SELDIN: Then, Joel, take to us Paragraph 30, please.
Q You wrote, "Never before have there been large cohorts of individuals seeking medical services to alter their secondary sex characteristics."
Do you see that?
A Yes.
Q What do you base that statement on?
A Well, we are looking right at a graph of the increases. I know that is Sweden. We could make a similar graph in other places.
You know, as I mentioned in my report also, you know, the base rate of gender dysphoria was seen as very low even by the DSM-5, which I believe is a pretty reputable source, two to fourteen per 100,000.
So, you know, clearly there was not large amounts of patients seeking services until recently.
Q The question that I have is in that sentence you say just seeking medical services to alter secondary sex characteristics.
You are referring to a chart about gender dysphoria children, adolescents in Sweden. I guess what I'm asking is when you make that broad

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statement, are you considering the history of cosmetic surgery and plastic surgery globally which does often, in fact, alter secondary sex characteristics?
A Okay. Yeah. I mean, I think point taken. People do have voluntary surgeries for those things and that has existed for a while. Yes.
Q So would it be fair to say that there have been large cohorts of individuals seeking medical services to alter their secondary sex characteristics.
They just may not have had gender dysphoria for that, correct?
A Well, you know, this report is related to gender dysphoria. So I assume, you know, and these charts are related to children.
So I would assume that it was understood that we were talking about children presenting to change their secondary sex characteristics to the other gender, which is accurate.
You are correctly pointing out that there are other circumstances where people have sought out surgeries to change their sex characteristics.
Q In Paragraph 28 you talk about referrals to certain gender clinics in England and elsewhere.

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Do you see that?
A Yes.
Q Would you agree that there is a difference between having gender dysphoria and being referred to a gender clinic?
A Yes.
Q Okay. So it's -- the base rate of gender dysphoria and referrals to clinics is not apples to apples, right?
A Well, you know, very likely they are related.
Q Very likely, but you were not certain?
A No.
MR. SELDIN: Joel, would you take us to Paragraph 33.
Q In your third line of Paragraph 33 you say, "Yet multiple lines of evidence point to direct social influences and online and social media contagion as major contributors to the remarkable rise in gender dysphoria in adolescents."
Do you see where you wrote that?
A Yes.
Q What multiple lines of evidence are you referring to here?
A Well, I go on in the report to talk about the increase in presentations to child psychiatrists

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of other disorders or problems that are seemingly acquired online or contributed to online which we have, it has been shown that there is a relationship between online viewing and suicidality, self-harm, multiple personality disorder, tic disorders.
So we have a significant literature that does show the influence of online habits and presentations to child psychiatrists for problems. That whole idea of culture and disorders and how the medical system's theories and naming of disorders and treatments influence patient presentations has gone back a long time.
I referenced the Shorter book which goes back to the Victorian era. So we have known for a long time that the way the medical establishment or clinics see problems can bleed out into the community and affect it.
In addition, there are currents in our society that are, you know, reflect viewpoints or ideologies that often are flowing through the media. And those seem to, you know, have influence on how people see themselves. That could be any number of ways. And I don't think that gender identity or gender dysphoria would be

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immune to any of those influences.
Q So the multiple lines of evidence you are referring to then is by inference or analogy that you would think that also applies to gender dysphoria?
A Well, it would be a pretty incredible coincidence that right at the same time that social media came on the scene and became widely adopted by children and adolescents and that the popularity of influencer and ideology related to transgender and gender dysphoria sort of came on the scene, that that was right at the same time that we had this large rise in presentations to gender clinics.
So it seems that there is very likely an interaction between the two. Certainly we should be skeptical and cautious when, you know, there is such a change so quickly.
Q You would agree that is correlation and not causation at this point?
A Correct.
Q When you say influencers, who were you referring to.
A Well, I don't have specific names of people online. Although over time we have heard many names. There are TV shows. There are people that

are online. There's a number of individuals who are transgender who are well-known personalities.

There are also subgroups. You know, influencers might be a strong word for this, but there are a lot of people who are active on the online communities, Reddit, and these type of places where adolescents and children can be influenced by what they encounter online.

Q Do you believe that a celebrity who is on social media merely existing as openly transgender is a source of social contagion?

A Well, they may be or may be not. I don't, I would not say merely existing. Definitely it would depend on how they present themselves and how they are talking about themselves.

It could be -- no, not by merely existing.

Q When you say it would depend on what they said and how they are presenting, what do you mean?

A Well, I think that we would have to be cautious about the presentation of individuals who may have a large influence over children and adolescents who may take celebratory views regarding transition.

That may have a large influence on minors. And so I think that there's a potential for those

who are celebratory to have an influence in a way that, you know, can especially for minors who already have mental health problems or are very easily influenced, could lead them to believe or develop a belief that transition is a solution to the problems that they have, or that their gender dysphoria, the solution to that would help them, could contribute to the development of gender dysphoria or contribute to the belief that a transition would be, you know, a good source for them.

Q Do you believe that to be the case even if there is no mention by that particular celebrity about any other co-morbid conditions?

You said celebratory. If someone really celebrates the fact that they have medically transitioned, do you believe that that is sufficient to cause social contagion in youth such that they will then believe that they also have gender dysphoria?

A Well, I don't know that is sufficient. It could be a contributor.

Q Is it possible that a celebrity who is celebratory about their medical transition really creates a more welcoming environment for people who already

have gender dysphoria to be more open about it?

A Yes, it's possible.

MR. SELDIN: Joel, please take us to Paragraph 52.

Q You wrote, "Yet most child and adolescent psychiatrists I speak with admit to me that they will not speak publicly on this subject due to how sensitive the topic is, expressing fears of hostilities from activists along with condemnation and retributions from others with their universities and organizations."

Do you see that?

A Yes.

Q Can you tell me which child and adolescent psychiatrists have said this to you?

A Are you asking me to out the people who said they do not want to speak publicly?

Q You represented to the court here that most of the people you talk with have said this to you. I would like to know who said this to you.

MR. PATTERSON: I object. There could be First Amendment issues here.

At a minimum, we should go confidential on this part of the transcript.

MR. SELDIN: I think it is presumptively

confidential for two days so we can work it out.

Q Dr. Kaliebe, who said this to you?

A So this is confidential? Is that what you are saying?

Q Yes. We can designate this portion as confidential.

MR. PATTERSON: You will not object to maintaining confidentiality of this portion, correct?

MR. SELDIN: No, I won't.

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Q Let's start with the folks you just named. You first named, I think, you counted five or six people.

Is that most of the psychiatrists that you have talked to? I'm trying to understand how you are coming to this conclusion of "most"?

A I talk to many more. I talk to many, many more psychiatrists. When I go to the child psychiatry meetings I'm trying to talk to people about these issues so that we can come up with more.

I just have not prepared a list to provide to out people who do not want to be outed during my deposition due to their fears of recrimination and hostility.

That was not something I thought I would be asked to reveal. If you want me to make a list and give it to you later, you know, but like I said, as I am representing in my report, that it's many people.

Q You were talking just a minute ago about a talk you gave in Puerto Rico. When was that?

A May 2 or May 3 I would guess.

Q What was the conference you were presenting at?

A It was the Oasis Child Psychiatry Conference.

Q What is the Oasis Child Psychiatry Conference?

A A continuing medical education conference that is presented in different places. Basically people pay a fee and they travel to wherever it is. This one was in Puerto Rico.

People like me who are experts provide talks on different things. I gave three talks at the Child Psychiatry Conference.

You didn't ask me about presenting CMEs. I did present this CME talk on child, on gender dysphoria. So if you want to add that to my expertise, you can. But this was at the Oasis Child Psychiatry Conference.

Q Who organizes that conference?

A It's a larger, it's under the umbrella of a large organization that does many different, they have a psychiatry conference. They have a child psychiatry conference.

They have many other things. I don't remember the name of the company. I don't remember the company of that organization.

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Q So it's, are they affiliated with a medical institution or association, or is this like a CME company?

A It's like a board review CME company.

Q Right. Was the topic of the conference you presented at specific to gender dysphoria?

A No. The topic of the conference was specific to child psychiatry. I presented three topics. Gender dysphoria was one of the three topics.

Q What were the other two?

A Traumatic brain injury and social media.

Q Had you presented any version of this presentation on gender dysphoria before?

A No.

Q Have you presented it again since May 2 or 3?

A No.

Q Have you presented other CMEs on gender dysphoria prior to May 2 or May 3?

A No.

Q Okay.

A The date might be a little off. I'm not sure. It was May. It was early May.

Q Okay. How many people attended your session on gender dysphoria?

A There were probably sixty to eighty in the room.

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Q Okay. And about how many people attended the conference?

A I would assume somewhere around that same number. It's also online.

Q The entire conference you think was under one hundred practitioners?

A Yeah. On site I would guess so. Yeah. I'm not -- it's a guess.

Q Did you reach out to Oasis about this presentation or did they reach out to you?

A I have spoken for them before. This was the third time that I have spoken for them. I spoke some at the adult psychiatry one contiguous with it.

I have done it twice before for them for child. They have an adult and then a child conference. I spoke a little at the adult and then also the child conference this time. They request me as a speaker. They reached out to me.

Q Did you discuss your involvement as an expert during your presentation?

A No.

Q I would assume when you say most of the psychiatrists that you speak with, and this may seem like a silly question, but you don't speak with most psychiatrists in the U.S. I take it,

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right?
A Correct.
Q You have stated you believe that it is controversial to take the position that you take regarding gender dysphoria, correct?
A Not controversial among psychiatrists or physicians, yet controversial in the public sphere. Yes.
Q So would it surprise you then that once you express some receptiveness to this view of gender dysphoria, would it surprise you then that what appears to be an unusually large number of folks would come to you expressing the same one?
A Well, mostly these are regular private conversations from people that I know. It's not like I was approached by the names that I gave you or the people that I'm speaking about when I say that child psychiatrists are afraid to talk about this, but feel supportive of my approach.
Q Dr. Weiss, let's go to Paragraph 53 of your declaration. We will scroll down a little bit.
MR. PATTERSON: Did you say Dr. Weiss?
Q Sorry. My mind is still in last week.
Dr. Kaliebe, you will see in this paragraph you talk about social media as an influence

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regarding teenagers.
Do you think that heterosexuality is a sexual identity?
A Could you repeat the question?
Q Is heterosexuality a sexual identity?
A Yes.
Q Do you believe that social media has an influence in how teenagers who are heterosexual express their identity?
A Identity, no.
Q You believe that teenagers who use social media who are heterosexual or straight, the way they express being straight is not influenced by social media?
A It could be. It could be.
Q Are you familiar with the movie genre of the teen rom com?
A Is that romantic comedy?
Q Right. You are generally familiar with the fact that a decent amount of media television or movies revolve around teenagers in high school who date.
Is that a fair description of a certain part of American media?
A Yes.
Q Do you think that those movies and TV shows when

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they show straight teenagers dating, do you think that that has an influence on how American teenagers date or their expectations of dating as straight teenagers?
A It could, yes.
Q All right. For teenagers who are not straight, who have a different sexual identity, do you think that media influences their expression more or less than heterosexual teenagers?
A I would not have an opinion more or less. I'm not sure.
Q Okay. And then do you think everyone has a gender identity?
A I think that is an open scientific question. I'm not, I would not say that that is a settled question. That has been an assumption that most people are going on.
That seems to be a common assumption. I'm not sure that it is a settled scientific question.
Q Do you think that most people have an internal sense of whether they are male or female or something else?
A I think we are getting into nuance about internal, what you mean by internal sense. Most people can identify themselves as either male or female. So

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I would say that is correct because that does exist in their brain. Yes.
Q When you say sense of themselves you mean as male or female? We will start there.
A Correct.
Q Okay. Do you think that -- okay. In Paragraph 54 of your declaration you talk about the -- I'm sorry. I lost my place here.
Yes. In Paragraph 53 you talk about Dr. Weigle's publication in the Psychiatric Times.
Do you see that about three lines up from the end of Paragraph 53?
A Yes.
Q Is the Psychiatric Times a peer reviewed journal?
A No.
Q Dr. Kaliebe, in Paragraph 54 you say -- in Paragraph 55 you say in my opinion --
MR. SELDIN: Joel, can you scroll down to Paragraph 55, please.
Q You say, "In my opinion, technological, ideological, and social factors underlie much of the recent increase in gender dysphoria in adolescents."
Do you see that?

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A Yes.
Q We will take a look at your report in Decker.
MR. SELDIN: Joel, will you pull that up? That is Exhibit 4, Paragraph 44. You say there, "It is plausible and probable that ideological and social factors underlie the increase in gender dysphoria."
Do you see that?
A Yes.
Q My question is in this earlier report in Decker you said it's plausible and probable that ideological and social factors underlie the increase.
Then in your declaration here you say, "In my opinion technological, ideological, and social factors underlie much of the recent increase in gender dysphoria in adolescents."
My question is, is this two ways of saying the same thing? Or are you holding this opinion to a different degree of certainty from April to now?
A I guess it was just the -- it seems to me that I'm pretty much saying the same thing on both occasions. I'm just perhaps fine tuning it. I don't know that it really adds more or less

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certainty, the change.
Q All right. In the Decker report you said it is plausible and probable that ideological and social factors underlie the increase in gender dysphoria.
Is it fair to say then that you are not sure, but this could be true?
A Well, I'm saying it is probable. So, yeah, I mean, I think in either case, you know, if it's my opinion, I think the -- I mentioned it is plausible because of it's so, you have had such panic in the academic community when there has been talk of social contagion that it's, you know, it has been really remarkable how people have fought against the idea that there possibly are social or online influences driving these things or having a large influence.
That is why I put in the word plausible there because there are academics who are saying that it's not plausible. But I think it is an extraneous word, so I did not use it in the next report.
Q As a general matter, would you expect teens who had something in common to find each other online?
A Yeah, they could. Yes.
Q And would you generally expect that small

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populations that tend to otherwise be isolated would find each other online?
A Yes.
MR. SELDIN: Joel, will you take us to Paragraph 57, please.
I'm sorry. Can you take us back to Exhibit 1 and then go to that Paragraph 57. I apologize.
Q Dr. Kaliebe, in Paragraph 57 you provide what you call, "A prescription for open exchange and deliberate consideration regarding gender dysphoria treatments..."
Do you see that?
A Yes.
Q Where does that prescription come from?
A Well, I don't know exactly where it comes from. I feel like it's an amalgam of thoughts that come from John Haidt, who I cited just below. He is a public intellectual who has commented about group think, the squashing of opinions within academia. He is a social scientist. That is in part from him.
It is in part from Jonathan Rauch, who wrought a book called The Constitution of Ideas, which is a quite thoughtful recent book that lays

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out, I think, even a list of something similar. This could come from Jonathan Rauch. Steven Pinker has written extensively on this same topic and the importance of rationality and the importance of a dialogue of ideas.
You could take this as far back as John Stuart Mill, who was originally one of the originals who sort of brought forth a lot of our ideas that underpin what some people call liberal science or scientific exchange today.
So this list is a time tested list and it's reflecting of much of the underpinning of how we have achieved, you know, science and moved knowledge forward.
As Jonathan Rauch talked about in his book, there is no one person who has a monopoly on the truth. We get to the truth by exchange, which is conflict, and we need that in order to understand both our opinions better and the opinions of others. And each of us, hopefully, with this conflict will help us all get closer to the truth.
So I know that was a long answer for where that list comes from. I'm pretty sure if I looked in those sources I could find a list that is

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similar. I don't know exactly where it comes from.
Q Have you evaluated any other areas of medicine that you believe have a credible evidence base to assess whether this prescription was followed?
A Well, I believe in a lot of medicine these things are broadly followed. So, yes, I believe in many places we have a rigorous scientific exchange on multiple matters within medicine. Yes.
Q I guess, have you personally examined any particular treatment in the field of medicine to say I wonder if they follow this prescription and have done this analysis?
A Yes. I think that the best example -- there are many examples, but I think the scholarly exchange regarding antidepressant medications is really a prime example of how we have a robust exchange of ideas.
Q At the end of that robust exchange of ideas that you believe took place with antidepressants, did any state ban the use of antidepressants in minors?
A No.
Q Okay. Do you think they should have?
A No.

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Q Is that an area with what we know now about antidepressants where you think individual clinicians have sufficient guidance to make decisions about their particular patients?
A I think that we still are affected by some distortions of that scholarly dialogue in the past.
It's in my report regarding undue influence of pharmaceutical companies which have swayed people in a different direction. Thankfully, there was enough rigor and enough people took interest, although, it took outside pressure because it was the lawsuit asking for a release of full information that helped lead to that.
But, yes, at this point those who are looking can find a rigorous dialogue of ideas and make decisions for themselves.
Q Do you think that that evolution would have benefited from a ban on the use of antidepressants in any population while it took place?
A No.
Q In Paragraph 58 you say, referring to this prescription, "This framework would depersonalize the search for truth and esteemed empirical dialogue, which has been in short supply on

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numerous topics within academia."
Do you see that?
A Yes.
Q What are the other numerous topics you are referring to here?
A I think in general many of our academic institutions and professional organizations included have gotten behind ideas of social justice.
I think social justice ideas at some point, you know, may or may not reflect the truth. So if your goal is social justice, it can bump up against rigorous science.
So I would say that in general that would be the one good example.
Q Which social justice topics do you think are bumping up against empirical science?
A Well, it could be any number of them. I think this is a case in point. So I think this is part of why it's in my report.
Rather than being seen as a dialogue related to what is the science and ensuring a rigorous scientific dialogue, it has been treated as if it's a social justice issue rather than an issue of what is good medical practice.

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But I think, you know, the issues related to hot button topics, race would be one.
Q In what way?
A Well, I think that when -- I think that after George Floyd's murder and other events that there has been, but that in particular, there was a call for a special influence on matters of race. Which is a great thing for people to be more attune to and to have scholarly dialogue.
But they asked for a certain viewpoint. I think a good example is Ibram Kendi's, you know, antiracism sort of viewpoint on it to be put forward as the way that we are supposed to handle it.
So a lot of our journals, in fact, the Child Psychiatry Journal, they declared itself an antiracist journal, which is joining an ideology on how to approach race, rather than calling for more open and rigorous dialogue about race, which would have been the more appropriate viewpoint for a medical journal.
Q I think you just described antiracism as a particular ideology about race.
What are the other ideologies about race that you believe exist?

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A Well, like I said, I don't have a countervailing ideology of it. Like I said, the journal in our, in child psychiatry declared itself to be an antiracist journal, which is an affiliation with that ideology.

I'm actually against affiliations with ideology. I don't know that there is a counter-ideology. We prefer it to just be a rigorous scientific dialogue about important issues. That is what we would be aiming for if you follow the prescription that I've laid out here.

Q Are there any particular principles in antiracism as an ideology that you think are antithetical to the search for the truth or scholarly dialogue that you think that journal should have undertaken?

A Well, I didn't, you know, I'm not prepared to go into a, you know, in depth into that. I would say there's a, there are some broad narratives about the world included in that, which is that certain groups are oppressors and other groups are oppressed.

That would be a primary narrative that is, can be accurate. But yet we would have to be

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nuanced about how we approached those things and that we should be very careful to make generalizations especially in the realm of science.

The more broad your generalization, the more likely that you are over inclusive and overgeneralizing. And so that would be the oppressor versus oppressed narrative, that would be a good example.

Another example of that would be the whole idea of race being codified into a more important marker of people's identity. Whereas, it's not actually a very scientific idea. It is a really complex idea.

People come from different backgrounds and origins. You know, where do you draw the line? How do we sort of determine this? And what do you do about mixed race couples? What do you do about people who look like they are one race, but they are the other? I mean, it's very complex.

So the broader narratives embraced are problematic when you come to, when you come to science. Then, also, it's a call for, I mean, when editors call for a certain viewpoint, once again, I just think that that is not what any job

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of an editor or a journal would be.

They can call for more viewpoints and discussions which would be great, but not to call out or prefer a certain viewpoint.

Q Do you think there are any viewpoints about race that journals should not seek to include?

A Well, I think that there, I think that certainly you are not going to, you know, considering where the dialogue is and who would be writing to psychiatry journals, you are only going to have thoughtful academics writing in and trying to talk about a nuance.

So not within the, not that I, not that a psychiatrist would write into a journal. I find it would be highly unusual that there would be any idea written in or someone who would submit for an article that would be outside of the bounds of what would be acceptable dialogue.

I would say maybe, you know, in theory there could be. In practice, there is not.

Q Do you believe that there is, as a normative matter, a view on race that a psychiatrist could seek to present to a journal that without hampering the search for truth the journal could say that is actually outside of the bounds of

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discussion?

A Well, if they were overgeneralizing, which is exactly what I'm talking about. Yes, so. I'm against people overgeneralizing.

So a journal editor should knock down any article that overgeneralizes.

Q Dr. Kaliebe, in the middle of Paragraph 62 in your declaration you say, "Supporters of gender-affirming treatment want to believe they have found an ethical and evidence based solution."

Do you see where you wrote that?

A Yes.

Q What do you think is unethical about gender-affirming treatment?

A Well, gender-affirming treatment as an actual clinical treatment can do harm. So I think it is unethical to do harm.

Q What harm do you think it does?

A Well, when you are asked to evaluate a child or an adolescent, they need to be seen in the context of a total individual and their total environment.

You would have a biopsychosocial formulation. They are in the process of identity development. So to see someone through just the lens of

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affirming can be harmful and can turn the discussion just towards gender identity or gender dysphoria rather than away from the traditional way that you would approach a patient.

So it's trying to, it is, I believe it's poor medical care to move to affirming automatically patients who present with gender identity issues or gender dysphoria.

Q So is the harm from the diagnosis of gender dysphoria, or from the possibility that the evaluation process does not discover other co-morbid conditions?

A There is not a problem with the diagnosis of the gender dysphoria. But there is a problem with an overemphasis on one component of people's identity and a turning away from the typical therapeutic approach which we have always used which does not jump towards affirmation, but lets a person develop in their own way and would be broadly based and notice what is the context, what other disorders, what else is going on, what traumas have occurred, you know. What other family issues are going on?

So, yes, I feel like that when this is proposed as a way to approach these patients, that

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it distorts care away from what would be a proper and traditional psychiatric approach.

Q Do you think that the care can be ethical if all of the traditional psychiatric or psychotherapeutic approaches that you are referencing had already happened or are happening concurrently?

Could then treatment that is gender-affirming be ethical?

A Well, if you are -- yes, it could be. It could be if they have had a proper workup and have, you know, that that is the approach that the clinician has decided after working with the patient for a long period of time.

But I'm talking about a psychotherapy approach. I assume that is what you are talking about, too. When you say gender-affirming care that can include medicalized care.

I want to be clear. I'm not talking about medicalized care. I think we are talking about therapy and therapeutic approaches.

Q I think we will talk about both. For psychotherapeutic approaches you believe it is possible to provide gender-affirming psychotherapeutic approaches to minors who are

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experiencing gender dysphoria, is that fair?

A Well, you could get to it after providing appropriate care, you know. Would there be a place down the road where you could decide that, you know, and I'm not quite sure what exactly you are meaning by affirmative care, but I assume you mean for, like, going along with the patient's conceptualization of what is going on, which would not be what we usually do in mental health.

We usually remain neutral about what is going on rather than joining a patient's conceptualization.

If at the end of the day, you know, would that mean is it okay for a clinician to use the pronouns that are requested by a patient, then I'm saying, yes. You know, that is perfectly reasonable and under certain circumstances, you know, yes.

But is it appropriate to ever completely go along with the patients' narratives or views of the world so that is, you know, a clinical decision that maybe you could get to.

MR. SELDIN: We have been going for another hour. I think most of the folks here are on East Coast time.

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Do we want to take a short break now and then go for an hour and then do lunch? How are folks feeling?

Dr. Kaliebe, will you be okay with a five minute break and then another hour?

A I will do whatever the group wants.

MR. SELDIN: Let's do that. We will come back at 12:27 Eastern.

(OFF RECORD AT 12:21 P.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 12:27 P.M.)

BY MR. SELDIN:

Q Dr. Kaliebe, welcome back after that short break.

In Paragraph 65 you describe a dynamic, "In fact, sophisticated language skills enable virtuosity in creating and promoting false narratives."

Then you go on to say, "These dynamics have arisen before in medicine, and it is my assessment this has occurred again with regards to medical interventions to treat gender dysphoria in minors."

Do you see that?

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A Yes.
Q What is your methodology for assessing that that has happened here?
A Well, I think if you look at a lot of the journal articles, the press releases from national organizations, the sort of what I would call cheerleading for affirmative care, that it seems to be that it's like a, more of a tribal dynamic than an actual usual discussion, a very complex nuanced evidence based and a new treatment population.
Within that environment clearly there is some who are, I believe, very caught up in a group think regarding these issues. So I can give you more details. But basically, the things that I put in my report sort of speak for themselves.
The way the professional organizations are framing their arguments, the way the people write the guidelines all speak to a moralized type of environment rather than the usual dialogue regarding medical evidence.
Q Is your primary concern the consensus or the enthusiasm?
A Well, the false consensus is definitely a problem because they are, without really undergoing the

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standard academic debate, they are sort of pretending like there is a consensus and this is all settled science.
Then the level of enthusiasm is also very problematic because the level of enthusiasm should be proportional to your confidence in your argument and the safety of your argument.
So when people are coming out very enthusiastic for something that, you know, is not settled and unclear clinically, that then, those -- so I would believe those are both problems.
Q Then you say that these dynamics have arisen before in medicine.
When have they arisen before?
A Well, when for a time lobotomies were popular and were sort of celebrated as curing a very difficult patient population with serious problems.
The person, you know, won the Nobel Prize for lobotomy. In retrospect it sounds horrible, but that is an example.
I think your, I mean, I think whenever you have intermixing of moralized environments -- on the flip side you could also say, like, pronunciations against, you know, making

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heterosexuality a disorder in the DSM would rise from moralized environments where people took what should be a scientific or medical issue and turned it into a disorder based on social or cultural elements.
Q So with your homosexuality example, do you think the moralizing environment led to its inclusion in the DSM or its removal from the DSM?
A Inclusion in the DSM.
Q Do you agree with its removal from the DSM?
A Yes.
Q Okay. In Paragraph 66 you talk about emotional reasoning. In the last sentence you say that it "helps explain opinion cascades, partisanship, and group think."
Do you see that?
A Yes.
Q Those are terms that come from sociology, is that correct?
A I mean, there's a, they -- I'm not sure exactly. They jump from field to field. So you can get those terms in a number of different fields.
Behavioral economics is a field that uses those terms. You know, we do talk about them some in medicine, too. Yes, I believe sociology and

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behavioral economics would be the, would be where I found them.
Q Is it fair to say these are not conditions that you diagnose as a psychiatrist?
A Behavioral economics was sort of founded by a psychologist. The only psychologist who won the Noble Prize, Daniel Kahneman, so it's within the realm of people who are experts in how the mind works and how we make decisions.
Is it directly psychiatric? I think it's important for you to size up the person in front of you and where they get their information and if they have cognitive distortions related to groups, you know, and the information that comes to them in groups they affiliate with.
I think modern psychiatrists should understand and know these things.
Q Do you think you have expertise beyond that of a well-trained psychiatrist to assess whether opinion cascades, partisanship, and group think are occurring?
A Well, I think I was mentioning that I would hope that all psychiatrists should understand these phenomenon and be able to see when they may apply.
Q Do you, yourself, believe above that level that

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any psychiatrist should have, do you believe you have particular expertise in identifying when these things are happening?
A Well, I put in a lot of work. As I mentioned in my report, I did present on misinformation at the child psychiatry conference. If you look at some of my articles, like my article on child obesity, I bring in a lot of the ideas related to behavioral economics and how to approach the world and how we, how human beings tend to fool themselves.
Yes, I probably put in more work than other psychiatrists on these matters.
Q Okay.
A I will say I read a lot. So, you know, I probably read a lot more than almost any psychiatrist that you will talk to.
So, yes. I do pull from lots of different things, but I think that what I'm pulling from here is important and most psychiatrists understand these dynamics.
Q Doctor, look at Paragraph 79. Dr. Kaliebe, in this paragraph you are talking about the opioid epidemic.
On the bottom of Page 27 there is a sentence

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that starts, "While a small number of patients may have achieved better pain control as a result, it came at the cost of creating legions of addicts."
Do you see where you wrote that?
A Yes.
Q And so is it fair to say that you have identified opioid prescription as an area in which providers were practicing either outside of the guidelines or recklessly?
A Well, what I was saying was, in fact, the guidelines were pushing them towards, they were exerting pressures on them to prescribe inappropriately.
So, no, you know, this was my whole point. You get, you get ideas that come from, you know, a small group, yet then can get taken up and become popular. Especially when you have the idea of you are being more compassionate so this is the right thing to do. You are a bad person to ignore someone's pain without realizing at the end of the day these are complex matters and you can do harm by opioid prescribing.
I believe that was pretty clear in what I wrote.
Q Do you believe that the treatment of gender

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dysphoria like the treatment of pain is a complex area?
A Yes.
Q Okay. And in response to the opioid epidemic, the states have implemented greater controls, is that fair to say?
A Yes.
Q But they have not banned them entirely?
A Correct.
Q Dr. Kaliebe, before the break we sort of talked about, we touched on this and I want to dig a little deeper.
So you say in Paragraph 83, you talk about "affirmative treatment." You put that in quotes.
What is affirmative treatment?
A Well, I believe it has two major components. I mean, one would be the idea that when someone presents with -- well, specifically we are talking children and adolescents here.
If a child presents and declares a gender identity that the clinician should agree with that identity. That is one component.
And then the other part of affirmative treatment is medicalized treatment such as puberty blockers, hormones, and surgeries.

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Q Where do you get that definition from?
A Of affirmative treatment?
Q Yes.
A I mean, I have seen much more complex descriptions of affirmative treatment. I think that is what it boils down to.
Q You say in Paragraph 83 there is a push for affirmative treatment.
How do you think the groups that you list in this paragraph are pushing the treatment?
A Well, if you look at the guidelines from WPATH, I think those are clear. The Endocrine Society and the American Academy of Pediatrics came out with guidelines that specifically advocate for them.
American Psychiatric Association has, I believe, they didn't come out with treatment guidelines, but they have come out in support of it in multiple ways, press releases, stuff on the website, publicity things and in their journals.
So there's, you know, the way that they selected articles and the articles that they publish all, they all seem to reflect an idea that those are the, that this is the approach that they favor as institutions.
Q When you say push for affirmative treatment, do

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you mean just the organizational support around the existing guidelines?
Or do you mean push for affirmative treatment at the individual level?
A Well, it seems clear to me that they want us to adopt this as treatment.
Q And what is your basis for saying that this kind of care is politicized?
A Well, I think, for one, if you look at a survey, opinions about these matters tend to clump in lines that go along political affiliation.
So for one, it's just a fact that is based on the surveys. There has been a number of surveys. It tends to be that people who are in, you know, in one political party have certain feelings about this and people in another political party have certain feelings about this.
So I cited a Regenerist article that did questions after people came out of polls. That was sort of a direct peer view published line of that evidence. There have also been a number of opinions polls.
The political parties, you know, have, I don't know that the, I don't know if the, to what degree the Republican party has come out, you

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know, with strong statements or push for these things. But if my memory serves me correctly, their administrative, I mean, political parties, whoever is in political power has some control over administrative issues.
So, I mean, I think that some aspects of the general idea or rights for transgender individuals is a politicized idea. So I think that that is where I say that. I would also say that if you look at the organizations -- I put some data in there.
These organizations, particularly the psychiatric ones, and the American Academy of Pediatrics, I could say that for sure, too, tend to be a left-leaning organization. They tend to support politics that are, you know, to the left of the center.
And also it's true if you will look at just even polls of who in what medical specialty aligns with what political party. One of the polls I saw had psychiatry was second to the most left-leaning of all of the specialities with only public health being more left-leaned.
So not surprising that the professional organizations follow the politics of the members

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that tend to lean in one direction. That is -- I put examples in my report.
Q Based on that definition of certain kinds of care being politicized, do you think that as a clinician that is a reason to provide or not provide certain kinds of care?
A Well, I think that it is not a reason you should be providing care based on what is good care. But it could make you more skeptical of these professional organizations' support for certain care because you know that they come out and support things that happen to lean in their political or within their, you know, thought level. They are very accepting of things that are, in that case, left-leaning.
Therefore, they are susceptible to confirmation bias, group think, group dynamics that would lead them to move away from a scientific, more clinical approach towards an ideological approach.
Unfortunately, I put in my report that is what I feel has occurred.
Q Are there other areas of psychiatry where you think the political alignment of psychiatrists or their organizing groups has negatively influenced

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care?
A Yes and no. I mean, there are different priorities that the organizations have. I mean, my priority and what I was trying to push for within the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association with some of the articles that I wrote and, you know, supporting in meetings, was a collaborative care, particularly working in federally qualified health centers.
So what I would love to see is for them to put an emphasis on getting primary care support to deal with mental health issues. Getting an emphasis on us growing more federally qualified health centers which are primary care clinics that provide like WIC and dental and, you know, mental health care to communities. You can only open an FQHC if you are an underserved or disadvantaged community.
So that is what I was pushing for us to do. We do do that some as an organization, push for that. I just feel like that would be a much better priority for an organization. So unfortunately, you know, they seem to be more at times interested in other things rather than what

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I think would be the most helpful approach.
It seems that sometimes the other things that they are interested in are things that are hot button political items rather than the actual, a great thing you can do like supporting primary care in disadvantaged neighborhoods.
Q So relative ranking of priorities aside, is there any individual kind of care in psychiatry that you think is being provided and should not be because of the political alignment of psychiatrists or the organized medical groups?
A No. I think gender medicine has been the first time that this type of ideological care has actually come in and affected, you know, patient care on a wide level. Yeah. I have never seen that before.
Q In Paragraph 84 you say in the third sentence, "I have directly observed over the last decade, but particularly the last 5 years, that these organizations have prioritized a politicized, narrow vision of social justice advocacy."
Do you see where you wrote that?
A It is kind of cut off at the bottom. Yes. I remember writing it.
Q Other than what you just called gender medicine,

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what else have you directly observed in the last five years that falls into this category?
A Well, I think we talked about race, so I think that is an issue that, you know, while an important issue and I'm glad that they want to emphasize it, the way that they have emphasized that has also has been very, it has been politicized. And the sort of policing of, or the curation of what goes in the journal, at least of the psychiatric organizations, does seem to be very narrow.
But that would be the other main thing that I can think of. There are probably more. That is what I can think of right now.
Q When you referenced just now narrow curation, are you talking about articles regarding the treatment of gender dysphoria or something else?
A Something else. I'm saying I do believe they do that. But since I was asked about what else is sort of politicized and the social justice, we spoke before about how they have come out with becoming antiracist journals rather than just saying we would like to focus more on race. Race is a really important topic. It is an important component of what goes on in society.

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Q Let's look at Paragraph 85 and 86 together. Dr. Kaliebe, you talk about your time co-chairing -- is AACAP the way you say that?
A Yes. People say AACAP.
Q When you co-chaired AACAP's media committee, it seemed like in Paragraph 86 you characterize that as a committee of content experts, is that fair?
A Yes. Yes.
Q And then in Paragraph 85 you are talking on the second line about special interest groups. You put that in quotes.
Do you see where you wrote that?
A Correct.
Q Is there a difference between special interest groups and content committee and content?
A Well, I was trying to differentiate that there are groups of people that do, that are attracted towards certain approaches. And so they could be a group of people that are not officially a committee.
So you could self-select in more ways than one. The committees are vehicles within the professional organizations.
Q What I'm trying to get at, your concerns about group think and opinion cascades, do you think

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that was in affect when you were co-chairing the AACAP committee on media?
A Yes and no. I think in the media committee we were always mindful to bring in diverse opinions of people. So we didn't want -- there are a lot of people who are generally negative about the media. They would want to present or talk about media in negative ways.
We were very conscious that humans seem to have a negativity bias and negative stuff gets noticed more. There are also positives with media. We are trying to cultivate in our presentations and in our output a balanced look.
So, you know, I don't think by any estimation anyone would think that our committee became one-sided or too, you know, too negative. But once again, you deal with clinical issues. So there is always some bias towards negative. That is something that we were cognizant about.
Q Are there other committees in AACAP that you feel didn't do as good a job providing that kind of balanced view other than the ones dealing with the treatment of gender dysphoria?
A Well, I think I had mentioned previously that at one point those who wrote -- or had in my

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report -- that those who wrote the pharmacology guidelines were overly enthusiastic, influenced, or excited or however you want to say it, regarding psychopharm.

So I think at times any of these committees can be somewhat overconfident or have opinions that lean towards interventionalism towards whatever intervention that the committee is about.

So I think that, yes, you know, the psychopharmacology committee would tend to be too much focused on psychopharmacology from the perspective of a regular psychiatric practitioner that has to take the different patients and use all sorts of different modalities and not just pharmacology.

The group dynamics have some affect on the other committees. I mean, I would probably guess that, or it is possible that there is some other committees that they also may interact with. I have not been to the, I think it's, like, I will probably mess up the name. I think there is, like, a race and diversity committee.

Is it possible that they would be, you know, could that committee be overly politicized? It is possible.

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Other than the gender committee I have never seen it affect clinical care in this way.

Q Dr. Kaliebe, at the end of Paragraph 87 you characterize the group that works in the area of gender dysphoria as "a well-intentioned but homogenous group of supporters."

What do you mean by homogenous?

A I am talking about at the beginning of the paragraph, they have self-selected into providing this type of care and are enthusiastic about it.

And so when you have a group of like-minded individuals that support it without really a -- more skeptical people end up not being on that committee. So that is my impression.

Q Just to describe a similar dynamic, the psychopharmacology committee, that they would have bias toward intervention using certain kinds of medication, is that also what you mean by -- would homogenous be a way to describe that as well?

A Yes.

Q Okay. Would you generally agree that a group of people that have a special interest in a topic is -- I guess, what I'm trying to ask you is when you were the chair of AACAP's media committee, did that committee benefit from the fact that its

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members had a special interest in media issues?

MR. PATTERSON: Objection. Assumes facts not in evidence.

You can answer.

A Yes.

Q Generally speaking, in your evaluation of group dynamics, if you have a small committee you would prefer folks who were interested in the topics rather than disinterested, correct?

A Well, no. I would give some nuance to that. I mean, I would really love to see -- I actually thought that it probably would be really quite helpful for -- let's go back to the psychopharmacology committee -- for there to be some, like, regular bread and butter practitioners on that committee so that the committee would be mindful of what is happening in the real world and how, you know, their proclamations on, you know, medications play out.

You know, especially as I've served in disadvantaged and underserved communities, you know, the idea that there is a medication solution for people's problems, you know, the guidelines were very heavy into pharmacologic, you know, solutions. And it just is not, it's just

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unrealistic on a massive level.

No, I think it would be best if there was a way to make sure that there is broad inclusion of people. But in reality, that is not how committees are formed. It is people that tend to be enthusiasts.

So I think there is some advantage to people being enthusiasts, but I think there are disadvantages, too. You know, as I mentioned the psychopharmacology example, you know, it would be nice for there to be a counterbalance of people in the field who are not so enthusiastic.

Q Do you think that is true for every field?

A Yes.

Q Dr. Kaliebe, in Paragraph 89 you talk about watchful waiting.

What do you -- is watchful waiting the approach that you prefer for treating minors with gender dysphoria?

A Well, I think a component of the approach, regarding certainly medicalization-wise I would say yes. I think that would make the most sense to let people grow up and then once they, you know, are adults to make decisions about hormones and surgeries when they are fully developed

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humans.
So medicalization-wise, yes. But I think as I mentioned before, I believe that it is ideal for people to get other types of, you know, to have a well-rounded approach to life which would include a number of things and potentially psychotherapy.
Q And so you, in this paragraph you say that the policy statement at issue from the AAP contained citation errors, overstatements, and mischaracterizations of the -- sorry -- you say it mischaracterized the long-standing and well-regarding clinical approach of watchful waiting.
How do you think they mischaracterized it?
A Well, they say it right there. "Watchful waiting is based on binary notions of gender."
I mean, to translate, that sounds like saying well, those people who do watchful waiting, they are just those old rubes who don't know any better.
We're the sophisticated new people that want to do this intervention. We are going to get rid of that approach is what we want to do because we know better now.
And I think that that right there kind of

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shows that they are failing to appreciate the nuance and difficult realities of when you have a developing situation and you don't know where it's going to go, it's often better to not intervene than to intervene and potentially do harm.
Q Do you agree that there are instances where not intervening can actually also cause harm?
A Are we talking about with gender dysphoria or just in general?
Q First, we will start in general. Do you agree there are situations where the choice not to intervene can also cause harm?
A Correct. Yes.
Q Do you think that there are instances in the treatment of gender dysphoria in minors where declining to intervene can cause harm?
A I would not frame it as causing harm. So I would not use those words.
Q What words would you use?
A Well, I would say that the not intervening would allow a patient to grow and develop. And then once they have a sort of fully developed self, then they can make decisions about medicalization of their body.
So I don't, I just, I think you have got --

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that would be a better way to say it.
Q So are you aware that some of the original proponents of the watchful waiting approach were the Dutch and Ken Zucker in Toronto?
A I mean, I would step back and just say, you know, watchful waiting is a term that we use in medicine all of the time. It was used for decades before it was adopted by gender medicine.
So I would say this is an old term that has lots of uses in medicines. So, yes, I would, I am aware that both Ken Zucker and those in the Netherlands have used that approach.
Q Both the Amsterdam Clinic and Zucker's Toronto clinic both treated adolescents with blockers and hormones once they reached puberty, is that right?
A Yeah. I mean, I don't have data about Zucker's treatment protocol or what was going on there. I can't speak to what treatment they were getting in the clinic. The Dutch clinic has published a lot of articles so we are familiar with that.
Q So in that respect, watchful waiting would apply to prepuberty at those clinics?
A Correct.
Q And so even those proponents of watchful waiting,

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they still recommended medical interventions when the incongruence of distress persisted into puberty?
A Yes, I know the Dutch did. I don't know that Zucker's protocol, I have not seen exactly how it was treated or what his approach was.
Q Do you oppose social transition for minors with gender dysphoria?
A Well, I think it's a complex subject. I think, yes, in that children with gender dysphoria it seems would be wise for them to be thought of as children with gender dysphoria, not transgender children.
We don't know what their, in the end development is going to be, so why not, I think it's most wise to keep them developing within their biological sex, be honest that they are a person with gender identity issues with gender dysphoria.
They may grow up to be a transgender individual as an adult. They may also grow up to be not transgender as an adult. Since we don't really know, why don't we more conservatively approach this and not socially transition them when they are young. That would be my

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recommendation.
That being said, you know, families can decide to do whatever they want to do and, you know, I don't know that there could not be some exceptions to that recommendation. But that would be my recommendation.
Q It sounds like you would agree that individual families might decide that for their particular child the appropriate way to address their gender dysphoria would be to allow them to socially transition?
A Well, they do decide that. Yes. I mean, like I said, I don't think that is a wise decision. But once again, that is a family decision. Whatever a psychiatrist says cannot change what a family does.
Q Would you support a ban on social transition among minors?
A Well, I do think that the society has always used biological sex as the main marker of what a minor, you know, how a minor is classified.
So I don't see a compelling reason to stop using biological sex as the marker which we -- especially considering these are children with gender dysphoria. They are not transgender

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children. Right? We don't know what the end of their trajectory will be so why are we going through this at this point?
Like I said, through human history the marker of biological sex has some, it has trade offs, but it has generally worked well for us. I would say that is the most sensible approach right now.
Q So my question was, I guess, do you think that there should be a ban on parents taking the approach of allowing their children to socially transition prepuberty?
A I don't know that I have an answer to that question because I've not thought about a ban. I have a clinical impression or what I would recommend. But I've not gone through the implications of that.
Q You said that some of the children who have gender dysphoria you believe may grow up to be transgender and some may not be transgender, is that right?
A Correct.
Q For the children who do grow up and are transgender, do you think they will have been harmed by not being allowed to socially transition while they were children?

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A My guess is that we, since we never know about what will happen with any one child we can't really say if any individual would have been better or would have been worse.
I would not frame it in terms of harm. Children have been growing up all through human history. We have generally not been socially transitioning them and it has not been a major, I think in general societies they have decided that not transitioning is the better trade off.
So continuing with that approach seems wise until we know better.
Q What do you base that statement on, that assessment of the trade off?
A Well, for one, through all of human history we have used biological sex as a main marker where we, how we divide children.
Children with gender dysphoria do have a harder time and are going to have significant problems. I think it's one of those issues of, like we often have in medicine where there is only difficult choices. There is no easy choice and no, like, clear that this is going to lead to some great solution.
However, since we know so many of these kids

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will grow up to be -- like I said, I consider them children with gender dysphoria. I do not consider their identity to be fixed. I would like everyone to have the opportunity to grow up and then become an adult and then decide about what their identity is.
Q What do you base that statement on that most of the children with gender dysphoria do not grow up to be transgender?
A That has been traditionally the data, that most childhood onset gender dysphoria children grow up and are typically, more likely the adult outcome is being a same sex attracted adult.
Q Is that a particular study you are thinking of when you say that?
A I have seen it referenced many times.
MR. SELDIN: Joel, will you take to us Paragraph 91.
Q Dr. Kaliebe, in this paragraph you talk about political activisms around laws pertaining to gender-affirming care.
Do you see that?
A Yes.
Q You characterize it as political activisms.
Do you think it's political advocacy for

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endocrinologists who treat diabetes to take a position on the affordability of insulin?
A No.
Q Why not?
A Well, that is not an issue that aligns with any particular politics. I have not seen any data that makes me think that Republican endocrinologists and Democrat endocrinologists see that differently. So, once again, it would not be a political issue because that seems to be a general medical care issue.
Q And so when you say political, do you mean measurable difference in opinion by a political party?
A Yes. Well, I don't -- I'm saying political saying these organizations seem very willing to get involved with political activism from a certain viewpoint. There could be any number of things where they -- you would think at least once maybe they would get, have some issue that is not from that same viewpoint, but it does not seem very -- they seem very willing to make things more political than they really are.
I believe that questions about gender-affirming care are clinical questions. And

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so I don't think that these organizations should be condemning people who see the evidence differently or want to be cautious.
But it seems like that is in the press releases where they would want to approach it. So I can't think it's anything other than political because they usually, let's say, the American Academy of Pediatrics would be respectful of people who want a cautious approach or parents that do not agree with this approach.
So, yes, I believe the way that they are approaching seems that it must be political.
Q Earlier you were talking about how you wish some medical organizations prioritized things like access to primary care through federally funded health centers.
Do you remember when we were talking about that?
A Yes.
Q Do you believe that that is a political issue?
A Not so much because it has bipartisan support. So I believe that would be an issue that would not be politicized because I think individuals on both, on both on the left and the right could get behind those things. So it's a less politicized issue.

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Q Do you think an endocrinologist who testifies before a legislative body about a particular bill is engaged in political advocacy?
For example, if there were a bill to make insulin free and an endocrinologist testified in favor of that bill, do you think that endocrinologist is engaging in political advocacy?
A It would depend on how they testified and in what way and exactly what the bill was. I could not say. I would not make a blanket statement that it was or wasn't.
Q So you think that the content of the opinion determines whether it is political advocacy or not?
A That is one component of how I would decide, yes.
Q What other components would help you decide whether that was political advocacy?
A Well, depending on the issue. Right? The issue at hand here is an issue that does have clumpings of political support in different parties and different sides.
So clearly, whenever you are talking about an issue that does have clear political implications, then that would make you at least be skeptical or consider that there is something political going

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on.
Q Do you think clinicians who provide legislative testimony about bills like Senate Enrolled Act 480 are engaged in political advocacy?
A It would depend on the testimony they are giving. So possibly or possibly not.
Q What would make their testimony political advocacy?
A Well, I don't know if you are asking me about are they providing, you know, references to studies? Are they talking about -- you know, I'm not sure what they are bringing up.
If they are trying to portray evidence as more than it really is or kind of, you know, if they use political language. I mean there are any number of ways that someone can reveal that they are more interested in advocating for a certain, you know, tribal political viewpoint than an actual sober discussion of what is the situation at hand.
I think most clinicians who would get up and testify should be able to remain respectful about the other side of the opinion and realize the trade offs and difficulties and nuances.
So if that is what they are doing and getting

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up and admitting all those things, then I would, you know, lean towards it not being so political.

If that is not what they are doing, then I'm leaning in towards it being more political.

Q In Paragraph 91 you are talking about this press release. You say, "Yet the press release frames these limits as discrimination based on gender identity, a moralized characterization of restrictions on care."

Why do you think that is a moralizing statement?

A Well, if I accuse you of discriminating I think that is a morale accusation. Right?

Whereas, normally when you are talking about medical care you would be talking about what is the evidence base for this medical care. Or let me show you this study that strongly supports my opinion.

That is what I would think that a medical organization would be doing, rather than claiming that this is discrimination.

Q So back to my example of an endocrinologist and insulin. If I am an endocrinologist and I testify before a legislative body, I treat a lot of people with diabetes. They need insulin. The cost of

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insulin means some of them don't get it. That is a negative outcome. I think this bill should pass because it will make insulin free.

Do you think any of that is political and moralizing?

A No. Because they are talking about a clear-cut medical, you know, situation that seems apolitical.

Q What if they then say, And I think it's discrimination against people with diabetes not to make insulin free? What then?

A I mean, they could say that. I think that that would be a, I mean, they would be trying to moralize the argument. I don't think it would be a compelling argument.

I'm guessing that people who are deciding about what could be paid for and not paid for are mostly working on economic arguments and not on discrimination arguments.

MR. SELDIN: Joel, in Paragraph 92 about two-thirds of the way down, if you could show us Paragraph 92. Thank you.

Q You are critical of the American Academy of Pediatrics. You say, "As such, a more appropriate perspective from a medical organization would be a

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call for reasoned dialogue to evaluate the moral claims on each side and examine the logic and data behind these moral frameworks and treatments."

Do you see where you wrote that?

A Yes.

Q Is your issue that, I guess, do you think the competing moral frameworks in this particular instance are equally worth debating?

A Well, I think there are multiple moral frameworks so you would have autonomy of patients. You would have parental decision rights. You would have whether an analysis of an evidence base is a moral one or a discriminatory one.

So there's multiple moral issues at play. There would be the moral issue of can someone consent or not consent? Is it moral to allow those things?

So there are just a number of ethical and moral issues that could be wrapped into any discussion.

Q So in the realm of pediatrics generally you have issues of assent and consent, is that fair to say?

A Yes.

Q So in that respect, every decision about pediatric medicine involves the moral issue of assent and

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consent, right?

A Yeah. I mean, you know, I would not quite -- I would say there's almost no moral issue for many or most regular pediatric treatment issues. Whether to get an antibiotic or whether to brace an arm after it's broken, you know, this is what most medical decisions are.

Most of them do not have difficult competing moral frameworks like permanent treatments to minors with gender dysphoria. That is a lot more complex.

Q Let's talk about some other medical interventions in pediatrics.

Are you familiar with Cochlear implants?

A Somewhat.

Q Do you think that there is any moral valiance to a decision about whether to provide those to a child?

A Well, not being my area of expertise, I don't know what the statistics are and how successful they are and how established they are.

There may or may not be on different treatments depending on all those things. If it's a well established treatment and they have a great evidence base on, then the amount of the moral

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dilemma is small.
When you have unknowns in a treatment or it's an experimental treatment, that is much more of a moral dilemma. I don't know Cochlear implants enough to tell you where I fall on that.
Q Do you believe then that the level of moral dilemma is inverse to the evidence base?
A Well, the less evidence base and the more potential harm would raise the moral implications. Yes.
Q Okay. So then in any area of medicine where there is an uncertainty about the evidence base or outcomes you believe there is a moral issue?
A Well, specifically, I mean, yes. Especially when we are talking about lifelong changing of characteristics of a developing adolescent.
So, yes. I mean, yes. But there is, you know, we are talking about something quite significant.
Q Well, are you familiar with ear pinning as a medical intervention in children?
A I mean, not very.
Q Well, I will represent to you that for children whose ears stick out there is a surgical intervention where you can pin their ears back so

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they stick out less.
Are you familiar with that?
A Okay. Yes.
Q Okay. Have you heard of such a thing?
A I have heard of it. Yes.
Q Okay. Do you think that that has moral implications?
A Not -- I don't know. But it sounds like that is a low risk surgery. So to me, I'm guessing that it's a low risk procedure which, you know, seems to be well received or work out the way that individuals who have gotten in the past want. I don't know how long it has been around for.
So it could be a significant moral issue if it's the first patient that it's ever been done on and there are some potential downfield negative effects that could be serious.
If it's a standard procedure that is done all of the time without much problem, then that makes it less of a moral issue.
Q Even though it permanently alters the appearance of the child you don't believe that that by itself raises a moral issue?
A Well, is the outcome -- you know, if this is an established procedure that has a known good

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outcome, then it reduces the moral or ethical dilemma.
Q You don't believe that all interventions that alter the bodies of minors involve moral dilemmas?
A I just said there are degrees. There would be a degree.
Q In terms of what should inform moral considerations around the provision of treatment to minors, we have talked about evidence based. We have talked about assent and consent.
Are there any other things that you think should factor into that moral calculus?
A Evidence base. Assent and consent. Family and parental viewpoints. There are any number of possible other inputs.
Q What do you mean by family?
A I think if a family -- in a family there may or may not be agreement with procedures. I think that is something to take into account.
Q Would that fall under assent and consent?
A I guess it could. Yeah.
Q In Paragraph 93 --
A I could say there is some -- you are asking about what moral dilemmas possibly you would have. I think, you know, we talked about the evidence

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base. But, also, you know, we don't really have an evidence base about a, you know, human developing identity, which is also something that we are treating. I just want to throw that out there. We are sort of fiddling with something which that is important and fundamental in human beings.
I just think that also raises caution beyond what a typical discussion of evidence base would be.
Q Are you offering an opinion in this case about the evidence base?
A Regarding gender-affirming care?
Q Yes.
A Well, I mean, yes. I've put, I did not concentrate on that in my report, but I think I make it clear in my report my assessment of the evidence base.
MR. SELDIN: Joel, can you pull up Exhibit 4. Take us to Paragraph 4, please. I'm sorry. Can you scroll up to the first page so we can see the caption.
Q Dr. Kaliebe, this was your report in the Decker case that we were talking about.
Do you see the case caption?

A Yes.
Q Then Paragraph 4 (b) and (c), Dr. Kaliebe, in your Decker report you offered the opinion at 4 (b), "There is no consensus in the field regarding the treatment of gender dysphoria, nor is there an evidence base sufficient to lead to any confident recommendations."
Do you see where you wrote that in your Decker report?
A I don't. Okay. Yes. Yes, I do.
Q Then in 4 (c) you said, "Multiple reviews of the evidence base regarding treatment of gender dysphoria indicate that the evidence for affirmative treatment is low quality."
Do you see where you wrote that in the Decker report?
A Correct. Yes.
Q There do not appear to be corresponding opinions of this nature in your declaration in this case.
That is why I'm asking, are you offering these opinions in this case here?
A Well, yeah. I'm not sure how to answer that in that I believe there are other experts in this case that are reviewing the evidence base.
Those are my opinions. But my -- in terms of

this case, I wrote in my report the things that I was emphasizing.
Q So is it fair to say that you, Dr. Kaliebe, the individual, hold these views, but you, Dr. Kaliebe, Indiana's expert in this case, are not offering yourself as an expert on these two points?
A I would not commit to that. Since I have put this in my report even though it's not exactly these same statements, I have mentioned the low quality evidence base.
Since I have mentioned that in my report and I am already speaking as an expert and I've gone on the record, I think I am affirming that this is my opinion and this opinion is in my report.
MR. SELDIN: I wonder if now is a good time to take a little longer break for lunch.
Dr. Kaliebe, Mr. Patterson, would that work for you?
MR. PATTERSON: Fine with me.
A Fine with me.
(OFF RECORD AT 1:31 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 2:15 P.M.)
BY MR. SELDIN:
Q Dr. Kaliebe, welcome back.
MR. SELDIN: Joel, could you pull Exhibit 1 back up for us.
Q This is your declaration that we have been talking about in this case.
MR. SELDIN: Joel, can you take us to Paragraph 121.
Q Dr. Kaliebe, in Paragraph 121 of your declaration you have some criticisms of SOC-8. I take it that is WPATH's Standards of Care 8?
A Correct.
Q And in Subsection A you say, "SOC-8 makes no analysis for why it prioritizes affirmation of gender identity over affirmation and acceptance of the physical sexed body."
Do you see where you said that?
A Yes.
Q What is affirmation and acceptance of the physical sex body?
A Well, it would be the concept that it is important for people to come to accept and work with the body that they have, which is a time tested approach, you know, in individuals who have

challenges and disorders, distress related to their body.
Q When you say time tested, what do you mean?
A Well, I mean in many other psychiatric disorders we have patients that are uncomfortable or distressed by the body that they have.
Someone with anorexia will starve themselves in order to, you know, not go into development or because they don't want to, because they have a distorted view of themselves, a body dysmorphic disorder.
During development, of course, many people are uncomfortable or distressed by the body that they have.
Q In prior declarations you refer to this as body affirmation.
Is affirmation acceptance of the physical sex body the same as body affirmation?
A Yeah. I mean, I think they are part of the same concept, yes.
Q Did you come up with this distinction between body affirmation and gender affirmation?
A Did I come up with it? Well, I think that this is a noticeable discrepancy by the way that we are asked to approach gender dysphoria compared to

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other disorders like I was, like I was mentioning previously.

So, yes. I don't have a clear source from where that comes from. It's just that I've noted that this is a very different approach to affirm and emphasize, you know, a psychological concept about self over the physical body.

Q Is there any literature where researchers discussed this distinction between gender affirmation and body affirmation?

A There probably is. You know, since we are in such a new field right now, you know, I don't think that there has been much on this regarding particularly this issue.

But I think there is significant literature in other disorders regarding patients, healthy patients, learning to come to peace with or love the body that they have or reducing their distress about the body that they have.

Q So it sounds like you are not aware of any studies on body affirmation versus gender affirmation as it pertains to gender dysphoria, is that correct?

A Correct.

Q In Paragraph 121, Subsection (d) another one of your criticisms is that, "SOC-8 downplays concerns

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related to detransitioning."

Do you see where you wrote that?

A Correct.

MR. SELDIN: Joel, can you please pull up Exhibit 14.

Q Dr. Kaliebe, have you seen this document before?

A Yes. It's the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.

I was referring to that in my report as the SOC-8.

MR. SELDIN: Joel, can you take us to Page 43 of the PDF, please.

Q Dr. Kaliebe, do you see where it says Statement 5.7?

A Yes.

Q Do you see, "We recommend health care professionals assessing adults who wish to detransition and seek general-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professionals in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process."

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Do you see that?

A Yes.

Q There is a whole section of SOC-8 that talks about detransition, correct?

A Correct. I think if you look at the amount of pages devoted to it, and I do see 260 pages on the document, that is why I was saying underemphasized the component.

Q What would be an appropriate emphasis in the SOC-8 for detransition?

A Well, I think a more realistic approach in regarding the new patient population, which has recently emerged. And we do not know what the rates of detransition will be in this new different patient population.

And so I think while it generally downplays it, reporting it to be rare, which I think, you know, once again, we are not totally clear on, the data is not so clear on how rare it really is.

But, secondly, it's especially pertinent considering the large rise in these treatments among minors and minors that are very different than the minors that were in the Dutch protocol or other early interventions.

MR. SELDIN: Can you take us back to

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Exhibit 1, please.

Q In Paragraph 122, Doctor, in Paragraph 122 you say, "There have been several other episodes I have learned about that have caused me to conclude that I do not feel comfortable relying on WPATH or its U.S. affiliate, USPATH, to guide my care of gender dysphoric patients."

A Yes.

Q What do you rely on to treat your gender dysphoria patients?

A My experience as a child psychiatrist. And I think patients are all human beings. They all share a lot of qualities. We have a wealth of clinical and other research data, which gives us a general approach on how to approach patients.

And so when a new population and a new treatment model comes in and asks you to do something a different way and you see that it has flaws and it's not, it has not, it does not have the evidence base that it claims to have, then you have to use your, you have to use what you know about other treatments, which are, of course, you know, which are generalizable in order to approach that patient population.

Q Earlier we talked about how in total you have

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treated maybe sixteen or seventeen patients with gender dysphoria.
How many of those are you currently treating?
A I would guess half that number.
Q Are they aware you are not using USPATH or WPATH standards of care in their treatment?
A I don't know that patients are ever aware of what guidelines or treatments or what approaches that you use as a clinician.
That would be no regarding any of my patients with any of my approaches.
Q Do you think a patient would want to know if you were intentionally not using consensus guidelines to treat their condition?
A Well, I don't believe these to really be consensus guidelines. So, you know, there is no reason to inform patients exactly where you are getting your clinical approach from.
You take it from all sorts of places. So I'm not -- no, I don't think it's necessary. I never inform my patients in other circumstances what guidelines I use or don't use. I don't think these patients are really any different.
Q Are any of the patients you are currently treating for gender dysphoria minors?

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A Yes.
Q Do you think their parents would want to know that you were not using WPATH and USPATH guidelines to treat them?
A Once again, parents have never ever in the past asked me about what guidelines I use for my treatment. So I think that it would be a discussion to have perhaps if there is a discussion about medicalization. So in those situations I'm more than happy to tell them what my perspective is.
But, once again, you know, you really don't usually go into treatment guidelines when you are discussing matters with parents or with patients.
Q Are you treating these particular patients with what you call body affirmation?
A Well, as I mentioned before, I think whenever you are referring people for things like physical activity, exercise, mindfulness approaches, those all have some elements of coming to peace with and using the body, appreciating the body that you have.
I think that approach is known because those are things that I talk about. I think it would be, I don't think I talk about my philosophy of

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treatment with any of my patients. I just provide recommendations and treatment.
Q Is it fair -- have you ever had a conversation with these patients or their parents in which you have explained what you explain here, that there is gender affirmation and there is body affirmation and you are going to prioritize body affirmation?
A I have, in a manner, yes. I think that as I have spoken with parents they have -- I have communicated to them what my approach is. I don't use those words. I will tell parents what I emphasize and don't emphasize in my treatment.
Once again, these are not the conversations, I mean, this is not usual -- you know, out in the community as a treater or in the clinics that I work in, I mean, this is not the level of conversation that you are typically having.
So I am not usually talking about which guidelines I use or what approach I use with patients. This is quite unusual.
Q Doctor, you have not told them there is no research about body affirmation versus gender affirmation?
A Well, hold on. Because you are claiming that

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there is some research, which is not accurate. There is research in all sorts of things. You are just saying in the exact specific condition of gender dysphoria, which we have almost no research on anything in regard to any kind of therapy with gender dysphoria.
It's such a new condition with this population with this large amount that we only now are starting to be able to roll out studies.
Once again, you are mischaracterizing what is going on. But, yeah. So, no, I don't have exactly that conversation because that is not an appropriate framing of it.
Q Well, have you had the conversation with parents or patients where you have said there is not any specific research on the use of body affirmation to treat your condition, gender dysphoria, but there is research for other conditions?
So what I will recommend in the absence of that research on your specific condition is that we use body affirmation instead of gender affirmation.
Have you had any kind of conversation like that with your patients?
A Well, you know, once again, I think we are talking

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about these large, you know, concepts rather than talking about specifics.

I mean, you know, you could still be affirmative, meaning use the pronouns the person was working with, and be affirmative in that you are supporting them. But, also, want to work with them in coming to peace with the body that they have.

Q Is that your general practice with your minor patients that have gender dysphoria, to use the pronouns that they want to be known by?

A Yes.

Q Earlier you were talking about how you treat patients given your desire not to use WPATH or USPATH guidelines.

Is it fair to say then that you consider your clinical practice sufficient to sort of establish guidelines for yourself?

A Well, I think when you are a child psychiatrist and you treat all of the different conditions that could come in, people come in with autism. People come in with psychosis. People come in with bipolar disorder. They come in with PTSD. They come in with all number of different problems. And then they have problems in development.

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They have problems of identity that are not related to gender. They have problems academically. They have neurocognitive problems. They have problems related to school. They have problems relating to getting into fights. They have family conflict.

So when you approach a patient clinically, you are putting together a treatment plan and an assessment that speaks to them specifically. So I'm using what, you know, is the, I would say, mainstream psychiatric approach with all these patients, including the patients with gender dysphoria.

Q So your description then of your clinical experience, that is sufficient you think to establish good clinical practices?

A I don't think that patients with gender dysphoria are that different than other patients that I should throw out all my training for everything else I do and do something that WPATH has determined to be the right approach even though my assessment of the evidence is that it's not the right approach. So, correct.

MR. SELDIN: Joel, will you take us to Paragraph 129, please.

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Q Dr. Kaliebe, in Paragraph 129 you are discussing Dr. Shumer.

Do you recall writing this paragraph?

A Yes.

Q In this paragraph at the very end you say, "This virtuous sense of self must at least raise concerns as to whether Dr. Shumer and other advocates engage in sober reviews of the evidence."

Do you see where you wrote that?

A Yes.

Q Would you generally agree that patients should receive competent and compassionate care, medical care?

A Yes.

Q Do you generally agree that transgender people are emerging and demanding specific kinds of care?

A Emerging and demanding specific types of care?

Yeah. I mean, this is, I think some of the questions that we have is a child, you know, a transgender person, or are they a child with gender dysphoria? Or is this a teenager with gender dysphoria or a transgender person?

So I think, you know, as your identity is still developing I think it's important for us to

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step back and look that we are not necessarily dealing with someone who at the end of the day should be best conceptualized as a certain person.

And that the fact that someone, that there are some demands for care, once again, is detailed elsewhere in my report. Yes, people should be compassionate and we should be competent.

But often the type of care that patients request is often not the best type of care for them. So, you know, I am somewhat agreeing with your characterization. But I think there is some nuance there.

Q We talked about this a little bit earlier. I wanted to clarify.

You said you prefer to treat, to consider children with gender dysphoria as children with gender dysphoria and not as what you called transgender children, is that accurate?

A Correct.

Q You would agree, though, that some, that at least some children with gender dysphoria are, in fact, transgender, right?

A No. Because we don't know what their identity really is or what it will be at the end. I don't think we are, I mean, putting a label on a child

that is still developing, I mean, that's not, I don't think it's a wise practice.
So I would not call them transgender as I have stated. I would call them a child with gender dysphoria.
Q And would you agree that some children with gender dysphoria come to identify as transgender adults?
A Yes.
Q Earlier we were talking about your concerns about some of the moralizing language that you think exists in discussions about the treatment of gender dysphoria.
Do you remember us talking about that earlier today?
A Correct.
Q And it seems like based on Paragraph 129 that you have some concerns about folks who use what you term, folks who use what you characterize as moralizing language that they can't soberly review the evidence.
Is that fair to say?
A Well, they may or may not be able to. It would raise, it would raise a level of skepticism.
MR. SELDIN: Joel, will you pull up

Exhibit 11.
Q Dr. Kaliebe, this is a printout of a website for an organization called Do No Harm.
Have you heard of Do No Harm before?
A I have heard the name. I'm not familiar with it, no.
Q You will see in the "About Us" section it says, "We are a diverse group of physicians, health care professionals, medical students, patients, and policymakers united by a moral mission: Protect health care from a radical, divisive, and discriminatory ideology."
Do you see where I read that?
A Yes.
Q Do you consider this the kind of moralizing language that gives you pause about an ability to soberly review the evidence?
A Well, I think they are using language similar to Turban and Karasic and Shumer. Yeah. I would think that those who look at any sort of group that has a mission, you know, you would have to be, you have to be skeptical and understand that they are potentially a part of a group.
MR. SELDIN: Joel, scroll down, please, to Page 6 of the PDF.

Q Dr. Kaliebe, you will see at the bottom there is a photo of Dr. Daniel Weiss, Senior Fellow.
Do you see that?
A Yes.
Q And I think we were talking earlier today, are you aware that Dr. Weiss is one of Indiana's experts in this case?
A I am now that you are asking me that question.
Q Would his membership in this group give you some pause about his ability to soberly review the evidence?
A No. I mean, I think that your, you know, the fact that someone has joined a group which is calling for cautious care under the circumstances would not necessarily, you know, give me pause.
So, no, I think, I mean, yes, is it possible that this could also have some group think or group identity issues, you know, distorting their viewpoint, it's possible.
I, you know, as I said before, it just means that you should look at what the person says and examine the evidence and the idea about ideas competing with each other.
Rather than personally attacking the person, you should identify the idea and evaluate the

quality of the evidence or the idea.
Q And so for clinicians like Dr. Shumer, do you think the same applies, that rather than simply judging him by his participation or any kind of group or gender clinic you should look at his ideas and evaluate them on the merits?
A Correct.
Q Okay.
MR. SELDIN: Joel, will you take us back to Exhibit 1, please.
Q Look at Paragraph 130. Dr. Kaliebe, in Paragraph 130 you talk about what you perceive to be a chilling effect on scholarly dialogue.
Do you see where you wrote that?
A In 130? I don't use those words there.
Q Sorry.
A It's not in Paragraph 130.
MR. SELDIN: Joel, are you on Exhibit 1?
JOEL SCHERER: Yes, this is Exhibit 1.
MR. SELDIN: Okay. I have something wrong with my pagination.
Q You do recall that there is some scholarly dialogue missing, right?
A Yes.
Q What specific articles do you think should have

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been published that have not been?
A Well, I think I say in the report there are many articles that should be published and many issues to be explored. We are in the infancy of medical and hormonal treatments for young people and we don't really have good long-term outcome data. We don't have any control data.
So, you know, we should be still debating what is the right approach considering the actual level of the evidence. We should be careful about promoting one type of care or the other and, obviously, be talking about what evidence base supports it.
I think specifically in the, in the arena of gender-affirming care what we should talk about, we should have articles in major medical journals about informed consent in relation to that. We should have articles regarding psychotherapy. We should have articles regarding special populations like traumatized individuals, personality disorders, autism.
I mean, we have so much to explore. There is so much more we don't know than what we do know. To, you know, to only sort of allow one type of an article or one perspective on this seems quite

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misguided.
Q Just to make sure we are talking about the same thing, in your declaration you list some specific instances of some specific articles that you believe should have been published that were not.
Just in your answer now you are talking more broadly about kinds of papers you wish you had seen.
Were you referring to anything specific?
A I don't know exactly what has been submitted that has not been published. So it is impossible for us to know what articles were rejected. I'm not quite understanding the question.
Q Well, fair to say you don't know if these, you are not sure if maybe these articles don't exist at all or they are being submitted and just not being published?
A Correct. Other than my letters to the editor which I know were rejected.
Q Do you know the rejection rate for letters to the editor?
A No.
MR. SELDIN: Joel, can you take us to Paragraph 142, please.
Q Dr. Kaliebe, in Paragraph 142 you talk about, "A

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colleague told me about a difficult experience with editors of the American Academy of Psychiatry and the Law Newsletter."
Do you see that?
A Correct.
Q Who is the colleague that --
A Josh Sanderson.
Q Okay. Do you know if he tried to get this article published anywhere else?
A It got published. He just, they just asked him to remove the actual behavior of the transgender individuals on the inpatient unit.
So the whole, you know, part of the article was to communicate that these are difficult situations that we are having on the inpatient unit with individuals who identify as transgender.
They forced him to take out the part about what was actually happening on the inpatient unit, thereby, stopping clinical exchange of information related to caring for individuals on inpatient units.
Q Did this colleague try to get his unedited article published somewhere else?
A I'm not aware.
Q In Paragraph 144 at the end you say, "Former sex

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researchers have left the field due to the harassment and intellectual bullying they received."
Do you see where you wrote that?
A Yes.
Q Who has left the field?
A I gave the one example of Debra Soh. I don't have a list in front of me. She is not the only one.
Q Who else do you think has left the field?
A I don't have that in front of me. I think you could read Debra Soh's book and it would provide a lot of detail about the harassment and anti-scientific atmosphere in which she endured.
Q Other than Soh, there is no one you can specifically remember?
A There are examples in her book. And if I could add on, I mean, it's not just about leaving the field. It's about staying away from areas of scholarly exploration, which there are plenty of examples. Right?
So, for one, it's difficult to get grants or to then be able to study things that are controversial in universities, especially controversial and related to gender dysphoria or

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transgender care.
So, unfortunately, that is, you know, we are reducing the amount of information flow due to these things.
MR. SELDIN: Joel, will you take us to Paragraph 145, please.
Q Dr. Kaliebe, in Paragraph 145 you talk about your personal interactions with psychiatrists.
Do you recall writing this paragraph?
A Yes.
Q Would you agree that your personal interactions with psychiatrists is a form of anecdotal evidence, right?
A Correct.
Q In Paragraph 145 you use the term automatic affirmation.
A Yes.
Q What is automatic affirmation?
A As I mentioned earlier, when a patient comes to you and has a certain perspective on something, it is not typical within mental health for you to automatically agree with their perspective.
So that is not what we do in any other situation, but for whatever reason with gender dysphoria we have been asked to, or there seems to

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be pressures that if someone says that they have a certain gender identity that we are obligated to agree with that. That is just a departure from typical mental health care.
Q Where does the term automatic affirmation come from?
A Well, that seems to be the approach which is being pushed. I don't know that term, I'm characterizing the affirmative approach as automatic or some component of it. I'm sure that there are people who consider themselves affirmative who do not automatically affirm or do not consider their affirmation automatic, yet it seems that there is some pressure to automatically affirm. So that is why I put that in there.
It seems very unusual that you would necessarily agree with a patient when in mental health care we don't affirm or agree with patients in general.
Q So automatic is your descriptive modifier based on your experience --
A Well, yes. It is one of the fundamental problems with gender-affirming care. So it's an underlying, you know, unstable base that gender-affirming care has in my assessment.

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Q Earlier in one of your answers you said clinicians were obliged to accept gender identity.
What did you mean by obliged?
A Well, as I have said before, we typically in mental health -- let's say you are working with an adult client and they come in and say I want to have a divorce.
You know, you are usually not going to be, I mean, any reputable therapist would be, like, let's sit down. Let's talk about it. Let's see what is going on. Let's understand your history and your current situation. Let's, I mean, let me hear more about this.
You don't, you know, a mental health provider would not be yes, you should get a divorce, or no, you should not. Right? I mean, that would be inappropriate. Certainly we would not offer anything like suggestions in matters of, you know, major life choices like a divorce.
At some point by getting to know a person you may get a sense of whether that would be a wise course for them or not. I'm just bringing that up as an example of what normally, how normally you would approach a patient in mental health when they say I have this situation.

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So you don't, you would not necessarily say yes, do something, or no, don't do something.
Q Are you aware of any clinicians who are not asking follow-up questions when patients present themselves saying I think I have gender dysphoria or I might be transgender?
A Yeah. If you look at the Hannah Barnes book, Time To Think, or you look at the whistleblower report, you can see that there is sufficient, significant evidence that within gender clinics there are a lot of pressures to automatically, and there are people in the community who say the first thing that you should do is immediately affirm. You have to go with it. This can never be challenged.
So, yes, I feel that clinicians, therapists, have a lot of pressure, especially if they are, if, especially probably in places like gender clinics to automatically affirm.
Q Based on your secondhand review of the literature you believe this is happening?
A Well, based on what I read in WPATH guidelines, and based on what I have read in Hannah Barnes' book, and based on my experience talking with other psychiatrists, and based on my experience

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going to meetings and listening to child psychiatrists who are presenting on gender dysphoria, yes, I believe this is what is happening.
Q If a patient presents themselves and says, you know, I think I have gender dysphoria or I think I'm transgender and I want you to use male pronouns for me, do you think it is automatic affirmation to begin using male pronouns for that person?
A It may or may not be. It depends on the circumstance.
Q In what circumstance would it not be automatic affirmation?
A Well, if you are, if their request to use male pronouns is in a situation where you, you know, there has been a long history of gender dysphoria or issues related to it and this is a well thought out process that emerges in therapy, or someone has already done a bunch of therapy work, if they are older, I mean, there are all sorts of factors that you may consider whether to go with that.
Or the next question might be why do you feel that way? What's going on? Tell me about that.
Usually in therapy you are asking questions

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regarding what is the experience of the patient and why they feel a certain way.
Q Would you agree that it's possible to do both? To say great, thank you, I will use male pronouns. Can you tell me a little more about that?
A That would be one choice, yes.
Q Would you consider that automatic affirmation?
A It could be. Yeah. If you are going to go with it, right, at the first request of a patient I would consider that automatic affirmation.
Q What do you think you should do instead?
A Once again, it depends on the clinical situation. I mean, I have written that in the report. Someone, you know, if someone comes up and they were just sexually assaulted and now they say, I want to, I want to use male pronouns. I'm going to change to this male name.
I would be, like, hold on. What's going on? You know, let me hear more about this. Let me hear what's behind your decision.
Yes, we want to talk about it because we want to know, and I would want to explore what exactly is happening.
Q That example that you just referred to about a patient recently being sexually assaulted, is that

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based on a specific patient or a hypothetical?
A Well, that is, that particular vignette would be a hypothetical.
Q So you are aware of that happening. That is an example that you came up with --
A There is evidence there is increased gender dysphoria after sexual assault. That is in my report. This is part of the concern that after a sexual assault there is evidence that there is more likely to be gender dysphoria.
Q That is a vignette that you came up with based on your reading of data, not a specific patient?
A Correct.
Q Okay. In Paragraph 145 you talk about some psychiatrists who are, many psychiatrists are "willing to use affirmative approaches selectively."
Do you see where you wrote that?
A Yes.
Q Is that what we talked about just now where you said depending on the therapeutic history it might be warranted to affirm someone by using their pronouns?
A Yes.
Q Do you think in a patient that had that kind of

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long therapeutic history it would be warranted to provide them with gender-affirming care, medical care in the form of puberty blocks or hormones?
A I think that we have already discussed this. I mean, if they are fully grown into adulthood that that would be worth considering.
Yes, if they are done developing and they are still not in a process of identity development that could make sense.
Q Do you think there are seventeen year olds who are sufficiently developed in their identity and have a long enough history that gender-affirming care in the form of hormones would be appropriate?
A I don't think that we have enough data about if seventeen year olds will maintain their identity that they have in order to justify that.
Q Can you imagine any circumstance in which it would be appropriate to provide hormones to a seventeen year old?
A I don't think it is a good clinical decision. So, no, I don't. In my opinion, it would not be wise.
MR. SELDIN: Joel, will you take us to Page 53, please. Can you scroll down a little bit. Go to Page 53. Thank you.
Q Paragraph 131 appears out of order. It is on the

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bottom of Page 53.
Do you see where you are discussing here Levine's list of assumptions misrepresented as facts.
Do you see that?
A Yes.
Q Then the third bullet down says, "All gender identity variations are biologically determined and inherently healthy."
Do you see that?
A Yes.
Q Do you believe that there are some gender identity variations that are inherently unhealthy?
A Do I believe there are some -- well, yeah. I mean, I think we have an open scientific question if some patient's gender identities are unhealthy for them, correct.
Q What do you mean by unhealthy for them?
A Well, we could go back to the data related to trauma and increased gender dysphoria. I mean, is the, you know, is this really an avoidance strategy to shield someone, you know, psychologically from the trauma that they had. Right?
So if someone develops a transgender identity

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or gender dysphoria after a sexual assault, it could be an unhealthy response to that. And that could end up being a, you know, you know, nonproductive, nonfunctional way for them to cope or react to that.
Q Do you think having a transgender gender identity is inherently unhealthy?
A No, not across the board. So I think that, you know, in an adult with an established transgender identity, the -- you would have a, a transgender identity -- everything in life is -- you know, so first of all, there are people that seem to just feel this very strongly. And it comes, and it has come from not a place of another disorder or trauma and it has been persistent for a long period of time.
So I think that is the group of patients where we are saying that that does not seem so much like this is an unhealthy or problematic identity.
Q So you would agree then that there are at least some transgender adults for whom there is no traumatic etiology for their transgender identities? It is just the way they are, correct?
A Correct.

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Q Do you feel that way about any minors?
A What I would prefer to conceptualize this as is that a minor is a developing individual with gender dysphoria. So I don't think clinically it is the right approach to consider them a fixed transgender individual.
And only time will tell if they end up being an adult who, you know, does have that fixed identity of a stable transgender identity. So, you know, for any one individual teenager or child, I mean, we don't know what their life will bring them or how they will develop.
Q If you could predict with a hundred percent certainty which children with gender dysphoria would grow up to become transgender adults, would you have the same objections to provision of gender-affirming care, medical care to minors?
A If you could predict with a hundred percent certainty?
Well, I guess I would have a number of caveats with that. We are saying someone without co-morbidities or other problems that possibly could be a contributing factor to developing it.
So I think, yes, I think you are -- then we would, you know, everyone would feel much more

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comfortable if we knew for sure or we knew what the person's individual development trajectory would be.
So, you know, I have never thought of that question before exactly like that. But, yeah, perhaps if we knew, if we knew a hundred percent.
Q Is there any other medical condition for which you think we should have a hundred percent certainty as to outcome before we provide it?
A You know, well, not that I know of. I do think this is an exceptional case because of the permanent changing of a person's, you know, trajectory with a, you know, low quality evidence base.
So that is the challenge here, is that we don't really know who is going to have what type of identity as an adult. We don't know the long-term outcomes. Yes, other situations where we were talking about things that do not have this risk level, sure, we don't demand such a high certainty.
I'm not saying that I'm demanding a hundred percent certainty. I'm saying I am demanding a lot more certainty than we have with the current patient population that we have.

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Q Would you support studies that would bring us closer to certainty about the, about what you believe would be --
A Yes. Yes.
Q You are aware that Senate Enrolled Act 480 does not include any carve outs for research?
A Yes.
Q Do you think that that is a mistake?
A I don't know all of the factors that go into making the bill. I would say, in general, I wish we would be studying things more. Especially if we were studying one pool of patients with psychotherapy and psychosocial treatments.
As long as we are actually studying alternatives, then I think studies are great. If all you are going to study is medicalized treatments, then we are going to be in the same boat down the road because we are not going to really know what treatments are better.
Q If I understand, you have opinions about study design.
Generally speaking, you would support studies?
A Correct.
Q Okay.

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MR. SELDIN: Joel, will you take us to Page 55, please.
Q Dr. Kaliebe, you will see in Paragraph 151 you talk about in the third sentence, "Psychotherapy involves getting patients to recognize their own thought patterns, disturbed emotions, and, when appropriate, includes challenging irrational, self-defeating, and harmful beliefs."
Do you see that?
A Yes.
Q Do you think gender dysphoria is an irrational, self-defeating or harmful belief?
A I believe that what I have seen in many patients with gender dysphoria is that it includes those types of beliefs, yes.
So when you have a patient who is saying, you know, who is so fearful of puberty, and they are saying this will be the worst thing. This will be so horrible. They are predicting a future that they don't know. They are assuming the worst. Right?
That is a classic assuming the worst cognitive distortion. Right? They don't know what will happen, but they feel it's bad. They have thoughts related to that.

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A lot of patterns in gender dysphoria are classic patterns that you have in all psychiatric disorders. If they seem quite amenable to treatment and if you can get patients to engage in such treatment, then they could be less disturbed.
Yes.
Q So you were talking about the dreaded puberty as a potentially irrational self-defeating or harmful belief?
A Yes.
Q But you believe there are some children with gender dysphoria who do grow up to be transgender adults, right?
A Correct.
Q So for those youth, their fear of puberty is not irrational, right?
A Well, it may be irrational because it may be out of proportion. So just because a possible outcome is that puberty will be bad, I mean, you know, puberty may be good.
That person does not know until they experience it. So they are assuming the worst and making themselves suffer more. This is a lot of what you do in therapy, is help people to have realistic and flexible thought patterns and accept

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what they have to accept and not making things worse for themselves.
You don't want people catastrophizing the worst and focusing on negatives. That is amenable to therapy. I think those could be quite helpful in patients with gender dysphoria.
Q You might disagree with the amplitude of their distress, but it would not be irrational to be worried about going through puberty that didn't match your gender identity, right?
A It is not all about rational. That is one component of it. An overfocus on negative things makes people more upset and causes them to do worse.
So there are many different components of how your thought patterns contribute to suffering. So we want to minimize suffering from people having flexible thoughts, alternative seeking, remaining realistic.
And so just the overfocus itself, even if it is rational, can be a harmful approach.
Q You talk about minimizing suffering as a generally good goal. We talked about, you know, children with gender dysphoria, minors with gender dysphoria who grow up to be transgender adults.

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Would you agree that it's good to minimize their suffering of going through puberty that does not match their identity?

A I don't know that we know enough right now to say whether that is -- even for the ones who end up being adults, I don't know that we know that it's not a better path, even if it's difficult, to go through puberty, become an adult, have a solidified identity and then make a choice to transition when you have gone through that even if it was painful or difficult or there was suffering involved.

So while, yes, we want to minimize suffering, I don't know that in your hypothetical that we would be. I think that is one of the many unknowns.

MR. SELDIN: Joel, will you take us to Paragraph 154 on the next page, please.

Q Five lines down you say, "Yet, the false binary of affirmative psychotherapy versus conversion for gender dysphoria is being used to push therapists away from consideration that acceptance of one's biological sex or resolution of gender dysphoria is a positive event."

Do you see where you wrote that?

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A Yes.

Q This false binary, what do you base that on?

A Well, a lot, there have been many attempts to call different types of therapy for gender dysphoria or approaches to people who are transgender as conversion therapy.

Conversion therapy usually was thought of as attempts to force changes in sexual orientation. Those are not any -- I mean, in the distant past those occurred. They were rejected by the mental health community a long time ago. They may exist in certain religious sects or in other parts of society.

But to then associate regular, you know, psychotherapy with conversion I think has done a lot of damage in that people don't want to engage in deep regular therapy with patients because for fear of this.

And because patients hear that therapy is not the solution to their problems. That they really just need to be affirmed and get medical treatments. So that can also interfere with the patient's willingness to do therapy when therapies are called conversion therapy.

Q So I'm trying to understand the distinction between this regular psychotherapy that you are talking about and affirmative therapy.

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Earlier you said it would not necessarily be affirming for a therapist or psychiatrist to say, Great, I'll use those pronouns. Can you tell me more about that?

I mean, what is the difference between regular psychotherapy and affirmative therapy in that instance?

A Well, that would be fine. It's fine to choose that approach. But as long as we are getting to the, Can you tell me more about that, and we are really truly going down that road it seems like many proponents of medicalized transitions for youth are not emphasizing how important it is for there to be a true process of actual exploration and a completion of identity development before medicalized treatment.

And I just think that, you know, the, calling therapies for gender identity or addressing elements of gender identity conversion therapy is an inappropriate attempt to, it's, it makes therapy a pejorative and it argues against therapy for kids who really could benefit from therapy.

MR. SELDIN: Joel, will you take us to Paragraph 168.

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Q Dr. Kaliebe, in Paragraph 168 you say in the second sentence, "Beyond standard psychotherapies, more specific and nuanced approaches for gender dysphoria exist, such as Exploratory Therapy." Then you include the URL for genderexploratory.com.

Do you see that?

A Yes.

Q Have you studied Gender Exploratory Therapy?

A I don't know what you mean by "studied." But I've looked at the site and the approach, yes.

Q What is the evidence base for this approach?

A Well, it's based on long-standing principles of psychotherapy. And as I note in other parts of my report, the evidence base in general for psychotherapy is quite good.

So since we are using lots of the techniques from standard therapy, my guess is that it would generalize and be quite good. Just like everything else, there are very few studies as we have a very new patient population.

Q You have a hypothesis that can work, but there is not an evidence base specifically for gender dysphoria?

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A There is a huge evidence base for psychotherapy. I don't see any reason that patients with gender dysphoria would be so different from all of the other patients. So we can look at the massive evidence base that there is for psychotherapy and assume that all human beings with struggles and problems and distress could benefit from talking.

People have been fine tuning and honing therapy for quite a while and there are lots of really well proven techniques. I have cited cognitive therapy in my report.

I mean, there is a really strong substantial base for this being a very effective tool. So I don't see any reason why it would not work in gender dysphoria.

Q You think you have a really good hypothesis, but there is not a study showing that --

A Yes. Yes. There is no study showing it does not work, right. There are a lot of studies that show it works for everything else. But, no, we do not have a specific study in this.

Q Right. Would you agree that gender dysphoria is distress based on the existence of psychological characteristics that don't align with their gender identity?

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A That is a complex question. I'm not sure that that is the primary driver for most of or --

Q Doctor, I don't mean to cut you off. I think maybe you misunderstood my question. I'm not talking about etiology. I'm just talking about what it describes.

As a descriptive matter, gender dysphoria as a distress because of having psychological characteristics that don't align with your gender identity, is that fair to say that is a descriptive matter?

A I'm not sure. I mean, I think those are elements of what is going on. But, in totality, we are not really sure what the children and teens, what factors are causing them to have the, you know, thoughts and feelings that they have.

But, yes, I mean, I would agree to that, you know, that part of the criteria is that there is distress about their physical characteristics.

So I think that there are some qualifications and that we really sort of have not fully developed theories and knowledge about what is driving gender dysphoria.

But, yes, I would agree that just by the criteria, you are talking about someone who has

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distress related to their secondary sex characteristics and physiology.

Q And even though you have talked about evidence for things like cognitive behavorial therapy as a treatment for other conditions, you are not aware of any studies regarding the effectiveness of CBT for the treatment of gender dysphoria, is that correct?

A Yeah. I'm not aware of any studies that don't say it treats it. But I'm not aware of any studies that say it does treat it.

There are lots of studies that say it works for a lot of things. It just has not been studied, correct.

MR. SELDIN: Joel, will you take us back to Page 56, please.

Q Dr. Kaliebe, in Paragraph 154 you say, "It is surely reasonable and compassionate for a psychotherapist to prefer a patient no longer to suffer with gender dysphoria."

Do you see where you wrote that?

A Yes.

Q It's your belief that gender dysphoria can resolve? Or it's your belief that gender dysphoria can possibly be resolved by a person

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accepting their biological sex, is that fair?

A I believe that a component of resolution of gender dysphoria could be in many cases, and maybe in all cases, that acceptance. So yes, that could be one component of it.

Q Would you agree that gender dysphoria can also be resolved by treatments that bring a person's body in line with their gender identity?

A I'm not so -- I think when you talk about the patient population of adolescents that we are treating, I'm not, I don't think that the evidence is overwhelming that that does resolve their gender dysphoria.

There's mixed evidence on that. So I would not say that that is a uniform response to gender affirming treatment. I would agree it does seem there is evidence in some cases it resolves gender dysphoria.

Q So I guess my question is if it's -- and we can disagree about the frequency. But if it's sometimes resolution through accepting their biological sex, or through changing physical characteristics to match gender identity, is it ethical to totally ban one of those two?

A Well, I would add there is a third that sometimes

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these would just resolve on their own.
So, yes, I think that we also have to understand and consider that gender dysphoria could just resolve without treatment. So we don't necessarily have to do a medicalized treatment for all individuals with gender dysphoria.
So would it appropriate? Well, I think in the case of developing minors, I think it is proper to argue that they should wait until complete development, and then have sufficient psychotherapy and other supports that would help them get to a place as an adult and with enough time that they have stayed gender dysphoric before moving on to medicalized treatments.
MR. SELDIN: Joel, will you pull up Exhibit 7. Take us to Page 1130, which is Page 168 of the PDF.
Q And so, Dr. Kaliebe, we were talking earlier about your testimony in the Decker trial that took place recently.
Do you remember we were talking about that?
A Yes.
Q This is going to be a long portion of me reading. My question at the end will be did I read that correctly.

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A Okay.
Q So you know where we are going. So on Page 1130 of this transcript at Line 11 the Court said -- or rather we will start at Line 9.
"THE WITNESS: Yes, I do not believe that we should be doing hormones and surgeries for developing adolescents."
"THE COURT: My question was therapy. And I think I take it from your answers that you don't think therapy that would make an adolescent comfortable with gender identity different from the sex assigned at birth is ever appropriate. Did I misunderstood it?"
"THE WITNESS: I would say a little bit. I think that we wouldn't have a goal of trying to change someone's gender identity in therapy. I'm not trying to get to one particular result. It's more you want to -- so if that's the end result that they have a, you know, a gender identity opposite from their natal sex, I am fine with that. I'm not opposed to that.
"I do think that you would have a leaning towards or it is sort of a better outcome for most kids most of the times, considering the co-morbidities and everything going on, that they

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come to peace with their natal sex because then they don't have all the problems that come from not having that, and the distress from not having that. But I'm okay with -- obviously, there are going to be people that are going to go on and be transgender and not be comfortable with their natal sex, so you could support that."
Did I read that correctly?
A Yes.
Q Do you still agree with that testimony that you provided in Decker?
A Yes, I think that was very similar to the conversation that we just had.
Q Earlier we talked about a situation in which you were comfortable with the certainty of the prediction.
For those children, for minors with gender dysphoria who go on to be transgender adults there may be a role for medical gender-affirming care for those people, would you agree?
MR. PATTERSON: Objection. It has been asked and answered several times.
You can answer again.
A You are saying as adults?
Q Yes. We will start with as adults.

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A Repeat the question then before I answer it.
Q So we talked about before those minors with gender dysphoria who go on to be transgender adults.
Do you believe that there is a role for gender-affirming medical care in the form of hormones for those individuals?
A Yes.
Q Is it your belief it is ever appropriate to provide that kind of medical care to someone who is under eighteen?
MR. PATTERSON: Objection. Objection asked and answered.
You can answer.
A My belief is that there is no evidence base to support that practice.
MR. SELDIN: Joel, will you take us back to Exhibit 1.
Q Dr. Kaliebe, we were talking earlier and you were talking about conversion therapy in the context of sexual orientation.
Do you remember that?
A Yes.
Q You said it was rare. Do you recall saying that?
A Yes. I qualified that conversion therapy was, if it is carried out these days, it's typically

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carried out within parts of our society that are not related to mental health care or medical care.
Q What do you base that statement on?
A That in all of my experience I've not encountered medical or mental health professionals who would attempt to change anyone's sexual orientation. Nor have I ever seen any compelling evidence of it in any of our medical journals.
Q Any evidence of it happening, you mean?
A Correct. Within the medical community or mental health community, correct.
Q We will look at Page 59.
Dr. Kaliebe, earlier you had mentioned that you thought trauma might have a role in gender dysphoria in some minors.
A Correct.
Q For minors who have no history of trauma this hypothesis would not be applicable, right?
A Correct.
Q And would you agree, or rather, do you think that there are people who have gender dysphoria who separate and unrelated have had some kind of trauma in their life?
A Correct. You can see if something occurred before the development of the gender dysphoria or at the

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same time as the development of the gender dysphoria.
We would call that a co-occurring disorder if it occurred at the same time or around the same time, but after the trauma.
Q Would you agree then that -- once someone's trauma has been adequately addressed it is possible that that person could still have gender dysphoria?
A Yes.
Q Okay.
MR. SELDIN: We have been going a little over an hour. Is now a good time for a five minute break for folks? Let's come back at 3:37 Eastern.
(OFF RECORD AT 3:31 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 3:37 P.M.)
BY MR. SELDIN:
Q Let's look at paragraph -- sorry.
MR. SELDIN: Joel, will you bring up Exhibit 15. Click us through to that link.
Q You recall earlier you mentioned this conference you spoke about. Oasis.

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A Yes.
MR. SELDIN: Joel, will you scroll down. Keep going.
Q I believe this is -- does this look like the agenda from the conference that you were talking about?
A Okay. Hold on. This is the adult conference.
Q Okay. The adult conference. Okay. There was a separate child conference?
A Correct.
Q Well, let's stay here for a moment. So, Dr. Kaliebe, you said that you provided three different CME lectures at this weekend in Puerto Rico, is that right?
A Of the child. Two for adult and three for child.
Q Okay. So are these the two for the adult that you were talking about?
A Correct. Yes.
Q So the agenda would be listed separately for the child conference?
A Yes.
Q I'm asking because I only saw two of the three. I was not sure where the third had gone. We will take a look at that in a second.
MR. SELDIN: Joel, will you pull up

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Exhibit 16.
Q Earlier you said you had a Twitter account. Is that your handle?
A It must be ancient. Maybe I just joined to read some things. I don't know that I have a handle. I don't ever tweet anything. Maybe when I logged in it connected to me through Google or some other way. Like I said, I have gone on to read things.
Q Is that photo there --
A That is me in the photo.
Q Is that a New Orleans Saints jersey?
A It is a Saint's jersey, yes.
Q So that is you. The bio says "psychiatrist and sceptic."
Does that sound like something you would write?
A It is. I don't remember -- anyway. Yeah. I would write that. I don't remember.
Q Okay. You don't have any reason to believe this is a different Kristopher --
A That is me.
Q Okay. All right. And then we will scroll down. You said you used Twitter to read some things.
It looks like that this profile liked this tweet by Dr. Jordan B. Peterson that says, "Why

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can't we tell the truth about Lia Thomas?"
It links to an article on spiked-online.com. Do you see that?
A Yes.
Q Do you recall liking this tweet?
A I believe that is accurate that I probably did.
Q Do you recall reading this article?
A I don't know that I ever read the article, no.
Q Okay.
A I may have. I may not have.
MR. SELDIN: Joel, scroll down.
Q You liked another tweet on March 28, 2022. This was posted by communik8e to Jordan Peterson. It says, "The Party told you to reject the evidence of your eyes and ears. It was their final, most essential command."
That is a George Orwell quote from 1984 superimposed on a photo of Lia Thomas. Do you recall liking this tweet?
A No. I don't doubt that I did if it showed up in my profile.
Q What do you think this graphic means?
A What does the graphic mean? Well, I think there is, the graphic means that there seems to be a problem with inclusion of biological males in

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women's sports and that we, you know, that this is an issue that seems, I think, important and that we should have an honest proper discussion about it.
And my opinion is that it's important to keep women's sports to those who are biologically female with whatever, you know, definition that you have. Yes, I would agree that is the main part.
The bigger part, though, is the, you know, there is an Orwell quote. As I was mentioning regarding, regarding, you know, silencing of debate, it seems like that we have not had any sort of proper dialogue, especially in the medical journals and within medical societies about how we are going to handle these complex issues.
So, you know, therefore, the George Orwell quote I think is, you know, part of why I tweeted it. Or why I liked it. I have never tweeted anything as far as I know.
MR. SELDIN: Joel, scroll down to the last page.
Q You will see you liked a tweet from Andre MCato on March 28, 2022. The tweet that you are liking says, "Who has the courage to interview Thomas and

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ask him how he justifies winning among women? In a free society, that interview would have already happened."
Do you see that?
A Okay. Yes.
Q Do you recall why you liked that tweet?
A No. I think it speaks for itself.
Q What do you mean?
A Well, I think that we should have a close look at what is going on. And, you know, to me this is a problematic issue when someone swims as a biological male for three years in college and then transitions and then swims as a female.
So, once again, this is something that I think is challenging, but there is a clear answer that most people would support. And I support that biological sex when it comes to sports is very important.
It is quite unfair for female participants if someone who is a biological male and gone through biological puberty is then allowed to compete with biological females.
Q You would agree that Senate Enrolled Act 480 has nothing to do with sports?
A Correct.

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Q Okay. And you will see that this tweet uses male pronouns to refer to Lia Thomas. Do you think that is appropriate?
A You know, once again, I don't think it's a big deal. I don't know that I noticed whether it used male pronouns or not. I mostly was liking things that brought up this issue of fairness and, you know, basically allowing women to compete fairly in women's sports, which I think is an important issue.
MR. SELDIN: Joel, I'm dropping into the chat a link which I will call Exhibit 17 for purposes of this exercise. If you can take us there.
Q Is Exhibit 17 the agenda for the child portion of the Oasis conference?
A Yes. You would have to scroll down to see the rest.
Q You will see -- Dr. Kaliebe, do you see there are two CMEs listed with your name next to them?
A Yes.
Q "Social Media and Cyberbullying: Prevention."
A Yes.
Q The second one is, "Cannabinoid: New Forms and New Problems."

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A Yes.
Q I guess my question is earlier you talked about presenting on gender dysphoria specifically at the child portion of this conference.
I'm just wondering why it's not listed here?
A Yeah. Well, that's a good question. I've not accessed this before. This is also garbled because the presenters do not match up. I did not represent on cannabinoids. I did present on the social media. Some of this is messed up.
Q Okay. Did you present one or two CMEs?
A Three. I presented three.
Q Are the three that you did listed here?
A No. So only one is listed here. I presented the social media one. I'm not sure if the other ones are wrong or what is wrong on this. I presented on the three. It was Social Media and Cyber Bullying. It was Traumatic Brain Injury and Gender Dysphoria. What is listed there is incorrect.
Q Do you recall what the title of that CME would have been on gender dysphoria?
A I know gender dysphoria. It was Reviewing the Evidence or something like that.
MR. SELDIN: Joel, will you please bring

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up Exhibit 3.
Q Earlier today we talked about this as the C.V. that you attached to your report in Boe v. Marshall.
A Yes.
Q Look at Page 107 of this PDF. You will see, Dr. Kaliebe, on Page 21 it says at the top that you were a member of Zero To Three from 2017 to 2021.
Do you see that?
A Yes.
Q What is Zero To Three?
A Zero to Three is an organization devoted to young children. So this is, there's a field, sometimes people call it infant psychiatry or infant mental health.
The first few years of life are incredibly important. This is an organization devoted towards supporting children, infants, young babies and also their caregivers, especially their mothers.
So Zero To Three is a professional organization of those devoted to trying to promote support for moms and babies.
Q Why did you stop being a member after 2021?

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A I had presented a couple times at their conference. I do a lot of different things. So that was not totally, or, you know, I didn't feel like it was -- I just do so many things. I had to give some things up. It's a great organization. I would be happy to join or contribute again in the future.
Q And then we will look at Exhibit 8 next. This is an article on the Zero To Three website dated December 15, 2021.
It says, "Embracing Diversity: Developing a Gender Identity."
Do you see this article?
A Yes.
Q Have you seen this article before?
A No.
MR. SELDIN: Joel, scroll down to "Supporting Healthy Development."
Q I will read something. My question will be did I read that correctly.
Under Supporting Healthy Development it says, "Make sure your child knows they have your support. Gender identity is a central part of a child's identity and well-being. Parents don't make their children cisgender or transgender.

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This is also not a choice children make - it is simply who they are. To grow up healthy, every child needs to know that they are fully accepted, loved, and supported."
Did I read that correctly?
A Yes.
Q Do you agree with that?
A Yeah.
Q Dr. Kaliebe it says, "Read stories that feature all kinds of families, as well as stories that include transgender, non-binary, and gender expansive characters. Shared reading is a powerful way for all families to nurture an inclusive worldview and challenge stereotypes from the start."
Then it links to some suggested titles.
Did I read that correctly?
A Yes.
Q Do you generally agree with that advice?
A You know, I don't, I'm not sure that if we are talking about Zero To Three, you know, which is really like, you know, very, very young children. I think, you know, it's debatable what positive influence you would have in a very, very young child introducing these different characters.

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I don't think, you know, I'm not necessarily opposed to it. But I'm also not thinking that this is a, you know, that this is necessarily important.

I mean, yeah, I mean, once again, I think I would honestly, I personally would have a somewhat different emphasis. I don't think there is anything wrong with reading stories that include transgender or nonbinary, or gender expansive characters.

Q Dr. Kaliebe, further down there is a section that says, "Build an inclusive community."

It says, "This is important for all kids, and it's especially important for kids who may later identify as LGBTQ. In the past, one of the toughest things for kids discovering that their sexual orientation or gender identity was different than those around them was a feeling of being alone. Actors, politicians, teachers, sports stars, family, and friends who are upfront about their identities help make the world more comfortable for questioning kids. Make it clear that all people are welcome in your community and in your household. Living your values in this way shows your child that they will be loved however

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they show up and whoever they become."

Did I read that correctly?

A Yes.

Q Do you agree with that?

A Yes. It is important for us to have broad roles, or a broad range of how what, of how children can act. I do think it is important that we accept boyish girls and girlish boys and don't try to pigeonhole kids into my particular gender expression.

So I would definitely agree that allowing a wide range of gender expression is important.

Q Do you think that extends to people who are transgender?

A Well, I think we have had this conversation already. Children with gender dysphoria I would not categorize as transgender. I would say they are a child with gender dysphoria because I don't think it is appropriate to place an identity on a child.

So within their life we should make room for children to express themselves in any way, including gender nonconforming ways.

So, yes, we are in agreement that we need to make space for all children, including gender

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nonconforming children. And that it is important for society to create space for gender nonconforming children.

Where I think we are not on the same page or there is some difference of viewpoint is that I think it's important to emphasize that what we are talking about in, you know, we are saying gender nonconforming could be fine and not gender dysphoria.

But if we are talking about a gender dysphoria child, I'm not for labeling that child a transgender child. I think that we can label them a child with gender dysphoria.

Q In the middle of this paragraph it says, "Actors, politicians, teachers, sports stars, family, and friends who are upfront about their identities help make the world more comfortable for questioning kids."

Do you see that?

A Yes.

Q Earlier today we were talking about whether celebrities who are openly transgender are a source of social contagion. You thought they might be.

Do you remember us talking about that?

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A Yes.

Q Do you think these two, this sentence and that belief are in tension with each other?

A Well, I think there's a lot of nuance. As I said, I think we have to be careful about anything that may encourage children to want to change their body prior to them fully developing as individuals.

So I think that there is a challenge there in wanting to accept a child as they are whether that is gender nonconforming or not. So making space for all children, but not having children feel pressured that they would need to change their body prior to them fully developing.

Q But per this paragraph just about people being upfront about their identities, do you think just being upfront about identity as a transgender adult, that that is a source of social contagion?

A No, that is fine.

MR. SELDIN: Dr. Kaliebe, Mr. Patterson, it may be that I'm able to wrap up soon. I think another break might help me determine that.

Would you be opposed to a longer break, about ten minutes until 4:13?

MR. PATTERSON: Fine.

(OFF RECORD AT 4:02 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:09 P.M.)
MR. SELDIN: Dr. Kaliebe, thank you for the conversation today. Unless Mr. Patterson has questions that I want to follow up, I think we are at an end.
MR. PATTERSON: I don't have any questions. I think we are done.

AND FURTHER DEPONENT SAITH NOT

_____
KRISTOPHER KALIEBE, M.D.

attorneys for the respective parties.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____ 2023.

Wendi K. Sulkoske
_____
Wendi Kramer Sulkoske, Notary Public

Commission Number NP0661030
My commission expires December 1, 2030.
My County of residence is Boone.

STATE OF INDIANA)
) SS:
COUNTY OF BOONE)

I, Wendi Kramer Sulkoske, Notary Public in and for said county and state, do hereby certify that KRISTOPHER KALIEBE, M.D., the deponent herein was by me first duly sworn to tell the truth in the aforementioned matter;
That the foregoing deposition was taken on behalf of the Plaintiffs at the time and place heretofore mentioned with counsel present as noted.
That the deposition was taken down in Stenograph notes, reduced to typewriting under my direction, is a true record of the testimony given by said deponent, and was thereafter presented to the deponent for signature.
That this certificate does not purport to acknowledge or verify the signature hereto of the deponent.
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties or otherwise interested in the event of this action, and am not in the employ of the

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NOTICE OF FILING

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al,)
)
Plaintiffs,) Case No.
) 1:23-cv-00595-JHP-KMB
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendants.)

In compliance with the Indiana Rules of Procedure, Rules of the Industrial Board or Federal Rules of Procedure, pursuant to Indiana Supreme Court Order dated 10/1/86, you are notified that the signed original deposition of KRISTOPHER KALIEBE, M.D., taken on behalf of the Plaintiffs on June 1, 2023 has been sealed and submitted to the originating party, along with the attached Errata Sheet(s), if applicable.

_____
(Date Received by Circle City Reporting)

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Indianapolis, Indiana 46204

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UNITED STATES DISTRICT COURT
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CASE NO. 1:23-cv-00595-JPH-KMB

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THE INDIVIDUAL MEMBERS OF THE)
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Defendants.)

The videoconference deposition upon oral examination of JAMES M. CANTOR, PH.D., a witness produced and sworn before me, Dana S. Miller, RPR, CRR, a Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiffs, appearing remotely from Ontario, Canada, on the 7th day of June, 2023, commencing at 9:35 a.m. pursuant to the Federal Rules of Civil Procedure.

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Mylene Laughlin

MODERATOR: Joel Scherer
Circle City Reporting

I N D E X O F E X A M I N A T I O N

I N D E X O F E X H I B I T S

Pursuant to the Indiana Supreme Court Case 20S-MS-236 signed March 31, 2020,

J A M E S M. C A N T O R, PH.D., having been first duly sworn or affirmed to tell the truth, the whole truth and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION

QUESTIONS BY CHASE STRANGIO:

Q Good morning, Dr. Cantor. How are you today?
A I'm good. Thank you.
Q My name is Chase Strangio. I am a lawyer with the ACLU representing the plaintiffs in this case. And I'll be asking you some questions today.

As I mentioned, there are also some law student interns sitting in, as well as my colleagues, Gavin Rose and Stevie Pactor, from the ACLU of Indiana.

Can you start by just stating your full name for the record, please.
A I'm Dr. James Michael Cantor, C-A-N-T-O-R.
Q And you've had your deposition taken before; yes?
A Yes, I have.
Q So you, generally speaking, know how this process goes?
A Yes, I do.

Q Okay. Still going to run through a few of the ground rules just to make sure we're on the same page.

So as you know, there's a court reporter here. When answering my question, I ask that you respond verbally out loud so that Dana can hear you. And to please wait for me to finish asking my question before you begin your response. Does that sound okay?
A Yep.
Q And if you don't understand my question, which is very possible, please let me know and I can try to word it differently. Is that okay?
A Yep.
Q And if you do answer my question, I will assume that you understood it. Does that make sense?
A I understand, yep.
Q And are you feeling okay today?
A Yes, I am. Thank you.
Q Okay. And are you on any medication that would impair your ability to truthfully and accurately answer my questions?
A No, I am not.
Q And is there any reason you don't feel able to give complete and truthful testimony today?

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A Nope.
Q Okay. Great. I think we can get started. And, as you know, at any point if you need to take a break, please let me know. I imagine we'll also break for lunch at some point. But if -- the only thing I ask is to just answer the question we're discussing before we break.
A I understand.
Q All right. So just starting with a little background. You have been retained by the defendants as an expert in this case; is that right?
A Yes, I have.
Q And how did you come to be retained as an expert in this case?
A Oh, goodness. I'm involved in several very similar cases. And it's difficult for me to remember exactly which one -- which way I got what e-mail from who for which case.
So I could speak in general, I don't -- as I say, I don't remember exactly how the first e-mail started, "Hi, Dr. Cantor, I was referred to you from," but it was essentially along those lines.
Q So someone in the State of -- someone at the State of Indiana Attorney General's Office contacted you

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and you didn't contact them; is that right?
A Yes, that's correct.
Q And do you remember who that was?
A As I say, because several of these offices often involve, you know, several different people, I can't remember exactly which e-mail came from which without going through my own e-mails to see who said -- who came in at what point in the conversation.
Q And do you remember approximately when that was?
A Within the past four or five months, I think. Again, as I say, there's a cluster of them. I'm not good on people's names to begin with.
So I hesitate to, again, without checking through my own e-mails, but it was roughly in that -- within the past couple of months. But without checking my e-mails, I can't be --
Q Understood.
A I know better than to depend on my memory when there are several very similar things all standing next to each other.
Q Understood. You said you were an expert in similar cases currently. What cases are those?
A On my CV, I listed all of the current cases. The states themselves would be Kentucky, Indiana,

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Montana, Arizona, Florida, Texas, Tennessee. And, again, without checking my list, I'm very probably leaving one or two out.
Q And Oklahoma?
A Yes. Thank you.
Q So that's in addition -- including -- excuse me. Including Indiana, that's one, two, three, four -- at least eight states currently in cases involving similar issues to the one here?
A Yes, that sounds about right.
Q And just so we're grounded in this case, are you aware that this case concerns an Indiana law called Senate Enrolled Act 480?
A Yes, I am.
Q And when this law was pending in the Indiana legislature, did you take a public position on the bill?
A No. The only testimony I had, and the only interest I've ever had, really, is in the content of the science.
So whenever I'm asked by the media, you know, representatives in any state or any country, members of the public, random e-mails I get, I'm always happy to share whatever I can about the science, but -- oh, and if somebody asks me a

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particular opinion about it, I'm perfectly happy to show, you know, whatever points -- where the science seems to contradict or match up with any given proposal.
But I haven't in this state, and I don't think in any state, given any particular support or detraction from any particular proposal. The only one I can think of where I did, I was specifically invited to come and appear in Ontario, none in the U.S.
Q So did you testify in support of Senate Enrolled Act 480?
A No, I did not.
Q Have you ever spoken with a member of the Indiana legislature about Senate Enrolled Act 480?
A No, I haven't.
Q Did you speak with anyone about Senate Enrolled Act 480 while it was pending?
A Not in any kind of professional capacity. But with so many states and so many conversations just amongst my colleagues and friends, I can't say that I've never had a comment about it in general. But I've never taken any public stance or given any, you know, public commentary on any of the -- on any specific proposal.

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I tend very specifically -- I do my best very specifically to speak, again, just to the science and to the general ideas and what ideas in general match what -- or fail to match up with whatever point in the science.
Q Understood. So have you -- other than the Ontario example, have you ever testified in any state legislature in the United States over pending legislation concerning transgender people or the treatment of gender dysphoria?
A No, I have not.
Q What did you do to prepare for your deposition today?
A Lots and lots of re-reading. I re-read, of course, the case files that I had, my comments, my responses to the other experts who submitted declarations. Re-read my own CV in case those relevant questions are asked. And I'm always keeping up with the literature, so there's always something I need to read, re-read.
Q You mentioned your case files. What are those?
A Oh, no, I meant because I'm involved in several different of the legal cases, in order to help me, you know, as much as possible keep straight which one is which, pardon the pun, just keeping track of

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which ones are involving which subset of issues and in what order things are happening, just to, again, keep my -- help me, as best as my aging memory can, which one is which.
Q So when you say your case files, you mean your files for this particular case?
A Yes.
Q And did you meet --
A Well, I shouldn't say this particular case, but they're in clusters. And so, it helps me, you know, keep a cognitive map of what's going in which direction.
But by case files, I don't mean patient cases. I mean the various set of legal cases and the various, you know, documentation that's available for each one. And some of the cases pertain to events that happened years ago and what was -- what the state of the science was at the particular time before.
So, again, keeping track of a rough timeline of what was available to whom and when.
Q So what is the cluster that this case would fall in?
A Oh, bans to medicalized transition of minors. The other clusters are the athletics-related bills and

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a set of bills that I would describe more generally as free speech bills, under what circumstances, you know, what person has a -- that somebody's comments which others are offended by, you know, to what extent the actual content of their comments actually line up with what the science and what the evidence itself has. I would say roughly those three main clusters.
Q So you --
A Oh, and I should add -- I'm sorry -- detransitioners. Now there are groups of detransitioners who are taking actions against their clinics and care providers.
Q So you're currently serving as an expert in cases involving medical care, athletics, what you explain as free speech and detransition. Is that a fair summary?
A Yes. My hesitation really is that my involvement in all of them is the same regardless of the application to which it's being put, the question is to me or I'm a scientist --
Q Understood.
A -- and, as I say I, I will tell anybody of any political angle or view whatever I can about the existing science. What we know, what we don't know

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and how to interpret science and the scientific method.
So those are the clusters, the topics to which that information is being put. But the information from me is the same regardless of who and how it's being put.
Q So just to simplify, you are offering your scientific opinion in cases involving medical care, athletics, free speech and detransition; is that right?
A Yes. I'd say that's a fair way to put it, sure.
Q And did you meet with counsel in preparation for today's deposition?
A Yes, I did.
Q How many times?
A Once.
Q And for how long?
A A full day, a long day.
Q So you met with counsel for one long day?
A Yes. Everything else has been mostly organizational e-mails, a few short Zoom calls. But specifically aimed at preparation for today was one full day.
Q What were the few short Zoom calls?
A Oh, again, reviewing the documents that have been

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submitted, you know, the basic process, the context.
Q Yes, I would only -- so I didn't know if you meant -- is that part of your meeting with counsel, or is that a separate part of your preparation? I don't need to know what you did with counsel.
A Oh, yeah, the e-mails and Zoom calls were background kinds of organization. The only preparation specifically for today was the one full day pre-prep -- or prep.
Q And who was present for that prep meeting?
A John Ramer and Roger Brooks.
Q Roger Brooks from ADF?
A Correct.
Q Is ADF involved in this case?
A I don't know the details of the arrangements, but the sequence of events was the first substantive case that I was involved in for which I was preparing a sizeable review of the scientific literature was a case in Alabama.
After that preliminary hearing -- preliminary injunction hearing, Alabama, the state, then again I want to use the word retained, but I don't know if that's actually the proper arrangement, but they then began to -- they took on Roger Brooks in order

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to help them coordinate the subsequent features -- not features, events, processing of that case --
Q Does Roger --
A -- and --
Q Sorry. Go ahead. You can continue.
A Then several other states, as I say, with very, very similar cases going on, same questions, same needs, also wanted to retain me.
They similarly began to coordinate with Alabama in order to, you know, minimize, overlap, you know, maximize the efficiency between each of the cases. They signed common interest agreements with each other.
So Roger then, in turn, became involved in helping to coordinate, you know, these -- they're not coordinated cases in any way that I'm aware of, but in order to help, you know, streamline everything, there is an amount of, you know, trying to use the best resources available across each of these various states and each of the people available to them.
MR. RAMER: Yeah, and --
A All of that to say I'm not aware of a direct relationship between Roger Brooks and Indiana, but through this set of coordinations, he is therefore,

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you know, at least indirectly involved because of his experience through all of it. You know, many people take his input and advice, you know, very seriously.
MR. RAMER: Yeah, sorry, I'll just -- I'm going to object and instruct the witness not to answer about the substance of conversations, obviously, with me as counsel in Indiana and Roger Brooks who is counsel in Alabama, subject to the protections there and also the common interest privilege and protections here, so --
MR. STRANGIO: Yes, understood. Not trying in any way to get at the substance of what was talked about, just who was there.
MR. RAMER: Right.
BY MR. STRANGIO:
Q Is Roger Brooks often present for your deposition preps subsequent to your involvement in Alabama?
A This was the only one. And he wasn't involved in the prep for Alabama. He became involved after the preliminary injunction hearing.
Q Got it. Do you have a relationship with ADF?
A No.
Q Did you speak with anyone other than your counsel and Roger Brooks about your testimony today?

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A Not other than in any logistical sense.
Q What do you mean by logistical sense?
A Making sure that I had a quiet place in order to be, clearing out my calendar for the day. You know, just old-fashioned logistical kind of, oh, this is happening.
Q Understood. And you talked about reviewing case documents and your report and the other expert reports in this case.
Any other documents that you recall reviewing in anticipation of today's deposition?
A Not specific documents, no.
Q Okay. And is there anything with you on your desk in front of you at the moment?
A I cleared my desk. I gave myself a blank pad of paper in case I need it, a clean copy of my report itself. But I didn't have time to print out a copy of my CV in case there was something I needed in reference to that. Other than that, it's coffee and water.
Q Understood. Okay. So the only printed document is your clean copy of your report in this case. So when we talk about that, you will have it in front of you; is that correct?
A Exactly, yes.

Q Great. Thank you for doing that, spare us some of the difficulties of the electronics.
A I don't know even if Lieutenant Uhura could have handled this much paper.
Q All right. Well, we will just jump right in, then. So I want to start by just marking a few exhibits, just for ease as we go along, starting with your declaration in this case.
MR. STRANGIO: So, Joel, if you can go ahead and pull up what's premarked as Exhibit 1, that would be great.
BY MR. STRANGIO:
Q And that's what, Dr. Cantor, you have in front of you, I gather.
Doctor, do you -- oh, wow, maybe I can actually move this -- do you recognize this document, Doctor?
A Yes, I do. It looks like the declaration submitted for this case.
Q And you understand this to be a true and accurate copy of the declaration that you submitted in this case?
A As best I can see, yes.
Q I can go down to the list of appendices, the bibliography. So, yes, it does appear to be that?

A As best as I can tell, yes.
Q And who wrote this declaration?
A I did.
Q Anyone help you?
A No. Again, the legal team, you know, did some proofreading, gave me heads-up with some formatting issues. The American Foreign Law Association uses a different bibliography method than I'm accustomed to. In my profession, we use the APA standards.
So, as I said, you know, technical details like that.
Q And did you discuss this declaration with anyone?
A Again, with the legal team to help ensure the topics that needed coverage would be included.
Q Anyone else?
A Not specifically that I can recall. As I say, because I'm involved in several cases, and the science that they need input on is the same science, using the same basic report updated, you know, as necessary, and, again, with feedback from the various groups in order -- various parties to make sure -- sometimes just a clarification of a sentence or to ensure that it includes the information that they need it to include.
So I don't want to say blanketly that nobody

else has, you know, had any input to it, but everybody who has had input, it's been on that same kind of basic back-and-forth, make sure it's clear. And what I can only describe as formatting things in the opposite way than we do in science.
In science, I'm accustomed to here's what we know. Here's the project I did, and here are our conclusions. Where legal documents tend to be organized in the opposite order. Here is my conclusion, then I'll get to subsequently the backup for how I got there.
Q Other than the various legal teams involved in all of the cases where you're currently serving as an expert, did you discuss the contents of this with anyone else?
A Outside of that, no, not that I recall.
Q And did you discuss the contents of your declaration with the other experts retained by the defendants in this case?
A No, I did not.
Q Does this declaration represent a complete statement of the opinions you intend to provide in this matter?
A Yes, it does, which isn't to say, you know, if asked a question about something else in the

research that I happened not to have covered in my report, or if somebody presents an argument making an error in scientific thinking, you know, other information can become relevant. But this is -- it summarizes my intention of everything I plan to be able -- I plan to be expressing.
Q So up until -- up to the point of today, this represents a complete statement of the opinions you intend to provide?
A Yes, that is correct.
Q Are you aware of any inaccuracies in the declaration that you submitted in this case?
A No, other than, as I say, I found missing half of a pair of parentheses, because the editor in me. Again, as soon as I submit something, that's exactly when I find a typo.
Q Yes, I understand this. Anything you would -- other than the parentheses, anything you would like to amend or correct in the declaration you submitted in this case?
A No. I found no factual or content error.
MR. STRANGIO: And let's go ahead, Joel, and pull up what's premarked as Exhibit 2.
BY MR. STRANGIO:
Q And just for your awareness, Doctor, this is going

to be your CV. Do you recognize this document?
A Yes, I do. It looks like my CV.
Q And is this a current and complete version of your CV, 32 pages?
A The only -- and there's -- yes, it's complete, with the caveat that I would have updated it with any additional cases that I've become involved with.
Q So the only thing that might be missing from this would be the addition of cases in which you've become involved as an expert witness; is that right?
A Yes, to the best of my recollection. I don't think there's been anything else that's changed since I submitted it.
Q So in 2022, you testified at a hearing in Alabama in a case concerning a law similar to SEA 480; is that right?
A Yes, that is correct.
MR. STRANGIO: And let's, Joel, go ahead and pull up what's premarked as Exhibit 3.
BY MR. STRANGIO:
Q And, Dr. Cantor, at the time this was the case called Eknes-Tucker; is that correct?
A Yes, that's my memory of it.
Q Doctor, does this appear to be a copy of your

testimony from that hearing? You can take a close look.
A As best as I can tell, that's what it looks like. The sentences that jump out at me match the -- match what I recall.
Q And did you testify truthfully in that hearing?
A Yes, I did.
Q Great. So that's all I have to premark for now. So let's go back to your CV, which is Exhibit 2.
MR. STRANGIO: If you could, Joel. Thanks.
BY MR. STRANGIO:
Q And before we have that in front of us, in paragraph 1 of your declaration in this case, you describe yourself as a sexual behavior scientist. What is that?
A That's a good question. It is a relatively small field in numbers of people. Because of the import of the issues to so many people in so many circumstances, it is like a very, very highly followed field.
I say that only because there isn't a very simple universally-agreed-upon term, like if I said I were an epidemiologist or endocrinologist or something, very many of us would simply refer to ourselves as sex researchers. But because sex

research is itself such a highly interdisciplinary field, saying one is a sex researcher describes the questions that we're pursuing and the kind of issues we're investigating, but within that one could be anything from a psychologist to a neuroscientist, an epidemiologist. It doesn't refer to the academic field referring to the tools that we use in order to address those questions.
So I usually would use a phrase like sex researcher or sexual behavior scientist in order to indicate the kind of questions in which I've spent my career investigating.
Q And when you say sex researcher, what are you referring to with respect to sex?
A Well, over the course of my career, I've handled, you know, many, many different kinds of questions.
In general, because I have a more technical background than most other sex researchers do, I've been able to apply, you know, much more sophisticated tools for doing those investigations.
For example, a lot of studies including, you know, many of the studies that the public are most aware of, really involve interviewing people or surveys or questionnaires or other relatively simple, relatively straightforward methods, but

they don't answer questions in the kind of way that have a great deal of weight.
For example, you know, is somebody born gay, or does somebody, you know, become gay is a question that very often comes down to, you know, some very technical, very biological studies. But because so many people who themselves call themselves sex researchers are just interviewing people, they just get a pile of what everybody thinks the answer should be.
So as I say, when I use the term, I'm refer -- when I use the term to describe myself, I'm refer -- using sexual behavior scientist because I'm investigating, you know, the motivations and the basis behind or supporting people's sexual behaviors, but I don't want to limit it technically to behaviors either.
For example, if there's somebody who's uncomfortable or trying to deal with being gay living in a straight world, you know, some of the questions are, "Doc, why am I different from other people?" Well, we're not talking about his behavior. We're not talking about some -- yeah, doing therapy with somebody in order to help them, you know, gain the self-confidence that they need

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in order to live a happy gay life.
But for the research itself, again, now we're talking more, you know, fundamental -- I don't know if I want to say traditional kinds of science, but we're applying the tools to sexual behaviors or sexual desires, sexual experiences, sexual intents, sexual fantasies, masturbatory fantasies.
Some of these, you know, are not visible behaviors, although they, you know -- some of these don't reflect external behaviors. They reflect, you know, what we infer to be internal states. And there is no one-to-one correspondence between external observable, objective characteristics and what people report being their internal experiences. That's especially true for people whose sexual interests are, you know, something that's stigmatized. They hide it, feel like they need to hide it. They hide it in different ways from different people in different circumstances, including to the themselves.
Q And what is your current job?
A I'm in private practice.
Q What kind of private practice?
A It's in clinical psychology as a clinical psychologist. My hesitation is, of course, as

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these cases became, you know, more and more frequent, it's now a larger and larger proportion of my time.
The majority of my career, as my CV says, is as a full-time scientist and member of the medical faculty. When I left CAMH, it was to go into private practice. And then as these various cases, again, came to -- started coming up, I was devoting more and more time to the cases.
So I'm in private practice and continue to see patients, but a larger portion of my time, again, is in consultation, expert witness testimony, and in summarizing the existing science for the needs of the various cases.
Q So let's take each piece separately. What percentage of your time currently would you say is occupied by your private practice?
A I guess my question is a little bit different if we're talking about corporate structure versus hours per week.
So far as the accountants are concerned, you know, everything I do is part of my private practice. If one means by private practice, you know, one-to-one therapy and seeing patients in a traditional clinical psychology kind of role --

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Q Yeah, that's --
A -- or used in a therapy kind of role --
Q What percentage of your week is spent seeing patients as a clinical psychologist?
A Roughly 20 percent of my time.
Q And what percentage of your time is spent serving as an expert witness?
A Roughly 80 percent, two-thirds of my time.
Q And are you regularly compensated $400 an hour for your expert witness time?
A I am now, yes.
Q And approximately how many hours per week do you spend serving as an expert witness?
A Oh, goodness. It's really hard to nail that down. Although I'm now doing it, I'll say, professionally, I'm still a scientist at heart. My thinking is still what my thinking always is, I want to know the right answer. I'm just genuinely curious, and I want to know how all of this stuff works.
So I will, for example, be posed a question which, you know, whatever lawyer has about whatever particular person's situation or case. I'll spend whatever, half an hour answering an e-mail or supplying whatever materials back up whatever the

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answer to their question is, but that then leads to, oh, wait a -- that leads me to start thinking about if that's true, wouldn't that mean. And now I'm reorganizing my own notes, and I'm, you know, reading and catching up on, you know, some obscure statistic that was used in whatever set of analyses.
And I'm, you know, now spending several hours -- I don't know if self-educating is exactly the right term, but scratching the itch of my own curiosity for which, you know, I became a scientist in the first place. And then later in the week I will get another e-mail from another person in an unrelated case asking a similar question, and I can now give them a more fulsome answer.
So I still only, you know, spent a limited amount of time working with either particular case, but I will have spent several hours, you know, investigating, thinking about and forming my own thoughts about whatever a given issue is.
Q So understanding that it's combined somewhat across cases, how many hours, approximately, per week would you say you spend serving as an expert witness?
A Typically, over the past few months, perhaps the

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past year, actually, might be a better guideline, over the past year anywhere from just two or three hours in bookkeeping and miscellaneous, you know, admin tasks up through full-time, up through 40ish hours, as an average, 10 to 15.

But, again, with the caveat that it runs anywhere from practically zero for a long period of time to, you know, almost obsessive because the -- some deadline is approaching with very little notice, or I got caught up with, you know, my own curiosity just leading me to that much more reading and thinking.

Q Understood. And so, you said for the past year it could range from anywhere between zero, two to three hours, up to full-time. Did I get that right?

A Yes, that would be about right.

Q And over the past year, about how much of your income would you say derived from serving as an expert witness?

MR. RAMER: Objection to the form.

A So if I'm remembering today's process correctly, I do still answer a question even though there's an objection in a deposition, even though --

Q Yes, sorry. Yes.

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A Got it. I'm just checking. Roughly 80 percent.

Q And on your CV, you're listed as the Director of the Toronto Sexuality Centre from 2017 through the present.

What is that position?

A When I left my hospital appointment, as I say it was to go into private practice. My intent was to begin a sex therapy clinic, which I did with several staff people, you know, also clinical psychologists, when I incorporated that group and I began that clinic, I named it the Toronto Sexuality Centre. And the legal designations appear just automatically titled me, therefore, as Director.

As time went on and it became apparent -- a bit clearer that a more substantial amount of my own time was going to be involved with legal cases rather than with clinical situations, I rebalanced what was going on in the clinic so that I am essentially just a solo private practitioner, but I still have the name of the clinic as the corporate entity.

Q So the Toronto Sexuality Centre signifies your private practice; is that right?

A Yes. That's an accurate summary, yes.

Q And when you say you left your hospital appointment

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to begin your private practice, when was that?

A In 2017.

Q And before 2017, what was your job?

A I was a senior scientist at one of the large psychiatric teaching hospitals -- well, the largest psychiatric teaching hospital up here in Canada, in Toronto, called the Centre for -- now called The Centre for Addiction and Mental Health.

Q And when you were at the -- when you were a senior scientist at that centre prior to 2017, did you have a clinical practice?

A No, other than in the last year of it, as I was preparing to leave it, I was, you know, building my -- I was sewing together my parachute before I jumped.

Q And in that role as a senior scientist at The Centre for Addiction and Mental Health, what were your responsibilities?

A They changed over the course of time. And as my career advanced with them -- again, also as my CV indicates, I began there as an intern the final year of my doctoral studies, then a postdoctoral fellow and so on progressing up the pretty traditional ladder for academic researchers.

My duties as a senior scientist then were I

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was in charge of my specific research projects. I was in charge of -- including obtaining the funding in order to, you know, pursue those projects itself.

I was then training and supervising the next line of junior scientists, plus my own students engaged in academic publications for the various studies that I was running. And, also, in its eccentric way as an ambassador to the field itself, I was one of the higher profiled scientists in that institution, largely due to my own, you know, success and standing within my own field.

And because the issues that I was studying are not just attention grabbing, but of the size of legal weight or size of social import where the results were not mere scientific curiosities, they had very, very obvious and very, very important potential implications for public health and public safety.

So my media -- social media, and as I say almost ambassadorial role itself became a large -- I don't know if I should call it official or unofficial portion of my career, of my work --

Q When -- sorry. Continue.

A Of my career there.

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Q And when you say ambassador to the field, what field is that that you're describing?
A Sex research, several different fields. Again, that's the nature of being part of an interdis-- such an interdisciplinary field.
Part of it was to sex research itself. Part of it was to the field of psychiatry. Even though I was not myself a psychiatrist, I was, you know, a member of the faculty of the Department of Psychiatry in the University of Toronto Medical School.
So helping the public appreciate the role of mental health, mental health research, psychiatry within the public health system, and to help people appreciate the potential benefits of scientifically oriented, evidence-based mental health treatment.
So a chunk, as I say, was to psychiatry. A chunk was to sex research. And a large chunk, as I say, to public welfare and public safety. I was specifically within the law and mental health program of the -- the abbreviation to the hospital -- again, it was the Center for Addiction and Mental Health, or C-A-M-H, it's pronounceable nickname is CAMH.
Q CAMH. Understood.

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A So --
Q How -- sorry. Continue, you can.
A Lost the train -- oh, so because my specific role was within their law and mental health program, a lot of -- a large chunk of the group for which I was -- you know, had an ambassadorial role was the integration of psychiatry and the law or mental health and the law.
What are the appropriate ways, what are the most effective ways, what are the most evidenced-based ways to ensure that people who were engaged in the legal system in various capacities, how does mental health interact with that.
So mental health issues not just in consent -- capacity to consent, but also people who break the law. People who break the law, you know, during a psychotic episode or people who break the law, you know, as motivated by some mental illness. And what's the correct way to get the right resources to the right person, not only to help the patient, but to also protect the health and safety of the people around the patient.
Q Understood. I think that's probably a good description of the field and your ambassadorial role.

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Going back to your clinical practice, your current clinical practice. What is the average age of the patients that you see?
A I don't think -- as we would say in statistics, nothing can mislead as much as the mean group, because you really need to know how dispersed they are. If I calculated a number, it would be --
Q Do you primarily see adults in your clinical practice?
A Yes.
Q Do you see any adolescents in your clinical practice?
A Yes.
Q How many?
A Oh, goodness. Today I think it's just down to two. As I say, I see very few people of any age, you know, currently.
Q Got it. And so you see about two adolescents. And how many adults?
A Roughly eight currently.
Q And any prepubertal children?
A No.
Q Has the -- oh, sorry, no. Just one more thing on your CV here. You have psychologist 2004 -- May 2004 to December 2011.

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Were you a clinical psychologist during that period?
A Yes, that's correct. But the term clinical psychologist isn't part of the formal title that the institution gave.
Q Did you see patients during that period?
A Yes, I did.
Q And were the majority of your patients during that period adults?
A Yes, they were.
Q Any adolescents?
A Yes.
Q What percentage of your patients during that period were adolescent, would you say?
A Roughly 5 percent, perhaps.
Q And has the entirety of your professional career as a psychologist been in Canada?
A Predominantly in Canada. I would hesitate to say all. The gray part of the line would be I was still in the U.S. while doing my master's degree. And I was employed as a research assistant specifically in neuroscience and in neuropsychology for several years.
The topics were -- had no direct relationship with the topics I study now, but it, of course,

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involved the same kinds of tools that are how to assess somebody's brain health, neuropsychological functioning, right down to the brain anatomy itself.

So the tools include several of the tools I still use today, but the topics and the behavioral syndromes that the people were exhibiting are different from the ones I study now. So I --

Q Have you had -- sorry. Go ahead, you can finish.

A So I was employed especially in a research context within psychology for a few years in the U.S. before I became Canadian.

Q Any clinical practice in the United States?

A Again, these overlap. The functions I was doing then was to help analyze on the research end information we were gathering from psychological and neuropsychological assessment and clinical assessment.

So it was clinical research, whether one counts that as research or clinical reasonably and appropriately checks both boxes. You can't do research -- the kind of research we were doing was based on the clinical work that we were doing. So the same task is legitimately described as both.

Q And was that between 1990 and 1992?

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A Yes, that is correct.

Q And going back to your clinical psychology practice or work from May of 2004 to December of 2011, you said about 5 percent of your practice was adolescent patients. Any prepubertal children?

A No.

Q You're not a medical doctor; correct?

A That is correct.

Q Not a psychiatrist?

A That is correct.

Q Not an endocrinologist?

A That is correct.

Q Have you ever prescribed puberty blockers to any individual?

A No, I have not.

Q Hormone therapy?

A No, I have not. I'm wondering -- I guess I have a question about your question.

How are you using hormone therapy to be different from a specific hormone? To me those are -- one is the subset of the other.

Q Well, do you prescribe medications?

A No, I do not.

Q So you've never prescribed puberty blockers to any individual?

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A That is correct.

Q And you have never provided gender-affirming hormone therapy to any individuals?

A That is correct.

Q Do you have any formal education or training related to the treatment of gender dysphoria?

A Yes. The Canadian training model is different from the American training model, however. So it's difficult to compare them one to one.

Also, it's not -- clear is not the right word -- to the extent that people who say that they're offering training models, it's not clear, and I don't want to take for granted that they are legitimate training models.

They are usually a list of information, people give it a title every -- and people in different circumstances or context will accept it as that, but these are not the kind of established, validated testing programs where anybody's, you know, tried to see what kind of outcomes and what the appropriate content of such programs are.

But to get to your question more specifically, the training model used up here in Canada is much more similar to the European models than to the American models. Where the American models, as I

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say, are, you know, here's a folder with a correct, you know, title and description to it, and here's the test at the end, that's that, we now call you qualified, Canadian and European models apply a much more apprenticeship-oriented model where here are the readings, here are the patients. Let's go over it all and start talking about it all and develop a more comprehensive way of integrating all of the information, acknowledging all of the unknowns that we have.

So, as I say, in Canada we don't have the kind of -- I don't know if credential-oriented is the right description, but, you know, on-paper method which is much more of the American model.

Q Well, when --

A I think there's also --

Q When did you have the Canadian model of formal training related to gender dysphoria?

A I would divide that into two pieces, a clinical portion and the research portion.

Q And when was the clinical portion?

A It was during my internship here. The final year of my training as a clinical psychologist.

Q And what year was that?

A Oh goodness.

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Q I can look on your --
A '98/'99, I think it was.
Q And when was your research module of training?
A Again, it's hard to nail it down within those terms, because it doesn't fit that kind of a model quite -- it doesn't fit that way of thinking about how the training works.
It's not like a plumbing or Calculus 1 where, you know, it's a pretty set, known, widely used set of material where people know what you get in Calculus 1.
A great deal of the relevant research, research methods would have been over the course of my postdoctoral study -- over the course of my postdoctoral studies, which would have been, you know, in the first few years of 2000.
But, again, these -- because of the nature of the model up here, because of the particular places and people that I was training with, there's much more of a blend across clinical and research.
I was in a research science facility in a clinical research program where the difference between clinical work and research is just how good your documentation is. If you see a bunch of people and have a rough memory, and you're only

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reflecting on your own recollections of it, you know, calling it clinical experience or anecdotal evidence, people would accept that as clinical work.
But if you then write down exactly how many people you saw, exactly how many people ended up with exactly what kind of situation, and you do it in a systematic way, now it's research, even though the functions themselves are the same.
Q So taking aside the how, this blended process, let's say, occurred between 1998 and the early 2000s; is that right?
A It's correct for timeline. But, again, I don't mean to be evasive, but to leave enough, you know, blurriness around the boundaries that there was no end of -- as of June, you are now qualified or you are no longer going to be doing any of this after this semester, none of it was that kind of a program.
Most training, as I say, is much more an apprentice kind of model where, "Oh, you're good at math. Could you give us a hand with" whoever it is doing whatever kind of a study. And so, now we're studying this kind of sexual or gender behavior instead of that kind of sexual or gender behavior.

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MR. STRANGIO: I'm about to sort of move into a slightly different section of the CV. Do you want to take a break, John, for five or --
MR. RAMER: I'd welcome a break, but it's up to Dr. Cantor, if he would welcome one.
THE WITNESS: Oh, more specifically, my coffee's empty. So yes.
MR. STRANGIO: Okay. Let's do five minutes and we'll come back in five. Thanks.
(A recess was taken.)
BY MR. STRANGIO:
Q On your website, Doctor, you describe the main focus of your research as being on the role of the brain and human sexual interests, especially atypical sexualities; is that right?
A Yes, that sounds right.
Q So the majority of your work, as you describe it, has been focused on what you describe as atypical sexualities?
A That's the best all-encompassing phrase I can think of to capture it quickly, but, yes.
Q What are atypical sexualities?
A As I say, I use the term specifically to be broad, but it's not an official term. To break it down into pieces, I would say it breaks down into sexual

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orientations other than, you know, predominant heterosexuality.
So it would include, you know, the various homosexualities, bisexualities, more recently people referring to themselves as asexual, some people adopt terms like hypersexual and so on.
For gender identity, you know, of course, it includes identifying originally as male or female. But now people, of course, identifying with, you know -- again, adopting very many different terms, describing it in very many different ways. And, of course, in the group of atypical sexualities that are called the paraphilias.
And, again, there's no concrete objective, clear demarcation for what counts as a paraphilia or not. In general, the phrase is used for people with a sexual interest pattern or sexual interest -- a sexual interest pattern either in people, kinds of people, or in activities that are not merely atypical, not merely statistically unusual, but that they experience that interest pattern as profoundly and as deeply as sexual orientation.
To them, you know, if the thing that they're attracted to is not involved in the situation, it

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to them is not a sexual situation at all.
Q Is being transgender an atypical sexuality as you describe it?
A As I describe it, I would include it among -- I would include gender identities and gender dysphoria within the term as I use those terms, but I also have to acknowledge that, again, these are not official terms with very specific lines. There are other people who would use, you know, these terms in different ways. And as long as we clarify who we're talking about, you know, we can have a perfectly productive conversation.
But I don't want to say, you know, I use the term one way; and, therefore, you know, if somebody else says it counts or it doesn't count that there even is a right or wrong to it. But I use the term because of its breadth in order to include things like gender identity.
Oh, and also in the atypical sexualities, I would also include the various kinks. And, again, what's a kink versus what's a paraphilia is not very clear. One blends into the others. There are kinksters for whom, you know, if the thing that they're into, yeah, some sexual encounters will include it, others not. But for others if it

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doesn't include whatever thing it is that they're into, it doesn't count at sex.
So it's tough to come up with a -- there's no good objective, definite, uniformly accepted boundary between them.
Q And have you done any research relating to transgender people and/or gender dysphoria?
MR. RAMER: Objection to the form.
A I have.
Q What was that research?
A I've done research on various relatively technical aspects, including, you know, how to develop, you know, formal questionnaires and the psychometric properties of those questionnaires.
I guess by psychometric I mean the statistical properties of how to form a test in order to make sure that the test is testing what you want it to be testing and not merely just asking the same question over and over and over again 10 different ways, but not providing 10 different pieces of information.
I've also done research on the role of the brain and age of puberty and how going through puberty at different ages affects, you know, the course of brain development.

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Q Any research on the mental health outcomes of people with gender dysphoria?
A No. I don't think I've done any direct work on clinical outcomes.
Q On page 10 of your CV, which is up here, I just want to ask you about a few things. You have here listed under your "Funding History" a five-year grant September 2015 entitled "Effects of sex hormone treatment on brain development: A magnetic resonance imaging" -- oh, no, sorry, is someone moving this? Okay. Sorry.
MODERATOR: It said you didn't have access to move it. So I was trying to give you control again. I think it's Zoom messing up. Sorry about that.
MR. STRANGIO: Oh, no, it's okay.
THE WITNESS: Oh, we need Lieutenant Uhura again.
MR. STRANGIO: I thought it was me.
BY MR. STRANGIO:
Q I'm going to start that over. So we have here under "Funding History" on your CV a five-year grant from September of 2015, "Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender

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dysphoria."
Do you see where I'm looking?
A Yes, I do.
Q And what is this grant?
A It was essentially as it sounds. It was an attempt to investigate what happens -- you know, what happens in the brain, doesn't happen in the brain. You know, in what patterns does the brain develop amongst people who are being treated and receiving different kinds of treatment, whether medical or nonmedical, over the course of puberty.
Q And you were not the principal investigator in this -- was it a study?
A It was a -- well, is a research grant. And so, it was the request for the government funding in order to conduct the study --
Q Did the government --
A -- studies, I should say.
Q Did the government provide the funding for this particular research question?
A Yes, it did.
Q And you were not the principal investigator for this grant?
A That is correct. That one was done by Dr. VanderLaan.

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Q What was your role?
A Again, I handled the technical parts. I was the -- I don't want to say the expert on brain anatomy, but I was the connective tissue between the, you know, neuroanatomists and the other sex researchers involved in the project.
Especially then, I was one of the very few people in the world at that time that had a foot in each of those camps and was able to help everybody, you know, coordinate and cross these various fields helping the sex researchers, you know, asking these questions, helping them understand how MRI research works. How, you know, brain analysis works. How the statistics are done. Why things are done the way that they're done. The strengths and shortcomings and different methodological principles available -- procedures available to them.
As I say, it's a highly, highly interdisciplinary field. And in order to use really these, you know, very, very high-end research techniques, you know, there are only a few people who can at the same time talk to both the sex researchers and the statisticians and the neuroanatomists.

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Q And this was a grant for a five-year period; is that right?
A Yes, that's correct.
Q Were your findings published?
A I hesitate to say mine, because those, of course -- that was before I actually left the academic world. But, yes, it's been published.
Q And where is it published?
A Oh, goodness. I don't remember. I'd have to look it up.
Q Is it in your CV?
A No, I didn't participate. As I say, once I left the academic world, then -- I was going to say left the project, but that makes it sound a bit more dramatic than true.
I'm, you know, in regular e-mail contact with several of these people and answer questions where I can here and there, but I wasn't dedicating --
Q But you didn't stay on as a co-investigator on this particular grant?
A Yes, in the sense that I didn't have the kind of active, ongoing, you know, regular input attending, you know, the weekly meetings and so on. But I -- at the same time, it wouldn't be fair to say that there was some kind of formal resignation process.

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It was just we all moved on, and that's that -- well, I moved on, I guess I should say.
Q And you're not listed in any of the papers that were published as a result of this grant?
A That's correct.
Q And there's a second grant listed at the top. That is from July of 2018 for five years. And this was "Brain function and connectomics" --
A Connectomics.
Q -- "connectomics following sex hormone treatment in adolescents experience gender dysphoria."
Was this a grant that was also received by your -- by this research team?
A Yes.
Q And you were not the principal investigator on this grant?
A That's correct.
Q Do you remain a co-investigator on this one?
A The situation is the same. This one, you know, was -- it was awarded in 2018, but, of course, the design and the submission was ahead of that.
My involvement was the same. I was essentially the consultant, you know, helping everybody communicate to each other, helping them figure out, you know, what are the kinds of brain

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features they should be looking at as the next logical steps.
Q And in what year did you leave -- or let's just -- I'll rephrase that.
In what year did you move on from this particular academic position and, therefore, this grant?
A I'd have to look through my e-mails to find the actual date of my formal letter of resignation from CAMH, but all of this was happening roughly around 2017, 2018.
Q And so you will not be an author on any of the published findings out of this grant?
A I've learned never to say never. It's not my plan and intent, but that isn't to say that if they come to me with, "James, we found, you know, this strange thing that we thought you'd find interesting, or we need your input on, or we ran into some piece of the mathematics we can't figure out," again, I have no -- I'm still a scientist at heart. I still enjoy the material. And I would do my best to try to fit it in.
Q For the two pieces of grant funding listed in your CV under "Funding History," you don't anticipate being involved in the published findings of either

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of them?
A That's correct.
Q How were the study participants recruited for these two grants?
A Through the clinics that see kids with gender dysphoria.
Q And do you know approximately how many individuals were enrolled in each?
A No.
Q More than 50?
A Again, I don't know. There are oftentimes changes in design that would have happened, you know, once the project itself got going.
As I say, I'm not involved in the day-to-day running of the project. So I wouldn't be apprised of progress or changes.
Q And how would you describe the study design of these two grant projects?
A Case control.
Q And what does that mean?
A A group of people who are undergoing one set of circumstances and series of brain scans, and we come up with what's essentially an average brain, if it could be called -- average brain image, if one could be called that. And then compared to

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people as matched on as many variables as we can, you know -- or they can, I should say, match them on similarly developed and equivalent average brain of the control group. And then through an exquisitely bizarre set of statistics use what's more like image analysis than, you know, traditional statistics in order to identify patterns in the averages of the images and connect that back to what are those differences in the images and the patterns, you know, tell us about the structure of the brain itself.
And then in turn, what do those changes in the structure of the brain tell us about the developmental processes that led to those differences.
Q And the control groups, were those study-enrolled participants, or was that a control developed from data of the general population?
A I'm sorry, could you ask that again? I'm not sure those are different groups.
Q Was the -- were there particular individuals enrolled in the study who were not receiving treatment that represented a control group?
A The control group would be people not receiving any kind of gender-related treatment, yes.

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Q And they also had a diagnosis of gender dysphoria?
A No, these would be -- depending on the question, each of these, again, were grants, you know, that were enabling the funding of several different research projects all boiling down to neuroimaging, but it wasn't like the final research paper which reported a single set of analyses, you know, to answer a specific question.
Different parts of the grant were aimed at answering different questions, each using different kinds of methods. Some would compare the gender dysphoric kids to non-dysphoric kids. Some would compare the gender dysphoric kids to their non-dysphoric siblings.
Q Got it.
A And in early pilot studies, we would even do it versus what I can only call stock brains, you know, there exist large databases, you know, of images that have been accumulated over many years, you know, and are just available as gen -- I hesitate to use the word generic, but generic-controlled samples because -- especially because getting MRIs on someone is so expensive that if we can get just a group of healthy controls that anybody can use, you know, with socioeconomic status already

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reported and controlled and age already reported and controlled that they, you know, can be used as a generic set of -- a generic control sample for just about any study. Typically that would be done early in development -- early in the development of a study.
Q But for these particular studies, you had at least two variables, one of which was experiencing gender dysphoria and one of which was receiving sex hormone treatment?
A My hesitation is a quibble in that, you know, those are not necessarily separate variables, you know, so they wouldn't get chopped apart so easily. But the issues, the features, you know, being investigated sometimes were the gender dysphoria itself and sometimes were the effects of the medications and treatments that they were receiving or potentially receiving.
Q But your controls neither had gender dysphoria, nor were receiving sex hormone treatment?
A That's my recollection of the plan, yes.
Q Okay.
A As I say, my involvement was in the design of -- was in the grant application which proposed the design of the studies. And it's not unusual for,

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you know, studies to need to be adjusted according to whatever's going on, you know, once the feet hit the laboratory ground.

So I couldn't say that, you know, as the studies were conducted and after my involvement was completed, I'll say, I can't speak to the current status of the programs and whether any changes were made, but the original plan was to do it as we described.

Q So going back to your clinical practice, you're an adult clinical psychologist; is that right?

A Yes, that's correct.

Q And as we discussed, you currently are treating approximately 10 patients in your private practice?

A Yes.

Q Are any of those patients transgender?

A They're not. No one is transgender in the way that most of the public uses the term currently. But, as I say, especially the public use the term in relatively vague ways that don't always match up with the science.

But I do have one at the moment for whom identity issues in general are a topic of their concern but -- a topic of their concern. So it really would depend on to whom I'm talking and in

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what context would this person's situation count is a legitimate question. And it depends on how people are using whatever terms and whatever ideas.

So if somebody, you know, gave me a description or said, you know, is this a person concerned with this, you know, we could say yes or no. But whether the person, you know, counts as gender dysphoric, counts as transsexual and so on depends on how the person is using those terms.

Q Is that person an adult?

A Yes.

Q And you have never treated a prepubertal transgender child; is that right?

A Yes, that is correct.

MR. RAMER: Objection to the form.

Q And you've never treated a transgender adolescent under the age of 16; is that correct?

A Yes, that's correct.

Q Have you treated anyone under the age of 16?

A No, I have not.

Q And as I understand from previous testimony, the extent of your clinical experience with transgender adolescents has been providing counseling to eight transgender patients between the ages of 16 and 18 in your career; is that right?

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A For being a formal clinician for cases, that number sounds about right, yes.

Q And that was the number you gave in your testimony in Alabama in May of 2022. So has that changed since then?

MR. RAMER: Objection to the form.

A No, I don't think there's been anybody else in that age range since that time.

Q Have you ever diagnosed a child with gender dysphoria?

A No. Diagnosis, of course, is a subset of clinical activities. So it's the same -- it's within the same boundaries.

Q Since you've never treated a child, you've never diagnosed a child with gender dysphoria it would be fair to say?

A That is it exactly. Lovely when logic lines up.

Q It's rare.

A A rare pleasure we can call it.

Q Have you ever diagnosed an adolescent with gender dysphoria?

A Not that I recall.

Q Have you ever monitored an adolescent patient with gender dysphoria who was being treated with hormone therapy?

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A That would depend on what one means by monitored. I wouldn't have followed such a person or monitored their medical treatment, for example. You know, looking out for or interviewing regarding, you know, physical side effects, that would have been done by one of the physicians on the person's clinical care team.

But I would have been involved in, you know, progress and effects and so on on the person's mental health status and development while they were undergoing physical transition.

Q Well, you would have. Were you ever involved?

A I was involved in such cases, yes. I meant hypothetically to be the different hypothetical -- to be the different ways to interpret the question, not my role in the case.

Q So that would have been with the eight patients that you have seen between the ages of 16 and 18, some of those patients were on hormone therapy?

A Yes, that's correct.

Q And how were you monitoring their well-being on hormone therapy?

A Oh, regular mental health assessment. As people were going through, you know, transition, you know, part of that, you know, during the clinical

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standards, especially of that time, you know, checking in regularly with their -- with psychologists and mental health professionals, you know, was part of the process.

So it was a combination of reviewing the various documents such as from schools and employers where relevant. And a lot of it, of course, face-to-face interviews and with the clients themselves.

Q And when was this?

A This would have been over the course of my -- while I was at CAMH for my internship and a few years after -- several years after.

Q Can you give me those particular range of years?

A Oh, 1998 through probably roughly 2005.

Q So you have -- since 2005, have you provided clinical treatment to any transgender adolescent?

MR. RAMER: Objection to the form.

A Of the eightish, a small -- twoish, perhaps, were between 2005 and today.

Q And when was the most recent adolescent patient with gender dysphoria that you saw as a clinical psychologist?

A Three years ago, four years ago. Again, depending on, you know, who counts which way, there are

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people who come in periodically for -- to check in or catch up or somebody is now later experiencing, you know, an unrelated issue, but because they know who I am and we have a developed relationship, you know, we can continue consultation or therapy or whatever's appropriate, or there will be somebody, again, not currently concerned with a gender-related issue, but had gender-related issues earlier in their lives.

So it's integrated as part of a comprehensive assessment in getting to know the person, but not necessarily the topic that brings them into therapy to begin with or brings them into therapy to see me specifically.

Q So just to summarize, in your career you have seen approximately eight transgender adolescents as a clinical psychiat -- excuse me.

In the course of your career, you've seen approximately eight transgender adolescents between the ages of 16 and 18, six of those were between 1998 and 2005?

MR. RAMER: Objection to the form.

A That sounds basically correct, yes. My, you know, knowledge and expertise and the material, of course, is about the science itself, not in the --

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when I see these people, this is what I do, as I say. I'm relying on the evidence itself, not my, you know, personal anecdotal experience with them.

Q And for the eight patients that you saw as a clinical psychologist, what was the nature of the counseling that you provided?

A The nature of the therapy and counseling with them really depended on whatever it was that was going on in their lives.

The research demonstrates that the people who do best are the ones who have -- who are able to navigate and who have the support in order to navigate typical, I'll say, life stretches and developmental courses.

So for many of these people, it was dealing with usual, you know, what do I do with my life, or I'm upset about or I'm having difficulty finding educational experiences or friendship groups or, you know, significant others.

So they were often -- I don't want to use the word generic, but they were, you know, very similar issues to what, you know, other people attending therapy would be experiencing. But the potential role that these other indicators had was greater for most of these people because they had

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additional stressors to be going through; and, therefore, needed that much more strength in order to be able to handle the stresses that accompany transition.

So the content of the therapy with them usually would be the same content as with anyone else, but there were -- there was for many of these people more on the line, for a lot of people a decision, for example, about what -- in the U.S. you say college, in Canada we say university -- in decisions about what university to attend would be attached to social engagements, social opportunities. The pressure on somebody who, of course, is not just gender dysphoria, sexual orientation often can have a similar impact, being in urban versus rural environments, conservative versus liberal environments. There's more on the line for somebody -- for youth experiencing gender dysphoria in planning or undergoing transition.

So the particular issues are the same. I'm sorry, I'm repeating myself, but the circumstance and context in which they're doing it is more complicated or there's more involved in it.

So it's often very useful for them to double-check their thinking or to receive, you

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know, feedback from somebody who's, you know, familiar with and experienced with, you know, other people going through similar issues.
Q So in some sense, you are providing to these eight adolescent patients counseling comparable to what you would provide to other patients?
A Predominantly. For some people it was specific questions or curiosities or questions or their own concerns about transitions, possibilities of transitions, possible futures for them. But they were not defined by their gender dysphoria or trans status. They had all the regular issues that, you know, very many youth have.
Q I want to talk for a minute about your appearance in other cases as an expert. So I'm going to just go right down to this last page here.
I'm trying to think, you mentioned a few states that aren't listed here at the beginning. So I guess my first question is: To the best of your recollection, is this a complete list of the cases in which you have been retained as an expert witness?
A No. I think there have been some new ones since then.
Q Can you tell me what those ones are?

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A I'm looking over, because on my bookshelf I have a three-ring binder for each one, because that's my list.
Q Why don't we do this, because you said -- is one additional case Kentucky?
A Yes.
Q Is one additional case Montana?
A Yes. My hesitation with that is that it's going to happen. They sent me the contract, but I haven't signed it and returned it yet. But by the end of business tomorrow, the answer will be yes.
Q Okay. So let's just say there's two or three others that are in the works in which you have not yet necessarily submitted any form of testimony. Is that accurate?
A Again, perhaps I'm quibbling on the phrasing, but for submitting testimony for Kentucky, I submitted my declaration 48 hours ago, I think.
Q Okay. Understood. And for Montana, you have not submitted anything yet?
A Correct. As I say, that -- you know, we're all anticipating it about to happen. And I would not be at all surprised if you're even more familiar with my deadlines on this one than I am. But it hasn't -- I'm waiting for the -- there's a funny

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old expression, dot and tittle. People used to dot the "I" and cross the "T." Turns out that there are words for those. The dot over the "I" is called the jot, and the cross on the "T" is called a tittle.
Q So that is where we are with respect to that. Understood.
Among these cases listed, can you tell me which ones you were deposed in?
A The Indiana case, A.M. versus. I would have to check my notes for BPJ.
Q Anything else you recall?
A No, not that I recall, because several of the cases -- well, a little less than half now were Frye hearings, they don't involve depositions.
Q Those are the criminal cases -- or, sorry, civil commitment cases?
A Yes. Again, I wasn't involved in the civil commitment itself. I was involved in the Frye hearing which, you know, was going to then get used in the -- the questions to those were whether the person was subject to civil commitment in the first place, hence the Frye hearing in order to investigate the scientific issues to decide whether the civil commitment regulations pertained at all.

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Q So let's -- we'll say -- we will continue to update as your testimony changes in these various cases and call it an ongoing process. Does that sound fair?
A That, yes, indeed sounds fair. As I say, the nature of these particular set of cases, it's, you know, me versus various combinations of, you know, people from the AR office versus various subsets of, you know, the same group of experts.
So it's, as I say, a rather bizarre, I don't know if I can say unusual, but eccentric, novel situation.
Q Well, going back to the cases involving transgender people, did you ever reach out and offer yourself as an expert in any of those cases?
A No, they all came to me.
Q And one of the cases you have listed here on your CV, No. 5, is Dekker, et al. v. Florida Agency for Health Care Administration. Do you see that?
A Yeah.
Q What was the nature of your involvement in that case?
A They needed a -- well, my basic involvement was the same as with the other cases. They needed, you know, to know what the science said and, you know,

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what the -- and feedback on the experts -- what the other experts have written and then, you know, comparing their claims against the content of the scientific literature again.

So the basic content of my involvement in that case was exactly the same as my involvement with each of the cases, is here are a bunch of claims, which ones match up with the science.

Q And you wrote a declaration in that case?

A Yes.

Q But you were not called to testify at trial in Dekker; is that right?

A That's my recollection, yes. I don't think it's gone to trial yet.

Q I can represent to you that it has gone to trial. So --

A Oh, okay.

Q -- if you haven't -- if you didn't testify there, I gather you didn't testify at that particular trial.

A That would make sense. My amnesia gets me, but not that bad.

Q So, yes, you did not unknowingly testify at the Dekker trial we're going to say.

A I almost want to say, can I testify in my sleep? Does that happen?

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Q I mean, you're the psychologist.

A Perfect answer.

Q And, yeah, so that was my only question on Dekker. So in your declaration in this case, you write about the practices of a selection of your European countries with respect to treatment of adolescents with gender dysphoria; is that right?

A Yes.

MR. STRANGIO: And, Joel, could we pull up Exhibit 1, which is Dr. Cantor's declaration in this case. I think I am -- am I in control? That's a great question, but --

THE WITNESS: Is this another you're the psychologist?

MR. STRANGIO: Yeah, I'm about to start asking for advice over here, but for now I think I can actually use this Zoom mechanism.

BY MR. STRANGIO:

Q Okay. So you do not provide a comprehensive summary of all the practices of country -- excuse me, you do not provide a comprehensive summary of the practices of all of the countries in Europe; is that correct?

A Correct. Again, my content was not about the, you know, political situation, policy situation. My,

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you know, comments are about the science itself. So I included -- what I included were the systematic reviews that were available, all of the, you know, comprehensive systematic reviews that were available.

And so, the countries that I mentioned are the countries that have used them, that have engaged in them, but I haven't -- didn't attempt to make a review of the political policy orientations of any countries -- well, set of countries.

Q So England, Finland, Sweden, France and Norway are the only countries that have done systematic reviews of the evidence with respect to the treatment of adolescents with gender dysphoria?

A That I am aware of. France didn't conduct its own. They conducted a review, but not the -- but not a systematic review of the original research.

Q Then why did you include France?

A They conducted a non -- a review, but not a formal systematic review of the evidence as they were, you know, evaluating their own set -- oh, actually, that would be a better way of phrasing it.

That I included the countries that have, you know, engaged in reviews of their policies, but, of course, the ones that I deal with, you know, in its

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own section emphasizing are, of course, the systematic -- the ones that conducted systematic reviews.

Q So there are no other countries in Europe that have engaged in reviews of their own policies other than these five countries?

A I don't think I can claim negative in that I haven't looked at every single country that did. Essentially these are the ones who have done it, who have conducted the kinds of reviews and then, you know, made conclusions and asserted policies on the basis of those reviews.

But I couldn't say that no other country has done it more than feasible -- it's theoretically possible, especially because they don't all publish everything in English, it's certainly possible that others have that I haven't become aware of.

Q But these were the ones that did reviews and came to conclusions with respect to the evidence similar to your own?

A Well, the ones that I reviewed, the ones that I included would -- included their conclusions, period. They happened to have come to the same conclusions about the science that I've come to about the science, but there was no -- I wouldn't,

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in fact I would work very hard to avoid, you know, the kind of cherrypicking where I would only cite, you know, or pick the ones who come to a particular conclusion in any direction.
Q But you're just not sure whether there are other countries in Europe that have done different reviews?
MR. RAMER: Objection to the form.
A Again, I haven't attempted a country-by-country search, you know, each in their various languages to see if there's something that's been less publicized or less internationally released.
So I can't say with any kind of certainty that none exist, but these are the -- so I can't say that none exist. I can only say that I'm not aware of any.
Q So you didn't do a systematic review of all of the countries' policies?
A Of countries' policies, correct.
Q On page 7, paragraph 16, you write here at the bottom -- towards the bottom of paragraph 16 speaking about the European policies, "These range from medical advisories to outright bans on the transition of minors." Did I read that correctly?
A Those sounds like my words. I'm just squinting to

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take the --
Q Yeah, here we go.
MR. RAMER: And, Doctor, you have your -- am I correct you have your blank printout as well?
Chase, is it okay if he consults that?
MR. STRANGIO: Yes, absolutely. I was about to get my reading glasses, but I also made it larger if that's helpful.
A Both are good, as I say. And here's my three-ring binder for this one.
Q So, again, we're in paragraph 16, page 7. "These range from medical advisories to outright bans on the medical transition of minors."
A Yes.
Q Which of the countries that you identified in your declaration have outright bans on the medical transition of minors?
A The UK, Sweden, Finland. Am I forgetting somebody?
Q So is it your opinion --
A Yes, those three.
Q It's your opinion that the UK, Finland and Sweden have outright bans on the medical transition of minors?
A People can certainly quibble over the definition of ban, but they have essentially, you know, reversed

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course from the wide availability that they had restricting it only to specific formal approved, you know, research studies.
Q So you consider accessing treatment in a formal approved research study to be an outright ban on medical transition?
MR. RAMER: Objection to the form.
A There's something funny embedded in that question. That one is that they are restricted to research studies which in turn select only particular people under particular circumstances -- in particular circumstances when they fit the -- whatever the inclusion criteria are for the study. I don't think it would be accurate to refer to that as access.
It's not access. You know, what they would be participating in, what they would be volunteering for is participation in a research study as a research subject, which is in turn medically supervised and so on, which is -- again, especially in countries -- this is one of the main distinctions between the U.S. and the rest of the world is that, you know, it's a public healthcare system. Access means access.
And, you know, so participating in or

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volunteering for studies that involve, you know, physical transition is not part of the you go to a doctor and you show your health card and you get access. That's -- as I said, that term does not accurately depict their situation.
Q We're not talking about access. We're talking about --
A I'm sorry, I thought you used the word.
Q -- outright bans on the medical transition of minors.
So my question was: Do you consider enrolling -- limiting treatment to a research study to be an outright ban on the medical transition of minors?
MR. RAMER: Objection to the form.
A Again, the use of the word treatment has some assumptions built into it that don't very accurately fit.
What the results of the systematic reviews of the science and, you know, to the best of my reading the science itself, says is that these are not ready to be called treatments. These are experiments. We're not sure when, for whom, under what circumstances and in which way, you know, these kind -- these interventions are helpful

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versus harmful and how to weigh the potential risks with the potential benefits.

It's not yet ready for prime time. To refer to it as a treatment would insinuate at least that, you know, it has already, you know, been subject to the kinds of analyses that we apply in providing evidence-based medicine.

Q Okay. Well, let's ask more specifically. None of the European countries that you mention in your report have restrictions comparable to the one that was passed in Indiana; right?

MR. RAMER: Objection to the form.

A Again, it's -- I can tell anybody, to the extent of my knowledge, what the content of the science is. And when I -- and to the extent that, you know, any given, you know, legal proceeding or law is written in lay language that a non-politician, non-lawyer can read, I can, you know, compare it against the content of the science.

The only distinction -- but I can't say that I know the details of all the European various regulations or those particular states within the U.S. The only distinction I'm aware of is whether research purposes are permitted exemption within the ban. But I don't think it would be legitimate

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to say that if there's an exception to it then it's not a ban.

Q So you would call it an outright ban even if it had an exemption?

MR. RAMER: Objection to the form.

A It would depend on the nature of the exception.

Q So if there was an exception for research, for example, you would call it an outright ban on treatment? Sorry, excuse me.

If there was an exception for research, you would call it an outright ban on the medical transition of minors?

MR. RAMER: Objection to the form.

A I would hesitate to make a blanket statement in case -- you know, I can imagine other at least theoretical, you know, reasons that I would or wouldn't call it. But I don't think that having an exception -- for this particular situation, you know, permitting -- again, we're not even talking a particular research study that's ongoing in any of these.

Such laws were -- regulations in Europe were going on despite that there was no research going on. That was one of the, you know, almost ubiquitous criticisms, was the lack of research.

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And research programs have not been initiated in these places yet.

So if a law, you know, permits -- in theory, in the future if somebody else comes up with this thing that doesn't yet exist, the current situation is still such that it's not available, but we're leaving room in the law just in case for the future?

It's difficult -- in that circumstance, yes, I think the word ban is including outright ban as a perfectly legitimate descriptor.

Q So in the UK currently, can an adolescent with gender dysphoria access puberty blockers as part of an approved research protocol?

A That's my -- as I say, I don't study closely the public policies of it. I can testify only to the content -- really only to the content of the science. But the way you describe it is roughly what I recall of their current policy. But I don't think that they have yet designed any such research studies.

So even though it, you know, maintains and reserves the potential, and as best as I can tell the intent in the future to do that, the process today, still for kids today, is that it's going to

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be a ban for the moment.

Things may -- as I say, exceptions, you know, they're leaving room for potential exceptions in the future, but they haven't happened yet.

Q So in paragraph 16 you talk about the various policies and details about the policies.

Is it now your position that you're not qualified to talk about the various policies in these different European countries.

MR. RAMER: Objection to the form.

A I refer to the content of their reviews of the science. And I, you know, share, re-review their conclusions of the science. And I demonstrate not their policies, but their changes to their policies in response to their evaluations of the science.

Q But you might not be that familiar with how those reviews are implementing the practice with respect to the delivery of healthcare in these countries. Is that fair?

MR. RAMER: Objection to the form.

A That's a bit overstated, I think. I haven't taken, and I have no current plans to take thorough -- and I speak as a scientist when I say thorough, I mean almost obsessive -- investigation of the ins and outs of the details. But on a relatively high

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level, I'm generally aware of their application or of applications of science and how it's getting used or misused in public policy.

But, as I say, I'm not a public policy expert. I haven't, you know, gone into the details of, you know, countries that are changing. I'm only investigating, you know, the individual groups as they are trying to gather the science for the application of their policies.

I think it would be fairer to say that I've spent some time and attention on the use of science in policy -- or the uses of this present body of science in policy, but I haven't studied, you know, policy in and of itself.

Q So is it your position that no adolescents with gender dysphoria are currently receiving puberty blockers to treat their gender dysphoria in the UK?

A No, that doesn't sound correct to me. Exactly because they're aware -- pardon the pun -- but because their policies are in a transitional status, there were, of course, you know, youth who were already receiving medical transition services. And that, as best as I recall, has been grandfathered in. I don't think that they, you know, stopped, you know, anybody who was already

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receiving treatment. So it wouldn't be fair to say that nobody is currently receiving treatment.

What they say they're aiming to put limitations on are the unnecessary or excessive or over availability where medicalized transition looks like is being used to displace other interventions that very, very feasibly could be better matched to these kids' needs and without the sacrifices and risks that are associated with physical transition.

Q So there are youth in the UK currently receiving puberty blockers for gender dysphoria?

MR. RAMER: Objection to the form.

A Again, I hesitate to say that, you know, flat out as a matter of fact, because that's not the -- they've already -- that's no longer a piece of -- you know, they've already completed their review of the science. And so, that kind of completes how -- you know, that level of how closely I'm following -- or that section of what I'm following of what they're doing.

They're now -- the implementation or what -- the policies to which they're applying the science is, you know, less a focus of what I follow than the application of the science itself. Their

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review of the science is largely complete.

Q So at least as to individuals who had been previously receiving puberty blockers for gender dysphoria, that treatment -- or, excuse me, that care is ongoing?

MR. RAMER: Objection to the form.

A My basic recollection is that they didn't cut off from treatment people who were -- medical treatment people who were already receiving medicalized transition services or at least while a minor.

Q That would be true for hormone therapy as well?

A I'm including hormone therapy or what most people call hormone therapy under medicalized transition, yes.

Q And in your report you also reference Finland. And just right now you referenced Finland as well; is that right?

A Yes, that sounds right.

Q And do you read and write in Finnish?

A No, I do not.

Q Do you have a certified translation of the COHERE 2020 document regarding their review?

A Not of the full document, no, I don't think.

Q So you're basing your understanding of the Finnish review on an uncertified translation?

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A No, that's not exactly true either. As a matter of fact, I was due to go to Finland in the next couple of weeks, but had -- you know, for a conference that they're holding, you know, bringing together the experts on exactly these topics.

And, of course, I'm in regular communication, you know, with people all over the world within my field and more and more commonly with this one. You know, they've also been, you know, discussing the issues themselves regularly in the media in English and Finnish.

And, you know, to the extent that they have also been, you know, releasing statements and conversations with other people within the program have been, again, in English. And all of it is exactly consistent with each other. Nobody's identified and nobody's, you know, claimed that there have been any contradictions in any of the available translations in any of the statements that the scientists involved with it -- you know, what they have said in English versus what they have said in Finnish.

There have been no contradictions between the conclusions that they came to versus the conclusions that have been produced by scientists

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in other countries.
Q But typically are the only systematic review an outline of the medical practices in Finland -- the only official versions of the systematic review for the Finnish medical authorities are in Finnish?
MR. RAMER: Objection to the form.
A I would have to check through my files to see if that's still true. Another publication -- by coincidence, not soon after I submitted this declaration -- again, I would have to look through and check to see if those were Sweden or Finland, recently published in English a peer-reviewed document, you know, summarizing the content of what was originally in their native language.
And, again, I keep mixing up several of the Scandinavian states, Finland and Sweden, and which one contained within itself, you know, English language summaries.
English is -- of course, you know, despite the original languages that many reports are published in, you know, throughout all of science, English is still the lingua franca. The circulation of the materials, the abstracts of the materials and so on are still circulated in English.
And my conversations with the scientists

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themselves, including the ones who publish the relevant studies, you know, we're in regular contact with each other who, you know, certainly have confirmed our whole conversations were based on, you know, the idea of what the studies said -- of what the studies resulted. Also --
Q And by studies, you don't mean studies, you mean systematic reviews; right?
A I'm kind of blending -- your mind is going exactly where mine was headed. These two are blended. The content of these systematic reviews -- of systematic -- the content of systematic reviews is largely the list of the papers getting reviewed.
So even though -- you know, and it is not at all difficult to determine in any language Appendix A is the list of studies included, you know, the list of studies in Appendix B are the studies that were not included. And those list of studies, you know, have English titles published in English journals and so on. And I'm very, very familiar with every one of those studies.
So they have produced, you know, what are entirely transparent lists of what was included and what was not included. This was not a dense text in which one needs a translation in order to

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identify subtle potential differences between how something was originally written versus described. The differences between what is included and what is not, what was determined to be useful versus not. And the result is very, very easy to determine.
And, as I say, the studies themselves are exactly the same studies that I'm very, very familiar with to begin with.
MR. RAMER: Chase, if you have a good breaking point, we've been going a little over an hour, but --
MR. STRANGIO: I think if it's okay with you both, I'd like to just finish up this section, and then we could even break for lunch around noon, or what are you thinking?
MR. RAMER: Over to Dr. Cantor, how he --
MR. STRANGIO: Yeah, are you --
THE WITNESS: That's fine with me.
MR. STRANGIO: Okay.
BY MR. STRANGIO:
Q So let's just take a step back. Finland has not cut off puberty blockers and hormone therapy for patients who had previously been receiving those interventions, have they?

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A To the best of my knowledge, Finland has grand-fathered people already receiving medical treatments, and that the ban is for additional cases.
They're attempting to stave off the -- or halt the flood of new cases for which it is not at all clear that the exist -- that the prior research applies to the new demographic and to the new phenomena that we're observing.
Q And for people prospectively seeking puberty blockers and hormone therapy for gender dysphoria, those interventions are available through clinical trials?
A Again, I don't think it's accurate to refer to -- the word access and the word treatment, you know, assumes that -- come with several assumptions that I don't think are valid. For example --
Q Well, I think I said interventions and available. Do you disagree with those formulations?
A Yes, for next-door neighbor kinds of reasons. That is it assumes a current situation that is allowed for, but is not assumed in the procedure itself -- policy itself. If, for example --
Q Let's pull up the Finnish policy, just so we are talking about the same thing.

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MR. STRANGIO: So that's Exhibit 7. Joel, you do that part; right? Thanks. Exhibit 7.
A Again, this looks ouija boardish from over here. You talk and magic happens.
Q Well, let's not go that far.
Is this the document that you're referring to from Finland?
A Yes, that looks like it.
Q Okay. And I just want to go first to -- so this is under the current care in Finland, "In clear cases of prepubertal onset of gender dysphoria that intensified during puberty, a referral can be made for an assessment by the research group at TAYS or HUS regarding the appropriateness for puberty suppression." Did I read that correctly?
MR. RAMER: Chase, can you zoom in a little bit?
MR. STRANGIO: Yeah, sorry about that.
A What you read was the content of that sentence, but interpreting what that sentence means requires a little more information -- well, chunks of significant information.
That text indicates that that would be the process and that they are leaving permission for that to happen, except they leave permission for

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that to happen. Missing from that sentence is that neither -- I'm saying this in a backwards kind of way -- they are limiting the permission to do that to those two hospitals. But when that sentence is isolated, it seems to suggest that, you know, those two hospitals are engaged in such research programs, and I don't believe they are.
It's, as I say, in the text of the policy it leaves permission for them to do that, but they have not set up the infrastructure to do it.
Also --
Q And you know that definitively?
A No, I don't know that --
MR. RAMER: Objection to form.
A -- definitively.
Q So they may have set up research program -- proto -- excuse me, they may have set up research groups at the two hospitals listed?
MR. RAMER: Objection to the form.
A Again, some things are getting left out there. You know, when this first came through, you know, the best of my understanding in conversations with these people was that there was no -- that there did not then exist such a situation. But as, you know, we've tripped over several times, these

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things are changing quickly. People are making plans, and I -- you know, the exact details of every policy are not what I follow.
So I necessarily need to leave room for the possibility that they have come up with one since the last time I happened to have heard from anybody there, but I -- they haven't received any kind -- I don't want to say they've received no publicity, they at least have not crossed my desk.
Also, in the establishment of their policy, you know, the intention of the policy is put it in place and then the government structure is move on.
If they conduct a study, find that, oh, it doesn't actually help these kids so we shouldn't do it anymore, the study wraps up and the rest of the ban remains in place. It leaves, again, in theory the opportunity for there being research, but it would not be fair to say that the situation is more limiting than it was meant to be.
They leave a loophole such that it can be used if it can lead to potential changes in the future, but none of those -- there's nothing in it that it assumes that it will be this everliving alternative way to receive medicalized transition services. It just gives permission as just in case, but there's

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no indication that -- no reason to interpret it either as permanent or as current.
Q So based on your understanding, those who had previously been receiving medicalized transition as adolescents can continue to receive it; is that right?
A So far as I know, they haven't cut off people already in a medicalized pipeline.
Q And that there is -- they have left open the possibility of future treatment through research. Is that fair?
MR. RAMER: Objection to the form.
A Again, for the same reasons as before, I hesitate to say treatment. They've left the door open through research, and then it will be open to the researchers, you know, whether to investigate whatever kind of interventions, changes, whether that counts as treatment, whether that cancels the type of treatment we're envisioning now is unknown.
Q And that's the same as in Sweden; correct? They have not -- in Sweden they have not cut off treatment for those who had previously been receiving medicalized transition, as you call it?
A That -- to the best of my knowledge, that's true, yes.

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Q And in Sweden they have left open the possibility that these interventions may be provided through research?
MR. RAMER: Objection to the form.
A Again, I would phrase it a different way, that they have -- that the regulation enables research. And then it's up to the researcher to know exactly what it entails, including the researchers not doing it at all.
Q Is it your view that there is no research in this area happening at all in Sweden at this moment?
MR. RAMER: Objection to the form.
A I don't recall there currently being such a study, no.
Q But you don't know?
A Again, I just reflexively leave myself some wiggle room in that these things are changing quickly, you know, they are of enormous interest. And I do not take for granted that, you know, in the very recent past that things have changed.
Q And you mentioned in our conversation Sweden, Finland and the UK, and then you also discuss France and Norway.
But France and Norway would not be examples of places that have, quote, outright bans on

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treatment; is that right?
A They have instead, you know, issued policy statements and advisories, you know, indicating their conclusion that medicalized transition is being overused too quickly, too often without sufficient consideration of less-risky alternatives, but they have not implemented -- they have not used the same policies strategies, I guess is the best term I can come up with, that the other countries have.
Again, I'm not a medical policy expert. And each of these countries, you know, is run different ways, and they have different tools available to them -- each of these governments has different tools available to them in the way that they regulate medicine, all of which are, you know, entirely unlike the American lack of government control over -- in the U.S. I hesitate to call it a medical system, it's more like a medical industry.
Q So these are all countries with medical systems that are fundamentally different from the U.S., you would say?
MR. RAMER: Objection.
A They have --
Q What was that?

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A Yes, each of these countries has an entirely public healthcare system, you know, very -- relative to which the U.S. remains a big international outlier.
Q Medicalized transition, as you call it, is available in France for adolescents?
A It has not reached the level of -- it has -- the documents they've released have not suggested the level of restriction that other countries have. But I don't know, and I don't recall any reports discussing what portions of that, you know, reflect, you know, local political interests or, as I say, the methods by which each of these countries controls -- manage is a better word, manage their healthcare system.
I don't know what the alternative strategies or controls the government had, how they get implemented or the extent to which they're issuing policy guidelines or advisories. You know, does that reflect a difference in their conclusion result of the science or just the political facility and speed with which they can produce such changes.
Q So based on your knowledge, neither France nor Norway have outright bans on either puberty blockers or hormone therapy for adolescents with

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gender dysphoria?
A It would be fair to say that current -- that although they have, you know, reversed course, you know, and they have scaled way back from the easy facilitation of medicalized transition, they haven't issued any language that suggests a yank as far back as strongly as the other countries have.
Q Well, I'm not asking for such a descriptive answer, just simply yes or no -- well, I'll say it this way, just is medicalized transition, as you call it, banned in either France or Norway?
A I'm not sure the question can be answered very accurately in just a yes or no, but I think it would be fair to say that the statements available are not as definitive as the ones in Scandinavia, for example.
Q Going back to the --
MR. RAMER: Hey, Chase --
MR. STRANGIO: Yes.
MR. RAMER: -- do you --
MR. STRANGIO: This will be my last question on this topic, and then I was thinking we could break for lunch.
MR. RAMER: Okay.
MR. STRANGIO: Yeah, sorry. I'm not going to

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take us down -- I'm not going through every country, I promise, John. I was going to pull up a map, actually, of the whole world, and we're just --

THE WITNESS: I was just going to say and now for Latvia.

MR. STRANGIO: Yeah. If we could just pull up what I have premarked as Exhibit 6.

BY MR. STRANGIO:

Q And before it comes up, Dr. Cantor, you reference in your discussion of the UK something called the interim report from Dr. Cass; is that right?

A Yes.

Q And this is a document that Dr. Cass put together that informed -- is this the document?

A Yes, it looks like it.

Q And what is this document?

A This was -- there were several documents that were released as a bulk. And I can't remember just from the particular date of this one exactly which one was which.

This was part of the series of reports and documents where she was indicating the basic results of the systematic review and the comparisons against -- comparisons of its

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conclusions of what the science said with their what was then current policy and why those policies needed substantial revision.

Q And then I just want to turn to page 9 here. And this is "A letter to children and young people" from presumably Dr. Cass. Is that a fair assessment?

A So far as I can -- so far as I know, yes. Oh, I should also add that I don't think it's fair to say that this is a document that she put together.

Q Fair enough.

A This was a very -- she was a leader of a very large, very substantial, very talented team. You know, she provided the leadership, and she was selected specifically because she was close enough to the material in order to understand the science, what was going on in the basic field, but not so close as to being a part of it and receiving money. You know, she wasn't making her living from it either.

Q Who is the -- who made up the team that she was leading?

A Oh, goodness, I couldn't name the particular people. I couldn't name the particular people.

Q You said it was a substantial team. How many

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people?

A Oh, that's a good question. I remember running across, you know, lists in which they were provided, but I -- these were not -- as I say, these aren't people who are regularly part of the sex research community where I would have run into them over the course of my career.

Q So you don't know exactly sitting here today the nature of the team that Dr. Cass led?

A No, that's not fair either. The nature of the team were people, you know, with expertise and background in assessment and public healthcare policy. They were, you know, people with the appropriate backgrounds in order to conduct the review. But I don't recall their names, and they're not -- I would have to go through the names to double-check. I don't think any of them was a sex researcher.

These are, you know, experts in medical outcomes and medical outcomes research and in its application to public healthcare policy.

Q And so, on this page here in this interim report authored by Dr. Cass, the second paragraph she writes, "I have heard that young service users are particularly worried that I will suggest that

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services should be reduced or stopped. I want to assure you that this is absolutely not the case - the reverse is true. I think that more services are needed for you, closer to where you live."

Is that correct? Did I read that correctly?

A That's the sentence that she wrote. But, again, in its context -- when removed from the context surrounding it, it would seem to be saying something other than what it seems to say when put back into that context.

I mean, you know, when isolated like that, you know, it almost sounds like she's saying that she wants to create more gender clinics so that people didn't all have to go to the same clinic in London. That's not what she was saying.

In the context of the fuller report and all the other changes, she was putting as diplomatically as a person can in such a polarized cultural situation that the services -- that they need more services, but not necessarily the exact kind of services that they were requesting. I'm even being ambiguous about this myself.

She wasn't saying that these people need more gender clinics, and we're going to put more gender clinics in more cities in order to facilitate your

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access to medicalized transition. She was recognizing that these people are, and they are, suffering from very substantial mental health issues that are getting unaddressed. Those are the services that she wanted to distribute, make more available. And she was recognizing that these people had great unmet needs, but that the --

Q So is it your -- finish. I'm sorry.

A But that medicalized transition was not necessarily the best, most-appropriate balance of the potential risks and potential benefits of the alternatives that were available to them.

So she wanted better access to services that would help the kids, but one can't isolate that sentence in order to say that she was taking for granted that the service that they needed was medicalized transition.

Q So is it your understanding that in England -- excuse me, is it your understanding that in England they are not expanding access to services including medical services outside of the central gender clinic?

MR. RAMER: Objection to the form.

A I'm not sure I'm following your question. When she says -- in general where she says services, she is

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referring broadly to mental health services and social services and help because these kids are in distress.

Q And excluding gender transition -- including medicalized transition services?

MR. RAMER: Objection to the form.

A Again, she's saying what she can say and leaving open possibilities acknowledging the large number of remaining unknowns. And that there are possibilities that things may change in the future as we get better evidence or if research produces something that we're not currently predicting.

So she's using carefully crafted language, in my judgment, to leave open the possibilities, but to not make particular promises or to lead anybody down a -- to mislead people down a particular path.

It is conceivable that, you know, future research may demonstrate that, okay, this is -- that this may indeed, at least for some number of these cases, perhaps that it would be possible that medicalized transition might be the best option, but we can't take that for granted.

What is very, very clear is that these kids are in genuine distress, and they're not receiving the supports they need for that distress. And

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although she didn't say it, the research is indicating that -- does suggest very, very strongly that these people are -- that very many of these youth are expecting that a physical gender transition would help them meet their psychological needs when it's not the best balance of potential risks and potential benefits -- risks and benefits for what they're aiming. So she --

Q She didn't say that, you're saying that?

A Correct. That would be -- that last part is my own assumption -- are my own words, you know. It is -- you know, what she said is consistent with it, but I can't say that that is exactly what she's saying.

I point out only that when take -- removed from the rest of the context around it, you know, it sounds like she's offering to expand medicalized transition, but that's not at all the full story.

MR. STRANGIO: I think we can go ahead and stop there. How long, John, and Dr. Cantor, do you want for lunch?

MR. RAMER: Over to Dr. Cantor.

THE WITNESS: Oh, I'm from New York. I can eat while talking.

MR. STRANGIO: I mean, same, but let's not do that for the sake of the court reporter, at least.

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So 40 minutes? Do you want to come back at ten of one Eastern Time?

MR. RAMER: 12:50 Eastern sounds good.

MR. STRANGIO: Okay. All right. See you then.

(The deposition was recessed for lunch.)

BY MR. STRANGIO:

Q So coming back to a conversation we started a while back, Doctor, just for the sake of this line of questioning, so you're not a pediatrician; is that right?

A Correct.

Q And you don't have any clinical expertise in the treatment of children?

A I don't know if it's fair to phrase it that way. I have no clinical experience in that I don't do the activity itself. But, of course, the effects on children and how it affects their development and their sexualities and so on I have a great deal of expertise in.

Q So you don't have any clinical experience in the treatment of children?

A Correct.

Q And limited clinical experience in the treatment of adolescents?

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MR. RAMER: Objection to form.
A Again, I don't know what limited means in the sense that, you know, it's -- most people have absolutely zero, and even a lot of the people who have experience with it have no experience in any other aspect of human sexuality and aren't able to perform a proper differential diagnosis.
Q But, generally speaking, in your clinical practice I think you said lasted -- or, excuse me, generally speaking in your clinical practice, approximately 5 percent of your patients were adolescents?
A Those numbers are correct, yes.
Q And do you have experience in pediatric research?
A Yes, in the same sense that I published papers regarding children -- the assessment of children, the effects of development over the course of childhood, or for that matter, you know, prenatal.
You know, I'm not a neonatologist, but by the same token brain development and what happens in the brain and during brain development even before birth is the very center of my background and expertise.
Q And that's -- you've published original research in that regard?
A I'm sorry, in which regard -- which of the --

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Q Excuse me, so you -- let me rephrase that.
Have you done any research trials in the area of pediatrics?
A What do you mean a research trial?
Q What does that mean to you?
A It doesn't mean anything to me.
Q So I don't know what a --
A Usually when somebody says trial they mean a clinical trial.
Q Have you done any clinical trials in pediatric research?
A No, I don't think so. Again, my hesitation is that -- just without scanning through my CV, just to make sure that there isn't one that I forget, as I say, you know, very often my involvement in projects is for the statistics or, you know, whatever technical piece that's relevant to the project that somebody on the team doesn't have.
My favorite analogy is with accounting. It doesn't matter if you're doing the books for one kind of an industry or the other kind of an industry. You know the accountant, and you know when the accountant is wrong. And it doesn't matter if they're selling cars or beef.
Q Got it. Have you reviewed the evidence base

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supporting clinical guidelines for pediatric conditions other than gender dysphoria?
MR. RAMER: Objection to the form.
A No, not that I recall.
Q So are you aware of whether other treatment protocols for pediatric conditions are supported by randomized controlled trials?
A Some are, some aren't. The question's a bit over-restricted in the sense that each of these questions requires several different aspects to be investigated at the same time and compared against each other.
Of course, the most relevant of those are the risk-to-benefit ratio, and in the large majority of investigations that are pertinent to children, you know, there are relatively few instances that are -- that make good comparisons to gender dysphoria when they have to be applied to children or when we're talking medical interventions specifically to adolescents, not prepubescence.
Q And are you aware as a general matter as to whether research is more limited in the area of pediatrics as compared with adult medicine?
MR. RAMER: Objection to the form.
A I've never undertaken such a comparison myself, but

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as a matter of, you know, how research -- how medical research is done, of course, I'm often involved in investigating or reviewing grants and a wide range of different topics.
It would be an error to isolate research on adolescents and interpret it in -- it would be an error to interpret the number of studies conducted with adolescents as opposed to, you know, age 18 and up or, you know, age of majority in whatever given state and jurisdiction, because very, very many illnesses are age linked. Young people have fewer diseases than older people.
So the priority is often, on average, lower for children than adults, because on average they're healthier, you know, they haven't had the long-term effects of whatever situation they're in, whether it's smoking, obesity and so on.
That isn't to say zero, and that isn't to say if you're young you're healthy, it's just that the difference of the people who suffer ill health, the young people are necessarily un -- less is a better word, less represented. So one has to be careful in not accidentally asserting a pattern that isn't associated with -- we can't take anything for granted.

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Q And are you aware of whether there are randomized controlled trials supporting medical treatment for precocious puberty?
A I don't think that there have been randomized trials for it, but it's not a fair comparison. But it wouldn't be fair to compare precocious puberty and puberty blockers for precocious puberty with the use of those same drugs for gender dysphoria.
Q Well, I'm not asking about gender dysphoria. I'm just saying just as to precocious puberty. There are -- you're not aware of any randomized controlled trials preventing medical treatments for precocious puberty?
A I haven't conducted a search for them.
Q So you're not aware of any?
A Not offhand, no.
Q What about randomized controlled trials supporting medical treatment for congenital adrenal hyperplasia?
MR. RAMER: Objection to the form.
A No, I can't think of randomized -- I can't think of a placebo-controlled randomized study. I would have to search to see if there have been randomized studies comparing different kinds of medicalized treatments with each other.

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Q But you're not aware of any offhand?
A No, not offhand.
Q Do you have any reason to know -- actually, let me rephrase that.
Do you know if pediatric conditions frequently have the type of evidence supporting treatment as available evidence for treatment of gender dysphoria?
MR. RAMER: Objection to the form.
A Again, that's not really a meaningful comparison, because there are very few issues that have the same risk-to-benefit ratio. And the great majority of disorders, especially with youth, we're talking about, you know, objectively diagnosed.
You can take a blood test and you either have it or you don't. It isn't a matter of, well, we'll talk about it and kind of decide and the child is telling you what their diagnosis is. So there are really very few like apples-versus-apples comparisons that can be made.
So if you just kind of add up how many are there, again, the result is misleading, because the population of related disorders are so small to begin with.
Q Well, let's take CAH, congenital adrenal

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hyperplasia, and just the medical intervention of -- surgical interventions on the genitals to make them conform to a more typical female genital presentation.
Are you aware of any data supporting the use of that surgical technique on infants with congenital adrenal hyperplasia?
MR. RAMER: Objection to the form.
A I'm sorry, am I aware of any --
Q Data on the efficacy of that surgical technique on treatment of infants with congenital adrenal hyperplasia?
MR. RAMER: Same objection.
A Not on mental health effects. There have been some case studies on, you know, the physiological outcomes, for whatever they're worth.
You know, does the cosmetic end point match up with generic surgical success, I'm not aware of such studies for mental health effects.
Q But it's possible, then, that that intervention causes harmful mental health effects on individuals with congenital adrenal hyperplasia. Is that true?
MR. RAMER: Objection to the form.
A It's certainly a fair hypothesis. In fact, there have been case studies, I don't remember if it's

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the name of the patient or the name of the author of the book, John Colapinto, who examined, you know a series of, you know, interventions that were done with children in order to make their physiology, you know, better match whatever -- oh, that was it. I'm thinking of the Reimer case. It wasn't a CAH. Never mind.
Q So you don't know of any data studying the mental health outcomes of surgical interventions on intersex -- sorry, excuse me, on infants with CAH?
A Not quantitative studies, no. There have been, you know, single case studies of people, you know, describing individual people, but not on -- not anything to which one would apply any statistics.
Q Do you have concerns about the impact of that surgical intervention on infants with congenital adrenal hyperplasia --
MR. RAMER: Objection to the form. Sorry.
MR. STRANGIO: No, no. Sorry, that was not a good question. I'll rephrase.
BY MR. STRANGIO:
Q Do you have any scientific objections to the nature of the evidence base supporting the surgical interventions on infants with congenital adrenal hyperplasia?

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MR. RAMER: Objection to the form. Beyond the scope.
A The question's kind of -- has a foot in science, and a foot in, you know, the related research ethics. And where it's properly science versus not is a legitimate conversation.
I have concerns in the usual medical and clinical research concern that intervening puts us in a position of responsibility, especially when we're talking about, you know, surgical interventions.
In all of medicine and medical researches -- I don't want to say it in Latin, because I'll mispronounce it -- but we're not going to -- we are bound not to do anything until we have very good evidence of its outcome.
So intervening surgically or medically at all should be withheld until we have, you know, solid objective evidence to demonstrate benefit.
So, again, I'm kind of -- you know, that's kind of scientific and kind of not. But I have concerns in that, you know, people were intervening medically and surgically without having a sufficient scientific research basis for dramatic intervention at all.

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Q But the law in this case explicitly exempts from prohibition those kinds of surgical interventions on infants with CAH. Are you aware of that?
A Yes. But, of course, you know, my purpose and testimony isn't about the law. It's about the nature of science, what the science says. And how any organization wants to implement it is up to them. I don't mean either to attack or defend any statute.
Q But you didn't weigh in as to the scientific base supporting those exempted interventions in this case?
A I didn't intervene at all. I --
Q I said weigh in.
A -- do have -- not exactly sure what the difference is. But, again, for a specific statute, I haven't said anything.
The only caveat I need to add is that it's very possible, although I don't have a specific recollection, it's very, very plausible that I would have spoken publicly about the application, again, of medical interventions in situations like the John Colapinto book about John Reimer -- Dan Reimer, John Reimer -- David Reimer, that was it -- about medically intervene -- about engaging in

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medical interventions without first having objective evidence about its risk-to-benefit ratio.
Q So I'm going to pull us to, just if you want to pull it up on your paper copy, page 46, paragraph 106 of your declaration, which is Exhibit 1.
A Got it.
Q Maybe I should have had that. Okay. And this is at the bottom of the page, from 46 to 47. You write, "Biologically, the sex of an individual (for humans and almost all animal species) as male or female is irrevocably determined at the moment it is conceived. Terms such as 'assign' obfuscate rather than clarify the objective evidence."
Did I read that correctly?
A That's the content of the sentence, yes.
Q What about infants with intersex traits?
A What about it?
Q Would this sentence apply to them?
A Yes. However, there's subtle and profound -- or there's a distinction that can be both subtle and profound, you know, in how people are using the word sex, especially in this context and in today's context, about what it means as a definition of sex and in what ways, you know, exceptions can and should be made.

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There are relatively few characteristics for which there don't exist, again, details, atypicalities for which not everything can be taken for granted, but they do not -- but these are often examples that prove rather than disprove the rule.
Q So what is the definition of sex that you're using here?
A That is exactly one of those profound and subtle -- distinctions that are both profound and subtle. In the context of gender dysphoria, it's a mistake to be saying that there is a definition of and that's that.
And then with people picking either chromosomes or hormones or, you know, subjective experiences, sex itself in science would be -- let me say this a different way. People are confusing definitions with construct validity.
In mathematics, we have a definition, and it will apply to the definition of the real numbers is the definition of the real numbers and there are no exceptions.
In science, we have what's called construct validity. There's -- although we will use the word fact, there is no such thing as a fact. We only have the best explanation we have for the

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observations we've made. And it remains eternally possible for some future exception to be made, and we just haven't seen it yet. There is no such thing as settled science as popular as the phrase has become.

Sex is not like defining a real number versus irrational number versus an imaginary number for which there exists no exceptions. Sex is, again, in science or in statistics what we would -- what is the overlap amongst each of the pieces, including all of chromosomes and genetics and so on, all of which overlap and match the great, great, great majority of the time.

Sex is that overlap, not the individual ingredients that are put into the very -- the overlap. So the identification of exceptions do not break the rule.

In most situations, you know, at birth visual inspection of the genitals is, you know, a perfectly convenient, if I can use that term, way to go about, you know, identifying the sex of the kid, because it matches up with all of the other features in the great, great, great majority of instances.

But phrases such as the one that I was talking

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about here assigned at birth, well, if the mother got a sonogram when she was six months pregnant, she knew what the sex of the kid was going to be in the great, great, great majority of cases months before the birth happened.

So, as I say, but that -- so the presence of exceptions in a long complicated chain of events going from conception, and in some cases even before conception for some, you know, chemical interactions with the mother's body, you know, through life experiences, you know, some of them chemical, some of them biological, some of them social, again, these are a large, large complicated set of interrelated factors which are irrelevant in the great majority of the time, but we only have an issue when there is some exception.

So then we need to look more deeply into the situation in order to decide what, if anything, would be the most helpful to the person in question. But as I say, these are all questions about construct validity. And, you know, if I ask a person what a house is, they can give me, you know, a rough idea that will fit in the great, great majority of the time. But then we can ask, you know, "Well, is this an exception? Does this

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cave count as a house? Does this hut count as a house? Does a hotel that you're living in" -- I'm just making these up. And one can come up with, well, there can be certain exceptions to certain pieces of it, but what makes the house the house is the consistent overlap of each of these characteristics. But that there can be an exception to one of the useful rules of thumb that we use does not mean the overall concept -- that the entire structure itself is wrong.

Q Well, I'm not asking if it was right or wrong. And I think in some sense maybe you're trying to respond to why I'm asking, not what I asked, because I am just focused on these words in your declaration, "The sex of an individual as male or female."

What did you mean by "The sex of an individual as male or female"?

A The overlapping set of -- again, because of the context in which I wrote the sentence, it isn't so easy to just lift the sentence out from the others.

By the sex of the individual, I mean the overall set of characteristics, you know, ranging from and including, you know, the multiple biological features which are mostly -- again, it's

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the exceptions that are hitting my head -- that are mostly determined at the point of conception and the chromosomal combination.

Q Mostly, but not always determined at the point of conception?

MR. RAMER: Objection to form.

A I wouldn't say always. Again, I'm leaving room for there are certain, you know, chemical interactions between the chromosomes, the mother's body, the potential zygote and so on which can influence what's going on biologically. They're rarely of interest to very many circumstances, situations, but they exist.

Q And so, coming back to your previous discussion, you would say that overall sex is a set of -- sorry, the overlapping set of characteristics, including multiple biological factors?

MR. RAMER: Objection to the form.

A Close. I would say it is the overlap --

Q Okay.

A -- amongst those biological features.

Q And what are those biological features?

A I don't know if they can be enumerated in full, but the primary ones are, of course, chromosomes, hormones. And biology, I'll say, from the neck

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down, you know, morphological form. And then neuroanatomy, anatomy from the neck up.
Q And all of those biological features are part of sex?
A Again, to say part of is to insinuate or the word kind of involves a way by which they go together. The best way I have -- I'm avoiding a mathematical term, factor analysis, but it is the overlap itself that forms the construct.
Science and biology don't work like mathematics or law where you can write a definition and then make all of your decisions based on that definition and expect the result to be correct. That's not how science works.
We give a best guess, and then we have to check to see if we were correct by making -- you know, designing a clever experiment to see if something might be an exception. And we remain tentative, because there remains always, at least in theory, the possibility of something being different.
Q Then in paragraph 107 regarding gender identity, you write, "In science, a valid construct must be both objectively measurable and falsifiable with objective testing."

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Did I read that right, correctly?
A Yes.
Q What did you mean by that?
A Well, again, I was pitting it specifically against trying to define or describe a concept according to something that is none of, that doesn't fit -- well, specifically against claims of an inner sense.
In science, there is no such thing as an inner sense. The purpose of science was to replace concepts based merely upon one's -- it's even more ephemeral than inner sense, it's what one says is their inner sense.
Q In medicine, though, there are phenomena that are not objectively measurable beyond patient report; right?
MR. RAMER: Objection to the form.
A Yes and no. There exists situations where when it's low cost, consistent with other measures which are objective and for which there are no major risks, a convenient way to identify it could be through something relatively subjective.
For example, you know, pain receptors in the brain, fine and important and very relevant for certain kind of research, but at the same time if

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there aren't enormous social pressures and enormous risks, we don't need to send to a brain scan everybody who comes in saying, "Doctor, my hand hurts."
If, however, there are other situations where, you know -- there also exists situations like phantom limb pain. Now all of a sudden we're looking at an exceptional circumstance and we can't take for granted what the person says their individual experience is.
So just saying that there exists exceptions, again, we can't from that say -- those exceptions don't disprove any such rule. There is a balance of risks and benefits.
If it's low cost and pretty low risk, then we can afford, we have the luxury of just going along with the subjective self-report. If, however, we're talking about something -- if that subjective self-report is now in contradiction with the objective available data, now we have a question. We can't so easily take for granted the accuracy of that subjective self-report.
Q But subjective self-report is often the basis for some medical interventions; is that correct?
MR. RAMER: Objection to the form.

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A They exist in certain circumstances, which as I say are when they're low risk and not in conflict with objective information we do have.
Q Do you think gender identity is real?
MR. RAMER: Objection to the form.
A That's a pretty philosophical question, if not outright Cartesian. Different people, of course, use that phrase, you know, to mean many different things in many different circumstances.
So there are different senses in which that, you know, can be a useful descriptor, but only partially accurate. And there are situations in which, you know, people completely either misuse the term or misidentify their own experiences by application of the term because they don't have a better term. They haven't been exposed to a better term, or they're under some kind of social or other pressure to use that term or use another term, for that matter.
So whether it exists really depends on what a person means and in what context.
Q Do you mean -- excuse me, do you use the term gender identity?
A The words will come out of my mouth in -- if we're in a context where what I'm trying to say is --

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will be well understood. If one is asking, you know, very detailed questions or very specific questions, then I'll use terms that, you know, more precisely and more accurately capture what a person is trying to say in using the phrase gender identity. It's even more --

Q What are some of those terms that people might -- that you think would be -- that would more accurately capture what people are trying to say?

A Oh, it depends on whatever it is I can infer about what they're trying to say, again, by the context of it. Very many people use the word, for example, to mean -- to assert their belief that they would be happier in a different social role if people treated them in a different way.

And the only -- and so they use the word gender identity, because it's now such a ubiquitous term. And in many parts of society, a lot of people feel pressure to just nod their heads and say uh-huh, even though they're not sure what it is exactly that they mean. And both of them are working from a series of assumptions, and each one is completely miscommunicating.

Again, with my scientific hat on, that's not an acceptable situation. That's not how

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information can, you know, be assessed or self-corrected, and we can't help each -- we can't help people that way. In fact --

Q How would -- excuse me. Go ahead, you can finish.

A In doing -- probably one of the most common questions in doing any kind of therapy with anything is, "What do you mean by that?" A person says whatever emotion it is, or they feel whatever emotion they're feeling about, you know, their mother, their brother, their significant other, whoever it is, "What do you mean you hate love?" Like/dislike are confused by, and it's the what are the criteria that led you to use whatever word or concept is the important part.

There are so many social, political and emotional pressures influencing gender issues now that, again, the term itself -- so many people are using the term in so many different ways, the term itself is not useful. People are using it for its cachet as much sometimes, if not more, for its accuracy.

Q So let's say -- how would you describe someone who 40 years ago, as a natal boy, let's say, said, "I am certain that I am a girl."

What is that -- what would you describe that

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certainty of being a girl?

MR. RAMER: Objection to the form.

A Again, there are a couple of things embedded in that. It's that, you know, if a child says it, you know, a child being certain is not reflective of a child being certain, you know. Very often children phrase things, you know, in dichotomous or simplified ways, you know, just as part of their not yet having developed more subtle understandings of them.

They will often assert things strongly because they feel emotionally strongly about them, so they use terms that are strong, even though that doesn't reflect actual certainty or evidence.

It's an almost ubiquitous experience for gay men to say that they -- or including myself even in this particular one -- to have memories or feelings of not being a boy or I'm a girl on the inside. But even though they will have used those terms, it's not an accurate perception. It's a use of the only vocabulary that they have available to them with a child's perception and experience of it.

Q What about an adult, 30 years ago none of the same social political context of now, who is a natal male asserts understanding or certainty of one's

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self as female?

MR. RAMER: Objection to the form.

A I'm almost self-conscious about I don't have to project I was there and listening to these people and in a -- you know, working in a clinic helping adults, you know, with gender dysphoria exactly to transition. And we had exactly this conversation, but not quite 30 years, closer to 25. And that's not how they described it. That's one of the flags that's -- you know, that increases my, you know, critical thinking ear, if I can mix my metaphors.

25 years ago, people felt -- at least the ones that I was encountering, people felt comfortable admitting to their doubt and uncertainty and "I'm not so sure, and I want to try this out and see how it goes."

Where the people coming into clinics now are -- the expression -- I'm losing the expression, are reporting to the test. They're -- you know, they think they know the right answer. And if they express doubt, then they won't be permitted to transition, so they don't express doubt. Or flip side that, you know, they're afraid that whatever services will be changed if they start describing, you know, I feel depressed or whatever negative

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emotions, so they don't tell the clinician.
So people today are describing in much more dichotomous, black-and-white terms things that to those of us who have been in this field for a while recognize as different. People were willing to express their doubt a generation ago, and they're not now.
Q What are you basing that on, your assertion about what's happening when people present themselves to clinics today?
MR. RAMER: Objection to the form.
A It's a combination of my own experiences, the reports of clinicians on both sides of the issues, those who, you know, basically see things, you know, with a critical eye that I apply, as well as clinicians who do not, you know, they also describe, you know, very, very dichotomous reports from their patients.
But there's a huge generational divide. The clinicians I should -- the large, large majority of clinicians, even calling themselves advocates and activists, are all very young. They didn't experience these clinics, these patients, these populations, these problems, these difficulties before the social media age.

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This is all they know. They didn't notice a difference. So far as they're concerned, things have always been like this, and this is a permanent situation. It's only the people who have been working in this field over a longer period of time who are able to look back at it and say, this doesn't match the evidence. These are not the people on whom we gathered that evidence.
The situations that suggest that, again, for the adults for whom this was a good idea, this is a different profile of what we were seeing before. And the research we gathered on that prior group does not automatically translate to the group that we're seeing now.
Q You said your experience with patients presenting to clinics, but you aren't currently seeing patients in clinics, are you?
A I'm not seeing the patients directly, no. Usually these would be either individual people coming to me, other clinicians coming to me to consult on whatever cases that they're seeing, the public discussions amongst, you know, groups fall along the spectrum. I should use a better term than spectrum, it's getting overused.
Q What clinicians have been coming to you to express

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this?
A I'm not sure what you mean by what clinicians. Are you asking for names?
Q Yeah.
A I don't know if I'm comfortable giving particular names. Usually these would be clinicians, again, from all over the world, you know, the U.S., Canada, Europe, asking for input or a contrast or observations that they have known -- that they have noticed with subsets of their patients whose stories are different, or they don't know how to interpret the story because the models they used to use don't seem to be fitting. They're not getting feedback from their clients in the same way the clients they used to see.
And, of course, you know, the clinicians and other sex researchers, you know, at a sex research and sex therapy clinic -- sex therapy conference that I'm a regular member of -- again, these are, you know, to me -- I've been going to these, I'll say it again, 25 years, you know, and these are common conversations among them. I feel like I need to add a caveat to that, too.
Conversations have also become -- I don't know if quieter is the right term. People now are

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almost ironically less comfortable now talking about it than it used to be. When gender identity and sexual orientation were more stigmatized, you know, height of the HIV era, clinicians and scientists would pride themselves on resisting the social stigma in order to talk about the issues. The mantra of those days was silence equals death.
It's reversed today. People now are often -- I shouldn't say moderates, the middle 80 percent are less comfortable discussing the issue, because people want to ask questions where they feel there is a vagary or uncertainty. But they've seen so many examples, and there exists -- again, since the onset of social media especially -- so many examples of where people are getting pilloried not merely -- not because they said what somebody thinks is the wrong thing, but for saying, basically, that they agree, but not strongly enough that they're leaving out another opportunity to be still more extreme.
Q What's an example of that?
A I can really only talk about them in a family of examples where somebody will talk about a point about a particular study. Actually, Twitter probably is the best example, because --

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Q So you're referring to things that happened on Twitter, not in medical communities?
A They --
MR. RAMER: Objection to the form.
A The situations don't divide quite so easily. It's because I'm, you know, a well-known member of that professional community that many of my Twitter conversations or Twitter threads are with other people that I know, again, from conferences, experts and the same background.
So it's not the same kind of a conversation that, you know, a member of the lay public would have --
Q Let me ask you this --
A -- with another, you know, stranger member of the lay public. These would be two professionals and experts in a topic having a conversation mediated by Twitter, but it's not the same as just two random nonexperts having a conversation.
Q Well, when you say -- when you referenced the examples of being pilloried, is that on Twitter?
A It includes Twitter. And because the nature of the medium allows for it, you know, happens like -- they happen louder and more often. But, no, these kinds of examples happen in every venue in which

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sex researchers have conversations.
Q Do you have examples from outside Twitter of this happening?
A Yes. Again, just about any conversation -- any social gathering -- social gatherings, for example, the social hours at conferences where usually, you know, it's at the end of the day, you know, whatever cocktail somebody is holding as people are just chatting and catching up since, you know, we're all old friends to each other -- most of us are old friends, you know, and then new batches of students and so on. But the conversations are now followed by who's listening. People are looking over their shoulders. People are adding phrases and caveats to their conversations that didn't used to be there.
Two specific examples come to mind. Again, I'm running through my head, because I don't want to, you know, be inappropriately naming other people in the context where they wouldn't have me do. Both of these happen to involve Ken Zucker by coincidence.
One would be a talk that he was giving at the Society for Sex Therapy and Research, SSTAR. And it was, you know, very much like other talks that

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Ken Zucker gives describing -- you know, sometimes he's giving talks about specific research that he was doing at the time on gender-dysphoric kids and their development.
And then, you know, when he was involved in the DSM, you know, many of his talks were about the ongoing negotiations in the formation of the clinical criteria for the DSM-5 this was. But rather than just raise their hand or disagree and have a conversation, the conversation was how dare you say whatever it is that the person disagreed with. Unlike not very many years before, you know, it wasn't agree to disagree, it wasn't even just disagree. It was if all I have to do is declare myself offended and now you're not allowed to say it, which was anathema to sex research, sex research is what it is exactly because of sex researchers who were willing to say things that were unpopular amongst whatever other groups.
Q But Dr. Zucker was the one giving the presentation in this example?
A Yes.
Q So he was speaking?
A Yes.
Q And you're describing the reaction of someone in

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the audience?
A Yes, interrupting it, and essentially the word cancellation hadn't yet existed, but were so upset that they didn't think that he should be allowed to complete his thought discussion, or said another way, other people didn't have the right to hear it.
Q When was this?
A Early 2010s.
Q And your other examples that you can think of are in social hours and conferences and on Twitter?
A Those are, of course, much more common, because those, you know, kinds of conversations are, you know, so very much more common than an annual conference.
And the other one -- specific one involving him, again, was at a conference -- that I was at a conference. I'm trying to remember the name of the researcher who did it. Again, Ken Zucker was giving a presentation. She had just finished hers and happened to have been sitting right behind me. And she was at full voice, you know, continuing to talk to herself, essentially, saying what she'd like -- well, didn't like about his conversation, until I finally turned around, you know, "Do you mind, you know, he's talking?"

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To which her response was, "Oh, I don't need to hear that."
Q So coming back to your --
A I couldn't --
Q -- declaration, just to ground us there. You write in some sections about social transition in prepubertal children.
What is your understanding of what social transition is?
A I hesitate to say my understanding is -- I hesitate to say my understanding in that my understanding is that, you know, many people use that phrase to say many different things.
So step number one is find out, you know, what it is the person I'm communicating with is trying to say even before we know if we're agreeing or disagreeing over any particular point.
So my understanding is the range of different definitions and applications people use. And then if we're actually going to do any kind of research or assert any kind of meaningful fact, we start with, well, in this circumstance what do me and whoever it is that I'm talking to or I and whatever author of the paper I'm reading, how is it being used in this instance so we can be talking about

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the concept -- the relevant concept.
Q So you don't have a singular definition of social transition that you use?
A I don't think it's -- I don't think anyone could say that there exists a singular definition.
Q And if you use it at various points in your declaration, is that based on how it's used in other places that you're referencing?
A Again, I would have to look through each time I mentioned it, but I, as a matter of habit, try to either make it explicit how I'm using it or make explicit -- if I'm addressing somebody else's comment, then I do my best to make sure that it's clear that, you know, I'm using that person's definition or I'm addressing whatever that person's conceptualization is.
Q And in your table of contents here pulled up on the screen, which I think it's IX.B.1, you have a section on what in the table of contents is, "Eleven cohort studies followed children not permitted social transition, all showing the majority to desist feeling gender dysphoric upon follow-up after puberty."
A Yep.
Q What does social transition refer to there?

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A There I was referring to Olson's study, recently out of California, which was the one exception among -- well, I shouldn't say exception among, exception in addition to that 11. Hers was the one study that followed kids who had already begun living as the other gender when they came into her clinic.
So when she reported her results of relatively few of these kids having desisted by puberty, exactly the opposite as the first -- as the prior 11, then, of course, I needed to cleave that, you know, there was an important difference between her one study and the other 11. That difference was, again using her words, I'm pretty sure, that they had socially transitioned.
So in that context, the meaning was, you know, that the relevant definition was the one that made the sample she was reporting on so distinct from the others, from the other studies.
Q Well, you describe all the others as following children who were not permitted social transition. So presumably there has to be a definition that applies to those 11 to know that children were not permitted to social transition.
MR. RAMER: Objection to the form.

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A Again, that's not a definition. These were studies, you know, that predated the existence of the term. So the studies themselves didn't say these kids were not permitted to transition socially. These were studies that did what the studies did.
And so, here we are, you know, sometimes decades later trying to summarize in an understandable, accurate, but still pithy -- pithy's not the right word -- succinct or concise way to capture what is it that made, you know, these 11 different from that one.
And the, you know, most applicable, shortest, easily -- hardest to misunderstand phrase would be social transition. But those papers didn't use that term at all, but they're meaningfully described with that term.
Q So what does it mean that they're meaningfully described with that term, since you're the one who applied that term to these 11 cohort studies?
A Oh, I think anybody reading the studies, the methods, the contents of them would very immediately come to the same conclusion that I did.
As I say, I'm not asserting that there was a specific definition with a set of criteria that

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says fit or not fit. There really is no overlap between what the set of 11 did and what Olson's recent one did.

It was an active part or it was an explicit part of the original 11 studies where the kids were not permitted to crossdress and adopt new names. They were, you know, encouraged to be as comfortable as possible in their biological selves, which is in -- which is exactly opposite to what Olson did, which was to let the kids -- I don't think it would be fair to say encourage, but -- indulge probably isn't the right word either, but the way she, basically, described it is that, you know, the kids came in very often already living socially as the other sex.

So because this was, you know, such a large, large difference between the original 11, we're not in a situation where subtle differences in wording or definition would change. You know, maybe one of these two 11 really were more like Olson -- the Olson study, the people -- the treatments, the therapies that kids who were coming into Olson's study were night and day different from the treatments being received by the first 11.

Q So the first 11 you have on this page 51; is that

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correct? This table?

A That sounds right. Just seeing what you have up there, that looks right, yes.

Q And seven of those were from the 1970s and '80s?

A Yes. As I say, this was ubiquitous, I would say since the '70s. It would be an error to say that all studies are old and, therefore, wrong.

Q I'm just not asking you to say whether they're old or not. I'm just asking a factual matter whether seven of them were published in the 1970s and the 1980s?

A That looks right, yes.

MR. STRANGIO: I'm happy -- I can keep going. It is an hour now if you want to take five.

MR. RAMER: Yeah, why don't we take five.

MR. STRANGIO: Okay.

(A recess was taken.)

BY MR. STRANGIO:

Q So I'm going to fill in this exhibit, which is one -- I'm going to take us to another section. So we're in -- here on paragraph 135, page 59 of your declaration, Doctor. It's at the bottom of the page discussing what you're referring to as adolescent childhood -- sorry, "Adolescent-Onset --

A Yep.

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Q -- Gender Dysphoria." And so, you write, "This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD)," citing to Littman 2018.

Did I read that correctly?

A Yes, that sounds correct.

Q And rapid-onset gender dysphoria is not a recognized diagnosis; is that right?

A Not in a diagnostic manual itself, but that shouldn't be interpreted to mean that the phenomenon doesn't exist.

Q And the paper that you cite, Littman 2018, was corrected as you note; right?

A There was a change to it, but nothing that meaningfully altered any of its actual conclusions.

Q On footnote 5 you reference, "After initial criticism, the publishing journal conducted a reassessment of the article. The article was expanded with additional detail and republished. The relevant results were unchanged."

Is that a correct reading of the footnote there?

A Yes.

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MR. STRANGIO: If we could, Joel, pull up Exhibit 8.

Q Does this appear to be the notice of republication of the Littman 2018 article?

A It appears to be, yes.

Q And at the top it says -- and I can zoom in so we can look more closely -- "After publication of this article" -- sorry, do you see where it begins that?

A Yes.

Q And then going down to the next paragraph -- oh, sorry. Under the second part of this corrected republication, there's a heading that reads, "Emphasis that this is a study of parental observations which serves to develop hypotheses."

Do you see that?

A Yes.

Q And then here at the top, about four lines down, "Rapid-onset gender dysphoria, (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."

Did I read that correctly?

A That's what that text says, but it's very difficult for a person to know what that means and what it

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doesn't mean without having a better idea of how, you know, science publishing works.
Q Well, so you noted that there was correction to the article, but did not reference that ROGD is not a formal mental health diagnosis.
Why didn't you mention that?
MR. RAMER: Objection to the form.
A It's not pertinent to the decision or question -- to the decision -- to the clinical question and the pertinent decisions that followed from it.
In the situation, the whole point of the current difficulty is that the profiles of the people coming to clinics and expressing profound often discontent that they do not match what is in the existing manuals and on which our existing knowledge base sits, that's the point.
Whether this new profile of person is better helped and better served by ROGD as a diagnosis unto itself, or if they actually are suffering other kinds of problems but we're just noticing the ROGD part of it because it's what they're saying on its face value, or if, you know, the previously -- you know, the well-characterized distinction between the adult-onset gender dysphoria -- and adult-onset gender dysphoria, if this is now just a

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new way of expressing one of those, well, we need to know that in order to know what to do with these kids. That this new presentation is not in the, in this case DSM is usually what people are referring to, that's the whole point.
This is new and we don't know what to do with it. Therefore, the medically and clinically appropriate thing to do is nothing until we have a better idea of what the potentials are, the risks and benefits are.
When we're talking the removal of healthy functioning tissue, that's a method of last resort until we've exhausted the other alternatives which don't involve as much potential harm.
If, you know, after we've exhausted the other possibilities and realize, yeah, this really is the best balance of the potential risks and benefits, okay, let's go ahead. But that entire set of questions was skipped.
We don't know if this is an independent phenomenon, a new subset of an old phenomenon, and if it is which phenomenon. These are people coming in, you know, in great emotional distress. Okay, but that doesn't mean that it's automatically what it is that they're saying out loud. We can't take

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for granted that they're like one of the other forms of gender dysphoria.
Q But in this paper, they're not saying it out loud; right? It's their parents?
A Oh, in studies of youth that is -- that's very common. That is -- as I say, it's difficult to interpret that sentence once lifted out of, you know, the rest of how this research is done. Interviewing parents and caregivers and so on is a very, very routine method of studying minors.
Q Exclusively interviewing parents and not the minors themselves is routine?
MR. RAMER: Objection to the form.
A For one particular study, absolutely. It's when asking a question, you know, it is exquisitely, exquisitely rare for any one study to be -- to answer -- you know, to answer any question.
Usually what we need, and the only way we know that we're on the correct path that we have the correct answer is when several different researchers working independently using different kinds of methods keep coming to the same result over and over. That's when we can be confident.
So in any research investigating or that's the pursuit of any question including this one, we need

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studies that talk to the kids, that talk to the parents, that talk to their psychologists, that talk to the physicians and other studies that don't talk to a person at all and stick to objective measures, you know, of whatever is appropriate to the question.
So this one particular study was the one that interviewed parents. It is neither the beginning nor the end. Is it one piece of the puzzle and an important piece when we need, you know, and it goes in the pattern of all the others.
So it's that, you know, contribution one piece at a time, yes, that is absolutely a routine method for investigations studying minors.
MR. STRANGIO: If we could go back, Joel, to Exhibit 1. Sorry, Joel, did you hear that, Exhibit 1? Thanks.
BY MR. STRANGIO:
Q Okay. Still on paragraph 135, you write after reference to the Littman article, "The patterns" -- and this, let me -- I can zoom in for you, although I think you have this in front of you, Doctor.
"The patterns reported by Littman have now been independently replicated by another study which also found it to be a predominantly female

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phenomenon, associated with very high rates of social media use, among youth with other mental health issues, and in association with peers expressing gender dysphoria issues." Citation to Diaz 2023.
A Yes.
Q Is that right?
A That reading of the text is correct, yes.
Q And if we can pull up -- well, let's see if we can do this without pulling up the exhibit for the sake of our limited technological skills.
Are you aware of changes to the Diaz article subsequent to publication?
A Yes, I am.
Q And you're aware that the second author of the publication, Michael Bailey, has since made public that the paper has been retracted?
A Yes. Of course, I need to add the caveat that arm of the drama happened after I submitted this. So it wasn't -- you know, I didn't have that knowledge when I wrote and submitted it. But, yes, I know that that's happened in the interim.
Q So the article that you cite further the prop -- the article that you cite for the proposition that the patterns reported by Littman have now been

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independently replicated was retracted?
A Again, there are some nuances in that. There are some nuances in that. The paper wasn't -- the basis of the retraction of the paper, which is itself now a means of enormous controversy, was not actually about whether the contents were accurate. No one has, you know, presented any demonstration that the results that they reported were incorrect.
So to the extent that one is actually seeking the truth in that if one wants to know what's going on, as best as we could tell with these kids, you know, the conclusions they came to are perfectly valid and, again, exactly the same. They, you know, completely independently come to the same conclusion as the Littman paper.
To the best of my knowledge, the nature of the controversy, I guess I can call it, which led to the formal retraction was -- oh, goodness -- was the database was pre-existing. The nature of the data were already collected by the time -- I guess it was Bailey became involved.
And in research ethics, there are different criteria that they use for pre-existing databases versus, you know, actively going and recruiting people in order to participate in a study or

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whatever.
The way that these data came, it was ambiguous. There are, you know, different groups that have different policies and different principles for, you know, under what circumstances should people have undergone how thorough of an informed-consent process.
In this particular one, the relevant guidelines would be those of the publisher itself, Springer who publishes the journal that this was printed in.
The policy of Springer is that it was up to the discretion of the editor in chief. And the editor in chief which said that, yep, nope, fine with him.
However, after the publication of the article, you know, the nature of it and that people didn't like the conclusions that it came to started a -- what I can only call a campaign to have it declared unethical, because they don't think that the editor's discretion was what they wanted it to be.
So, again, that became, you know, whatever pressures. And then it goes, you know, behind closed doors, and I don't know what's going on. And then the publisher ultimately decided to --

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that the paper should be officially retracted. But there were never any allegations, and there were never any conclusions that the content or the conclusions themselves were in error.
So whether that should be -- so does that count or does that not count? It's hard for me to come to any conclusion that people are going to accept or reject the contents of that paper according to whether they accept or reject its implications. The content of the paper, however, has not been in question.
Q But just as a factual matter, in this paragraph one of the papers was corrected and one was retracted?
A I don't think -- such a characterization, again, just kind of insinuates a situation that is the opposite of the truth.
The correction -- again, in general publishing a correction is the formal name of a post-publication change. It is -- you know, but in the context where people are, you know, liking or disliking a finding, the word correction is getting used to imply that one of the conclusions was wrong or something in it was incorrect, which is not the case.
The content that was changed to Littman was

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adding detail. None of the conclusions changed, no errors in it were found. It's the decision was, well, add the necessary detail in order to demonstrate that nothing was skipped because this particular audience isn't going to take anything for granted.

So she added the detail, but the nature of editorial publishing is that such changes are called correction. So, again, to just take that sentence out is to -- is easily mistaken as an assertion that something was incorrect.

Same with the Diaz paper. To call it a retraction without the, you know, details of what led to the retraction is to insinuate or to kind of, you know, leave a reader or listener the impression that there was something wrong, that there was an error in the conclusions of the paper, and so its conclusions ought not to be given any weight.

That's not the case. The conclusions were never in question, and nobody's changed any of the conclusion -- nobody's asked for any changes to the conclusions or demonstrated that there was an error.

People have been -- there were people who were

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upset and protesting about -- well, again, their motivations are, you know, pretty -- are relatively clear, but the content -- the rule that was being contested was the method and amount of disclosure, you know, of the people who participated in the study. But there was never any question in the accuracy of the study itself.

Q Is your view that it was only retracted because of external pressures?

MR. RAMER: Objection to the form.

A I haven't seen any evidence, and I haven't -- I don't think I've heard any accusations otherwise.

Q So you think that the journal just retracted it because of external pressures, not concerns about the informed consent as --

A The journal didn't retract it. The publisher did.

Q Excuse me, the publisher retracted it out of concerns about a lack of informed consent, that was not a true reason?

MR. RAMER: Objection to the form.

A I don't think the situation breaks down quite that way. And it's essentially what the publisher themselves said. They indicated that they were receiving those kinds of communications. There was -- I'd have to go back and read the original

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letter they sent. The policy that they have, you know, it was entirely explicit that it was left up to editor's discretion. So essentially they as publisher overturned the editor's use of that discretion.

Again, I don't think any of that is ambiguous. And I'm not aware of anyone anywhere in that pipeline -- at least the parts, you know, to which I'm privy, I've not seen any communications or evidence or discussion otherwise.

Q Going to page 62 -- uh-oh, what have I done? So beginning on page 62 of your declaration, you distinguish between suicide and suicidality; is that right?

A Yeah, again, I hesitate to say that, you know, I distinguish. I'm just, you know, orienting people to the proper uses of the vocabulary. So people who are, you know, not psychologists, you know, reading this don't accidentally mistake one to mean the other, which, again, especially in this context very many groups are actively doing.

Q So, I mean, in essence you note that they're distinct clinical phenomena; is that right?

A I know that these are distinct phenomena, yes.

Q You note, sorry. I know that you know that. You

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note?

A Oh, I note that, yes.

Q I don't actually know, so --

A And perfectly legitimately, the public doesn't. That's not their job. You know, this isn't the kind of stuff that people discuss. And that's what leads so many people to misunderstand the content of these studies, especially when things are being lifted out of context.

So in order to understand the context of these studies, you know, I have to start out with, as I say I do, here are the definitions. Here's how I'm going to use them. If you read these other, here's how they use them. Which one we use, I don't care, but as long as we're all using the same one, we can have a productive conversation.

Q And so, understanding they're distinct clinical phenomena, you would agree that both should be clinically addressed?

MR. RAMER: Objection.

A Oh, yes, absolutely.

Q And that reducing suicide and reducing suicidality are both positive outcomes?

A Yes, absolutely. The difficulty that society comes to is that it is exactly because it is part of

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these being such different phenomena that the way to deal with them effectively is very different. So --
Q Understood.
A -- not merely a matter of -- you know, using suicide when we mean suicidality, that's not merely, you know, exaggerating. It's failing to help get the right kind of help to the right group of people. And so, you're disadvantaging them both. And everybody's harmed or failed to be helped.
Q In paragraph 142, and this is on page 63, you write, "Social media voices today loudly advocate 'hormones-on-demand' while issuing hyperbolic warnings that teens will commit suicide unless this is not granted."
Did I read that correctly?
A Yes, that's the content of my sentence.
Q What are hormones-on-demand?
A With minimal assessment consideration of alternatives, it's removing whatever safeguard one can find an excuse to remove.
This is another one of the differences that have changed over time, which is relatively apparent to those of us who have been in this field

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for long periods of time and have watched the removal of safeguards as opposed to people who have recently come into the field and are only aware of the current status and don't realize that this is a change.
So people are often referring to, you know, history's long-standing criteria. No, the current criteria are not long-standing at all. These are brand-new and untested.
The subset of studies which suggest success use the relatively high standards that used to be in place at that time. Today people have removed the real-life testing requiring months, years in some cases, of psychotherapy and expect still to get the same results.
Q There's no citation on this sentence about hormones-on-demand; right?
A Correct. And that's also why I put it in quotes. I'm using it as a general description to capture the basic idea of what's going on.
Q So that's not based on any specific practice?
MR. RAMER: Objection to the form.
A No, that's not true either. It's the -- you know, the term itself is, you know, my own expression in order to describe the situation. But the situation

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that I'm describing is, you know, quite concretely real.
As I say, it's the -- I'm referring very specifically to the removal of the safeguards that were in place when the available data were first gathered. And the reason why, that just because we're -- that after removing those safeguards and after removing the assessment procedures and so on, that expecting different -- expecting the same result after changing the -- after removing those safeguards is what makes the current situation an experiment, you know, without the knowledge of the experimentees.
And I use the word hormones-on-demand to refer to situations where -- and to clinicians who believe that asking for hormones or medicalized transition services is sufficient, and from that point forward, the clinician's predominant duty, now with only very rare exceptions, to find ways to provide them. Rather than to accept it as one of the possibilities, let's try the less potentially risky ones first.
Q And what -- who are the social media voices?
A Oh, again, the ones whom I happen to run into regularly. There's certainly no shortage of them,

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only because his name is forefront of my mind for the moment, would be, for example, Jack Turban.
Q So you would consider Jack Turban to be a social media voice?
A Yes, I think it would be fair to describe him that way. I don't want to be unfair to him either. I wouldn't say he's limited to being a social media voice.
Q So you mean clinicians on social media?
A I would include clinicians on social media.
Q And you think that non-clinicians on social media are relevant to your assessment of current clinical practice?
MR. RAMER: Objection to the form.
A No, I wouldn't say that either. How I use that phrase, and how I would still use that phrase, really, is that that is the medium through which one would run into, you know, such voices. I mean, if one is looking to find, you know, how these ideas are getting communicated, they're largely getting communicated through social media.
It is hard to avoid the observation that it was the onset of social media that changed, you know, the public perception and treatment, including professional treatment, of gender

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dysphoria is one of very many, very profound changes that all started with identical timelines. Among them is this sudden and exquisitely rapid, literally exponential increase in rates of mostly adolescents, mostly biological female reporting gender dysphoria.

It's unfortunate, it is not helping that generation at all. Gender dysphoria -- or that enormous exponential increase in gender dysphoria is only one of several dysphorias, all of which have exponentially been increasing since the onset of social media.

Q What are the other dysphorias?

A The other major ones are reports of depressions, anxieties and, again, suicidality.

Q On page 91, paragraph 204 -- Joel never should have given me control of this.

A Would it be inappropriate for me to say, oh, this sounds like a significant other kind of a comment?

Q Okay. 204. Here, Doctor, you are talking about sterilization without proven fertility preservation options. You write, "Clinical guidelines for the medical transition of gender among children include the need to caution and counsel patients and parents about what are euphemistically called

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'options for fertility preservation.'" And then you cite the Endocrine Society Guidelines.

Is that -- did I read that correctly?

A That's that one sentence, yes.

Q Shouldn't clinicians counsel patients about options for fertility preservation?

MR. RAMER: Objection to the form.

A Again, that's why I'm pointing it or was trying to emphasize that what I'm pointing out is that they're doing that euphemistically, where the term they're using is sterilization, which is essentially guaranteed for somebody who goes from puberty -- or halted puberty with puberty blockers to cross-sex hormones.

The very phrase "fertility preservation" works under the assumption that you were fertile in the first place. And the sequence of blocking puberty and taking prepubertal gonads and putting them on cross-sex hormones is the prevention of ever-developing fertility. It's not preservation.

That's an adopting of the term -- adoption of a term if, for example, a man with testicular cancer is going to undergo chemotherapy, which, again, would, you know, interfere with, if not outright destroy, his ability to produce viable

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sperm. That would be a person who is fertile, and we are trying to maintain, we're trying to preserve his fertility. To say that --

Q So I understand that. This is a reference to the clinical guidelines for medical transition generally.

So taking aside puberty blockers, there are fertility preservation options for persons who undergo hormone therapy, are there not?

MR. RAMER: Objection to the form.

A Again, that to me is why I referred to this as you've -- as a euphemism. There exists a range of interventions and a range of their harms.

To pick the mildest phrase which describes the mildest harm, and then generalize that to apply to the entire range where the controversy is at the other extreme where there is again sterilizing these children, you know, we end up with a situation where the terminology is being used in accordance with the person's political or other views rather than my automatic preference as a scientist make the word -- make the phrase precise and accurate.

And fertility preservation is amongst the terms that is, again, being a euphemism and not

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accurately describing the risks and potential harms in a way that would allow for a legitimate and meaningful calculation of the risk-to-benefit ratio.

Q But you don't think that counseling a patient that there are no options for fertility preservation in some instances, and then counseling a different patient that there are some options for fertility preservation in other instances is an appropriate way to describe a range of medical intervention?

MR. RAMER: Objection to the form.

A I haven't seen a document that does that. I don't believe the Henbury policy did that. It consisted only of the use of the mildest terms.

I also think it's an error to use, again, an all-encompassing term like patient. We are talking a prepubescent child and having an adult conversation about whether they want to have children. That conversation is not comparable in any meaningful way to a 30-year-old adult male, with in this example testicular cancer, who is able to come to an adult brain decision over children, not children, the potential for his own future fertility.

Asking a prepubescent that is using a global

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all-encompassing term like patient is another example of obscuring the most, you know, severe and dramatic of these situations using exactly the same term that we should use, you know, in describing the most mild of the range of issues and the risk-to-benefit ratio.

Q In that paragraph you write, "The decision to undergo medicalized transition also represents the decision never to have biological children of one's own."

Do you think that might be the most extreme interpretation of a range of potential outcomes?

MR. RAMER: Objection to the form.

A Oh, again, the same. When somebody is giving one extreme, I'm pointing that out to -- you know, I'm red flagging it by pointing out the missing part of the extreme, which requires me to name the missing part of the extreme. The whole point is that this is a wide range.

Q But someone who, say, undergoes a double mastectomy can still have biological children of one's own?

MR. RAMER: Objection to form.

A The situation, at least in theory, can exist. But there are no reliable numbers, I think either in the U.S. or Europe, about the proportions and

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overlap of, in your example biological women, undergoing mastectomy versus cross-sex hormones versus puberty suppression.

Of course, you know, sterility and decisions about the sterility being made by a prepubescent brain comes from people who are on puberty blockers pretty much as puberty starts and then going on to cross-sex hormones.

Q So you're describing a subset of the people who undergo medicalized transition in this sentence?

MR. RAMER: Objection to the form.

A Hang on, I was still stuck on the prior part. Again, the sterility is for people who are on puberty blockers followed by cross-sex hormones.

A biological female put on puberty blockers and then put on cross-sex hormones doesn't develop the breasts for which a double mastectomy would be required in the first place.

Q So, I'm sorry, your phrase undergoing a medicalized transition only refers to people who go from puberty blockers to gender-affirming hormones?

MR. RAMER: Objection to the form.

A I didn't mean my sentence to be a complete review of, you know, several different potential combinations of the several different variables.

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Again, my purpose was to demonstrate that it is inappropriate to the point of misleading for a professional medical society of all groups to use only the mildest and most euphemistic of language ignoring -- again, in a document meant for physicians, not meant for the patients themselves, describing, you know, only the most optimistic balance of risk-to-benefit ratio as opposed to recognizing the full range of varying situations.

And, again, in the case specifically of the Endocrine Society statement, in complete absence of the consideration -- I shouldn't say complete absence, but at the same time as failing to integrate the large number of complete unknowns and still unexplored alternatives before we get to the most dramatic of the options.

Q I'm just trying to understand this sentence that you wrote --

A I'm sorry.

Q -- which is, "The decision to undergo medicalized transition also represents the decision never to have biological children of one's own."

In that sentence, medicalized transition only refers to patients who go from puberty blockers to hormone therapy; is that right?

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MR. RAMER: Objection to form.

A No, my one sentence cannot be considered on its own without the other sentences that I purposefully put it together with.

Q So you're not willing to say -- you're not willing to accept that someone who only undergoes a mastectomy, for example, could still have biological children of their own?

MR. RAMER: Objection to the form.

A In its context, my sentence doesn't contest that. I'm filling in the missing pieces. So the one sentence taking out just, you know, ends up leaving different pieces missing. It takes the whole set of them where I'm pointing out, you know, the pieces of the puzzle are missing. So I'm alerting the reader to the missing pieces.

Well, it's true that I am not alerting people to the not missing pieces. I only need to alert people to the missing pieces.

So the one sentence on its own is what, in my view, is one of the missing pieces. There's no purpose to that sentence to point out the pieces that were already there to begin with.

Q Do you think that testosterone impairs fertility for every natal female who takes it?

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A For everyone? No. The most -- the powerful effect, the essentially sterilizing issue happens with the combination -- that happens from the combination essentially applying cross-sex hormones to gonads that still have prepubertal cells.
Q Got it.
A So the automatic sterilization goes from the -- goes to people who essentially were going from puberty blockers to cross-sex hormones without time in between to develop adult quality viable gonad tissue, that I don't remember if it was in this report, but it was exactly that error for which I was faulting several of the other experts, as they report, you know, some of the relatively mild side effects of one or the relatively mild side effects of the other where the actual danger is in the combination, and nobody mentions the combination.
Q Understood. Earlier you were talking about prepubertal children making these decisions about fertility, but in the United States it's their parents consenting to treatment; right?
MR. RAMER: Objection to form.
A I don't think -- that doesn't really describe the full sentence. It's not like the parents are deciding -- the parents aren't talking with each

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other should we have grandchildren. The parents are trying to figure out, you know, what would help, you know, increase the mood or discomfort of the profound unhappiness of their child.
And so, from their point of view, they're doing their best to do what they think their kid wants or what they imagine their kid would want or will have wanted when the kid is later an adult and looking back on the whole thing.
So the parents generally are trying to guess what the kid would want is -- what the kids would want. It's also, I think, unfair to describe the parents' decision-making process as consent as if it's a cognitive process, when the consent is in the legal meaning they are providing on paper what we deem to be consent. But it's a misleading use of the term to equate legal consent with making the kid's decision for the kid, when the basis of what the parent's legal decision is going to be is their best guess for what they think the kid would want if the kid were an adult, which the kid isn't.
Q And that's the nature of pediatric medicine as a general matter?
MR. RAMER: Objection to form.
A This isn't like pediatric medicine as a general

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matter. That's the whole problem. In pediatric medicine in general, we have objective evidence of an objective process for which we can give -- I'm making this part up -- a blood test to verify that the kid has -- you know, to use a usual example, whatever intersex condition.
This is exactly the opposite condition. We have zero objective evidence, only subjective self-report from a prepubescent kid which conflicts entirely with all of the available objective evidence. That is entirely unlike the rest of the pediatric medicine -- or that is entirely unlike, if I can talk in italics, the process of general pediatric medicine.
Q On page 109 --
A I'm there. Speak of the devil.
Q Okay. So this is in paragraph 259. You write of Dr. Turban, "Dr. Turban's employment as director of a gender program in child and adolescent psychiatry represents a significant conflict of interest: The income he derives from his medical treatment of these children would be directly affected by the outcome of this case."
Did I read that correctly?
A Those are the sentence -- that's the sentence I

Page 173

wrote, yes.
Q And Dr. Turban is a psychiatrist; correct?
A Yes, so far as I know.
Q And he is employed in a child and adolescent psychiatry program?
A Yes. Is it up to a year yet? Recently, but, yes.
Q But you maintain that his income is derived from endocrine treatments?
A Did I say endocrine?
Q You said his medical treatment. I don't know what you're referring to there.
A I meant it relatively broadly. It's -- again, I don't know details about how the specific hospital works. But the usual procedure, and I don't recall him ever pointing out an exception, is to engage in these procedures as a multidisciplinary team.
As a psychiatrist, he would ultimately be responsible for the mental health assessment or lack of mental health assessments used in deciding who would go on to endocrinological treatments. And the endocrinologist would be responsible then for ensuring the physical ability of the child to respond to the medications as desired, but not the decision whether to.
Q Do you think that everyone who works in a

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multidisciplinary gender clinic has a conflict of interest in these cases?
MR. RAMER: Objection to the form.
A I don't see any way around the idea that when the legality of providing a service is in question that there is a conflict of interest for the people providing that service.
Q Well, Dr. Turban doesn't provide any of the services directly that are the subject of the Indiana law; right?
MR. RAMER: Objection to the form.
A I don't know what director would -- I don't know what you mean by direct. If one is in charge of -- I don't mean to equate the situations, but if one is the manager of a McDonald's, just because you're not serving the hamburgers doesn't mean that you are not affected if they shut down the whole restaurant.
Q So if they ban puberty blockers and hormones and surgery, it's your view that not only are the endocrinologists and the surgeons conflicted -- possessing a conflict of interest, but the psychiatrists are as well?
MR. RAMER: Objection to the form.
A Yes, everybody involved in the provision of the

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service. And if the -- to the extent that the provision of the service is multidisciplinary, and he is the doctor -- he is the director directing the entire process, he is ultimately responsible for it.
And it would be that entire -- it would be the entire service he is directing that would be switching to the other use of the term directly influenced by regulations and findings that limit or ban or restrict the provision of that very service.
Q So is it just the directors of the program or every physician who works at a gender program?
MR. RAMER: Objection to the form.
A I don't think I necessarily need to allow for the possibility that there could be an exceptional situation that doesn't immediately come to mind, but to -- it's I can't think of a situation in which one can be a specialist in providing a specialized service that -- for which one would not be in a conflict of interest if that service is prevented.
The only exceptions, and I'm not even sure they count as exceptions, depending on -- again, in different hospitals in the U.S. is the

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international outlier in this again, there can be, or I can imagine there existing a situation in which, for example, a nurse is simply assigned a department. And if one department is restructured or canceled, then he, she, or they are reassigned to another clinic so that it's, you know, relatively invisible to them, I can imagine the possibility for certain circumstances like that.
I cannot imagine such a situation from the person -- from a person legitimately holding the title director.
Q Do you believe that the physicians who treat patients at gender clinics would not have jobs if puberty blockers and gender-affirming hormones were banned?
A I would be surprised certainly if they became unemployed. But, again -- but they would be, you know, in any meaningful way highly impacted.
Q They couldn't practice other aspects of their specialties?
MR. RAMER: Objection to the form.
A They would be forced to. As I say, they would be impacted, but I would be surprised if they ended up unemployed.
Q So their income wouldn't necessarily be impacted?

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MR. RAMER: Objection to the form.
A I don't think that fairly describes the situation. It's -- I don't think that fairly describes the situation, no.
Having one's means of income being required, you know, against one's will to have to change what one does for a living in order to maintain one's income represents a significant conflict of interest.
Q So based on that, are the only legitimate experts those who do not treat adolescents with gender dysphoria?
A That's --
MR. RAMER: Objection to form.
A That's a different question. And as I enumerated within my report, it is a standard procedure in producing a systematic review in order to get people who do not have a direct interest in the outcome of it.
And that's exactly how Vivienne Cass in the UK was chosen. And that's how all of the other groups in all of the other countries were selected. To pick an odd example, if one wanted to know if reading fortune tea leaves were scientifically valid, you could not do it by asking only the

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fortune tea leaf readers.
One needs to be able to -- in order to be without a conflict of interest, one needs to be one step further away than receiving income from the provision of the service in question.
Q So you believe Dr. Turban is biased because you think his compensation is tied to a certain clinical outcome?
MR. RAMER: Objection to the form.
A I don't think I said biased. I'm, you know, acknowledging he's in a conflict of interest. The nature --
Q So you -- okay. Go ahead. Sorry.
A The nature of his writings suggest that, you know, he has very, very strong beliefs about the situation. But, again, the term bias is for me to engage in some mind reading that I'd hesitate to. It is perfectly legitimate, and it's a matter of, you know, objective evidence to indicate that this is a legitimate conflict of interest.
Bias is more cognitive -- is a more cognitive situation, which is, I think, a legitimate accusation, but I couldn't say that I have an objective means of demonstrating it unlike conflict of interest.

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Q So you think that compensation can have an improper influence on a clinician's perspective?
MR. RAMER: Objection to the form.
A That's not a reference to the proper audience. The people who are in need of protection, and the people who are meant to be protected by conflict-of-interest principles are not the providers of the service, but the recipients of the service.
Q What are conflict-of-interest principles?
A Oh, I don't mean them -- as I said, I mean them generically. If I were going to receive, you know, any medical service, I expect of the institutions, whether it's government or medical boards depending on one's jurisdiction, that if I'm going to be receiving what I expect to be evidence-based medicine, I expect that evidence to be evaluated by people other than the person actually providing me the service.
If I knew that the only person reviewing my provider was my provider, I would be in a very different situation of confidence in making my own healthcare decisions than if a person at arm's length were in charge of reviewing the procedures my provider provides.

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Q Do you think being paid by an advocacy organization might have an improper influence on a clinician's opinion?
MR. RAMER: Objection to the form.
A I can imagine situations where it would, and I can imagine situations where it wouldn't. So I wouldn't automatically -- it would be a legitimate conclusion, but it doesn't have the automatic people provided -- the quality of service provision or the -- tenability's not the word. The safety and effectiveness of providing a service has to be conducted by people at arm's length from it.
If one is at a -- is in a position where one is advocating a particular view, then it's completely transparent that one is, you know, of that view or advocating for whatever that situation is.
That's entirely unlike healthcare where one is expected to be -- expected and depended upon to be entirely objective, but it's not -- the expectations and the people who were meant to be protected by it are of a different kind.
Q Were you aware that Indiana's expert, Daniel Weiss, testified before multiple state legislatures in favor of laws like SEA 480?

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MR. RAMER: Objection to the form.
A I'm not even sure who that is.
Q And that he was compensated by Do No Harm for that testimony?
MR. RAMER: Objection to the form.
A Same, I don't think I know who that is.
Q Is that a conflict of interest to testify before a state legislature regarding a law and be compensated by an advocacy organization?
MR. RAMER: Objection to the form.
A I'm still missing a piece. I don't know who or what it is that we're talking about.
Q Well, I don't think you even have to know who he is. He's one of Indiana's experts in this case, an endocrinologist. But he testified regarding a law like SEA 480, and for that testimony was compensated by Do No Harm, an advocacy organization.
I'm just trying to understand under your framework for conflict of interest, would that be one?
MR. RAMER: Objection to the form.
A No, I don't think so. Acting in a political capacity advocating for a political view doesn't have the same expectations of neutrality as would a

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physician -- as a patient coming to a physician expecting to receive objective feedback and advice from the physician.

In a governmental situation, there will -- there would generally be people advocating on one side, people advocating on the other side. And the influence of whatever money for whatever decision it is, is almost, I don't know how cynical -- one could be -- it would be perfectly fair to be cynical. But that is not the same decision-making process or position of vulnerability that a patient has in expecting the advice they get from their own doctors to be.

Q So is the conflict of interest you describe with respect to Dr. Turban about a conflict of interest with his patients, not as an expert in this case?

MR. RAMER: Objection to the form.

A The conflict I'm referring to is the combination of them.

Q Page 124 --

MR. RAMER: Hey, Chase, we've been going for --

MR. STRANGIO: So the question I have is, I'm close to the end. Do you want to sort of go 20 more and try to wrap it up, or do you want to take

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a break and then finish? We can take a break, I can check in with my side, and then we'll just finish up after the break?

MR. RAMER: I'd appreciate the break.

MR. STRANGIO: Yeah, yeah, yeah, let's do it. Let's do it. I was trying to get us done, but understood.

MR. RAMER: No, I appreciate that, too.

MR. STRANGIO: Yeah, it's fine. It's fine. Five minutes?

MR. RAMER: Works for me.

Doctor?

THE WITNESS: Okay. See you in five.

(A recess was taken.)

BY MR. STRANGIO:

Q Okay. I'm on page 124, paragraph 299 regarding Dr. Shumer, you write, "Despite his use of dramatic terms, Dr. Shumer is not a mental health expert qualified to assess mental health outcomes, and he cites no evidence to justify any predictions of suicidality or other predictions of outcomes."

Did I read that correctly?

A Yes.

Q Do medical doctors not typically assess their patient's mental health?

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A Not in the manner -- not in that manner, no. Again, not -- they're generally, unless they have specific training, again, specifically for assessment of such mental health concerns, it tends to be limited to what a brief screening and standardized questions of, in general, things to be on the lookout for. But that's not the context or situation that he's describing or -- that he's describing period -- semicolon. Nor is it the basis for predicting what future situations that do not currently exist will bring, you know, on the basis of no evidence whatsoever.

Q And in the previous paragraph you write, "Dr. Shumer's report provides a highly misleading discussion of the risks of GnRH agonists and cross-sex hormones."

Did I read that correctly?

A Yes.

Q And are you an endocrinologist qualified to make assessments of the risks of GnRH agonists and cross-sex hormones?

MR. RAMER: Objection to the form.

A That statement doesn't require an endocrinological background.

Q Do you use social media?

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A A little bit.

Q Twitter as we've been discussing?

A Yeah, I try to keep it to roughly, you know, a tweet or two a day. Usually I'm working on something else and it occurs to me, oh, people would be interested to hear that and I'll post it, or there's a precious pithy thing that, ooh, that kind of crystallizes it, so I'll release that.

Q And is your handle @JamesCantorPhD?

A Yes, that's correct.

MR. STRANGIO: Can we pull up what's marked as Exhibit 11.

BY MR. STRANGIO:

Q On February 23 of this year, do you recall tweeting, "The only ones who crave affirmation more than trans teens are their doctors"?

A I recall that tweet, yes.

Q What did you mean by that?

A The interactions that I've had with them, with the ones who in turn discuss or refuse to discuss the relevant issues on social media are unlike the healthcare providers I interact with in any other aspect of human sexuality and unlike the scientists I interact with on any other issue. There's much, much less discussion of the content and much, much

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more discussion of how it's going to look.
Q And when you're talking about the interactions, you're talking about interactions on social media?
A Not just. Of course, you know, it is exactly because the bar for entry into social media is so low that, you know, the proportion of the publicly available statements, it takes up so much more than it. But, no, it's not limited to social media.
Q Do you think that doctors who treat transgender adolescents are doing so for reasons other than concern for their patients?
MR. RAMER: Objection to the form.
A As happy as I am to call out what I think is an unhealthy influence of one's personal characteristics in one's professional practice, I wouldn't dichotomize it either.
I would not say as a general rule that -- I do believe, or I have every reason to believe, that they genuinely believe that they are helping, but the set of cases, situations, willingness to take on risks, willingness to disagree with a popular idea in the face of evidence suggests that there is, as I say, an unhealthy or disproportionate balance of the several inputs and motivations to behavior.

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And, again, I don't mean to isolate people involved with this issue versus rest of world so much as I've been involved with very many, you know, controversial issues. That's not only the nature of sex research, but it's the nature above all the other branches, even of sex research, it's much more a part of the study and of atypical sexualities.
So relative to other care providers and other scientists involved with providing professional care to people with other atypical sexualities, the cluster of personalities, the type of conversations that are had and not had, the unwillingness to respond to the most legitimate, even published criticisms, this group of people are unlike those working in any other area of atypical sexuality.
Q And what is -- who is this group of people?
MR. RAMER: Objection to the form.
A People publicly advocating. I really want to say extremists, I think I want -- I have a hard time finding a different word than extremists, but people with an un -- with a disproportionate conviction of what they're doing is correct without having balanced it against the enormous number of unknown potential alternatives -- or potential

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alternatives.
Q And is that description one that you would apply to all doctors that treat trans teens?
MR. RAMER: Objection to the form.
A No, I would automatically hesitate to -- I would automatically -- I would reflexively refuse to --
Q What about would you apply that description to most doctors that treat trans teens?
MR. RAMER: Objection to the form.
A I don't think there's a meaningful way -- no, I would have to couch it more than that. Again, I'm speaking, you know, on social media referring to the other people involved in the discussion on social media. And today, more than ever, the number of people that -- I think I was making this point earlier, that people with relatively moderate or relatively balanced or nuanced perspectives are silencing themselves for fear of being attacked by either extremists on one side or extremists on the other side for not being far enough to that given extreme.
So it's because they've self-silenced. Again, outside of the people who were speaking publicly, and I mean to be speaking of the people who are speaking publicly, I would not reflexively

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generalize that to people who are keeping quiet -- publicly quiet.
Q Including those people who are keeping quiet publicly and continuing to treat adolescents with gender dysphoria with medical interventions?
MR. RAMER: Objection to the form.
A Well, again, the continuing to treat is to assume that there was a baseline against which to compare them that doesn't exist. This really wasn't getting done in the way and by the numbers of people and without the supervision or tracking or external review that --
Q I wasn't referring to the temporal in the way you're responding. I just meant someone who's currently prescribing, let's say, gender-affirming hormone therapy to adolescents but isn't speaking publicly on the matter.
Would this tweet apply to them?
MR. RAMER: Objection to the form.
A No. Again, I pretty much mean it to be people who were speaking -- other people who were participating in the same forum.
Q And so, when you refer to extremists, are extremists those who support the provision of hormone therapy to adolescents with gender

dysphoria?
MR. RAMER: Objection to the form.
A Not necessarily. There are -- what's missing are the people who merely support. There are very -- there are few speakers who merely support.
The people I would call extremists would be those for whom there exists no alternative. There is that -- the person asked for it has sufficient basis to do everything you can to make sure that they get it. Rather than cover bases, let's try other things first. Let's not start with the most dramatic of alternatives. Let's skip all of the many unknowns and we're not so sures and use it as a method of first resort. And any resistance is immediately dismissed as politically anathema rather than we're not so sure, let's be more careful until we can be more sure.
Q Is the Endocrine Society Clinical Practice Guideline on treatment of gender dysphoria with respect to adolescents an extremist's position?
MR. RAMER: Objection to the form.
A I don't have an objective way to differentiate extremists from going farther than it should relative to the quality of evidence available.
Q Have you treated any of the individual plaintiffs

in this case?
A No, I have not.
Q Have you ever practiced as a clinical psychologist in Indiana?
A No, I have not.
Q And do you have any personal knowledge of how treatment for gender dysphoria is provided to adolescents in Indiana?
A Not in any direct way. Again, the nature of my expertise is not the specifics of the policy or the patients involved, but on the science according to which the legal system and legislatures are attempting to establish policy.
MR. STRANGIO: Just one sec. I'm going to --I don't have anything else on my end.
THE WITNESS: That was a fast 20 minutes.
MR. STRANGIO: So I'll pass -- it was slightly less. I'll pass the witness.
MR. RAMER: And I have no questions for the witness. And we'd just like to review and sign.
AND FURTHER THE DEPONENT SAITH NOT.

_____
JAMES M. CANTOR, PH.D.

STATE OF INDIANA)
) SS:
COUNTY OF BOONE)
I, Dana S. Miller, RPR, CRR, a Notary Public in and for the County of Boone, State of Indiana at large, do hereby certify that JAMES M. CANTOR, PH.D., the deponent herein, was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in above-captioned cause.
That the foregoing deposition was taken on behalf of the Plaintiffs, appearing remotely from Toronto, Canada, on the 7th day of June, 2023, pursuant to the Applicable Rules.
That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction, and that the typewritten transcript is a true record of the testimony given by said deponent; and thereafter presented to said deponent for his/her signature;
That the parties were represented by their aforementioned counsel;
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of either party, or otherwise interested in the event of this action, and am not in the employ of the attorneys for either party.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 2023.

_____
Dana S. Miller

Commission Number 0675790
My Commission Expires:
January 17, 2024

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NOTICE OF DEPOSITION FILING
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION
CASE NO. 1:23-cv-00595-JPH-KMB

K.C., et al.,)
)
Plaintiffs,)
)
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendants.)

In compliance with the Indiana Rules of Procedure, Federal Rules of Civil Procedure and/or the Rules of the Industrial Board, you are notified that the signed original deposition of JAMES M. CANTOR, PH.D., taken on the 7th day of June, 2023, has been sealed and submitted to the originating party, along with the attached Errata Sheet(s), if applicable.

(Date received by Circle City Reporting)

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MS. EAGAN: No, Your Honor.

THE COURT: All right. State's case.

MR. DAVIS: Your Honor, the State calls Dr. James Cantor when you are ready.

10:39:28 THE COURT: I'm ready.

JAMES CANTOR, MD,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

10:39:46 BY MR. DAVIS:

Q Good morning, Dr. Cantor.

A Good morning.

Q Would you state your full name?

A James Michael Cantor.

10:40:02 Q What is your profession, Dr. Cantor?

A I am a clinical psychologist and neuroscientist.

Q What degrees do you have? Academic degrees.

A Bachelor's degree in computer science and mathematics, a master's degree in applied psychology, and a Ph.D in clinical

10:40:17 psychology.

Q Where do you work?

A I am currently in private practice in Toronto, Canada.

Q And what is the nature -- are there any particular focuses of the counseling you provide or the research that you have

10:40:32 performed?

A Human sexuality and atypical sexualities.
Q Would that include studies of gender identity?
A Yes, it is. Yes, it does.
Q Are you knowledgeable about the research surrounding gender dysphoria?
10:40:47
A Yes, I am.
Q Have you analyzed research concerning the benefits and harms of different ways of treating gender dysphoria?
A Yes, I have.
10:40:54
Q Do you have skills and expertise assessing the strengths and weaknesses of scientific studies?
A Yes, I do.
Q And do these skills and expertise include judging what those studies do and do not prove as a matter of science?
10:41:13
A Yes.
Q Have you treated people who presented with gender dysphoria?
A Yes.

MR. DAVIS: Your Honor, we proffer Dr. Cantor as an
10:41:25
expert on psychology, human sexuality, research methodology, and the state of the research literature on gender dysphoria and its treatment.

THE COURT: Any objection?

MS. EAGAN: No, Your Honor.

10:41:37
THE COURT: All right. He will be accepted for that

purpose.
BY MR. DAVIS:
Q Dr. Cantor, there is a notebook in front of you with a blue cover. Would you please turn to the second tab?
10:41:51 A I'm sorry. It just occurs to me I didn't bring my reading glasses. They're in my brief case.
MR. DAVIS: Your Honor, can the witness get his glasses?
THE COURT: Absolutely.
10:42:43 THE WITNESS: Part 2, you said?
BY MR. DAVIS:
Q Yes. Tab 2, which is Defendants' Exhibit 2.
Can you identify that document, Dr. Cantor?
A Yes. That is my report, which I submitted for these
10:42:54 proceedings.
Q Thank you.
I think actually, since we just heard Dr. Antommaria, I would like to begin with addressing some things that we heard this morning.
10:43:02 Did you have the opportunity hear this morning's testimony by Dr. Antommaria?
A Yes, I did.
Q Did you understand Dr. Antommaria to testify that randomly controlled studies are not available in this area of medicine?
10:43:16 A Yes.

Q Did he then say, if you understand -- as you understand, that because the randomly controlled trials are not available, we can rely on observational trials?
A That is roughly what I understood him to say, yes.
10:43:33 Q Do you have any response to that?
A Yes. That's not -- it is true that none of the existing studies are randomized, but it is entirely untrue that we therefore can rely -- can make decisions based on the least reliable kinds of studies.
10:43:48 There is a wide, wide range of studies in between, and there's a wide, wide, range of different scientific methodologies that we can employ in order to minimize the laws that we get from completely randomized studies.
It's also actually possible if we wanted to conduct such
10:44:09 studies such as by allowing people to undergo different parts of a treatment at different times, so we can compare the differences between them when one group has started on that type of treatment and the other hadn't yet.
Q Okay. So the randomized trials would be considered like
10:44:29 the gold standard, the top-tier level of scientific research?
A Randomization is one factor in determining how high quality a study is. It is not a -- it's neither an all or nothing.
Q I understand. But did I understand you to say that if you
10:44:47 assume that's not available, that's no reason to drop down to

the lowest quality of evidence?
A That is correct.
Q I understood Dr. Antommaria to testify that the level of evidence supporting the WPATH and Endocrine Society guidelines is comparable to the level of evidence supporting other treatments in pediatrics. Can you respond to that?
A I am not aware, of course, of all the other treatments in pediatrics. However, there are no studies yielding positive effects of either the Endocrine Society standards or the WPATH standards.

The studies which have shown effects have used the Dutch model, which uses a higher set of standards than either the Endocrine Society or the WPATH group.
Q Speaking of the Dutch study, I also understood Dr. Antommaria to say there is no high quality evidence supporting the use of psychotherapy alone for gender dysphoria. Do you agree with that?
A No, I do not.
Q What would you say in response? What's the countervailing evidence?
A There exists roughly 15'ish studies following up these kids at all. All of the studies, which without exception that used medical interventions also used psychological -- psychotherapy at the same time. So all of the studies which could seem to show a benefit for medical interventions are

unable to distinguish that it was the medical intervention causing the benefit, versus the psychotherapy causing the benefit.

Of those studies, two were designed in a way that it was possible to peel apart the effects of psychotherapy versus medicine -- the Costa study and the Achille study. The full references are in my report.

In the Costa study, there was a -- there were two phases. There was a phase that people went through when they received psychotherapy alone. And then in the subsequent phase, they received both psychotherapy and medical interventions.

There were no significant differences between the group. Both groups improved, and there were no significant differences between the group that received psychotherapy alone and the group that received psychotherapy plus medical interventions.

The other study, the Achille study, used a statistical method to control for the effects of psychotherapy. That group also improved after medical intervention, but when the effects of psychotherapy were statistically controlled, there was no additional benefit of the medical interventions after that.

Q I want to break some of that down. You mentioned studies where all the participants were receiving both psychotherapy and medical-affirming care at the same time, right?

A Correct.

Q Is that the Dutch -- oh, is the Dutch protocol, the Dutch

study an example of such a study?
A Both Dutch studies, the 2011 and the 2014, yes.
Q If, at the end of that trial, you look and see the people that were receiving both psychotherapy and medical-affirming
10:48:06 care at the same time, improved in mental health at the end of the trial, can you as a scientist tell whether the improvement is the result of the pharmaceuticals or the psychotherapy?
A Not in the design of those studies, no. That's what in science is called a confound.
10:48:27 Q Confound?
A Correct.
Q What does that mean, confound?
A It describes exactly that situation. When two things are done at once, when you see the result, you can't peel apart
10:48:37 which -- which of those two interventions was responsible or the interaction between those two interventions was responsible.
Q Okay. But the Costa and Achille study, on the other hand, they do provide scientific evidence that psychotherapy alone is
10:48:53 helpful, did --
A That's correct.
Q Okay.
A That psychotherapy is helpful and not the medical interventions.
10:49:01 Q I also understood Dr. Antommaria to say that he had not

read studies about detransitioning. But if it ever became relevant, he would make an effort to review such studies.

You are familiar with the body of the literature concerning gender dysphoria, correct?

10:49:21 A Yes.

Q In your opinion, are the studies of detransitioning relevant to someone trying to assess the benefits and harms of these treatments?

A Yes, of course. It's very difficult -- detransition would

10:49:35 be the situation that one is trying to avoid. The best way to avoid a situation is to understand that situation.

Q Dr. Antommaria said that there are prospective observational trials that demonstrate the efficacy of puberty blockers in gender-affirming care, and then later said the

10:49:59 trials he is referring to were primarily the Dutch group studies.

Are those the studies you just mentioned, the 2011, 2014 studies?

A Those are the Dutch studies that usually we use. I can't

10:50:12 know if he is referring to some other study that I didn't make a specific reference to.

Q That's fair.

In this area of medicine, when someone's talking about the Dutch studies, the Dutch group studies, is it your

10:50:25 understanding they're generally referring to these 2011 and

2014 studies from the Dutch project?
A Almost always, yes.
Q Okay. And those are the studies you just mentioned that have the confound problem, right?
10:50:36 A Correct.
Q You can't unpack whether it's the psychotherapy or -- not from that study, you can't unpack whether it is the psychotherapy or the pharmaceuticals that are making the difference?
10:50:47 A That's correct.
Q Okay. More generally, I'd like to read for you a statement from the plaintiffs' brief in support of their preliminary injunction motion.
For the record, it's Doc 8 at page 18.
10:51:07 Dr. Cantor, the plaintiffs wrote in that brief, For more than four decades, medical organizations have studied and created an evidence-based standard for the medical treatment of transgender patients. This standard confirms that transition, including puberty blockers and hormone therapy where
10:51:26 appropriate, is the only safe and effective treatment for gender dysphoria?
Dr. Cantor, does the research literature support that statement?
A No, it does not.
10:51:37 Q Do you understand the plaintiffs primarily to be pointing

to the guidelines of medical organizations such at WPATH and the Endocrine Society and the American Academy of Pediatrics to support their positions that wish to continue giving these treatments to children?

10:51:52 A Yes. They cited those repeatedly.

Q Okay. What observations have you had about the WPATH guidelines and whether they have support in evidence?

A The WPATH guidelines and the Endocrine Society guidelines have been tested among the set of -- as I say, roughly 15

10:52:13 outcome studies, some of them have used the WPATH guidelines or Endocrine Society guidelines instead of the Dutch protocol. And those studies demonstrated that there was no improvement at all.

I shouldn't say none at all. One of them used several

10:52:36 kinds of measures of improvement, and I think it was all but one demonstrated no differences at all. And one small one gave an indication that suggested the possibility.

Q Have these organizations acknowledged anything about desistance rates -- these organizations, I'm referring

10:52:57 specifically to WPATH and the Endocrine Society?

A I can't say that they've never addressed it, but to the extent if it was ever addressed, they are grossly, grossly minimized.

Q Can I refer you to paragraph 12 of your report on page 4?

10:53:33 A I got it.

Q You say in that paragraph that the plaintiffs' documentation -- and I assume by documentation, you mean their -- the pleadings in this case and the briefs that you had seen?

10:53:50 A That's correct.

Q You said the plaintiffs' documentation misrepresents the contents of the associations' policies themselves.

Which associations were you speaking of there?

A They mentioned several other societies which made short

10:54:04 statements in general support of sexual diversity, but without actually issuing specific standards about how to treat people in that community with what or at what ages.

Q And what inconsistencies did you see between what those organizations have said and the arguments you saw in

10:54:23 plaintiffs' briefing?

A The plaintiffs referred to the societies as if they were providing very specific support for very specific policies rather than general recommendations to provide, for example, respect and values for diversity, but no specific guidelines.

10:54:48 Q Okay. Well, looking at paragraph 12, is one of your points here looking at the bullet points that even WPATH and Endocrine Society acknowledge as you write, that desistance of gender dysphoria occurs in the majority of prepubescent children?

10:55:04 A That is correct.

Q And then turning the page, were there other issues you saw that the statements -- that these organizations believed and plaintiffs' briefing was inconsistent with what the organizations had stated?

10:55:16 A That the issue of mental health and that mental illnesses and similar concerns need to be resolved before considering transition rather than depending on transition to be the resolution of, for example, depression and anxiety.

Q And have any of these organizations acknowledged that

10:55:42 puberty-blocking medication is an experimental not a routine treatment?

A Yes, they have used that phrase.

Q Which organization?

A Again, I would have to look up to see exactly who used

10:55:52 which word. I believe it was WPATH, but I again have to go back and check to make sure that it was they.

Q And let's turn to the American Academy of Pediatrics. And I will refer you to your appendix.

And, Dr. Cantor, if you look at the top of the page, you

10:56:12 will see a line of blue figures. And it's page X out of 106. The appendix I am referring to is page 100 out of 106.

A Got it.

Q What does the American Academy of Pediatrics or AAP, what do they recommend in this area of care?

10:56:42 A They recommend what I can best describe as affirmation on

demand.
Q Okay. Did you review their recommendation when it came out?
A Specifically I reviewed the sources on which they based their recommendations.
Q Okay. Did you write about that?
A Yes, I did.
Q And does that appear as an appendix to your report beginning at page 100 of that pdf?
A That is correct. I summarized all of my comments. I submitted them to a journal where they underwent peer review. And it's an official published peer-reviewed paper.
Q This is not a letter to the editor?
A That is correct. This is part of a scientific -- now part of the scientific literature.
Q What did you comment upon?
A I really just checked what the authors of the AAP policy, Dr. Rafferty, what their claims were, what they said was in their references versus what was actually in their references.
And not only did their sources not contain what they were alleged to have obtained, they often contained the very opposite of what the AAP policy said they contained.
Q Did you have an agenda to disprove -- to prove or disprove anybody when you undertook that review of the evidence?
A I wouldn't say an agenda other than to set the record --

pardon the pun -- straight.

This was a situation where these sources I had known for many years. I had read them when they had first came out.

And when AAP came out with its policy, I was stunned by its content. And as I read what they were basing it on, my recollection was immediately this is not what those sources said.

So immediately I just started double checking myself. Did I misread something? Am I misremembering something?

And as I just checked in my own files with copies of these papers -- most of these papers already in it, my memory was correct. They said as -- the kinds of things I recalled them to be saying.

Because we were now talking a major medical association rather than an individual other scientist. This was different from just one scientist like me disagreeing with another scientist. This was now -- now had the potential to cause a great deal of damage to a great number of people.

So because I had the ability to do it, I simply summarized the contents of the original paper and contrasted point by point the claims being made by AAP and simply quoting verbatim what was in the original studies.

That entire thing was published, and the AAP has never responded. They were approached by the media, and they just would refuse to talk even to the media. They have yet to have

any response.
Q So to date, the AAP has not responded to the criticisms that you raised?
A That is correct.
10:59:42 Q I will refer you now to page 6 of your report. Going by the numbers at the bottom of the pages.
A Yep.
Q As you noted in your review of the plaintiffs' expert report -- well, first off, did you review the expert reports
11:00:08 submitted by the plaintiffs by Dr. Hawkins and Dr. Ladinsky?
A Yes, I did.
Q And did you note that they studied a 2016 Olsen study claiming that it proves that transition reduces the risk of mental illness? That that was their claim?
11:00:23 A Correct.
Q Does the Olsen study show that?
A Just referring to my own report. Ultimately, no, it did not. There was several statistical errors in the Olsen study. The data were obtained then by the -- they -- upon request, and
11:00:45 Olsen provided their data to another author who reanalyzed -- I should say, correctly analyzed the Olsen data, who demonstrated that Olsen's data did not contain evidence of improvement. In fact, it contained evidence of deterioration.
Q So in your opinion, does the 2016 Olsen study support
11:01:04 plaintiffs' position that children need these affirming --

these medicalized affirming treatments in order to improve their mental health?

A No, it does not. Making such a claim is a half truth. It would ignore the subsequent entries in the scientific literature.

Q And what about the de Vries study that plaintiffs cited in which you address on page 9 of your report? And does it show that medical transition of minors improves mental health?

A No. It contains part of the confound. The de Vries study as part of a Dutch group also included psychotherapy during transition. So it is not possible to differentiate which type of therapy, medical or psychotherapy, is responsible for the benefits reported in that study.

Q I see. So participants in that study did have improved mental health, correct?

A Yes.

Q But it's just not possible scientifically to tell what caused the improvement?

A Correct.

Q And what about the Greene and Turbin studies plaintiffs' experts cited which you discuss in paragraph 24 of your report?

A Yep.

Q Do those studies show that medical transition improves mental health?

A No, they do not. These are retrospective correlational

studies. They are not able of describing any causal effect coming to any causal conclusion.

Q Okay. Now, you mentioned there that -- you say this very pattern is what one would predict from clinical gatekeeping. What do you mean by clinical gatekeeping?

A One of -- across the various clinical standards are to prevent somebody with mental illness from undergoing transition. So such people are being held back. They're being filtered out of groups who do undergo transition.

So when a clinic then compares the people who underwent transition to the people in their files who did not undergo transition, they are necessarily comparing a group of people from whom the mental illness was removed and comparing them to a group of people from whom the mental illnesses were not removed.

So when you see better mental health amongst the people who had transitioned, the improvement is not because of the transition, the improvement is because you have removed the people with the worst mental health from the group in the first place.

Q Okay. So is it correct, then, that one thing you might see in these studies is by picking out the people with the best mental health, and giving them the treatment, then comparing them to the people with lower mental health, then, of course, the people who went through the study would do better?

A That is correct.
Q Did you review any of the other studies that plaintiffs have submitted into evidence such as the Allen study, the Turban articles, the Biggs (phonetic) study, the Lopez de Lara
11:04:24 study, Tordoff?
A Yes, I have.
Q Do you have any comments on those studies and whether they support plaintiffs' position?
A They suffered from the same methodological problems as the
11:04:35 other studies.
Q Did any of those studies support the position that medical transition improves mental health?
A No, they did not.
Q In minors with gender dysphoria?
11:04:47 A Correct. No, they do not.
Q Oh. What has been called the Yale study by Brouware, B-R-O-U-W-A-R-E, was the first named author. Did you review that one?
A Yes, I did, but it wasn't a study.
11:05:07 Q What was --
A Apparently, that was a report submitted by those authors for another -- or for a combined set of court cases.
Q Okay. But you would not refer to that document as a scientific study?
11:05:21 A From the Yale group with -- again, the name I don't -- I

hesitate to try to pronounce, but, no, it was not a study at all. It was those authors' report reviewing the literature and providing their opinions.

Q Okay. As a matter of fact, Dr. Ladinsky was asked about 11:05:39 that study yesterday. And for the record, that testimony appears on page 116 of the rough transcript.

The question was: In this document, do the authors also cite a number of peer-reviewed studies that contradict some of the supports or the principles that the State articulated as 11:06:00 the reasons for SB 184? And Dr. Ladinsky responded, They do, a considerable compendium of them.

Is she right? Did those authors show that there are studies that contradict the State's position in this case?

A There was such a statement. There was no meaningful way 11:06:21 to try to put together what claim went together with what source. Rather than -- what's done more typically either in science or in pause, best as I understand, is here the claim and here is the source justifying it. Here is next claim, here the source justifying it.

11:06:38 Instead, that document made a long series of unsourced claims and then provided a long series -- a series of very large footnotes with 20 and 30 references. And there was just no way to see what fact was alleged to have come from what source.

11:06:56 Q So we've talked about whether the literature the

plaintiffs' -- the studies that plaintiffs cite to support their position. Let's talk about whether the literature supports the State's position. But a little background first.

Could you describe from your review of the literature just what's the difference between adult onset gender dysphoria, child onset, and adolescent onset? And I know this is a broad question, but I just mean like age groups.

A Usually we would be referring to these as a prepubescent onset. Then the literature is very, very long, but reported on adult onset. And by adult, on average, these were people in their 20s and in their 30s and 40s. It was very, very distinct. It was not, you know, a bell-shaped curve with some midpoint around 18 or 19 years old.

It's only within the past --

THE COURT: Hold on one second.

Go ahead. Sorry.

THE WITNESS: It's only within the past ten years or so that a different profile has begun to emerge and was noticed by clinicians. And that now is being called either adolescent onset or rapid onset.

Now, all three of these groups have in common that they're complaining about the same thing. Doc, I feel like I am in the wrong body. Doc, I am the brain of one, but in the body of the other.

So the way that they describe it is similar. But every

objective way we have of measuring these people shows that these are independent phenomena. They are not related except in the way that people describe the situation, describe what they're experiencing.

11:08:50 The best analogy I have would be if somebody came to a doctor saying I have a headache. Okay. I got it. Got that's a symptom. I have some more questions. But we cannot from that say that a migraine headache is the same thing as a tension headache is the same thing as having just suffered a 11:09:08 head injury.

The causes are different. How we respond to them is different. And the other characteristics about each of these are different. They only resemble each other in the most superficial ways.

11:09:19 Childhood onset or prepubescent onset gender dysphoria appears to be entirely unrelated to adult onset gender dysphoria. And the two of those appear to be entirely unrelated to the rapid onset or adolescent onset gender dysphoria.

11:09:40 BY MR. DAVIS:

Q Well, let's break that down. Adult onset, typically people who present with what you're referring to adult onset gender dysphoria, what age are they when they come into the doctors' office and say, something's wrong?

11:09:50 A On average, in their 30s and 40s.

Q Okay. Has there been research considering whether those -- that universe, the adult onset universe does well after transitioning?

A Those who are mentally healthy by and large do, do well after transition.

Q Can you apply those studies to consider whether someone with child onset gender dysphoria is going to do well after transitioning?

A No. Because these are independent phenomena. The information from one does not -- from one group does not generalize to the other.

Q Comparing the adult and the child onset, what is the difference that makes the studies of one, you know, it's not apples to apples?

A Correct.

Q Okay. What is the difference between those patients?

A The -- they -- as I say, differed in just about every objective measure we've been able to apply to them.

There are, of course, the ages themselves. Something -- the sex ratios in them are different. The adults are almost 100 percent biological male. There's more of a mix amongst the childhood onset.

The adults are almost always attracted to females. That is to say, relative to being biological male, they are almost always heterosexual.

The childhood onset almost always are attracted to the same biological sex. They are almost always homosexual.

Q Talking about the child onset, is that a new phenomenon, child onset gender dysphoria?

11:11:31 A I wouldn't say new. It's been systematically studied for 20 to 30 years'ish.

Q From the literature that you reviewed, do most of these kids, if not socially transitioned and given hormones, will they want to transition after reaching puberty?

11:11:52 A Generally not.

Q And page 36 -- excuse me -- paragraph 36 of your report, Dr. Cantor, what statistics do you provide about the rates of desistance among those presenting with childhood onset gender dysphoria?

11:12:15 A The exact numbers are between 61 to 88 percent of them desist. In the appendix in my report, I list all of the studies that have ever been conducted with that group, all the outcome studies that have been conducted with that group.

Q We probably both need to slow down just a little bit

11:12:37 for...

A I'm from New York. It just happens.

Q We'll do our best.

Dr. Hawkins was asked about your paragraph 36 yesterday. And I will represent that on page 30 of the rough transcript,

11:12:54 she said that when the study such as the ones you're citing

offers this elevated rate of desisters, quote, what we tend to find is that the initial cohort that was given the diagnosis of gender dysphoria is actually false.

My question, Dr. Cantor, is: Does the research literature support Dr. Hawkins's statement?

A No. As I say, I listed every single such study.

Q Do we have any tools today that reliably tell us which kids will desist and which kids will persist?

A No, we do not. There have been some attempts to develop such a test, but they have never been able to find a good characteristic, a feature, a pattern, a test result in which the majority continued to want to persist.

The best that they have ever been able to do was find a tool which distinguished unlikely to want to persist versus even less likely to want to persist.

Q There's been testimony about something called the DSM-5. Do you know what that is?

A Yes, I do.

Q What is it?

A The full name is the Diagnostic and Statistical Manual of Mental Illnesses, published by the American Psychiatric Association.

Q If someone were to claim that now that we have the DSM-5 we may be able to do a lot better with identifying who's the desister and who is the persister, is there any research on

that?
A No. Nobody's ever tried to differentiating any of the DSMs from DSM-I through its various versions to the current one.
11:14:38 Q So there have been at least five?
A There was a I, a II, a III, III-R, IV, IV then had a text revision. They switched some of the commentary around the diagnoses, but they didn't change any of the diagnostic criteria themselves. There was then the 5. And there is as of
11:15:01 last month a 5 again with a text revision, but no changes to any of the actual diagnostic criteria.
THE COURT: Mr. Davis, how much longer do you think we will be?
MR. DAVIS: Your Honor, direct will take us up to
11:15:14 about noon, I would predict. There's just a lot to cover with Dr. Cantor.
THE COURT: I am not rushing you. I am just trying to get a road map of that.
So how long do we think cross might be?
11:15:25 MS. EAGAN: It's difficult to predict because I am not sure what else he may say, but maybe an hour, hour or less, I would think.
THE COURT: All right. I am leaning toward an earlier lunch than we did yesterday. So maybe -- if it's okay with
11:15:45 you, let's just go ahead and find a stopping point at your

leisure, and we will just pick back up after lunch.

MR. DAVIS: Thank you, Your Honor. This is as good as any.

THE COURT: Is it?

11:16:00 MR. DAVIS: Yes. We have just talked about DSM-5. Going to watchful waiting next. This is as good a place as any.

THE COURT: Okay. Good. Good. With that said, then are we still on target with your last witness?

11:16:17 MR. DAVIS: Yes, Your Honor. Ms. Wright is here. I don't know if she is in the courtroom yet or not, but she is in Montgomery, and she will be ready to go when we finish with Dr. Cantor.

THE COURT: We think the length of that witness would

11:16:30 be what?

MR. DAVIS: Oh, I would say direct would be well under 30 minutes, but I don't know about cross.

THE COURT: Okay. All right. Okay. Well, I think we're on target.

11:16:38 Let's take a good long lunch today. Let's see here. Let's come back at 12:45.

MR. DAVIS: Thank you, Judge.

THE COURT: Thank you.

MR. DOSS: Judge?

11:16:54 THE COURT: Yes?

MR. DOSS: Closing, how long would you like?

THE COURT: You know, I mean, this is important. I'm not going to, you know, jack everybody up on this, but to the extent you can hold it to around 25, I think would probably be a good thing.

11:17:07

And in your openings, I think you really road mapped it very well, both sides did.

So, you know, again, I know the arguments. I'm really interested in, you know, some analysis with case law. And I am going to be directly asking about a few cases. I'm very interested to know parallels between the Arkansas decision and that law. And then I may give you some hypotheticals that you won't like.

11:17:22

See you after lunch.

(Recess.)

11:17:40

THE COURT: All yours, Mr. Davis.

MR. DAVIS: Thank you, Judge.

BY MR. DAVIS:

Q Welcome back, Dr. Cantor.

We spoke earlier about the Dutch protocol. Did the participants in those Dutch studies have psychotherapy before beginning treatment? Before that study?

12:51:00

A They were receiving treatment as part of their participation in the study. I don't think they reported whether anybody happened to have attempted psychotherapy before

12:51:21

approaching the clinic at all.

Q Okay. Forgive me if I'm mistaking which study is which. I was reading about a study that described the psychotherapy that was available to the participants as extensive. And that that extensive psychotherapy was at least two years. Which study am I thinking of?

A That wouldn't have been a particular study so much as what they use in their process in general.

And then the Dutch group was reporting the results, you know, of -- periodically over the course of the study.

Q I see.

A But by the time the first set of results, their earlier study, the 2011 study, the participants in it will have already been through a substantial amount of therapy.

Q Okay.

A They also emphasize that in assessing the children that it's a very extensive assessment, and the assessment itself was also ongoing over the course of the study.

So even before deciding who might be eligible for hormones, they have now many, many months to years' experience with the particular case even with a particular child even before making a decision. That's very, very different from just having an appointment, taking a test, and then having a diagnostic decision an hour later.

Q That is exactly what I was meaning to ask you about. I

was using sloppy language.

So this extensive assessment that happened before some of these children began treatments, they were assessed, you said, over a course of a couple of years?

12:52:59 A Correct.

Q Okay. So does literature support having such an extensive assessment period before subjecting someone to these treatments?

A I don't know if I would say support it, but all of the

12:53:16 conclusions that come from the literature depend on it.

Q Thank you.

Is there a way of treating gender dysphoria that some practitioners refer to as a watchful waiting approach?

A Yes. Watchful waiting usually refers specifically to

12:53:40 withholding any decision about medical interventions until they have a better idea or feel more confident for a particular case about whether that kid is going to be a persister or desister. It is given the knowledge that that's available that the majority of these kids do desist. Nobody wants to make a

12:54:00 decision upon first appointment.

And so -- so they tend to provide psychotherapy, whatever kind of care, whatever is appropriate to the individual kid until enough time has gone by to give -- to suggest is this a kid whose feelings like they're feelings are slowing down and

12:54:19 they just need more time, are they building up, or are they

staying steady?

So the watchful waiting period would be postponing any decision about medical interventions until the clinicians had some confidence.

12:54:31 Q While you are watching and while you are waiting, are you just leaving him alone, or her?

A No. That would be the time during which one would be supplying a therapy for whatever else is going on in the kid's life.

12:54:42 Q Okay.

A Usually they're associated with -- there's a great deal of what we call comorbidity. They're also suffering from other problems at the same time, either depressions, anxieties, early evidence of personality disorders, for example. And it's never

12:55:00 clear whether their gender dysphoria is a result of those other psychological problems.

So by helping them develop the tools to deal with those other problems, if they remain dysphoric afterwards, we know that the dysphoria wasn't the result of those other problems.

12:55:17 So rather than just leaving them alone, they're still receiving support, and the family is still receiving support over that period.

Q So I believe you pointed out in your report that clinical guidelines suggest that mental health issues such as the

12:55:33 comorbidities you mentioned should be resolved before

transition; is that correct?
A Yes.
Q Okay. Why?
A Because it's never clear what's causing what. We cannot from a correlation conclude anything about a causation. It's very possible, and it's been frequently observed that a lot of these kids are using gender issues as an explanation for the unhappiness that they're experiencing elsewhere in their life.
So rather than developing the skills to -- for example -- better social skills. If a person feels awkward and they're withdrawing from kids their own age, we are not sure if they want to transition because they're blaming gender dysphoria for why they feel unpopular or uncomfortable, and we're not -- versus we can't tell if anxiety or depression is a result of how they're being treated by the rest of society.
So it's only by helping them deal with and by giving them the skills to overcome those other disorders that we can see if the gender dysphoria itself resolves just as a result of that.
Q So if a person is suffering from depression, or is struggling with their own sexual identity, or some type of abuse, or any of these other comorbidities, explain how this psychotherapy process would work, how a psychotherapist such as yourself would try to dig down into the issue and see if that is something that's generating these feelings that are being mistaken as gender dysphoria, or whether the gender dysphoria

is its own thing.

A Just to be specific, I'm specifically an adult clinical psychologist. I see clients ages 16 and up. So it wouldn't be me personally.

12:57:23 What the literature shows about these kids is that they can be very, very diverse. It certainly is feasible that they are experiencing, for example, depression or anxiety as a result of social transphobia, but that doesn't explain the other things that we're observing.

12:57:41 For example, a transphobia doesn't cause autism, which is another very, very common disorder in that group. Transphobia wouldn't cause the development of borderline personality disorder, which we're seeing in very, very, large proportions among the teenagers.

12:57:58 So although certain symptoms like anxiety and depression can feasibly be the result of social reactions to being trans, but that does not explain the overall phenomenon. What does better explain the overall phenomenon is that there is some thing troubling this kid, and it is resulting in both the

12:58:20 psychological symptoms, depression, anxiety in someone, and also producing the gender dysphoria, that discomfort with being their natural sex.

Q I would expect this could vary wildly from patient to patient, but if you -- and I recognize and thank you for

12:58:37 clarifying that you deal with a more adult-age group.

But if you're helping someone, an adolescent, work through some of these issues, how often do you think a psychotherapist would want to see the patient and over what period of time?

A It does vary widely. And the kind of disorders that they're reporting do tend to be the kinds that require very long-term interventions.

As I say, autism, and related Asperger's syndrome, and also very, very high rates of borderline personality disorders, which, again, is a very, very long-term disorder to help somebody deal with.

Q Fair to say this would not be two or three sessions?

A Correct. This would be over the course of months or years.

Q Does the research literature show that there are risks associated with medical transitioning?

A Yes, quite substantial, including both loss of -- primarily loss of function, and depending on the person's point of view, whatever the cosmetic effects are.

Q What are the risks of the watchful waiting approach in providing psychotherapy in helping the child deal with any underlying emotional issues?

A There don't appear to be any, at least any concrete.

Q I will refer you to paragraph 68 of your report, Dr. Cantor.

Tell me what the advantages there are to a patient, what

opportunities it opens up to him or her if any emotional issues are dealt with before the decision to transition.

A If a person fails to deal with whatever emotional issues before it transition, and then transitions and discovers that they continue with whatever psychological issues are pervading them, they have gone through the entire transition process entirely unnecessarily. They haven't been helped. They have now lost whatever -- they have now been sterilized, lost whatever sexual -- or other functions, but it hasn't actually resulted in any improvement in their psychological function.

If you go the other way around and you help the person deal with psychologically whatever it is that's going on, they still retain the option for transition after that. And it's that situation that the professional societies have repeatedly -- that the standards of care have repeatedly pointed out.

Q So watchful waiting approach does not eliminate a person's ability to transition to the opposite sex later in life if they so choose?

A Correct.

Q Does the research literature show there's any relationship between children who present with gender dysphoria and those who later in life turn out to identify as gay?

A Yes. The large majority of the ones who believe that they were born the wrong sex turn out to be gay or lesbian.

To a prepubescent child who doesn't yet have a sex drive, they have no way to interpret why they feel different from other boys or other girls their age. It's only with the onset of sex drive that they start -- and start developing crushes and physical attractions that they now have the information they need to realize why they're different. But to an eight year old or to prepubescent children, the only explanation they have for why they're not like other boys or not like other girls is they must be the wrong sex. They're misinterpreting their feelings.

13:01:58 13:02:18

THE COURT: Let's take a quick time out.

So, you know, I guess I'm wondering how both sides are wanting me to use all this expert testimony. I mean, the Eleventh Circuit has said more than one time that, you know, medical psychiatric professionals are in a far better position to make decisions about medical and psychiatric issues than judges are.

13:02:31

So I guess I want to know from each side real quickly, how do y'all envision that I use these experts? I mean, are you asking me to say, well, this guy's science is junk and this guy's science is perfect; or something in between? What am I -- tell me how you envision me using this.

13:02:48

MR. LACOUR: May I?

THE COURT: Perfect. Absolutely.

MR. LACOUR: Your Honor, as we began the opening

13:03:05

statements, when there's an area of medical uncertainty, the State has wide discretion to regulate. So if it's not so clear to you as to which side's experts have it right, if you see that uncertainty, then under Supreme Court precedent, the State
13:03:29 is allowed to regulate.

The State has to think about all 5 million Alabamians. We have to take all that into account when regulating in these areas where it is not certain.

The judge has an important but a limited role in our
13:03:45 federal system to see whether those judgments the State has reached in those areas of uncertainty somehow conflict with the Constitution.

And we submit we have come forward with evidence to at least put into question whether there is this consensus that
13:04:03 has been proclaimed by the plaintiffs here.

Again, I think the bar on the plaintiffs is quite high, to show an absence of uncertainty, or to show some great certainty.

And when you look at the international studies and the
13:04:19 literature reviews, when you hear from very qualified experts like Dr. Cantor, who have applied great rigor to these studies that are being relied upon by the plaintiffs, by their experts, by the AAP, for example, then I think that is enough to create that doubt to create that space for uncertainty. And when that
13:04:45 is there, the State can step in.

So that's how we see it. We don't think that you sit here as an independent medical board to assess whether a particular treatment is going to be the best for any particular individual. The role of the federal courts in our federal system, the laboratories of democracy is to see if we have done something that is somewhat inexplicable.

I think there is ample evidence to explain why the State has done what it's done in addition to the lengthy legislative findings in SB 184.

13:05:22 We have come forward with multiple experts from fields of endocrinology, psychology, and pediatrics, and have brought forward substantial amount of other peer-reviewed research and literature reviews to show that this very novel area of the law -- keep in mind the UAB clinic didn't open until

13:05:44 seven years ago. This is a novel area of medicine, rather -- is just, in the State's judgment, too risky. And if that's a reasonable judgment for the State to make, then that's the end of the case.

THE COURT: All right. Mr. Doss.

13:06:03 MR. DOSS: Your Honor, I'm unaware of a case that establishes that principle that's so long as there's uncertainty and a reasonable judgment, then that alone is sufficient for the State to violate constitutional protections.

The standard of review is what I think helps frame some of

13:06:23 this testimony. So, for example, if strict scrutiny applies,

it is the State's burden to establish a compelling state interest. And that its infringement on the constitutional protection has been narrowly tailored.

And I guess to preview Your Honor for closing, that is a 13:06:40 key focus that I plan to spend some time with in closing on why this testimony we've heard yesterday and today, number one, does not establish a compelling State interest. But number two, even if you assume that it does establish some interest by the State, the interest that the State has identified and the 13:06:58 regulation that it has imposed are mismatched. It's not narrowly tailored for the very reasons offered by the State through its witnesses.

And based on the standard of review, it is not a reasoned judgment. That's not the test for when a constitutional 13:07:13 violation has occurred. The test is whether there is satisfaction of this demanding standard for the law's viability.

And so as I mentioned in opening, I don't think that Your Honor's job for the purpose of this hearing is deciding 13:07:31 ultimately maybe even who is right. It's to show that there is scientific -- there are standards of care that exist, there are approved approaches to dealing with these issues. These are real medical diagnoses. These are real medical treatments.

And though the State may disagree them, that's not enough 13:07:50 to establish the violation of the constitutional rights, Your

Honor.

THE COURT: And on that note, at least from what I can tell from both sides, State and government, and original plaintiffs, am I correct to say that everybody agrees that these are real diagnoses? Or no?

13:08:07

MR. LACOUR: Your Honor, could you --

THE COURT: And I am going to say this one more time. I don't need head nods. It is out of hand. This is not entertainment. This is the real world and the law. So we're not in a movie theater. I don't need head nods. I don't need approval or disapproval. If you want to do that, take it outside.

13:08:25

Go ahead.

MR. LACOUR: Your Honor, I think -- Your Honor, we agree that gender dysphoria is a psychological diagnosis, but as we have shown in both our written evidence and through witness testimony from both defense witnesses and plaintiffs' witnesses, we don't know whose gender dysphoria is likely to persist. And that's very important.

13:08:46

Even Dr. Antommaria this morning said that if you -- the level of certainty you have --

13:09:07

THE COURT: You are giving me more detail than I want. I just need you to answer my question.

MR. LACOUR: Okay. Can I respond to something Mr. Doss said before?

13:09:21

THE COURT: Very quickly.

MR. LACOUR: He is unaware of the standard. We cited it multiple times in our P.I. response. It's Gonzales vs. Carhart, a 2007 decision from the Supreme Court where the federal government had regulated partial birth abortion. That was an area of medical uncertainty.

13:09:32

There were -- I will go back and I will look at the filings in that case, but I would be shocked if the AMA did not chime in, in favor of the plaintiffs who were challenging the ban on partial birth abortion there saying that it was a safe or necessary -- medically necessary treatment for some people.

13:09:46

It was enough that Congress found medical uncertainty there. And there were values, as well, in unborn life that Congress was able to promote even though there were medical organizations.

13:10:04

I will confirm this before closing, but I am fairly certain there were medical organizations who were not fans of Congress's action there.

Even so, and even in an area like abortion where there is more law at least for the last 49 years in that space, addressing some right to abortion, even then, that ban was upheld by the Supreme Court.

13:10:16

THE COURT: And I'm sure you can get into that on closing.

Let's go back to my original question. Just answer it

13:10:31

succinctly for me.

MR. LACOUR: And that would be are these real diagnoses?

THE COURT: Yes. Just answer my question in two sentences.

MR. LACOUR: Gender dysphoria is a diagnosis. I think the debate is how should it be treated. And SB 184 is expressed in Section 6.

There's no ban on psychotherapy whatsoever. The ban only applies to these novel risky potentially long-term harm-inducing or causing medications.

THE COURT: So no argument from the State on status, diagnosis, any of that? You are only -- your only issue is treatment; is that correct?

MR. LACOUR: Correct, Your Honor.

THE COURT: Got it. Thank you.

Anything else, Mr. Doss? And I will give the government a shot --

MR. DOSS: No, Your Honor.

THE COURT: -- if they want to be heard.

MR. CHEEK: Nothing else to add that hasn't already been said, Your Honor. Thank you.

THE COURT: Okay. All right.

Mr. Davis, I have gotten right in the middle of your witness again. Sorry. Pick it back up.

MR. DAVIS: I certainly understand, Judge.

BY MR. DAVIS:

Q Okay. Dr. Cantor, we to try to pick up where we were.

Let's take two young boys, eight years old, say. So puberty hasn't started yet. They both have gender dysphoria, even though they may not really understand it yet.

And I know I'm asking you to assume some things that an outside observer may not be able to confirm just by looking at that child.

And let's assume that both those young boys would, if not intervened with transitioning care, would both grow up to identify as gay.

So the boy who is left alone to go through natural puberty, what does he come to understand once puberty kicks in?

A Once he -- as puberty kicks in, of course, sex drive comes in as a part of that, and he starts experiencing sexual attractions and sexual arousal.

That, then, because he is experiencing it towards other men, teachers, peers, whoever it is, he can now -- he now has the opportunity to understand the nature of his experiences and why he doesn't feel quite like other boys, why he doesn't feel as masculine, and why he doesn't feel as masculine.

Now, in otherwise healthy circumstances, he will grow up to be a healthy gay man.

Q Now, the other boy is given puberty blockers. What

happens in his case?

A Such a person who does not develop sexual -- the capacity for sexual arousal and sexual attractions because the very biological features which produce that have been held from him, he never experiences an orgasm. He never experiences sexual arousal, and doesn't have the opportunity to understand the other potential explanations for why he feels the way he does, and go from a child's understanding of why he doesn't feel like other boys, to an adult's understanding of why he doesn't feel like other boys.

By blocking puberty, you are blocking the very information that he needs to understand his own situation.

Q And you are not claiming to describe every person who is experiencing gender dysphoria, I take it?

A Correct.

Q Does the evidence show that sexual orientation changes after a person identifies as gay or lesbian?

A No. There is no evidence to suggest that sexual orientation is unstable or changes.

Q What does the evidence show about whether a person's gender identity can change?

A That shows the very opposite. Among the children, it changes in the majority of them.

They're even people who identify and describe themselves, for example, as being fluid, the very definition of which is

that their gender identity changes on a constant basis.

Q Are you familiar with the argument that if we do not allow minors to transition medically, the result will be increased suicides within these group of young people?

13:14:38 A I've heard that said, yes.

Q Does the research literature support the argument that denying these treatments will lead to an increase in suicidality?

A No, it does not.

13:14:50 Q Are you familiar with what other countries are doing, with respect to treatment of gender dysphoria?

A Yes, I am.

Q Are there any changes going on in recent years?

A Very much. In fact, things -- it's almost as if the

13:15:10 pendulum has reached its far point, and it's now coming back to a much more moderate evidence-based tone.

There was really -- sparking off of the social media age more than anything else, we're able to identify a greatly, greatly accelerated, great and greatly expanded number and type

13:15:31 of person who was potentially going to go through transition entirely, unlike the groups which we had previously studied.

Several countries, especially in Europe, permitted them with lower and lower standards. And then once the reports started coming out that that was failing greatly, they're now

13:15:53 restricting very, very quickly and very, very greatly.

The two most substantial bans have been in Sweden and in Finland. And there are also now very, very strong statements urging the medical field to pull things back in the UK and in France.

13:16:08 Q Dr. Ladinsky testified yesterday that -- I don't have her exact words in front of me -- but she said that what's going on in the UK and Sweden and Finland isn't as relevant here because those countries have a centralized health-care system, whereas we have a less centralized health-care system, and all these

13:16:35 experts unrelated can see the same child.

That's a poor paraphrase. The record will speak for itself. But assume she made that type of testimony. Would you agree with her?

A No. I can't see the logic of it. It's certainly

13:16:53 feasible, in fact, more than likely that decisions are made differently when there are centralized boards and a centralized authority charged specifically with reviewing the evidence that will be the basis of the medical procedures of that country, and the U.S. lacks that.

13:17:11 But there's no reason to think that that situation would change the actual outcomes of the actual children getting the actual interventions.

Q So is it possible, then, that a more centralized health-care system may provide the ability -- an even greater

13:17:24 ability to study and evaluate the risks and benefits of

gender-affirming care?
A That's demonstrably true. That is exactly the process they have gone through. They have published the results of exactly their reviews, and that is how their health-care systems -- that is what their health-care systems are responding to.
13:17:40
The American professional associations have not gone through such a comprehensive process. They're merely coming up with policies and citing only individual pieces of studies that appear to support it, rather than a comprehensive review.
13:17:54
Q I want to close a loop on adolescent onset gender dysphoria. We talked about ways different groups are different.
What's unique about this group of adolescent onset, or you referred to it also as rapid onset gender dysphoria?
13:18:11
A Yeah. It's been called both.
Where both the childhood onset and the adult onset are primarily male, the adolescent -- the adult onset and childhood onset are primarily male. The adolescent onset is primarily is female. They present with a different set -- it's a different epidemiological set of characteristics, and the evidence that we have about both adults and children don't seem to apply to that middle group.
13:18:28
Q Does this group of people presenting with gender dysphoria in their adolescence -- you said primarily female?
13:18:45

A Yes.
Q Do they tend to have any issues or comorbidities in common with each other?
A The most common one of those would be borderline personality disorders and other difficulties with integrating socially into their environments. As I say, such as autism and Asperger's syndrome.
Q You are not saying that's true for everyone presenting with gender dysphoria for the first time in their adolescence?
13:19:13 A Correct.
Q But many?
A Correct.
Q What does the research literature show about the desistance or detransition rates of people who transition after
13:19:25 first presenting with gender dysphoria in their adolescence?
A There has never been any such study.
Q Did you review the plaintiffs' reply brief, Dr. Cantor?
A Yes, I did.
Q Did you see any response to your report in plaintiffs' reply?
13:19:41 A Not a single comment. My name was never mentioned. None of the studies that I cited were referred to. None of the arguments were addressed. I don't believe I was quoted anywhere in it, unlike the other experts.
13:19:56 Q I did note a line that the plaintiffs criticized the

defendants' experts in general for relying on older studies.
A Yes. I saw that claim. I was a bit confused by it.
In my report, I provided a comprehensive list of every single study. There were 11 in total. So the old studies were listed, the new studies were listed. It was comprehensive.
13:20:18
It was also a tangential argument. As I said, the 11 studies which have been conducted were unanimous in their findings. They all found the same thing. The majority desists.
So it doesn't matter even if one did rely only on the older studies, the newer studies showed exactly the same thing as the older studies.
13:20:33
Q We spoke a little bit about some of the things we heard from Dr. Antommaria this morning. I want to turn to some of the things in his report.
13:20:55
You reviewed his written expert report, did you not?
A Yes, I did.
Q He -- Dr. Antommaria wrote on -- in paragraph 17 of his report -- and I will find a copy if you need it, but this is one sentence.
13:21:07
Quote, gender-affirming medical care is supported by clinical studies. Is he right?
A That's true for adults, but that's not true for the other groups.
Q And Dr. Antommaria spoke about how if a drug is FDA
13:21:21

approved in one area, it's okay to use it off label in another area?

A That's what he said, yes.

Q What does the research literature say, or what opinion do you have about using the same drug, a puberty-blocker in the case of a person who's six, seven, eight, the purpose is to -- precocious puberty, what about the cases of precocious puberty and using puberty-blockers to help someone medically transition at the beginning of normal puberty?

A Well, the ability to use a medication off label is not a blanket permission to give any drug you want for any reasons you want or for any conditions you want.

Ultimately, it's going to depend on what the scientific literature itself says, which in turn is what the various regulatory bodies use to make their decisions to decide what's off label or on label to begin with.

So because a medication would be useful for some people in some situations and some circumstances, does not mean it's automatically going to be useful for other people in other circumstances. Indeed it could be deleterious.

If you use a puberty-blocker in somebody with precocious puberty, you are pushing somebody who is far below the average age of puberty, and you are bringing them closer to the species-typical range of puberty.

If you give that same drug to somebody who is already

having a typical age of puberty, you are now pushing them outside of the species-typical age.

Q Thank you, Dr. Cantor.

I am going to sum up. Does the research literature support plaintiffs' claims that we need to treat children and adolescents with gender dysphoria with social transition puberty-blockers and cross-sex hormones?

A I'm sorry. Could you say that -- I missed the first half of that sentence.

Q My apologies.

Does the research literature support plaintiffs' claims that we need to treat children and adolescents with gender dysphoria with social transition, puberty-blockers, and cross-sex hormones?

A No. That's terrible overstatement.

Q Does the research literature support Alabama's description of these treatments as experimental?

A Yes. They're fairly called experimental.

Q When does a drug or a course of treatment stop being experimental?

A That's an excellent question. There is no real test for it. There is no objective way to decide something is one versus the other.

Science is never finished. It's always possible for there always to be some future piece of information that changes what

we know.

There are, of course, you know, different situations -- drugs, issues under active investigation, where it's very clear that it's still experimental, and others where, you know, there is only very little question left.

13:24:32

For this particular situation, we have a very small number of studies that in certain situations might look like they might be helping, but a much larger body of better performed studies showing that the improvement is not actually coming from the transition itself.

13:24:47

Indeed, there were other areas of the report that were referred to already ongoing studies testing exactly these interventions. Well, that there exists ongoing tests of these interventions is pretty much the definition of calling something experimental.

13:25:05

Q If scientists are eventually able to replicate the same results under the same conditions over and over again, can you then pretty much say something is established?

A Yes.

Q Has anybody been able to replicate the results of, say, the Dutch study that showed at least some positive results with a combination of treatments?

13:25:17

A No. Most of the studies have demonstrated no improvement in these children from medical transition.

Q Do you understand plaintiffs to argue that Alabama is out

13:25:32

of step with groups like the American Academy of Pediatrics?
A Yes, I've heard them say that.
Q What's your response?
A Well, it's actually the American Academy of Pediatrics which is out of step with the international standards.
Q Is there a consensus, a medical consensus internationally in support of these treatments?
A There is now a very quickly developing one. It is still ongoing debate, so I would hesitate to describe it -- describe that there is a solid consensus.
As I say, really what we have seen is a pendulum swing which is overswung and now is substantially and very quickly correcting itself.
Q Is the pendulum swinging in favor of medical transition use of puberty-blockers and cross-sex hormones for children and adolescents?
A No. It's swinging now against that.
Q Is there a medical consensus in the United States for the best way to treat gender dysphoria?
A No, there is not.
MR. DAVIS: Thank you, Dr. Cantor.
THE COURT: So I do have a question myself.
Dr. Cantor, you said that an adult should be affirmed in their transgender status.
THE WITNESS: An otherwise mentally healthy adult,

yes.

THE COURT: All right. So make it clear to me, then, when should an adolescent or a child be affirmed in that status?

13:27:10 THE WITNESS: That, to me, is an empirical question. We are not sure actually when the best time do that is. Every time we check, we keep finding that, no, that's not exactly the right way. No, that's not exactly quite working. And when we do think we have run into a clue that gives us 13:27:26 an idea of when, we are not able to recreate that situation.

THE COURT: Is that case by case, then?

THE WITNESS: I would hesitate to say case by case exactly because --

THE COURT: Let me rephrase it. Under what 13:27:44 circumstances would you affirm a child or an adolescent?

THE WITNESS: I can't say that there's a situation -- all of the situations will be gray. I can't think of any evidence that would give us the kind of certainty in any case that would outweigh the potential risks.

13:28:19 THE COURT: So you would never affirm a child or an adolescent?

THE WITNESS: Not with the current evidence available, no.

THE COURT: Okay. All right. Cross?

13:28:28 CROSS-EXAMINATION

BY MS. EAGAN:

Q Good afternoon, Dr. Cantor.

A Good afternoon.

Q Dr. Cantor, you are an adult clinical psychologist, correct?

A Yes.

Q You are not a medical doctor?

A Correct.

Q Your private practice -- in your private practice in Toronto, the average age of your patients is 30 to 35 years old?

A Average, that would be about right, yes.

Q You've not ever provided clinical care to transgender prepubertal children?

A Correct.

Q You have not provided care to a transgender adolescent under the age of 16?

A Correct.

Q The extent of your experience, Dr. Cantor, working with transgender adolescents consists of counseling six to eight transgender patients between the ages of 16 and 18; isn't that correct?

A Yes.

Q So your clinical experience with gender dysphoria really lies in the counseling of adult patients?

A Correct.
Q And you acknowledge that gender dysphoria in children does not represent the same phenomenon as adult gender dysphoria, correct?
13:30:24 A Correct.
Q And, in fact, to use your words, they differ in every known regard, from sexual interest patterns to responses to treatments?
A Correct.
13:30:36 Q Dr. Cantor, you have never diagnosed a child or an adolescent with gender dysphoria?
A Correct.
Q Never treated a child or an adolescent for gender dysphoria?
13:30:48 A Correct.
Q You have no experience personally with monitoring patients who are undergoing puberty-blocking treatment?
A Correct.
Q You don't know what type of monitoring is typically done
13:31:04 or not done on those types of patients; isn't that fair?
A No.
Q No, that's not fair?
A Well, you -- I personally didn't do it, but I am aware of the procedures that are done.
13:31:15 Q Okay. But you have no experience with that?

A That's correct.
Q Similarly, you have never monitored -- or you have not monitored an adolescent or teenage patient on hormone therapy?
A Correct. Until -- well, I wouldn't be monitoring the 13:31:34 status in any case, so, yes, that's correct.
Q I am going to switch to UAB Children's, the gender clinic here in Alabama.
Have you ever spoken to a child or adolescent who was treated at the gender clinic here in Alabama?
13:32:00 A No.
Q Have you ever spoken to any former patients of the clinic?
A No.
Q You weren't here yesterday to hear Dr. Ladinsky talk about the treatment protocols they have at children's UAB, were you?
13:32:12 A Correct.
Q You weren't here to listen to the results of treatments provided to adolescent patients at UAB's Children's in the gender clinic; fair?
A Yes. They have never published them.
13:32:27 Q And you weren't here to hear them?
A Correct.
Q Dr. Cantor, you have no personal knowledge of the assessment or the treatment methodologies that are used here in Alabama at UAB Children's Hospital, correct?
13:32:42 A Correct. Correct.

Q You do not know the disciplines of the medical providers who are part of the treatment team involved in that assessment at UAB Hospital?
A Correct.
13:32:56 Q Now, I heard your opinion that it's important to assess the mental health issues of an adolescent patient to see whether that is a potentially contributing factor to gender dysphoria and whether there's a need to address. That's a fair statement of your opinion?
13:33:17 A I'm sorry. Would you repeat that, please?
Q Sure. It's your belief that mental health issues need to be assessed and addressed before a transition occurs?
A Correct.
Q Do you know what assessment protocols at UAB Children's
13:33:31 are to address mental health issues before a child is put on any transitioning medication?
A No, I do not.
Q Do you have any idea or do you know what the doctors at UAB Children's discuss with their adolescent patients about the
13:33:48 risks and the benefits of medical treatments at UAB?
A No.
Q Wouldn't you agree -- well, never mind. I am going to move on.
Dr. Cantor, I want to talk with you a minute about -- or a
13:34:18 little bit about your criticisms of the various studies

regarding the efficacy of puberty blockers and hormone treatments, okay?

A Yep.

Q As I understand your report and your testimony today, one of the criticisms you have of some of those studies is that it relies on participant's self-assessment I believe is the language that you used.

Essentially, it is based upon what socially transitioned youth and their family is reporting about their mental health in these studies?

A I would say that's incomplete. My criticisms would be relying on such subjective accounts entirely for all the decision making rather than using it as one part of the decision making.

Q In other words, basing your study based upon what the participants in the study tell you how they're feeling at different points in the study?

A Being limited to that is a problem, yes.

Q And I believe the way that you phrased it, you said, subjective self-reports about how one is doing may not be reflecting reality objectively.

A Correct.

Q But, Dr. Cantor, self-reports about how one is doing may reflect reality, fair?

A That's correct.

Q So when somebody says, I am doing well, my mental state is better, that very well may be the case?
A May be the case, yes.
Q Another complaint that you have, I believe, is what you call confounded data. And I believe you referred to the de Vries study for that?
A The two de Vries's studies, yes. As a matter of fact, it's all but two of all papers in that set of literature.
Q And by confounded data, the way that I am understanding it, what you're saying is that you are not able to tell because the data is, quote, confounded, whether one's improved mental health for a minor who has socially transitioned, whether that came from the actual medical services, whether it came from the psychotherapy, or whether it came from the combination of both?
A Correct.
Q But one thing, Doctor, that you do have to admit is when adolescents with gender dysphoria have transitioned through a combination of medical services and psychotherapy, you have to admit that based upon the studies, their mental health improved, correct?
A No. There were several studies that showed no improvement even though -- even though they were receiving both. I've listed them in my report.
Q Can you direct me to where in your report those are, please, sir?

A Sure.

THE COURT: While he is looking, did you say your target is an hour; is that right?

MS. EAGAN: Yes, sir. I believe I should be able to be done in an hour.

13:37:33

THE WITNESS: Page 20, footnote 40.

BY MS. EAGAN:

Q I'm sorry, sir?

A Page 20, footnote 40. The Carmichael study, the Hisle-Gorman, et al, study, and Kaltiala.

13:37:48

My full sentence was, New studies continue to appear at an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health, footnote 40 -- or again, those were the specific studies -- and then or lack of improvement beyond psychotherapy alone, footnote 41.

13:38:23

Q Certainly, Dr. Cantor, though, there are many study -- or there are studies that indicate when adolescents with the combination of medical service and psychotherapy transition, their mental health has improved. You agree with that statement?

13:38:40

A I would have to check to see if the number is zero or a handful. There have been reports of there having been such improvement, such as the Branstom study, which once it was reanalyzed, discovered to have problems, and the finding was withdrawn.

13:39:00

So there -- again, I would have to go through and check to be sure that it's not zero. It would be fair to say that there might have been a study which found such a thing. But the majority of studies are finding either no improvements or deteriorations, or it's a situation that we call a failure to replicate.

13:39:17

Q Sir, I am a little bit confused, because I want to go to two of your studies that you have actually talked about today, the Costa study and the Achille study.

Now, as I understand your testimony today, in those studies, there was -- the studies reported that there was an improvement in mental state for adolescents who were treated with medication and psychological treatment in transition that there was an improvement, but in those, you said you can't tell whether it's from the medication or from the psychological treatment?

13:39:33

13:39:58

A No. The Costa study and the Achille study associated the improvement specifically with the psychotherapy and ruled out that the effects were due to the medical interventions.

Q Okay. Well, let's pull those studies, Doctor, and let's look at those.

13:40:13

If you could, there should be a notebook up there that has plaintiffs' exhibits in it. Is that one plaintiff, sir?

If you could please, sir, turn to Plaintiffs' Exhibit 34.

A Yes.

13:40:55

Q All right. Plaintiffs' Exhibit 34, is this the -- do you say Costa or Costa?
A I'm sorry?
Q Do you say Costa?
13:41:05 A My guess is Costa. I have never met the person.
Q All right. Exhibit 34 that you have in front of you, is that the Costa study?
A Yes, it is.
Q All right. So, Doctor, I first want to focus in on --
13:41:18 well, let me ask this: This study was aimed at assessing gender dysphoric adolescents' global functioning after psychological support and after puberty suppression, correct?
A Yes.
Q Bear with me. I am going to take this out so I can put it
13:41:42 up on the Elmo, sir.
All right, sir. I am going to direct your attention to results that I have highlighted on my copy. Okay? According to the abstract here, the results?
A Yes.
13:42:18 Q At baseline, gender dysphoric adolescents showed poor functioning with -- it defines the mean scores. So baseline means at the start of the study, correct?
A Usually it does. I would have to check that that's exactly how they used the term.
13:42:35 Q All right. We will get to the details of that in a

minute.

Okay. Gender dysphoric adolescents' global functioning improved significantly after six months after psychological support. And then it goes on to say, Moreover, gender dysphoric adolescents receiving also puberty suppression had significantly better psychosocial functioning after 12 months of puberty suppression compared to when they had received only psychological support.

Did I read that right, sir?

13:43:07 A Yes.

Q Do you remember the methodology that was used for this study, sir?

A Roughly.

Q Pardon?

13:43:14 A Yes. Roughly.

Q Sorry. I meant to -- all right. And do you recall that the methodology was everybody started at baseline. For the first six months all of the adolescents received psychological counseling. And then for the next 12 months beyond that, one

13:43:36 group received puberty blockers, and one group just continued to receive psychological counseling. Do you recall that?

A Yes.

Q All right. And then I am going to direct you, sir, to page 2211 of the -- if you look at the blue writing on the top,

13:44:12 it's page 6 of 9.

A Yes.
Q All right. And I am going to direct you, sir, to on the CGAS on follow-up?
A Yes.
13:44:32 Q All right. And I am going to start at the second paragraph where it says delayed eligible. Do you see where I am talking about?
A Yes.
Q This is talking about there were three follow-ups, right,
13:44:43 at 6 months, at 12 months, and at 18 months for this study; is that correct?
A That sounds familiar to me, yes.
Q And let's read through that together.
Delayed eligible gender dysphoric adolescents, who
13:44:55 received only -- and gender delayed, GD adolescents, is your recollection that those were adolescents who were eligible to receive puberty blockers, but they delayed them for six months so that they had everybody at a -- doing psychological study? Do you remember this is the group that gets the puberty
13:45:17 blockers?
A Yes, that sounds correct.
Q Okay. The delayed eligible gender dysphoric adolescents who received only psychological support for the entire duration of the study -- excuse me -- I take that back.
13:45:29 This was actually the group that just got the

psychological -- had significantly better psychosocial functioning after six months of psychological support, okay?

However, despite scoring better at the following evaluations, they did not show any further significant improvement in their psychosocial functioning.

Did I read that right?

A Yes.

Q Also, the delayed eligible group continued to score lower than a sample of children adolescents without observed psychological psychiatric symptoms even after 18 months of being in psychological support.

So what that's saying is after 18 months, they were still below a group that did not have psychological therapy or issues, correct?

A Yes.

Q On the contrary, the immediately eligible group, who at baseline had a higher, but not significantly different psychosocial functioning than the delayed eligible group, did not show any significant improvement after six months of psychological support. However -- and this is the key -- immediately eligible adolescents had a significantly higher psychosocial functioning after 12 months of puberty suppression compared to when they had received only psychological support.

Did I read that correctly?

A Yes.

Q Then you see at the top of this, there is a chart. And when you look at this chart, the bottom is actually the three different check-ins. Time zero is baseline, when the study started, right?

13:47:18 A Yes.

Q Time one is the six-month check-in, correct?

A Yes.

Q And during that six months, both groups are getting just psychotherapy, correct?

13:47:31 A Yes, I believe so.

Q The rest -- and just to orient us.

The red group, the red line is the group of adolescents who only got psychotherapy or psychotherapy through the entire 18-month study, right?

13:47:46 A Yes.

Q The green line that you see that goes up -- goes up and keeps going up, that is the line of adolescents who receive puberty blockers; fair?

A Yes.

13:47:59 Q And so, Doctor, to get to the ultimate conclusion of this study that you say shows that puberty blockers don't work or don't give any improvement in mental condition over psychotherapy, the conclusion, this study confirms the effectiveness of puberty suppression for gender dysphoric

13:48:37 adolescents. Recently, a long-term follow-up evaluation of

puberty suppression among gender dysphoric adolescents after that CSHT, which is hormone therapy and GRS, which is puberty blockers, has demonstrated that gender dysphoric adolescents are able to maintain a good functioning into their adult years. This present study, together with this previous research, indicate that both psychological support and puberty suppression enable young gender dysphoric individuals to reach a psychosocial functioning comparable with their peers.

Did I read that conclusion correctly?

13:49:17 A Yes.

THE COURT: Ms. Eagan, when you reach a comfortable spot, let's take a post-lunch break.

MS. EAGAN: Perfect. We're good, Judge. We can go ahead and break now.

13:49:35 THE COURT: Okay. I will see you in 15 minutes.

(Recess.)

THE COURT: Go ahead, Ms. Eagan.

MS. EAGAN: Thank you, Your Honor.

BY MS. EAGAN:

14:09:00 Q Dr. Cantor, my understanding from paragraph 63 of your declaration is that the other study that you point to in support of your assertion that testing revealed that puberty blockers did not improve mental health any more than mental health does on its own is the Achille study you mentioned

14:09:29 earlier today; is that right?

A Yes.
Q If you, please, sir, could turn to Plaintiffs' Exhibit 42 in that binder in front of you, and this would be the plaintiffs' exhibits that we were looking at earlier.
14:09:42 A Yep. Got it.
Q All right. Is Plaintiffs' Exhibit 42 the Achille study that we just mentioned?
A Yes.
Q All right.
14:09:59 MS. EAGAN: Your Honor, do you mind if I take this off of this?
THE COURT: That's fine.
BY MS. EAGAN:
Q All right. I am going to -- so this is Plaintiffs' 14:10:15 Exhibit 42.
And the Achille study, again, was -- in this case if we look at the abstract, the background of the study or the purpose of the study was to examine the associations of endocrine intervention puberty suppression and/or cross-sex 14:10:35 hormones therapy with depression and quality of life scores over time in transgender youths.
That was the purpose of the study, correct?
A Yes.
Q And looking down to the results section, between 2013 and 14:10:56 2018 -- so this went over a five-year period, right?

A Yes.
Q And there were 50 participants in the study, correct?
A That sounds right, yes.
Q All right. And that they received endocrine intervention both -- some were in the form of puberty blockers, and some were in the form of cross-sex hormones, but endocrine -- and over that time period and completed three waves of questionnaires.
Is that your recollection of this study?
A Yes, roughly.
Q Okay. And when that was -- with those treatments, mean depression scores and suicidal ideation decreased over time, which means their depression was -- went down, or they got better. Suicidal ideation went down, which is improvement, correct?
A Yes.
Q While mean quality of life scores improved over time.
And then it goes on to say, When controlling for psychiatric medications and engagement in counseling, regression analysis suggested improvement with endocrine intervention. And then it goes on to say that this reached significance in male to female participants. And the male to female participants, those are ones that were receiving hormone therapy, correct?
A I believe they were both receiving hormone therapy. It

was not significant in one group, and so they're just reporting the successful in the other and not reporting the nonsuccessful group.

Q Well, let's talk about that. Let me pull up paragraph 63 of your declaration.

When you're discussing this study, here is what you said. You said that upon follow-up, some incremental improvements were noted; however, after -- so, in other words, upon follow-up, they saw improvements.

But after statistically adjusting for psychiatric medication and engagement and counseling, quote, most predictors did not reach statistical significance.

And that's your basis -- that statement is your basis to say there was not a statistical significance of difference between just counseling versus with meds; is that right?

A I'm sorry. Could you say that part again?

Q The language that you seize onto, to say that puberty blockers did not improve mental health more than mental healthcare did on its own --

A Right.

Q -- was the statement in the study that most predictors did not reach statistical significance.

A Well, I wouldn't say that I derived that just from that sentence. It's just easier to convey that idea to readers by using the sentence. My evaluation of the study is by those

statistics directly.

Q All right. Let's go to the language in the study that they talk about, the regression analysis that you were just referencing there.

14:14:11 Okay. And this is here in the regression analysis.

Let me first say this: The mean changes over time. And it does say, Mean depression scores decreased. Quality of life improved, but did not reach statistical significance.

But then when you go on to the regression analysis, here 14:14:39 is what it says. It says, Given our modest sample size -- which in this case was 50 people, right?

A Yes.

Q Given our modest sample size, particularly when stratified by gender, most predictors did not reach statistical 14:14:57 significance.

So one of the contributing factors to that, of course, was the size of the number of participants, correct?

A Yes. In statistics, that's a truism. The precision of the statistics is the direct -- direct result of the sample 14:15:20 size.

Q Okay. And then it goes on to say, That being said, effect sizes values were notably large in many models. In the male to female participants, only puberty suppression reached a significance level. And it gives the number in one of the 14:15:43 sample -- one of the tests, and associations with the two other

scores approached significance.

And then it goes on to say, For female to male participants, only cross-sex hormone therapy approached statistical significance.

14:15:57 All right. Statistical significance are not -- on all planes, the numbers improved, correct?

A No. That's -- the very meaning of determining -- factoring in whether something is statistically significant or not.

14:16:15 Q Ultimately, the writers of this study stated, if you look at the next paragraph -- or look on the discussion part if you want -- can you see the screen up here?

A Oh, I have the same thing on this screen.

Q Oh. You have got one. Okay, good.

14:16:31 Our results suggest that endocrine intervention is associated with improved mental health among transgender youth.

Did I read that right?

A Yes. Those are their words.

Q Doctor, to be clear, you agree that the U.S.-based medical

14:17:15 association guidelines and position statements are in support for the use of medical treatment combined with mental health treatment for adolescents with gender dysphoria, correct?

A I don't think I would phrase it quite that strongly. Most of the associations are using relatively vague terms. And it's

14:17:35 not clear when they're talking about adults or children, when

they're talking about transition, medical services versus psychotherapy, or a relatively blanket statement of demonstrating respect. I can only accept that they're endorsing a particular treatment when they're endorsing a particular treatment.

So is there a specific association or specific statement you have in mind?

Q The major medical associations that were involved in this space endorse the use of medications to treat gender dysphoria in children -- excuse me -- gender dysphoric adolescents once they reach puberty when appropriate?

A I can think of two medical associations, one interdisciplinary association, and the other -- and all of the others are, as I say relatively, vague words of support, and it's not clear exactly what it is that they're recommending.

Q Well, my understanding is what you like to look at is the international standards. That's what you're talking about today in support of your opinions?

A Oh, I looked at each of them, and I think I described each of them. I did my best not to leave any out.

Q So, and according to you, the Dutch approach is internationally the most widely-respected and utilized method for the treatment of children who present with gender dysphoria?

A Yes.

Q And the Dutch approach is also, I believe, what you call that watchful waiting approach?
A No.
Q Okay. The Dutch approach is what is accepted -- I have already said what you said.
14:19:24
The Dutch approach says social transition can happen at age 12, puberty blockers may be prescribed at age 12, hormones at age 16, and then resolve other mental health issues before transition. That's the Dutch method?
14:19:43
A Yes.
Q Do you know how that approach aligns with protocols that are utilized at UAB Children's in Alabama?
A I don't know.
Q In any event, what you say is internationally the most
14:20:03
widely-respected and utilized method for treatment of children who present with gender dysphoria, you would agree that that approach would be a felony in Alabama with this new law, correct?
A Yes. It's true that the Alabama law didn't leave an
14:20:26
exception for research purposes.
Q Okay. So let's talk about the European countries that you mentioned very briefly, the UK, Finland, Sweden and France.
When you look at those four European countries, Doctor, not one of them has enacted a ban to puberty blockers and
14:20:46
hormone treatments as Alabama has done here, correct?

A No.
Q That's not correct?
A Correct. That is not correct.
Q UK has not fully banned puberty blockers and hormone treatments in youth 18 and younger?
A That's correct.
Q Finland has not banned -- let me ask it this way: Has Finland banned blockers and hormone treatments in youth ages 18 and under for gender dysphoria?
A Yes, I believe it has.
Q It has?
A I believe so.
Q A blanket ban? Should I refer you to paragraph 131 of your declaration, sir?
A Hang on. That's just where I am now.
Q Okay.
A Oh, yes, they did leave an exception for hormones. The total ban was on surgery.
Q Thank you, sir.
Sweden, has Sweden put an absolute ban on puberty blockers?
A Yes.
Q And bear with me. Have they put a ban on puberty blockers and hormone treatments in youth ages 18 and under for gender dysphoria in Sweden?

A 18 and under?
Q Yes, sir.
A No. They allowed exceptions for 16 year olds -- 16 year olds within research circumstances.
14:22:32 Q Has France banned the use of puberty blockers and hormone treatments for adolescents ages 18 and under?
A No.
Q Can you point me to a single country, Doctor, in Europe that has put a blanket ban on the use of puberty blockers or
14:22:50 hormone treatments for youth ages 18 and under for gender dysphoria?
A Blanket ban in the way you're describing it, no.
THE COURT: How about any country?
THE WITNESS: No, not that I know of.
14:23:04 BY MS. EAGAN:
Q I want to turn very briefly to the subject of -- I will use your word desistance.
If you turn to paragraph 36 of your declaration.
A Yes.
14:23:36 Q In that -- you state, Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty ranging from 61 to 80 percent desistance across the large prospective studies.
I know that's a point that you also raised earlier today.
14:23:59 So I want to ask this question: Of those that number, do

you know, Doctor, what percentage of those kids cease to want to be the other gender -- that's using your words -- before or as they enter puberty, in other words, before they actually get into puberty? Do you know how many of those desisters are in that window?

A I must not be understanding your question, because it makes me want to say the same number that's in the report, 61 to 88 percent. What's different from what I said and what you're asking?

Q The 61 to 88 percent, is that children that realign with their birth sex before -- or as they're entering into puberty, that's that number?

A Yes.

Q Okay. All right. So I want to focus on a different category of youth. Let me ask you this: The medications in the United States, puberty blockers and hormone treatments cannot be given to kids for gender dysphoria until after they've actually entered into puberty, correct?

A Very many clinics are doing it as close to the beginning as soon as puberty starts as they are able.

Q But it's once they have entered puberty?

A Yes.

Q So let me ask you about that category of youth.

And that is adolescents who have entered into puberty, okay, and who have been -- have suffered from gender dysphoria

persistently, consistently, and insistently in childhood leading up to puberty, okay?

A Okay.

Q Do you have any data regarding what percentage of those individuals desist after they enter into puberty?

A No. I don't think that level of follow-up has yet been conducted.

Q And, Doctor, in fact, it's your belief that the majority -- that while the majority of prepubescent kids cease to feel trans, you know, to puberty or during puberty, in other words, as they enter into puberty, the majority of kids who continue to feel trans after puberty rarely cease?

A That does seem to be the case, yes.

Q Okay. Doctor, are you being paid to be here to testify today?

A Yes.

Q What's your rate?

A 400 an hour.

Q Who is paying your fees?

A The Alabama state -- State of Alabama.

Q Okay. Dr. Cantor, have you attempted to recruit parents in Alabama whose children have gender dysphoria and were prescribed or referred to gender-affirmative treatments, have you tried to recruit them to give a witness statement in this case that they believe the treatments are harmful?

A No.
Q Do you tweet?
A Yes.
MS. EAGAN: Your Honor, may I approach?
14:27:49 THE COURT: Yes.
BY MS. EAGAN:
Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet Dr. James Cantor retweeted. And it's -- let me say this: Is this a tweet that you actually did?
14:28:40 A No. I --
Q You retweeted?
A Retweeted, exactly.
Q From a group called Genspect, or what's -- I don't tweet. Would you call that a group? I guess it's a group called
14:28:56 Genspect?
A It's there is a group called Genspect, and this is their Twitter account.
Q All right. And then you retweeted it?
A Yes.
14:29:03 Q And it says, Urgent. Attention. Alabama parents, if your child experienced gender dysphoria and was prescribed or referred to gender-affirmative treatments and you believe these treatments are harmful, please direct message, e-mail us at once. We are looking for witness statements. Can be anon.
14:29:26 By anon, I guess that means anonymous, correct?

A That would be my reading, yes.
Q All right. Doctor, have you seen a sworn statement under penalty of perjury for any Alabama parent whose kid received puberty blockers or hormones and the parent said the
14:29:50 medications hurt their kid more than they helped them?
A I'm sorry. Did you ask have I seen such a statement?
Q Yes, sir.
A Not that I recall.
MS. EAGAN: Nothing further.
14:30:05 THE COURT: Any redirect?
MR. DAVIS: Short.
THE COURT: Ms. Eagan, did you intend to offer that into evidence or no?
MS. EAGAN: Oh, yes. Thank you, Judge. I offer
14:30:37 Plaintiffs' Exhibit 45.
THE COURT: It will be admitted.
REDIRECT EXAMINATION
BY MR. DAVIS:
Q Dr. Cantor?
14:30:51 A Hi.
Q Is it true as a clinician you are not treating anyone who has presented with gender dysphoria as an adult or as a child?
A I treat adults with gender dysphoria, not children.
Q You are not treating them while they are adolescents or
14:31:09 children, you are not currently treating someone who is like

under age 16?
A Correct.
Q Okay. But you are familiar with the research literature on these issues, correct?
14:31:19 A Yes, quite.
Q And even those that are studying -- or children in adolescents?
A Of course.
Q You're knowledgeable about the treatment they're
14:31:29 receiving?
A Yes, very.
Q And are you knowledgeable about what the research shows about the efficacy of these treatments?
A Yes.
14:31:35 Q You had an exchange with Ms. Eagan where you admitted that a fact that is self-reported by a participant may be true?
A Correct.
Q What's the rest of that sentence?
A It is certainly not necessarily true. We need something
14:31:53 objective before we can make any decisions upon it.
Q Let's turn to the Costa study. That's at Tab 38 of the book of plaintiffs' exhibits.
MR. DAVIS: Your Honor, I'm sorry. I left a notebook. May I step over?
14:32:40 THE COURT: Certainly.

THE WITNESS: I'm sorry. You said Tab 38?
BY MR. DAVIS:
Q I was mistaken, Dr. Cantor. It was 34.
A 34 of the defendants'?
14:33:02 Q No. Of the plaintiffs' book.
A Yes. Now I'm back there.
Q Okay. Now, you have a line in your report in paragraph 57 of your report that I will just read to you.
It says, Both groups improved in psychological functioning
14:33:25 over the course of the study, but no statistically significant differences between the groups was detected at any point?
A Correct.
Q Okay. Are the three groups represented by the three colored lines -- the three groups you're talking about, the
14:33:41 three groups on the three colored lines on this chart I'm showing you?
A Part of the information is contained in that graph, yes.
Q Okay. Does this table tell us more about the statistical significance or lack thereof shown in the Costa study?
14:34:02 A Yes, it does. The results of this table, although much harder to read, indicate that there was no statistical significance between the groups.
Q Okay.
A What was changing in the groups was change over time
14:34:13 within the group relative to the same group previously. But

there were no changes -- no significant differences between the groups themselves.

Q Okay. What does it mean in a study if a finding lacks statistical significance?

14:34:29 A That there was a substantial probability of getting a pattern like that just by random chance.

Q And are there any reasons other than puberty suppression that the delayed group did not have the same change over time as the immediately eligible group?

14:34:45 A It's not exactly clear if they didn't change just as much. That's one of the ambiguities that, again, comes from statistics. When you look at it in different ways, you can see different aspects, different aspects of it.

Q And the authors actually noted statistical significance or

14:35:11 lack thereof, did they not, in the language that are bracketed there? It says, this difference failed to reach significance possibly because of sample size?

A That is correct.

Q Have you said anything about the Costa study in your

14:35:24 report that you need to withdraw after your exchange with Ms. Eagan?

A No. Everything I said is accurate.

Q Okay. Is the same true for everything that you have said about the Achille study?

14:35:39 A Yes. Everything I said was accurate. Nothing in the

prior discussion changed it.
Q The UK is still reviewing these treatments, are they not?
A They are in the middle of deciding what to do with what they have now discovered from their comprehensive review of the literature, which showed what they were doing was wrong.
Q What did they discover?
A They discovered that they said exactly what I said, that there is no evidence to support the medical transition of these children.
Q And they have not yet decided how to respond to that revelation, correct?
A Correct. They have now taken that report, and they're now reorganizing and deciding exactly what it is that they're going to do.
Q And in France, is it not correct that they've said about hormones that the greatest reserve is required for their use?
A That is correct.
Q And is it true that, quote, they have said that speaking of hormones, they're irreversible nature must be emphasized?
A That is correct.
Q And in Sweden, is anyone under 16 getting puberty blockers or hormone treatments?
A No. That is banned.
Q And what about over 16? Youth -- like --
A Between 16 and 18, they're permitted to do it, but only

within recognized research programs. A regular physician can't.

Q And how many such research programs are going on at present?

14:37:04 A Oh, in Sweden?

Q Are you aware of any?

A I am aware of one lab that has two locations. I don't know what its current status is with its current research program.

14:37:20 Q Okay. Can you say whether a single child under 18 is currently receiving hormones for the purpose of transitioning in Sweden?

A I don't know.

MR. DAVIS: Thank you, Dr. Cantor.

14:37:39 THE COURT: Any recross?

MS. EAGAN: No, Your Honor.

THE COURT: May this witness be excused?

MR. DAVIS: Yes, of course, Your Honor.

THE COURT: All right. You can step down, sir.

14:37:48 THE WITNESS: Thank you.

THE COURT: All right. Call your next witness.

MR. DAVIS: Your Honor, the State calls Ms. Sydney Wright.

THE COURT: All right.

14:37:54 SYDNEY WRIGHT,

EXHIBIT 11
Witness: James Cantor
Date: 6/7/23
Dana Miller, RPR, CRR

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION
NO. 1:23-cv-00595-JPH-KMB

K.C., et al.,)
)
Plaintiff(s),)
)
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendant(s).)

The videoconference deposition upon oral examination of PROFESSOR DIANNA T. KENNY, a witness produced and sworn before me, Brandy L. Bradley, RPR, a Notary Public in and for the County of Hamilton, State of Indiana, taken on behalf of the Plaintiffs at the remote location of the witness, Sydney, New South Whales, Australia, on the 30th day of May, 2023, pursuant to the Indiana Rules of Trial Procedure.

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I N D E X O F E X A M I N A T I O N

I N D E X O F E X H I B I T S

Pursuant to the Indiana Supreme Court Case 20S-MS-236 signed March 31, 2020, PROFESSOR DIANNA T. KENNY, having been first duly sworn to tell the truth, the whole truth and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION,
QUESTIONS BY GAVIN M. ROSE:

Q Good morning, Doctor. How are you today?
A I'm fine. Thanks.
Q Can you state your name for the record, please.
A It's Dianna Theadora Kenny.
Q That's Dianna with two Ns; correct?
A Yes, and Theadora with an O, not an A, so T-h-e-a-d-o-r-a, and Kenny there's no E, K-e-n-n-y.
Q And I heard you before we went on the record say that you would prefer to be addressed as Dianna; is that correct?
A That's fine, yeah.
Q If I fall into old habits, do you prefer doctor or professor?
A Professor.
Q Dianna, have you ever had your deposition taken before?

A Not in America, no.
Q Have you in Australia?
A Yes. Well, I mean, you don't call them -- it's not exactly the same process, but yes.
Q You've been asked questions under oath for purposes of a court case?
A That's right, yes.
Q I, obviously, know nothing about the rules of depositions or their equivalent in Australia, so I will go over the rules real quick with you. You understand that this is a formal asking and answering of questions under oath; correct?
A Yes.
Q Okay. The court reporter has asked me to remind you, which I would have done anyway, that because she is writing down everything that we say it is very important that you wait until I finish my question before providing your answer.
A Okay.
Q And I will try to give you the exact same courtesy; is that fair?
A Yes, it is. Could I get you to sit back a fraction because I can only see that much of your face?
Q I'm sorry. Is this better?

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A That's better, yes.
Q Can you still hear me okay?
A Yes, I can.
Q Okay. We had an issue with Zoom not long ago where I had it set to the wrong microphone so I'm used to leaning over something and I don't have to now that it's set correctly, so I apologize.
A Thank you.
Q The court reporter has also asked me to remind you that because of the distance between you and us there very well may be a lag time in the video or in our communication, so, for that reason, too, it's important for you to wait until I finish to begin your answer, okay?
A Okay.
Q In other depositions in this case we have been taking a short break every hour or so. My plan, if everybody is tolerating it, is to go a little longer than that, at least for the beginning, simply because we're already in the evening hours right now, but if at any time you feel like you need a break to stretch your legs, get a drink of water, use the restroom, please, speak up and we can certainly make that happen.

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Is that okay?
A I'm perfectly happy to go for -- I'm used to doing long stretches. I have a long attention span. I know it's going to get very late over there, so it's fine with me to just, yeah, extend those breaks.
Q Well, I have a short attention span and horrible knees so, please, forgive me if I'm the one that needs a break.
A Okay.
Q Do you have any questions about the process?
A No.
Q Okay. What did you do to prepare for today's deposition?
MR. FISHER: I'm going to object to the extent it calls for communication with counsel.
Q Without telling me the content of anything you spoke with your attorneys about today's happenings, did you speak with your attorneys in advance of today's deposition?
A Yes.
Q And when did you speak with them?
A Over the course of the last month. Well, speaking means communicating, documents, you know, going through what was required in my

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report, things like that.
Q Did you have a meeting or conversations specifically for the purpose of preparing you for today's deposition?
A A brief meeting.
Q When did that take place?
A I think that was last Thursday morning, my time.
Q Of course. Did you speak with anyone other than the attorneys for Indiana to prepare for today's deposition?
A No.
Q Did you review any documents in advance of today's deposition?
A Yes.
Q Which documents did you review?
A The primary documents that I reviewed are listed on the front of my declaration. Do you want me to go through them? You'll have them in front of you, but I have them here if you need them.
Q That was going to be my next question. Do you have any documents in front of you that you plan on referencing during the deposition?
A I have my declaration.
Q Okay. Is that the only document you have in front of you?

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A I was advised that that was the only document I was permitted.
Q That's perfectly fine with me. I just want to make sure.
The declaration that you have in front of you, does it have the attached exhibits, I think A through E?
A Yes, A through E. The ones you just sent like 10 minutes ago?
Q The declaration that your attorneys provided to us have, I think, five attachments. The first was your CV and then the other four were medical records pertaining to each of the plaintiffs. Do you have those attachments in front of you?
A No, I don't, no.
Q And it sounds like you have received copies of several exhibits that I e-mailed to your attorneys a short while ago?
A Yes, I received them about three minutes before this call.
Q Okay. And is anyone else in the room with you?
A No.
Q And are you physically located in your home?
A Yes, in my office, yes.
Q Your home office?

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A My home office, yes.
Q And you said this while we were off the record, but that's in Sydney, New South Whales, Australia?
A That's right.
Q While we're talking today, Doctor, I have several exhibits that I am going to show you. Unlike the other attorneys in this case, I have decided to go out on a limb and explain to the court reporter that I will try to use the share-screen function to show them myself. Because of how that works, you will only be able to see one page or part of one page on your computer. I promise I'm not trying to trick you. If you need me to scroll down or anything like that, please, just let me know and I'm more than happy to do so. Is that fair?
A Yes, that's fine.
Q You will also notice as we go through some of them that I have highlighted portions of the exhibits. The only reason for doing so -- and I freely admit that that was me that did so -- is to try to direct my eyesight so that I don't waste your time as I try to find what I'm looking for, but that's why some portions will

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be highlighted.
MR. FISHER: Gavin, can I interject for a second?
MR. ROSE: Of course.
MR. FISHER: To the extent that she needs full context for any of those documents, do you have an objection if she opens the full document that she received by e-mail?
MR. ROSE: Of course not.
Q Okay, Doctor, I'm going to pull up using the share-screen function what I have marked as Exhibit 1. And do you see that in front of you right now?
A Yes.
Q And I can scroll down if you need for me to; although, I can tell you that it's 14 pages long. I assume you recognize this as your curriculum vitae?
A Yes.
Q And this is the version that your attorneys provided to us just over the weekend. I assume that it's still current; is that correct?
A Yes, that's correct.
Q Okay. And you're currently employed, I understand?

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A Yes.
Q And it looks from your CV like you're employed as a consultant presently?
A That's right.
Q And that's for a business called DK Consulting?
A Yes.
Q And I assume the DK is you?
A Yes.
Q Are you the -- I'm sorry, I talked over you.
A That's okay. I just said it's not very original. No symbolism in that at all, yeah.
Q Are you the only employee of DK Consulting?
A I have an assistant, like an administrative assistant.
Q Okay. Is that the only other employee?
A Yes.
Q And has this been your only employment since 2019?
A Yes.
Q And by "since 2019," I mean since you retired from being a professor.
A That's right, yes.
Q Do you currently have any patient care responsibility?
A I'm in full-time private practice, so yeah.

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Q Is that through DK Consulting or just separate?
A No, no, that's through DK Consulting.
Q Okay. And I assume that you provide psychotherapy to your patients?
A Yes, I provide psychotherapy; I provide marriage and family therapy; I do child and adolescent assessments; and I do mediation and family dispute resolution.
Q When you do child and adolescent assessments, is that for anyone in particular?
A Well, in recent times, it's children being brought for gender dysphoria, so a large part of my practice currently are children and families with a young person who is declaring themselves transgender.
Q And when you say that you work full time in private practice, is that more or less 40 hours a week that you see patients?
A It's more like 60 hours a week.
Q And approximately what percentage of that would you say are for patients who have identified themselves as transgender?
A I'd say two-thirds, but they're not all patient contacts, the 60 hours, because I include preparing depositions for Indiana among the

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hours that I spend working. So, in my clinical hours, I would say at the moment two-thirds.
Q And, I'm sorry, that was just a bad question then. About how many hours each week are you working as a clinician?
A About 30.
Q Okay. So about 20 hours or so each week you're treating or assessing patients for gender dysphoria?
A Yes.
Q And are all the patients with gender dysphoria that you see minors?
A Yes, I specialize in minors.
Q I'll come back to your clinical practice in just a little bit. It looks from your CV like you served as a professor at the University of Sydney in various capacities from 1988 through 2019. Is that accurate?
A That is.
Q Your last position was as an honorary professor of psychology and a professor of music?
A Yes.
Q I'm just curious, but why music?
A Sorry?
Q I said I'm just curious, but why music?

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A Why music? It's a very long story and it's probably for another time, but I, you know --
Q Let me ask you this because I couldn't tell from your CV. Is it teaching music or is it teaching the psychology of music or performance anxiety or what have you?
A I established a research center at the Sydney Conservatorium of Music which is a faculty of the University of Sydney. So, when the Sydney Conservatorium of Music amalgamated with the university, it was a freestanding tertiary institution, and then there was a lot of legislative changes to reduce the number of tertiary institutions and the Sydney Conservatorium amalgamated with Sydney University and became a faculty, but we were a research-led university and it didn't have any research as a tertiary institution. It was primarily concerned with training young musicians.
And they were looking for somebody who had research expertise and who knew about music and how the university structures ran, applying for research grants, setting up a research laboratory, so the magic finger was pointed at

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me. And, for those years, I had two professorships that I had to juggle and get this search established. So I didn't do any undergraduate lecturing in that position. It was all as a director of research center and I was primarily supervising Ph.D. students but also doing a lot of research, applying for grants, writing papers, and so forth, yeah.
Q Thank you. In your role as a professor of psychology or I guess before that a lecturer in psychology, were there specific subjects that you taught?
A Yes, I was specifically hired for my expertise in developmental psychology and so I was primarily responsible for both the undergraduate and the postgraduate teaching in subjects like infant and child psychology, developmental psychology, developmental psychopathology. What else? Current issues in adolescent psychology, all those kinds of subjects, child and adolescent assessment.
Q Of the psychology courses that you taught, did any of them concern treating gender dysphoria or providing gender-affirmative care?
A There was no such thing when I started at the

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university and there were no courses anywhere in Australia because the incidence and prevalence of that condition was estimated to be minutely small and we, therefore, focused on the much more prevalent conditions that children present with in childhood. So it wasn't on the radar. Let me put it that way.
Q Did you teach any courses about that subject toward the end of your career with the University of Sydney?
A No. Towards the end of my career as a professor, I was primarily supervising Ph.D. students and executing research grants, conducting research, and generally organizing the research program that I've described before.
Q Have you taken any courses pertaining to gender dysphoria?
A Well, there aren't any formal courses even now that I'm aware of in Australia and I would have to vet them very carefully before I book any of those courses because Australia has unquestioningly, and without due thought and consideration, adopted what we call here as gender ideology and as soon as I see the contents of the description of gender ideology,

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I become, you know, quite twitchy and disturbed by the scientifically fallacious information that's being propagated, particularly in our entrance primary and secondary schools.

So I have engaged in a very detailed undertaking to educate myself based on my thorough training and many, many years of clinical experience developing my own model and my own clinical practice approach to these young people.

Q In the middle of your answer there you used the phrase "what we call here as gender ideology," and I'm just curious who "we" is in that sentence.

A Well, it's generally referred to in that way in the media and media who are somewhat less than supportive of things like gender-affirming care, for example, and all the new lexicon, the new terminology, you know, that's being propagated by the machinery of the trans advocates.

Q Okay. And I asked if you had taken any courses pertaining to gender dysphoria and maybe I didn't ask the question in the right way. Other than your personal investigation and review of the literature and certain materials, do you

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have any professional training specific to gender dysphoria or its treatment?

A As I explained, there are no such courses. People have just adopted practices from overseas. And, I mean, there are courses within courses, so, for example, in cultural studies there's a subcourse called gender and sexuality and within that course they would cover the discourses, the current discourses, but it's more in the area of sociology or critical studies. And my field is psychology so there's not really any intersection unless I choose to read some literature in that field, but there's no such discrete course as gender-affirming care.

Q Okay. During your time as a professor for, if I'm doing the math right, 30, 31 years, did you have patient care responsibilities at the same time?

A Yes, I had rights to private practice throughout my academic career.

Q And about how many hours each week were you seeing patients? And I'm sure --

A About 10.

Q Okay. And was that more or less consistent

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throughout your time teaching?

A Yeah. I mean, it varied according to, you know, circumstances, but, on average, I would say that would be about right.

Q So, prior to your time in private practice following your tenure with the University of Sydney, were any of the patients that you saw diagnosed with gender dysphoria?

A Do you mean when I was at the university?

Q Yes. I'm sorry.

A No. I only kind of became involved in about 2019 when a colleague of mine, who is an adolescent psychiatrist, called me and said a few psychiatrists are getting referrals of these young children who are gender dysphoric and wanting to transgender and none of them had very much experience with child and adolescent psychology or psychiatry. And he asked me if I would review a couple of cases that he had been referred and have a case conference, a peer consultation. And it was from that point that I started to take on cases myself and to really intensively educate myself about what was going on and what was happening in this field, so it's really been for the last coming into five years.

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Q And do you remember what time of the year in 2019 you left the University of Sydney?

A July.

Q So would it be after that time that you began looking into gender dysphoria?

A Yes.

Q Okay. And then it looks from your CV like from '86 through '87 you were a psychologist in private practice?

A Yes, I was.

Q During this time did you see or treat any patients with gender dysphoria?

A No. I might say that they didn't exist in Australia in 1986/'87.

Q Okay. Then I want to, if it's okay, just briefly focus on your clinical experience after you left the University of Sydney where you've been seeing patients and looking into gender dysphoria. Is that okay?

A Yeah.

Q Approximately how many patients with gender dysphoria or gender identity issues did you see over this period or have you seen over this period?

MR. FISHER: I'm going to object to the

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form of that question. It's unclear whether those are two separate categories or you're conflating them together?

MR. ROSE: That's a perfectly fair objection and if Tom had not called me, I would have rephrased it myself.

Q How many patients diagnosed with gender dysphoria have you seen since you left the University of Sydney, more or less?

A Well, it depends on whether you're talking about seeing them for assessment or seeing them for therapy. If I just counted the young people that I had seen for assessment, it would be in the vicinity of 150 to 180, and, of those, I would have taken probably 50 to 60 into long-term therapy.

Q And pretend I know almost nothing about the practice of psychology, but what is, I guess, the assessment? A patient gets referred to you from some source and what happens then when you're assessing them?

A Well, I always meet with the parents first and I get a full developmental history because there's a great deal of dispute about onset and I want to get a very clear picture from the parents

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about when their child first expressed ideas about being transgender and so forth. So I do a very careful historical overview of their developmental milestones. I also want to understand how they're performing at school. I also want to review any of the previous assessments that they've had for intellectual ability, any intellectual disabilities, learning disabilities, have they had an assessment for autism spectrum disorder, ADHD, have they ever been diagnosed with depression and anxiety, are they on any medications. So that is quite an extended interview with the parents.

And during that time I'm also assessing the marital and parental dynamic so I'm looking for power imbalances in the marital diet, I'm looking for whether there's a lack of respectful interactions between the parents, and I'm also looking for whether there's any disagreement about how they should proceed with their child. And quite often you'll see one parent who is more supportive of allowing the transition and another parent who is not approving. So all of these things are extremely important.

And then I will see the child on his or her

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own and that might go from one to three sessions depending on what I'm exploring with the child and what I think is happening in terms of this child's life.

After that assessment of the child, I meet again with the parents and I give them an overview of my opinion and how we should proceed or how I recommend that the family proceed.

Q Just a couple of questions about that.

MR. FISHER: Gavin, I'm sorry to interrupt you. I just want to alert you. Because you're sharing your screen, when people are sending you text messages they're popping up on my screen. I'm doing my best to ignore them and not look at them, but I noticed at least one of them was from Chase so I thought I'd better alert you because probably you don't want me to see those.

MR. ROSE: I appreciate that. Thank you. Can we go off the record for just a second?

(A discussion was held off the record.)

QUESTIONS BY GAVIN M. ROSE:

Q Okay. Doctor, you just explained the assessment process when you see a patient for the first time for gender dysphoria, and my question to you is going to be whether there is an age range

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of the children that you assess.

A I've seen children as young as three to four and I usually -- I have seen some young adults in their 20s, but the majority are under 18 years of age or around. You know, I've seen quite a few like 17, 18-year-olds.

Q Would you say the majority are in their adolescence?

A Yes, I would.

Q Approximately how many children preadolescence have you assessed for gender dysphoria?

A I think it would be less than a quarter of the presentations.

Q So, if I'm doing the math, maybe 30-ish?

A Yeah. I mean, it depends on whether you count the peripubertal children, you know, the 11 and 12-year-olds because some children are reaching puberty at younger than average ages. So a child might be pubertal at 10 and so it would be a question of whether you would count that child as a child or as an emerging adolescent, so it gets a little bit gray if you wanted to strictly categorize them. The majority, I would say, would be between 10 and 18.

Q Okay. And of the 150 to 180 patients you've

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assessed, how do you decide which ones will become the 50 or 60 that you accept for longer-term treatment?
A I make an assessment about whether the young person is capable of entering into a psychotherapeutic process. That's one criterion.
Another is whether it is more (inaudible) to work directly with the parents and, quite often, I will choose to do that in the first instance. So I will meet with the parents more regularly than the child and I will -- I suppose the word is coach, you know, coach them about parenting and how to manage, you know, the child's behavior generally and how to manage the statements or, you know, gender sort of related issues, so that's another way that I work.
And, in some cases, I'll work with the family, usually the young person and the parents together. In most cases I don't include siblings. If I do do family therapy, it's just with the identified child.
So I have a very broad perspective on the kinds of interventions that I undertake and they're based on very careful assessment of the

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dynamics of the family, the capacity to engage in particular psychotherapeutic processes, and that involves a capacity for insight and reflective function. And, you know, if not, I step it down to psychoeducation, behavioral management. But I do find that an open exploratory psychodynamic/psychotherapy approach is more effective if it's suitable for that young person and the family.
Q And you began that answering by saying that one of the things you look at in determining whether to accept a patient for longer-term treatment is whether they're capable of entering into the psychotherapeutic relationship or possibly the process. What type of patient is not capable of doing that?
A Well, you have to be very careful about young people with autism spectrum disorder. In the early days and even now, I did take some of those into individual therapy because they were extremely distressed young people. And, because of their cognitive rigidity, cognitive immaturity, their literal interpretation of the world, and some of them display quite obsessional features in both their behavior and

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their thinking, you come to a point where it does not seem to be the best intervention for that type of young person and so I seek other methods, usually primarily working intensively with the parents.
Q And when you assess a patient are you attempting to -- are they coming to you with a diagnosis or are you attempting to diagnose them?
A I'm not primarily focused -- I presume you're meaning a diagnosis of gender dysphoria?
Q Sure.
A Yeah. The parent will usually tell me in the first assessment interview what their child is saying and doing with respect to gender and what their demands are and expectations. When I see the child, I'll ask them why they've come to see me, what is their understanding of why they've visited with me today, and I usually take the assessment from that point. And you would be amazed at how many of them don't start with gender.
Q How many minor patients have you diagnosed with gender dysphoria, if any?
A I think one.
Q And how old was that patient?

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A Four.
Q And when you diagnosed that patient with gender dysphoria, what diagnostic criteria did you use?
A Well, I mean, the only acceptable one in current situation is DSM-5 that you will see from my declaration that I have great concerns about the DSM-5 as do a large number of my colleagues.
Q Are those the criteria that you used in diagnosing that one patient, though?
A I look at those criteria, but I primarily am concerned with the behavior of the child.
Q What, if any, criteria other than the DSM-5 did you consult in diagnosing that patient?
A I look at their general adaptation, whether they're meeting developmental milestones, whether they're capable of expressing an independent idea about themselves because quite often there are subtle communication dynamics happening between parents and children, and, you know, I mean, of course, the simplest one is that mother speaks for the child and that's why it's important to spend some time with the child alone. And, often, because I do a lot of work for the family court in Australia and for the Office of the Department of Public Prosecutions

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where there are allegations of child sexual abuse, they're really, really, you know, very damaging custody disputes and so on.

Q I'm sorry for interrupting, but I was going to ask: Did the tools or criteria that you used in addition to the DSM-5, do they come from any publication? Are they written down anywhere?

A Well, they come from the development psychology literature and also the literature on dynamic psychotherapy.

Q But there's no specific one page, two-page list of criteria that you can point me to for these?

A Well, I have been a coauthor of two clinical guides for the management of children with gender dysphoria. One of them was an international consortium that I contributed a very significant portion of that document. I've also contributed in a major way to the clinical guide published by the National Association of Practicing Psychiatrists, and I've also written some therapeutic treatment guides for clinicians that I've presented at meetings and conferences for consideration.

Q You described this one patient that you diagnosed with gender dysphoria. Were any of

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the other patients that you saw for gender dysphoria diagnosed with gender dysphoria by another professional?

A By and large, my practice involves what's called tertiary referral, so a lot of these young people come to me when the parents have been horrified by what's been going on in the gender clinics.

So one of the typical ways that it happens is that the child declares him or herself transgender. The mother takes the child to the general practitioner. That's the family treating doctor. The doctors will then refer these children to either gender-affirming (inaudible) pediatricians or to the gender clinics. And once you're on that, as the Swedish call it, the "trans train," there's almost only one stop and that's transition.

And, so, when the parents go to these establishments, they're actually excluded from the process. They're being made to wait outside. If the parent wants to contribute their perceptions of their child and their worries about their child and maybe transition isn't the right thing for them, they're taken

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off and told that they're the problem and to get out of the child's way. And, you know, as soon as this child starts the transition process, all of these serious psychological problems up to and including self harm and school refusal and, you know, the old standards of depression and anxiety, they're all going to magically disappear if you start pumping the child with puberty blockers and cross-sex hormones.

Q I'm sorry, Doctor.

A I'll finish my answer.

Q I'm sorry, Doctor. You've actually gone well beyond the question that I've asked so I'd like to turn back to the question that I asked which is: Other than the one patient that you diagnosed with gender dysphoria, had any of the other patients that you've seen for gender dysphoria been diagnosed with that condition by some other professional?

A Well, I was about to finish my answer when you cut me off. So the answer is yes and I'm telling you the root by which they've been diagnosed after maybe one half-hour session by the gender clinic.

Q And the reason I ask that question is I'm trying

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to hone down on, I guess, whether you believe that you have only had one patient with an accurate diagnosis of gender dysphoria or whether you believe you've had a number of patients with an accurate diagnosis of gender dysphoria.

A Well, I was attempting to answer that question in your previous question which is I am a tertiary referral source. So the parents who become horrified at what's going on at the gender clinics are the people who are most likely to come to see me so they're already convinced that the diagnosis of gender dysphoria is inaccurate and inappropriate for their child, and, so, that would be the patient group that I see. I'm not seeing the captured parents. They're staying at the gender clinics.

Q Okay. And, other than that one patient that you diagnosed with gender dysphoria, did you agree with the assessment of the parents that every other patient you saw for gender dysphoria had been inaccurately or inappropriately diagnosed with that condition?

A I don't make definitive statements of that kind until I've worked with the parents and with the

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child. It's an open question that has to be explored very carefully as well as all of the other comorbid presentations that the child usually presents with. I can tell you one thing for sure and that is I haven't seen a child without a comorbid presentation who comes telling me that they're gender dysphoric, so there's usually serious pathology in the child and the family.

Q Have any patients come to you with a diagnosis of gender dysphoria where your assessment and prolonged treatment, if it goes that way, confirms the diagnosis?

A I don't confirm the diagnosis.

Q Okay. You keep medical records for each of your patients; is that correct?

A Of course.

Q And on the medical records that you keep, do you have a list of diagnoses for which the patients have presented or been confirmed? Do you have a list of diagnoses for each patient?

A Yes.

Q And how many patients of the 50 or 60 that you've accepted into long-term treatment do your records reflect a diagnosis of gender dysphoria?

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A Zero.

Q And what about the one person that you diagnosed with gender dysphoria?

A I didn't make a definitive statement. I said it was likely a diagnosis that needed to be considered seriously, but because of the child's age and, you know, cognitive immaturity, I suggested that the parents engage in active watchful waiting for a significant period of time before taking any action.

Q And do you continue to see that patient?

A I see the parents. I don't see the patient at this point.

Q Have you ever seen a patient who was taking either puberty blockers or gender-affirming hormones?

A Yes.

Q And were those subsequently discontinued?

A No. Oh, well, I mean, one has to look at each case individually, but there's only a small number that I'm seeing who had already started that process and, to date, they have not discontinued and I'm not pressuring them to discontinue. You know, these young people on cross-sex hormones around 16, 17, 18, so I

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engage in an exploratory process with them, but, once they do start taking the cross-sex hormones, the landscape changes because these medications, of course, affect the total body and the way they think about themselves and their neurological as well as physical functioning.

Q And, please, correct me if I'm wrong because I might have just misheard a word. Did you say that you've only seen one patient taking hormones?

A No, I've seen three or four.

Q Okay. And were those three or four patients patients that you simply assessed or were they accepted into longer-term treatment?

A I have one in long-term treatment. I've been seeing him for two years, and when I started to see him he wasn't taking hormones. The others have turned 18 during their therapy and decided that they were going to proceed to cross-sex hormones. And, yeah, I don't know if that answers your question.

Q It does. Thank you. And I didn't ask it right the first time and I apologize for that, but same questions about puberty blockers. How many

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patients have you seen who are taking puberty blockers?

A Probably not many, two or three.

Q And, again, same question. Were those patients that you accepted into longer-term treatment?

A Well, I did attempt to, yes.

Q Attempt but did not ultimately?

A Well, when the decision was made, you know, that puberty blockers were the magic bullet, that kind of foreclosed any further discussion.

Q Why did it foreclose any further discussion?

A Well, they found the magic solution.

Q A short while ago in talking about the one patient who you diagnosed with at least likely gender dysphoria, you said that you told the parents to wait and evaluate for I think you said a considerable amount of time. Does that sound right?

A Yes.

Q How long do you consider to be a considerable amount of time?

A It varies with different patients, but I was very mindful if I communicated this to the parents that one of the only robust studies that looked at childhood onset of gender dysphoria

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and followed them for 20 years, 88% of them desisted by like adulthood and I think it was 60% identified as gay young men. And I communicated that developmental trajectory to the parents and said that they needed to exercise extreme caution in allowing the child to follow his natural developmental trajectory and that any social transition or prescription of puberty blockade would derail that developmental trajectory.

Q And, I'm sorry, how are you defining social transition?

A Where the child changes his or her names or pronouns. They start to dress in the stereotypically style of the opposite sex where they grow their hair long or cut their hair short, that kind of thing.

Q When you have a patient that presents to you as transgender, do you use particular pronouns in referring to that person?

A I avoid pronouns altogether because I'm having first person conversation with a young person and I do not use --

Q Well, you talk about the patient with their parents, though; right?

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A Not often, no. I usually separate the consultations with parents and children.

Q I'm so sorry for the misunderstanding, Doctor. I did not mean you talk about the patient with the parents in the same room. I meant you have a separate conversation with the parents about the patient; correct?

A Yes.

Q And when you're speaking to the parent do you use pronouns to refer to the child?

A I follow the parent and, in the majority of the cases that I see, the parent is insisting on the child's birth name and natal pronouns.

Q Are there cases where the parent has referred to their child using their non-natal pronouns?

A Yes, I had one last night and, I mean, it wasn't her first session. I've seen her before and she is now using her daughter's preferred name and masculine pronouns. And I have discussed that with her, you know, why is she doing that and how does she think it's helping her child, and I then seek permission from the parent to call the child by his or her given name and pronouns.

Q And I assume your medical records use the sex the child was assigned at birth when they have

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to?

A Yes. I need to do that for clinical purposes because I need to get a picture in my own mind, a template of this child, and quite often I have to do file reviews and case reviews and you will notice in my declaration that I have referred to these four young people using pronouns of their natal sex and their given name except in one case where the given name has been expunged completely, but that is my clinical practice.

Q Okay. Doctor, in your CV, which should still be in front of you, Page 2 lists your membership in various professional organizations; is that correct?

A Yeah.

Q And I assume you remain a member of each of the organizations you list here?

A No, I said that I -- well, in my CV, obviously, it doesn't say that, but somewhere I said, I think it was in the bio, you know, preceding this, I was a member or eligible for membership if I let the membership lapse and in some cases I have let the membership lapse because the fees are ridiculous and you have to be very selective.

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Q Okay. Of the professional societies you list on your CV, which of these societies or organizations do you remain a member?

A Only the Australian Psychological Society, but I have at one time or another been members -- oh, and the International Association of Relational Psychoanalytic Psychotherapy. Oh, and I'm a member of the Australian Dispute Resolution Association, yeah.

Q And when was the last time you were a member of the American -- or an international affiliate, it looks like, of the American Psychological Association?

A I let those go after I left the university.

Q So 2019 or so?

A Yeah.

Q Is that because the university was paying your membership dues?

A Oh, no. No, we have to pay our own membership dues.

Q Why did you let your membership lapse then?

A There's just so much available on the Internet now. It just wasn't value for money. I mean, the Australian Psychological Society, the fees are $1,000 a year and you just have to be

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selective.
Q And what does it mean to be an international affiliate of the American Psychological Association? I just don't know what that means.
A That means that if you're not American, you can't be a full member.
Q Gotcha. Other than the organizations that you list here on Page 2 of your CV, are you currently a member of any other professional organizations?
A Yes, I'm a council member of the University of Sydney Association of Professors and I'm a council member of the Australian Association of University Professors. I'm a member of the Society for Evidence-Based Gender Medicine.
Q And if I refer to that organization just as SEGM, S-E-G-M, you'll know what I mean?
A I will.
Q How did you become a member of SEGM?
A I was invited.
Q By whom?
A There were two founding directors and I think one of them is Australian and he put my name up to the American cofounder and they invited me together.

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Q And when did you first become a member?
A I'd say maybe three to four years ago.
Q Have you ever held a leadership position with the organization?
A No, I avoid administration and hierarchies and, you know, political positions like the plague. I'm a clinician, I'm a researcher, I'm a writer, and I don't have time for that and I'm not interested in that, yeah.
Q Have you ever been compensated by SEGM for any reason?
A Yes, I have been on one occasion.
Q I assume this was for giving a talk or presentation to a meeting?
A I wrote some extensive material for their clinical guide.
Q I'm sorry, I missed a word there. Wrote some what material?
A Extensively. I wrote some very long documents for them when we were putting together the clinical guide and it was an honorarium. I didn't ask for payment, but they appreciated the amount of time and effort that I devoted to that. And I was perfectly prepared to do it voluntarily so it was just a gesture rather than

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-- it wasn't a contract. It was an honorarium.
Q Does SEGM hold meetings or conferences?
A Yes.
Q How often?
A I believe about once a month there's a Zoom meeting and from time to time, you know, people get together in person but it's very difficult when you're in Australia. You have to be very selective where you travel.
Q Do you have to be invited to become a member?
A I believe so.
Q Are you aware that statements by SEGM have been cited in support of a formal opinion in Texas that took the position that the provision of certain gender-affirming care to a minor constitutes child abuse?
A Yes.
MR. FISHER: I was just gonna object. I wasn't sure what formal opinion. Could you maybe --
MR. ROSE: I can state for the record, Tom, but when Attorney General Paxton issued his formal opinion declaring the provision of certain care to be child abuse under Texas law he cited SEGM, I think, a couple times.

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MR. FISHER: Paxton did, okay. Thank you.
MR. ROSE: And I didn't see a point to bring that up and I apologize, bringing the actual document up.
Q And I guess my question to you, Doctor, is whether you believe that providing gender-affirming care to minors in the form of puberty blockers or hormones constitutes child abuse.
A I would prefer to avoid a motive language. I do believe it's very poor medicine to derail a child's natural developmental trajectory precipitously when the drugs that have been prescribed have known demonstrated (inaudible) to the human body.
Now, child abuse in this country, and I'm sure in yours, carries with it a legal definition and so I don't think it's helpful to use a motive language when trying to discuss the best treatment and management of young people who are declaring themselves gender dysphoric.
Q And, I'm sorry, Doctor, I would know the answer to this question if you were a psychologist in America. As a psychologist in Australia, are you authorized to prescribe medications?

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A No.
Q Are you a member of any advocacy or political organizations?
A No.
Q Have you been in the past?
A You mean advocacy for gender-affirming care?
Q I meant in general and we can narrow it down from there.
A No, I'm not a member of any political party. I'm not a member of any religious organization. I'm not a member of any gender or sexuality-based organization. I am a completely free agent.
Q Okay. My understanding is that you have testified before several legislatures and other decision-making bodies concerning transgender persons or the provision of gender-affirming care; correct?
A Well, only one formally in America and that was in Alabama.
Q And I'll do that one first. Do you mean that you played a role in the Alabama bill similar to Indiana's before that bill was passed?
A Yes.
Q You, I assume, submitted written comments

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advocating for it to be passed?
A The original bill, yes.
Q And have you testified before legislatures or other decision-making bodies in Australia about the issue?
A I have provided written and oral submission to the New South Whales Parliament and the Queensland Parliament and written submissions to the National Parliament in Canberra on various bills associated with gender.
Q Let me take those one at a time, I'm sorry, because I just don't understand how broad your answer was. For the parliament in New South Whales, was there more than one bill that you submitted comments on?
A Just scroll down so I can see and just remind myself.
Q I apologize.
A Just keep going. Keep going down to the submissions. Okay. Stop. The submission to the New South Whales Parliamentary Inquiry for the Education Legislation Amendment of Parental Rights, I had a written submission and appeared. I was invited to appear to the parliamentary inquiry. Then there was the submission and

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invited presentation to the Queensland government inquiry into the Health Legislation Bill in 2019 to outlaw conversion therapy. And the submission to the ACT -- that stands for Australian Capital Territory -- government into the proposed amendments to outlaw conversion therapy. And I believe I submitted a similar submission to the Victorian Parliament on conversion therapy as well and I've just neglected to put that in.
Q Okay. And other than -- maybe this would have been a better way to do this. Other than the possible submission to the Victorian Parliament, is every time you have testified or submitted written testimony to a decision-making body in Australia about gender-affirming care, is that contained on Page 6 of your CV here?
A Yes.
Q And the one to the Victorian Parliament was also on conversion therapy?
A Yeah.
Q Have you been compensated for your testimony to any of these bodies?
A Only Alabama and Indiana. The other have been all pro bono.

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Q And, by your compensation in Alabama and Indiana, you mean after a lawsuit was filed?
A I don't understand.
Q I'm sorry, Doctor. I'm trying to figure out whether you were paid for submitting testimony to the legislatures while a bill was being contemplated or whether you're just talking about being paid to serve as a witness after a bill was passed and challenged in court.
A I think they -- the Alabama and Indiana situations are similar, so, yeah, a bill was passed, now there's an appeal, and I have written a report. Tom will be able to explain that a lot better than me. I don't want to say the wrong thing.
MR. FISHER: I'm of no use to Gavin in any of this.
Q I understand. Thank you. Page 3 of your CV describes some of your activities for court-referred clients. Do you see that?
A Yeah.
Q And when did you assume these responsibilities?
A Oh, I've been doing that kind of work 10 to 15 years.
Q You mean you have over the past 15 years?

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A Yeah.
Q And I assume these are cases where a court in Australia, for one reason or another, wants a child to be evaluated; is that fair?
A Yes, and they can also be referred for court-mandated therapy.
Q In your responsibilities for court-referred clients, did any of the issues arising from that concern gender dysphoria?
A No, because the work that I've done for courts related to gender dysphoria have been written review and literature review and clinical practice documents, so these court-referred clients are usually to do with parental capacity, custody, time with, and, you know, any assessment that would make it necessary for the child or the family to enter into a therapeutic process.
Q Okay.
A I'll say no to that in terms of gender dysphoria. This work, more or less, preceded my work on gender issues.
Q Okay. And then Page 4 of your CV indicates that you also consult for the Tribunal of the Catholic Church; correct?

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A I have, yeah.
Q Is that something you currently do?
A The last case I did was probably about a year ago, maybe more, but I have been doing it for a very long time but I've kinda pulled back because I've just got too much work in other areas.
Q And, just very briefly, what did your consultancy for the church or does it entail when they refer something to you?
A Usually cases of marriage where one party is -- one or both parties is seeking an annulment of the marriage, and it's a very arcane system and it actually behaves very much like a court of law. There's a defender of the faith and a defender of the couple so it's quite adversarial, it can be, and, extraordinarily, the Catholic Church will sometimes find that there are no grounds for annulment. And usually people who go and seek annulments, they're devout Catholics and they wanted to remarry in the Catholic Church, but they can't remarry in the Catholic Church. They can only have a civil marriage unless their previous marriage has been annulled, and so they're the people who seek

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annulments.
So I do a marriage assessment and I see the couple and, you know, I do all the normal things that I would normally do as a psychological assessment of these couples to assist them and support them in -- you know, it's usually a very fraught and stressful time for these couples.
Q Okay. And then I'm going to scroll through this real quick. And, I'm sorry, Doctor, did you say that you have a copy of your CV in front of you?
A No, I don't, no.
Q Okay. Then I will scroll through real quick. I'm going to scroll through Pages 5 through 8 of your CV real quick, and my question to you is going to be whether this, as it purports to, the articles, reports, presentations that you have given specifically concerning gender dysphoria-related issues is going to be my question. Spoiler alert.
Look through to the bottom there. Is that an accurate description of what you identify in Pages 5 through 8?
A Yeah, pretty much.
Q Okay. The very last entry under that subheading related to gender dysphoria appears to be a

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radio interview that you gave in 2015. Do you see that?
A Yes.
Q I've read the transcript to this interview. It's my assumption it was mistakenly placed here, but I will just ask you. Did this interview specifically concern gender dysphoria or any issues related to it?
A I'm sorry about that. Let me just turn my phone off. It is misplaced, I'm afraid to say, because the date of 2015 is prior to my work in the gender dysphoria area, so I apologize for that error.
Q That was my assumption. I just wanted to make sure the record reflected that. And if that's the only error you make in a 14-page CV, you have done quite well for yourself.
Okay. The date you've given for when you started focusing on gender-related issues of 2019 you've indicated, more or less, coincides with when you left the University of Sydney. I'm wondering, first and foremost, why you left the University of Sydney.
A Well, after 31 years, I'd had enough and I was wanting to get back into clinical work and the

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tertiary system in this country is somewhat less than conducive to genuine academic work. It's just turned into a corporate bazaar and I no longer felt the affinity that I've always felt for academic life and my academic institution in particular, but it was time for a change.

I wanted to work clinically and I wanted to be free to express my firmly-held positions on certain topics. And you, no doubt, are very aware that there have been several academics around the world who have been sacked from the universities for expressing a contrary view, but that didn't motivate me. I have to be very clear about that because I hadn't really written or published anything or even formed my opinions firmly in 2019, but I did note with interest how other academics were being treated around the world if they dared to express a contrary view and I wouldn't find that acceptable.

Q Was there anything specific at the University of Sydney that indicated to you you would not be allowed to express your opinions related to gender dysphoria?

A Oh, absolutely. You just had to look at the new policies and, you know, colleagues using -- you

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know, you can see our names up here on the Zoom and suddenly putting in preferred pronouns and there were all sorts of indications that, you know, the opinions were only going one way and there was no room for academic debate, but I do stress that that was not a motivator for me personally.

Q Okay. I'm going to scroll back up to Page 5 of your CV. Toward the bottom of the page is an article with the lead author R. D'Angelo that you coauthored titled One Size Does Not Fit All. Do you see that?

A Yeah.

Q Other than this publication, have any of your writings concerning gender dysphoria or its treatment been published in any peer-reviewed journals?

A No, not at this point.

Q But this D'Angelo article was published in a peer-reviewed journal?

A Yes, it was.

Q And it's my understanding from looking at the article that it's a direct response to an article that had been published by Jack Turban and others?

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A Correct.

Q Pages 7 through 8 of your CV identify keynote and invited presentations and podcasts that you have given pertaining to gender dysphoria. Do you see that?

A Yes.

Q Is this a complete list of the presentations that you have given concerning gender dysphoria?

A Look, it might not be complete. I, you know, was under extreme time pressure to get all the materials prepared for this deposition and I did focus very much on the content, you know, reviewing the literature, writing, and then I had to focus an enormous amount of attention on doing the case file reviews of the four plaintiffs so it may not be an exhaustive list.

Q Is it fair to say that you intended it as an exhaustive list but there might have been some presentations that simply slipped your mind as you were preparing this?

A Quite possibly, yes.

Q Are there any presentations that you intentionally left off?

A No.

Q Okay. First of all, we've been going for about

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an hour and a half. Are you still good to go for a while?

A Yes, I'm fine.

MR. ROSE: Please, if anyone needs a break, feel free to speak up, but, as I say, I'm more than happy to keep talking as long as anyone will let me.

THE WITNESS: I just wonder if I could have a one-minute adjournment. I'll be back in one minute.

MR. ROSE: That's perfectly fine.

(A recess was taken.)

DIRECT EXAMINATION CONTINUING,
QUESTIONS BY GAVIN M. ROSE:

Q My understanding is that you have been retained by the State of Indiana to offer expert testimony in this case. Is that your understanding as well?

A Yes.

Q And you understand that this litigation generally challenges a complete ban on providing certain gender-affirming care to minors diagnosed with gender dysphoria?

A Yes.

Q In order to become involved in this case, did

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you reach out to Indiana or did Indiana or its attorneys contact you?
A The latter.
Q And you're being compensated at an hourly rate of $400 U.S.?
A Yes.
Q Do you know approximately how many hours you've devoted to this case so far?
A I've kept a running total, but it's well over 100. Well over, yeah.
Q How does the hourly rate of $400 compare with the rate that you charge to clients for psychotherapy?
A It's extremely generous.
Q What is your hourly rate to provide psychotherapy?
A I work on a sliding scale so people who are in financial hardship I work for what's called the Medicare rebate, which is the amount that is covered by the nationalized healthcare cover in Australia, and for people who own planes, boats, and tennis courts I charge about, depending, 250.
Q I'm sorry, did you say 350? 250?
A 250. And that's a lot less in American dollars

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because our Australian dollar is only worth about $.68 to your dollar at the moment.
Q And that's what I was going to ask. That's in Australian dollars?
A Yeah. Yeah.
Q Okay. At the outset of this deposition you indicated that you had your expert declaration in front of you?
A Yes.
Q Is that still the case?
A Yes, it is.
Q Okay. I'm going to share my screen just very quickly right now and pull up what I marked as Exhibit 2. And I assume that you recognize this as the expert declaration you have submitted?
A Yes.
Q And I will tell you at the outset that I did not include any of the attachments that your attorneys provided to us. If it's okay with you, I am going to stop the share of this and both you and I can reference our hard copies and I assume that will be much quicker than me scrolling up and down through this. Is that okay?
A That's okay.

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Q Okay. Did you draft your declaration yourself?
A Yes.
Q Did anyone other than you draft any portion of it?
A No.
Q Did anyone other than Indiana's attorneys review or comment on it before you finalized it?
A No.
Q Have you conferred with any other professionals about this litigation?
A No.
Q Are you familiar with -- and by familiar, I just mean do you know who they are. Are you familiar with the other individuals that Indiana has designated as expert witnesses in this case?
A No, I don't think I am. I haven't been specifically advised, no.
Q And my only question to you is whether you have conferred with any of them about this case.
A No.
Q Okay. I'm pulling up just very quickly what I have marked as Exhibit 3. Do you see that?
A Yes.
Q Have you seen this document before?
A Yes.

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Q It's my understanding that this is a summary prepared either by Indiana's attorneys or by you in conjunction with Indiana's attorneys indicating which medical records you have attached to your declarations as Exhibits B, C, D, and E. Is that correct?
A Yes.
Q Since leaving the University of Sydney, are there any conditions or diagnoses other than gender dysphoria that you consider yourself specialized and emphasize your practice in?
A I'm best known for developmental and educational psychology type diagnoses, but I also have an international reputation in the treatment of music performance anxiety and I have many peer-reviewed international publications and have developed a completely new theory about music performance anxiety so that would be an expertise I'm well known for.
The other well-known area is the area of sexual offending and I've written extensively on child sexual abuse and juvenile sex offending.
So they would be kind of super specialties that I have, but, in general, in the field of developmental and educational psychology.

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Q Okay. You indicate in your expert report -- and I don't think you have to look at it, but I think it's Paragraph 9 -- that you have become a tertiary referral source and you mentioned that here as well.
A Yeah.
Q What does that mean, becoming a tertiary referral source?
A Well, it means people have gone through other steps before they get to me.
Q Okay. And are there particular persons or entities from whom you receive a significant number of referrals?
A I get most of my referrals directly from parents who have spoken with each other. There are some parent support organizations who will recommend parents to me and so they'll come through that route as well.
Q Okay. In your declaration you indicate that you are one of only a few clinicians practicing exploratory psychotherapy with persons with gender dysphoria because of so-called conversion therapy bans that have been passed in some Australian states. I assume you're familiar with that.

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A Yes.
Q What Australian states have passed a ban on conversion therapy?
A Queensland, Victoria, the ACT, and I think one in Tasmania is about to go through. And, yeah, I think that they're the four, yeah.
Q And I assume you've reviewed the laws that were being proposed and then passed in these states?
A Yes.
Q Are they all, I guess, functionally identical, for lack of a better word?
A Yeah. Yeah, I would say.
Q I'm going to pull up what I have marked as Exhibit 4. Do you see that document in front of you?
A Yes, but I can't read it.
Q That's perfectly fair. I will represent to you that the, I guess, fifth page of the PDF, which has an internal pagination No. 1, says "The Parliament of Victoria enacts:" And I'm just wondering if you recognize this as Victoria's ban on conversion therapy.
A Yes, I recognize it, yes.
Q And my assumption is that you, yourself, practice in New South Whales?

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A That's right, yes.
Q Is there a conversion therapy ban that has been enacted in New South Whales?
A Not a legal ban, but there's a huge amount of pressure against therapists who are not practicing gender-affirming care.
Q And, I'm sorry, I just didn't understand from your declaration. Are you saying that the psychotherapy that you perform to patients with gender dysphoria would be illegal if you did the same thing in Queensland, Victoria, or the ACT?
A Yes.
Q My understanding is that Australia is at least considering a nationwide ban. Is that your understanding?
A Yes, that's my understanding.
Q Has it been passed yet?
A No.
Q Okay. In Paragraph 10 of your declaration you indicate that you're unable to list the Australian cases in which you've testified as an expert because of laws protecting the identity of minors; correct?
A Yeah.
Q But there have been approximately 100 of those

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cases?
A That includes my child sexual abuse cases. They're not all related to gender dysphoria. And it also includes the family court cases and the children's court cases. They involve custody disputes but not related to gender dysphoria.
Q And that was going to be my question is we looked at the court-referred clients portion of your CV. Is that what those 100 cases refer to?
A No, no, no. That's post the court process, the court referred. These are assessments for or expert witness regarding the actual call of matter.
Q Of those 100 cases, approximately how many concern gender dysphoria or related issues?
A Oh, I think only about three.
Q And I assume those were in the last few years?
A Yeah.
Q And then the one American case you identify is the case challenging a ban similar to ours in Alabama?
A Yes.
Q And you identify the case as Bowman, but I assume, if you know, it's the same case that I

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know as Eknes-Tucker?
A I'll take your word for that.
Q Okay. Doctor, I am ready to move into slightly more substantive matters. Thank you for your patience as I went through that.
I want to be perfectly clear from the outset. Do you consider gender dysphoria to be a valid medical diagnosis?
A No.
Q Are there any circumstances under which you believe a patient may accurately be diagnosed with gender dysphoria?
A Let me put it this way. I think there is a phenomenon that one could describe as gender dysphoria, but the diagnostic process is what I'm referring to as lacking validity. So, in answer to your first question -- could you just repeat your first question about gender dysphoria?
Q My first question was whether you consider gender dysphoria to be a valid diagnosis.
A Diagnosis, no. I have major diagnostic concerns with the way in which gender dysphoria is being diagnosed, but I'm not challenging the existence of a phenomenon, a clinical phenomenon, that can

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be described as gender dysphoria.
Q What does that mean, a clinical phenomenon?
A Well, you know, if a patient comes to you and says, "Look, I've got very low mood, I'm not sleeping, I've lost my appetite, I've got no motivation," you'll say, "Well, you know, that sounds like a depressive process," and I need to explore that further with the patient.
Similarly, with gender dysphoria, you know, children will come with their narrative about I've always wanted to be a boy and I've always wanted to play with boy things and, in the extreme cases, they want to cut off their sexual organs and so forth. So, of course, one has to be alert to the possibility that there is a clinical process in which the child is uncomfortable in his or her own body and that needs to be explored.
Q Do you believe that there are any circumstances under which a child who presents with that clinical phenomenon should be allowed to receive puberty blockers or gender-affirming hormones?
A Under almost no circumstances would I think that is a valid approach to take.
Q You qualify that with "almost no." What are the

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circumstances where you think that might be a valid approach?
A Well, if you look at the historical literature and, you know, the amount of writing that occurred, you know, pre sort of 2005 to '10, this was a vanishingly rare diagnosis, vanishingly rare. For example, some of the population figures given for the prevalence of gender dysphoria pre the common era of gender dysphoria, let's put it that way, Sweden was reporting one in one million. The DSM-5 reported 1 in 27,000 females and one in 10,000 males. So, you know, these figures are extremely low so I'm not going to be absolutist and say there is no circumstance under which it's not an appropriate diagnosis, but the degree to which it's being diagnosed today is of great clinical concern.
Q And, Doctor, my question was: How would a child have to present to you for you to believe it to be appropriate for that child to receive puberty blockers or gender-affirming hormones or is that just off the table entirely?
A It's very close to being off the table.
Q How about for adults? Do you think adults

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should have the ability to receive gender-affirming hormones or even gender-affirming surgery?
A Under very special circumstances. Under the original treatment protocol for an adult seeking transgender surgery was that they had to live in their chosen sex for two years and undergo intensive psychotherapy before they would be cleared for surgery. None of those safeguards are in place for young people.
Q If they were in place, would you believe it would be appropriate for them to receive this sort of gender-affirming care?
A In vanishingly rare cases.
Q And can you imagine a child who presents who has consistently over a number of years presented as a sex different than the birth sex who has been in therapy for years and who is presenting with no comorbidities and a certain level of distress, can you imagine yourself thinking it appropriate for that person to receive gender-affirming medications?
A I don't think such a person exists.
Q Okay. I want to turn, at long last, to social contagion and your description of social

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contagion. My understanding is that you separate your declaration into two chapters; correct?
A Yes.
Q And will you flip to Paragraph 21 of your declaration on Page 11?
A Okay. So I'm going to have to change glasses frequently when I'm looking at my declaration. So you said 21?
Q 21.
A Alright.
Q Are you there?
A Yes.
Q You don't have to do so out loud, but will you read Paragraph 21 to yourself real quick?
A Yeah, I've read it.
Q Okay. We'll get to the specifics momentarily, but my first question is if this paragraph provides a fair summary of the conclusion that you offer in the first chapter of your declaration.
A Yes.
Q You use the language "social contagion may have a major role" to play, and I'm curious about your use of the word "may" in that sentence.

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A Well, I'm not absolutist or prescriptionist because I am not omnipotent and my paper is based on very careful analysis and inference. And the reason that it is based on analysis and inference is that there has been no empirically-driven epidemiological study to test my hypotheses and that's why I say "may."
Q And you're familiar, I assume, with an article and ultimately a correction to that article that was published by Dr. Lisa Littman who was then with Brown University?
A Uh-huh.
Q I'm sorry. Yes?
A Yes.
Q And you're aware, I assume, that she describes her work as "generating hypotheses, not conclusions"?
A Yes.
Q And you just used that word, too. Is it fair to say that you are describing to us a hypothesis?
A Yes, it is fair to say that, but some hypotheses are more robust than others and I believe this to be a very robust hypothesis.
Q Will you turn to Paragraph 108 of your declaration?

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A Did you say 108?
Q 108 on Page 55.
A Yes.
Q Are you there?
A Yes, I am.
Q And in that paragraph you describe a "core group of 'actual' cases," I assume of gender dysphoria. Do you see that?
A Yes.
Q And by "core group of 'actual' cases," you meant actual cases of gender dysphoria?
A Yes.
Q And it appears to me that you're indicating in this paragraph that social contagion may affect some "actual cases" of gender dysphoria but may also affect some other, I assume, nonactual cases. Is that a fair statement?
A Yes, that's a fair statement.
Q And how does the social contagion affect the actual cases?
A Well, it's the disinhibition effect that if -- you see, I'm trying to cover all my bases here because all of the literature that I've read, all the epidemiological literature available on gender dysphoria, will identify a case. It

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might be 1 in 84,000. It might be 1 in 1 million. It might be 1 in "twenty-two hundred and fourteen thousand." There's data predating 2010 that shows, you know, very consistently that there are cases but they're vanishingly rare. It wouldn't even qualify for -- well, an orphan diagnosis qualifies because --
Q Let me stop you there because I think you've gone well beyond the --
MR. FISHER: Gavin, let her finish the answer, please. You keep doing this. You gotta let her answer. She's trying to provide you an answer.
MR. ROSE: I think she keeps stepping well beyond my questions, Tom.
A I'm sorry. I'll be very specific. It's okay. It's okay. The answer is: Yes, there are some actual cases. We don't know how many. And of those actual cases, the current (inaudible) of transgender affirming everything would help that vanishingly rare case who had not yet enacted or done anything about their genuine gender dysphoria to come forward for treatment.
Q And I think you referred to that at the outset as a disinhibition effect. Is that fair?

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A Yeah. Yeah.
Q It might make some people just feel more comfortable coming forward?
A Yes.
Q Okay. I want to make sure I understand generally now what types of things might serve as the social contagion you described as capable of causing persons to mistakenly identify as transgender. You describe, first and foremost, influences from peers, celebrities, social media. Is that a fair statement?
A Yeah. It obviously goes way beyond that, but, yes, they are factors that are included.
Q And I guess my question is: If a celebrity or other influential person does nothing more than openly identify themselves as being transgender, is that something that you think can have this social contagion effect?
A Yes.
Q There does not need to be any attempt at overt coercion of any sort?
A No.
Q What if a public library or a school library chooses to either carry or display books pertaining to gender-related issues, is that

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something that can have a social contagion effect?
A Absolutely. Particularly as they're universally full of misinformation.
Q What if a person is simply subjected to a book with a transgender protagonist, can that have a social contagion effect?
A Yes, it can. The Internet site Anime was recently boasting that it now had 279 characters that were known cisgender.
Q Do you know how many cisgender characters it has?
A Half a dozen.
Q And the Internet site Anime, is that anime.com?
A I presume.
Q You know throughout your declaration that in recent years there have been significant increases in persons identifying as transgender or in seeking care from gender clinics. I assume you agree that's a fair summary?
A Yeah.
Q I assume you agree that there are other factors in addition to social contagion that might also cause an increase in persons identifying as transgender?

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A Well, you have to go back to my paragraph that tries to explain the statistical complexity. I would argue that what explains the exponential increase in young people presenting as transgender is primarily accounted for by the phenomena of social contagion.
Q And I understand that and you used the word "primarily." I'm just wondering what other factors might also account for that.
A Well, the other factors I see as secondary factors. So gender dysphoria has become a vehicle for young people who are very distressed about themselves in some way that something has gone wrong with their development, so they're unhappy, they're discontent, they don't have a peer group, they're lonely, they may be in conflict with their parents, they may have and they will have significant comorbid conditions. So gender dysphoria has become, you know, the overarching umbrella on which disturbed young people are hanging their hats, so to speak, because they get such a receptive response to declaring themselves transgender, whereas if they said, oh, I'm depressed or I'm anxious, well, that's very garden variety and it doesn't

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get above the threshold of concern, whereas young people presenting with gender dysphoria have this whole machine around them now. It really gets their parents' attention. It really gets them noticed and, you know, managed and so forth. So these are secondary things.
But, I mean, I have parents coming to me who show me thousands of text messages that their child had received from groomers and predators on the Internet trying to convince young people to transition. You're really trans. If you say this about yourself, it means that you're really trans. And some of them have gone to the point of actually sending minors cross-sex hormones through the Internet as a gift to the young person.
Q Do you believe that better understanding of gender dysphoria has played any role in the increase in the number of persons identifying as transgender?
A I don't think there's any better understanding that I've noticed in the last 10 years.
Q Do you think increases in the availability of treatment have led more persons to come forward as transgender?

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A Absolutely, but in a socially contagious way.
Q Are you aware of studies indicating that more persons will seek care for a condition when that condition becomes destigmatized?
A You know, the destigmatized argument has a small amount of merit, but it can't possibly account for the numbers and the trajectories on graphs that we're seeing with gender dysphoria.
Q Are you familiar with a body of professional literature specifically concerning increased numbers in patients seeking treatment for HIV as the condition became destigmatized?
A Sure.
Q And you agree that there were significant increases in persons seeking treatment for that condition?
A Yes, because they had a diagnosable medical condition that could be treated with scientifically evidence-based medications.
Q In your opinion, can social contagion work the other way around if someone is subjected to messages that being transgender is wrong or simply does not have access to any books with a transgender protagonist? Can that cause a transgender person to remain in the closet, so

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to speak?
A There is absolutely no evidence for that assertion one way or the other, but if you want me to give an educated guess, it's possible but it would be extremely unusual.
Q In the report that you submitted in the Alabama case -- and I didn't print it out or pull it up for you -- you noted that the "ominous trend" whereby more persons are identifying as transgender has "rarely been systematically studied" either theoretically or empirically. I understand you might not recall the precise verbiage, but do you recall expressing sentiments similar to that?
A Yes.
Q And I assume that's still an accurate statement of your beliefs?
A Well, it's not my beliefs. It's an empirical fact.
Q Are you aware of any peer-reviewed studies at all that attempted to systematically study whether social contagion has led to increases in transgender identification?
A Did you use the word "peer-reviewed" or -- what was the wording exactly?

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Q Sorry, I will repeat the question. Are you aware of any peer-reviewed studies at all that attempted to systematically study whether social contagion has led to increases in transgender identification?
A Well, Jack Turban actually claims that he's systematically and emphatically disconfirmed social contagion, but, given that I only deal with robust scientific literature that uses a scientific method, I will say no because his study does not fall into that category.
Q Are you aware of any peer-reviewed studies at all that attempted to determine what proportion of the increase in transgender identification over recent years can be attributed to social contagion?
A I have stated at the outlet that my conclusions are inferential and deductional. I looked at social contagions in a range of other adolescent psychopathologies and the same mechanisms and the same dynamics and the same upward swings in prevalence have occurred in at least six adolescent psychopathologies that have been systematically studied. Now, there's no will to systematically study social contagion and gender

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dysphoria and the reason for that is that it will disprove the basic tenant of gender ideology.
Q Doctor, I'm sorry to cut you off. I don't mind that you're trying to explain your answer, but the question I asked you first was a yes or no question. We do need to make sure the record is complete and clear so I do want to make sure I get a yes or no to the question about whether you're aware of any peer-review studies that attempted to determine what proportion of the increase in transgender identification can be attributed to social contagion.
A I've already answered that question and then I tried to qualify it and was unable to finish my answer.
Q Is it fair to say that there are no peer-reviewed studies that attempt to determine what proportion of the increase in transgender identification over recent years can be attributed to social contagion?
A Yep.
Q I'm sorry. Did you say yes or no?
A I said yep.
Q Is that a yes?

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A Yes, it's a yes.
Q Okay. I'm going to pull up for you real quick what I have marked as Exhibit 5. And do you see that in front of you?
A Yes.
Q Beginning in -- and you can go there if you want, but in Paragraph 81 of your declaration you describe an article that was written by Dr. Littman who we mentioned.
A Yes.
Q And I understand that there was ultimately a correction to that article, but you recognize what I have in front of you as the original article that Dr. Littman authored?
A Yes.
Q And both you and Dr. Littman discuss "rapid-onset gender dysphoria"; correct?
A Yes.
Q Prior to Dr. Littman's article in 2018, are you aware of any professional literature that used that term?
A No.
Q Is rapid-onset gender dysphoria a diagnosis listed in the DSM-5 or its text revision?
A No.

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Q Is it identified in the International Classification of Diseases, ICD-9?
A No.
Q Is there an objective measure that you or Dr. Littman are using to determine when or weather the onset of gender dysphoria is "rapid"?
A It's adolescent onset as opposed to early childhood onset.
Q And that was going to be my question. Is the term saying anything other than that a person first identified themselves as transgender during their adolescency rather than earlier?
A Well, it's the timing but also the rapidity of the onset so it becomes manifest in a very short period of time during adolescence.
Q Do you have a way of distinguishing between someone with "rapid-onset gender dysphoria" and someone who had dysphoria for a longer period of time but simply delayed in coming out through pressures or family dynamics or what have you?
A That would be very unusual, but the way that I assess it is through very detailed clinical interview.
Q Do you have any patients that you've diagnosed

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with rapid-onset gender dysphoria?
A Well, I don't tend to be beholden to diagnoses, but the majority of my caseload would, if you wanted to use that term, would fit into that categorization.
Q Okay. It's my understanding that for her study Dr. Littman posted a survey on three different websites where parents had reported sudden or rapid onsets of gender dysphoria in their children; is that correct?
A That's my understanding, yes.
Q And then I understand they were subsequently reposted to a fourth website, a Facebook group?
A Uh-huh.
Q Sorry. Yes?
A Yes.
Q And of the three websites that Dr. Littman originally posted the survey, are you aware that they have all taken a position on the provision of gender-affirming care to transgender youth?
A The parents?
Q The websites.
A Oh. No, I don't think I was completely clear about that.
Q Do you have an understanding that all three of

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those sites have taken a position that was "unsupportive" of gender transition?
MR. FISHER: I'm going to object. I'm not sure that the meaning of that is clear or where it's coming from.
MR. ROSE: Why don't I get an answer first and then I can explain, if that's okay.
Q Do you need me to repeat the question, Doctor?
A Yes.
Q Do you agree that all three of the sites on which Dr. Littman posted the survey have taken a position that is "unsupportive of [gender] transition"?
MR. FISHER: Same objection. You may answer.
A Okay. Concerned and questioning.
Q Would it surprise you to know that in her notice of correction to this article Dr. Littman characterized all three of these websites as being "unsupportive of [gender] transition"?
A Look, I probably read it, but I've been reading hundreds of papers since then and details will sometimes escape one's attention.
MR. ROSE: And, just for the record since I'm speaking instead of writing, the "gender"

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there is in brackets. The quote is "unsupportive of transition" and the "gender" is taken from context.
Q One of the websites that Dr. Littman indicates the survey was posted to is called Youth Trans Critical Professionals. Are you familiar with that website?
A Yes.
Q Have you ever visited it?
A I tend not to spend a lot of time visiting websites.
Q Have you ever visited it?
A I've clicked to it.
Q The reason I ask is that if you go right now, you pick up a language saying that the website is now private and it cannot be accessed, and I'm wondering if you were aware of that.
A No.
Q Okay. And you understand that Dr. Littman directed her survey toward the parents of transgender youth, not the youth themselves; right?
A Yes.
Q When you provide psychotherapy to one of your patients, are there any circumstances at all

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where you would rely exclusively on a parent's report about what was going on with their child?
A No, I do what's called triangulation and I include in my case formulation information from every possible source that is available to me.
Q And one of those sources is obviously speaking with the child themselves; correct?
A Of course.
Q And I assume in speaking with the child you would want to know not just what they're going through but also if there were any reasons that their parents would not be aware of what they're going through; is that fair?
MR. FISHER: I'm going to object. I'm not sure what is meant by "what they're not going through."
THE WITNESS: Yeah, I know. Thank you.
Q Do you understand the question, Doctor?
A I think you'll have to reword it.
Q Let me just ask this more generally. In your field of psychotherapy, I assume that self-reporting provides a useful and sometimes vital source of information; is that fair?
A Yes.
Q Okay. And you're aware, I assume, that the year

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after Dr. Littman first published her article she published a corrected version of the same article along with a notice of correction?
A There was a (inaudible) after the publication of her article and it was taken down after it had already gone through a rigorous peer-review process, so, to please the naysayers, a couple of sentences were added and so I wouldn't call it a substantive correction. The data remained unchanged and the conclusions remained unchanged.
Q Okay. But there was a corrected version published; correct?
A Well, there was a slightly altered version published.
Q And at the same time of that publication there was also a separate notice of correction explaining the reasons for the revision that was published in the same journal?
A Yes.
Q I'm going to click over to Exhibit 6. Do you see that in front of you?
A Yes.
Q And you recognize this, I assume, as the notice of correction?

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A Yes.
Q In this notice, Dr. Littman says that "This report ... does not validate the phenomenon," and it appears from context that the phenomenon is rapid-onset gender dysphoria. Do you see that in the middle of the --
A Yeah. Yeah.
Q Do you agree that Dr. Littman's study does not validate of phenomenon of rapid-onset gender dysphoria?
A Absolutely. It was a very preliminary early notice of something interesting, and all new discoveries are made through noticing changes in patterns in the environment and that can lead to all sorts of astounding new discoveries. So it would be foolish, and nor did she do so, claiming that this study proved anything other than the report of this group of parents.
Q Okay. Do you know Dr. Littman personally?
A No.
Q Okay. And I'm going to click over to Exhibit 7. And do you see that in front of you?
A I do.
Q A short while ago, you mentioned a study by Dr. Turban and others that sounded like you took

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issues with, and am I correct that this is that study?
A Yes, it is.
Q This was published in a journal called Pediatrics?
A Yeah.
Q And that's a peer-reviewed journal; correct?
A Let's just say they have a peer-review process that has been degraded in recent times.
Q Has the process itself changed to your knowledge?
A No, the process is still the same.
Q If it had not been for the article's publication of Dr. Turban's article or others like it, would you believe that the peer-review process of Pediatrics had been degraded in recent years?
A I would have to judge that article by article, but it's astounding to me that some of the papers that I see published on the subject have actually got through a peer-review process if it was truly anonymized and objective.
Q I understand that you might take issue with some of the data or the source of the data, but you understand that Dr. Turban and others analyzed data from several states that was collected by

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the Centers for Disease Control and Prevention; correct?
A That one, I believe from memory, is from the Youth Risk Behavior Survey.
MR. ROSE: Okay. Doctor, if you don't mind, my bladder is desperately requesting that I call a break. I'm okay with just five minutes. If anyone needs a longer break, I'm more than happy with that, too.
THE WITNESS: Five minutes is fine with me.
(A recess was taken.)
DIRECT EXAMINATION CONTINUING,
QUESTIONS BY GAVIN M. ROSE:
Q Doctor, do you still have your declaration in front of you?
A Yes, I do.
Q I will have you turn to Paragraph 85 on Page 41 if you don't mind.
A Yeah.
Q In this paragraph, you mention an August 2021 statement by the Coalition for Advancement & Application of Psychological Services or CAAPS calling for the elimination of the use of rapid-onset gender dysphoria; correct?
A Yes.

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Q It's my understanding that CAAPS, with two As to our court reporter, is a nonprofit coalition of various professional organizations involved in the science of mental health. Is that a fair summary?
A I guess so, yes.
Q Well, I took it directly from their website, so I hope it is. Okay. I am going to show you what I've marked as Exhibit 8. Do you see that in front of you?
A Yes.
Q And you, I assume, recognize this as the statement to which you were referring in Paragraph 85 of your declaration?
A That's right, yes.
Q And you understand, I assume, that numerous other -- I won't count them, but numerous other organizations also signed on to the statement?
A Yes.
Q Including both the American Psychological Association and the American Psychiatric Association, I think?
A Yes.
Q I'm looking, I guess, generally at Paragraph 87 of your declaration. I don't know, Doctor, if

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you will need to look at it for this series of questions, but I certainly invite you to if it would be useful to you. In this paragraph --
A Sorry for interrupting. It's very hard. I've got a visual impairment and it's very hard for me to go from screen to page, back and forward, and I'm just wondering if you would be able to quickly put that up on the screen for me.
Q I can certainly do that. I can't promise it will be quickly, but I can certainly do that.
A Okay.
Q Do you see that in front of you?
A Yeah.
Q It's Paragraph 87 of your declaration; correct?
A Yes.
Q And I'm not going to get into precise numbers, but it sounds here like you're describing, I guess, differences in the share of persons identifying as transgender between adolescents and younger children over several decades; is that fair?
A Yes.
Q I think you say that prior to 2000, children age 3 to 12 years identifying as transgender greatly outnumbered adolescents?

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A Yes.
Q And my understanding of your report is that you believe the increase in the percentage of adolescents identifying as transgender is because that group, and particularly persons assigned female at birth in that group, are particularly susceptible to social contagion; is that fair?
A Yes.
Q Is it fair to say that you think that social contagion played a minimal role before the year 2000 in causing persons to identify as transgender?
A Yes.
Q Is there an age at which you think persons assigned female at birth have matured enough that they're less likely to be susceptible to social contagion?
A Could I register my disagreement with the phrase "assigned female at birth"? Could you, please, just say "a natal female" because sex is not assigned at birth. Sex is determined at conception by the presence of X and Y chromosomes. It is not assigned at birth, so I would appreciate if you could just use the

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phrase "a natal female" or "a natal male."
Q Why don't I just state for the record that when I use the phrase "assigned female at birth," I am referring to what you would refer to as a "natal female," okay?
A But I don't want any more documents than necessary to reflect flawed and fallacious scientifically-lacking gender ideology of which the phrase "assigned female at birth" is a major contributor.
Q Do you understand what I mean when I say "assigned female at birth"?
A I understand what you mean, but you're expressing it incorrectly.
MR. FISHER: I'm concerning along these lines that it's gonna end up putting words in her mouth that she doesn't want, and I think that that's probably part of her concern, too.
MR. ROSE: Well, she can certainly answer however she feels comfortable, but I am going to use the verbiage with which I feel comfortable.
Q And, as I stated for the record, when I use the phrase "assigned female at birth," I'm referring to what you would refer to as "a natal female." Is that fair?

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A Yes.
Q Okay. The question that precipitated this was whether there is an age at which you believe that persons assigned female at birth have matured enough that they are less susceptible to social contagion?
A There's a clear set of studies that shows that susceptibility decreases with increasing age and cognitive maturity, so children are more susceptible, in general -- we're talking in population figures here but there's a lot of, you know, variation at an individual basis, but, statistically, in general, at a population level, children tend to be more susceptible than young adolescents; young adolescents tend to be more susceptible than older adolescents; and older adolescents tend to be more susceptible than young adults, onwards.
So there's not a cut-off. There's not, you know, 15 is the cut-off at which you're susceptible and then after 15 you're not susceptible. It's a gradient rather than categorical, but that, from a statistical perspective, is what the findings have been.
Q And I apologize for repeating you. I really

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just think I missed a word. It sounded like you were saying that children are the most susceptible, young adolescents next, older adolescents next, and adults are the less susceptible; is that fair?
A From a population statistically, a generalized perspective, yes.
Q I understand there may be variants with particular individuals; correct?
A Well, one variation that has been noted is that children who are securely attached to their parents are less susceptible compared with children who were not securely attached and that could occur anywhere from early childhood to late adolescence, so there's very important modifiers of that statement.
Q I had asked the initial question about whether there was an age at which persons assigned female at birth are mature enough, and you gave me that hierarchy and that's perfectly fine. I assume the same hierarchy exists for persons assigned male at birth?
A The natal males, yes, the same hierarchy exists.
Q And we were talking in general, but as it relates to the social contagion effect of

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transgender identification, it's the same hierarchy, right, children most susceptible, then young adolescents, then older adolescents, then adults?
A Well, when you look at the literature on uptake of behavioral phenomenon in different age groups, you find this effect across the board whether it's substance abuse, self harm, suicidality, and so forth, so it's a fairly robust finding.
Q Okay. I'm going to scroll up on your declaration again to Paragraph 84. Do you see that?
A Yes.
Q And in this paragraph you're describing, at least for most of it until the last sentence, a study published by Indremo and others?
A Yes.
Q And this was a study that tracked a number of referrals to clinics providing gender-affirming care after positive or negative media coverage?
A Yes.
Q And it sounds to me from your language like you're describing in this paragraph increases in referrals following positive media coverage and

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decreases following negative media coverage; is that fair?
A That's fair.
Q And the study you cite concerning the negative media coverage is the Indremo, the Swedish study from 2020?
A Yes.
Q I'm flipping over to Exhibit 9 now. And do you see that in front of you?
A Yes, I do.
Q And I assume that you recognize this as the Indremo and others study?
A I know where you're going with this and it's a question of emphasis, but the results are the results. Indremo is trying to present it as, you know, let's get all the media coverage positive, but his study is, in fact, a perfect example of social contagion. Negative coverages reduces clinic numbers and positive coverage increases them and so it's really quite a robust demonstration of social contagion.
Q I'm sorry, Doctor, my question was literally just do you recognize Exhibit 9, the Indremo study that you cite?
A Yes, I do. I do recognize it, but I was

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anticipating where you were going with it.
MR. FISHER: Doctor, let me just suggest let's not anticipate. We'll get through it faster.
THE WITNESS: Thank you. Okay. I'm sorry.
Q You're perfectly fine. I don't mind at all. I just wanted to make sure the record was clear on that front.
A Okay.
Q And my understanding is that the Indremo study actually studied the relationship between three different media events and referrals to gender clinics; correct?
A Yes.
Q One positive media event and two negative media events?
A Well, the two negative were connected. They were Part 1 and Part 2 of the same series.
Q And then there was also one positive media event?
A Yes.
Q And do you understand that for the positive event and for the first of the negative events the Indremo study actually found no relationship between media coverage and transgender clinic

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referrals?
A Say that again. Sorry.
Q You understand, don't you, that for both the positive media event and the first of the negative media events the study actually found virtually no change in the number of referrals to gender clinics following the media coverage; correct?
A It's been some time since I've read the details of the article. It's just not my memory of it. I thought -- let me just see that conclusion.
Q I've moved you down to the results section. Do you see that on the --
A Yeah.
Q And you agree that the majority of this section describes the changes in referrals following the second negative media event; correct?
A Okay. So we're looking at time-specific changes. So in the three months following the event, referrals decreased by 25% overall, by 32% for individuals being natal females, and by 25% for those aged 13 to 18.
Q And you understand that those statistics that you just recounted relate to the changes in referrals following the second negative media

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event; correct?
A Yeah. Yeah.
Q Do you see the last line of the results section that says for the other two media events no changes in referral counts or time trends were observed?
A Yes, I do see that and I actually forgotten that part of it.
Q Is it fair to say that in your expert report you only described one of the three events studied in the Indremo study?
A I was reporting the three-month follow-up data, so I'd have to go back and just revisit that.
Q Okay. Then flipping back to your expert report still on Paragraph 84, the last sentence of that paragraph after you talk about the Indremo study says, "On the contrary, increased positive media coverage of trans issues resulted in an increase in referrals to gender clinics." Do you see that?
A Yeah.
Q The study you cite for that is Pang and others?
A Yes.
Q And, just for the record, I think you cite the same study earlier in your report for a similar

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proposition.
A Yes.
Q Just proving to you that I read the entire thing.
A I'm very impressed.
Q I was gonna say I could write my memoirs three times over and end the night with your report here.
Okay. I'm flipping over to Exhibit 10. And, again, my first question to you is whether you recognize this as the Pang report that you cite.
A Yes.
Q And I will just tell you the page numbers on this exhibit do not line up with page numbers that you cited elsewhere in your report simply because of where I got it from, I assume.
Okay. My understanding is that Dr. Pang and others studied referral rates to gender clinics in Australia and the UK following media coverage related to transgender issues. Is that your understanding?
A Yes.
Q Okay. I'm going to flip over to the PDF Page 5 where I have highlighted a portion beginning

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with "The search strategy." You don't need to do so out loud, but can you read the highlighted portion to yourself?
A Yes, I'm familiar with it, yes.
Q And this describes the search criteria or terms that Pang and others used to find media items to study in their report?
A Yes.
Q And you agree that these criteria included any media coverage that contained the words gender, transgender, or gender dysphoria as well as child or adolescent; correct?
A Yes.
Q If there had been stories in the UK or Australia during the relevant time period similar to the negative media events that were covered in the Indremo study, do you agree that they would almost certainly have fallen within the search criteria?
A It would only be a surmise, but it's likely.
Q It would have been very difficult to write about that without using the words transgender and either child or adolescent; right?
A Sure.
Q Okay. I'm going to scroll down to Page 9. And

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at the bottom of that carry-over paragraph at the top, Pang and others write, "Testing whether negative media coverage is associated with reduced referral rates (and conversely whether positive coverage is associated with increased referral rates) would thus be a useful next step." Did I read this correctly?
A Yes.
Q Would it surprise you to learn that this is the only sentence in the entire study where media coverage is referred to as either negative or positive?
A Could you go back up to the top of the article?
Q Tell me where to stop.
A I just want to see the abstract. Okay. Keep going. Okay. Just stop there. Come back down actually. No, go up.
Q Sorry.
A There. Stop there. Okay. And you're saying that he's talked about media coverage generally as opposed to positive or negative media coverage.
Q And do you agree with that?
A What in particular?
Q Do you agree that the study authors are talking

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about media coverage in general and not media coverage as either positive toward transgender issues or negative toward transgender issues?
A Well, saying it's positive or negative is kind of drilling down, but the fact that he showed a strong association between media coverage and increased referrals is a demonstration of social contagion.
Q I'm going to flip back over to Exhibit 2 where you say, "On the contrary, increased positive media coverage of trans issues resulted in an increase in referrals to gender clinics," and I want you to explain to me where you got that "increased positive media coverage" language.
A I'd probably have to read the whole paper again to tell you where I got it. I hope it wasn't an overstep inference on my part, so I presume, obviously, that I inferred from the paper, but I would have to review the paper again to identify how I drew the conclusion that it was positive media coverage as opposed to any media coverage.
Q Prior to today, when was the last time you looked at that study?
A Oh, it was some time ago.
Q Okay. I'm going to scroll down still on your

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declaration to, I think, Paragraph 129. Do you see that in front of you?
A Yes, I do.
Q And do you see at the bottom of that paragraph you state, "The authors, however, did concede that ... increased media content (specifically via social media) might act as a ... means of social contagion"?
A Uh-huh.
Q I'm sorry. Yes?
A Yes.
Q And you underlined "might act as a ... means of social contagion"; correct?
A Yes.
Q And that was still in reference to the Pang study; correct?
A Yes.
Q I'm going to flip back over to Exhibit 10 and scroll down to Page 9. And you will see at the top of the paragraph immediately above the Limitations heading, Pang and others begin their statement with, "However, we are also mindful that others have speculated that increased media content (specifically via social media) might act as a double-edged sword or a means of social

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contagion." Did I read that correctly?
A Yes.
Q And that is the language from which you are quoting?
A Yeah.
Q The declaration?
A Yeah.
Q And what I want to know is how the authors saying "we are mindful that others have speculated" in their article translated to "the authors, however, did concede that" in your expert declaration.
A The very fact that he mentioned it, you know, implies that it has to be considered as a serious hypothesis.
Q You think that him mentioning that others have speculated about the effect of increased media content means that he's conceding that it might act as a means of social contagion?
A Yes, I think his disarming that possible conclusion.
Q Okay. In Paragraphs 94 and 95 of your declaration -- and, I'm sorry, it won't all fit in on one page, but you understand that these paragraphs generally concern various data from

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the United Kingdom and from Australia; correct?
A Yeah.
Q And, for much of this data, the citation is provide is to either Kenny, DT 2021 or Kenny, DT 2022. Do you see that?
A Yep.
Q And these citations are obviously you; correct?
A They're obviously me, yes.
Q And are they referencing something that has been published or simply data that you've collected?
A Well, it's been published on my website, but the figures were provided by the gender clinics and I converted them from either text or tabular form into a graph.
Q Has this data been published in any peer-reviewed journal?
A I think similar data has been used in peer-reviewed publications. (Inaudible) had to have used similar data to have done his study.
Q Your chart wherein you reference both referrals to gender clinics in the UK and Australia provides under it that Australian data was provided by "gender clinics under freedom of information applications." Do you see that?
A Yeah.

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Q Did the UK data come from similar requests?
A No, the UK data was published on the NIH website.
Q And I understand that -- and I'm looking at Figure 3 here. Do you see the entirety of Figure 3 on this screen?
A Yeah.
Q I understand that the figure is in thousands so you can't garner precise numbers from this, but, from looking at the chart, it appears to me that the Australian data shows either zero or roughly zero referrals to gender clinics all the way through 2013; is that correct?
A Yeah.
Q And the UK data shows roughly zero through 2006 or 2007 at which point it starts increasing slowly?
A Yes.
Q Is this because there were simply no gender clinics prior to these dates?
A My understanding is that the UK only had the Tavistock gender service. Right up until it's closure, I think it was the only service offering so-called gender-affirming care, so it was a sole referral agency.

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Q I'm sorry, I didn't mean to cut you off. Just while it was fresh on my mind, I was going to do it for the court reporter, but T-a-v-i-s-t-o-c-k. Do I have that correct, Doctor?
A Yeah. Yeah.
Q So my question was whether it's your understanding that there were no gender clinics in these countries during the periods of time where the chart indicates that there were zero or roughly zero referrals to clinics.
A Well, as I've just answered for the UK, that there was a clinic, but it did receive a very low number of referrals. In Australia there would have been a couple of clinics but nowhere near as many as there are now.
Q A couple of gender clinics even before 2013?
A Look, I can't give you the precise numbers and dates of clinics. I believe that they were incorporated into the pediatric departments of the major children's hospital, so it would have been people consulting about children who were presenting with gender dysphoria, but they were probably not called gender clinics and there wasn't a specific service for that purpose until

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more recently.
Q So, when these charts indicate zero or near zero, you agree it's likely because people were receiving care through something other than formal gender clinics; is that fair?
A Yes, it's probably fair, yeah.
Q And do you know when Tavistock opened?
A I know there's data before like 2000, I mean back as far as 2000, but beyond that I don't know.
Q Do you know when it closed?
A I think it's formally closing September 2023.
Q Okay. In Paragraphs 97 and 98 of your declaration, we'll start here, but do you generally see what these paragraphs are talking about?
A Yes.
Q It looks to me like you're describing data showing increased referrals to gender clinics in certain Australian states. Do I understand that right?
A Yeah.
Q And Figure 4 separates it out by each state?
A Yes.
Q And I think you describe in text that the

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increased referrals were primarily in three states, Western Australia, Queensland, and Victoria. Do I have that right?
A Yes.
Q I assume on your chart WA is Western Australia?
A That's right.
Q And VIC is Victoria?
A Yes.
Q And QLD is Queensland?
A Yes.
Q My understanding is that Melbourne is the largest city in Victoria. Do I have that right?
A Sydney is the largest.
Q I'm sorry. Is Sydney not in New South Whales?
A Sydney is in New South Whales.
Q Sorry. I said Victoria. Is Melbourne the largest city in Victoria?
A Oh, I see what you mean. , it is, yes.
Q Okay. I'm sorry. I have to admit my knowledge of Australian geography is less than yours so I would've been happy to be told I was wrong there.
A Well, my knowledge of your 51 states is very sparse in my mind as well, so we're even.
Q We're somewhere between Los Angeles and New

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York. That's all you need to know.
A Okay.
Q Certainly that's all people in either Los Angeles or New York care about.
Okay. My understanding, and please tell me if I'm wrong, is that the first health clinic catering solely to the needs of transgender persons or gender diverse persons in Melbourne was opened in 2016. Is that your understanding as well?
MR. FISHER: I'm gonna object just because there's lack of definition behind those descriptions you just provided.
Q And you can answer the question, Doctor.
A I was just going to say a plane was flying overhead and I missed the substantive issue in your question.
Q Sure. My understanding is that the first health clinic in Melbourne catering solely to transgender and gender diverse persons opened in 2016. Is that your understanding as well?
MR. FISHER: Same objection. You can answer.
A I couldn't give you the precise year, so, if you have researched the question and found that it

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was 2016, I will accept that answer.
Q You understand that it opened sometime in the last 5 or 10 years; right?
A Yeah. Yeah.
Q And what's the name of that clinic in Melbourne?
A It's called the -- it's in the Royal Children's Hospital -- the Adolescent Gender Service, I think it's called, or something of that nature.
Q Okay. And then in Western Australia, the capital and the largest city is Perth; right?
A Yeah.
Q I don't know why I didn't have an exhibit for you for Victoria and I made you guess at that. I'm sorry for making you do that, but I'm going to pull up Exhibit 11 and see if there's a rotate button.
MR. FISHER: You have to subscribe.
Q Okay. Why don't I flip to my own Exhibit 11 and read you the highlighted portion that I have taken there. And I will tell you that this is a printout that I took from the web page of the Government of Western Australia's Mental Health Commission, and the portion I have highlighted says that the gender identity service "was created in 2015 to address the gap in services

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available to young people in WA experiencing problems with their gender identity."
Is it your understanding that the gender identity service opened in Western Australia in 2015?
A Yes.
Q And I assume that that's the largest gender clinic in Western Australia?
A Yes.
Q And then Exhibit 12 is another printout that I've taken from the website of the Government of Queensland wherein the article they published has someone saying that there was no multidisciplinary gender service in Queensland before the establishment of the gender clinic at Children's Health Queensland in 2017. And my question to you is: Is it your understanding that the gender clinic at Children's Health Queensland first opened in 2017?
A Yes.
Q Okay. In Paragraph 105 of your declaration, which spans two pages, but do you see the top of Paragraph 105 there?
A Yes. Yep.
Q And you provide a citation here to Tegg, 2022,

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personal communication?
A Yep.
Q And I assume that the citation is to something that was just relayed to you by whoever Tegg is?
A Yes.
Q And Tegg, I assume, is Simon Tegg?
A Yes.
Q And are you aware that Mr. Tegg is part of a group called Fully Informed?
A Yes.
Q Are you aware that that group has played an active role in advocating in favor of policies in New Zealand that would prevent children from accessing gender-affirming medications?
A Of course.
Q To your knowledge, has the data you received from Mr. Tegg been published in any peer-review journal?
A Not to my knowledge.
Q Okay. I'm going to scroll down just as an example to Paragraph 107. Do you see that there?
A Yeah.
Q The citation that you provide at the end of that paragraph is to a -- your guess is as good as

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mine on the pronunciation -- Respaut & Terhune, 2022; correct?
A Yep.
Q This article here, Respaut & Terhune, is it published in a peer-review journal?
A I'd have to look at the reference.
Q I will just tell you that I found it and your references are at the end of your declaration, but Respaut & Terhune are actually reporters for Reuters. Does that refresh your recollection?
A Well, I have quoted some journalistic pieces from reputable journals, yes, because they have access to information that's very difficult for people, you know, to obtain by any other means, so I have done that on a couple of occasions.
Q And when you have relied on media stories for the information you provide in your expert report, you provide the citation in roughly that format, right, just the author and the year?
A Yeah. Yeah. That is the accepted APA referencing convention.
Q Is it fair to say that there are several other citations that you provide in your expert report that are just media stories?
A There's a small handful out of 200 plus

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references and it's because I wasn't able to source the information from anywhere else.
Q And every media story that you relied on, is that cited in the references portion at the end of your declaration?
A Yes.
Q I'm going to scroll down to Paragraph 131 real quick. And I don't know how every single paragraph I've chosen actually spans two pages, so I apologize for that, but do you see the beginning of Paragraph 131?
A I do.
Q And in this you are describing an article published by Dr. Turban and others in 2021?
A Yes.
Q I'm going to bring up Exhibit 13 and ask you, first and foremost, if Exhibit 13 is that article that you're citing.
A Yep.
Q And, generally speaking, in your expert declaration you're relying on Dr. Turban's article to describe the detransition rates amongst persons who had previously been diagnosed with gender dysphoria. Is that a fair summary?

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A No, because in this study Turban conflates transgender with gender diverse and that's a fatal flaw for any study to do that.
Q Okay. And I apologize, that wasn't the portion that I was trying to focus on and that's just my verbiage, but you're relying on Dr. Turban's study to discuss the detransition rates. Is that a fair summary?
A Not detransition rates generally but the detransition rates that he reports in that study.
Q Okay. Do you understand that Dr. Turban's article did not just seek to collect data on the rate of so-called detransition but also sought to analyze why persons detransitioned?
A I don't think he's capable of psychoanalyzing anything and I don't necessarily think he claimed to do so.
Q Do you understand that the report itself purports to provide data on why persons detransitioned?
A Yes.
Q Do you understand that the data set that he relied on was of people who currently identify or identified at the time of the article as

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transgender?
A Or gender diverse.
Q Or gender diverse. I'm sorry. You understand that; correct?
A Yes.
Q So every person in the article who had "detransitioned" subsequently retransitioned. Is that your understanding of what the article purports to report?
A It's very difficult to work out exactly what it purports to report.
Q Okay. Well, you're relying on the article to talk about detransition rate and my question to you was whether you were aware that everyone in the article subsequently retransitioned; correct?
A I'm not sure I'm aware of that now only because it's been some time since I read the paper.
Q The article speaks for itself so if you're not aware of it, that's perfectly fine and I don't have to prolong the issue.
Are you aware that the article also classified the reasons for "detransition" --
A Yes.
Q -- as either -- I'm sorry, I wasn't done with

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the question. Why don't we start there, though. You're aware that the article also classified the reasons for detransition; correct?
A Yes. Yes.
Q And it classified them, while having specific categories as well, into external and internal reasons. Is that your understanding?
A Yes.
Q And you're aware that the article found that the overwhelming majority of persons with a history of detransition cited at least one external reason for that; correct?
A Yes.
Q Do you agree that that finding is consistent with your social contagion hypothesis?
A Look, I'm afraid that I don't base any of my inferences or conclusions on the work of Jack Turban because it's almost all universally flawed research, methodologically suspect, and one cannot draw conclusions or make generalizations from the purported conclusions that he draws from his own research.
Q Well, imagine some professional other than Dr. Turban who you respected. If they published a scholarly article finding that of 100 persons

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who "detransitioned," 82.5% of them cited at least one external factor as a reason for their detransition, would you believe that that is consistent with your social contagion hypothesis?
A Well, that eventuality has never occurred. It's never been reported before or since, so it would be merely an assumption to say that a reputable scientist had found those results. So, to take the next leap and say whether it was consistent or not consistent with social contagion, my hypothesis, is really not appropriate.
Q Okay. I'm going to click over to Exhibit 14.
MR. FISHER: Gavin, can I interrupt for just one second?
MR. ROSE: Of course.
MR. FISHER: I just want to point something out. Please go off the record for just one second.
(A discussion was held off the record.)
Q Doctor, I have in front of you right now what I've marked as Exhibit 14, and I assume that you are familiar with this?
A Yes.
Q This is an article that you authored and was

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published in 2021. Do I have that correct?
A Yeah.
Q I understand that there is significant, I guess, elaboration in your expert declaration, but is it fair to say that many of the opinions you express in your expert declaration are also expressed in this article Exhibit 14?
A Yes.
Q And my understanding is that this article was published in a collection of articles by various Australian professionals. Do I have that right?
A Yes.
Q And the collection was devoted to the "transgendering" of children and adolescents; is that right?
A Yeah.
Q Was your article published anywhere else?
A Not at this point, no.
Q Has it been published -- I'm sorry, I was confused by your response. By "not at this point," do you mean not currently or do you mean not at the time that it was published in the collection of articles?
A No to both questions.
Q Okay. My understanding is that the article

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collection was edited and published by a sociologist in Australia named Geoffrey Holloway. Do I have that right?
A Yes.
Q Were you compensated for writing or submitting your article?
A No.
Q Okay. I'm pulling up Exhibit 15 and I will just tell you before we get into this that I have not taken the entire publication. What I have here, I think, is the cover page, the table of contents, and the editorial that appears as Section 1 to the publication. Do you recognize this as those portions of that collection in which your article appear?
A Yes.
Q The editorial that appears indicates that one of the key objectives of the publication was "to promote the campaign for a national, public inquiry into the transgendering of children and adolescents." Do you see that?
A Yes.
Q Is that your understanding as one of the key objectives of the publication?
A Yes.

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Q Is that one of the reasons that you submitted your article for inclusion?
A Yes.
Q What is the transgendering of children and adolescents?
A The transgendering refers to a process of persuasion that children are "born in the wrong body," that their gender identity, however defined, does not align with their natal sex, and the transgendering is the process whereby medical professionals assist the child to bring their sexed body into line with their reported gender identity using means such as puberty blockade, cross-sex hormones, and sex reassignment surgery.
Q In your declaration you refer on several occasions to the "trans activist lobby." You're familiar with that, I assume?
A Yes.
Q Is the transgendering of children and adolescents being accomplished or attempted by the trans activist lobby?
A Absolutely.
Q Is there anyone other than the trans activist lobby that is performing the transgendering of

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children and adolescents?
A Well, the lobby is an open social network that has a number of means of propagation, one of which is the Internet, social media, the misteaching of children, schools using curricular that is scientifically incorrect, so they're being coquetted at very young ages, five and six.
If you have a look at some of the educational materials and curricula, children as young as five and six are being told that girls can have penises and boys can have vulvas and there are crude drawings, anatomical drawings, for which children are not really ready and should not be exposed. They're also being told that they can have whatever gender identity they like.
And, furthermore, you know, there are other means of propagation including this whole movement of drag queen story time where drag queens go into schools and libraries, community libraries, and other public places where very young children assemble and play and they're read transgender story books about transgender theories and transgender (inaudible) and a

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gender unicorn where further incorrect information is disseminated and propagated. That's what we call the transgendering of children.
Q Your article, Exhibit 14, were you solicited to submit an article to that publication?
A Well, the word "solicited" is slightly loaded. I was invited to contribute an article.
Q And I wasn't trying to load anything. I was asking whether they invited you or whether they had an open call for articles and you just happened to submit one. But they invited you to submit an article?
A I believe so, yes.
Q Okay. Did you submit your article for publication anywhere else?
A Not that particular article. I did attempt to get it published in a peer-reviewed journal and, unsurprisingly, it was not considered politically correct enough and so I was unable to get it published.
Q What journal was that?
A The Archives of Sexual Behavior.
Q And when did you submit it to that journal?
A A version of it was submitted about a year ago,

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maybe about that.
Q So after it appeared in this collection?
A Probably.
Q Other than that journal, did you submit it for publication anywhere else?
A I've done versions of it under invitation to other sources and publications and so forth. It's never the same version. It's always tailored and very much shorter than the declaration. The declaration is probably the longest and most detailed version of my work on this topic.
Q Other than the one peer-reviewed journal from which it was rejected, did you submit it to any other peer-reviewed journals?
A I think I already answered that question and I said no.
Q Oh, I'm sorry. I thought you had two. I'm not trying to trick you up. I just don't have a realtime transcript, so I apologize.
A The chapter that I submitted to the Brunskell-Evans edited volume was peer-reviewed and I just haven't really been focused on peer-reviewed publications. (Inaudible) at the moment having left the university to publish and

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most of my colleagues have had the experience of putting a huge amount of work into a paper and not even get past the first round of reviews, so I haven't pursued that avenue of dissemination, but I do have over 200 international peer-reviewed journal articles. So I'm not incapable of reaching a bar for peer review, but it's almost impossible to get articles critical of the current transgender position past a peer review.

Q Okay. I'm back in your declaration right now and I am going to bring up, I guess, the end of Paragraph 140 and the beginning of Paragraph 141. Do you see that in front of you?

A Yep, I do.

Q It appears to me that Paragraph 140 ends with a quote from a British neurosurgeon about lobotomy; correct?

A Yep.

Q And then in Paragraph 141 you apply this quote to the practice of transgendering children and young people. Is that a fair summary?

A That's a fair summary.

Q And you have in that paragraph a statement that "These young people are also 'totally ruined as

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social human beings.'" I assume that by "These young people" there, you're referring to transgender persons?

A I'm referring to young people who have had their bodies medically and surgically altered in a vain attempt to change their sex.

Q What does it mean to be totally ruined as a social human being?

A It means that one suffers, as I say later on in that paragraph, pervasive mistreatment and violence, severe economic hardship and instability, discrimination, significant negative physical and mental health impacts, and so forth.

Q Do you believe that the plaintiff children in this case have been totaled ruined as social human beings?

A I think they have suffered enormously. They're very vulnerable young people and, I mean, obviously, I wouldn't apply that phraseology to very young children, you know, who still have the opportunity to be rehabilitated if they received the right care rather than the one-size-fits-all care of gender affirmation for which, you know, they are, in all likelihood,

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not appropriate.

Q Sorry. One second, please. I'm sorry, Doctor, my co-counsel heard something that I didn't hear and we're probably both wrong on one front or another.

What role does whether or not a person has had gender-affirming surgery play in your determination as to whether they are totally ruined as social human beings?

A What role does surgery play in ruining them? Is that what you're asking?

Q Sure, let's start there.

A Okay. It's a significant traumatic insult on the body to remove perfectly healthy organs, the result of which will impair their sexual function. Many of them suffer ongoing and significant medical complications including chronic pain, infection, fistulas, bleeding, and, you know, in the case of male to female, they have to constantly dilate which I'm told causes significant pain. Many of them are sexually dysfunctional or are not able to feel comfortable enough to expose their naked bodies to other people. So, to the extent that those situations have eventuated from sex reassignment

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surgery, the answer to your question would be yes.

Q Do you believe that children who have been given access to gender-affirming medications, either puberty blockers or hormones, but have not had surgery, do you believe that they are totally ruined as social human beings?

A I don't think it's fair that you characterize my view as everybody who's had gender-affirming care of some kind or another are totally ruined human beings because it depends on the age of the child, it depends on the nature of the treatment, what age it was commenced at, and, you know, the kind of support they got and what was the final outcome, but if your question was about puberty blockade -- is that correct? Were they totally ruined human beings?

Q I said puberty blockers or gender-affirming hormones, but if you have different --

A Okay.

Q -- for the two, please --

A Well, some of the adverse effects of puberty blockade are -- I mean, I'm sure I'm not going to be able to include everything right at this moment, but the ones that come to mind are

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questions of future fertility, bone density and bone grown and their final height. It carries significant risks of weight gain and there are a significant number of children who report headaches and hot flashes and, more recently, a phenomenon called pseudotumor cerebri which, if not treated promptly, may cause blindness.

So this drug is not safe and, in some respects, it's not reversible because what it, in fact, does is delay puberty including the growth of the sexual organs, and if the child remains on puberty blockers for longer than two years, the growth of their sexual organs may not return to what they would have been had they been allowed to mature without puberty blockade.

The other thing that happens with puberty blockade is, of course, their peers are going through puberty and so all of the factors that made them feel different and gender dysphoric in the first place are often exacerbated because they remain in a prepubertal state while what used to be their best friends and peers are all moving into the next stage of development which is sexual maturation. So there are the possible problems caused by puberty blockade.

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So, if we move on to the cross-sex hormones, some of the problems with prescribing testosterone to women are, of course, well, first of all, the suppression of menses, the permanent infertility, and ovarian uterine atrophy that occurs with longer-term use often necessitating the removal of a young woman's uterus and ovaries because they atrophy and cause enormous pain. Then we have clitoral discomfort, vaginal atrophy which, of course, makes sexual intercourse very difficult. They often have cyst formation on the ovaries, pelvic pain, a condition called polycythemia which means that they develop too many red blood cells which carry medical risks. There's increased dyslipidemia, acne, oily skin. Some of them develop hypertension, some of them develop Type 2 diabetes, mood swings, increased frustration and anger and aggression, a risk for deep vein thrombosis.

That's what I can think of at the moment. I'm sure there are more, but, you know, these drugs are touted as being, you know, oh, wow, this is really going to get you what you want, but these issues are skated over, at best.

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So, if we move to the adverse effects of estrogen on males, we see things like, again, deep vein thrombosis, high triglycerides. Some of them will get hyperprolactinemia which means they will start to have discharge from their nipples. They can develop a condition called hyperkalemia which is excessive potassium which can really upset the metabolic balance in the body which can affect the heart. Again, Type 2 diabetes, hypertension, weight gain.

Yeah, these drugs are dangerous drugs. They're synthetic dangerous drugs to be pumping into young children and adolescents.

Q And, just to be clear, Doctor --
A I beg your pardon.
Q I'm sorry, I didn't mean to cut you off there. I thought you were done.
A Well, I'm sure I've missed something, but that will have to do for now.
Q And, just to be clear, Doctor, you're not a medical doctor, are you?
A I'm not.
Q In your CV you make reference to what appears to me to be a two-part podcast called The Medical Scam of the Century. Do you know what I'm

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talking about?
A I do know what you're talking about.
Q Is it fair to say that you consider the "transgendering of children and adolescents" to be the medical scam of the century?
A Yes.
Q You're familiar, I assume, with the Australian Psychological Society; correct?
A Of course.
Q And, I'm sorry, I just forget. Is this one of the organizations you're still a member of or is it something --
A Yes, it is. Yes, I'm still a member.
Q And you're aware that this organization has published an information sheet recommending mental health practices that affirm transgender people's experiences?
A Yes.
Q And I'm pulling up Exhibit 16 for you. Do you see that in front of you?
A Yes.
Q You recognize this as that information sheet?
A Yes, I do.
Q And you understand that, along with this, the same organization published a one-page summary

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of its information sheet; correct?
A I do.
Q And I'm pulling up Exhibit 17. And you recognize this as that summary; correct?
A Correct.
Q You previously mentioned the Royal Children's Hospital in Melbourne; correct?
A Yes.
Q And my understanding is this is the largest children's hospital in Melbourne?
A Yes, it is.
Q Is it the largest one in Australia? I just don't know.
A No, there's the Westmead Children's Hospital and the Prince of Whales Children's Hospital in New South Whales.
Q But you're aware that it has published treatment guidelines for the treatment of transgender and gender diverse children and adolescents; correct?
A Yes.
Q And what's the relationship, if you know, between The Royal Children's Hospital and AusPATH?
A Well, the director of the gender service at The

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Royal Children's Hospital is one of the coauthors of AusPATH.
Q I'm pulling up for you what I have marked as Exhibit 18. Do you see that in front of you?
A Yes, I do.
Q You recognize these as the treatment guidelines that have been published by AusPATH for the treatment of transgender and gender diverse children and adolescents?
A Yes.
Q And these are the treatment guidelines that you reference in your declaration occasionally as the AusPATH guidelines?
A Yes.
Q And my understanding is that this is the Australian body similar to WPATH?
A Yes.
Q We just briefly touched on this, but in your declaration you repeatedly describe the influence of the trans activist lobby and I'm wondering -- and maybe I asked you this or something close to this, but I'm wondering who, in your estimation, comprises the trans activist lobby.
A Look, I think in a footnote I said I'm using it

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as a summary term for the vast network of individuals and organizations who are propagating gender-affirming care.
Q Do you believe that the trans activist lobby has a leader or a leadership structure?
A The trans activist lobby, which is my summary term so that I don't have to list multiple individuals and organizations, is an open system network so it's got many, many influencers and many networks and subnetworks that have, you know, been -- it's been a very, very effective marketing machine.
So it's got very great many modes, you know, that can attract children, so we've got TikTok, we've got Insta -- Instagram not so much. What are the others? I'm having a mental block about these websites, but there's many of them that spend a great deal of time, you know, attracting young people to these sites and, you know, talking to them in very positive terms about transgendering and they can be whatever gender they like. And it often attracts young children who are marginalized and who are looking for a group, looking to belong, looking to be important and special.

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And, yeah, so it's not any one individual, but I did do a social network diagram for what's going on in Australia and the network consists of politicians, sadly the Australian Human Rights Commission, the Commissioner for Children and Young People, the eSafety Commissioner. They're all singing the same song and there's no capacity to (inaudible) the unanimous kind of voice about gender-affirming care.
So, you know, I'm not being extremist or, you know, it's not a conspiracy theory to call it a trans lobby. It's a summary term for what's happening in society currently and it's very, very concerning.
Q And the deep dive that you said you took -- and I'm sorry if I'm putting words into your mouth -- into persons in power in Australia, it's my understanding that that is available on your website?
A What particularly?
Q I'm sorry, I will pull that up at the next break and make sure we're talking about the same thing.
I assume you believe that the trans activist lobby is global and not limited to

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Australia; right?
A Oh, absolutely.
Q And The Royal Children's Hospital in Melbourne is a member of the lobby?
A Look, I don't want you to put that kind of notion into my mouth. I'm not kind of reifying the transgender lobby as some, you know, star chamber organization that's infiltrating the world, but The Royal Children's Hospital acts as a major harbor of this open social network disseminating misinformation and advocating for gender-affirming care very strongly, both politically and in the courts. These are facts. They're not part of a conspiracy theory.
The Australian standards of care have been strongly influenced by the WPATH guidelines and the WPATH guidelines have been strongly influenced, so there's this mutual kind of network of social influence to the point that you would call it brute think because if you have a look at the early documents like the standards of care, you'll see the same authors across different guidelines and standards of care. So we've got Henriette van de Waal and Peggy Cohen-Kettenis from the Amsterdam Clinic

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who were authors of the 2006 Dutch protocol and we see their names appear repeatedly on these standards of care compilations over the last few years as well as the Endocrine Society. And there are other names as well that keep coming up like Louie Myer (phonetic) and so forth.
So there is this group think that has developed around the guidelines including the Australian Psychological Society. It's one voice speaking and there's no room for doubt. And, so, there is this collective rationalization of thinking where there's a lot of -- you know, there's no admission of any other alternative point of view. They don't survey the alternatives and every time an alternative is offered like social contagion or like the fact that many of these gender diverse children will grow up to be gay adults if left alone. They don't admit any other possible way of helping and managing these young people, so they do not appraise properly the risks of their own preferred solution which is gender-affirming care. They scoff at the idea of the reversibility of some of their treatments. They selectively choose information and they have

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this err of invulnerability that if you belong to this group of gender-affirming care, clinicians, politicians, teachers, et cetera, then we have the truth. We have the absolute truth. And all I'm saying, people outside of that network are saying: Please think about alternatives, please think about possible harm, please think about irreversibility. And it's not happening.
Q Is it fair to say that you believe that the American Medical Association has been improperly influenced by the trans activist lobby?
A Yes.
Q Is it fair to say that you believe the American Psychiatric Association has been improperly influenced?
A Yes.
Q How about the American Psychological Association?
A Look, I've put a big list in my declaration and if you have a look at all of their position statements, there's very little variation, you know, between them and it's --
Q I'm sorry, Doctor. We're gonna be here all night if you don't just answer the question.

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A Okay.
Q The question was whether you believe the American Psychological Association has been improperly influenced by the trans activist --
A Yes.
Q And the same for the Endocrine Society?
A Yes.
Q Earlier in your deposition I showed you what was Exhibit 8, the statement by the CAAPS organization that had been signed by a couple dozen other organizations. Do you remember that document?
A Yes, I do.
Q Is it fair to say that you believe that each of those organizations has been improperly influenced by the trans activist lobby?
A Well, they're part of it so they influence each other. It's a bidirectional influence.
Q And the various Australian state governments that have passed bans on conversion therapy, have they been improperly influenced by the trans activist lobby?
A Well, I mean, I'm afraid I have to seriously question their intellectual capacity to put a bill like the banning of conversion therapy into

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parliament. It's an extremely poorly-worded document and it's unlikely to catch anyone in its net, but what it has done is scare off therapists from treating these children in any way whatsoever. So now there is an extreme shortage of skilled child and adolescent therapists to help these young people because almost no one wants to touch this patient group because of that legislation.

Q You understand, I assume, that a federal judge in the Alabama case where you submitted an expert report issued an injunction against the statute banning certain types of gender-affirming care for minors; correct?

A Issued an injunction against gender-affirming care?

Q I'm sorry, that's lawyer talk. Issued an order for preventing the statute from taking effect.

A Yes.

Q Is it your position that that judge was improperly influenced by the trans activist lobby?

A I don't have an opinion on that.

Q I'm pulling up for you what I have marked as Exhibit 19. Do you see that document in front

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of you?

A Yes.

Q I assume you're familiar with this?

A Yes.

Q These are the informed consent standards that AusPATH has promulgated for gender-affirming hormone therapy?

A Yeah.

Q I'm popping Exhibit 18 back up for you and my question to you is whether you use any portion of this document, the AusPATH treatment guidelines, when you provide therapy to transgender persons or persons who identify as transgender.

A Was your question: Is there any part of the document that says children should have therapy?

Q My question was whether there's any portion of this document that you rely on when treating a patient who walks through your door.

A No.

Q And is the same true for Exhibit 19, the informed consent standards?

A There are more general informed consent standards that every practicing clinician must adhere to, but the gender-affirming therapists

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don't even adhere to their own standards of informed consent and most of them don't even understand what constitutes informed consent.

MR. ROSE: Off the record for a sec.

(A discussion was held off the record.)

Q Doctor, you ready to power forward?

A Sure.

Q Chapter 2 of your declaration -- excuse me. You have a separate what you call chapter of your declaration that specifically concerns the named plaintiffs in this case; is that fair?

A Yeah.

MR. ROSE: And, Tom, before we plow forward, just a matter of housekeeping. We want to make sure that Exhibits B, C, D, and E of the doctor's declaration as well as I think they will be Exhibits 20 and 21 of this deposition and any testimony about those are maintained as confidential. I assume that's not an issue and we can obviously figure out how that needs to work for the Court?

MR. FISHER: Right. Agreed. No objection to that.

Q Okay, Doctor. Just very generally, have you personally evaluated any of the plaintiffs?

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A As stated in my report, no, I haven't.

Q Have you interviewed them at any time?

A No.

Q Have you interviewed any of their parents?

A No.

Q Have you ever communicated in any fashion with either them or their parents?

A No.

Q Have you ever communicated about the plaintiffs with any professional who has evaluated or treated any of them?

A No.

Q It's fair to say that your opinions about them come exclusively from a review of the medical records that you were provided; is that correct?

A As stated in my report.

Q Sorry. That's a yes?

A Yes.

Q Do you have an understanding as to whether each of the plaintiffs received mental health therapy before seeking or being prescribed either puberty blockers or gender-affirming hormones?

A Did you say do I have an understanding?

Q Do you understand whether the plaintiffs received mental health therapy before seeking or

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being prescribed gender-affirming medications including puberty blockers?
A It wasn't entirely clear exactly what they received by way of psychotherapeutic support because, as I say, in the documents before me only vague references were made. So I didn't see any process notes, I didn't see any case formulation, I didn't see any progress, goals, or anything that one would normally see documented in a clinical process.
Q Okay. I am bringing back up your expert report, Exhibit 2. Do you see that in front of you?
A Yeah.
Q I am going to scroll down to Paragraph 198. Okay. Do you see Paragraph 198 and the associated footnote 34?
A Yes.
Q In this portion of your declaration you're describing a visit that Plaintiff K.C. had with the doctor managing her Type 1 diabetes. Do you see that?
A Yeah.
Q And you underscore in your report that K.C. was reported to have "no dysmorphic features." Do you see that language?

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A Yes.
Q And you speculate in the footnote that it's unclear whether the doctor meant dysphoric or dysmorphic or was --
A Yes.
Q -- using the terms interchangeably; is that correct?
A Yes.
Q I assume you understand that gender dysphoria and body dysmorphic disorder are two entirely separate diagnoses; right?
A They're not two entirely separate diagnoses, but they have different emphases.
Q And they're listed separately in the DSM; correct?
A Yes.
Q Do you have an understanding that persons with diabetes are more likely to develop an eating disorder that might lead to body dysmorphia?
A Yes.
Q So do you agree that for a doctor managing a patient's diabetes whether a patient displays dysmorphic features might be particularly noteworthy?
A Yes.

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Q But you still think the diabetes doctor, despite using the phrase "dysmorphic features," might have been intending to reference K.C.'s gender dysphoria?
A Well, he then goes on to say "sweet transgender girl," so it's ambiguous.
Q Okay. I'm going to scroll down to Paragraph 229. Do you see that in front of you?
A Yes. Yes.
Q You're describing here an assessment of M.W. that you indicate took place on January 4th, 2022. Is that a fair statement?
A Yes.
Q My review of the medical records, I'll just tell you, does not reveal anything from January 4th but does indicate that M.W. had an initial evaluation at Riley Gender Health Connect on April 14th, 4/14/22. Is it possible that you simply got the dates wrong?
A Well, given that I had to scroll through literally thousands of pages on Notepad formatting, it is possible I got the date wrong. And, also, Americans reverse the date and month and it may have occurred for one of those two reasons.

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Q I understand that and I'm not blaming you. And, for the record, I did go through other portions of your declaration to see whether you were adopting the American style of month/day or whether you were not. I'm certainly not blaming you.
In your report of this encounter you indicate that M.W. was neutral about certain secondary sexual characteristics, satisfied with other things, and also neutral about characteristics such as hair, voice, and general appearance. I understand that I'm not quoting everything, but you see the language I'm referencing; right?
A Yes. Yes.
Q And you underlined "voice"; right?
A Uh-huh.
Q Sorry. Yes?
A Yes.
Q Why did you underline "voice"?
A Because voice is one of the characteristics around which young people claim extreme dysphoria.
Q So is it fair to say that you underlined "voice" because you thought M.W. being neutral about

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that was more noteworthy than some of the other items reported?
A Yes.
Q I'm going to flip over to what I've marked as Exhibit 20 which, as you will see, is the encounter on April 14th, 2022. And I will scroll down to, I guess, Page 3 of the document using the PDF page numbers. I have highlighted a couple aspects of the report there. Do you see the portions I have highlighted?
A Yes.
Q And I will just tell you that this -- and I'm not trying to trick you. I can scroll back and forth if you want me to. The language I highlighted matches almost verbatim the language that you report in Paragraph 229 of your declaration. Is it fair to say that this is the document that you were looking at?
A Well, I didn't get it in that form. In that form it's actually interpretable, but I got it in incredibly narrow paragraphs and the average scores were kind of above the text interpretation so it was quite difficult for me to make sense of it. I mean, presented like that, it looks much more interpretable than the

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form that I got it in which was a Notepad document.
Q So is it possible that you misinterpreted M.W.'s medical records as you were going through them?
A I hope I didn't. I took great care not to, but it looks as if I did not misinterpret anything on this occasion.
Q Okay. And all of the medical records that you reviewed, did you receive them all in the same format that was difficult to read?
A Most of them were in Notepad format. I got a couple that were scanned Word or PDF documents, but they weren't like -- the text was fuzzy, and they were the two primary forms in which I got the records.
Q And the Notepad format was the one that you were indicating was difficult to read?
A Yeah, and I had hundreds of those files to go through.
Q Okay. I will scroll up just a little bit on Exhibit 20 now to the top of that Page 3. It looks to me like what Page 3 is doing here is providing a summary of the intake paperwork that M.W. and, under the caregiver's portion, M.W.'s parents completed. Is that fair?

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A Yeah.
Q I assume you were provided a copy of that pre-intake paperwork itself as well?
A As I said, but not in this form.
Q Okay. I understand the formatting might have changed, but I'm flipping over to Exhibit 21 and I will ask you whether this appears to you to be the pre-intake paperwork for M.W. that is summarized in Exhibit 20.
A I don't believe I've seen that document.
Q Okay. Is there a reason you would not have seen it?
A I don't know. I would remember that if I had seen it and I haven't seen it.
Q I'm going to scroll down just a little and I will represent to you this is the self-report portion and I'm on Page 6 right now. Do you see the highlighted portion about how M.W. feels about his breasts?
A Yes.
Q And you acknowledge that he indicates that he was very dissatisfied with them?
A Yep.
Q I'm scrolling down just a little bit farther. You see the same thing about voice and chest?

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A Yes.
Q And I'm looking at Page 7 now, but you see that M.W. actually reported that he was very dissatisfied with his voice?
A Yes.
Q So is it fair to say that the statement in your declaration that M.W. was neutral about his voice is inaccurate?
A According to the document that I reviewed, no, it's not inaccurate because that was the information in front of me, but, as I said in the beginning of my Chapter 2, that had I been presented with any information subsequent to my report, it might cause me to change my opinion.
And just because a child says they're dissatisfied with their breasts and voice, it doesn't mean that you automatically jump into a diagnosis of gender dysphoria and send them off for gender-affirming care.
Q Okay. Well, we've established that Exhibit 20 which indicates "Tended to report feeling neutral about characteristics such as hair, voice, and general appearance" is what you were looking at for that portion of your declaration; correct?

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A Correct.
Q I'm going to scroll up on the same document then to the top of Page 2 where it says that M.W. "Reports feeling significant dysphoria related to chest, voice, and menstrual periods." Do you see that?
A Yep.
Q And do you still think it was accurate for you to report that M.W. is neutral about his voice?
A From the documents that were in front of me, I reported that accurately.
Q This is part of the same document, Doctor.
A Look, I would like you to have a look at the Notepad files that I was sent. They were disjointed. They didn't necessarily even follow one sentence continuing on the next line. Sometimes I had to scroll down several lines to get the end of a sentence. I was under extreme time pressure. I was given some medical records two days before I had to file my report. I was up all night for three nights in a row trying to complete the work.
But, even under all of those circumstances, even if a young child reports dysphoria in relation to chest, voice, and menstrual periods,

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I do not jump to the conclusion that this child is suitable for gender-affirmation care.
Q And the circumstances you described about your difficulties reviewing the medical records, I assume that applies to the medical records of all four plaintiffs?
A Well, most of them were given to me in that format, in Notepad format.
Q Is that a yes?
A Yes.
Q Okay.
A But I didn't just rely on those medical records. I also was given the declarations of the parents and I had the parent reports from their lawyers as well, so it was multiple sources of information.
Q I'm back in Paragraph 229 of your declaration. In the middle of this paragraph you say "there is no evidence of a marked incongruence between M.W.'s experienced/expressed gender and (all) primary and/or secondary sex characteristics." Do you see the language that I have just quoted?
A Yeah.
Q Why is "all" in parentheses?
A Because, generally speaking, the child would

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need to express a global dissatisfaction with their body overall. I mean, you know, quite often children will not like something about themselves. I don't like my hips or I don't like my shoulders. That doesn't make them either body dysmorphic or gender dysphoric.
So, perhaps, it would've been better to put "most" rather than "all," but I was just drawing that point so that people wouldn't misconstrue that one dissatisfaction or a few dissatisfactions would meet criteria.
Q Let me put it this way, Doctor. Is "all" in parentheses because the rest of that sentence is a direct quote from the DSM-5 criteria for gender dysphoria?
A Yes, it is. I am quoting from the criteria from DSM.
Q So you added the word "all" to the criteria?
A Well, I probably did add it, yes, for emphasis.
Q Okay. Doctor, I was reading an interview that's linked from your website to a website called xxxkidernet.com. Are you familiar with the interview that I'm referencing?
A Yep.
Q And I don't have it up in front of me, but I did

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copy this quote. And I'm going to read this quote to you and then the questions I'm going to ask is going to be whether you recall making this statement and whether it is an accurate statement of your beliefs.
You were quoted as saying, "Transgender advocates state that in transgenderism -- the belief/assumption that one has been born in the wrong body -- the body must be aligned to one's gender belief, not one's belief to one's biological body. They assume that the mind is correct in its perceptions and beliefs and the body is diseased and must be treated."
Do you recall making that statement or something similar to it?
A Yes.
Q And is what I quoted an accurate statement of your beliefs?
A Yes.
Q When you provide psychotherapy to a transgender patient or a patient identifying as transgender, is one of your methods to attempt to align their belief to their biological body?
A This is a grave misunderstanding of the process of exploratory psychodynamic psychotherapy. I

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don't try to do anything except provide a safe space for the young person to know their true feelings and to express them, and whatever conclusion they draw at the end of the psychotherapeutic process is not any attempt on the part of the therapist to engineer a particular outcome.

And what I find in the majority of cases is that after the first few sessions the child just stops talking about gender dysphoria and wanting to transition and we start talking about their emotional distress and pain in relationship to what is happening in their primary attachment relationships and also other issues that are of great concern to them such as bullying and discrimination, isolation, lonliness, a fear of not meeting expectations. Many of them have very deeply entrenched self-punity, internalized self-punity xxthat need to be dealt with and often we have to deal with how they manage their emotional distress through self harm.

So every time a child or anybody comes into an exploratory psychodynamic psychotherapy it's what's on the mind of the patient, what the patient brings to that session that the

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therapist focuses on. So, no, I do not have a goal of aligning anything with anything else.

Q Okay.

A It's to support the young person to understand themselves better.

Q Okay, Doctor. I'm going to pull up what I have marked as Exhibit 22. Do you see that in front of you?

A Uh-huh.

Q Sorry. ?

A Yes.

Q That's for the court reporter, not for me.

A I understand. I understand.

Q You recognize this as a presentation that you gave in November 2021 to the organization that we previously called SEGM?

A Yes.

Q And this presentation is not listed on your CV. Does this refresh your recollection as to whether there are presentations that you omitted?

A Right. Okay. I'll be sure to add it next time.

Q Was this presentation given at a conference of some sort?

MR. ROSE: You're on mute, Tom, if you're

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trying to talk.

MR. FISHER: Is there any reason you can just make it bigger for the doctor?

MR. ROSE: Oh, I had no idea, Tom.

Q I'm sorry, Doctor, I didn't realize you were leaning forward to try to read it.

A Right.

Q Is this better for you?

A Yes. Thank you. Yes.

Q Okay. I'm sorry, Doctor, let me repeat the question. The question was whether this presentation was given at a conference of some sort.

A Yes, it was, yes.

Q Did you give it in person, online?

A Given that it's November '21, it was probably online.

Q It would have been a conference of the Society for Evidence-based Gender Medicine?

A No, not necessarily. I'm just characterizing -- I'm just situating myself as a member of that organization.

Q Gotcha. And I don't know where I got this from, but it's in my notes so I'll just ask you. Was this given at a conference of the National

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Association of Practicing Psychiatrists?

A Oh, that's highly likely, yes.

Q I'm positive I saw it somewhere, but I don't know where I got that from. Is that an Australian organization?

A Yeah, it's a national organization, yes.

Q But the nation of Australia?

A The nation of Australia.

Q I assumed by how practicing was spelled.

Okay. And what we have here is the PowerPoint, I assume, that accompanied this presentation?

A Yes.

Q Did you create the PowerPoint yourself?

A Yes, I did. This is a presentation of a distillation of my theory development of what is required in assessment and therapy of young people presenting with gender dysphoria, so, yeah, it is a model that I've developed.

Q Okay. And on the very last page of your presentation you included an image of what appears to be a rose with the verbage "TRANS IS NOT BEAUTIFUL," correct?

A Yes.

Q Do you consider this image to be a hateful one?

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A The image with or without the "NOT"?
Q As you presented it at the conference.
A Hate was not in my heart. Why didn't you show more interest in the slides in between?
MR. ROSE: Doctor, I have no further questions. Thank you very much for your time this morning for you/this evening for us.
MR. FISHER: Can we take maybe 20 minutes?
(A recess was taken.)
CROSS-EXAMINATION,
QUESTIONS BY THOMAS M. FISHER:
Q Dianna, you were asked earlier by Mr. Rose about -- and this was a while ago so I'm certainly paraphrasing here, but I think the discussion was treatment of children who had started puberty blockers. Do you remember that discussion?
A Yes.
Q And I think the question from Mr. Rose was something along the lines of: Well, did you continue treating them, that child? And you said no. And then the follow-up, of course, was: Well, why not? And your response was something like: Well, they had found the magic solution. And that was the end of the

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discussion. Do you remember that?
A Yes.
Q Okay. So I was hoping you could explain to us a little bit more about what you meant when you said that.
A What I meant was that families go through a lot of heartache when a child declares themselves transgender, not all but most, and parents have difficulty tolerating their children's distress and most parents want to do what's going to make their children happy. And by "magic solution," I'm referring to a treatment that they've been convinced is going to improve their child's not only gender dysphoria but all the comorbid presentations that the child has as well.
And there is, not always but very, very often, a honeymoon period where everything seems to settle down. It's like, you know, the child is getting this almost magic treatment that's going to take away all the gender dysphoria and everybody then breathes a sigh of relief, but they're really breathing a sigh of relief over this very short-term period and all the complications that may come in the future are brushed aside because peace is being restored

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and the child appears happier in the short term.
But most studies show that pubic blockade has no positive effect on mental health presentations. It's just a placebo effect, but it feels like magic at the time.
Q So, in that circumstance then, because there was that honeymoon period, the family would discontinue seeing you at that point?
A Yes. Yes, they would discontinue other forms of therapy.
Q Okay. Alright. Later in Mr. Rose's questioning he asked about so-called conversion therapy bans in some of the Australian states. Do you recall that discussion?
A Yes, I do.
Q And I think that the sum and substance was pretty much all of those so-called conversion therapy bans were materially identical. Is that your recollection?
A Yes.
Q Tell us about what that means, the conversion therapy bans that those Australian states have enacted. What, in particular, are they trying to ban?
A Well, they're actually based on a completely and

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utter red herring. I don't know if you know that expression in America, but it means that it's a (inaudible). It's just based on shimmering sand because what they're claiming -- like conversion therapy is defined as trying to change the sexual orientation of homosexual individuals to heterosexual, and there was some conversion therapy practiced many, many years ago, decades ago, and maybe there are tiny little pockets in religious groups and so forth that is still trying to practice that but it's certainly not accepted in mainstream medicine, and it has never been practiced in its form, which was created for homosexuality, on transgender individuals. So there is no such thing as conversion therapy for transgender individuals.
And the definition of conversion therapy is a question that Mr. Rose put to me about my psychotherapy and that is: Do you aim to change the child's perception of the gender identity to align with their body? Now, that's conversion therapy, but psychotherapy doesn't try to do that.
So the only conversion therapy is

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gender-affirming care. It doesn't exist in any other form and it's a defunct treatment. It's proven to be inhumane, unethical, and medically ineffective. So it's all part, I'm sorry to say, you know, the transgender machinery, building up straw men to attack and pull down, and then there was so much dancing in the street when these conversion therapy laws got through parliament.

Q What can you do in your practice that psychologists in those states with conversion therapy bans cannot do when it comes to treating gender dysphoria?

A Well, there's two ways of looking at it. One is that anything that isn't gender-affirming care may be interpreted as conversion therapy, but you can only be prosecuted under that act if an actual patient makes a complaint about you. So a trans group or an advocacy group making a complaint that they know you're practicing something other than gender-affirming care cannot bring a complaint, so the patient or the patient's parent needs to directly complain about you.

But, in reality, it carries 18 months jail

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and a $30,000 fine if you're convicted under this act, but I doubt very much whether anybody could be convicted under that act because conversion therapy is not even defined properly in these new laws and it's never been practiced to anybody's knowledge in the transgender space.

Q But, just to be clear, your understanding of those laws is that they mean to say that anything other than gender-affirming care is conversion therapy?

A Yes.

Q Okay. Then at the end of Mr. Rose's questioning, he brought up a slide at the end of a long presentation that you gave, I think, and -- well, first of all, do you recall what that presentation was?

A Yes, I do. Yes, I was presenting my new model of exploratory psychodynamic psychotherapy starting with what I thought were essential assessment examinations that need to be done at the beginning, and then I outlined some of what I believe underlies the genesis of gender dysphoria and then how I work with the family to resolve some of those issues.

Q Well, and when Mr. Rose was asking you about the

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last slide, you, I think, made a comment about how you wished he would be more interested in what came before that. Do you remember making that comment?

A Yes, I do. Yes.

Q I was wondering what sparked that. What was it that you had hoped Mr. Rose would have been more interested in?

A Well, it was a very serious presentation presenting a new model of therapy that has not been presented before or outlined, you know, actually put into a coherent form so that clinicians can meet and discuss, compare notes, and, you know, talk about the process of psychotherapy. So it was the result of, you know, four to five years of very intense study on the subject and, you know, working constantly with young gender dysphoric people, and to go to the last slide, I mean, all we saw was the first slide and the last slide, which I think is a little bit cheap.

Q And what about that last slide that said, as I reall, it had said "TRANS IS BEAUTIFUL" and you put the word "NOT" in, "TRANS IS NOT BEAUTIFUL." Do you remember that?

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A Yes, I do, yes.

Q What did you mean by that?

A Well, if you look at the foregoing slides, you would see that the life of young people after they transition is actually worse in so many ways compared to before they transition. Yes, they're already having difficulties, there are a lot of problems, a lot of comorbidities, but when you look at studies that show what happens to these young people after they transition, that's when the suicide rate increases.

A long-term Swedish study that followed up people who'd had transgender surgery for 30 years showed that their suicide rate was 19 times higher than in the general population matched for age and sex. So transgender cross-sex hormones and sex reassignment surgery does not cure suicidality. It actually exacerbates it.

And the same goes for the other common comorbidities that you see with young people premorbid and that is vastly increased rates of depression, suicide, self harm, acting out, unemployment, homelessness.

And that was my summary way of saying

becoming transgender is not beautiful. In other words, it's not la dolce vita, the beautiful life that people envisage/fantasize about because their previous life was so difficult and in some cases traumatic. So it was part of a whole kind of complex constellation of factors that I had been talking about previously.

MR. FISHER: I don't have any further questions.

MR. ROSE: Just another hour, hour and a half maybe, Doctor. Doctor, it's 11 o'clock at night here. My boss is in my office and I have been told that if I ask you a single question, I will be fired on the spot, so I have no further questions.

MR. FISHER: We'll take signature.

AND FURTHER THE DEPONENT SAITH NOT.

_____
PROFESSOR DIANNA T. KENNY

STATE OF INDIANA)
) SS:
COUNTY OF HAMILTON)

I, Brandy L. Bradley, RPR, a Notary Public in and for the County of Hamilton, State of Indiana at large, do hereby certify that PROFESSOR DIANNA T. KENNY, the deponent herein, was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the above-captioned cause;

That the foregoing deposition was taken on behalf of the Plaintiffs at the remote location of the witness, Sydney, New South Whales, Australia, on the 30th day of May, 2023, pursuant to the Applicable Rules;

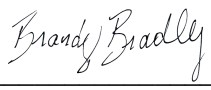
That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction, and that the typewritten transcript is a true record of the testimony given by said deponent, and thereafter presented to said deponent for his/her signature;

That the parties were represented by their aforementioned counsel.

I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of either party, or otherwise interested in the event of this action, and am not in

the employ of the attorneys for either party.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 2023.



_____
Brandy L. Bradley, RPR

Commission No. NP0682101
My Commission Expires:
April 13, 2024

(Originating Party)
Gavin M. Rose
ACLU of Indiana
1031 W. Washington Street
Indianapolis, IN 46202

NOTICE OF DEPOSITION FILING

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION
NO. 1:23-cv-00595-JPH-KMB

K.C., et al.,)
Plaintiff(s),)
-vs-)
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,)
Defendant(s).)

In compliance with the Indiana Rules of Procedure, Federal Rules of Civil Procedure and/or the Rules of the Industrial Board, you are notified that the signed original deposition of PROFESSOR DIANNA T. KENNY, taken on the 30th day of May, 2023, has been sealed and submitted to the originating party, along with the attached Errata Sheet(s), if applicable.

_____
(Date received by Circle City Reporting)

CIRCLE CITY REPORTING
135 N. Pennsylvania Street
Suite 1720
Indianapolis, IN 46204
(317) 635-7857

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Change or Suppression (Conversion) Practices Prohibition Act 2021

No. of 2021

TABLE OF PROVISIONS

Clause *Page*

Change or Suppression (Conversion) Practices Prohibition Act 2021†

No. of 2021

[Assented to]

The Parliament of Victoria enacts:

Part 1—Preliminary

Division 1—General

1 Purposes

The main purposes of this Act are—

(a) to denounce and prohibit change or suppression practices; and

(b) to establish a civil response scheme within the Victorian Equal Opportunity and Human Rights Commission that will—

(i) promote understanding of the prohibition on change or suppression practices under this Act and matters relating generally to change or suppression practices; and

(ii) consider and resolve reports of change or suppression practices; and

(iii) investigate serious or systemic change or suppression practices; and

(c) to prohibit engaging in change or suppression practices, including through creating offences in relation to engaging in change or suppression practices and certain related activities; and

(d) to amend the definitions of ***sexual orientation*** and ***gender identity*** in the **Equal Opportunity Act 2010**; and

(e) to include sex characteristics as a protected attribute under the **Equal Opportunity Act 2010**; and

(f) to make consequential amendments to certain Acts.

2 Commencement

(1) Subject to subsection (2), this Act comes into operation on a day or days to be proclaimed.

(2) If a provision of this Act does not come into operation within the period of 12 months beginning on the day on which this Act receives the Royal Assent, it comes into operation on the day after the end of that period.

3 Objects of this Act

(1) The objects of this Act are—

(a) to eliminate so far as possible the occurrence of change or suppression practices in Victoria; and

(b) to further promote and protect the rights set out in the Charter of Human Rights and Responsibilities; and

(c) to ensure that all people, regardless of sexual orientation or gender identity, feel welcome and valued in Victoria and are able to live authentically and with pride.

(2) In enacting this Act, it is the intention of the Parliament—

(a) to denounce and give statutory recognition to the serious harm caused by change or suppression practices; and

(b) to affirm that a person's sexual orientation or gender identity is not broken and in need of fixing; and

(c) to affirm that no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming; and

(d) to affirm that change or suppression practices are deceptive and harmful both to the person subject to the change or suppression practices and to the community as a whole.

4 Definitions

In this Act—

associate, in relation to a body corporate, means the following—

(a) an employee or agent of the body corporate to the extent that the employee or agent is acting within the actual or apparent scope of their employment or within their actual or apparent authority;

(b) an officer of the body corporate;

Australian Health Practitioner Regulation Agency means the Australian Health Practitioner Regulation Agency established by section 23 of the Health Practitioner Regulation National Law;

board of directors means the body (by whatever name called) exercising the executive authority of a body corporate;

change or suppression practice has the meaning given by section 5;

Chief Commissioner of Police means the ***Chief Commissioner*** within the meaning of the **Victoria Police Act 2013**;

Commission has the same meaning as it has in the **Equal Opportunity Act 2010**;

Commissioner has the same meaning as it has in the **Equal Opportunity Act 2010**;

compliance notice means a compliance notice issued under section 45(1);

corporate culture of a body corporate means an attitude, policy, rule, course of conduct or practice existing within the body corporate

or within a part of the body corporate, as the case requires;

Director of Public Prosecutions means the Director of Public Prosecutions appointed under section 87AB of the **Constitution Act 1975**;

enforceable undertaking means an undertaking accepted under section 43;

gender identity has the same meaning as it has in the **Equal Opportunity Act 2010**;

Health Complaints Commissioner means the ***Commissioner*** within the meaning of the **Health Complaints Act 2016**;

health service has the same meaning as it has in the Health Practitioner Regulation National Law;

health service provider has the same meaning as it has in the Health Practitioner Regulation National Law;

IBAC means the Independent Broad-based Anti-corruption Commission established by the **Independent Broad-based Anti-corruption Commission Act 2011**;

injury has the same meaning as it has in section 15 of the **Crimes Act 1958**;

investigation means an investigation under section 34;

officer, in relation to a body corporate, means an officer (as defined by section 9 of the Corporations Act) of the body corporate to the extent that the officer is acting within the actual or apparent scope of their employment or within their actual or apparent authority;

Ombudsman means the person appointed as the Ombudsman under section 3 of the **Ombudsman Act 1973**;

organisation means an unincorporated body or association, whether the body or association—

(a) is based in or outside Australia; or

(b) is part of a larger organisation;

person affected by a change or suppression practice means a person towards whom a change or suppression practice is being, or has been, directed;

police officer has the same meaning as it has in the **Victoria Police Act 2013**;

produce includes permit access to;

protected information has the meaning given by section 50;

serious injury has the same meaning as it has in section 15 of the **Crimes Act 1958**;

sexual orientation has the same meaning as it has in the **Equal Opportunity Act 2010**;

Tribunal means the Victorian Civil and Administrative Tribunal established by the **Victorian Civil and Administrative Tribunal Act 1998**;

Victoria Police has the same meaning as in the **Victoria Police Act 2013**;

Victorian Inspectorate means the Victorian Inspectorate established by the **Victorian Inspectorate Act 2011**.

5 Meaning of *change or suppression practice*

(1) In this Act, a ***change or suppression practice*** means a practice or conduct directed towards a person, whether with or without the person's consent—

(a) on the basis of the person's sexual orientation or gender identity; and

(b) for the purpose of—

(i) changing or suppressing the sexual orientation or gender identity of the person; or

(ii) inducing the person to change or suppress their sexual orientation or gender identity.

(2) For the purposes of subsection (1), a practice or conduct is not a change or suppression practice if it—

(a) is supportive of or affirms a person's gender identity or sexual orientation including, but not limited to, a practice or conduct for the purposes of—

(i) assisting a person who is undergoing a gender transition; or

(ii) assisting a person who is considering undergoing a gender transition; or

(iii) assisting a person to express their gender identity; or

(iv) providing acceptance, support or understanding of a person; or

(v) facilitating a person's coping skills, social support or identity exploration and development; or

(b) is a practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—

(i) to provide a health service; or

(ii) to comply with the legal or professional obligations of the health service provider.

(3) For the purposes of subsection (1), a practice includes, but is not limited to the following—

(a) providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy;

(b) carrying out a religious practice, including but not limited to, a prayer based practice, a deliverance practice or an exorcism;

(c) giving a person a referral for the purposes of a change or suppression practice being directed towards the person.

(4) For the purposes of subsection (1), a practice or conduct may be directed towards a person remotely (including online) or in person.

6 Act binds the Crown

This Act binds the Crown in right of Victoria and, so far as the legislative power of the Parliament permits, the Crown in all its other capacities.

7 Contravention does not create civil or criminal liability

A contravention of this Act does not create any civil or criminal liability except to the extent expressly provided by this Act.

8 Extra-territorial application

(1) This section applies if—

(a) a person engages in conduct outside, or partly outside, Victoria; and

(b) there is a real and substantial link between the conduct and Victoria.

(2) This Act has effect in relation to the conduct as if it had been engaged in wholly within Victoria.

(3) For the purposes of subsection (1), there is a real and substantial link with Victoria if—

(a) a significant part of the conduct occurs in Victoria; or

(b) the conduct occurred wholly outside Victoria, but the effects of the conduct occurred wholly or partly in Victoria.

Division 2—Change or suppression practices are prohibited

9 General prohibition on change or suppression practices

A person or organisation contravenes this Act if the person or organisation engages in a change or suppression practice.

Note

A contravention of this Act by a person or organisation may result in a report being made under Part 3, which sets out the civil response scheme.

Part 2—Offences relating to change or suppression practices

Division 1—Offences

10 Offence of engaging in one or more change or suppression practices that cause serious injury

(1) A person (***A***) commits an offence if—

(a) A intentionally engages in a change or suppression practice directed towards another person (***B***); and

(b) the change or suppression practice causes serious injury to B; and

(c) A is negligent as to whether engaging in the change or suppression practice will cause serious injury to B.

Penalty: In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A intentionally engages in change or suppression practices directed towards another person (***B***); and

(b) any or all of the change or suppression practices, considered as a group, cause serious injury to B; and

(c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause serious injury to B.

Penalty: In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

11 Offence of engaging in one or more change or suppression practices that cause injury

(1) A person (***A***) commits an offence if—

(a) A intentionally engages in a change or suppression practice directed towards another person (***B***); and

(b) the change or suppression practice causes injury to B; and

(c) A is negligent as to whether engaging in the change or suppression practice will cause injury to B.

Penalty: In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A intentionally engages in change or suppression practices directed towards another person (***B***); and

(b) any or all of the change or suppression practices, considered as a group, cause injury to B; and

(c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause injury to B.

Penalty: In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum.

12 Offence of taking a person from Victoria for a change or suppression practice

(1) A person (***A***) commits an offence if—

(a) A takes another person (***B***) from Victoria, or arranges for B to be taken from Victoria; and

(b) A intends that a change or suppression practice directed towards B will be engaged in outside Victoria (whether by A or another person); and

(c) a change or suppression practice directed towards B is engaged in outside Victoria; and

(d) the change or suppression practice causes injury to B; and

(e) A is negligent as to whether the change or suppression practice will cause injury to B.

Penalty: In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A takes another person (***B***) from Victoria, or arranges for B to be taken from Victoria; and

(b) A intends that change or suppression practices directed towards B will be engaged in outside Victoria (whether by A or another person); and

(c) change or suppression practices directed towards B are engaged in outside Victoria; and

(d) any or all of the change or suppression practices, considered as a group, cause injury to B; and

(e) A is negligent as to whether any or all of the change or suppression practices, considered as a group, will cause injury to B.

Penalty: In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

13 Offence of advertising a change or suppression practice

(1) A person commits an offence if—

(a) the person publishes or displays, or authorises the publication or display of, an advertisement or other notice; and

(b) the advertisement or other notice indicates, or could reasonably be understood as indicating, that the person or any other person intends to engage in one or more change or suppression practices, other than

for the purposes of warning of the harm caused by such practices.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

(2) It is a defence to a charge under subsection (1) if the accused proves that the accused took reasonable precautions and exercised due diligence to prevent the publication or display.

14 Production of documents relating to advertising offence

(1) For the purpose of proceedings under section 13, the Commission may, by written notice, require any person to produce any documents specified in the notice to the Commission.

(2) A person must not refuse, without reasonable excuse, to produce a document referred to in subsection (1) to the Commission.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

Division 2—General matters relating to offences against this Part

15 Corporate criminal responsibility for offence against this Part

(1) For the purposes of a proceeding against a body corporate for an offence against this Part, the following must also be attributed to the body corporate—

(a) relevant conduct engaged in by an associate of the body corporate;

(b) knowledge of an associate of the body corporate;

(c) intention—

(i) of the body corporate's board of directors; or

(ii) of an officer of the body corporate; or

(iii) of any other associate of the body corporate if a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the formation of that intention.

(2) If an officer of a body corporate engages in conduct that constitutes an offence against this Part, the body corporate must be taken to have also engaged in conduct constituting the offence, and may be proceeded against and found guilty of the offence whether or not the officer has been proceeded against or found guilty of that offence.

(3) In a proceeding against a body corporate for an offence against this Part brought in reliance on subsection (2), it is a defence to the charge for the body corporate to prove that it exercised due diligence to prevent the conduct engaged in by the officer.

16 Who may bring proceedings for an offence under section 13

Proceedings for an offence under section 13 may be brought by—

(a) the Commission; or

(b) a police officer; or

(c) a person who is authorised to do so, either generally or in a particular case, by the Commission.

Part 3—Civil response scheme

Division 1—Functions and powers of Commission

17 Functions and powers of Commission

(1) The Commission has the following functions—

(a) to develop and provide education in relation to change or suppression practices;

(b) to receive reports about change or suppression practices from any person;

(c) to request further information regarding reports of change or suppression practices from persons who make a report and persons or organisations alleged to be engaging in change or suppression practices;

(d) to determine appropriate responses to reports on the basis of information provided and the wishes of persons affected where those persons are involved in making reports;

(e) to offer education to persons and organisations engaged in change or suppression practices;

(f) to establish processes for facilitating an outcome in relation to matters in certain reports that meet the needs of persons affected by change or suppression practices;

(g) to focus on ensuring that persons affected by change or suppression practices receive support by directing them to appropriate support services;

(h) to support persons who are or may be victims of criminal offences under this Act to voluntarily report these to police.

(2) The Commission has all the powers necessary to enable it to perform its functions.

18 Functions of Commission—educative function

(1) The Commission must—

(a) establish and undertake information and education programs in relation to change or suppression practices; and

(b) promote and advance the objects of this Act and be an advocate for this Act.

(2) The Commission must undertake programs to disseminate information and educate the public with respect to—

(a) the objects of this Act; and

(b) any other matters relevant to the provisions of this Act.

19 Functions of Commission—research function

(1) The Commission may undertake research into any matter arising from, or incidental to, the operation of this Act that it considers would advance the objects of this Act.

(2) The Commission may collect and analyse information and data relevant to the operation and objects of this Act.

20 Commission may report on educative or research functions

The Commission may, at any time, submit a report to the Attorney-General on any matter arising from the performance of the Commission's functions under section 18 or 19.

21 Functions of Commission—receiving reports and facilitating outcomes

The Commission must—

(a) receive reports under section 24 from persons affected by change or suppression practices (or persons acting on their behalf), or other persons; and

(b) establish policies and issue procedures and directions on the manner in which such reports should be dealt with; and

(c) in the case of a reports made by persons affected by change or suppression practices (or persons acting on their behalf), establish policies and procedures for the facilitation of an outcome in relation to the matters in the report.

22 Staff of Commission

Any staff that are necessary for the purposes of administering this Act are to be employed under Part 3 of the **Public Administration Act 2004**.

23 Delegation

The Commission, by instrument, may delegate to the Commissioner or a member of staff of the Commission referred to in section 22 any of the Commission's functions, duties or powers under this Act other than this power of delegation.

Note

Under an Order made by the Governor in Council under section 16 of the **Public Administration Act 2004**, the Commissioner has all the functions of a public service body Head in relation to employees of the Commission.

Division 2—Reporting change or suppression practices to Commission

24 Reporting change or suppression practices

(1) A person affected by a change or suppression practice, or any other person, may make a report to the Commission in relation to an alleged change or suppression practice.

(2) A report must be in the prescribed form (if any).

25 Principles for responding to reports

The principles for the Commission responding to reports are—

(a) a response should be provided to the person who made the report; and

(b) a response should be informed by the needs and wishes of persons affected by change or suppression practices; and

(c) a response should be appropriate to the report; and

(d) a response should be fair to all persons; and

(e) a response should be consistent with the objects of this Act.

26 Commission may request more information

The Commission may request a person who makes a report or a person or organisation who is alleged to be engaging in a change or suppression practice to provide any further information that the Commission considers necessary to assist in determining its response to a report.

27 Consideration of reports

(1) This section applies if, in considering a report, the Commission is satisfied that a person or organisation is engaging in, or has engaged in, a change or suppression practice.

(2) In responding to the report, the Commission must as far as practicable have regard to the following matters, to the extent that information about the matters is reasonably available to the Commission—

(a) the wishes of the person or persons affected by the change or suppression practice;

(b) whether the change or suppression practice was a one-off event or a pattern of behaviour;

(c) the number of people affected by the change or suppression practice;

(d) the nature and extent of the harm caused by the change or suppression practice;

(e) any steps taken by a person or organisation to stop engaging in the change or suppression practice or to address the harms caused by the change or suppression practice.

28 Responding to reports

(1) The Commission, after considering a report, may do one or more of the following—

(a) offer targeted education to persons or organisations reported to have engaged in change or suppression practices;

(b) in the case of reports made by persons affected by a change or suppression practice, offer facilitation of an outcome in relation to the matters in the report;

(c) refer the report to another person or body under section 29;

(d) decline to respond to the report in accordance with section 30.

(2) Participation in facilitation of an outcome in relation to matters in a report is voluntary.

29 Referral of reports

(1) Subject to subsection (3), if the Commission considers that a report relates to conduct that would be more adequately dealt with by another person or body, the Commission may refer the report to the other person or body.

(2) The persons or bodies to which the Commission may refer a report include, but are not limited to, the following—

(a) the Health Complaints Commissioner;

(b) the Australian Health Practitioner Regulation Agency;

(c) the Ombudsman;

(d) Victoria Police.

(3) The Commission must not refer a report under subsection (1) without the consent of the person affected by the change or suppression practice to which the report relates, unless required to do so by a law dealing with mandatory reporting.

30 Discretion to decline to respond to report

The Commission may decline to respond to a report if—

(a) the report refers to persons or organisations who can no longer be located; or

(b) the report relates to conduct in respect of which sufficient information is no longer available; or

(c) the report relates to conduct that has been adequately dealt with in another forum or would be more appropriately dealt with in another forum; or

(d) having regard to all the circumstances, the Commission considers it is not appropriate to respond to the report.

31 Withdrawal from facilitation of an outcome

If the Commission is facilitating an outcome in relation to a matter in a report, any person involved in the facilitation may withdraw at any time by informing the Commission that the person no longer wishes to participate.

32 Agreements resulting from facilitation

(1) This section applies if, after the Commission facilitates an outcome in relation to a matter in a report, the persons engaged in the facilitation (the ***parties***) reach agreement with respect to any of the matters.

(2) Any party may request that a written record of agreement be prepared by the parties or the Commission.

(3) A request must be made within 30 days after the agreement is reached.

(4) If a record of agreement is prepared by the Commission following a request under subsection (2)—

(a) the record of agreement must be signed by or on behalf of each party; and

(b) the Commission must certify the record of agreement.

(5) If a record of agreement is prepared by the parties following a request under subsection (2)—

(a) the record of agreement must be signed by or on behalf of each party; and

(b) on the request of a party, the Commission may certify the record of agreement.

(6) If the Commission certifies a record of agreement under subsection (4)(b) or (5)(b), the Commission must give each party a copy of the signed and certified record of agreement.

(7) The refusal of the Commission to certify a record of agreement does not affect the validity of the agreement.

33 Registration of agreements

(1) Any party to an agreement reached under section 32 may, after notifying each other party in writing, lodge a copy of the signed and certified record of agreement with the Tribunal for registration.

(2) Subject to subsection (3), the Tribunal must register the record of agreement and give a certified copy of the registered record of agreement to each party.

(3) If the Tribunal, constituted by a presidential member, considers that it may not be practicable to enforce, or to supervise compliance with, a record of agreement or part of a record of agreement, the Tribunal—

(a) in the case of a record of agreement, may refuse to register the record of agreement; or

(b) in the case of a part of a record of agreement, may refuse to register the part of the record of agreement that it considers may not be practicable to enforce, or to supervise compliance with.

(4) On registration, a registered record of agreement or a registered part of a record of agreement—

(a) is taken to be an order of the Tribunal in accordance with its terms; and

(b) may be enforced accordingly.

(5) The refusal of the Tribunal to register a record of agreement or any part of a record of agreement does not affect the validity of the agreement.

Division 3—Investigations

34 When investigation may be conducted

The Commission may conduct an investigation under this section into any matter relating to this Act—

(a) that raises an issue that is serious in nature or indicates change or suppression practices that are systemic or persisting; and

(b) that indicates a possible contravention of this Act; and

(c) that relates to a class or group of persons; and

(d) that would advance the objects of this Act.

35 Commission to conduct investigation as it considers fit

(1) Subject to this Division, the Commission may conduct an investigation in the manner it considers fit.

(2) In conducting an investigation, the Commission is bound by the principles of natural justice, unless otherwise expressly provided in this Division.

36 Power to compel provision of information and production of documents

(1) If the Commission reasonably believes that—

(a) a person is in possession of information or a document that is relevant to an investigation; and

(b) the information or document is necessary for the conduct of the investigation—

the Commission may by written notice require the person to provide the information or document or both.

(2) A notice referred to in subsection (1) must specify that the person must do either or both of the following within a reasonable period specified in the notice, or on a reasonable date and at a reasonable time specified in the notice—

(a) give the Commission a document containing information required by the notice;

(b) produce to the Commission the documents specified in the notice.

(3) A document referred to in subsection (2)(a) must be signed by the person or, in the case of a notice served on a body corporate, an officer of the body corporate.

(4) If a document is produced to the Commission in accordance with a notice under this section, the Commission may—

(a) take possession of the document; and

(b) make copies of the document or take extracts from the document; and

(c) retain possession of the document for as long as is necessary for the purposes of the investigation to which the document relates.

(5) The Commission must allow a document retained under this section to be inspected, at all reasonable times, by any person who would be entitled to inspect the document if it were not in the possession of the Commission.

37 Power to compel attendance

(1) The Commission by written notice may require a person to attend before the Commission, at a reasonable time and place, to answer questions if the Commission reasonably believes that—

(a) the person has information that is relevant to an investigation; and

(b) the information is necessary for the conduct of the investigation.

(2) A person who is required under this section to attend before the Commission—

(a) is entitled to be paid a reasonable sum for the person's attendance; and

(b) is entitled to have a legal or personal representative present.

38 Compliance with notice requiring attendance or production of documents

A person must not, without reasonable excuse, fail to comply with a notice of the Commission under section 36 or 37.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

39 Protection against self-incrimination

It is a reasonable excuse for a natural person to refuse to give information, answer a question or produce a document under this Act if the giving of the information, the answering of the question or the production of the document would tend to incriminate the person.

40 Disclosure of identity of persons who give information or documents

(1) This section applies to a person who has given or who will give evidence, information or documents to the Commission as part of an investigation, whether or not the person is compelled to do so under section 36 or 37.

(2) The Commission may give directions prohibiting the disclosure of the identity of the person, or prohibiting the disclosure of information that would be reasonably likely to identify the person, if the Commission considers that preservation of the person's anonymity is necessary—

(a) to protect the person's security of employment, privacy or any right protected by the **Charter of Human Rights and Responsibilities Act 2006**; or

(b) to protect the person from victimisation.

41 Publication of evidence, information or documents

(1) The Commission may give directions prohibiting or limiting the publication of—

(a) any evidence given before the Commission or any information given to the Commission as part of an investigation; or

(b) the contents of any document produced to the Commission as part of an investigation.

(2) Subsection (1) applies whether or not a person was compelled to give the evidence or produce the information or document under section 36 or 37.

(3) In deciding whether or not to give a direction under subsection (1), the Commission must have regard to the need to prevent such of the following as are relevant to the circumstances—

(a) prejudice to the relations between the Government and the Commonwealth Government or between the Government and the Government of another State or a Territory;

(b) the disclosure of deliberations or decisions of the Cabinet, or of a Committee of the Cabinet;

(c) prejudice to the proper functioning of the Government;

(d) the disclosure, or the ascertaining by a person, of the existence or identity of a confidential source of information in relation to the enforcement of the criminal law;

(e) the endangering of the life or physical or psychological safety of any person;

(f) prejudice to the proper enforcement of the law or the protection of public safety;

(g) the disclosure of information the disclosure of which is prohibited, absolutely or subject to qualifications, by or under another Act;

(h) the unreasonable disclosure of the personal affairs of any person or organisation;

(i) the unreasonable disclosure of confidential commercial information.

42 Outcome of an investigation

(1) After conducting an investigation, the Commission may take any action it considers fit.

(2) Without limiting subsection (1), the Commission may do any of the following—

(a) take no further action;

(b) enter into an agreement with a person about action required to comply with this Act;

(c) accept an enforceable undertaking;

(d) issue a compliance notice to a person.

Division 4—Remedies

43 Enforceable undertakings

If, following an investigation, the Commission believes that a change or suppression practice has occurred, is occurring or is likely to occur, the Commission may accept a written undertaking from a person under which the person undertakes to take certain actions or refrain from taking certain actions to comply with this Act.

44 Register of enforceable undertakings

The Commission may keep a register of enforceable undertakings that is available to the public.

45 Compliance notices

(1) If, following an investigation, the Commission believes that a change or suppression practice has occurred or is occurring, the Commission may issue a compliance notice to a person who is wholly or partly responsible for the change or suppression practice.

(2) A compliance notice must set out the following—

(a) the basis for the Commission's belief that a change or suppression practice has occurred or is occurring;

(b) the provisions of this Act (if any) that the Commission believes the person has contravened;

(c) the date by which the person must take or refrain from taking specified actions in relation to the change or suppression practice;

(d) the further action that the Commission may take if the person does not take or refrain from taking specified actions;

(e) that the person may apply to the Tribunal for review of the issuing of the notice or any term of the notice.

(3) A person may, within 28 days of receiving the compliance notice, apply to the Tribunal for a review of the issuing of the compliance notice or of any term of the compliance notice.

46 Failure to comply with enforceable undertaking or compliance notice

(1) This section applies if—

(a) the Commission has accepted an enforceable undertaking from a person; or

(b) the Commission has issued a compliance notice to a person.

(2) If the person fails to comply with the enforceable undertaking or the compliance notice—

(a) the Commission may apply to the Tribunal to enforce the undertaking or the notice; and

(b) the Tribunal may make an order requiring the person to comply with the undertaking or notice.

Note

Under section 133 of the **Victorian Civil and Administrative Tribunal Act 1998**, non-compliance with an order of the Tribunal is an offence.

47 Vicarious liability

(1) For the purposes of this Part, if a natural person engages in a change or suppression practice in the course of employment (including as a volunteer) or while acting as an agent—

(a) subject to subsection (2), both the natural person, and the employer or principal, as the case requires, are taken to have engaged in the change or suppression practice; and

(b) the person towards whom the change or suppression practice was directed or another person may make a report under section 24 in respect of—

(i) the natural person; or

(ii) the employer or principal; or

(iii) both the natural person and the employer or principal.

(2) The employer or principal is not taken to have engaged in the change or suppression practice if the employer or principal proves, on the balance of probabilities, that the employer or principal took reasonable precautions to prevent the natural person engaging in a change or suppression practice.

48 Who may bring proceedings for an offence under this Part

Proceedings for an offence under this Part may be brought by—

(a) the Commission; or

(b) a police officer; or

(c) a person who is authorised to do so, either generally or in a particular case, by the Commission.

49 Reports etc. that relate to organisations

If a report under this Act relates to change or suppression practices alleged to have been engaged in by an organisation—

(a) the Commission may request information under section 26 from the president, secretary or other similar officer of the organisation; and

(b) the Commission may offer targeted education to the president, secretary or other similar officer of the organisation; and

(c) the president, secretary or other similar officer of the organisation may be a party to facilitation of an outcome for the purposes of Division 2 of this Part.

Part 4—General matters

Division 1—Secrecy

50 Definition

In this Division—

protected information means information concerning the affairs of a person or organisation, being information obtained by a person to whom section 51 applies—

(a) in the course of performing functions or duties or exercising powers under this Act; or

(b) as a result of another person performing functions or duties or exercising powers under this Act.

51 Secrecy

(1) This section applies to a person who is or has been—

(a) the Commissioner; or

(b) a member of the staff of the Commission referred to in section 22;

(c) a person (other than a person referred to in paragraph (b)) acting under the authority of the Commission or the Commissioner.

(2) A person to whom this section applies must not, either directly or indirectly, make a record of, disclose or communicate protected information to any person unless —

(a) it is necessary to do so for the purposes of, or in connection with, the performance of a function or duty or the exercise of a power under this Act; or

(b) it is necessary to do so to prevent a credible and imminent threat of harm to one or more persons; or

(c) it is necessary to do so to comply with a mandatory reporting obligation; or

(d) the disclosure, communication or production is to a court in accordance with section 52; or

(e) the information is already in the public domain; or

(f) the information does not identify any person or organisation; or

(g) all persons or organisations identified by the information have consented to the disclosure of the information.

Penalty: Level 9 fine (60 penalty units maximum).

52 Disclosure to courts

(1) Subject to this section, a person to whom section 51 applies must not be required—

(a) to produce in a court any document containing protected information; or

(b) to disclose or communicate protected information to a court.

(2) Subsection (1) does not prevent a person to whom section 51 applies disclosing or communicating protected information or producing in a court any document containing protected information if the disclosure, communication or production —

(a) is necessary for the purposes of, or for a prosecution under or arising out of, this Part; or

(b) is required by an order of a court for the purposes of a criminal proceeding; or

(c) is with the consent of the person or organisation to whose affairs the information relates.

Division 2—Provisions relating to certain proceedings

53 Commission not to prejudice certain proceedings or investigations

(1) The Commission must not perform the functions or duties or exercise the powers of the Commission under this Act in a manner that would prejudice any—

(a) criminal proceedings or criminal investigations; or

(b) investigations by the IBAC or the Victorian Inspectorate.

(2) For the purposes of ensuring compliance with subsection (1), the Commission may consult any of the following—

(a) the Director of Public Prosecutions;

(b) the Chief Commissioner of Police;

(c) the IBAC;

(d) the Victorian Inspectorate.

54 Person bringing proceedings presumed to be authorised to do so

In a proceeding for an offence against this Act it must be presumed, in the absence of evidence to the contrary, that the person bringing the proceeding was authorised to bring it.

55 Commission may assist in proceedings as amicus curiae

(1) The Commission may assist a court or tribunal as amicus curiae in the following proceedings, with the leave of the court or tribunal—

(a) proceedings in which the Commission considers that the orders sought, or likely to be sought, may significantly affect the rights relating to change or suppression practices in relation to persons who are not parties to the proceedings;

(b) proceedings that, in the opinion of the Commission, have significant implications for the administration of this Act;

(c) proceedings where the Commission is satisfied that it would be in the public interest for the Commission to assist the court or tribunal as amicus curiae.

Division 3—Annual report and review of Act

56 Annual report

In its report of operations for a financial year under Part 7 of the **Financial Management Act 1994**, the Commission must include a description of the performance of its functions in relation to change or suppression practices during the financial year.

57 Review of this Act

(1) The Attorney-General must ensure that an independent review of the operation and effectiveness of this Act commences 2 years after the commencement of this Act and is completed within 6 months.

(2) The Attorney-General must ensure that the review is conducted by a person who, in the opinion of the Attorney-General, possesses appropriate qualifications and expertise related to change or suppression practices.

(3) The person conducting the review must consider the following—

(a) whether the criminal offences contained in this Act are effective;

(b) whether the civil response scheme is effective, including whether broader investigation and enforcement powers are required;

(c) whether a redress scheme should be developed.

(4) A person who undertakes the review must give the Attorney-General a written report of the review as soon as practicable after completing the review.

(5) The Attorney-General must cause a copy of the review to be laid before each House of the Parliament within 15 sitting days of that House after receiving the written report.

Division 4—Regulations

58 Regulations

(1) The Governor in Council may make regulations for or with respect to the following matters—

(a) forms to be used for the purposes of this Act;

(b) any other matter or thing required or permitted by this Act to be prescribed or necessary to be prescribed to give effect to this Act.

(2) Regulations made under this Act—

(a) may be of limited or general application; and

(b) may differ according to differences in time, place or circumstance; and

(c) may confer powers or impose duties in connection with the regulations on any specified person or specified class of persons; and

(d) may apply, adopt or incorporate, with or without modification, any matter contained in any document, code, standard, rule, specification or method formulated, issued, prescribed or published by any person—

(i) wholly or partially or as amended by the regulations; or

(ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or

(iii) as formulated, issued, prescribed or published from time to time.

Part 5—Amendment of definitions in the Equal Opportunity Act 2010

Division 1—Amendment of definitions

59 Definitions

(1) In section 4(1) of the **Equal Opportunity Act 2010**, for the definition of ***gender identity*** **substitute**—

"***gender identity*** means a person's gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references;".

(2) In section 4(1) of the **Equal Opportunity Act 2010 insert** the following definition—

"***sex characteristics*** means a person's physical features relating to sex, including—

(a) genitalia and other sexual and reproductive parts of the person's anatomy; and

(b) the person's chromosomes, genes, hormones, and secondary physical features that emerge as a result of puberty;".

(3) In section 4(1) of the **Equal Opportunity Act 2010**, for the definition of ***sexual orientation*** **substitute**—

"***sexual orientation*** means a person's emotional, affectional and sexual attraction to, or intimate or sexual relations with, persons of

a different gender or the same gender or more than one gender;".

60 Attributes

After section 6(o) of the **Equal Opportunity Act 2010 insert**—

"(oa) sex characteristics;".

Division 2—Transitional provisions

61 New Division inserted

After Division 2 of Part 14 of the **Equal Opportunity Act 2010, insert**—

"Division 3—Transitional provisions relating to the Change or Suppression (Conversion) Practices Prohibition Act 2021

197 Definitions

In this Division—

commencement day means the day on which Part 5 of the **Change or Suppression (Conversion) Practices Prohibition Act 2021** comes into operation;

old Act means the **Equal Opportunity Act 2010**, as in force immediately before the commencement day.

198 Conduct, disputes and investigations before commencement day

(1) This section applies to—

(a) conduct engaged in before the commencement day; and

(b) a dispute brought to the Commission before the commencement day that had not ended before the commencement day; and

(c) an investigation of the Commission that had not been finally determined before the commencement day.

(2) The old Act continues to apply in relation to the conduct, dispute or investigation, as the case requires, as if the amendments made by Part 5 of the **Change or Suppression (Conversion) Practices Prohibition Act 2021** had not been made.".

Part 6—Consequential amendment of Acts

Division 1—Amendment of the Equal Opportunity Act 2010

62 Obstructing Commission

In section 185(1) of the **Equal Opportunity Act 2010**, after "Act" **insert** "or the **Change or Suppression (Conversion) Practices Prohibition Act 2021**".

63 False or misleading information

In section 186 of the **Equal Opportunity Act 2010**, after "Act" **insert** "or the **Change or Suppression (Conversion) Practices Prohibition Act 2021**".

Division 2—Amendment of the Family Violence Protection Act 2008

64 Meaning of *emotional or psychological abuse*

In section 7 of the **Family Violence Protection Act 2008**, after the second dot point under the heading "**Examples—**" **insert**—

"• an adult child repeatedly denigrating an elderly parent's sexual orientation, including by telling them it is wrong to be same-sex attracted and that they must change or the adult child will no longer support them;".

Division 3—Amendment of the Personal Safety Intervention Orders Act 2010

65 Meaning of *harassment*

In section 7 of the **Personal Safety Intervention Orders Act 2010**, at the end of the paragraphs under the heading "**Examples**" **insert**—

"A repeatedly leaves pamphlets in B's mailbox that state that it is wrong to gender transition and that everyone's gender expression should match the sex they were assigned at birth.".

Part 7—Repeal of amending Parts

66 Repeal of amending Parts

Parts 5 and 6 and this Part are **repealed** on the first anniversary of the first day on which all of the provisions in those Parts are in operation.

Note

The repeal of these Parts does not affect the continuing operation of the amendments made by these Parts (see section 15(1) of the **Interpretation of Legislation Act 1984**).

Endnotes

1 General information

See www.legislation.vic.gov.au for Victorian Bills, Acts and current authorised versions of legislation and up-to-date legislative information.

† *Minister's second reading speech—*

Legislative Assembly:

Legislative Council:

The long title for the Bill for this Act was "A Bill for an Act to prohibit change or suppression practices, to amend certain definitions in the **Equal Opportunity Act 2010** and for other purposes."

By Authority. Government Printer for the State of Victoria.

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CORRECTION

Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria

Lisa Littman

Notice of republication

After publication of this article [1], questions were raised that prompted the journal to conduct a post-publication reassessment of the article, involving senior members of the journal's editorial team, two Academic Editors, a statistics reviewer, and an external expert reviewer. The post-publication review identified issues that needed to be addressed to ensure the article meets *PLOS ONE*'s publication criteria. Given the nature of the issues in this case, the *PLOS ONE* Editors decided to republish the article, replacing the original version of record with a revised version in which the author has updated the Title, Abstract, Introduction, Discussion, and Conclusion sections, to address the concerns raised in the editorial reassessment. The Materials and methods section was updated to include new information and more detailed descriptions about recruitment sites and to remove two figures due to copyright restrictions. Other than the addition of a few missing values in Table 13, the Results section is unchanged in the updated version of the article. The Competing Interests statement and the Data Availability statement have also been updated in the revised version. The original version of the published article is appended to this Correction as S1 File.

This Correction Notice serves to provide additional clarifications and context for the article in response to questions raised during the post-publication review of this work.

Emphasis that this is a study of parental observations which serves to develop hypotheses

This study of parent observations and interpretations serves to develop the hypotheses that rapid-onset gender dysphoria is a phenomenon and that social influences, parent-child conflict, and maladaptive coping mechanisms may be contributing factors for some individuals. Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon. Additional research that includes AYAs, along with consensus among experts in the field, will be needed to determine if what is described here as rapid-onset gender dysphoria (ROGD) will become a formal diagnosis. Furthermore, the use of the term, rapid-onset gender dysphoria should be used cautiously by clinicians and parents to describe youth who appear to fall into this category. The term should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals. This article has been revised to better reflect that these parent reports provide information that can be used to develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Because this is a study of parent reports, there is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives. Examples

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where parent answers reflect their perspective of the AYA include answers concerning the child's mental well-being, the parent-child relationship, and whether the child has high expectations about transitioning. However, it is also important to note that there are other survey items where the parent would have direct access to information about their child and that those answers reflect items that can be directly observed. Examples of this type include age, natal sex, diagnoses given by medical providers in the presence of the parent, directly observed behaviors of the child and the child's friend group, school performance, whether the child has dropped out or required a leave of absence from school, has been unable to hold a job, whether the child went to a clinic, or received treatment. Readers are reminded to keep in mind that this is a study of parent report and consideration of what information parents may or may not have access to is an important element of the findings.

Questions on whether the article describes adolescent-onset gender dysphoria or if it describes something new

There is some controversy over whether what is described as rapid onset of gender dysphoria, particularly in natal females, falls under the existing definition of late-onset or adolescent-onset gender dysphoria or whether it represents a new kind of development or presentation. This controversy might be a false dichotomy because both might be true. Although recent observations of adolescents and young adults who are predominantly natal female having a sudden onset of gender dysphoria symptoms beginning during or after puberty might technically fall under the existing definitions and criteria for adolescent and adult gender dysphoria [2], the substantial change in the demographics of patients presenting for care, the inversion of the sex ratio with disproportionate increase in adolescent natal females [3–5], and the new phenomenon of natal females exhibiting adolescent-onset and late-onset gender dysphoria [6–8] signal that something new may be happening as well. These changes may indicate that there are new etiologies leading to gender dysphoria and it is unclear, particularly without research about these new populations, whether gender dysphoria in this context has the same outcomes, desistence and persistence rates, and response to treatment as the gender dysphorias that have been previously studied.

Expanded discussion of qualitative analyses

Because this is a descriptive, exploratory study into a new topic with very little existing data, the addition of the qualitative analysis of two questions in addition to the quantitative analysis allowed for a greater depth of information to be used in the development of hypotheses. A grounded theory approach was selected as the strategy of choice for handling the qualitative data. There were two reviewers consisting of a professor with a PhD degree and expertise in qualitative methods (MM) [9] and the author (LL) who holds an MD and MPH degree, and has published both qualitative and quantitative research papers [10–11]. Each reviewer independently read and re-read the open-text responses in an iterative process to identify major themes arising from the data. Once each reviewer independently listed major themes and coded the open-text responses according to those themes, both reviewers compared notes to collaboratively revise and refine the major themes identified. Once an agreed-upon final list of themes was developed, attention was turned back to the data to code the open-text response with the final list of themes. After this task was completed, LL selected salient quotes to reflect each major theme, shared the quotes with MM, and both discussed collaboratively until agreement for the final list of major themes and associated quotes was reached. The incorporation of both the qualitative and quantitative analysis allowed for a more vivid picture of parent

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perspectives about the friendship group dynamics and behaviors and clinician interactions than could have been obtained from just one type of analysis.

Clarification of study design, methods, and related limitations

As mentioned in the article, the study design of this research falls under descriptive research: as such, it did not assign an exposure, there were no comparison groups, and the study's output was hypothesis-generating rather than hypothesis-testing [12]. Descriptive studies often represent a first inquiry into an area of research and the findings of descriptive studies are used to generate new hypotheses that can be tested in subsequent research [12–13]. Because of the known limitations of descriptive studies, claims about causal associations cannot be made [12], and there were none made in the article. The conclusions of the current study are that the findings raise certain hypotheses and that more research is needed. Simple descriptive metrics to describe the quantitative characteristics of a sample in a descriptive study are the appropriate measures to use in this study. Additionally, because the data were collected at one point in time, no claims of cause and effect can be made.

All research methods have advantages and limitations. Obtaining information from parents (and guardians) about the health and well-being of children and adolescents is an established method of research [14]. Parental report, used elsewhere and in this study, offers the advantages of collecting data from adults who are knowledgeable about the child, who are able and willing to complete research activities such as detailed surveys, and who can provide details that are not available by other methods. Limitations of parental report include information that parents may not be aware of and parental biases. Anonymous surveys, used elsewhere and in this study, are advantageous for topics that might be stigmatized and can allow participants to be more honest in their responses but introduce the limitation that the researcher cannot verify the identity and experiences of the participants. The use of targeted recruitment and convenience samples, used elsewhere and in this study, offers the benefit of connecting with hard-to-reach populations but introduces limitations associated with selection bias that can subsequently be addressed by further studies. For the current study, selection bias may have resulted in findings that are more positive or more negative than would be found in a larger and less self-selected population. Subsequent studies should address these issues.

Updated Information about recruitment

Concerns were raised that this study only posted links to the recruitment information on selected sites that are viewed as being unsupportive of transition. However, announcements about the study included requests to distribute the recruitment information and link, and because information about where the participants encountered the announcement was not collected, it is not known which populations were ultimately reached. It has come to light that a link to the recruitment information and research survey was posted on a private Facebook group perceived to have a pro-gender-affirming perspective during the first week of the recruitment period (via snowball sampling). This private Facebook group is called "Parents of Transgender Children" and has more than 8,000 members. This means that parents participating in this research may have viewed the recruitment information from one of at least four sites with varied perspectives. Specifically, three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender. And, one of the sites that posted recruitment information is perceived to be pro-gender-affirming. The rest of the Correction notice will refer to recruitment from the four sites that are known to have posted the survey in the first week of

recruitment: 4thwavenow, transgendertrend, Youth Trans Critical Professionals, and Parents of Transgender Children.

Parental approaches to gender dysphoria and views on medical interventions

To oversimplify parental approaches as simply "accepting" or "rejecting" misrepresents the range of responses and complexity of approaches that parents take when addressing the needs of their gender dysphoric children. Parental approaches are complex and cover many variables. For example, one parental approach might be to affirm the child as a person, support gender nonconformity, support gender exploration, support mental health evaluation and treatment as needed, support the exploration of potential underlying causes for the dysphoria while expressing caution about medical interventions. Another approach might be to affirm the child's newly declared gender identity, support gender nonconformity, support a liberal approach to medical intervention while expressing caution about mental health evaluation and caution about the exploration of potential underlying causes for the dysphoria. To categorize the former as "rejecting" and the latter as "accepting" would be inaccurate.

This study recruited participants based on whether participants thought their child exhibited a sudden or rapid onset of gender dysphoria beginning during or after puberty and did not recruit based on parental beliefs about what types of approaches toward gender dysphoric AYAs are best. Although one of the sites posting recruitment information might be considered to hold a pro-gender affirming perspective and three sites might be considered to hold a cautious or even negative perspective about medical or surgical interventions, the site where a participant first heard about the study may not be an accurate reflection of their beliefs and whether they endorse or disagree with the content of the websites. Data about where participants first heard about this study were not collected. Future studies should seek a wider array of websites to post recruitment information, recruit from clinicians with varied approaches to gender dysphoria, and ask specific questions about parental beliefs regarding their approach to their child's gender dysphoria, including: whether parents support or don't support gender exploration, gender nonconformity, mental health evaluation and treatment, exploration of potential underlying causes for dysphoria, non-heterosexual sexual identity, and whether they hold a liberal, cautious or negative view about the use of medical and surgical interventions for gender dysphoric youth. Exploration about what types of affirmation are endorsed by parents including affirmation of the child as a person and affirmation of the child's gender identity would also be valuable.

Expanded discussion about limitations and biases

Regarding the reporting of gender dysphoria, an absence of childhood gender dysphoria and whether the AYA was gender dysphoric at the time of survey completion were based on parent report of whether certain indicators of gender dysphoria were observed prior to puberty or at the time of the survey. These determinations were not diagnoses made by clinicians. Three of the indicators listed in the DSM-5 include information that a parent might not have access to (unless the child told them directly) [2], and therefore answers based on parent perceptions may not accurately reflect the experiences or traits of the AYAs themselves. However, the other five indicators include readily observable behaviors and preferences that would seem difficult for a parent not to notice such as: strong preference or strong resistance to wearing certain kinds of clothing; strong preference or strong rejection of specific toys, games and activities; and strong preference for playmates of the other gender [2]. It is possible that a parent could have ignored some of these indicators, though other people in the child's life may

have observed them. To improve the reliability of this measure, future studies should include evaluation from clinicians with input from parents, AYAs and from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members who knew the youth during childhood to verify the whether the readily observable behaviors and preferences were present or absent during childhood.

For a clinician to make a diagnosis of gender dysphoria in childhood, a child would need to exhibit at least six of the eight indicators. Given that 97.6% of the participants reported 2 or fewer readily observable indicators, even if hypothetically all participants incorrectly underreported all three of the subtler indicators, 97.6% would still have fewer than six indicators. So, although no clinical evaluation was performed and a clear presence or absence of a diagnosis cannot be verified, given the reports of the easily observed behaviors and preferences, it can be said that it would be very unlikely for these AYAs to have met criteria for childhood gender dysphoria if they had seen a clinician for an evaluation.

There is expected variation in how objective parents can be about their own children. Some individual biases may limit the objectivity of parents. This descriptive study was not designed to explore or measure the objectivity of participants. Participants may have first learned about this study from one of four (or more) sites described previously where recruitment information was posted. It is possible that exposure to websites that take a cautious or negative approach to transition during adolescence and young adulthood and exposure to websites that take a pro-gender-affirming approach might influence how parents report about their children's experiences. There have not been any studies to determine if parents who seek information from online sites in general, don't seek information from online sites, or seek information from specific online sites, including the four sites noted for this study, differ in their ability to provide objective assessments of their children. However, if there were an excess of participants who, compared to other parents who take surveys reporting on their children, were less able to be objective about their children, it could limit some of the findings of the study, particularly for findings that are more interpretive rather than the findings that are more concrete.

The research survey did not specifically ask whether parents supported their AYAs' exploration of gender identity, so whether and what numbers of participants supported their child's exploration of gender identity is unknown. However, if there were an excess of parents who did not support the exploration of gender identity, it could potentially result in higher reports of declining mental health. The parents' perception that their child's mental health and the parent-child relationship were worse after the child announced a transgender-identification could be due to several variables such as conflict between parent and child, maladaptive coping mechanisms, or worsening psychiatric issues unrelated to gender. The trajectories for adolescent-onset gender dysphoria are not well understood and additional research is desperately needed.

There are many ways that parents can provide support for their child which include: affirming them as a unique and valuable person and as a loved member of the family; supporting their emotional and financial needs; supporting them in pursuing their interests; supporting them to develop the skills needed for self-sufficiency; supporting their choices of gender nonconforming clothing and interests; supporting their exploration of their identity; and supporting them in their critical thinking skills. Parental support is multifaceted and should not be oversimplified into a binary of whether a parent agrees or disagrees with a specific medical course. This study was not designed to measure different types of support provided by parents or levels of support. If there were an excess of parents who were unsupportive of their children, it might affect some of these initial findings. The nature and extent of parental support—including the many different ways that parents can support their children in becoming healthy, self-sufficient adults—is well worth further study.

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Clarification of Fig 1

The purpose of Fig 1 was to provide the reader with a quick sense of what kinds of advice can be found and shared on Reddit and Tumblr. One example includes an excerpt from a publicly available Tumblr blog that posted a list of purported indirect signs of gender dysphoria. This excerpt is indeed an example of advice that can be found on Tumblr. Note, however, that the excerpted Tumblr post itself does not reflect the full content of the original blog it refers to, nor does the excerpt in Fig 1. The original blog is titled, "'That was dysphoria?' 8 signs and symptoms of indirect gender dysphoria" [15].

Discussion of the ICD-11 change from "gender dysphoria" to "gender incongruence"

The ICD-11 will go into effect in January 2022, and, with this change, the new diagnosis of "gender incongruence" will replace "gender dysphoria." Because the current descriptive, exploratory study raises hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria and concludes that more research is needed, it is unlikely that the change in diagnostic criteria will appreciably change the conclusion of the study, although the terminology may become outdated.

Supporting information

S1 File. PDF of the original article version that was published on August 16, 2018 (two figures removed due to copyright restrictions).
(PDF)

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Coalition for the Advancement & Application of Psychological Science

CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD)

As an organization committed to the generation and application of clinical science for the public good, the Coalition for the Advancement and Application of Psychological Science (CAAPS) supports eliminating the use of Rapid-Onset Gender Dysphoria (ROGD) and similar concepts for clinical and diagnostic application given the lack of rigorous empirical support for its existence.

There are no sound empirical studies of ROGD and it has not been subjected to rigorous peer-review processes that are standard for clinical science. Further, there is no evidence that ROGD aligns with the lived experiences of transgender children and adolescents.

Despite the lack of evidence for ROGD and its significant potential for creating harm, it has garnered increased attention in the general public and is being misused within and beyond the field of psychology. For example, recent medical articles have started including ROGD in their overview of adolescents with gender incongruence, and there has been an increase in books, videos, podcasts, and training directed to parents and clinicians offering strategies for diagnosing and treating ROGD. The proliferation of misinformation regarding ROGD is also infiltrating policy decisions. Currently, there are over 100 bills under consideration in legislative bodies across the country that seek to limit the rights of transgender adolescents, many of which are predicated on the unsupported claims advanced by ROGD. Thus, even though ROGD is not a diagnostic classification or subtype in either the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), nor is it under consideration for inclusion in future editions, it is critical to address the misinformation regarding ROGD now.

Research on gender identity development in children and adolescents continues to evolve and these advances will likely influence diagnosis and empirically-based standards of care, as well as the legislative landscape impacting trans people's access to care and legal protections. The available research is clear that transgender people are subjected to marginalization, stigmatization, and minority stress, which have significant detrimental effects on health and well-being. Terms, such as ROGD, that further stigmatize and limit access to gender-affirming and evidence-based care violate the principles upon which CAAPS was founded and public trust in clinical science.

CAAPS supports eliminating the use of ROGD and similar concepts for clinical and diagnostic application given the lack of empirical support for its existence and its likelihood of contributing to harm and mental health burden. CAAPS also encourages further research that leads to evidence-based clinical guidelines for gender-affirming care that support child and adolescent gender identity development. CAAPS opposes trainings that encourage others to utilize this concept in their clinical practice given the lack of reputable scientific evidence to support its clinical utility. Finally, CAAPS recommends expanding community education about these topics to reduce the stigma and marginalization that contribute to mental health burden.

Signatories:

American Psychological Association (APA)

Society for the Psychology of Sexual Orientation and Gender Identity, American Psychological Association, Division 44

Society for a Science of Clinical Psychology (SSCP)

Society of Clinical Child and Adolescent Psychology (SCCAP), American Psychological Association, Division 53

Society of Behavioral Medicine (SBM)

Society for the Psychological Study of Social Issues (SPSSI)

Association for Behavioral & Cognitive Therapies (ABCT)

National Association of School Psychologists

Council of University Directors of Clinical Psychology (CUDCP) Board

Asian American Psychological Association (AAPA)

Society for the Psychological Study of Culture, Ethnicity, and Race

MSU Research Consortium on Gender-based Violence

State, Provincial and Territorial Psychological Association Affairs (Division 31, APA)

American Psychological Association, Division 22 Rehabilitation Psychology

New York Association of School Psychologists (NYASP)

Society for Community Research and Action (SCRA)

Society for the Study of School Psychology (SSSP)

Society for Child and Family Policy and Practice (Division 37 of the American Psychological Association)

Society of Personality and Social Psychology

Association for University and College Counseling Center Directors (AUCCCD)

Psychologists' Association of Alberta

Saint Louis University, Clinical Psychology Program

American Psychology-Law Society; Division 41 of APA

Michigan State University, Department of Psychology, Clinical Science Area

Psychologists in Public Service, American Psychological Association, Division 18

American Psychiatric Association

Society of Pediatric Psychology (SPP), Division 54 of the American Psychological Association

Society for Research in Child Development

National Association of Psychological Research and Graduation Programs

Council on Social Work Education

Stony Brook University, Clinical Psychology Program

Michigan State University Twin Registry (MSUTR)

Society of Counseling Psychology, Division 17, American Psychological Association

National Latinx Psychological Association (NLPA)

Anxiety and Depression Association of America

The Society of Clinical Psychology, APA Division 12

American Group Psychotherapy Association

University of Miami Department of Psychology

Portuguese Psychologists Association

Diverse Sexualities Research and Education institute

National Association of Social Workers

Puerto Rico Psychology Association

Association for Psychological Science

Connecticut Psychological Association

Howard Brown Health

American Association for Marriage and Family Therapy

British Columbia Psychological Association

World Professional Association for Transgender Health (WPATH)

Associations for Psychologists in Academic Health Centers

Nebraska Psychological Association

GLMA: Health Professionals Advancing LGBTQ Equality

Michigan Psychological Association

Arizona Psychological Association

New Hampshire Mental Health Counselors Association

Florida Psychological Association

Minnesota Association for Marriage and Family Therapy (MAMFT)

AIP— Italian Association of Psychology

Manitoba Psychological Society

Georgia Psychological Association

Vermont Psychological Association

Illinois Psychological Association

Delaware Psychological Association

CAAPS

About Contact Follow

PSYCHOTHERAPY FOR TRANSGENDER DECLARING ADOLESCENTS

Dianna Kenny PhD MAPsS MAPA
Professor of psychology (rtd), The University of Sydney
Society for Evidence-based Gender Medicine

15 November 2021

Four distinct groups

- ***Early onset during preschool.*** I have not been referred a case of early onset GD. They are very rare.
- ***Adolescent onset (ROGD).*** By far, most referrals to my practice are for young people aged 12-17, predominantly girls. This presentation will focus on this group.
- ***Over 18s and young adults*****.** Unlike the bias towards females in ROGD referrals, the over 18s referred to my practice are more equally distributed between males and females. The majority are referred by parents. Their management is complicated by the fact that they are legally adults and able to make their own decisions independently of parents.
- ***Mature aged adults.*** Many present after the breakdown of their marriages with a history of long term cross-dressing and fantasies about being the other sex. Others present as single adults who have been socially transitioned for many years, having first identified as butch lesbians, and decide to finalize their transition surgically.

Intake assessment

- **Family constellation**, family conflict /dysfunction, marital and sibling dynamics
- **Psychological evaluation** – ADHD, ASD, self-harm, suicidality, suicide attempts, anxiety, depression, incipient BPD, and psychosis
- History of **body dysmorphia**, eating disorders
- **School life experiences** e.g., attitude towards school, peer rejection, bullying, truanting, academic performance, post school aspirations
- **Cognitive immaturity, concrete thinking, cognitive rigidity, and cognitive distortions**, lack of understanding or misunderstanding of gender ideology and capacity to critically review it (given the illogical and scientifically unsound basis of the ideology)
- **Understanding of the gravity and irreversibility of medical/surgical transition**; what GA treatment entails, and the consequences of treatment (e.g., infertility, sexual dysfunction, complications of cross-sex hormones and surgery, lifelong patienthood).
- **Sexual experience** history – sexual relationships, sexual abuse experiences, sexual knowledge, sexual anxiety
- Emerging awareness of **ego dystonic sexual orientation** - > internalized homophobia
- **Social contagion** (influence of social milieu e.g., schools, gender clinics, internet, online transgender communities)
- Perceptions and misperceptions of **gender roles**
- **Systemic function of ROGD** e.g., defiance of parents, finding an “in group,” being “seen”, denying the development of their sexed bodies, fear of adulthood, fear of sexual relationships.

TRANSITION, SELF HARM AND SUICIDALITY

The vulnerable (traumatized) part of the self is hated so it is subsumed into the omnipotent self which is the part that suppresses doubts and anxiety and presses for transition.

If the traumatized self pushes for recognition of psychic pain, the young person may resort to self-harm and suicidal ideation which is a form of acting out of their self-hatred against their bodies.

Affirming clinicians collude with the patient's own attacks on the traumatized self by "traumatizing" their bodies with cross-sex hormones and mutilating surgery.

Hope that transition will restore young person to an ideal state – medics become omnipotent creators of this ideal state. When this fails, the patient sinks into further self-hatred which is enacted through self-harming and suicidal states.

Mechanisms of social contagion

- Peer contagion
  - has a powerful socializing effect on children beginning in the preschool years.
  - By middle childhood, gender is the most important factor in the formation of peer associations, highlighting the significance of gender as an organizing principle of the norms and values associated with gender identity.
  - ROGD have often experienced peer rejection, bullying, hostility and/or social isolation and hence feel marginalized from peer groups. They will gravitate to the Rainbow clubs in schools where everyone is accepted without question, especially if they declare an alternative gender, whereupon they are lauded and validated, even when they had no previous intentions to do so.

Social contagion

A very powerful phenomenon underlying the staggering increases in primarily adolescent girls declaring themselves transgender.

Social contagion identified as a mechanism in eating disorders, self harm and suicide, substance abuse, emotion, and now gender dysphoria.

Mechanisms of social contagion

- Deviancy training
  - deviant attitudes and behaviours rewarded by the peer group
- Co-rumination
  - a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer dyad.
  - Results in increases in internalizing disorders and gender confusion.
  - Girls more affected

Social contagion

A very powerful phenomenon underlying the staggering increases in primarily adolescent girls declaring themselves transgender.

Social contagion identified as a mechanism in eating disorders, self harm and suicide, substance abuse, emotion, and now gender dysphoria.

A boy has a special needs younger sister who gets all the attention. Watching his mother tend to his sister one day, he said “Mummy, you will only love me if I am a girl.”

A loved father appears to love her brother more than his daughter and spends much more time engaged in male pursuits with his son. She says, “I want to be close to Dad but he spends all his time with my brother and never with me.” She concluded it was better to be a boy and declared herself transgender. Now she is in a perpetual rage that her father does not accept her transgender identity because she feels she has nothing more to offer him.

A mother tells her pre-adolescent daughter who is described as a “tomboy” about the sexual abuse she experienced as a child by her stepfather and the sexual assaults she endured as a teenager. Her daughter formed the view that girls are unsafe in the company of men and are constantly at risk of harm particularly as they approach puberty. She decided that being a female “sucked” and that she would prefer to be a male in order to keep herself safe and strong.

A 15-y old girl has a mother who has been diagnosed with BPD. She has lived with her mother’s emotional storms and capriciousness all her life. When she has an outburst, her father says, “You have your mother’s BPD, and I don’t want to have to deal with that again.” He would then leave the house. Her father told her, “It is because you were the firstborn - the firstborn girl in Mum's family always got the worst mental illness.” This girl formed the view that men and boys are saner than women and girls and that it would be preferable to change gender rather than turn out like her mother.

Family Constellation

Identity is not hard-wired – it develops in a social world where the young person experiences attachments, trauma, abuse, or misperceives the meaning of experiences because of cognitive immaturity or concrete thinking.

Need to explore identifications (I want to be like…) and dis-identifications (I do not want to be like…)

A 14-year-old natal boy first came out to his parents as **GAY**.

He soon changed that declaration to **BISEXUAL** when he experienced a powerful crush on a female classmate. After she rejected him, he came out as **TRANS** and demanded puberty blockade and cross sex hormones.

In therapy, his demands for transition were strident and incessant. He constantly asked me when I was going to tell his parents that he could go ahead with his transition.

He shaved his legs, arms and body hair, grew his hair long, and started to wear eye makeup and nail polish. He ordered female clothing from the internet and wore it secretly in his room. When his parents confiscated these clothing items, his female friends lent him their clothes to wear until I advised his parents to put a stop to this. Teachers at his school started calling him by his preferred name and pronouns until I advised his parents not to allow this.

Several months after therapy commenced, while still vehemently protesting his trans-female identity, he wrote a letter to his parents apologising for misleading them. He said he now realised that he was not a trans-female but a **DEMIGIRL** (denoting partial non-binary, partial female gender identity).

He changed this orientation shortly thereafter to **DEMIBOY**, before again writing to his parents, telling them that he was only joking about the whole thing and that they were the only people who had taken it seriously.

I advised his parents to eat humble pie to give their son the opportunity to exit the gender maze without losing face.

The next day he asked his parents to take him for a haircut. **STRAIGHT**

Sexual orientation

Many young people are confused about their sexual orientation and often conflate sexual orientation with gender identity.

ROMANTIC AND SEXUAL RELATIONSHIPS

Majority of young GD adolescents

(i) have had no sexual experience (crushes from a distance, hand holding and kissing)

(ii) disdain genital sex as "gross"

(iii) are indifferent to loss of sexual function, fertility

(iv) are confused about the nature of "trans" relationships e.g.,

A self-declared non-binary male (natal sex = male) in a relationship with a transgender declaring natal female (i.e., a trans man) told their parents they were in a gay male relationship. Similarly, two natal females, both transmen, rejected the suggestion that they were a lesbian couple and stated that they were a gay male couple.

Anime character against a pansexual flag

Case example: Artem, aged 15

Artem, aged 15, from a Middle Eastern country that is homophobic, was referred by his mother for a range of issues but specifically because he had declared himself **transgender**. He was post pubertal, facially and bodily hirsute with a deep male voice. Artem was insistent that he was transgender and was impatient to commence his social transition and to obtain prescriptions for cross sex hormones.

Of himself:

I see myself as **bisexual**. I have feelings for guys and girls, more like a **pan**-thing. I have had a boyfriend who identifies as male and pan since last year. We get together just the two of us - we visit each other's houses. I guess I would be OK with being **GAY**. For me, it fluctuates.

Of his mother, Artem said:

Mum knows I have this friend. She doesn't know that he is **my boyfriend**. I don't think Mum will take it well because she asked me if I still liked girls. She wouldn't take kindly to knowing I am gay and have a boyfriend.

Of his father, Artem said:

Dad is trying to suppress his **queer phobia**, but he says bad things about LGBTQ. He is anti it all; he got angry with me for refuting what he was saying. Dad said **gay is about anal sex and that is gross**. Then Mum told him to shut up and I went to my room and cried. Dad is anti queer for sure, he tries to suppress it because he still loves me. I felt very disappointed in Dad when he expressed these sentiments. He will be very freaked out if he thinks I am **queer, gay, or trans**.

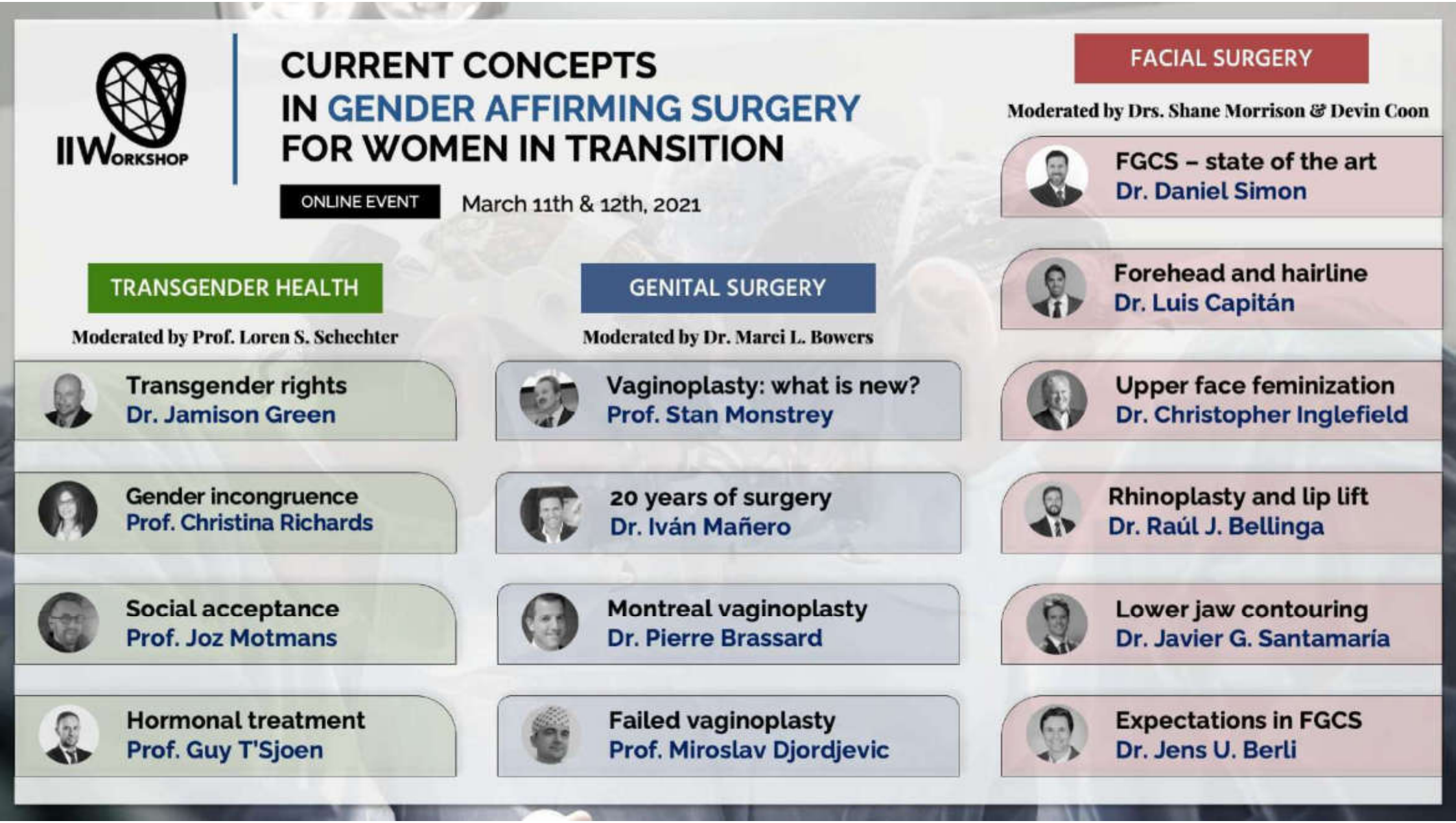
Internalized homophobia

An adolescent realises that s/he is same-sex attracted. Finding this unacceptable, due to parental and/or internalized homophobia, the adolescent reasons as follows:

Being same-sex attracted is bad and shameful. My parents will reject me if I am gay. If I am a boy attracted to other boys, I must be a girl and therefore need to transition so that my attraction to boys becomes heterosexual.

Conclusions

- Imperative to keep the **developmental path** open into adulthood (need **frontal lobe maturation** that occurs in early 20s)
- **Psychological trauma** from the past forms part of their psychic structure in the present. The expression of these **traumas are socio-culturally embedded** (i.e., social contagion permits particular forms of "acting out" these traumas).
- Envy and rivalry part of human condition -> **unconscious envy** is a factor in trans identification
- GD adolescents need assistance to explore their **defences and internal psychic conflicts and managing their psychic pain** before irreparably altering their bodies. "The body is used to act out something that cannot be accepted or processed by the mind." (Evans & Evans, 2021, Ch 2, p. 28).
- **Clinicians should not collude with the phantasy that the "embodied" self can be altered or removed.**


IIWORKSHOP
CURRENT CONCEPTS
IN GENDER AFFIRMING SURGERY
FOR WOMEN IN TRANSITION
ONLINE EVENT
March 11th & 12th, 2021
TRANSGENDER HEALTH
Moderated by Prof. Loren S. Schechter
Transgender rights
Dr. Jamison Green
Gender incongruence
Prof. Christina Richards
Social acceptance
Prof. Joz Motmans
Hormonal treatment
Prof. Guy T'Sjoen
GENITAL SURGERY
Moderated by Dr. Marci L. Bowers
Vaginoplasty: what is new?
Prof. Stan Monstrey
20 years of surgery
Dr. Iván Mañero
Montreal vaginoplasty
Dr. Pierre Brassard
Failed vaginoplasty
Prof. Miroslav Djordjevic
FACIAL SURGERY
Moderated by Drs. Shane Morrison & Devin Coon
FGCS – state of the art
Dr. Daniel Simon
Forehead and hairline
Dr. Luis Capitán
Upper face feminization
Dr. Christopher Inglefield
Rhinoplasty and lip lift
Dr. Raúl J. Bellinga
Lower jaw contouring
Dr. Javier G. Santamaría
Expectations in FGCS
Dr. Jens U. Berli

Conclusions

- **Sexual development poses a threat** to young people as it signifies approaching adulthood, the demands of which they feel ill equipped to manage.
- **ROGD** as a "trauma" or **a response to the reality of puberty** that one now has a **sexed body**.
- Rigid **adherence to peer norms** temporarily assuages vulnerabilities because the young person has found others like him/her who are acting out in the same way.

TRANSITION could be

i. related to a grievance against the parents and a struggle for autonomy/individuation
ii. related to an idea that one can create an ideal self
iii. protective against feelings of inadequacy, anxiety, jealousy, and disappointment
iv. a triumph over feelings of vulnerability
v. a repudiation of the sexed body and adulthood


TRANS IS NOT
BEAUTIFUL

In the Matter Of:

K.C., ET AL

-v-

INDIVIDUAL MEMBERS OF MEDICAL LICENSING BOARD OF INDIANA, ET AL

Dr. Catherine Bast + Michelle (Mixhi) Marquis, 30(b)(6) Mosaic

May 15, 2023

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al.,	)	
	)	
Plaintiffs,	)	
	)	
-v-	)	CASE NO.
	)	1:23-cv-00595-JPH-KMB
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,	)	
	)	
Defendants.	)	

The 30(b)(6) deposition upon oral examination of MOSAIC HEALTH AND HEALING ARTS, INC., by DR. CATHERINE BAST and MICHELLE (MIXHI) MARQUIS, witnesses produced and remotely sworn before me, Debbi S. Austin, RMR, CRR, Notary Public in and for the County of Hendricks, State of Indiana, taken on behalf of the Defendants via Zoom videoconference on May 15, 2023, at 9:37 a.m., pursuant to the Federal Rules of Civil Procedure.

STEWART RICHARDSON & ASSOCIATES
Registered Professional Reporters
(800)869-0873

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Informed Consent for balancing hormones in Gender Divserse people

We believe that even if you are younger than 18, you get to make choices about your own body. We respect your choices. This signed document indicates that we have discussed hormone treatment for your needs and that you understand what we know and what we don't know about potential risks of changing the hormone balance in your body, and what changes are permanent and which are not. This document also indicates that one adult in your life over the age of 18 is supporting you in this decision.

Hormone blocking at the level of LH/FSH

Methods: subdermal implant (Supprelin), injections (Lupron)

Both same mediation: luprolide

What we know:

- Luprolide prevents the anterior pituitary gland from making FSH and LH which means that neither testosterone or estradiol will be made by the organs that you were born with. Some testosterone gets made in the adrenal glands (usually small amounts) and this will continue. Some estradiol is converted from testosterone to estradiol in fat under the skin and this will continue. We know that LONG term blocking of testosterone and estrogen will weaken bones.
- This medicine has been used for years in the treatment of precocious puberty.

Permanent changes: none

What we don't know:

- How many years of blocking before either testosterone or estrogen is needed to support bone development, early data suggest that 3 years may be the line
- The effect on long term fertility
- The effect on long term metabolism.

Please sign here if you have read the above and talked with your provider about any other questions that you might have and you want to begin hormone blocking.

Printed Patient Name	*Date of Birth*	*Printed Parent Name*	*Date*
Patient Signature	*Date*	*Parent Signature*	

Exhibit 10 05/15/23

Informed Consent for balancing hormones in Gender Diverse people

MOSAIC Health & Healing Arts

We believe that you get to make choices about your own body. We respect your choices. This signed document indicates that we have discussed hormone treatment for your needs and that you understand what we know and what we don't know about potential risks of changing the hormone balance in your body, and what changes are permanent and which are not.

Increasing testosterone:

What we know:

Increasing testosterone in the body leads to some changes that are permanent and some that are not..

Permanent:	Not permanent:
Voice deepening	*Skin changes: more oily, sometimes more acne*
Clitoris growing	*Hair growth on body*
	Hair loss on head (sometimes permanent)
	Fat redistribution
	Stopping periods
	Increasing Red blood cell production
	Increased muscle mass and creatinine production

• People whose bodies are at higher concentration of testosterone have higher risk of heart disease, high cholesterol and high blood pressure. These are all modifiable by diet, exercise and medications. Taking testosterone that is NOT made by your body does not increase your risk of these effects MORE than if your body made it.
• Testosterone is dangerous to unborn babies.
• It is possible to get pregnant while on Testosterone EVEN if periods have stopped.
• For those that engage in sexual activity that could produce a new human, condoms are first line and consider copper IUD (non hormonal birth control).

What we don't know:

• How hormonal birth control (depot shot, birth control pills, Mirena IUD) interact with testosterone
• What Testosterone does to fertility. Some trans men come off T and get pregnant and birth babies, have no long term data on these humans

Please sign here if you have read the above and talked with your provider about any other questions that you might have and you want to begin taking testosterone.

Printed Patient Name	*Date of Birth*	*Printed Parent Name*	*Date*
Patient Signature	*Date*	*Parent Signature*	

Exhibit 16 05/15/23

Informed Consent Model of Care

The informed consent model of care respects your fundamental human right to self-determination and bodily autonomy. The purpose of this document is to indicate, in writing, that you consent to masculinizing hormone therapy as part of a gender affirmation process. This form may be signed by any person of sound mind over the age of 18, or younger, with the cosignature of a parent or guardian.

This document relates to the hormone testosterone. Your provider will discuss with you all of the information relating to starting hormone therapy. Please read and understand the following information, and raise any questions you have with your provider.

Patient Information Sheet:
Expected changes on masculinizing hormone therapy

Typical changes from Testosterone *(varies from person to person)*

Average timeline	*Effect of Testosterone*
1–3 months after starting testosterone	• decreased estrogen in the body • increased sex drive • vaginal dryness • growth of the clitoris - typically 1–3 cm • increased growth, coarseness, and thickness of hairs on arms, legs, chest, back, & abdomen • oilier skin and increased acne • increased muscle mass and upper body strength • redistribution of body fat to the waist, less around the hips
1–6 months after starting testosterone	• menstrual periods stop
3–6 months after starting testosterone	• voice starts to crack and drop within first 3–6 months, but can take a year to finish changing
1 year or more after starting testosterone	• gradual growth of facial hair (usually 1–4 years) • possible male-pattern balding

Patient Information

Permanent changes expected while on masculinizing hormone therapy:

- Increased facial and body hair
- Deepened voice
- Enlargement of erectile genital tissue (phallus / clitoris)
- Possible male pattern balding
- Possible permanent infertility

Reversible changes possible while on masculinizing hormone therapy:

- Increased libido
- Body fat redistribution
- Coarser and oilier skin
- Acne of face, chest and back
- Stopping of menstrual periods
- Vaginal dryness
- Raised cholesterol
- Increased blood pressure
- Mood changes - aggression, depression

Potential side effects and risks of masculinizing hormone therapy:

- Polycythemia - increased number of red blood cells, resulting in "thickened" blood
- Increased risk of cardiovascular disease
- Difficulty controlling blood sugars in people with diabetes
- Osteoporosis
- Liver damage
- Increased salt and water retention

Masculinizing hormone therapy affects everyone differently, and there is no way to predict exactly how the body will change. Some of the long term effects of masculinizing hormone therapy are not yet known.

The use of masculinizing hormones do not guarantee infertility, and contraception should be used when having sex that puts someone at risk of pregnancy. Getting pregnant while taking testosterone could put the baby at serious risk of harm.

Gender affirming hormone therapy means that provider visits will be necessary to have blood tests at regular intervals throughout life. Appointments will be more frequent at first, and then every 6-12 months when hormone levels are stable. Be ready to make this commitment to health.

Gender affirming hormones are only a part of overall health, and a range of preventative health activities are recommended. These include but are not limited to:

- Cervical screening tests at appropriate intervals, as recommended by my provider
- Regular breast mammograms if appropriate, in consultation with provider
- Quitting smoking
- Immunisations
- Regular STI screening, depending on level of risk
- HIV prevention, depending on level of risk
- Regular physical activity, including resistance exercise for bone health
- Healthy eating

Stopping gender affirming hormone therapy is always an option. Please talk to your provider about your goals and your growing and changing self awareness.

Informed Consent for balancing hormones in Gender Diverse people

MOSAIC Health & Healing Arts

We believe that you get to make choices about your own body. We respect your choices. This signed document indicates that we have discussed hormone treatment for your needs and that you understand what we know and what we don't know about potential risks of changing the hormone balance in your body, and what changes are permanent and which are not. This document also indicates that one adult in your life over the age of 18 is supporting you in this decision.

Increasing estrogen:

What we know: increasing estrogen will cause...

Permanent changes:
Breasts

Not permanent changes:
Skin changes: softening
Body hair decrease
Body fat redistribution

Is it possible to achieve levels of estrogen in the body that will make these changes by simply taking estrogen alone, sometimes an androgen blocker can help speed the process.

Androgen blockers:

Spironolactone (blood pressure medication that also blocks Testosterone receptors)—side effects of increased urination and possible increase in cortisol, people report brain fog, depression

Bicalutamide: binds and inhibits testosterone receptors—side effects of elevated blood pressure, rash and elevated liver enzymes

What we don't know:

- Effect on long term fertility. There are folks who have been taking estrogen and then stop and are able to produce viable sperm again but we don't know what the long term effects are on these sperm or any new humans created with them.
- How your body with metabolize estrogen. Some people do very well on oral formulations, some need injectables.
- Exact relationship between estrogen levels and development of blood clots but we have not had any difficulty with bio identical estradiol in people without a known clotting disorder.

Please sign here if you have read the above and talked with your provider about any other questions that you might have and you want to begin increasing the estrogen balance in your body.

Printed Patient Name	*Date of Birth*	*Printed Parent Name*	*Date*
Patient Signature	*Date*	*Parent Signature*	

Exhibit 17 05/15/23

Informed Consent Model of Care

The informed consent model of care respects your fundamental human right to self-determination and bodily autonomy. The purpose of this document is to indicate, in writing, that you consent to feminizing hormone therapy as part of a gender affirmation process. This form may be signed by any person of sound mind over the age of 18, or younger, with the cosignature of a parent or guardian.

This document relates to the hormones estrogen and progesterone, as well as testosterone blocking medications. Your provider will make a medical decision, in consultation with you, about the medications that are best for you, keeping in mind your overall health during your gender affirmation process. Your provider will discuss with you all of the information relating to starting hormone therapy. You are asked to read and understand the following information, and raise any questions you have with your provider.

Patient Information Sheet: Expected changes on feminizing hormone therapy

Typical changes from Estrogen *(varies from person to person)*

Average timeline	*Effect of Estrogen*
1–3 months after starting estrogen	• softening of skin • decrease in muscle mass and increase in body fat • redistribution of body fat to buttocks and hips • decrease in sex drive • fewer instances of waking up with an erection or spontaneously having an erection; some trans women also find their erections are less firm during sex, or can't get erect at all • decreased ability to make sperm and ejaculatory fluid
Gradual changes (maximum change after 1–2 years on estrogen)	• nipple and breast growth • slower growth of facial and body hair • slowed or stopped balding • decrease in testicular size

Typical changes from Anti-Androgens *(varies from person to person)*

Average timeline	*Effect of blocking*
Testosterone 1–3 months after starting antiandrogens	• decreased testosterone in the body • decrease in sex drive • fewer instances of waking up with an erection or spontaneously having an erection; some trans women also have difficulty getting an erection even when they are sexually aroused; some have painful erections • decreased ability to make sperm and ejaculatory fluid
Gradual changes (usually at least 2 years)	• slower growth of facial and body hair • slowed or stopped balding • slight breast growth (reversible in some cases, not in others)

Patient Information

Permanent changes expected while on feminizing hormone therapy:

- Breast and nipple development
- Decreased testicular size
- Possible permanent infertility

Reversible changes expected while on feminizing hormone therapy:

- Softening of skin
- Decreased muscle mass and increased body fat
- Decreased libido
- Reduced spontaneous morning erections
- Reduced ability to achieve or sustain an erection
- Reduced ability to ejaculate and reduced volume of ejaculatory fluid
- Slowed or stopped balding
- Slowed rate of growth of facial and body hair
- Improved cholesterol

Side effects of feminizing hormone therapy

- Headaches
- Nausea
- Fluid retention and bloating
- Breast and nipple tenderness
- Mood disturbance, such as teariness, depression or anxiety
- Fatigue
- Blood clots, deep vein thrombosis or potentially fatal pulmonary embolism
- Stroke

Potential risks of feminizing hormone therapy:

- Blood clots, deep vein thrombosis or potentially fatal pulmonary embolism
- Stroke
- Increased risk of heart disease or heart attack
- Raised blood pressure
- Liver damage
- Osteoporosis

Feminizing hormone therapy affects everyone differently, and that there is no way to predict exactly how bodies will change. Some of the long term effects of feminizing hormone therapy are not yet known.

Continuing to smoke any product containing nicotine (cigarettes, tobacco, electronic vaporisers) while taking estrogen may increase risk of developing a blood clot, deep vein thrombosis or a potentially fatal pulmonary embolism.

The use of feminizing hormones does not guarantee infertility, and contraception should be used to avoid unwanted pregnancy if having sex with someone who could become pregnant.

Gender affirming hormone therapy means that provider visits will be necessary to have blood tests at regular intervals throughout life. Appointments will be more frequent at first, and then every 6-12 months when hormone levels are stable. Be ready to make this commitment to health.

Gender affirming hormones are only a part of overall health, and a range of preventative health activities are recommended.

These include but are not limited to:

- Regular breast mammograms from an appropriate age, in consultation with my provider
- Quitting smoking
- Immunizations
- Regular STI screening, depending on my level of risk
- HIV prevention, depending on my level of risk
- Regular physical activity, including resistance exercise for bone health
- Healthy eating

Stopping gender affirming hormone therapy is always an option. Please talk to your provider about your goals and your growing and changing self awareness.

REV02072022

MOSAIC
Health & Healing Arts

Feminizing Social Transitions: What to know

Transitioning is any change or adjustment that decreases feelings of dysphoria and increases feelings of euphoria or feeling affirmed in your gender expression.

Transitions can be social, medical, surgical, and/or legal.

There is a long list of ways someone can transition socially. For someone who is feminizing, this may look like...

Shifting pronouns

Shifting pronouns to she/her, they/she, she/they, or other pronouns that feel affirming are some of the first social transitions people try out. Finding pronouns that feel affirming and in line with your gender identity is important.

Changing names

Changing one's name is another social transition that people find to be affirming. One may practice trying different names out online, with romantic partners, family, or friends.

Tucking garments

Those looking to feminize may benefit from using tucking garments. These are garments that safely tuck the penis to diminish the look of a bulge and help one feel more comfortable in certain clothing.

Dressing differently

Changing the way that one dresses may aid in reducing feelings of dysphoria. Wearing more traditionally feminine clothing/shoes/accessories/ undergarments or other clothing that feels affirming to one's gender expression can be helpful.

Wearing makeup and painting nails

Wearing makeup and painting finger/toenails are more ways people can feel more affirmed in their gender expression and can decrease feelings of dysphoria.

Wearing prosthetics

Wearing prosthetics that give the appearance of a larger chest may help those that are feminizing to feel more affirmed in their gender identity. This may also be done by stuffing a bra with socks or other materials.

Exhibit
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REV02072022

MOSAIC
Health & Healing Arts

Masculinizing Social Transitions: What to know

Transitioning is any change or adjustment that decreases feelings of dysphoria and increases feelings of euphoria or feeling affirmed in your gender expression.

Transitions can be social, medical, surgical, and/or legal.

There is a long list of ways someone can transition socially. For someone who is masculinizing, this may look like...

Shifting pronouns
Shifting pronouns to he/him, they/he, he/they, or other pronouns that feel affirming are some of the first social transitions people try out. Finding pronouns that feel affirming and in line with your gender identity is important.

Changing names
Changing one's name is another social transition that people find to be affirming. One may practice trying different names out online, with romantic partners, family, or friends.

Chest binding
Binding the chest to give the appearance of a more flat chest may feel affirming to someone who is looking to masculinize. Ensuring that you are binding correctly with garments made for this purpose is extremely important. Do not bind with Ace bandages.

Using stand-to-pee devices
Using stand-to-pee devices can be helpful for those that may have dysphoria about how their pee sounds or their inability to use a urinal.

Using a packer
Packers may be used to give the feeling or look of having a penis.

Dressing differently
Dressing in a way that feels more masculine can be a great way to express one's gender. This could mean wearing clothes/shoes/accessories that are considered traditionally masculine, wearing boxers/briefs, or any other items that feel affirming.

Using period underwear
Periods can cause feelings of dysphoria and using traditional period products isn't always ideal for those using the men's restroom. Underwear from brands like Thinx are made to be worn during one's period and can be washed for continual use.

Exhibit
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CIVIL ACTION NO. 1:23-cv-00595-JPH-KMB

K.C., et al.)
)
Plaintiffs,)
)
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendants.)

REMOTE DEPOSITION OF JANINE M. FOGEL, MD

The deposition upon oral examination of JANINE M. FOGEL, MD, a witness produced and sworn before me, Colleen Brady, Notary Public in and for the County of Monroe, State of Indiana, taken on behalf of the Defendants, with the witness located in Indiana, on the 17th day of May 2023, at 12:39 p.m., pursuant to the Federal Rules of Civil Procedure with written notice as to time and place thereof.

APPEARANCES
(All appearances via videoconference)

FOR THE PLAINTIFFS:
Kenneth J. Falk
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FOR THE DEFENDANTS:
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FOR THE DEPONENT:
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ALSO PRESENT:
Zef Cota, concierge tech
Julie Conrad, general counsel for Eskenazi
Harper Seldin, counsel for plaintiff
Melinda Holmes, counsel for defendant
Gavin Rose, counsel for plaintiff

INDEX OF EXAMINATION

INDEX OF EXHIBITS

(Time noted: 12:39 p.m.)

JANINE M. FOGEL, MD,

having been duly sworn to tell the truth, the whole truth, and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION,

QUESTIONS BY THOMAS M. FISHER:

Q Dr. Fogel, good afternoon. My name is Tom Fisher. I am a lawyer at the Attorney General's Office and I'll be taking the deposition of Eskenazi today. And as I understand it, you're the designated witness for Eskenazi today.

Is that generally your understanding, what we're doing?

A Yes.

Q I hope not to take too long. We do have some questions to get through. We are going to start off by looking at some documents that have been produce in this case.

So just make sure that we are all on the same page as to what this case is, let's mark as Exhibit 1, the complaint in this case. If I can show that on the witness?

THE CONCIERGE: I'm introducing it. Please

ESKENAZI HEALTH GENDER HEALTH PROGRAM

ESKENAZI HEALTH

BE HEALTHY.
BE WELL.
BE ACCEPTED.

Exhibit 0008
5/17/2023
FOGEL

Eskenazi_000001

At Eskenazi Health, our doors are open for everyone. The Eskenazi Health Gender Health Program was created because everyone deserves quality health care.

SERVICES INCLUDE:

- Hormone therapy
- Referrals to specialties such as speech therapy, nutrition, mental health counseling and psychiatry
- Legal assistance
- Gender affirming surgery
- Care coordination and case management
- PrEP for HIV prevention
- Family planning and gynecological services
- Spiritual care

All program staff members follow the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People. For more information, please visit **EskenaziHealth.edu** or call **317.880.6042**.

Status **Active** PolicyStat ID **12196959**

Effective	8/20/2013
Approved	8/15/2022
Revised	8/15/2022
Next Review	8/14/2025
Owner	Andrea Heid: LEGAL ADMINISTRATION MANAGER
Policy Series	Hospital Plan of Care

Gender Health Program

Scope of services:

- **Types of Patients:** Gender diverse
- **Age of Patients:** Adults and older adolescents
- **Goal:** To provide comprehensive medical care and mental health services to gender diverse adult patients and older adolescents.

Method used to assess:

Each patient receives an initial psychological and social assessment by our Licensed Clinical Social Worker (LCSW). The focus is on Gender Dyphoria and additional mental health concerns, such as depressive and mood disorders, including anxiety, bi-polar disorder, etc. Our psychiatric providers are available to further assess c-morbid mental disorders, and to prescribe medication if needed. After the initial assessment with the LCSW, the patient is scheduled at a later date with one of our physicians or Nurse Practitioner.

Scope and Complexity of Patient Care:

Transgender patients are very complex and carry numerous co-morbid stressors. A collaborative effort is required to ensure appropriate care plans are designed to meet the needs of each patient. Gender identity, and the dysphoria resulting from existing incongruence, requires medical and mental health professionals to work collaboratively.

Resources/Functional Relationships:

Within the Gender Health Program practice there is a medical director, family practice physicians, program coordinator, Licensed Clinical Social Workers, Psychiatric physician, speech pathologist, dietician, RN, referral coordinator and victim advocate, LPN, medical assistant, attorney.

The Program Coordinator is willing and available to serve as the liaison to billing and insu

companies for billing concerns, verification of benefits, and obtaining pre-certifications for patients. The Gender Health Program Coordinator also counsels patients and provides a linkage to address issues around transitioning as well as medical social work services.

Standards of Care Guidelines:

The Gender Health Program adheres to the most current standards of care from the World Professional Association for Transgender Health (WPATH) and the Diagnostic Statistical Manual (DSM).

A. **Staffing**

1. **What system/data is used to determine appropriate staffing?**
    a. Staffing levels based on
        i. Patient need (number and complexity)
        ii. Previous year's patient visits
        iii. Acuity of patient care needs for teaching and management and services provided.

2. **Staffing Plan:**
    a. Registered Nurses—1
    b. Licensed Practical Nurses—1
    c. Medical Assistants/Healthcare Techs—1
    d. Licensed Clinical Social Worker-4
    e. Program Coordinator-1
    f. Referral Coordinator -1
    g. Speech Therapist -1

3. **When the need for staffing variances arises, how is the level of staff adjusted?**
    a. Staffing is planned for maximum capacity.
    b. If patient volume is decreased due to decreased provider coverage (e.g., inpatient service, vacation, conference), staff may be floated to another site or take time off using benefit time or non-paid time off.
    c. If staffing is decreased due to vacancies, vacation, or illness, additional staff may be obtained from another site or use of the float pool.

4. **How do you assess the adequacy of the allocation of human resources to support patient safety?**
    a. Patient, visitor, and employee incidents are tracked and reviewed regularly for patterns and trends. If any pattern or trend emerges, it is reviewed for potential causes.

B. **Qualification of Staff**

1. **Qualification/skills level required of staff**:
    a. Competencies for staff members are defined in the job descriptions and

are specific to each position.

b. Competency check offs are done at hire and as needed

c. Specific skills are assessed annually per the Ambulatory Care Education Plan.

d. Educational in-services provided as needed based upon evaluation of documentation, skills and procedures, review of evidence based practice and new products or procedures.

2. **How do you provide in-service/continuing education to maintain/increase competency of staff? How do you identify staff needs for education?**

    a. In-services and educational programs are provided through the clinical education department, videos, and outside resources.

    b. Recurrent educational opportunities include:

        i. E-Learning sessions

        ii. CPR certification

        iii. Annual education requirements

        iv. Age-specific training

        v. In-services and conferences

3. **How do you assess the adequacy of the allocation of human resources to support patient safety?**

    a. Patient, visitor, and employee incidents are tracked and reviewed regularly for patterns and trends. If any pattern or trend emerges, it is reviewed for potential causes.

    b. Patient and employee satisfaction is monitored and reviewed for perception of the staffing.

4. **How does the department identify staff needs for education?**

    a. Observation and audits

    b. Performance appraisals

    c. Requests from staff and providers

C. **Description of communication/collaboration/functional relationships with other departments and services:**

1. **Describe internal and external methodology of communication.**

    a. Internal (within the clinic): regular site staff meetings, memos, voice mails, e-mails, face-to-face interactions, rounding, posted information and telephone conferences.

    b. External (outside the clinic):

        i. Communication from outside sources through other departments, directors, and leadership meetings.

ii. Multi-disciplinary & interdepartmental meetings
iii. The Shared Governance Ambulatory Council
iv. Department staff, leaders, and other visitors present at staff meetings
v. All-employee meetings, memos, e-mails, publications
vi. Journals and periodicals

2. **Describe how the department works with other departments to provide multidisciplinary care to the patient.**
    a. Via referrals and consultations, some to which patients may go to Eskenazi Health and some consultants/services may be within the clinic.

D. **What are the goals of the Department or Service and how is progress toward meeting these goals monitored?**
    1. To support gender diverse patients requiring health care intervention in a specialty care setting, by providing courteous professional care, with a dedication to inform and teach.
    2. Provide a safe and welcoming healthcare environment for gender diverse patients. The welcoming environment is facilitated by the use of preferred name and pronouns when interacting with and referring to gender diverse patients.
    3. Restrooms in the clinic area (4 total) are all gender neutral with signage inclusive of a man, woman and wheelchair to provide an inclusive, therapeutic environment.
    4. Goals are monitored through direct observation, quality improvement, and communication.

E. **Plans to improve the quality of services:**
    1. **What are the system-wide performance improvement projects and customer satisfaction projects that this department participates in?**
        a. The clinic system goals include:
            i. Access to care
                1. Administration is continuing to monitor availability for adult patients by continuing to monitor the schedules, no show rate, and patient perception reports.
                2. Phone access will be monitored by the length of time callers wait and the number of patients who disconnect the call prior to talking with staff.
            ii. Quality of care
                1. Improvement in quality measures from current baseline.
            iii. Customer Service
                1. Patient satisfaction scores as distributed by Risk

Management

a. Access scale > 4

b. Office scale > 4

iv. Financial Accountability

1. Remaining within budget without comprising work situations, patient or staff safety, or quality of care.

b. Individual areas within the clinics have specific goals for improving issues within that section that are monitored and shared with staff. At least one will be chosen and reported throughout the year.

2. **How are the results of Performance Improvement Initiatives reported to the hospital leadership, and shared with the members of the staff in your department?**

a. They are shared with staff via staff meetings and postings at the site.

b. All results are shared with Eskenazi Health leadership and at the leadership meetings, and via the internet and operations reports.

c. In addition, results are shared Eskenazi Health Directors Meeting with reporting to the Eskenazi Health Board.

Approval Signatures

Step Description	Approver	Date
	Crissy Lough: CHIEF - QUAL RISK REG & PATIENT SAFETY	8/15/2022
	Andrea Heid: LEGAL ADMINISTRATION MANAGER	8/11/2022

ESKENAZI HEALTH

Eskenazi Health Welcomes All

Eskenazi Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sex, veteran's status, sexual orientation, or gender identity or expression. Eskenazi Health does not exclude people or treat them differently because of race, color, religion, national origin, age, disability, sex, veteran's status, sexual orientation, or gender identity or expression.

Eskenazi Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

We offer language services that enable us to communicate in your preferred language while we care for you. If you have any questions or if you need immediate assistance communicating with us, please call Eskenazi Health Multicultural Affairs at 317.880.5000.

If you believe that Eskenazi Health has failed to provide these services or discriminated in another way on the basis of race, color, religion, national origin, age, disability, sex, veteran's status, sexual orientation, or gender identity or expression, you can file a grievance with: Eskenazi Health Office of Patient Experience, Lisa Ramirez, 720 Eskenazi Ave., Indianapolis, IN 46202, 317.880.8333, 317.880.0519 (fax), patient.experience@eskenazihealth.edu. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Eskenazi Health Office of Patient Experience staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Exhibit 0010
5/17/2023
FOGEL

ESKENAZI
HEALTH

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 317.880.5000.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 317.880.5000.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 317.880.5000.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 317.880.5000.

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဥ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 317.880.5000 သို့ ခေါ်ဆိုပါ။

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0005.088.713 (رقم هاتف الصم والبكم: 0005.088.713).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 317.880.5000 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 317.880.5000.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 317.880.5000.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。317.880.5000 まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 317.880.5000.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 317.880.5000.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 317.880.5000.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 317.880.5000 'ਤੇ ਕਾਲ ਕਰੋ।

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 317.880.5000 पर कॉल करें।

ESKENAZI HEALTH CENTER OF EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH
Indianapolis, Indiana

Rev. 3/16 | INFORMED CONSENT FOR FEMINIZING HORMONE THERAPY - PAGE 1 OF 3

The use of hormone therapy for gender transition/affirmation is based on many years of experience treating trans persons, Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood.

This informed consent asks you to consider the expected benefits of hormone therapy and the possible side effects of hormone therapy, so that you can decide, with your medical provider, if hormone therapy is right for you. By signing this form, you are stating that you have discussed the risks and benefits with your medical provider or a member of the medical team and that you understand how these benefits and risks apply to you personally.

Androgen (testosterone) blockers are used to decrease the amount and/or block the effect of testosterone on and reduce the male features of the body.

Estrogen (usually estradiol) is used to feminize the body; estrogens can also decrease the amount and effect of testosterone. Your medical provider will determine the form of estrogen (pills, patches, gels or shots) and the dose that is best for you based on your personal needs and wishes, as well as considering any medical or mental health conditions you might have.

Each individual person responds to hormone therapy differently, and it is difficult to predict how each person will respond. You agree to take the androgen blockers and/or the estrogen only as prescribed and to discuss your treatment with your medical provider before making any changes.

The Expected Effects of Feminizing Hormone Therapy

The feminine changes in the body may take several months to become noticeable and usually take up to 3 to 5 years to be complete.

Changes that will be PERMANENT; they will not go away, even if you decide to stop hormone therapy:

- Breast growth and development. Breast size varies in all women; breasts can also look smaller if you have a broader chest.
- The testicles will get smaller and softer.
- The testicles will produce less sperm, and you will become infertile (unable to get someone pregnant); how long this takes to happen and become permanent varies greatly from person to person.

Changes that are NOT PERMANENT and will likely reverse if hormone therapy is stopped:

- Loss of muscle mass and decreased strength, particularly in the upper body.
- Weight gain. If you gain weight, this fat will tend to go to the buttocks, hips and thighs, rather than the abdomen and mid-section, making the body look more feminine.
- Skin will become softer and acne may decrease.
- Facial and body hair will get softer and lighter and grow more slowly; usually this effect is not sufficient and most women will choose to have other treatments (electrolysis or laser therapy) to remove unwanted hair.
- Mate pattern baldness of the scalp may slow down or stop, but hair will generally not regrow.
- Reduced sex drive.
- Decreased strength of erections or inability to get an erection. The ejaculate will become thinner and watery and there will be less of it.
- Changes in mood or thinking may occur; you may find that you have increased emotional reactions to things, Some persons find that their mental health improves after starting hormone therapy. The effects of hormones on the brain are not fully understood.

Hormone therapy will not change the bone structure of the face or body; your Adam's apple will not shrink; the pitch of your voice will not automatically change. If necessary, other treatments are available to help with these things.

_____ I have questions about the possible effects of hormone therapy.

_____ My medical provider or a member of the medical team has answered my questions about the effects of hormone therapy.

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The Risks and Possible Side Effects of Estrogen Therapy

- Loss of fertility (unable to get someone pregnant). Even after stopping hormone therapy, the ability to make healthy sperm may not come back. How long this takes to become permanent is difficult to predict. Some persons choose to bank some of their sperm before starting hormone therapy.
- Because the effect on sperm production is hard to predict, if you have penetrative sex with a natal female partner, you or your partner should still use birth control (e.g. condoms).
- Increased risk of developing blood clots; blood clots in the legs or arms (DVT) can cause pain and swelling; blood clots to the lungs (pulmonary embolus) can interfere with breathing and getting oxygen to the body; blood clots in the arteries of the heart can cause heart attacks; blood clots in the arteries of the brain can cause a stroke. Blood clots to the lungs, heart or brain could result in death.
- Possible increased risk of having cardiovascular disease, a heart attack or stroke. This risk may be higher if you smoke cigarettes, are over 45, or if you have high blood pressure, high cholesterol, diabetes, or family history of cardiovascular disease.
- Possible increase in blood pressure; this might require medication for treatment.
- Possible increased risk of developing diabetes.
- Nausea and vomiting (like morning sickness in a pregnant woman), especially when starting estrogen therapy.
- Increased risk of gallbladder disease and gallstones.
- Changes in blood tests for the liver; estrogen may possibly contribute to damage of the liver from other causes.
- May cause or worsen headaches and migraines.
- May cause elevated levels of prolactin (a hormone made by the pituitary gland); a few persons on estrogen for hormone therapy have developed prolactinomas, a benign tumor of the pituitary gland that can cause headaches and problems with vision and cause other hormone problems.
- May worsen depression or cause mood swings.
- May increase the risk of breast cancer. The risk is probably higher than in natal men but lower than in natal women; the risk probably is related to how long you take estrogen therapy.

The Risks and Possible Side Effects of Androgen Blockers (Spironolactone)

- Increased urine production and needing to urinate more frequently; possible changes in kidney function.
- A drop in blood pressure and feeling lightheaded.
- Increased thirst.
- Increase in the potassium in the blood and in your body; this can lead to muscle weakness, nerve problems and dangerous heart arrhythmias (irregular heart rhythm).

_____ I have questions about the risks of hormone therapy.

_____ My medical provider or a member of the medical team has answered my questions about the risks of hormone therapy.

_____ I would like to discuss ways to help me quit smoking.

You understand that

- Smoking may greatly increase the risks of taking hormone therapy, especially the risk of blood clots and cardiovascular disease. If you smoke, you should try to cut back or quit. If you have other risks for blood clots or cardiovascular disease, your provider may ask you to quit smoking before you start on hormone therapy.
- Taking estrogen in doses that are higher than recommended by your doctor will increase your risk of side effects and may not produce better feminizing effects.
- You will need to stop taking hormones for a few weeks before and after any surgery.

- Treatment with estrogen is expected to be lifelong; suddenly stopping estrogen treatment after you have been on it for a long time may have negative health effects.
- You may choose to stop taking hormone therapy at any time or for any reason. You are encouraged to discuss this decision with your medical provider.
- Your provider may decrease the dose of estrogen or androgen blockers or stop prescribing hormone therapy because of medical reasons and/or safety concerns; you can expect that the medical provider will discuss the reasons for all treatment decisions with you.
- Hormone therapy is not the only way that a person may appear more feminine and live as a female; your medical provider and/or a mental health provider can help you think about these other options.

You agree to

- Take androgen blockers and/or estrogens only at the dosage and in the form that your medical provider prescribes.
- Inform your medical provider if you are taking or start taking any other prescription drugs, dietary supplement, herbal or homeopathic drugs, or street drugs or alcohol so that you can discuss possible interactions with and effects on your hormone treatment.
- Inform your medical provider of any new physical symptoms or any medical conditions that may develop before or while you are taking hormone therapy and discuss the evaluation of these conditions. Inform your provider if you think you are having bad side effects from the medications.
- Keep regular follow up appointments; this may include appointments for mammograms and prostate exams.
- Have regular monitoring blood testing done; your provider will discuss with you what tests are necessary in order to monitor for potential harmful effects and to ensure that your hormone therapy is safe and effective.

_____ I have questions about my rights and responsibilities with taking hormone therapy.

_____ My medical provider has discussed my questions and concerns with me.

By signing this form you acknowledge that you have adequate information and knowledge to be able to make a decision about hormone therapy and that you understand the information your medical provider has given you. Based on this information;

_____ I choose to begin estrogen only.

_____ I choose to begin taking androgen blockers only.

_____ I choose to begin both estrogen and androgen blockers.

_____ I do not want to begin hormone therapy.

_____ Patient's name on health insurance

_____ Patient's preferred name, if different

_____ Patient signature

_____ Date

_____ Provider name

_____ Provider signature

_____ Date

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A5-6. Onset and Timing Effects of Hormone Therapy

Masculinizing Effects of Testosterone		
Effect	Onset (months)	Maximum (years)
Skin oiliness/acne	1-6	1-2
Fat redistribution	1-6	2-5
Cessation of Menses	2-6	
Clitoral Enlargement	3-6	1-2
Vaginal atrophy	3-6	1-2
Emotional changes		
Increased sex drives		
Deepening of voice	3-12	1-2
Facial/Body Hair Growth	6-12	4-5
Scalp Hair Loss	6-12	
Increased Muscle Mass & Strength	6-12	2-5
Coarser Skin/Increased Sweating		
Weight Gain/Fluid Retention		
Mild Breast Atrophy		
Weakening of Tendons		

* Masculinizing effects are shown in their general order of appearance.
** Permanent effects are indicated in red.

Feminizing Effects of Estrogens & Anti-androgens		
Effect	Onset (months)	Maximum (years)
Decreased Libido	1-3	3-6
Decreased Spontaneous Erections		
Breast Growth	3-6	24-36
Decreased Testicular Volume	3-6	24-36
Decreased Sperm Production	Unknown	Unknown
Redistribution of Body Fat	3-6	24-36
Decrease in Muscle Mass	3-6	12-24
Softening of Skin	3-6	Unknown
Decreased Terminal Hair	6-12	> 36

NOTE: Possible slowing or cessation of scalp hair loss, but no regrowth. No change in voice.

* Feminizing effects are shown in their general order of appearance.
** Permanent effects are indicated in red.

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

A Risk is greater with oral estrogen administration than with transdermal estrogen administration.
B Additional risk factors include age.
C Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

ESKENAZI HEALTH CENTER OF EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH
Indianapolis, Indiana

Rev. 2/16 | INFORMED CONSENT FOR MASCULINIZING HORMONE THERAPY - PAGE 1 OF 3

The use of hormone therapy for gender transition/affirmation is based on many years of experience treating trans persons. Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood.

This informed consent asks you to consider the expected benefits of hormone therapy and the possible side effects of hormone therapy, so that you can decide, with your medical provider, if hormone therapy is right for you. By signing this form, you are stating that you have discussed the risks and benefits with your medical provider or a member of the medical team and that you understand and accept how these apply to you personally.

Testosterone is used to masculinize the body, to reduce the female features and increase the masculine features. Your medical provider will determine the form of testosterone (shots, gels or creams, patches, implanted pellets) and the dose that is best for you based on your personal needs and wishes, as well as any medical or mental health conditions you might have. Each individual person responds to testosterone differently, and it is difficult to predict how each person will respond. You agree to take the testosterone only as prescribed and to discuss your treatment with your doctor before making any changes.

The Expected Effects of Masculinizing Hormone Therapy

The masculine changes in the body may take several months to become noticeable and usually take up to 3 to 5 years to be complete.

Changes that will be PERMANENT; they will not go away, even if you decide to stop testosterone therapy:

- The pitch of your voice becomes deeper
- Increased growth thickening and darkening of hair on the body.
- Growth of facial hair.
- Possible hair loss at the temples and crown of the head (male pattern baldness) with possible complete baldness.
- Increase in the size of the clitoris/phallus.

Changes that are NOT PERMANENT and will likely reverse if testosterone therapy is stopped:

- Menstrual periods will stop, usually within a few months of starting testosterone.
- Possible weight gain. If you gain weight, this fat will tend to go to the abdomen and mid-section, rather than the buttocks, hips and thighs, making the body look more masculine,.
- Increased muscle mass and upper body strength.
- Possible feeling of more physical energy.
- Skin changes, including acne that may be severe.
- Increased sex drive.
- Changes in mood or thinking may occur; you may find that you have a decreased emotional reaction to things and possible increased feelings of anger or aggression. Some persons find that their mental health improves after starting hormone therapy. The effects of hormones on the brain are not fully understood.

_____ I have questions about the possible effects of testosterone.

_____ My medical provider or a member of the medical team has answered my questions about the effects of testosterone.

The Risks and Possible Side Effects of Testosterone Therapy

- Possible loss of fertility; you may not be able to get pregnant after being on testosterone therapy for some time; how long this might take to be a permanent effect is unknown. Some persons choose to harvest and bank eggs before starting on testosterone therapy.
- Testosterone is not reliable birth control, however. Even if your periods stop, you could get pregnant; if you are having penetrative sex with a natal male partner, you should discuss using some form of birth control with your medical provider.
- If you do get pregnant while taking testosterone, the high levels of testosterone in your system may cause harm and even death to the developing fetus.
- Other effects of testosterone on the ovaries and on developing eggs are not fully known.
- Some trans men, after being on testosterone for a number of months, may develop pelvic pain; often this will go away after some time, but it may persist; the cause of this is not known.
- The lining of the cervix and walls of the vagina may become more dry and fragile; this may cause irritation and discomfort; it also may make you more susceptible to sexually transmitted infections and HIV if you have unprotected penetrative sex.
- The effects on the risk of breast, uterine and ovarian cancer is not known.
- Possible changes in cholesterol, higher blood pressure and other changes to the body that might lead to an increased risk of cardiovascular disease (heart attacks, strokes and blockages in the arteries).
- Possible changes in the body that might increase the risk of developing diabetes.
- Increased appetite and increased weight gain from both muscle and fat.
- Increased risk of apnea (breathing problems while you are sleeping).
- Possible abnormalities in blood tests for the liver; possible worsening of damage to the liver from other causes.
- An increase in the hemoglobin and hematocrit (the number of red blood cells); if this increases to levels higher than is normal in males, it may cause problems with circulation, such as blood clots, strokes and heart attacks.
- Increased sweating.
- Weakening of tendons and increased risk of injury.
- Possible worsening or triggering of headaches and migraines.
- Possible increase in frustration, irritability or anger; possible increased aggression and worsened impulse control.
- Possible worsening of bipolar disorder, schizophrenia and psychotic disorders or other unstable moods.

_____ I have questions about the risks of testosterone treatment.

_____ My medical provider or a member of the medical team has answered my questions about the risks of testosterone.

_____ I would like to discuss ways to help me quit smoking.

You understand

- Smoking cigarettes may increase some of the risks of taking testosterone therapy.
- Taking testosterone in doses that are higher than recommended will increase the risks of testosterone treatment; higher doses will not necessarily work better to masculinize the body; in fact, abnormally high amounts of testosterone can be converted to estrogen that may interfere with masculinization.
- Testosterone treatment is expected to be lifelong; suddenly stopping testosterone after a long time on the medication may have negative health effects.
- You may choose to stop hormone therapy at any time and for any reason. You are encouraged to discuss this decision with your medical provider.

- Your provider may decrease the dose of testosterone or stop prescribing testosterone because of medical reasons and/or safety concerns; you can expect, that the medical provider will discuss the reasons for all treatment decisions with you.
- Hormone therapy is not the only way that a person may appear more masculine and live as a male; your medical provider and/or a mental health provider can help you think about these other options.

You agree to

- Take testosterone only at the dosage and in the form that your medical provider prescribes.
- Inform your medical provider if you are taking or start taking any other prescription drugs, dietary supplements, herbal or homeopathic drugs, or street/recreational drugs or alcohol so that you can discuss possible interactions with and effects on your hormone treatment.
- Inform your medical provider of any new physical symptoms or any medical conditions that may develop before or while you are taking testosterone and discuss the evaluation of these conditions; inform your provider if you think you are having bad side effects from the testosterone.
- Keep regular follow up appointments; this may include appointments for Pap smears, pelvic exams and mammograms.
- Have regular monitoring blood testing done; your provider will discuss with you what tests are necessary in order to monitor for potential harmful effects and to ensure that your testosterone treatment is safe and effective.

_____ I have questions about my rights and responsibilities with taking hormone therapy.

_____ My medical provider has discussed my questions and concerns with me.

By signing this form you acknowledge that you have adequate information and knowledge to be able to make a decision about hormone therapy and that you understand the information your medical provider has given you. Based on this information;

_____ I choose to begin testosterone therapy.

_____ I do not want to begin testosterone therapy.

_____ Patient's name on health insurance

_____ Patient's preferred name, if different

_____ Patient signature

_____ Date

_____ Provider name

_____ Provider signature

_____ Date

A5-6. Onset and Timing Effects of Hormone Therapy

Masculinizing Effects of Testosterone		
Effect	Onset (months)	Maximum (years)
Skin oiliness/acne	1-6	1-2
Fat redistribution	1-6	2-5
Cessation of Menses	2-6	
Clitoral Enlargement	3-6	1-2
Vaginal atrophy	3-6	1-2
Emotional changes		
Increased sex drives		
Deepening of voice	3-12	1-2
Facial/Body Hair Growth	6-12	4-5
Scalp Hair Loss	6-12	
Increased Muscle Mass & Strength	6-12	2-5
Coarser Skin/Increased Sweating		
Weight Gain/Fluid Retention		
Mild Breast Atrophy		
Weakening of Tendons		

[1] Masculinizing effects are shown in their general order of appearance.
[2] Permanent effects are indicated in red.

Feminizing Effects of Estrogens & Anti-androgens		
Effect	Onset (months)	Maximum (years)
Decreased Libido	1-3	3-6
Decreased Spontaneous Erections		
Breast Growth	3-6	24-36
Decreased Testicular Volume	3-6	24-36
Decreased Sperm Production	Unknown	Unknown
Redistribution of Body Fat	3-6	24-36
Decrease in Muscle Mass	3-6	12-24
Softening of Skin	3-6	Unknown
Decreased Terminal Hair	6-12	> 36

NOTE: Possible slowing or cessation of scalp hair loss, but no regrowth. No change in voice.

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Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

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What You Need to Know About Filling Prescriptions and Prior Authorizations for Medication

How does my prescription get to the pharmacy? Which pharmacy will it go to?

You can choose to fill your prescription at any pharmacy that accepts your health insurance. Take your paper prescription to the pharmacy, or your provider can send it electronically. Always tell your provider's office which pharmacy you use. It is very important to tell your provider if you change to a different pharmacy.

Please note, some prescription medications are not allowed to be sent electronically. Ask your provider for details about your prescriptions.

What name will be on my prescription?

Your prescription has to be written using the name on your health insurance card. If you do not have health insurance, your prescription has to match the name on your ID.

When you change your legal name, call your health insurance company to report your name change. Eskenazi Health cannot change the legal name on your medical chart until we have a copy of your new health insurance card or ID.

Do I have to show my ID to pick up a prescription?

If you are picking up a medication that is a controlled substance, you will be asked to show your ID. A controlled substance is a drug that has laws regulating its use and distribution. Testosterone is a controlled substance and will always require you or someone with you to show an ID.

The pharmacy says my insurance won't cover my prescription. What should I do?

Ask the pharmacist for the reason your medicine is not covered. If the medication needs a prior authorization, please see the question below. If the medication is not covered for another reason, please call your provider or send a message to your provider through MyChart to discuss the reason and available options.

My prescription needs a prior authorization. What does that mean, and how do I get one?

Your pharmacy will try to fill your prescription using your health insurance. Sometimes prescriptions are denied because they need prior authorization. Prior authorization is a process used by health insurance companies to decide if they will cover a medication. It is an extra step to help improve patient safety and reduce cost.

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Your pharmacy should tell your provider, either electronically or by fax, that your medication needs a prior authorization. Sometimes the provider does not get the message. You can send your provider a message through MyChart, or call the Eskenazi Health Gender Health Program office at 317.880.6042, choose your language preference and then select No. 3 to let us know your medication needs a prior authorization. You can also ask your pharmacy to fax a notice to your provider at 317.880.0445.

We will contact your insurance company. If the insurance company approves the prior authorization, your pharmacy can fill your prescription right away. Your pharmacy will notify you when it is ready to pick up.

How long will it take to get prior authorization?

Every insurance company is different. Most make a decision in a few days, but some can take up to two weeks. To check on the status of your prior authorization, call your pharmacy to see if your prescription will go through. You can also send a message to your provider through MyChart, or call the office at 317.880.6042, choose your language preference and then select No. 3.

What if my prior authorization gets denied?

Sometimes insurance companies deny prior authorizations. If that happens, you and your provider will get a letter explaining why it was denied. If you get a denial, please contact your provider to talk about what to do next.

I want to use a different pharmacy. How do I change?

Call your new pharmacy and ask them for help transferring your prescription. Have the phone number of your old pharmacy available. Your new pharmacy will tell you when your next refill is ready to pick up.

Please note, medications that are controlled substances can only be transferred once. If you need to change pharmacies more than once and you have a prescription for a controlled substance (including testosterone), send a message to your provider through MyChart, or call the office at 317.880.6042, choose your language preference and then select No. 3.

What if I can't afford to pay for my prescription?

Prescriptions can be expensive even with health insurance. If your prescription costs more than you can afford, send a message to your provider through MyChart, or call the office at 317.880.6042, choose your language preference and then select No. 3. There may be other ways to lower the cost.

How do I get a refill of my prescription?

The first time you fill your prescription, the medicine label will tell you how many more times you can refill it before you need a new prescription from your provider. If you have refills left, please call your pharmacy and ask them to refill your prescription. If you do not have any refills left, your provider will need to send a new prescription to your pharmacy. Please let your provider know you need a new prescription by sending a message through MyChart or calling the Eskenazi Health Gender Health Program office at 317.880.6042, choose your language and then select No. 3.

Eskenazi Health Gender Health Program Phone Number 317.880.6042
Eskenazi Health Gender Health Program Fax Number.....317.880.0445

Support Groups

The support of other people who have shared experiences can be immensely helpful, especially during the many changes that come with transitioning. Here are some support groups around Indiana for gender diverse people to come and talk about the challenges we face and the joys we experience, share resources and information, and find community.

GenderNexus
3733 N. Meridian St., Ste. 310
Indianapolis, IN 46208
317-650-5988
https://gendernexus.org/calendar/
See website calendar for group dates & times

TransIndy
Visit website to request to join closed Facebook group for meeting information
https://transindy.org

Indiana Youth Group (ages 12-24)
3733 N. Meridian St.
Indianapolis, IN 46208
317-541-8726
www.indianayouthgroup.org
See website calendar for all group dates & times

Trans Solutions Research and Resource Center
104 E. 38th St.
Indianapolis, IN 46205
317-602-4431
https://transsolutionsrrc.org

BU Wellness Network
1712 N. Meridian St., Ste. 200
Indianapolis, IN 46202
317-931-0292
https://buwellness.org
See Services -> Support for current groups

Damien Center
26 North Arsenal Ave.
Indianapolis, IN 46201
317-632-0123
https://damien.org
See Events calendar for group dates & times

Muncie OUTreach
www.muncieoutreach.org
See Events calendar for group dates & times

Trans Lafayette
Pride Lafayette Community Center
640 Main St.
Lafayette, IN 47901
765-423-7579
www.facebook.com/translafayette

Mosaic Health & Healing Arts
330 Lakeview Dr.
Goshen, IN 46528
574-537-2680
https://mosaichha.org/calendar/
See calendar for group dates & times and info for how to reserve a spot

Pride Center of Terre Haute
630 Wabash Ave.
Terre Haute, IN 47807
812-244-1329
www.pridecenterterrehaute.org
See Services for groups and contact info

Tri-State Alliance
501 John St., Ste. 5
Evansville, IN 47713
812-480-0204
www.facebook.com/tristatealliance

Virtual Grief Support Group – LGBTQIA Community Members Grieving Loved Ones
Peer-led group supported by https://mygriefangels.org
Register in advance at Eventbrite

Dis-Queer: A Disability LGBTQIA+ Support Group
accessABILITY Indiana at www.abilityindiana.org
Register in advance at Eventbrite