

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

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1 DANIEL WEISS, M.D.
 2 the witness herein, having been first duly sworn to
 3 tell the truth, the whole truth, and nothing but the
 4 truth, was examined and testified as follows:
 5 EXAMINATION,
 6 QUESTIONS BY MR. SELDIN:
 7 Q Dr. Weiss, good morning.
 8 A Good morning.
 9 Q My name is Harper Seldin. I'm an attorney for the
 10 plaintiffs. You and I will be doing this
 11 deposition today.
 12 Just a couple table setting things, have you
 13 ever been deposed before?
 14 A I have.
 15 Q How many times?
 16 A Two times.
 17 Q When was that?
 18 A That is mentioned in my C.V. The last time was
 19 2021. The time before that I believe was 1993,
 20 but the C.V. will indicate with certainty.
 21 Q Great. So when you are referring to your C.V.,
 22 you are referring to the two prior times you
 23 served as an expert witness in other matters?
 24 A Yes.
 25 Q Great. Okay. So some of this will be familiar to

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1 you, but we will go over it anyway just so we are
 2 on the same page.
 3 Today I will be asking you questions. You
 4 will provide answers. Those answers must be
 5 verbal. Head shakes will not come through.
 6 Uh-huh, huh-uh will not come through.
 7 If you answer a question, I will assume that
 8 means that you understood my question. If you
 9 don't understand my question, let me know and we
 10 will try again.
 11 Does that sound good to you?
 12 A It does. I understand.
 13 Q Now, is there any reason today, medication or
 14 otherwise, that you would not be able to
 15 understand me, understand my questions, and
 16 provide truthful responses?
 17 A No.
 18 Q Okay. The only other thing I will say is let's
 19 just try not to talk over each other. Even if you
 20 anticipate where I'm going, let me finish my
 21 question. I will try to let you finish your
 22 answer. That way Wendy will not yell at us, which
 23 is always my goal.
 24 The other thing is if you need to take a
 25 break at any time, let me know. I just ask if

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1 there is a question pending that you answer the
2 question and then we can take a break.
3 A I understand.
4 Q Great. Do you have anyone in the room with you
5 today?
6 A No.
7 Q Do you have any notes with you today?
8 A No.
9 Q Do you have a copy of your declaration in this
10 matter with you?
11 A I do.
12 Q Great. That will make it easy.
13 MR. SELDIN: Just for purposes of making
14 sure we have the exhibits right, Erica, would you
15 pull up what is marked as Weiss Exhibit 1. Great.
16 Q Does this appear to be the expert declaration that
17 you submitted in this case, or the first page of
18 it?
19 A It does.
20 Q You can see this PDF has about 113 pages on it.
21 Does that sound about right?
22 A It does.
23 Q Is this the same document as the one you have in
24 front of you?
25 A Yes.

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1 Q Does this declaration contain all of the opinions
2 that you intend to offer in this case?
3 A No.
4 Q What other opinions do you intend to offer in this
5 case?
6 A Other opinions might arise during the deposition.
7 Q Okay. So as of right now, these are all of the
8 opinions that you intend to offer in this case?
9 A They are.
10 Q Okay. So there are no additional opinions in your
11 mind or elsewhere that you intend to offer. As we
12 talk you may have further opinions?
13 A That is correct.
14 Q Okay.
15 MR. SELDIN: Could you pull up Exhibit 2.
16 Q Dr. Weiss, I'm showing you Exhibit 2. You will
17 see it has the case caption and notice of
18 deposition and request for production of
19 documents.
20 Have you seen this document before?
21 A I don't recall receiving this document, seeing
22 this document, no.
23 Q I will represent to you that it's the notice of
24 deposition and request for production of documents
25 that we gave to the State Attorney General's

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1 office in connection with this deposition.
2 If you look midway down the page it says
3 Request for Production of Documents. This is a
4 request from the plaintiff that you produce in
5 connection with this deposition your current C.V.
6 first.
7 Starting there, do you see that request?
8 A I do.
9 Q You included a C.V. with your declaration. Is
10 that your current C.V.?
11 A Yes.
12 Q Okay. I believe if you scroll all of the way to
13 the back of your C.V., Page 75 it's dated May 10,
14 2023.
15 A That is correct.
16 Q I take it there have been no changes to this in
17 the last sixteen days?
18 A Correct.
19 Q Great. Then, in addition, you will see back to
20 Exhibit 2 at the bottom of the page it asks that
21 you provide, "The declaration report, and rebuttal
22 report the deponent has most recently submitted as
23 an expert witness in any litigation related to the
24 provision of gender-affirming care to minors, if
25 such a declaration, report or rebuttal report has

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

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

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1 To prepare for today's deposition did you
2 speak to Ms. Youngs or any of the other attorneys
3 at the Attorney General's office?
4 A Yes.
5 Q Okay. When did you talk to them?
6 A Yesterday.
7 Q And for about how long?
8 A Oh, about two hours.
9 Q And do you recall which attorneys were present?
10 A Ms. Youngs and Mr. Fisher.
11 Q Was there anyone else present during your
12 preparation?
13 A No, there was not.
14 Q Other than that two hour conversation yesterday
15 with Mr. Fisher and Ms. Youngs, did you speak to
16 anyone else to prepare for today's deposition?
17 A No.
18 Q Okay. Did you speak with any of the other defense
19 experts in this case to prepare for today's
20 deposition?
21 A No.
22 Q Okay. Did you review the, to prepare for today's
23 deposition did you review any of the expert
24 declarations from the plaintiff experts.
25 Dr. Shumer, Dr. Karasic, Dr. Turban?

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1 A Yes, all three of them.
2 Q And have you reviewed the transcripts of their
3 depositions in this case?
4 A Only Dr. Turban's.
5 Q Do you recall when you reviewed Dr. Turban's
6 deposition?
7 A About a week ago.
8 Q Any other materials you can think of that you read
9 to prepare for today's deposition?
10 A No.
11 Q Have you spoken with any of the defense experts in
12 this case in any context at all?
13 A No.
14 Q Okay. So we know we are talking about the same
15 folks, have you ever had a conversation with
16 Dianna Kenny?
17 A No.
18 Q Kristopher Kaliebe?
19 A No.
20 Q Paul Hruz?
21 A No.
22 Q James Cantor?
23 A No.
24 Q I want to talk a little bit about your
25 professional background.

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

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

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

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

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

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

Page 19

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

Page 20

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

Page 21

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

Page 22

1 is that correct?

2 A Yes.

3 Q Is it fair to say then that this has been a

4 running list of your continuing medical education

5 participation from 1985 to 2021?

6 A It's not complete because there will be continuing

7 medical education I will do but from reading

8 journal articles or from going online, going to an

9 online reference called Up To Date.

10 So this extensive number of so-called

11 category one credits I would obtain from that. I

12 don't list that on the C.V.

13 Q So then is this list of sixty-four classes just

14 ones that you have physically attended as opposed

15 to done online?

16 A That is correct. Basically meetings that might be

17 online meetings or more often in-person meetings.

18 Q Okay. So you may have done additional continuing

19 medical education independently online --

20 A Correct.

21 Q -- but that might not be covered here?

22 A Correct. And you will notice it says 2021. That

23 is the time when we happened to have a worldwide

24 pandemic.

25 Q Roundabout then, yes.

Page 23

1 A Yeah.

2 Q It seems that these seem to be mostly about

3 diabetes and metabolic disorders.

4 Is that about right?

5 A The broad area of diabetes endocrinology, yes.

6 There are other internal medicine related topics.

7 Correct.

8 Q Is any of this continuing medical education

9 pertaining to assessing gender dysphoria?

10 A No.

11 Q Does any of it pertain to diagnosing gender

12 dysphoria?

13 A No.

14 Q Does any of this pertain to treating gender

15 dysphoria?

16 A No.

17 Q Does any of it pertain to providing

18 gender-affirming care?

19 A I don't use that term. But treating gender

20 dysphoria does not relate to that.

21 Q And why don't you use the term gender-affirming

22 care?

23 A Perhaps we can defer that to later on in the

24 discussion because it's not -- I think it's gender

25 harming care. It's person harming care. It is a

Page 24

1 euphemistic term that is not appropriate to the

2 interventions that are, that some practitioners

3 apply to these minors. I think it's harmful. So

4 I don't call it gender-affirming.

5 Q So as part of your explanation you said it's

6 harmful to minors.

7 Do you also believe it's harmful to adults?

8 A Yes.

9 Q So you would not use the term gender-affirming

10 care for a person of any age?

11 A Correct.

12 Q So when I use the term gender-affirming care I'm

13 referring to in some part the medical procedures

14 that are listed in Senate Enrolled Act 480 in this

15 case.

16 If I refer to that broadly as treating gender

17 dysphoria, would we understand each other?

18 A I think it is a better term to use the term

19 treating gender dysphoria with hormones, puberty

20 blockers, surgery.

21 I would not call it gender-affirming care. I

22 think it is euphemistic and misleading language.

23 Q So just to make sure that we continue to

24 understand each other in this deposition, I will

25 likely use the terms gender-affirming care and

Page 25

1 treating gender dysphoria interchangeably.

2 You and I will understand that we are talking

3 about the same kind of care. You just have a

4 different view about whether gender-affirming care

5 is the appropriate way to characterize it, is that

6 fair?

7 A That is a fair statement.

8 MS. YOUNGS: And if necessary, can we

9 specify as to what aspect because it is kind of a

10 large umbrella and it might be confusing.

11 MR. SELDIN: I think we can figure it out

12 as we go along in the context.

13 Q It's fair to say then that you have had no

14 continuing medical education about treating gender

15 dysphoria since 1985?

16 A No, I don't think that is fair. Because

17 continuing medical education includes studying the

18 scientific literature. It may not be category one

19 credit based upon the AME designation of what

20 category one is.

21 But it would be category two credit. I have

22 had extensive category two credits, but I don't

23 list category two credits on this C.V.

24 Q What is the difference between category one and

25 category two credits?

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1 A It is a designation that the AMA comes up with.
2 If you are studying a publication, analyzing it
3 carefully and reading it, that is considered
4 category two.
5 But if you are attending a meeting and they
6 have certified it as category one, then you get
7 category one credit. You can click on some sites
8 and get category one credit pretty easily.
9 But category two credit is still very
10 meaningful. Reading journal articles. Reading
11 the scientific literature. I have done extensive
12 reading on gender dysphoria that would be, that
13 would achieve many, many credits in category two.
14 Q And in terms of maintaining your medical license,
15 do category two credits count towards that?
16 A They do, but they are not as important. You have
17 to have a minimum of category one for maintaining
18 your license.
19 Q Is there a minimum number for category two?
20 A No.
21 Q So is it fair to say then that you could not
22 maintain your medical license merely by using
23 category two credits?
24 A That is correct.
25 Q Okay. I take it then when you have category one

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1 credits you receive some kind of a certificate or
2 acknowledgment so when the licensing board asks if
3 you are current you can demonstrate you have
4 attended the requisite number. Is that fair?
5 A That is correct.
6 Q Lawyers have something similar so I'm assuming
7 there are so many ways to track continuing
8 education of any kind.
9 Do you receive similar acknowledgments for
10 category two credits?
11 A No.
12 Q So pardon my ignorance. Is there such a thing as
13 category three?
14 A I have never heard of it.
15 Q Is it fair to say then that you have independently
16 researched and read about the treatment of gender
17 dysphoria which you characterize as category two
18 credits, but you don't have a running list of
19 that?
20 A Correct.
21 Q Do you recall the first time that you pursued any
22 continuing medical education about the treatment
23 of gender dysphoria?
24 A I was doing some reading during a period of time
25 when I was treating adults, which was

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1 approximately 2003 to 2013. So I read the
2 literature during that period of time.
3 Q So you have been in practice since about 1985, is
4 that right?
5 A Practice outside of Iowa since 1986.
6 Q Right. So from 1986 to 2002, let's say, you did
7 not have any continuing, any medical education
8 about the treatment of gender dysphoria. That all
9 began in 2003?
10 A I don't think that is accurate to state that
11 because there was some treatment of gender
12 dysphoria during my training in Iowa at the
13 University of Iowa.
14 There was a physician who was probably the
15 only doctor in the state treating adults with
16 gender dysphoria. I learned aspects of treatment
17 from him. That would have been during my
18 fellowship at the University of Iowa in the 1980s.
19 Q Who was that doctor?
20 A Dr. John MacIndoe.
21 Q I'll claim this is for the court report, but it's
22 for me, can you spell that?
23 A M-A-C-I-N-D-O-E.
24 Q Tell me a little bit about this training that you
25 received at the University of Iowa with

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1 Dr. MacIndoe?
2 A So he would see an occasional adult patient with
3 gender dysphoria. I would go into the exam room
4 and assess the patient along with Dr. MacIndoe and
5 talk about hormonal interventions.
6 Q About how many of those patients do you think you
7 encountered with Dr. MacIndoe?
8 A Maybe twelve.
9 Q Over what period of time?
10 A Years.
11 Q Two years? Four years?
12 A Two years.
13 Q Two years. Was that the length of your fellowship
14 at the University of Iowa?
15 A Yes.
16 Q Was your fellowship in a particular specialty?
17 A Yes. So the training, you know, there's four
18 years of medical school after college. And then
19 there is residency, which is three years. And
20 then two years of fellowship.
21 So the fellowship, my expertise, my
22 fellowship is in that subspecialty of internal
23 medicine called endocrinology metabolism.
24 Q So over the course of your two year endocrinology
25 fellowship with Dr. MacIndoe you believe you

Page 30

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

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1 Q So you would not have been diagnosing them with --
2 A No, I was not.
3 Q And do you recall what treatments these
4 approximately twelve adults were provided as a
5 result of Dr. MacIndoe's care?
6 A It was opposite sex hormone treatment.
7 Q When you say opposite sex hormone treatment, what
8 do you mean?
9 A So biologic males were given estrogen or androgen
10 blockers. Biologic females were given
11 testosterone.
12 Q And for these twelve patients do you recall how
13 many times you would have seen them?
14 A Maybe three times for each of the twelve patients.
15 Q Did Dr. MacIndoe in your presence speak to these
16 patients about how their treatments were working?
17 A Yes.
18 Q And what did they tell you and Dr. MacIndoe?
19 A That was a long time ago so I can't recall
20 specifics on that.
21 Q Do you recall generally how these twelve adults
22 fared on this treatment?
23 A My recollection from forty years ago is that they
24 valued the physical changes that they were
25 experiencing.

Page 32

1 Q Did you keep in touch with Dr. MacIndoe?
2 A No.
3 Q During your two year fellowship you would see
4 these patients as part of learning as a fellow
5 with Dr. MacIndoe.
6 Did you have any experience treating gender
7 dysphoria between the end of your fellowship and
8 2003?
9 A I don't recall treating when I was with University
10 Mednet, no. I think I only was treating when I
11 was an independent practice from 2003 on. There
12 were relatively few patients until the last decade
13 or so. Ten, fifteen years.
14 Q Between the end of your fellowship and 2003 did
15 you advertise any clinical expertise in treating
16 gender dysphoria?
17 A I did not advertise at all. I didn't need to.
18 Patients would come to me with their endocrine
19 disorders. I was not promoting myself. I didn't
20 need to. I was a sole endocrinologist in this
21 group of 110 doctors. I didn't speak up or talk
22 about my expertise in that area because there was
23 no need to. There were patients sent to me for
24 that.
25 Q So you didn't treat any patients' gender dysphoria

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1 from the end of your fellowship until 2003?
2 A Correct. They were not sent to me. I was not
3 asked to treat them.
4 Q Did you have any patients who were transgender
5 between the end of your fellowship and 2003?
6 A I don't recall.
7 Q Looking at your C.V. if you look at Page 16, Roman
8 Numeral XII, do you see your bibliography?
9 A Yes.
10 Q You will see that this runs through Page 18.
11 There is a Number 26 for the last publication.
12 Do you see that as well?
13 A I do.
14 Q Do any of these publications in your bibliography
15 pertain to the treatment of gender dysphoria?
16 A None.
17 Q Do any of them pertain to the assessment or
18 diagnosis of gender dysphoria?
19 A No.
20 Q Have you ever conducted any original research
21 about gender dysphoria?
22 A No.
23 Q Have you ever conducted any original research
24 about gender identity or transgender people?
25 A No.

Page 34

1 Q Have you published any peer reviewed articles
2 about the treatment of gender dysphoria?
3 A No.
4 Q Have you published any not peer reviewed articles
5 about gender dysphoria?
6 A No.
7 Q Thank you, Dr. Weiss. I'm now going to turn to
8 Page 20 of your C.V. This is Roman Numeral XIII,
9 Presentations to Medical Professionals.
10 A Yes.
11 Q You will see that first presentation is dated
12 March 31, 1981, correct?
13 A Correct.
14 Q Then if we go to Page 62 of your C.V., you will
15 see that the last entry is 564 and is dated
16 November 9, 2022.
17 Do you see that?
18 A Say that again.
19 Q I'm saying do you see the last entry in this
20 section?
21 A 564?
22 Q Yes.
23 A Yes, I see it.
24 Q Is it fair to say then this is a complete list of
25 your presentations from 1981 to 2022?

Page 35

1 A That is correct. This is to medical
2 professionals, yes.
3 Q Are any of these presentations regarding gender
4 dysphoria or its treatment?
5 A No.
6 Q On Page 63 of your C.V. it says, "Note, Dr. Weiss
7 continues to be a speaker presenting at programs
8 across the United States. However, as of June
9 2007 only programs that were non-promotional in
10 nature are listed above."
11 Did I read that correctly?
12 A You did.
13 Q What does that mean?
14 A So I have been a speaker for pharmaceutical
15 companies and those presentations relate to their
16 medications and teaching doctors about these new
17 medications.
18 So I listed some of those. Many of those
19 were listed early on among those presentations to
20 medical professionals.
21 As of June 2007 only the programs that were
22 not promotional, that were not pharmaceutical
23 related were listed. So those were just didactic
24 in nature without a sponsor by a pharmaceutical
25 company.

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

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

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1 morning programs so they don't interfere with
 2 patient care.
 3 Q And you listed Mounjaro as one of the medications
 4 that you do promotional presentations for.
 5 Are there other medications that you have
 6 done presentations for? That was a bad question.
 7 I'm trying to ask you of the medications that
 8 you have made promotional presentations about,
 9 have they all related to the treatment of
 10 diabetes?
 11 A No. So there have been medications for treating
 12 cholesterol. There have been medications for
 13 treating osteoporosis. There have been
 14 medications for treating diabetes. Medications
 15 related to obesity.
 16 There are so many over the years because I
 17 have been in practice for over thirty-five years.
 18 I have been doing promotional programs since the
 19 1980s.
 20 Q Of the medications that you have done these
 21 promotional presentations for, have any of them
 22 been for the treatment of gender dysphoria?
 23 A No.
 24 Q Okay.
 25 A Let me also spell Mounjaro for the court reporter.

Page 39

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

Page 40

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

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1 Q Why was that?
 2 A Most endocrinologists that I have interacted with
 3 are not on board with, are not convinced that the
 4 evidence is good or they are uncomfortable
 5 treating with opposite sex hormones for those
 6 people with gender dysphoria so they don't see
 7 those people.
 8 Q When you say uncomfortable, do you mean because of
 9 their perception of the evidence base or some
 10 other reason?
 11 A I think it's their perception of the evidence
 12 base, yes.
 13 Q What would you say in response to that?
 14 A Now I would support them. I can understand their
 15 feeling that the evidence is very weak because it
 16 is both for adults and for children.
 17 Back then when I was treating, obviously, I
 18 was not aware of how weak the evidence was.
 19 I was offering treatment. I was the
 20 principal person in northern Ohio treating people
 21 with gender dysphoria during that ten years of
 22 time I was treating.
 23 Q But at the time you were providing treatment to
 24 adults?
 25 A Correct.

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

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1 their care. Or I should say more specifically,
2 they didn't follow up with me so I suspect they
3 discontinued their care because there was no one
4 else who could offer that care in the area.
5 Q When you say that you stopped seeing new patients,
6 what year did you stop seeing new patients for the
7 treatment of gender dysphoria?
8 A 2013.
9 Q Have you seen any patient for the treatment of
10 gender dysphoria since 2013?
11 A For the treatment of gender dysphoria, no.
12 Q Okay. So I want to make sure I have the timeline
13 correct. From 2003 to 2013 you saw patients for
14 the treatment of gender dysphoria.
15 In 2013 you stopped seeing new patients for
16 the treatment of gender dysphoria.
17 A Correct.
18 Q So for the existing patients that you had with
19 gender dysphoria, the last one of those people
20 that you saw would have also been in 2013?
21 A No. No. I continued seeing them until I left
22 Ohio.
23 Q What year was that?
24 A I left Ohio in December of last year, 2022.
25 Q So when was the last time you saw a patient that

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1 you were treating for gender dysphoria?
2 A Around that time. December of 2022.
3 Q Okay. So in your declaration I think you said
4 that you treated approximately one hundred
5 patients for gender dysphoria, is that correct?
6 A Yes.
7 Q Does that hundred patients include the twelve you
8 saw during your fellowship?
9 A No.
10 Q Okay. Of the hundred patients that you saw, that
11 was from 2003 to really 2020, right?
12 A 2022.
13 Q 2022. I apologize. Well, from when you left
14 Ohio?
15 A Yes.
16 Q Okay. So how many of those patients do you think
17 you treated continually over that period of time?
18 A Well, if seventy percent left that would leave
19 thirty.
20 Q So when you left Ohio in 2022 you still had thirty
21 patients you were treating for gender dysphoria?
22 A Correct.
23 Q Okay. And what did you tell them about why you
24 would be discontinuing care with them?
25 A Moving to Utah.

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

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

Page 47

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

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

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

Page 50

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

Page 51

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

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

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1 A Yes.
2 Q Did either of these cases involve the treatment of
3 gender dysphoria?
4 A No.
5 Q Did either case involve anyone who was transgender
6 to the best of your knowledge?
7 A No.
8 Q Are there any other cases that you were a
9 testifying expert that you didn't include here?
10 A No.
11 Q Are there any cases where you were a consulting
12 expert that you didn't include here?
13 A No.
14 Q Are there any other cases where you have been
15 retained as an expert, but have not yet testified?
16 A Not that I recall.
17 Q There are several other states that have passed
18 laws similar to Senate Enrolled Act 480.
19 You are not an expert in any of those, are
20 you.
21 A No. I have submitted written testimony in
22 multiple states for legislation similar to the
23 Indiana bill, but I've not provided any expert
24 declarations in any other states.
25 Q And you have not been retained as part of

Page 54

1 litigation?
2 A No.
3 Q Is that something that you are interested in
4 doing?
5 A I think it's important to provide the science and
6 the facts and provide balance in this because I
7 think a lot of harm is being done to minors.
8 Q On Page 64 of your C.V. it has Participation in
9 Clinical Trials and then it goes to the next page.
10 For these trials what has your role been?
11 Are you the principal investigator for all of
12 these?
13 A Yes.
14 Q Okay. So in your declaration you talk about
15 having been the principal investigator in about a
16 hundred clinical trials.
17 Those are the ones listed here, is that
18 correct?
19 A Yes.
20 Q Do any of these pertain to the treatment of gender
21 dysphoria?
22 A No. It would be great if one did because there
23 are no randomized clinical trials with comparator
24 control groups for the treatment of gender
25 dysphoria in adults or minors.

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1 Q And were all these trials sponsored by
2 pharmaceutical companies?
3 A No.
4 Q Which ones were not sponsored by pharmaceutical
5 companies?
6 A The second one, the efficacy of fluoxetine. That
7 was an investigator initiated trial. I did that
8 one without funding. There was the ACCORD trial
9 in which I was a principal investigator. That was
10 analogous to a health sponsored trial. That
11 should be listed here. That is listed on Page 65.
12 That is Action to Control Cardiovascular Risk in
13 Diabetes. That was a National Institute of Health
14 sponsored trial. So that was also not a
15 pharmaceutical trial.
16 All of the others were pharmaceutical
17 sponsored trials except for Page 72, 2011 to 2012
18 Trial-Net was an NIH sponsored trial.
19 Q So with the exception of those, the rest of those
20 indicate at the end there has been a sponsor. So
21 I take it the rest of them were sponsored by
22 pharmaceutical companies?
23 A Correct.
24 Q Have you supervised any clinical research about
25 the treatment of gender dysphoria?

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

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1 in support of legislation related to gender
2 ideology.
3 Q When did you first become a senior fellow in Do No
4 Harm?
5 A It was something like March or so of this year.
6 Early this year.
7 Q March of 2023?
8 A Correct.
9 Q And how did you learn about them?
10 A It's a long -- how did I learn about them? That
11 is a short story. I just saw the, I think I saw
12 something online with regard to what their efforts
13 were.
14 The head of the organization is the former
15 dean of the University of Pennsylvania School of
16 Medicine. He is a nephrologist. He is just
17 brilliant and articulate. I think his goals are
18 wonderful. They are well -- just the motivation
19 and the goals are really noble.
20 Q And do you remember where online you learned about
21 them or what you were doing online when they
22 popped up?
23 A I do not remember.
24 Q And so that is how you learned about them. What
25 happened next?

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

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

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1 Do No Harm?
 2 A I don't think so.
 3 Q Okay.
 4 A I don't think so.
 5 Q So --
 6 A Wait. Excuse me.
 7 Q Yeah.
 8 A Yes, I must have known about Do No Harm because,
 9 as I said earlier, Do No Harm said to please send
 10 comments to Florida if you support this
 11 legislation.
 12 That is when I sent this email to Florida.
 13 And it was only because of the Do No Harm email
 14 sent to their members, most of them who are
 15 physicians I think.
 16 Q And when did you become a member of Do No Harm
 17 separate from being a senior fellow if those are
 18 different things?
 19 A They are different things. I think I became a
 20 member sometime last year. I do not recall when.
 21 It may be mentioned on my C.V. I don't think so
 22 though.
 23 Q Just so I understand the timeline, sometime in
 24 2022 you are online. You learn about Do No Harm.
 25 Is that when you became a member?

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1 A Yes, when I saw the work they were doing. Yes.
 2 Q And then you start getting Do No Harm's emails.
 3 One of them was sometime before October 24, 2022
 4 that solicits folks to send comments into Florida.
 5 And that is what prompted this email from you
 6 with the attached comments. Is that an accurate
 7 sort of summary of what we have been talking
 8 about?
 9 A Yes.
 10 Q Okay. And then did you send a copy of this to Do
 11 No Harm?
 12 A Only when asked after.
 13 Q Okay. So Do No Harm said to send comments. They
 14 say then thank you for sending comments. Please
 15 send us a copy of what you sent?
 16 A Correct.
 17 Q Then you heard back?
 18 A Yes.
 19 Q Do you remember about when between October 24,
 20 2022 and becoming a senior fellow that you heard
 21 back?
 22 A I don't remember.
 23 Q Okay. And when you did hear back who reached out
 24 to you?
 25 A Kristina Rasmussen, who is their kind of chief

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

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

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

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1 yes. I think that is right.
2 Q Other than the legislative testimony that you
3 referred to, and you listed some states just now,
4 have you ever provided legislative testimony on
5 another topic other than the treatment of gender
6 dysphoria in minors?
7 A Another topic outside of gender dysphoria?
8 Q Correct.
9 A Yes. I have submitted video testimony in Ohio
10 about not requiring vaccine mandates to people
11 before -- it had to do with vaccine mandates. It
12 was that topic.
13 Let's see what else. That was about two
14 years ago I think. I can't recall any other
15 testimony.
16 Q Would that have been vaccine mandates in Ohio?
17 A Yes.
18 Q What was your position on vaccine mandates?
19 A They should not be required by the state.
20 Q Why was that your position?
21 MS. YOUNGS: Objection. What is the
22 relevance to the vaccines?
23 Q Dr. Weiss, what was your position on the vaccines?
24 Why was that your position?
25 A My position at that point was that there was, it

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

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1 the House, Families, Aging and Human Services
2 Committee to support the Save Adolescents From
3 Experimentation Act.
4 Q Would that have been -- do you recall was that
5 HV 454?
6 A That sounds familiar.
7 Q Was this testimony May 19, 2022, does that sound
8 about right?
9 A It does.
10 Q Okay.
11 MR. SELDIN: Erica, can you pull up
12 Exhibit 32.
13 Q While Erica finds that, Dr. Weiss, I have a link
14 to the recording of that testimony.
15 My question will be is that you, is that the
16 testimony?
17 A If it looks like me it probably is.
18 Q Famous last words in the court of law. We will
19 make sure it's you.
20 MR. SELDIN: Erica, if you could get us to
21 32.
22 Q While that comes up, Dr. Weiss, so in May of 2022
23 you were not a member of Do No Harm yet?
24 A No.
25 Q You were not a senior fellow yet?

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

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

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1 he contacted me. He said would I be interested in
 2 just joining the organization. You know, it's
 3 basically a non-political organization that tries
 4 to provide the best science and the best evidence
 5 for taking care of people with gender dysphoria.
 6 So I joined.
 7 There's, they have discussions online and so
 8 on. They have several physician members that
 9 are -- I'm just, I'm just connected to them. I'm
 10 really not a member of the group in that sense.
 11 They allow me to access their kind of interactive
 12 site.
 13 Q Do you have to be a member to access the -- are
 14 you talking about -- you are on their website?
 15 A Yes, that is all. I'm not even listed. You will
 16 not find me, if you go to SEGM you won't see my
 17 name there because I'm just -- I know about them.
 18 They have their resources basically.
 19 Q Who was the doctor from SEGM who reached out to
 20 you about testifying in Ohio?
 21 A Dr. William Malone. M-A-L-O-N-E. He is an
 22 endocrinologist.
 23 Sorry. What was that question? Now repeat
 24 the question.
 25 Q You said a doctor had reached out to connect to

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1 you from SEGM, the organization CCV, is that
 2 right?
 3 A I misspoke. Okay. Right. The doctor who asked
 4 me about Ohio is Dr. Beck.
 5 Q Who is Dr. Beck?
 6 A He is actually one of the founding members of
 7 SEGM.
 8 Q You found SEGM because Dr. Malone. Once you were
 9 part of SEGM Dr. Beck got in touch and asked you
 10 about supporting this bill in Ohio?
 11 A Correct.
 12 Q Okay. And then the organization that was
 13 supporting the bill in Ohio that you were involved
 14 with related to your testimony was CCV, is that
 15 right?
 16 A I think that is what it's called. There are many
 17 organizations supporting the bill. CCV was the
 18 one that reached out to me and gave me a copy of
 19 the bill. They communicated with me.
 20 Q You will see actually we have up on the screen the
 21 Exhibit 32-C which is from CCV.org.
 22 A Okay.
 23 Q I take it that was the organization you are
 24 talking about there. I think they have a
 25 recording of your testimony online.

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1 A Okay. Good.
 2 Q Okay.
 3 A So my recollection was accurate.
 4 Q We love to hear that in a deposition. So during
 5 that testimony you talked about how you estimated
 6 that seventy-five percent of your patients failed
 7 to persist in their treatment with you.
 8 Does that sound about right?
 9 A I think I modified that to seventy percent in my
 10 statements to you earlier and in my declaration.
 11 Q But the word "persist" is the word that you used.
 12 A Okay.
 13 Q I guess my question will be what does persistence
 14 mean? Like we were speaking earlier about your
 15 patients didn't return to treatment with you.
 16 When you say didn't persist, is that what you
 17 meant?
 18 A Yes. So when they discontinued their care with me
 19 I would equate that to lack of persistence in
 20 their treatment. Although, accurately as you
 21 stated, I can't be sure what happened to those
 22 people.
 23 Q We have talked about other reasons that people
 24 might not have returned to you for care. It could
 25 have been that they lost their insurance perhaps?

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1 A Correct. Many of those people were on Medicaid.
 2 That is possible. Sure.
 3 Q It could have been possible they were happy with
 4 the results they got and didn't feel the need for
 5 further treatment?
 6 A That would be, that would be desistance if they
 7 stopped. They would not have discontinued
 8 hormonal, you know, to say -- well, then they
 9 would basically desist. They would say I don't
 10 really need this any more and they would stop
 11 hormonal treatments.
 12 Q Well, I think I'm asking a different question.
 13 There are some treatments that, I mean, someone
 14 might say I want to take testosterone because I
 15 want my voice to be lower. Once their voice
 16 achieved that pitch, they might say I have
 17 achieved what I desired and I don't need more.
 18 A That would not be the case in these people because
 19 they are all adults who have their voices. Their
 20 vocal cords will not change after the treatment.
 21 They are all post puberty.
 22 Q As part of your testimony you have talked about a
 23 patient who had regretted the removal of their
 24 testicles.
 25 Does that sound familiar?

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

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

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

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

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

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

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

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

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1 to be compelling?

2 A I didn't see clear evidence that the children were

3 improving.

4 Q Do you have any firsthand knowledge of a minor

5 being provided with treatment for gender dysphoria

6 without parental consent?

7 A What do you mean by firsthand knowledge?

8 Q Well, we talked earlier about how there are

9 circumstances you believe where children can

10 assent to medical treatment and their parents can

11 consent and the provision of that treatment is

12 appropriate based on that informed consent

13 process.

14 Are you personally aware of a minor receiving

15 treatment for their gender dysphoria where that

16 didn't happen? Are you personally aware of that?

17 A I know of circumstances in which minors have

18 gotten hormones through Planned Parenthood without

19 parental consent.

20 Personally knowing them as someone I've taken

21 care of or in my, that lives in Ohio nearby, a

22 neighbor, no. I don't have that kind of personal

23 awareness.

24 Q You said during your testimony in Ohio that it was

25 immaterial that you had not visited any

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1 multi-disciplinary clinics in Ohio that were

2 treating pediatric patients.

3 Do you recall saying that?

4 A I think so.

5 Q Do you still believe that to be true that it's

6 immaterial?

7 A Yeah, I think it does not matter.

8 Q Okay. So you are comfortable relying on

9 secondhand reports to describe what you believe is

10 happening in that --

11 A They are very powerful statements by parents who

12 attend with their child at the clinic. So when

13 people say they have a very thorough evaluation,

14 they do not do any of that. They don't do this.

15 They will evaluate the child from a psychological

16 standpoint over months and really address all of

17 their other problems, that does not happen.

18 I don't believe it happens. I never hear

19 that it happens. With my experience with adults

20 it didn't happen. The parents don't say that it

21 happens. The comments from the extensive

22 evaluation, extensive interviews in Time to Think

23 that I've referenced in my bibliography at the

24 Gender Identity Development Center in the U.K.

25 that has decades more experience than we do in the

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1 United States, and the affidavit of Jamie Reed.

2 And I think there will be many coming out

3 along with many, many parental testimonies that

4 describe how minimal the evaluation is.

5 And we just see the plaintiffs. We don't see

6 extensive evaluation of these children. I mean,

7 look at these sad stories of these children who

8 felt terribly traumatized and they are treating

9 them with hormones.

10 There was one that was physically and

11 sexually abused by the father. Another one who

12 has two biologic male parents. One of whom is

13 transgender.

14 You wonder how much of this is pressure on

15 the child to have hormonal treatment. That all

16 needs to be explored. It's just not being done.

17 Q Dr. Weiss, I'm sorry to cut you off.

18 MR. SELDIN: Ms. Youngs, we will designate

19 parts of this testimony regarding the medical

20 records of the minor plaintiffs as confidential.

21 MS. YOUNGS: Certainly.

22 MR. SELDIN: Ms. Youngs, I believe in

23 Dr. Weiss' declaration he has several paragraphs

24 that we would like those designated as

25 confidential and redacted. I just wanted to flag

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1 those for the court reporter and for you that that

2 is how we would like to proceed. I assume that is

3 not going to be a problem?

4 MS. YOUNGS: No.

5 Q Sorry for that little bit of housekeeping.

6 Do you think that there are any minors who

7 are properly evaluated for gender dysphoria?

8 A I hope so.

9 Q For those minors who are properly evaluated, do

10 you still oppose the treatment for gender

11 dysphoria?

12 A The hormonal, or what you might call

13 gender-affirming care, yes, because I think it is

14 personally harmful and it does not help. There

15 are safer less harmful interventions like

16 supportive exploratory psychotherapy.

17 Q So it's not just the evaluations, because even if

18 a minor were appropriately evaluated, thoroughly

19 had a diagnosis of gender dysphoria and you agreed

20 with that, you would still oppose the provision of

21 the treatment of their gender dysphoria either

22 through puberty blockers or hormones, is that

23 correct?

24 A I would be more clear in stating that a thorough

25 proper evaluation would very, very likely reveal

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1 factors in the family dynamics, history, sexual
2 abuse, physical trauma, bullying, social
3 isolation, autism spectrum disorder or depression,
4 anxiety.
5 That all could be addressed and there would
6 be no need for hormonal interventions that would
7 be not helpful and likely harmful.
8 Q Do you think it's possible that there are minors
9 who do not have any history of trauma, do not have
10 any co-morbid conditions, do not have any social
11 or familial pressure and, nonetheless, had gender
12 dysphoria that would benefit from treatment?
13 A I think they may benefit from treatment. But the
14 treatment is best hormonal or hormonal
15 interventions.
16 So even if such children did exist and, of
17 course, in the Dutch study they found not very
18 many of them. They had no other significant
19 psychosocial issues, they treat them with these
20 hormonal interventions and I don't think they
21 helped them as we will discuss.
22 Q So you don't believe that there are any minors who
23 had gender dysphoria period, or who have gender
24 dysphoria?
25 Well, first question, do you believe there

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1 are any minors who have gender dysphoria?
2 A Sure.
3 Q And just gender dysphoria, no co-morbid
4 conditions?
5 A Well, I think there is an explanation. They may
6 not have obvious co-morbidities. I think with
7 supportive therapy, one would be able to identify
8 reasons why they have rejected their natal sex.
9 And those children, their dysphoria would
10 likely resolve with that therapy. Because really
11 what the goal is, the goal of treatment for gender
12 dysphoria is not to make the person look like
13 another sex. That is not the goal.
14 The goal is to resolve the dysphoria, the
15 distress. Right? So if you can resolve the
16 distress with really safe reversible interventions
17 to addressing the biopsychosocial issues, that is
18 what should be done.
19 Q So you believe there is no way to resolve gender
20 dysphoria through physical changes, is that what
21 I'm hearing you say?
22 A I don't think physical changes are helpful. This
23 would be the only disorder listed in the DSM for
24 which there is an intervention to modify
25 appearance to fix the mental disorder. It's the

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1 only one.
2 Q Let's say I have a three year old child who has no
3 history of trauma, no co-morbid conditions,
4 nothing else going on except for gender dysphoria.
5 Do you believe that that child is a candidate
6 for medical treatment of their gender dysphoria as
7 they get older?
8 A So I think the diagnosis of gender dysphoria in a
9 three year old is extraordinarily difficult. What
10 is a three year old's understanding of gender?
11 If you have had kids you know that boys like
12 to put on mommy's shoes. Girls like to wear, you
13 know, daddy's glasses. I mean, boys have, there
14 is just exploration and children do these things.
15 They might say they -- are they going to say
16 they don't like their penis. They don't know what
17 gender is at the age of three or four. I think
18 that is frankly absurd, most of that.
19 And we know, we talk about this later, those
20 kids, that resolves over time in most of those
21 children. If it does not, then they need
22 supportive therapy to help them out.
23 Q You can't imagine a circumstance in which a child
24 could be accurately diagnosed with gender
25 dysphoria?

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1 A In the absence of all other psychiatric or family
2 dynamics, social causes, bullying, social
3 isolation, influences of other children, no, I
4 think there are other factors that explain it.
5 It's a symptom of something else that is
6 going on.
7 Q You said they should receive supportive therapy.
8 What do you think the goal of that therapy
9 should be?
10 A I think to resolve their dysphoria and to address
11 their anxiety, depression. How they feel about
12 themselves. Because it's not -- the child might
13 come and say I really want to be a girl. Okay.
14 Tell me more about that.
15 This is not conversion therapy. We are
16 talking about just helping them out to feel less
17 distress, less anxiety. What is going on in your
18 life? What's happening at home? Does your dad
19 beat your mom up? Is there alcoholism?
20 I mean, in the four plaintiffs we see a lot
21 of that going on. None of these four children
22 would have qualified for treatment based upon the
23 only solid evidence that's claimed to be solid,
24 it's really weak, which is the Dutch protocol.
25 Because the Dutch excluded those people with

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1 any significant psychosocial issues. All four of
2 the plaintiffs have major psychosocial issues.
3 They would never have been treated per the
4 evidence that we have, which is the Dutch
5 protocol.
6 Q So earlier you said that, you know, the resolution
7 of the gender dysphoria was not going to come from
8 changing physical characteristics.
9 So the goal of that supportive exploratory
10 therapy would be to be at peace with one's
11 assigned sex, is that right?
12 A Correct. I think that being at peace would come
13 not with a focus on you have to accept your sex.
14 Not with something that might be called conversion
15 therapy. But really with exploring everything
16 that is going on in the child's life.
17 What has happened here? What happened? How
18 were they raised? What is going on? Have you
19 been abused? Have you been -- how safe are you at
20 home? What is going on at school? Do you feel
21 isolated? Do you have friends?
22 All of those issues. We know that social
23 media for all these girls has a powerful impact on
24 their reasons for all of a sudden now when they
25 are adolescents deciding they want to be boys.

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1 Q You believe that once all those issues have been
2 fully explored and addressed if they exist,
3 nonetheless, it's not appropriate to provide
4 gender-affirming, to provide treatment of gender
5 dysphoria to minors?
6 A To provide -- nonetheless, it would not be
7 appropriate to provide hormonal treatment, either
8 puberty blockers, opposite sex hormones, surgical
9 reassignment to minors, correct. That would not
10 be appropriate.
11 Q If you believe it or not, we started by talking
12 about your testimony in Ohio. I will now turn
13 back to that.
14 During that testimony in May of 2022 you were
15 still seeing patients, adult patients who you were
16 treating for gender dysphoria, is that right?
17 A Correct. Those would have been follow-up
18 patients, but not new ones.
19 Q Was your provision of treatment for gender
20 dysphoria to adults particularly lucrative?
21 A No.
22 Q During your testimony in Ohio you compared
23 gender-affirming care to providing weight
24 affirming care with an eating disorder.
25 Do you recall that part of your testimony in

Page 92

1 Ohio?
2 A Yes.
3 Q The term weight affirming care, does that come
4 from somewhere or did you make it up for your
5 testimony?
6 A I made it up.
7 Q Okay. You talked about how you provide
8 promotional presentations for Mounjaro. That's,
9 is that Tirzepatide?
10 A Yes, it is. Does Wendy know how to spell that?
11 It's T-I-R-Z-E-P-A-T-I-D-E.
12 Q So my understanding is that Mounjaro has some
13 profound weight loss side effects, is that
14 correct?
15 A Yes.
16 Q What about a patient who came to you in your
17 practice and said, I'm very overweight. I don't
18 want to go outside because I'm so overweight. I
19 don't want to see my friends because I'm so
20 overweight. I feel like this body is preventing
21 me from participating in society.
22 Do you think it would be appropriate to treat
23 that person with weight loss drugs?
24 A So I, as I said, I'm a diplomatic of the American
25 Board of Obesity Medicine. I'm very knowledgeable

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1 about treating obesity.
2 Obesity has many adverse consequences. We
3 want to help people as best we can to help them
4 lose weight. There are medications approved for
5 the obesity. Yes, I treat those people.
6 Most of them are not dissatisfied with their,
7 well, their appearance, but they are really
8 struggling with knee pain, with sleep apnea and
9 other adverse consequences, medical consequences,
10 that derive from their weight. There is
11 medications approved for treating weight.
12 Mounjaro has been studied. It works really
13 well, but it's not yet approved for weight loss.
14 I would not give Mounjaro to those people. I
15 would offer them other medications which are
16 approved for weight loss by the FDA.
17 Q I'm not surprised. But you could imagine a
18 patient who said in addition to my knee pain and
19 my sleep apnea, I want to lose weight for that,
20 but I want to look thinner because I want to be
21 thinner in society.
22 Would that be an okay reason to provide
23 someone with a weight loss drug?
24 A It would depend on their body mass index.
25 Q Assuming it was not unsafe for them to lose

Page 94

1 weight?

2 A If their body mass index is above thirty and that

3 is one of their concerns, sure, I would do that.

4 My example with the weight affirming

5 intervention was related to a minor, a seventeen

6 year old, who came in and said I'm too fat. And

7 she has anorexia nervosa. Okay? That is a

8 condition which children eat very little. It's

9 usually females. They eat very little. They have

10 no, their menstrual periods stop. They are really

11 underweight, but they still see them, they see

12 themselves as too fat.

13 They want to have a, they feel bad about

14 their body. They feel they are too fat and so

15 they want to lose weight.

16 So if they came to a physician and said I'm

17 really fat. I feel bloated. I am really fat. We

18 don't give them medication to lose weight when we

19 as physicians judge them to be underweight.

20 So we would not do that. We would not affirm

21 their self-diagnosis. Which is what is happening

22 with gender-affirming care. The child says I want

23 hormones. Oh, okay. I want to be the opposite

24 sex. We will take care of that.

25 You just basically affirm them instead of

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1 having the physician make the diagnosis. In the

2 case of anorexia you are underweight. You have a

3 psychiatric disorder -- this may not be the way we

4 say it -- but we will try to help you out. Let's

5 talk about it. What's going on? What's going on

6 at home? I will send you to a therapist.

7 Q So in your weight loss example, the reason that

8 you think that that would be problematic, this

9 prescribing a weight loss medication to a minor

10 who was underweight and also had anorexia would be

11 one, primarily, because it would be unsafe for

12 that person physically to lose weight?

13 A There are a few reasons. One is that it's not

14 appropriate. The person, the patient made the

15 wrong diagnosis. I make the right diagnosis. I'm

16 the physician. You are underweight. Your problem

17 is not your weight problem. It's something else

18 going on. That is why you are not eating.

19 The best treatment for you is not a change in

20 your body appearance. It is therapy. We need to

21 figure out what is going on here. Why are you not

22 eating?

23 Q But to go to the other side, there are

24 circumstances in which someone who had a BMI that

25 was higher than it should be who wanted to lose

Page 96

1 weight and, therefore, change their body and it

2 was not medically contraindicated for them to lose

3 weight. So if their primary reason for wanting a

4 drug was they wanted to lose weight, you could see

5 that that would be acceptable medical practice?

6 A Yes. Weight loss in people who are obese is

7 medically beneficial. No question.

8 Q So in your testimony in Ohio you had some

9 criticism for advocacy groups and activist

10 positions.

11 I believe you said "Most of these societies

12 are heavily influenced and swayed by activists and

13 by physicians who run transgender clinics who have

14 a profit motive."

15 Does that sound like something you said in

16 your testimony?

17 A It does.

18 Q Okay. I think you also said that medical

19 societies have been co-opted by these activists.

20 Does that sound like something that you said

21 in your testimony?

22 A It does.

23 Q Do you think that physicians who treat patients at

24 clinics in academic institutions are profit

25 motivated?

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1 A Some of them might be. I think the academic

2 centers make money off certainly the surgeries and

3 the patients. I think the physicians themselves

4 who are treating are probably uninformed about the

5 evidence base and how weak it is.

6 If they really would honestly and objectively

7 look at the evidence base, they would see that

8 they are really harming these children rather than

9 helping them and they would not treat.

10 Q But it was your experience in providing treatment

11 for gender dysphoria to adults in your private

12 practice that was not particularly lucrative?

13 A No. I had not many patients. I think there is

14 more -- I was not running a transgender clinic

15 like some physicians. I think there is more money

16 in the surgeries than there is in just prescribing

17 medications.

18 But I'm not sure I -- if you have a gender

19 clinic and that is mostly what you do, you do not

20 want to lose those patients.

21 Q So when we were talking earlier about Do No Harm,

22 you said that you didn't include it on your C.V.

23 attached to your declaration because some people

24 think it's a politically motivated organization.

25 Do you remember that we were talking about

Page 98

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

Page 99

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

Page 100

1 in the health care field."
2 Do you see that?
3 A Yes.
4 Q So later on in your declaration in Paragraph 70,
5 you say that doctors, like all groups, are
6 susceptible to group think and social contagion.
7 Do you see that?
8 A I do.
9 Q Okay. So there is a list of organizations that
10 have endorsed or approved the treatment of gender
11 dysphoria for minors.
12 One of them is the American Medical
13 Association which, I assume, you are familiar
14 with?
15 A Sure. There are about thirty, twenty-five or
16 thirty percent of doctors who are members of that.
17 So the vast majority of doctors are not a member.
18 Q Do you think that the AMA, the American Medical
19 Association, do you think of that as a politically
20 motivated organization?
21 A Yes.
22 Q Do you think that that is an organization that has
23 been overtaken by group think and social
24 contagion?
25 A Yes.

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1 Q For the American Academy of Pediatrics, are you
2 familiar with them?
3 A Yes.
4 Q Is that an organization that you think is a
5 political advocacy organization?
6 A Not entirely. It has many political advocacy
7 positions. I think they have adopted viewpoints
8 that are not based upon good evidence in many
9 respects. And gender is one of them.
10 Q So you think that that, in that respect that is
11 subject, it has been overtaken by group think and
12 social contagion?
13 A Absolutely.
14 Q I am going to ask similar questions for another
15 couple organizations.
16 The American Psychiatric Association, do you
17 consider that a political advocacy organization?
18 A So I would not use -- I think that it's not a
19 political advocacy organization, but they failed
20 to carefully look at the evidence in the treatment
21 of gender dysphoria.
22 And so they have been swayed by the position
23 that the transgender activists take in that
24 regard. I think that is a clear way of stating
25 it. So it's not entirely a political advocacy

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1 group. They have been affected by these activists
2 and their positions fail to address the science
3 and the evidence.
4 Q Do you feel the same about the American
5 Psychological Association?
6 A Yes.
7 Q Do you feel the same way about the American
8 Academy of Family Physicians?
9 A Yes.
10 Q And in that same regard, do you consider them as
11 having been overtaken by group think and social
12 contagion?
13 A Yes.
14 Q So that I understand, the organization Do No Harm
15 that you belong to, you do not think of that as a
16 political advocacy organization?
17 A No. It is very difficult for people to be
18 outspoken and take positions that are not so
19 popular especially when there is -- I think one
20 can be labeled a transphobe. And, you know, you
21 can be accused and there is a tendency of threats
22 and violence from the other side.
23 So I think there are complex reasons why
24 people might take a stance in this regard. Many
25 of these people that are thinking the same are

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

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

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1 course of your almost twenty years in Ohio?
2 A I was in Ohio since --
3 Q I asked that poorly. From 2003 to 2022 during
4 your independent practice, you saw thousands of
5 patients?
6 A Okay. To clarify, my independent practice was
7 stopped when I was employed by Lake Health. That
8 was the end of 2019.
9 Q Okay.
10 A So 2003 to 2019 I was independent. Then I was
11 employed. You know, if you do multiply those
12 years times the 3,000 you will get that. That is
13 a lot of patients.
14 Q And so of that large number, about one hundred
15 during that whole time you treated for gender
16 dysphoria?
17 A Correct.
18 Q So a very small part of your overall practice?
19 A Correct.
20 Q And I believe in your declaration you describe
21 yourself as the principal physician in northern
22 Ohio offering hormonal treatment for adults with
23 gender dysphoria, is that correct?
24 A Correct.
25 Q And that was based on those patients during that

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

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

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1 A A letter from a therapist.
2 Q Did you require the therapist to have any
3 particular kind of background or licensure?
4 A Well, they had to be a licensed therapist.
5 Q Okay. You didn't require a psychiatrist, for
6 example?
7 A No.
8 Q A letter from a therapist. What would you look
9 for in that letter?
10 A I would look for a statement that that person met
11 criteria for gender identity disorder, which was a
12 DSM criterion or term at that point. And that
13 they were an appropriate candidate for hormonal
14 intervention.
15 Q You would require a letter from a therapist saying
16 that they had been diagnosed with gender identity
17 disorder in the DSM 4?
18 A Right.
19 Q And that they were an appropriate candidate for
20 treatment for their gender dysphoria using
21 hormones, correct?
22 A Yes.
23 Q Okay. And did you require anything else in the
24 letter?
25 A No.

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

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1 So there is movement towards changing the
2 terminology. But in gender dysphoria they have to
3 have significant distress associated with the
4 gender identity.
5 In either case, the people who would come to
6 me wanted hormonal treatment. Whatever you called
7 it, gender identity, gender dysphoria, they wanted
8 hormonal treatment to modify their appearance so
9 they would feel better.
10 Q Did the move from the DSM 4 to the DSM 5 have any
11 bearing on your decision to stop seeing new
12 patients?
13 A No, it did not.
14 Q Did you do any independent evaluation of the
15 diagnosis for, at the time, gender identity
16 disorder in your patients?
17 A Yes, I would question what their story was on
18 their feelings about their gender. When did it
19 start? What else was going on?
20 I was not treating depression, anxiety. I
21 did not address, you know, their childhood
22 upbringing and whether they were abused sexually
23 and those kinds of things, you know.
24 My hope was that the therapist would be
25 providing that.

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1 Q Did you have a particular evaluation or set of
2 questions or was this more general patient
3 history?
4 A There would be questions. I would ask about the
5 onset of their symptoms. I would go through the
6 whole history of when they started to reject their
7 natal sex.
8 It kind of went -- it was open with no, you
9 know, it was with open-ended questions so they can
10 talk to me about that like a therapist might but,
11 you know, in a forty-five minute session. I would
12 explore again on the next visit how they were
13 doing emotionally.
14 Q So someone comes to your office. They have a
15 letter. You have an initial appointment of
16 forty-five minutes.
17 At the end of that appointment would you
18 prescribe any medical treatment or would you
19 require them to come back?
20 A In most cases I would prescribe in these adults.
21 Occasionally I would ask them to come back. One
22 person who was eighteen who had a letter, but I
23 was really uncomfortable, there was a lot of stuff
24 going on with her. She was going off to college.
25 She wanted to have -- and I would not, I would not

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1 have been able to evaluate her for quite some time
2 after.
3 So I said I don't feel comfortable giving you
4 hormones at this time. I think you need to come
5 back. She was one I declined to prescribe. I
6 didn't really feel that she was adequately
7 evaluated.
8 Q Did that patient come back to you for treatment or
9 did you see that patient?
10 A I did not see her again. That was around probably
11 2012, 2013.
12 Q So right when you were going to stop seeing new
13 patients anyway?
14 A Yes.
15 Q And were there any other patients who you did
16 not treat in a similar way based on your
17 assessment?
18 A There were a few people that I wanted to have come
19 back and discuss further. But most people I would
20 initiate therapy on the first or second visit in
21 these adults.
22 Q Were there any patients -- what was the youngest
23 patient who you prescribed hormones or other
24 medication to?
25 A Probably twenty-one, twenty-two.

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1 Q So you saw one potential patient who was eighteen
2 and you ended up not providing treatment.
3 Then the next youngest patient you actually
4 prescribed to you believe was twenty-one or
5 twenty-two, is that accurate?
6 A Yes.
7 Q For the folks that came to you with a letter, were
8 most of them just starting hormones or had they
9 been getting hormones from someone else?
10 A Most of them had not been on any hormones at all.
11 Q So you would have been starting them on hormonal
12 treatment?
13 A Yes.
14 Q Of the hundred patients that you saw, what
15 percentage do you think you were starting new as
16 opposed to continuing someone else's
17 prescriptions?
18 A Probably ninety-five percent.
19 Q Typically what medications would you prescribe?
20 A So I would give testosterone to females. I would
21 give spironolactone, which blocks androgen action.
22 I would give estrogen along with that to those
23 males, biologic males. So biologic males would
24 get spironolactone and estrogen. It was Estradiol
25 usually.

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

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

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1 A Probably about maybe fifteen or so. Fifteen to
2 twenty. Something like that.
3 Q Had had surgery of any kind?
4 A Yes.
5 Q Of those fifteen to twenty do you recall which
6 surgeries they had?
7 A Most of them had mastectomies. Bilateral
8 mastectomies.
9 Q You said most of those fifteen to twenty. Do you
10 have an estimate of --
11 A So I would say -- yeah. So maybe five or so had
12 other surgeries besides mastectomies. So general
13 reconstruction or augmentation, mammoplasty. That
14 kind of thing. Breast implants.
15 Q Did you follow any guidelines or standards of care
16 in your practice regarding the treatment of gender
17 dysphoria?
18 A During that period of time I was following
19 Endocrine Society guidelines.
20 Q Do you recall which ones?
21 A Well, it would not have been 2017 because I
22 stopped in 2013. So it was 2009.
23 Q Okay. And then did you use the WPATH guidelines
24 at all?
25 A No.

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

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1 A Yes.
2 Q Okay. Did you independently advertise that you
3 provided these services? Or no?
4 A No.
5 Q What prompted you to stop seeing new patients in
6 2013 for the treatment of gender dysphoria?
7 A Well, I had a gradual realization that I was
8 really not helping people. Yes, they had these
9 physical changes, but they still had a lot of
10 psychiatric stuff going on.
11 Lots of them had anxiety and distress and
12 depression and sleep problems. They felt bad.
13 They were -- I was urging them to follow up more
14 regularly with a therapist. And there was an
15 increasing number coming out. I should not say --
16 I should say calling the office to be seen.
17 I would give priority over the years to get
18 those people in promptly to the practice even
19 though there was a delay, you know, my next
20 opening might be three months and I would try to
21 find a spot for the people with gender dysphoria.
22 I felt then that my other patients were suffering.
23 So the combination of that and what I was
24 doing was not helpful and my other patients were
25 losing out. I said that's okay. I'm not going to

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

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

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

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

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1 potential harms come to fruition in those
2 patients?
3 MS. YOUNGS: For clarity, that's gender
4 dysphoria?
5 Q Yes. Just for gender dysphoria treatment.
6 A I would say no.
7 Q You also said in Paragraph 8, the last sentence,
8 "I also found that these persons had minimal
9 psychological evaluation for their psychic
10 distress."
11 Did I read that correctly?
12 A You did.
13 Q So when you say that do you mean -- what do you
14 mean?
15 Do you mean prior to them initiating
16 treatment with you?
17 A Prior and even after.
18 Q But at the time that you provided treatment you
19 thought their evaluation had been sufficient for
20 you to start them on hormones?
21 A That is what I thought at the time. In retrospect
22 I would say no, that it was inaccurate.
23 Q Today what would you consider an appropriate
24 psychological evaluation for an adult prior to
25 providing treatment for gender dysphoria?

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

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

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

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1 endocrinologists in the area?
2 A Correct.
3 Q Okay. So rather than them having no care they see
4 you?
5 A Or they have to travel far.
6 Q Just to be clear, none of your patients are
7 treating for gender dysphoria?
8 A Correct.
9 Q Do you have any patients who are transgender?
10 A I have a couple of questioning patients. They are
11 non-binary or they are questioning.
12 Q And have they come to you for any kind of hormonal
13 treatment for gender dysphoria?
14 A No.
15 Q How many of those patients do you think you have?
16 A Two.
17 Q Okay. Out of how many total patients?
18 A I have to do the math again.
19 Q I know you have been seeing patients since
20 February.
21 A February. Yes.
22 Q Is it a couple hundred? Is it dozens? How many
23 people --
24 A A few hundred.
25 Q Do you prescribe puberty blockers in your current

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1 role?
2 A No.
3 Q Do you prescribe testosterone or estrogen in your
4 current role for anything?
5 A Testosterone, yes. Estrogen I leave to the OB/GYN
6 doctors.
7 Q What do you prescribe testosterone for in your
8 current role?
9 A People who have low testosterone. Men, biologic
10 males who are low on testosterone.
11 Q So I understand, you provide testosterone
12 prescriptions to patients who were assigned male
13 at birth?
14 A Yes. Biologic males and they have -- their
15 testosterone was found to be low at some point.
16 So I am replacing their deficiency in
17 testosterone.
18 Q The two non-binary or questioning patients that
19 you have, have you told them about your
20 perspective on the treatment of gender dysphoria?
21 A No. Because it was not appropriate for what I was
22 seeing them for.
23 Q What were you seeing them for?
24 A A thyroid problem.
25 Q Are those adults or are they under eighteen, those

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

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

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1 A Yes.
 2 Q Do you see a little bit down it links to WPATH?
 3 Do you see that?
 4 A Yes.
 5 Q It also links to the Endocrine Society guidelines?
 6 A Yes.
 7 Q As well as the Report for the U.S. Transgender
 8 Survey in 2015?
 9 A Yes.
 10 Q Have you spoken to your employer about their link
 11 to these resources?
 12 A No.
 13 Q Do you think it is a mistake they link to these
 14 resources?
 15 A Yes.
 16 Q Do you think it's ill advised?
 17 A Yes.
 18 Q If you scroll all of the way down you will see
 19 under Referrals it says, "Please direct any
 20 questions or comments to Associate Medical
 21 Director of LGBTQ Health, Matt Bryan." Then there
 22 is an email.
 23 Do you see that?
 24 A Yes.
 25 Q Have you ever reached out to Matt Bryan?

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

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

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

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

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

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1 increasing their number of children they are
2 harming.
3 Q Dr. Weiss, you have referred to other countries
4 and what they are doing.
5 MR. SELDIN: Erica, can you pull up
6 Exhibit 26, please.
7 A Florida is not another country.
8 Q We will get there.
9 A Okay.
10 Q Dr. Weiss, this is an Amicus brief that Do No
11 Harm, your organization, filed in a case called
12 Dekker v. Weida.
13 Do you see the document that I'm looking at?
14 A I do.
15 Q Have you seen this brief before?
16 A No.
17 Q Did you work on this brief?
18 A No.
19 Q Were you asked about this brief?
20 A No.
21 Q And were you aware that Do No Harm filed this
22 brief?
23 A No.
24 Q Okay.
25 MR. SELDIN: So Erica, if you can scroll

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

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1 MS. YOUNGS: Can we pull up the originals
2 as exhibits?
3 MR. SELDIN: We will do a little more on
4 this first. I think we will probably get there.
5 MS. YOUNGS: Okay.
6 A Sweden is 102.
7 Q Let's look at 102 in your declaration.
8 MR. SELDIN: Erica, can you pull up
9 Exhibit 1, Paragraph 102.
10 Q We will probably come back to this exhibit as
11 well.
12 A I have it.
13 Q Great. Are you looking at Paragraph 132?
14 MS. YOUNGS: 132?
15 Q Dr. Weiss, where are you?
16 A I am sorry. I pulled up the original hard copy of
17 the reference 102 in my declaration. I do have
18 that.
19 Q Dr. Weiss, do you have other documents in front of
20 you other than your declaration?
21 A I just have all my references. That's all. They
22 are all on my declaration.
23 Q You have the full text of all of the items that
24 are listed in your bibliography?
25 A Yes.

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

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1 MR. SELDIN: Maybe at a break we can sort
2 this out, Ms. Youngs. We might need copies of
3 those.
4 MS. YOUNGS: I presume it's just
5 everything that is in the bibliography.
6 A It is.
7 MR. SELDIN: I have no reason to doubt
8 that. I think we are entitled to see them.
9 MS. YOUNGS: Well, I don't know that we
10 can produce them at this moment.
11 MR. SELDIN: I don't need them today. I
12 will need them eventually.
13 MS. YOUNGS: Okay.
14 MR. SELDIN: I suspect with FedEx from
15 Utah to here we will get them next week or the
16 doctor can scan them.
17 Q Let's start from the beginning. Dr. Weiss, at the
18 beginning of your deposition I asked you what you
19 had in front of you. You confirmed you had your
20 declaration, which included your C.V., is that
21 right?
22 A Right.
23 Q Okay. And you also have hard copies of the
24 references in your bibliography on your desk, is
25 that right?

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

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

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1 A An hourly rate.
 2 Q What is that hourly rate?
 3 A I think \$325.
 4 Q What activities are you compensated for?
 5 A For my efforts to prepare expert testimony for
 6 those legislative bodies.
 7 Q You became a senior fellow in March 2023, this
 8 year?
 9 A Approximately early this year.
 10 Q So we will talk through the testimonies since
 11 then. But fair to say you believe Do No Harm
 12 would have compensated you for your time involved
 13 in some of that?
 14 A Yes.
 15 Q Do you receive compensation from Do No Harm for
 16 any other activities?
 17 A No.
 18 Q Do you know who provides the funding for Do No
 19 Harm?
 20 A No.
 21 Q Have you discussed this case with anyone at Do No
 22 Harm?
 23 A No.
 24 Q Have you discussed your declaration with anyone at
 25 Do No Harm?

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

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

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1 A If I was with Do No Harm, yes.
 2 Q And did you have to travel to testify at that
 3 hearing?
 4 A No.
 5 Q Who wrote your remarks for that hearing?
 6 A Daniel Weiss. Me.
 7 Q Did anyone review them other than your wife maybe
 8 for grammar?
 9 A No.
 10 Q And would anyone at Do No Harm ever have read
 11 them?
 12 A Only after they were submitted.
 13 Q I think you mentioned earlier that you testified
 14 in Montana, is that correct?
 15 A I believe that is correct.
 16 MR. SELDIN: Erica, could you pull up
 17 Exhibit 22.
 18 Q These are minutes from the Montana Senate. If you
 19 will scroll down to Page 3, the third from the
 20 bottom you will see your name, Dr. Daniel Weiss,
 21 Do No Harm.
 22 Do you see that?
 23 A Yes.
 24 Q Would this have been the January 27, 2023 hearing
 25 that you testified at in Montana?

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1 A Correct.
 2 Q Who asked you to testify at that hearing?
 3 A Likely Do No Harm.
 4 Q Were you compensated for your testimony at that
 5 hearing?
 6 A Yes.
 7 Q Did you have to travel?
 8 A No.
 9 Q Did you testify live or was it just written
 10 remarks?
 11 A I don't remember.
 12 Q Did you write your remarks?
 13 A I did.
 14 Q Did anyone other than your wife review them?
 15 A No.
 16 Q Would Do No Harm have read them before you gave
 17 them?
 18 A No.
 19 Q Would they have read them after?
 20 A I'm sure after they were submitted.
 21 Q Then we will pull up Exhibit 21.
 22 Dr. Weiss, in addition to your testimony in
 23 2022 did you testify again this year in support of
 24 a bill to ban care?
 25 A For minors with gender dysphoria?

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

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

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1 Q This was not a gotcha. I was really asking for
2 the answer on this one. It was not a trap.
3 You provided testimony in support of this
4 bill in North Dakota, right?
5 A Yes.
6 Q And were you compensated for providing this
7 testimony?
8 A I believe so, yes.
9 Q Would that have been by Do No Harm?
10 A Yes.
11 Q And then, again, did you write these remarks?
12 A I did.
13 Q Yourself?
14 A Yes.
15 Q Okay. I believe that we have talked about your
16 testimony in Ohio twice.
17 Dr. Weiss, when I say testimony, I mean live
18 or written remarks. You have provided testimony
19 in some form in support of bills that would ban
20 the treatment of gender dysphoria in minors in
21 Ohio, Utah, North Dakota, Montana, and earlier we
22 spoke about your letter to the Florida Board of
23 Medicine.
24 Does that all sound correct to you?
25 A That treatment we are talking about is -- sorry.

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

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1 testified in Indiana and Wyoming.
2 Did you testify in those places?
3 A I believe so.
4 Q Okay. Do you recall anything about your testimony
5 in Wyoming?
6 A Just it was similar written testimony. I think
7 that was live in Wyoming. I'm pretty sure it was
8 live. I'm pretty sure.
9 Q Do you recall when?
10 A Sometime this year. This spring.
11 Q Did Do No Harm compensate you for that testimony?
12 A I believe so.
13 Q Did you testify in support of Senate Enrolled Act
14 480 in Indiana?
15 A There was a bill in Indiana that I did support. I
16 submitted written testimony. It was not in
17 person. I don't remember the bill number. It had
18 to do with gender dysphoria care in minors.
19 Q Do you recall when that was?
20 A I think it was sometime this spring.
21 Q You don't think it was Senate Enrolled Act 480?
22 A I don't know. I don't recall.
23 Q Are there any other states where you provided
24 testimony on this or a similar topic that we have
25 not talked about?

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1 A Not that I recall.
 2 Q Dr. Weiss, do you keep a running list anywhere of
 3 the places in which you have provided this kind of
 4 testimony?
 5 A Yeah. I have a list of folders that have
 6 testimony that I submitted. I have one for the
 7 different states.
 8 Q That would be the list that you would refer to
 9 in trying to determine where all you have
 10 testified?
 11 A That would be the closest to a list, correct.
 12 Q Roughly do you know how much in total Do No Harm
 13 has compensated you for all of your legislative
 14 testimony?
 15 A Maybe about \$8,000.
 16 Q Earlier we talked about why you don't include
 17 Do No Harm on your C.V. as one of your
 18 affiliations.
 19 I'm curious why you don't include any of your
 20 legislative testimony on there either?
 21 MS. YOUNGS: Can you clarify? Don't
 22 include what where?
 23 A I don't understand.
 24 Q The legislative testimony that we just spoke
 25 about, that does not appear on your C.V., is that

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

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1 Q This is from the Do No Harm website. It says,
 2 "Protecting Minors from Gender Ideology."
 3 Is that the ideology that you believe is
 4 being referenced there?
 5 A Yes.
 6 MR. SELDIN: Erica, can you please pull up
 7 Exhibit 27.
 8 Q Dr. Weiss, these are the FAQs from Do No Harm's
 9 website. You will see that the first two are
 10 "What is Critical Race Theory?" and "What is
 11 anti-racism?"
 12 Do you see those two?
 13 A Yes.
 14 Q Do you do any work for Do No Harm regarding
 15 critical race theory and anti-racism?
 16 A No.
 17 Q So your sole focus in your work with Do No Harm is
 18 gender ideology?
 19 A Yes.
 20 Q Are you on social media?
 21 A No.
 22 Q No Twitter? No Facebook?
 23 A None at all. In fact, I eliminated a Facebook
 24 account about a decade ago. Never used Twitter.
 25 They are dangerous.

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

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

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1 Practice Guidelines in your practice?
2 A On what particular disorder?
3 Q Any disorder?
4 A Some of them.
5 Q Okay.
6 MR. SELDIN: Erica, could you pull up
7 Exhibit 12.
8 Q Dr. Weiss, what I'm about to show you is from the
9 Endocrine Society website. It's a list of their
10 clinic guides by topic area. I'm going to ask you
11 for these topics that are listed, whether you
12 practice in this space and whether you use any
13 guidelines.
14 So going from the top, do you treat adrenal
15 conditions?
16 A Yes.
17 Q Do you use the Endocrine Society guidelines to
18 treat those?
19 A Some of them.
20 Q How about for hypoglycemia?
21 A Yes.
22 Q Do you treat that condition?
23 A Yes.
24 Q Do you use the Endocrine Society guidelines for
25 those conditions?

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1 A Yes.
2 Q Okay. Then just looking through the rest of this,
3 you will see there are several other conditions
4 listed.
5 How about for bone health and osteoporosis?
6 A I treat that.
7 Q Do you use these guidelines?
8 A Some of them.
9 Q And then for male reproductive endocrinology?
10 A Yes.
11 Q Are you a reproductive endocrinologist?
12 A No.
13 Q How about for diabetes, mellitus and glucose
14 metabolism, do you use the guidelines?
15 A I don't know what they are. I don't tend to refer
16 to them because I'm an expert. They are probably
17 outdated by the time they are written. I see so
18 much diabetes and I'm very current on the
19 literature on that.
20 I treat many people with diabetes. I don't
21 care about the Endocrine Society guidelines for
22 that.
23 MR. SELDIN: Erica, could you pull up
24 Exhibit 31?
25 Q Dr. Weiss, this is clinical guidelines from the

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

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

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1 monitoring (CGM) rather than self-monitoring of
2 blood (SMBG) glucose by fingerstick for patients
3 with type I diabetes receiving multiple daily
4 injections (MDIs)."
5 Do you see that?
6 A I do.
7 Q Do you agree with that recommendation?
8 A Yes.
9 Q Is that something that you use in your practice?
10 A Absolutely.
11 MR. SELDIN: Erica, can you take us to
12 Page 11.
13 Q You will see where it says Justification For The
14 Recommendation.
15 Do you see that?
16 A Yes.
17 Q It says there, "The panel justified a strong
18 recommendation despite the low quality of
19 evidence, based on recognition that iatrogenic
20 hypoglycemia is the limiting factor in the
21 glycemic management of diabetes and is a major
22 concern for individuals with diabetes and for
23 their family members."
24 Do you see that?
25 A I do.

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

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

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1 A I think it's, a lot of it is tradition. I think
 2 there are a number of reasons.
 3 Q Well, they are different specialities, though,
 4 right?
 5 A They are.
 6 Q So there are differences in how to treat pediatric
 7 patients versus adult patients?
 8 A True.
 9 Q And how do you know that most pediatricians stop
 10 care at eighteen?
 11 A Thirty-six years of practice.
 12 Q Then, Dr. Weiss, in Paragraph 10 of your
 13 declaration you say that you have training in
 14 diagnosis and treating patients with some mental
 15 health disorders including depression.
 16 Do you see that?
 17 A Yes.
 18 Q What training have you received in diagnosing and
 19 treating patients with some mental health
 20 disorders?
 21 A Some of it is from during residency in internal
 22 medicine. Some of it is from reading. Some of it
 23 is from online conferences. Some of it is from
 24 in-person conferences.
 25 Q And depression is a DSM 5 diagnosis, is that

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1 right?
 2 A Yes.
 3 Q Is that a diagnosis that you make in your
 4 practice?
 5 A Yes. Depression is common with diabetes, for
 6 example.
 7 Q Why is that?
 8 A It's not known.
 9 Q Do you have a theory?
 10 A No.
 11 Q So endocrinologists can sometimes be qualified to
 12 make a mental health diagnosis then?
 13 A Absolutely.
 14 Q So not just psychiatrists can make these kind of
 15 diagnoses, but other clinicians can?
 16 A Most people who treat depression are primary care
 17 people.
 18 Q Have you ever received any training in diagnosing
 19 gender dysphoria using the DSM 5?
 20 A The DSM 5 came out in 2013 and that's when I
 21 stopped treating.
 22 Q So you would not have received training in
 23 specifically how to use those criteria to
 24 diagnose?
 25 A It does not take a lot of training. That is why

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

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

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1 Did I read that correctly?

2 A Yes.

3 Q So if someone cannot perform the reproductive role

4 of being male you would consider them not to be

5 male?

6 A There might be exceptions with intrasex --

7 disorders of sexual differentiation, which are

8 exceedingly rare.

9 Q But you believe there could be some males who

10 cannot perform their reproductive role because of

11 an intrasex condition, but are nonetheless male?

12 A Right. If someone was born without testes, but is

13 XY and otherwise a male, he is still a male, but

14 he is born without testes.

15 There are women that are born without

16 uteruses. They have disorders where that is how

17 they are born.

18 So those are really rare exceptions and that

19 would be a person that would still be that same

20 biologic sex. Otherwise, no. I'm not talking

21 about these people here though.

22 Q Would you consider chromosomes to be definitive in

23 determining sex?

24 A Examine the external genitalia. And then if there

25 is a question, chromosomes.

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1 Q So you agree that a visual inspection of an

2 infant's external genitalia does not provide

3 information about the reproductive capacity as an

4 adult, right?

5 A It does in almost all instances. There are very

6 few instances in which it does not. So we don't

7 have to assign sex at birth. You examine the

8 child and you can determine what their sex is in

9 all likelihood.

10 Unless they have some unusual disorder, they

11 will be -- they might be infertile. Yes, there

12 are some infertile people, but otherwise they

13 would have the potential for reproductive

14 capacity. But that is not all it is.

15 I think you are kind of changing the wording

16 of this because we are changing the topic because

17 what I have said here was that those changes,

18 those hormonal changes to a person with gender

19 dysphoria do not enable them to have reproductive

20 capacity.

21 And now you are asking what is a boy or a

22 girl? What is a male or female? That is a

23 different question.

24 Q And so using your definition of men and women or

25 boys and girls, you believe that there are some

Page 172

1 men who are born infertile, but are nonetheless

2 still men, right?

3 A Correct.

4 Q There are some women who are born infertile, but

5 are nonetheless still women, correct?

6 A Correct.

7 Q In Paragraph 24 you have a quote from Dr. Levine

8 about twelve year olds. Then you make some

9 reference to the plaintiffs in this age when they

10 were four.

11 My question is just, have you ever done a

12 biopsychosocial assessment of a child of any age?

13 A No.

14 Q So for that statement about four year olds and

15 twelve year olds are you just relying on your

16 common sense there?

17 A Common sense and being a father.

18 Q Then in Paragraph 25 you say, in the second

19 sentence you are talking about adolescents. You

20 say, "One series of 1,655 youth, mean age of 15.7

21 years, reported that 55% had friends who also

22 'came out' as transgender around the same time."

23 Do you see that?

24 A Yes.

25 Q As a general matter does it surprise you that

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1 adolescents would go online and find people with

2 whom they had common traits or interests?

3 A This is not speaking to that. It's not that they,

4 they said they were gender dysphoric or

5 transgender and then they found the people.

6 It's that they found these people online and

7 then they came out. Or they found these, they had

8 these friends and they all came out and said that

9 they were transgender at the same time.

10 That should raise concerns that that might be

11 some element of social contagion or peer

12 influence.

13 Q So imagine an adolescent who has never been on the

14 internet. They have parents that keep them away

15 from screens entirely. They come to believe or

16 realize that they are transgender. would it

17 surprise you when they went online and they would

18 look for other people who were transgender?

19 A That would not surprise me at all. But there are

20 no adolescents that don't go online.

21 Q Dr. Weiss, in Paragraph 26 of your declaration in

22 the third sentence, second line, you say, "There

23 are no standards of care accepted by most

24 practitioners, either internationally or within

25 the United States."

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1 Do you see where you said that?

2 A I do.

3 Q What do you mean when you say "most

4 'practitioners'?"

5 A That is what I said. Most practitioners.

6 Q How do you know that most practitioners don't

7 accept those guidelines?

8 A During my thirty-five years of experience of

9 teaching many of those in the health care field

10 and interacting with hundreds and hundreds of

11 physicians, I know that most are not supportive of

12 the so-called WPATH or Endocrine Society

13 guidelines. And for that reason they chose not to

14 treat.

15 From seeing the statements and evaluation by

16 other countries they don't endorse the treatment

17 that we are doing in the U.S. These other

18 countries have had many years of experience above

19 and beyond the United States.

20 So it's not, it's kind of -- it is a fiction

21 that it's some kind of universal, you know, or

22 that it's endorsed around the world, this

23 particular approach to care. There's a lot of

24 disagreement.

25 Q You believe that based on your conversations over

Page 175

1 your career with folks about this topic that you

2 have accurately ascertained that most of them do

3 not agree, notwithstanding what the major medical

4 associations have said?

5 A Some of those organizations have made those

6 statements and many physicians are not members of

7 those organizations.

8 And it's not just my conversations with

9 physicians. It is also what is seen and what

10 other countries have concluded, as we will talk

11 about I'm sure.

12 Q Then, Dr. Weiss, in Paragraph 26 you say, "The

13 goal of treating children with gender dysphoria is

14 to resolve their gender related distress."

15 Do you see that, the first sentence of

16 Paragraph 26?

17 A Yes.

18 Q When you say that, do you mean pre-puberty

19 children?

20 A All children.

21 Q How are you defining children?

22 A Anyone under eighteen.

23 Q So you mean both children who have not hit puberty

24 and children who have hit puberty?

25 A Correct.

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1 Q What is that statement based on?

2 A Well, it would be based upon the approach of most

3 physicians including Dr. Shumer and Dr. DeVries

4 and Dr. Cohen-Kettenis, the people who started

5 the Dutch protocol, and other treating

6 physicians.

7 The goal is not to modify the appearance of

8 the body. The goal is to relieve the psychic

9 distress related to the gender incongruence. That

10 is what they say. That is what -- the Dutch

11 protocol initially started with that goal in mind.

12 Q So when you say that the goal is of relieving,

13 resolving gender related distress, you are

14 referring to resolution through non-hormonal

15 interventions?

16 A No. That should be the goal. That should be the

17 goal of all treatments. The goal, the reason that

18 hormonal treatments have been implemented is not

19 because they want to create these people who are

20 looking like the opposite sex, but really to help

21 the child's psychic distress.

22 That is the initial reason for the whole

23 Dutch protocol. That is the basis -- that is the

24 best evidence that the Endocrine Society invoked

25 for the management of children and adolescents

Page 177

1 with gender dysphoria, is the Dutch protocol.

2 The Dutch said the reason to treat these

3 children and to treat early is to relieve their

4 gender related distress.

5 Q You believe that relief should not come in the

6 form of bodily changes?

7 A That is correct, because it does not work.

8 Q In paragraph, that same Paragraph 26, you say at

9 the very end, "Psychotherapy can be very

10 beneficial in patients with gender dysphoria and

11 lead to their desistance."

12 Do you see where you said that?

13 A I do.

14 Q Based on your prior statement do you mean patients

15 of all ages?

16 A Yes.

17 Q What is desistance?

18 A Desistance would be, could be defined -- people

19 define it differently.

20 I would define it as no longer rejecting your

21 natal sex.

22 Q Is that a term that you would use for both

23 children who have not hit puberty and also

24 adolescents?

25 A Yes.

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1 Q Okay. Is detransition a term that you are
2 familiar with?

3 A Yes.

4 Q What does that term mean to you?

5 A That term relates to those who took therapies,
6 hormonal therapies, blockers, or opposite sex
7 hormonal therapies, to appear as the opposite sex
8 and after a period of time decide -- or maybe even
9 surgery, underwent surgery -- then changed their
10 mind and wanted to return to their natal sex.

11 Q What is the difference then between desistance and
12 detransition?

13 A Desistance is just discontinuing the efforts to
14 appear as the opposite sex. Detransition is
15 already, those children or adolescents or adults
16 who made the change to the opposite sex, the
17 change in the appearance, took those therapies or
18 interventions and now they want to return to their
19 natal sex.

20 Q So when you say desistance, do you mean the
21 resolution of gender dysphoria, or an
22 identification to the sex assigned at birth?

23 A It would be the identification with the sex
24 assigned at birth. What their psychic state is,
25 that does not speak to that other than they are

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1 returning to their, accepting their natal sex.
2 They might have depression, anxiety, who
3 knows.

4 Q So in your mind, desistance then is the resolution
5 of gender dysphoria by identification with the sex
6 assigned at birth, is that what you mean by
7 desistance?

8 A There is more work that needs to be done in this
9 area to study this. Unfortunately, little has
10 been done.

11 Desistance would be defined as no longer
12 having dysphoria related to your gender.

13 Q Okay. And is that different from identifying with
14 your sex assigned at birth?

15 A No, I would say it was the same. You are now
16 returning and identifying with your natal sex.

17 Q If a patient is receiving psychotherapy but
18 continues to have severe gender dysphoria, do you
19 think medical intervention is ever appropriate?

20 A No. By medical intervention you are talking about
21 to change the appearance of the child and giving
22 them opposite sex hormones? Is that what you are
23 referring to?

24 Q We have been talking about treatment with
25 hormones --

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1 A I think it's never appropriate.

2 Q Is that true, it's never appropriate for a person
3 of any age?

4 A We are talking about children and adolescents
5 right now. I don't think it is appropriate for
6 any age because I don't think any evidence
7 supports those hormonal interventions as being
8 beneficial.

9 Q So, Dr. Weiss, say that you have a patient who has
10 gender dysphoria and receives the interventions
11 that we have been talking about to treat that in
12 the form of hormones and that fully resolves their
13 gender dysphoria.

14 They are back to zero gender dysphoria.
15 Would you consider that a successful outcome?

16 A I think that hypothetical case is merely
17 hypothetical. It just does not happen. You are
18 implying causation from the intervention. I think
19 there is no convincing evidence that those
20 hormonal interventions are the key to, or are
21 causal in improving any gender dysphoria.

22 I think it is very unclear and it actually
23 may worsen it. And, remember, so are you going
24 to -- are you telling me that that child has no
25 psychotherapeutic intervention during that period

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1 of time?

2 You are just applying hormonal intervention
3 and then they get better? I think that is very
4 interesting. I've not seen any reports of that.
5 And I don't think that exists. I would wonder
6 whether the child would have desisted otherwise
7 without your harmful interventions.

8 Q So let's say you have two patients. One who
9 receives both psychotherapy and the medical
10 interventions that we have been talking about in
11 the form of hormones. That completely resolves
12 their gender dysphoria.

13 Then you have another patient who only
14 receives psychotherapy and their gender dysphoria
15 resolves because they desist and begin to identify
16 with their sex assigned at birth.

17 Do you think one outcome is better than the
18 other?

19 A Yeah. I think the intervention that is least
20 invasive, least potentially harmful is always the
21 best intervention.

22 So not giving hormonal treatments to these
23 children with normal bodies that might lead to
24 irreversible effects is always best to minimize
25 harm. The harm is minimized if it's just a

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

Page 183

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

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

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

Page 186

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

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

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1 A Yes.
2 Q So you see where it says, "Moreover, this request
3 is vague, overboard, and unduly burdensome to the
4 extent it requests records for 'a related
5 condition' because there are no conditions
6 inherently related to gender dysphoria."
7 Did I read that correctly?
8 A Yes.
9 Q Would it surprise you to learn that the medical
10 records that have been produced in this case all
11 pertain to the treatment of gender dysphoria?
12 A I think that statement that there are no
13 conditions inherently related to gender dysphoria
14 is ridiculous. It's absurd.
15 The whole patient psychiatric psychosocial
16 status is related to gender dysphoria. Their
17 family situation. Whether they were sexually
18 abused. That is related to gender dysphoria.
19 Whether they are physically abused. Were they
20 bullied. All those.
21 So there are no conditions related to gender
22 dysphoria, that is a ridiculous remark. It's
23 antithetical to any psychological care that that
24 person might require.
25 Q Earlier we were talking about diabetes. You said

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1 a lot of your patients with diabetes also have
2 depression, correct?
3 A Yes.
4 Q Do you consider depression and diabetes to be
5 related conditions?
6 A There is more depression in people with diabetes
7 and that is perhaps in part because of the burden
8 of the diabetes care. But that is just an
9 association.
10 Q Other than that case, have you ever evaluated the
11 medical records of a minor?
12 A Yes.
13 Q When?
14 A Over my thirty-five years of practice I have. I
15 took care of children down to the age of five.
16 Q We talked about you thought that was less than one
17 percent of your practice overall, correct?
18 A Maybe a little more earlier then and then it
19 became less later. Yes.
20 Q You have interacted with the records of your minor
21 patients, correct?
22 A What is the question?
23 Q I'm asking, we are talking about when you treated
24 minor patients as a small part of your practice
25 you interacted with their medical records as their

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1 physician?
2 A Yes. I also would have reviewed previous records
3 when I was assuming care for that child.
4 Q How long did your review of the medical records
5 take in this case?
6 A I don't remember. Hours.
7 Q Can you estimate approximately how many hours you
8 spent reviewing the medical records in this case?
9 A The medical records of the four plaintiffs, maybe
10 five hours.
11 Q Who did you discuss your review with, if anyone?
12 A I just reviewed them on my own.
13 Q Did you discuss, this is a yes or no question, did
14 you discuss your review with the attorneys for the
15 state of Indiana?
16 A Yes.
17 Q Did you discuss your review of the medical records
18 with any other physician?
19 A No.
20 Q Did you discuss them with your wife?
21 A No.
22 Q Then I assume I know the answer to this, have you
23 shared those medical records with anyone else?
24 A Absolutely not.
25 Q In Paragraph 29 you say one of the plaintiffs had

Page 191

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

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

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

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1 from the -- I believe I'm not confusing. No. No.
2 That is A.M. I'm sorry.
3 With K.C. there is somewhere in the record
4 where that was apparent about a transgender
5 parent. I don't recall.
6 Q If it's not K.C.'s parents would you need to
7 revise your declaration?
8 A It's possible I am mistaken with regard to that.
9 That is what I saw, that there was a parent who
10 identified as transgender and was a biologic male.
11 Q And why was the sex of the parents notable to you?
12 A How they identify is notable because I would be
13 curious as to whether there was pressure on the
14 child from the age of four to socially transition.
15 That is unusual. So that ought to have been
16 explored by any biopsychosocial evaluation in this
17 child who has multiple medical problems.
18 Q In Paragraph 31 of your declaration you say, "The
19 mother of M.W. questioned the rapid onset of
20 gender dysphoria in her," you use the term
21 "daughter."
22 You said, "However, after a telephone call
23 with a health care provider, she no longer
24 expressed concern, though the file does not
25 explain."

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1 Do you see that?
2 A Yes.
3 Q Why was it notable to you that the clinicians
4 addressed the mother's concerns?
5 A That is not what was notable. What was notable
6 was the mother had those concerns. What happened
7 to those concerns? How were they addressed?
8 Q I mean, in general it's a good thing when
9 clinicians express concerns of parents in the care
10 of their children, right?
11 A Yes.
12 Q Doesn't that mean there was not immediate
13 affirmation here if, in fact, the mother had
14 questions that were strong enough that she
15 followed up with the clinician?
16 A They rate parents on their degree to which they
17 affirm. You know, so they are really evaluating
18 parents on an ongoing basis if they do any
19 questioning of them, of the gender issues that the
20 child has.
21 So I would wonder what happened here. We
22 don't know what the conversation was and whether
23 was the parent told if you don't affirm M.W. she
24 will kill herself. Was it that kind of a threat
25 which we often hear occurs in these kind of

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1 settings. I don't know. I wonder about that
2 because this later onset expression of gender
3 dysphoria in this sixteen year old suggests it has
4 not been an ongoing gender issue for years with
5 the child.
6 Q So it raises concerns in your mind when gender
7 dysphoria begins to appear in a later adolescent,
8 is that what I'm hearing you say?
9 A Yes.
10 Q You also don't believe that a three year old can
11 accurately express gender dysphoria, is that
12 right?
13 A Yes.
14 Q So there is no age between three and sixteen where
15 you think a child can accurately report gender
16 dysphoria?
17 A Well, they can mistakenly report it, but that does
18 not mean there are not co-morbidities or reasons
19 why they are feeling dysphoria that could be
20 addressed without hormonal interventions.
21 They can be dysphoric and attribute it to
22 their gender. But especially for a new, rapid
23 onset in this setting there is usually factors.
24 Like I think she had just broken, she had a
25 relationship that just broke up. She had a bad

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1 experience in school. Yes, that was M.W.
2 So there was a stabbing at the school. So
3 that needed to have been explored. This feeling
4 of gender incongruence, why did it come up all of
5 a sudden? But it is not clear to me from the
6 records that there was any exploration of that and
7 they moved right onto testosterone at the second
8 visit with the first visit being a video visit.
9 Q In your practice do you do telehealth visits?
10 A Yes. That is with established patients.
11 Q During the pandemic did you have any new patients
12 that started with telehealth?
13 A No.
14 Q Were there doctors in your practice who did?
15 A Not new patients, no. We only did televisits for
16 a short period of time. Then we were seeing them
17 in the office.
18 Q In Paragraph 32 of your declaration you are
19 discussing an informed consent sheet. In the last
20 two lines you said, "Among the potential
21 undisclosed harms are infertility, baldness, and
22 an increased risk of heart attacks and stroke."
23 Do you see that?
24 A I do.
25 Q This was for M.R.

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

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

Page 200

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

Page 201

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

Page 202

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

Page 203

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

Page 204

1 Q And what does institutional social transition
2 mean?
3 A It means that the child adopts a different name
4 and pronoun and lives as the opposite gender.
5 Q So you don't think that is an appropriate
6 intervention?
7 A Correct.
8 Q And in your view of gender-affirming therapy, is
9 the therapist pushing that or just merely not
10 opposing it?
11 A The therapist would push it.
12 Q What about a therapist that does not push it, but
13 says this is an option. How do you feel about it?
14 A I think that hypothetical situation is not one
15 that is realistic or meaningful.
16 Q So in your open exploratory supportive
17 psychotherapy would social transition be discussed
18 at all?
19 A It might come up.
20 Q What do you think the therapist's response should
21 be when it comes up?
22 A It really depends on the situation and the child.
23 It's so complex. It is an interplay of so many
24 factors.
25 Q Do you think there is ever a situation where the

Page 205

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

Page 206

1 about?

2 A Yes. I referenced some papers.

3 Q Is there anything other than the papers that you

4 reference in your complaint -- I'm sorry -- in

5 your declaration?

6 A Yes. Yes. There are therapists who use it all of

7 the time and children and adolescents benefit from

8 it.

9 Q Which therapists do you know that are providing

10 the kind of open explorative supportive

11 psychotherapy that you are talking about?

12 A What do you mean by "know"?

13 Q You said you know there are therapists that

14 provide this kind of therapy. I am asking who is

15 it?

16 A Someone like Dr. Kenneth Zucker. Dr. Steven

17 Levine. Dr. Cantor. James Cantor. Dr. Marcus

18 Evans. There are others.

19 Q The same Dr. James Cantor who is a witness for

20 Indiana in this case?

21 A Yes.

22 Q Were you aware that both Dr. Zucker and Dr. Levine

23 have treated adolescent patients with

24 gender-affirming care?

25 A I'm not aware that they prescribed hormonal

Page 207

1 therapy for those people.

2 Q Are you aware of whether or not they recommended

3 hormone therapy for those people?

4 A No.

5 Q Would your view of their practice change if you

6 learned they had, in fact, prescribed

7 gender-affirming care in the form of hormones for

8 these patients?

9 A What was the question again?

10 Q Well, you told me that you think Dr. Cantor and

11 Dr. Zucker were providing the kind of open

12 exploratory supportive psychotherapy that you

13 think should be happening. Right?

14 A Right.

15 Q And I asked were you aware that they prescribe or

16 have recommended the prescription of hormones for

17 their patients with gender dysphoria. You said

18 you were not sure. Is that correct?

19 A I'm not aware that they, themselves, prescribed it

20 or that they recommended it.

21 If they did recommend it or prescribed it I

22 think they were doing, that recommendation was

23 inappropriate and not based upon good evidence.

24 Maybe they were not aware of the evidence at that

25 point when they prescribed it.

Page 208

1 Q So I will represent to you that Dr. Zucker's

2 clinic did treat adolescents with hormones.

3 Does that give you pause as to the

4 psychotherapy that he is providing?

5 A No.

6 Q So you think it's possible to provide the kind of

7 psychotherapy you think is appropriate while also

8 prescribing hormones to adolescents?

9 A I don't think it's appropriate to prescribe the

10 hormones.

11 Q In Paragraph 39 of your declaration, I believe

12 that takes us to Page 9, you say, "No other mental

13 disorders listed in the DSM are treated with

14 medication or surgery with the goal of altering

15 body appearance or function."

16 Do you see that?

17 A I do.

18 Q There is no citation for that, correct?

19 A Correct.

20 Q Would you agree the brain is part of the body?

21 A Yes.

22 Q So psychotropic meds do change bodily function to

23 the extent that they change brain function. Would

24 you agree with that?

25 A I agree that they do change brain function. Yes.

Page 209

1 Psychotropic medications are not intended to

2 change body appearance.

3 Q Would you want to revise that statement to say

4 that the goal is altering body appearance then as

5 opposed to function?

6 A That might be better.

7 Q Dr. Weiss, in Paragraph 58 of your declaration,

8 which takes us to Page 13 -- the heading is Gender

9 Dysphoria and Associated Psychosocial Conditions.

10 Do you see where that is?

11 A Yes.

12 Q What is a psychosocial condition?

13 A What is the question?

14 Q What is a psychosocial condition?

15 A Social conditions would be the environment the

16 child is living in. So that is the family,

17 friends, school.

18 The psychological status has to do with their

19 mood, their interest in things, their sleep. Are

20 they anxious. All those factors.

21 Q So in Paragraph 58 say, "Most current data show

22 that 70% of children with gender dysphoria have

23 had recent trauma, history of abuse, autism

24 spectrum disorder, homosexual orientation,

25 depression, anxiety, or bullying."

Page 210

1 Do you see where you said that?

2 A I do.

3 Q Why is homosexual orientation worth remarking on

4 here?

5 A It is really important. If a parent has expressed

6 or discussed an objection to be homosexual and the

7 child has some homosexual orientation, that child

8 might find it more acceptable to identify as

9 transgender than to express their homosexual

10 sexual orientation. That would be one example.

11 Q Are there other examples where homosexual

12 orientation would be notable?

13 A Well, there might be some so-called internalized

14 homophobia if the child feels bad about being gay

15 or lesbian. But it's more acceptable and it is

16 kind of considered cool to be transgender. They

17 come out as transgender, but they really have a

18 homosexual orientation, gay or lesbian.

19 That is apparent with some of those people

20 who end up detransitioning. They really realize

21 they were gay or lesbian and that it was a mistake

22 for them to transition.

23 Q Do you think as a general matter it's more

24 socially acceptable to be transgender than it is

25 to be gay currently?

Page 211

1 A Yes.

2 Q Why?

3 A I don't know. Mores and cultural. Things change.

4 Q So it's your belief that currently in the

5 United States it is more socially acceptable to

6 express being transgender than to express being

7 gay, lesbian, or bisexual?

8 A In many environments, yes, I do believe that. And

9 really, it's really the child's perception. It's

10 not what I think. It's what the child perceives.

11 If the child perceives that it's more, that it's

12 more acceptable in his or her environment to be

13 trans rather than to be gay or lesbian, they may

14 kind of reject their homosexual sexual orientation

15 and express a transgender identity.

16 Q I guess we are talking about two different things.

17 One is your perception and then a child's

18 perception. So it's your perception that it's

19 more socially acceptable to be transgender than it

20 is to be gay, is that correct?

21 A Yes. But I don't think that is important. What

22 is important is the child's. We need to evaluate

23 each child to see what is going on from an

24 intrapsychic standpoint that leads them to feel

25 dysphoric, have gender dysphoria.

Page 212

1 And for some of these children it's a

2 homosexual orientation that needs to be explored.

3 They need to be accepted and affirmed that if they

4 are gay or lesbian that that is okay. That is

5 good. We don't have to give you hormones and

6 blockers and all this stuff.

7 It is not for them. We can be treating their

8 condition with the wrong intervention if we give

9 them gender-affirming care.

10 Q So from your perspective, it is preferable for an

11 individual to be gay or lesbian as opposed to

12 transgender?

13 MS. YOUNGS: I think that is a

14 mischaracterization of his testimony.

15 A I would agree with that. I'm not placing any

16 judgment on it. I'm saying that from the

17 standpoint of what we are talking about here,

18 which is treatment of gender dysphoria, that it's

19 important to understand the basis for that child's

20 feelings.

21 And for some of those children it's a

22 homosexual orientation. They need to be affirmed

23 from that standpoint and that will help them. It

24 will be really -- that will come out with open

25 exploratory supportive psychotherapy and you don't

Page 213

1 need to give them hormones.

2 Q So in your view then after a period of open

3 exploratory supportive psychotherapy, as you have

4 defined it in your declaration, you think as a

5 medical outcome it would be better if the patient

6 subjected to that therapy concluded that they

7 were, in fact, gay or lesbian as opposed to

8 suffering from gender dysphoria that required

9 treatment through hormones?

10 A Well, hormones are not required. And I would not

11 use the word "subjected." It is not a harmful

12 intervention, talk therapy. It is kind and caring

13 and supportive and open. And, you know, it's

14 everything that children should be getting that

15 they might not get from mom or dad. It depends on

16 the household.

17 The outcome would be wonderful if they could

18 avoid irreversible harm from hormonal

19 interventions or even surgical reassignment.

20 Q You expressed concern earlier that co-morbid

21 conditions were not being adequately addressed in

22 minors with gender dysphoria.

23 Is that a fair characterization of what we

24 have been talking about?

25 A Yes.

Page 214

1 Q Are there other medical treatments that you think
 2 are inappropriate for adolescents who are
 3 currently experiencing depression or anxiety?
 4 A Not that I can think of.
 5 Q Are there other medical treatments that you think
 6 should not be provided to adolescents because they
 7 have been bullied or have experienced trauma or
 8 abuse?
 9 A Medical treatments other than hormonal
 10 interventions for gender dysphoria?
 11 Q Other than that?
 12 A No.
 13 Q Would you agree that someone can have more than
 14 one condition that might require two different
 15 kinds of treatment?
 16 A Yes.
 17 Q But it is your position that even if an adolescent
 18 has no other diagnosis other than gender dysphoria
 19 they are still not a candidate for hormonal
 20 intervention or puberty blockers?
 21 A That is my view because there, because the
 22 evidence does not support benefit from those
 23 interventions.
 24 Q So in that case it would not be the existence of
 25 co-morbidities. It would be your view of the

Page 215

1 evidence base that would cause you to believe
 2 that?
 3 A Right. The evidence does not support benefit from
 4 hormonal interventions for gender dysphoria even
 5 in the absence of major co-morbidities.
 6 Q In Paragraph 60 of your declaration you say at the
 7 end, "When the GRADE score is 'low,' the true
 8 effect is likely to be markedly different from the
 9 estimated effect."
 10 Do you see that?
 11 A I do.
 12 Q Can you give me an example of that?
 13 A Can you be a little more specific in what you are
 14 asking?
 15 Q Sure. You say when the GRADE score is low that
 16 the true effect is likely to be markedly different
 17 from the estimated effect.
 18 And there is no citation there, right?
 19 A Well, the citation relates to GRADE. That is what
 20 GRADE, that is what -- the citation still relates
 21 to citation 42, which is on GRADE.
 22 Q Okay. So that is how you believe GRADE
 23 characterizes low in terms of quality?
 24 A Yes. That is right out of the GRADE criteria.
 25 Q All right. And can you give me an example of

Page 216

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

Page 217

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

Page 218

1 monitoring in patients with diabetes. There's
2 just no comparison whatsoever.

3 Q Is that because you don't believe we should give
4 credence to the self-report of the minors who
5 receive this care who say this is making me feel
6 better on a daily basis?

7 A I think the patients can't diagnose themselves.
8 Glucose measurements on a continuous glucose
9 monitoring reader or an iPhone app, glucose
10 measurements are very different from, I feel
11 better and I think it's from that shot. There is
12 no comparison.

13 Q You have patients with diabetes.

14 A Yes.

15 Q Are they able to tell based on how they feel in
16 their body that maybe their blood sugar is getting
17 low?

18 A Often no.

19 Q Is there a point at which they can?

20 A Sometimes. But often no. They need a measurement
21 tool.

22 Q If you had a patient who came in and said I just,
23 I'm not feeling particularly well. Would that be
24 something that you would want to explore further
25 in your treatment of them with diabetes?

Page 219

1 A Sure. Why are they not feeling well?

2 Q So you do believe that patient's self-report has
3 some role in medical diagnosis?

4 A Oh, of course. Part of that, the most important
5 part of the engagement is the history, what is
6 going on. The patient can't diagnose their own
7 condition. They can't -- they will come in and
8 say I think that pill is giving me this problem,
9 but they are on twelve pills.

10 Well, how do we know which pill? We can't
11 rely on the patient to make the diagnosis.

12 Q In Paragraph 64 of your declaration you talk
13 about, you know, essentially what would be a
14 randomized control study.

15 Is that a fair summary of what you are
16 talking about in Paragraph 64?

17 A Yes.

18 Q Is there any evidence that supportive
19 psychotherapy alone can treat gender dysphoria?

20 A Yes. It's low quality evidence, but there is.

21 Q Would you expect people to sign up for a study
22 where the intervention only had low quality
23 evidence?

24 A It depends.

25 Q What does it depend on?

Page 220

1 A How well the informed consent process is. And I
2 think if people were clearly informed of the
3 weakness of the evidence for hormonal
4 interventions and the potential harm, they might
5 sign up for it. It might be difficult to do the
6 study.

7 Q You think that the low quality evidence for the
8 supportive psychotherapy that you are talking
9 about, there is a form of informed consent that
10 could be sufficient that you could ethnically sign
11 people up for that group?

12 A For that group and the comparative group, it might
13 be this would be an experiment, a clinical
14 research trial where people were fully informed.

15 As you know, I'm an expert in clinical
16 research. They would be fully informed from the
17 outset with what is called equipoise. Not the
18 doctor convinced that the best approach is
19 hormones. But the doctor unsure of what the best
20 approach is.

21 And then be able to convey that to the person
22 who signed up and say these are your two options.
23 We can see how you do. Then they randomly are
24 assigned to one group or the other.

25 Q So the other group in your study, they would be

Page 221

1 receiving hormones, is that right?

2 A That is part of clinical research.

3 Q So you think this kind of study would be a good
4 idea?

5 A Well, if the physicians in the United States
6 continue to push these interventions which are so,
7 I think, unhelpful and potentially harmful,
8 perhaps this would get them to back down and say,
9 look, this is what needs to be done and this is
10 what is recommended.

11 Some other countries have said we need to put
12 a stop to this right now. We need to evaluate it
13 further. This would be a means to evaluate it.

14 Q You are aware that Senate Enrolled Act 480 bans
15 care all together even in a research setting,
16 correct?

17 A No, I was not aware of that.

18 Q Are you in favor of a law that bans care entirely
19 without a research exception?

20 A I think I would have to see how -- what the
21 research would be. You can call it research and
22 have no control group. We are doing research.

23 There are publications where they call it
24 research and I don't think it adds meaningfully to
25 the evidence base. So it has to be a really well

Page 222

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

Page 223

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

Page 224

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

Page 225

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

Page 226

1 treating needs to know the interaction between
2 those two and treat both of them and maybe taper
3 off on one of those medications. Your depression
4 is much better. Maybe we can drop back on your
5 meds for your ADHD or vice versa.
6 You can't do that if you were doing hormonal
7 interventions and you have already transitioned
8 the person. That is not something that you can go
9 up and down on.
10 Q In Paragraph 80 of your declaration you are
11 talking about a quote and then you say at the end,
12 "Elsewhere this author writes that there are
13 'numerous gaps in knowledge' in transgender
14 medicine."
15 Do you see that?
16 A Yes.
17 Q Are there gaps in knowledge in other areas of
18 medicine?
19 A Not as much as in transgender medicine. And the
20 gaps are so large in transgender medicine that
21 practitioners are inclined to treat with these
22 interventions that I think are harmful.
23 Q So when there are gaps in knowledge in medicine do
24 you believe that we should withhold care?
25 A No. The care just continues to improve and change

Page 227

1 over time. But we always want to have the care be
2 the least harmful possible.
3 Q And so you would agree then that the way you close
4 those gaps to get to a place of care that is more
5 effective and less harmful is through research?
6 A Correct.
7 Q In Paragraph 86 of your declaration you say that
8 GnRH analogs are approved for use in children with
9 a relatively rare disorder called central
10 precocious puberty.
11 Do you see that?
12 A Yes.
13 Q So would you agree that for children experiencing
14 that condition GnRH analogs are safe to use?
15 A They appear to be. And there is no other
16 treatment for those children.
17 Q What about a child who has both precocious puberty
18 and gender dysphoria, would you consider GnRH
19 analogs to be an appropriate treatment?
20 A Yes, for the precocious puberty. Not for the
21 gender dysphoria.
22 Q But if they had both, you would still find it
23 appropriate to use the GnRH analog to treat them?
24 A For the precocious puberty. I've not seen a
25 single report of a child who has both though.

Page 228

1 Q In Paragraph 90 of your declaration you say,
2 "Seizures have been reported in children receiving
3 puberty blockers."
4 There is no citation to that sentence. Do
5 you see that?
6 A The citation comes in the next sentence.
7 Q Okay. So you believe that footnote 60 applies to
8 both those sentences?
9 A I think so. Let me check. Yes, it does apply to
10 both sentences.
11 Q So is that the Bangalore Krishna study?
12 A Yes.
13 Q Okay. Was that study in children who are being
14 treated for precocious puberty?
15 A Yes. There is very little data on children
16 treated with puberty blockers for gender
17 dysphoria. Very little published data.
18 Q So because central precocious puberty can only be
19 treated with GnRH agonists or puberty blockers,
20 even though there are some rare side effects it's
21 still an appropriate treatment in your mind?
22 A Yes.
23 Q So you would agree that medical interventions can
24 always have rare side effects?
25 A They can always have side effects. We don't know

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1 how rare these are in their use with children with
2 gender dysphoria because the data are not there.
3 These children -- there is no reporting. There is
4 no collection of data. They are just being
5 treated.
6 Q I'm asking you a broader question. Generally
7 speaking, medical interventions can have side
8 effects and some are more common, some are more
9 rare?
10 A Correct.
11 Q And even for medications or treatments where there
12 are those side effects, if the treatment on
13 balance benefits the majority of patients they
14 will continue to be prescribed, is that fair to
15 say?
16 A Yes, as long as the person knows the risk versus
17 benefit and gets full informed consent.
18 Q In Paragraph 96 of your declaration you say:
19 "Children who fail to progress through puberty are
20 infertile."
21 Do you see that?
22 A Yes.
23 Q Okay. So puberty blockers themselves don't cause
24 infertility though, right?
25 A They should not if we look at the data on

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1 precocious puberty. There is no good published
2 data in the treatment of children with gender
3 dysphoria.
4 Q Would you agree once the puberty blockers stop and
5 the child progresses through endogenous puberty we
6 have no reason to believe that blockers have a
7 negative effect on fertility?
8 A They should not. Although, there is not data
9 published for those with gender dysphoria.
10 Q You would agree with that statement when it is
11 used for precocious puberty?
12 A Yes, it appears that it does not impair fertility.
13 But the data that is published in the children
14 with precocious puberty is primarily biologic
15 females usually.
16 We have very, very little data on biologic
17 boys and their ability to conceive when puberty
18 blockers are stopped in them.
19 Q And that is something that you probably would want
20 more data on, right?
21 A Yes.
22 Q Can you think of other medical treatments that can
23 cause infertility in children that are minors?
24 A Chemotherapy.
25 Q You believe there are circumstances in which

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

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1 A Yes.
2 Q Is that statement generally true of all pediatric
3 interventions?
4 A Yes.
5 Q So it's not specific to the provision to treating
6 gender dysphoria in minors?
7 A Correct.
8 Q So you were talking earlier about the treatment of
9 Type I diabetes in minors and their transition to
10 adult endocrinologists.
11 A Yes.
12 Q Do you believe that, generally speaking, pediatric
13 endocrinologists do understand the long-term
14 effects of treating Type I diabetes in children?
15 A Yes.
16 Q Then in Paragraph 109 of your declaration you say,
17 "Short-term effects of testosterone given to natal
18 females include acne, baldness, facial hair,
19 clitoral enlargement and pelvic pain. There may
20 be deepening of the voice."
21 Do you see that?
22 A Yes.
23 Q And so for a person whose goal it is to reduce
24 their gender dysphoria, would you agree that some
25 of those side effects are actually intended

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

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

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

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1 Is it your understanding that the treatment
 2 of gender dysphoria using blockers and hormones is
 3 still being provided in the U.K. in some form?
 4 A That is still an option.
 5 Q Then in Paragraph 132 you discuss Sweden. In the
 6 second sentence you talk about, "Its new
 7 guidelines stated that the risks of hormonal
 8 interventions outweighed benefits and that
 9 hormonal interventions in minors can only be used
 10 as part of a research protocol."
 11 Did I read that correctly?
 12 A Yes.
 13 Q So in Sweden they are still providing care, but
 14 limited to research studies?
 15 A They are providing care, but it's hormonal
 16 interventions that are limited to research
 17 protocols.
 18 Q Yes. So you would agree then that hormonal care
 19 is still being provided to adolescents in Sweden
 20 in the context of research protocols?
 21 A Yes.
 22 Q Okay. Which in your view might be beneficial in
 23 the United States as well in the context of a
 24 randomized control trial?
 25 A Right. Carefully designed randomized control

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

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

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1 contagion in the same way as the AMA and other
 2 organizations?
 3 A Yes.
 4 Q Do you think that there are any large medical
 5 systems in the United States that have not been
 6 subjected to that kind of group think and social
 7 contagion?
 8 A No.
 9 Q We were talking about your prior experience as an
 10 expert in two cases. I believe that is in your
 11 declaration in Paragraph 13.
 12 Do you have that portion of your declaration
 13 up?
 14 MS. YOUNGS: Paragraph 13?
 15 MR. SELDIN: Yes.
 16 MS. YOUNGS: Okay.
 17 Q Okay.
 18 A Yes.
 19 Q For Suzanne Platz did you write a report?
 20 A Yes.
 21 Q Were you deposed?
 22 A Yes.
 23 Q Did you testify at trial?
 24 A No.
 25 Q Did the case go to trial?

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1 A No.
 2 Q Was your expert opinion in that case challenged in
 3 the form of a Daubert motion or a state
 4 equivalent?
 5 A No.
 6 Q For the second case, William Blair, did you do a
 7 report?
 8 A Yes.
 9 Q Were you deposed?
 10 A Yes.
 11 Q Did you testify at trial?
 12 A Yes.
 13 Q Did any party file a Daubert motion as to your
 14 testimony or try to limit it in some way?
 15 A Not that I'm aware of.
 16 Q In either case was your testimony limited or
 17 excluded by the court in any way?
 18 A No.
 19 Q Have you ever had to retract a research paper?
 20 A No.
 21 Q Have you ever had to issue a correction for a
 22 research paper?
 23 A No.
 24 Q Have you ever been sued for medical malpractice?
 25 A No.

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1 Q Have you ever been the subject of professional
 2 discipline?
 3 A No.
 4 Q Or sanctioned by the licensing board?
 5 A No.
 6 Q Have you ever had a professional complaint filed
 7 against you?
 8 A No, not that I'm aware of.
 9 Q Have you ever been arrested or charged with a
 10 crime?
 11 A No.
 12 Q Have you ever been the subject of a Title Nine
 13 complaint?
 14 A No. What is Title Nine?
 15 Q Have you ever worked at an academic research
 16 institution?
 17 A No. The answer is no, I've not been the subject
 18 to a Title Nine complaint.
 19 Q Have you ever been accused of any other form of
 20 discrimination or harassment?
 21 A No.
 22 Q Recalling earlier we were talking about your
 23 senior fellowship with Do No Harm. You also
 24 mentioned being a member of, I believe, SEGM,
 25 S-E-G-M, is that correct?

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1 A Yes.

2 Q Are there any other organizations like that that

3 you belong to?

4 A Like what?

5 Q Like Do No Harm or SEGM?

6 A How are you characterizing them?

7 Q Are you a member of any other organizations that

8 take a position on the provision of treatment for

9 gender dysphoria?

10 A No.

11 Q Are you a member of any other organization that

12 takes the position on gender ideology as to how

13 Do No Harm uses that term?

14 A I will correct that statement. The answer is yes,

15 there is one other organization. They take a

16 position on treatment of gender dysphoria. That

17 organization is AAPS, American Association of

18 Physicians and Surgeons.

19 They have been around since the 1950s. They

20 also have a view that is similar to Do No Harm's

21 view.

22 Q And what was the extent of your involvement with

23 AAPS?

24 A I'm just a member.

25 Q Do they have a newsletter that you read? Do you

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1 go on their website? What is the nature of your

2 belonging to that organization?

3 A I just pay dues. I get a regular mailing and

4 newsletter. They have, they have been involved

5 in -- I think they filed some Amicus briefs in

6 various cases. I don't know about gender cases.

7 And my membership there is in my C.V.

8 Q So other than Do No Harm, SEGM and AAPS, are there

9 any other organizations of which you are a member

10 that are similar in their beliefs regarding gender

11 ideology or the treatment of gender dysphoria?

12 A No.

13 MR. SELDIN: If we could take another

14 break. It's possible I'm done.

15 MS. YOUNGS: Okay.

16 MR. SELDIN: Would you be amenable to ten

17 minutes? Let's come back at 4:37 Eastern.

18 MS. YOUNGS: Okay.

19 (OFF RECORD AT 4:27 P.M.)

20 (AT THIS TIME A SHORT RECESS WAS HELD OFF

21 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS

22 WERE HAD:)

23 (ON RECORD AT 4:37 P.M.)

24 BY MR. SELDIN:

25 Q Dr. Weiss, thank you. Unless I have some

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1 follow-up questions from any questions Ms. Youngs

2 might ask, I have nothing further for you today.

3 Thank you for your time.

4 MS. YOUNGS: I have no rebuttal questions.

5 (OFF RECORD AT 4:41 P.M.)

6

7

8 AND FURTHER THE DEPONENT SAITH NOT.

9

10 (Signature waived.)

11

12 _____

13 DANIEL WEISS, M.D.

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1 STATE OF INDIANA)

2) SS:

3 COUNTY OF BOONE)

4

5 I, Wendi Kramer Sulkoske, Notary Public in

6 said county and state, do hereby certify that the

7 deponent DANIEL WEISS, M.D. was sworn to tell the

8 truth in the aforementioned matter:

9 That the deposition was taken on behalf of

10 the Plaintiffs at the time and place heretofore

11 mentioned, with counsel present as noted;

12 That said deposition was taken down in

13 Stenograph notes, reduced to typewriting under my

14 direction, is a true record of the testimony given

15 by said deponent; and that the reading and signing

16 by the deponent were waived, the witness being

17 present and consenting thereto.

18 I do further certify that I am a

19 disinterested person in this cause of action; that

20 I am not a relative or attorney of any of the

21 parties or otherwise interested in the event of

22 this action, and am not in the employ of the

23 attorneys for the respective parties.

24

25

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

4
5 *Wendi K. Sulkoske*
6 _____
7 Wendi Kramer Sulkoske, Notary Public

8
9 Commission Number NP0661030

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

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THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD

May 26, 2023

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THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD

May 26, 2023

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THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD

May 26, 2023

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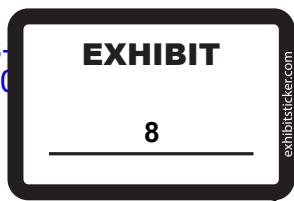
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Daniel Weiss MD CDECS PNS CPI FAPCR

Chair of the House of Representatives, Vice Chair of the House of Representatives, Ranking Member of the House of Representatives, and member of the House of Representatives, and Human Services 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 not 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

Daniel Weiss MD CDECES PNS CPI FAPCR

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.

Daniel Weiss MD CDCES PNS CPI FAPCR

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

Daniel Weiss MD CDCES PNS CPI FAPCR

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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](#)



You don't often get email from drdanweiss@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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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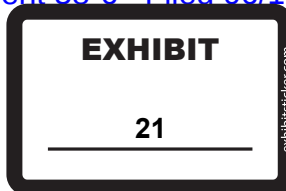
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Daniel Weiss MD CDECES PNS CPI FAPCR

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.

Daniel Weiss MD

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

Daniel Weiss MD

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

Daniel Weiss MD

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.

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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.

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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.”

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

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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

Kozłowska, 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

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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:

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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.

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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.

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

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

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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 Preventiolo* 2023;

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

Gurralla 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.

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This case report describes the challenges faced by a woman who detransitions 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.

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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.

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 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

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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 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.

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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

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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.



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.

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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.

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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.

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 response 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. Only 24% let their clinician know 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](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 an 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

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.

CIRCLE CITY REPORTING
135 North Pennsylvania Street, Suite 1720
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(Via Video Conference)

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 Bailey Steinhauer, Andrew Shaw
 Charles Ferguson

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1 KRISTOPHER KALIEBE, M.D.
 2 the witness herein, having been first duly sworn to
 3 tell the truth, the whole truth, and nothing but the
 4 truth, was examined and testified as follows:
 5 EXAMINATION,
 6 QUESTIONS BY MR. SELDIN:
 7 Q Dr. Kaliebe, good morning.
 8 A Good morning.
 9 Q My name is Harper Seldin. I'm an attorney with
 10 the ACLU for the plaintiffs on this matter.
 11 Joining me is Stevie Pactor, along with Gavin
 12 Rose, along with some interns as well as an intern
 13 from the national office.
 14 How are you this morning?
 15 A I'm good.
 16 Q So just to do a little bit of table setting and
 17 some housekeeping and then we will get right to
 18 it.
 19 MR. SELDIN: Mr. Patterson, I don't know
 20 if you want to enter an appearance for the
 21 record?
 22 MR. PATTERSON: I'm appearing on behalf of
 23 the defendants and to defend this deposition.
 24 Q Dr. Kaliebe, have you had your deposition taken
 25 before?

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

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

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1 Q As of this moment it contains all of the opinions
2 that you intend to offer?
3 A Yes.
4 MR. SELDIN: Joel, could you scroll us
5 down toward the end.
6 Q Dr. Kaliebe, I don't believe there was a C.V.
7 attached to this declaration. I just want to go
8 to the end. I believe it just includes a list of
9 publications. I just want you to confirm that
10 that is the case.
11 A Correct.
12 Q Okay.
13 MR. SELDIN: Joel, can you pull up
14 Exhibit 3 for us.
15 Q My question, Dr. Kaliebe, is just going to be do
16 you recognize this document?
17 A Yes.
18 Q What is this?
19 A This is another report, expert report for the
20 state of Alabama.
21 Q And I believe there was a C.V. attached to the end
22 of this.
23 MR. SELDIN: Joel, if you can scroll down
24 for us, please. I believe it starts at about
25 Page 87 of the PDF.

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

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

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

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

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1 Q Did you have an opportunity to review your
 2 deposition transcript in Decker to submit an
 3 errata?
 4 A Yes.
 5 Q Did you submit any errata?
 6 A Yes.
 7 Q Did your errata address your different
 8 understanding of those questions or --
 9 A My errata contained what I thought were misquotes
 10 of myself. I didn't see the errata as a time to
 11 change my answer on things. I just saw it as a
 12 time to correct any errors in the transcript. So
 13 that is what is in the errata.
 14 Q When did it become apparent to you that perhaps
 15 you would have changed some of your answers in
 16 this deposition if you had understood the question
 17 differently?
 18 A When I read the transcript.
 19 Q Okay. So is it fair to say -- so you read the
 20 transcript for errata. You changed what you
 21 believed were misquotes, but you did not seek to
 22 address to change your answers when you had a new
 23 understanding of the questions?
 24 A Correct.
 25 Q Okay. So for purposes of this deposition let's

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

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1 wrong page on this one. Give me a second.
2 A I was the second witness in the afternoon.
3 Q Let me find the right page. I apologize.
4 MR. SELDIN: Joel, I think it's 1095 or
5 try Page 133.
6 Q Dr. Kaliebe, do you see where it says Direct
7 Examination and then --
8 A Yes.
9 Q Is this a copy of your trial testimony in Decker?
10 A Yes.
11 Q Were you truthful during that testimony?
12 A Yes.
13 Q Did you do your best to answer honestly?
14 A Yes.
15 Q Was that true when the state of Florida was asking
16 you questions?
17 A Yes.
18 Q Was that also true when plaintiffs in that case
19 were asking you questions?
20 A Yes.
21 Q I believe that the court in that case also asked
22 you some questions while you were on the stand.
23 Do you recall that?
24 A Yes.
25 Q Did you do your best to be truthful when answering

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1 the judge in that case?
2 A Yes.
3 MR. SELDIN: Joel, can you pull up
4 Exhibit 6 for us.
5 Q Dr. Kaliebe, have you ever seen this document
6 before?
7 A Yes.
8 Q What is this document?
9 A It's a Plaintiff's Memorandum of Law in Support of
10 Motion to Exclude Expert Testimony of
11 Dr. Kristopher Kaliebe.
12 Q Is it your understanding then that the plaintiffs
13 in Decker tried to exclude your testimony in that
14 case?
15 A Yeah. I just found that out the other day.
16 Q I'm sorry. You said --
17 A Yes. I guess so. I just found out.
18 Q Do you know whether the court has resolved this
19 motion yet?
20 A No.
21 Q Were you aware prior to testifying for Decker that
22 this motion had been filed?
23 A No.
24 Q Thank you so much.
25 MR. SELDIN: Joel, we can take that down

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1 for now. Thank you.
2 Q Dr. Kaliebe, I will ask you some questions about
3 how you prepared for today's deposition.
4 Just to head trouble off at the pass, I'm not
5 asking you what you talked about with your
6 lawyers. I'm asking you questions about the where
7 and who, but not the what.
8 I'm sure Mr. Patterson will cut you off if
9 you try. I just want to be clear about that ahead
10 of time.
11 So my question is just going to be how did
12 you prepare for today's deposition?
13 A Well, I did have a meeting, I think it was Sunday,
14 with the lawyer for about forty-five minutes. So
15 I had one meeting with the lawyer. The other prep
16 was I read my report. I read the deposition that
17 I gave. I read my trial testimony.
18 Q When you say you read the deposition that you
19 gave, are you referring to the deposition in
20 Decker that we were just talking about?
21 A Yes.
22 Q When you say your trial testimony, are you
23 referring to the trial testimony in Decker that we
24 were just discussing?
25 A Correct.

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1 Q Do you recall which lawyer you met with for about
2 forty-five minutes this past Sunday?
3 A Yeah. I hate to -- I do not remember Brian's last
4 name. There has been a lot of switching of the
5 lawyers.
6 Q Any part of their name will do.
7 A Brian.
8 Q Did you say Brian?
9 A Yes.
10 Q Is that Brian Barnes with Cooper and Kirk?
11 A I believe it is.
12 Q Any other attorneys that you spoke with?
13 A No.
14 Q Okay. Any other meetings other than that
15 forty-five minute meeting?
16 A No.
17 Q Did you speak with anyone else at all in
18 preparation for today's deposition?
19 A No.
20 Q Okay. Other than your report or your declaration
21 in this case, your deposition testimony in Decker,
22 and your trial testimony in Decker, did you review
23 any other documents to prepare for today's
24 deposition?
25 A Well, I continually am educating myself and

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1 reading more reports, articles, and such. None of
 2 them were in preparation for this deposition
 3 though.
 4 Q Did you review the expert declarations from
 5 Dr. Shumer, Dr. Karasic, or Dr. Turban?
 6 A I did.
 7 Q Did you review the transcription of their
 8 depositions?
 9 A I did.
 10 Q Did you review any of the declarations submitted
 11 by Indiana's other experts?
 12 A No, I did not.
 13 Q I'm sorry?
 14 A No. I don't believe so. Just those three.
 15 Q In the process of preparing for today's
 16 deposition, did you review any of the medical
 17 records of the plaintiffs in this case?
 18 A I reviewed medical records, but not regarding, you
 19 know, it was a while back. It was not regarding
 20 this deposition.
 21 Q So did you review the plaintiffs' medical records
 22 in your declaration?
 23 A I did review them. But I decided, it was decided
 24 to not, you know, include anything regarding those
 25 records in my report.

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1 So if that answers your question, I reviewed
 2 the records. I did not, you know, formulate
 3 opinions or, you know, add anything into my report
 4 related to that. So I did review them, but I
 5 didn't comment on them.
 6 Q Have you spoken to Diana Kenny, who is one of the
 7 experts in this case that Indiana has proffered?
 8 A No.
 9 Q Have you spoken with Daniel Weiss, who is another
 10 of the Indiana experts in this case?
 11 A No.
 12 Q Have you spoken with Paul Hruz?
 13 A No.
 14 Q Have you spoken with James Cantor?
 15 A No.
 16 Q When we were talking earlier about your deposition
 17 in Decker you referred to part of the transcript
 18 where you discussed speaking with your wife,
 19 Dr. Olga Kaliebe, who is a board certified
 20 endocrinologist, is that correct?
 21 A Yes.
 22 Q Have you spoken with your wife, Dr. Kaliebe, about
 23 this case?
 24 A No.
 25 Q Did she assist in any way in your declaration in

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1 this case?
 2 A No.
 3 Q Thank you, Dr. Kaliebe.
 4 Anything else that you did to prepare for
 5 today's deposition that we have not covered?
 6 A No.
 7 Q Then Dr. Kaliebe, I want to talk a little about
 8 your background. You are board certified in
 9 psychiatry, is that correct?
 10 A Yes.
 11 Q You are also board certified in child and
 12 adolescent psychiatry, is that correct?
 13 A Yes.
 14 Q And forensic psychiatry as well?
 15 A Correct.
 16 Q Do you have any other board certifications?
 17 A No.
 18 Q Do you have any formal training in sociology?
 19 A Well, I believe during medical school and
 20 residency, yeah, training in the broad range of
 21 the field, which sociology is somewhat included
 22 within psychiatry. So psychiatry has some
 23 sociology included.
 24 Q Was there a specific course in sociology that you
 25 took as part of your medical training?

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1 A Well, since psychiatry deals with biopsychosocial
 2 phenomenon in people, sociology is a component of
 3 how you are trained. So the social part is quite
 4 important.
 5 As I said, what people think about how you
 6 approach the patient is biopsychosocial. So
 7 social is a major component. In psychiatry we
 8 frame our approach to patients as biopsychosocial.
 9 So social matters are essential and a large part
 10 of psychiatry. So there's a lot of psychiatric
 11 training and medical school training.
 12 So, yes, it is quite important to be up on
 13 social matters and understand social interactions.
 14 That is a large component of our training.
 15 Q And how are you defining sociology?
 16 A Well, how am I defining sociology? In psychiatry
 17 social matters are very important. Social
 18 interactions are the basis of sociology is my
 19 understanding. So that is how I was applying
 20 them.
 21 Q Fair to say that in psychiatry you are treating
 22 individual patients, correct?
 23 A Well, you do. You treat families. You treat them
 24 within a context. You are also asked for input
 25 regarding matters that are more broad. So, you

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1 know, it depends. Yes. Typically our model is
2 individual patients or families.
3 COURT REPORTER: Doctor, I'm sorry. you
4 are cutting out and I am having a hard time
5 hearing you.
6 MR. SELDIN: Let's go off the record.
7 (OFF RECORD AT 10:00 A.M.)
8 (AT THIS TIME A SHORT RECESS WAS HELD OFF
9 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS
10 WERE HAD:)
11 (ON RECORD AT 10:01 A.M.)
12 BY MR. SELDIN:
13 Q Thank you, Dr. Kaliebe. Do you treat families in
14 your psychiatry practice currently?
15 A When you practice child psychiatry you typically
16 do see the family. Right? You have to see the
17 family. So you are doing family work.
18 Q I'm not asking typically. I'm asking do you
19 specifically treat families currently in your
20 psychiatry practice?
21 A Yes. I mean, when you work in child psychiatry
22 you work with the family, yes.
23 Q And when you say you work with the family, you
24 mean providing psychiatric treatment to the family
25 and consulting with the family about the child?

Page 23

1 A Well, neither of those is the right way to frame
2 it. You work with a child and family together.
3 The child may be the assigned patient, but you are
4 working with the entire family.
5 Q Do you prescribe medication as part of your
6 psychiatry practice?
7 A Yes.
8 Q Are you prescribing medication to any of the
9 parents or the family members of your child
10 patients as part of your practice?
11 A No.
12 Q Do you provide psychotherapy as part of your
13 psychiatric practice?
14 A You would provide parent training. So, yes, you
15 are providing -- it's not, it's family work so you
16 do some family therapy. Even when you are in a
17 room with a parent and the child together that is
18 a therapeutic interaction with both members.
19 Q Then other than the training in sociology that you
20 talked about as part of your medical training, do
21 you have any other training in group dynamics or
22 organizational dynamics?
23 A We receive some of that training as, you know, in
24 medical school and during your residency and
25 because I was the program director and was

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1 involved in training when I was at LSU you do
2 learn about a lot of organizational stuff because
3 you do the trainings that the universities do to
4 help understand how to run a residency and work
5 with trainees.
6 There is some organizational work, some
7 organizational training that I received as part of
8 that. Each medical school has a medical education
9 department. They do trainings about other work
10 systems.
11 Q Anything other than that?
12 A Not that I recall.
13 Q And then in your declaration you said that gender
14 dysphoria and its treatment were part of your
15 professional training.
16 Do you recall that part of your declaration?
17 A Yes.
18 Q Okay. And what professional training did you
19 receive on gender dysphoria or its treatment?
20 A Well, at the time it would have been called gender
21 identity disorder. I use the modern term. But
22 when you are doing a general psychiatry residency
23 your section of the training in medical school
24 includes a section of training or learning that
25 includes those disorders.

Page 25

1 In child psychiatry residency, you have
2 training that includes those disorders. So at
3 every level of training you get some education
4 regarding, you know, at that point it was gender
5 identity disorder, but now it's called gender
6 dysphoria.
7 Q Did you take any specialized or targeted classes
8 that dealt with gender identity disorder or
9 gender dysphoria as part of your medical school
10 training?
11 A No.
12 Q Okay. Have you done any continuing education on
13 gender identity disorder or as it was previously
14 called or gender dysphoria?
15 A Yes.
16 Q What continuing education have you done?
17 A Okay. So I attend meetings at the American
18 Academy of Child and Adolescent Psychiatry, they
19 have CME meetings at every annual meeting. And I
20 attended in the last four years, five years, I
21 would guess about half a dozen, maybe more, of the
22 presentations, or I bought the, you know, you get
23 the audio package later.
24 With COVID it kind of got messed up so it was
25 not the usual conference. We were doing online

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1 not real time so you could watch later. Because
 2 of that I would not say that all of the ones I
 3 watched every single minute of, you know, during
 4 that online period.
 5 When you are in person you know that you sit
 6 there through the whole presentation. So I would
 7 estimate at least six presentations which are CME
 8 presentations from the American Academy of Child
 9 and Adolescent through the annual meeting.
 10 Most of them were at the time of the annual
 11 meeting, but some of them were later because I get
 12 the package where you can watch them later so if
 13 you miss something you can go back and watch.
 14 I was at the American Psychiatric Association
 15 meeting last year and attended a CME meeting
 16 related to gender dysphoria and adolescents. And
 17 I downloaded, or I also participated in one of the
 18 American Psychiatric Association trainings related
 19 to gender dysphoria this year.
 20 Q So it sounds like those first six CME credits that
 21 you were talking about, were those all related to
 22 gender dysphoria or its treatment?
 23 A Yes.
 24 Q Okay. So the past four or five years about how
 25 many hours of CME training do you think you have

Page 27

1 had on gender dysphoria or its treatment?
 2 A About ten.
 3 Q Okay. And so six years ago and later about how
 4 many hours of CME credit do you think you had
 5 related specifically to gender dysphoria or gender
 6 identity disorder?
 7 A Only to the degree it was included in larger
 8 programs. So at that point I had not sought out
 9 any. So one answer to that question is none.
 10 Or only as it was included in course reviews
 11 or other classes. Because when you do, when you
 12 go to the annual conference there's a performance
 13 and practice feedback that you do, which is asking
 14 and answering questions about different topics in
 15 child psychiatry. That includes topics related to
 16 gender dysphoria.
 17 Then also when you do board review there are
 18 sections of board review that are also related to
 19 gender dysphoria and gender dysphoria treatments.
 20 That is a general review of all topics, but it
 21 includes those.
 22 So I did retake my boards, I'm guessing in
 23 2005. Then in 2015 would have been my redo for my
 24 child psychiatry boards. So I would have to
 25 study. But you do get CME for taking the board.

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1 That is considered continued medical education,
 2 taking the board review.
 3 Q Doctors have a better deal than lawyers when it
 4 comes to CLEs.
 5 A It's expensive.
 6 Q Other than the ten hours we talked about and the
 7 education that you would have gotten in the
 8 ordinary course as part of your board
 9 certifications and continuing training, anything
 10 else since 2005?
 11 A I do not believe anything else that was CME.
 12 Q Okay. How did you come to be an expert in this
 13 case?
 14 MR. PATTERSON: I will object to the
 15 extent it calls for attorney/client privilege
 16 communication.
 17 Q Let me break it down a little more in smaller
 18 chunks to see if we can avoid the problem. This
 19 is a yes or no question.
 20 Did the state of Indiana reach out to you
 21 about becoming an expert in this case?
 22 A Yes.
 23 Q So you did not affirmatively reach out to them, is
 24 that correct?
 25 A Correct.

Page 29

1 Q When was the first case -- excuse me.
 2 Prior to Decker, were you an expert in any
 3 case involving gender dysphoria or its treatment?
 4 A No.
 5 Q Other than Decker and Boe v. Marshall, have you
 6 been involved in any case involving gender
 7 dysphoria or its treatment?
 8 A No.
 9 Q In your C.V. and in Boe and in your declaration
 10 you listed your prior expert engagements.
 11 Fair to say other than Decker, Boe, and this
 12 matter, none of the rest would pertain to gender
 13 dysphoria or its treatment?
 14 A Correct.
 15 Q In which case did you become an expert first,
 16 Decker or Boe?
 17 A Decker.
 18 Q Okay. In the Decker matter in Florida, did the
 19 state of Florida reach out to you about becoming
 20 an expert?
 21 A Yes.
 22 Q Were any third parties involved in making that
 23 connection between you and the state of Florida?
 24 A I actually don't know.
 25 Q Prior to Decker had you ever held yourself out as

Page 30

1 an expert in gender dysphoria or its treatment?

2 A No.

3 Q Have you ever lobbied before a state legislature?

4 A No.

5 Q Have you ever testified before a state

6 legislature?

7 A No.

8 Q The same question at the federal level, have you

9 ever lobbied for federal legislature?

10 A No.

11 Q Have you ever testified before Congress?

12 A No.

13 Q You are aware this case involves Senate Enrolled

14 Act 480 in Indiana, correct?

15 A Correct.

16 Q Have you made any public statements for or against

17 Senate Enrolled Act 480?

18 A No.

19 Q Have you ever made any public statements for or

20 against any other laws pertaining to the treatment

21 of gender dysphoria in minors in other states?

22 A No.

23 Q No op eds or letters to the editor? Nothing like

24 that?

25 A Correct.

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1 Q Dr. Kaliebe, I will ask you some questions about

2 your background. They come from the portions of

3 your declaration and when we talk about it if you

4 would like to refer to those, let me know and we

5 will pull up Exhibit 1.

6 My questions will be what were the

7 circumstances of starting or stopping various

8 jobs. I'm not trying to trick you. If you want

9 to refer to that for dates, just let me know.

10 According to your declaration you stopped

11 being the assistant professor at LSU Health

12 Science Center in 2016, is that correct?

13 A Yes.

14 Q What prompted the end of your employment there?

15 A I moved to Tampa, Florida. It did not totally end

16 my employment with LSU. I'm not exactly sure how

17 long I remained with some contracts in Louisiana.

18 I retained my medical license in Louisiana and

19 still had an LSU collaborative care contract when

20 I moved to Florida. I can't exactly say that it

21 ended.

22 I mostly became a University of South Florida

23 employee and had moved to Tampa. I had a

24 collaborative care contract, I believe it was for

25 one more year at LSU, you know, doing psychiatry

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1 and collaborative care back to Louisiana. But I

2 mostly moved from Louisiana to Florida, thereby

3 changing my work from mostly LSU to mostly the

4 University of South Florida.

5 Q Did your role at LSU involve clinical treatment?

6 A Yes.

7 Q Did it involve clinical supervision?

8 A Yes.

9 Q Did you teach?

10 A Yes.

11 Q Did you perform research?

12 A Yes.

13 Q Okay. Did you have any administrative

14 responsibilities?

15 A Yes.

16 Q Here is the tough question, what percentage of

17 your job do you think was clinical treatment

18 versus the other things we just talked about?

19 A So when I was at LSU my job involved, it changed

20 over time. That is not a question that I can

21 answer easily because there were different times

22 with different roles.

23 Mostly I would do clinical work. So, you

24 know, I was mostly a clinician. But I would say I

25 was heavily a clinician educator. So I was always

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1 very involved with the training programs and

2 teaching. So I always had a large teaching role.

3 In my clinical sites I would have students or

4 residents come with me where I was working a lot

5 of the time and people would, you know, sit in

6 with me. So I had a clinical role, which included

7 some resident supervision. Then if you want me to

8 breakdown the numbers --

9 Q I think that is a good answer. Thank you.

10 A Okay.

11 Q In your current role at USF do you have roughly

12 the same mix of responsibilities in terms of being

13 a clinician and teaching?

14 A Well, yes and no. When I moved to Florida I was

15 offered a number of contracts in corrections which

16 was actually a little bit more time in juvenile

17 corrections than I was spending in Louisiana. So

18 I do more correctional work in Florida than I was

19 doing in Louisiana hours-wise.

20 Recently I'm doing more forensic cases so I'm

21 doing more forensic work. My clinical role in

22 Florida was significantly decreased in terms of,

23 like, having an individual patient clinic. Right?

24 So I have two resident clinics right now.

25 But that is, you know, a lot less sort of

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1 direct patient care and, you know, very little
2 independent patient care compared to what I was
3 doing in Louisiana.
4 Q Dr. Kaliebe, how long have you been practicing
5 psychiatry?
6 A Well, I finished my first residency in, which
7 would be the general psychiatry residency as I
8 transferred into child psychiatry, that would be
9 in 2004.
10 At that point, because I was already
11 moonlighting, which was an independent practice,
12 you know, I would say my first independent
13 practice was 2001 or 2002. So during your
14 residency sometimes you are also independent
15 practicing. So I would have to say 2001 would
16 probably be my first year of independent practice.
17 I graduated medical school in 1999.
18 I know during your first year of residency no
19 one does any independent practice. That is one
20 way to answer the question.
21 Another way to answer is when I finished all
22 my fellowships and residencies, that would be
23 July 2005 because I did general psychiatry. Then
24 I did child and adolescent psychiatry.
25 So general for three years. Child psychiatry

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1 for three years. Forensic psychiatry for one
2 year. And finished in July of 2005.
3 Q Fair to say then you have seen patients in some
4 capacity for about twenty-two years?
5 A Correct. You could say my residency started on
6 July 1 of 1999.
7 Q Round numbers, is it fair to say you have treated
8 thousands of patients in that twenty plus year
9 period?
10 A Correct.
11 Q Of those thousands of patients how many of them
12 have you treated that have had gender dysphoria or
13 gender identity disorder?
14 A As you have probably seen in my deposition, there
15 is a -- it is probably around sixteen or seventeen
16 patients right now.
17 Q I believe you had a colloquy with the court in
18 Decker that led you to that number about sixteen
19 or seventeen.
20 Do you recall that part of your testimony?
21 A Yes.
22 Q Okay. Of those sixteen or seventeen patients with
23 gender identity disorder or gender dysphoria, how
24 many of them were under eighteen?
25 A I would guess twelve or thirteen of them.

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1 Q So twelve to thirteen were under eighteen? Then
2 we will call it --
3 A I'm not sure how you count the people that you saw
4 and they were below eighteen and now they are over
5 eighteen in that question.
6 Q When you started seeing those people under
7 eighteen, if we use that definition, does the
8 twelve to thirteen still stand?
9 A We will make it thirteen if it's when I started to
10 see them. You know, that is my, I'm, that is the
11 best estimate that I can give you.
12 Q I will spot you the one. We will call it
13 thirteen.
14 Of those thirteen did you diagnose any of
15 them with gender dysphoria?
16 A Yes.
17 Q How many of them did you diagnose with gender
18 dysphoria?
19 A There are different ways to answer that question.
20 All of them are diagnosed with gender dysphoria
21 and had come to me with that diagnosis or some
22 question regarding that diagnosis.
23 Now, are you asking am I the first person to
24 diagnose gender dysphoria for that patient? Or
25 are you asking me did I continue a diagnosis of

Page 37

1 gender dysphoria?
2 Q We will break it down into small chunks to get
3 exactly at that question. Of those thirteen
4 patients how many of them when they arrived in
5 your office already had a diagnosis of gender
6 dysphoria?
7 A I would guess maybe ten.
8 Q Okay. Of those ten who arrived in your office
9 already with a diagnosis of gender dysphoria, how
10 many of those did you also diagnose with gender
11 dysphoria?
12 A I'm trying to think back if there was any. I
13 believe there was a continuation of a diagnosis in
14 all patients.
15 Q So of those ten who showed up with a diagnosis of
16 gender dysphoria, in none of them you said, I
17 don't think that is correct. You don't have
18 gender dysphoria.
19 A Well, you are asking me questions about when they
20 present for treatment. You know, you see people
21 over time. So it may be a different answer at the
22 end of the day did they always leave the practice
23 also with a gender dysphoria diagnosis, you know,
24 that is a slightly different question.
25 I believe there was continuation of the

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

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1 A Yes.
2 Q I believe that leaves four adults who you have
3 seen or treated who had gender dysphoria.
4 The same set of questions. When they showed
5 up in your office did all of those four adults
6 already have a diagnosis of gender dysphoria?
7 A Yes.
8 Q Did you continue the diagnosis for all four
9 adults?
10 A Yes.
11 Q I'm sort of zooming out to the sixteen or
12 seventeen people who you have seen with gender
13 dysphoria.
14 Did any of them have a gender identity
15 disorder diagnosis, or were they all post DSM-5?
16 A Post DSM-5, correct.
17 Q Did you recommend or prescribe any treatment for
18 the gender dysphoria that you diagnosed in these
19 individuals?
20 A Yes.
21 Q What treatment did you prescribe?
22 A Well, I recommend when a child presents with
23 gender dysphoria that they enter psychotherapy.
24 Q Anything other than psychotherapy?
25 A No. I mean, if you are talking about treating --

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

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

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1 time do they spend on the different devices? What
2 other activities, you know, might be better than
3 the extra time online? Are there any things that
4 are good or positive they are doing online? Those
5 could be increased or the important part of it.
6 But that is advice that I do think is
7 pertinent and I give to all patients. So that
8 would include, you know, that would include
9 patients with gender dysphoria. They would get
10 the advice to, you know, basically eat food to
11 improve their diet. Move their body, physical
12 activity. Mixed in with mindfulness. Hopefully a
13 mindful practice of moving their body and properly
14 managing, because today's kids are so heavily
15 involved in electronics and it's so much of their
16 social world. So managing those things.
17 That is not everything that I tell people,
18 but that is a standard, you know, speech that I
19 give or discussion that I have with every single
20 patient. It would be applicable in this case in
21 addition to my referral for, you know,
22 psychotherapy.
23 Q And is it fair to say that you didn't say to any
24 of those patients that I think if you do more yoga
25 or are more mindful you will no longer have gender

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1 dysphoria?
2 It was just part of your general suite of all
3 your patients you see, you think that is a good
4 plan for everyone to do yoga and limit screen
5 time and be --
6 A No. I would not say it like that. I would say
7 there is a significant possibility that people can
8 help with their distress about their body through
9 the practices that I'm recommending and by
10 managing, you know, what is coming into their
11 brain through, you know, media.
12 So, yes, I do think particularly in these
13 cases this would be a part of the treatment plan.
14 I think it is something that is important to
15 communicate to the patients.
16 Q Are there any randomized controlled trials,
17 studies, regarding yoga as a treatment for gender
18 dysphoria?
19 A No.
20 Q In your declaration you said that you were
21 consulted about providing a second opinion and
22 coordinating care regarding a patient with gender
23 dysphoria in the Louisiana Juvenile Correctional
24 System.
25 Do you recall that part of your declaration?

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1 A Correct.
2 Q Is that patient included in your sixteen or
3 seventeen, or is that a separate person?
4 A Actually it was not included.
5 Q Who asked you for a second opinion?
6 A Well, at the time when I moved to Florida I still
7 had a relationship with the clinic with the
8 correctional system in Louisiana. If you remember
9 what I said, I moved here. I kept the Louisiana
10 license. I was still doing work in Louisiana.
11 As the most senior clinician within the
12 company that has all of the contracts for the
13 juvenile justice in Louisiana, whenever they have
14 challenging cases I was likely to get consulted.
15 That was a patient who was moving facilities
16 and so they asked my opinion. They asked, you
17 know, basically what approach should they have.
18 So that was actually working for the company at
19 that time and they consulted me.
20 Q I take it that was because it was a juvenile
21 correctional system that that person was under
22 eighteen?
23 A That person -- well, I don't want to speak too
24 much about individual patients because, you know,
25 especially when we get into specifics about where

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1 they are and how they move.
2 Q Well, we can designate this portion of your
3 deposition transcript as confidential.
4 A Can we?
5 Q Yes.
6 MR. SELDIN: Mr. Patterson, I don't know
7 if you are aware of the confidentiality order that
8 we have in this case. We have been using that to
9 designate portions in other expert testimony
10 pertaining to the plaintiffs.
11 If it's appropriate here, we can designate
12 this portion as confidential so I can inquire into
13 his expertise.
14 MR. PATTERSON: Yes. We can designate it
15 confidential, but I would say to the extent he is
16 under any obligations not to disclose any
17 information even in a confidential setting he has
18 to abide by those. I'm okay with this being made
19 confidential.
20 MR. SELDIN: Great.
21 Q The particular individual about whom you provided
22 a second opinion, was that person a minor?
23 A They, since this is not -- I mean, I don't believe
24 that in this context that this would be too, that
25 I'm revealing too much. I do want to not speak

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1 too specifically because, obviously, we are, when
 2 you talk about individual patients, any of this
 3 could be trackable. I do not want to say anything
 4 that would reveal anything about any patient that
 5 I'm treating. Right?
 6 So I'm trying to keep it as general as
 7 possible. Redacted
 8 Redacted
 9 Q Redacted
 10 Redacted
 11 Redacted
 12 Redacted
 13 A Redacted
 14 Redacted
 15 Redacted
 16 Redacted
 17 Redacted
 18 Redacted
 19 Redacted
 20 Q Redacted
 21 Redacted
 22 Redacted
 23 Redacted
 24 A Redacted
 25 Redacted

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1 Redacted
 2 Redacted
 3 Q Redacted
 4 Redacted
 5 Redacted
 6 A Redacted
 7 Redacted
 8 Redacted
 9 Redacted
 10 Redacted
 11 Q Also, in your declaration you said that you
 12 provided an opinion about whether a pediatric
 13 patient was competent to assent to the
 14 administration of puberty blockers.
 15 Doctor, do you recall that part of your
 16 declaration?
 17 A Yes.
 18 Q In what capacity were you consulted on that? I
 19 guess which contract was that a part of?
 20 A It was within the USF, you know, child psychiatry
 21 realm.
 22 Q Okay. When you provided that opinion, was that to
 23 someone you were supervising or a lateral
 24 colleague?
 25 A Lateral colleague.

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1 Q What was your opinion on their competence to
 2 assent?
 3 A Well, my opinion was that at the age they were
 4 that it seems unlikely that they would have full
 5 knowledge or capacity to fully assent, you know,
 6 or if you want to say consent to the procedure.
 7 It seemed -- the particular wording of the
 8 question was not can they assent or not. It was
 9 more do they have the, you know, capacity to fully
 10 understand what they are agreeing to.
 11 Q Do you recall how old that person was?
 12 A I don't, I don't remember for sure. But I do
 13 think it was twelve or thirteen.
 14 Q And were you asked to provide an opinion on that
 15 child's parents' ability to consent to the
 16 treatment?
 17 A No.
 18 Q Did you have any concerns based on what you heard
 19 in that consultation about the parents' ability to
 20 consent?
 21 A No.
 22 Q You also said that you have been consulted
 23 regarding psychotherapeutic approaches to young
 24 adult patients who detransition.
 25 Do you recall that part of your declaration?

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1 A Correct.
 2 Q When you say young adult, I take it you mean those
 3 people were over eighteen?
 4 A Correct.
 5 Q You also said you collaborate in the care of
 6 patients with gender dysphoria as part of your
 7 work with the Florida Medicaid psychiatric
 8 hotline.
 9 Do you recall that part?
 10 A Yes.
 11 Q And about how many patients have you collaborated
 12 in the care with for those hotline calls?
 13 A That also had gender dysphoria?
 14 Q Yes.
 15 A I'm trying to think if it was two or one. Only
 16 one that I remember. So one time.
 17 Q Did your involvement in that care go beyond that
 18 phone call?
 19 A No.
 20 Q How many patients have you consulted about in
 21 connection with your work on the Florida Medicaid
 22 psychiatric hotline?
 23 A Good question. Twenty. Thirty.
 24 Q Dr. Kaliebe, have you conducted any research about
 25 gender dysphoria?

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1 A No.
 2 Q Any research on gender identity generally?
 3 A No.
 4 Q Any research focusing on the treatment of
 5 transgender people?
 6 A No.
 7 Q Have you published any papers on those topics?
 8 A No.
 9 Q Have you supervised any research on those
 10 topics?
 11 A No.
 12 Q Have you ever had to retract a research paper?
 13 A No.
 14 Q Or issue a correction to a research paper?
 15 A No.
 16 Q Have you ever been sued for medical malpractice?
 17 A No.
 18 Q Have you ever been the subject of professional
 19 discipline?
 20 A No.
 21 Q Have you ever been sanctioned by a licensing
 22 board?
 23 A No.
 24 Q Have you ever had a professional complaint filed
 25 against you?

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1 A No.
 2 Q Have you ever been the subject of a Title Nine
 3 complaint?
 4 A Not that I know of.
 5 Q Have you ever been arrested or charged with a
 6 crime?
 7 A No.
 8 Q Are you on social media?
 9 A Yes.
 10 Q What social media do you use?
 11 A Use would probably be a strong word because I'm on
 12 social media, but I do not use social media
 13 generally. I have a Facebook account. I believe
 14 I have an Instagram account that links to my
 15 Facebook. I never actually go on Instagram. So
 16 it's very rare that I'm on Facebook. That would
 17 be the only social media that I'm on.
 18 I will, I occasionally have gone on Twitter.
 19 I don't make it a practice to go on Twitter. But
 20 I have gone on Twitter. I don't have a presence.
 21 I don't post. I don't do any of those things.
 22 Sometimes to access things I'm occasionally linked
 23 to Twitter. I would not say I really have a
 24 Twitter account, but I've gone on Twitter.
 25 Q I think the youth call people like us lurkers.

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1 That is the technical term. I don't know if you
 2 have encountered that in the practice with your
 3 youth?
 4 A Yes, I have used that term.
 5 Q Fair to say you fall more on that side of the
 6 continuum?
 7 A That is fair to say, yes.
 8 Q Have you given any interviews in either
 9 traditional media or elsewhere on the topic of
 10 gender dysphoria?
 11 A Given any interviews? Yes.
 12 Q What interviews have you given on the topic of
 13 gender dysphoria?
 14 A Well, I haven't, I was contacted by someone to do
 15 an interview. I talked briefly with the person.
 16 I don't have their name in front of me. This was
 17 quite recently. So I was contacted by someone to
 18 do an interview regarding some of the stuff I
 19 guess that has gone on, you know, in this case or
 20 with professional organizations.
 21 Q Do you recall the name of who --
 22 A I don't. I don't.
 23 Q Do you recall what publication they were with?
 24 A I don't.
 25 Q Do you recall --

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

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

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

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1 again, considering the stakes that I'm getting
2 asked, I mean, it's a tough discussion. But, yes,
3 those are some of the factors that I thought
4 about.
5 Q In your answer you said you thought you had a duty
6 to your patients in this regard.
7 Were you referring to the sixteen or
8 seventeen patients with gender dysphoria that you
9 have treated?
10 A Yes. And to all patients, yes.
11 Q And of the sixteen or seventeen patients with
12 gender dysphoria, you believed as a psychiatrist
13 that they all, in fact, had gender dysphoria,
14 correct?
15 A Yes, that they had that diagnosis. Correct.
16 Q You said you thought there, that you wanted to
17 participate in more academic dialogue about this
18 topic.
19 Do you believe that Senate Enrolled Act 480
20 furthers academic dialogue on this topic?
21 A I think just, like anything else in life, there
22 are trade offs. So it might. It might not. I
23 guess we would have to see what the results of it
24 are.
25 Q You said trade offs. Do you believe that the

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1 trade off of banning medical treatment for gender
2 dysphoria in minors in Indiana is an acceptable
3 trade off to possibly further academic dialogue on
4 this topic?
5 MR. PATTERSON: Object. This is outside
6 of the scope of his testimony.
7 You can answer.
8 A Well, I don't think, I think that is only one of
9 the implications of the law. So, no, that is not
10 the primary implication of the law. It is an
11 implication of it.
12 Q I'm sorry. What is not a primary implication of
13 the law?
14 A The law's effect on the academic or scholarly or
15 public dialogue is a secondary effect and not a
16 primary effect.
17 Q Do you agree with the primary -- I take it then
18 that you are supportive, however, of the primary
19 effect of Senate Enrolled Act 480, which is to
20 prohibit gender-affirming care for minors in the
21 state of Indiana?
22 MR. PATTERSON: Object. The law speaks
23 for itself.
24 You can answer the question if you
25 understand it.

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

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1 A If we are going to ask me about my patients I
 2 would like to go off the record again.
 3 MR. PATTERSON: You mean confidential?
 4 A Confidential, yes.
 5 Q I think the way we have been doing this is that
 6 when we remember during the deposition we say it
 7 and then when we get the transcripts we mark it.
 8 A Okay. So you would like me to answer? As long as
 9 its confidential then I will answer. ^{Redacted}
 10 Q Redacted
 11 Redacted
 12 Redacted
 13 A ^{Redacted}
 14 Q Redacted
 15 A Redacted
 16 Redacted
 17 Redacted
 18 Q Redacted
 19 Redacted
 20 Redacted
 21 A Redacted
 22 Q Of the thirteen, how many of those patients were
 23 receiving care that would otherwise be banned by
 24 the state of Indiana?
 25 A Well, I mean, one at one time would have been.

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1 Q Redacted
 2 Redacted
 3 A Redacted
 4 Q Redacted
 5 Redacted
 6 A Redacted
 7 Redacted
 8 Redacted
 9 Redacted
 10 Redacted
 11 Q Redacted
 12 Redacted
 13 A Redacted
 14 Redacted
 15 Redacted
 16 Redacted
 17 Redacted
 18 Redacted
 19 Q Dr. Kaliebe, you are testifying on behalf of the
 20 state of Indiana, right?
 21 A Yes.
 22 Q They are defending a law that bans
 23 gender-affirming care for minors.
 24 Part of your expertise is predicated in your
 25 representation to the court that you have treated

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

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1 process of actually developing as an individual
 2 before they moved on to consider such things.
 3 And in such cases, they should have a period
 4 of time where they are able to interact with
 5 mental health professionals and explore their
 6 identity, explore how they got to the place where
 7 they are, explore what possibly might be other
 8 things that could be involved that would lead
 9 them, you know, to have this gender dysphoria.
 10 So that should all be worked up prior to
 11 initiation of these treatments. And as someone
 12 who is a growing, developing adolescent, they
 13 should finish their development or very close to
 14 finishing it before they make permanent changes in
 15 their bodies. Those are some of the
 16 psychological.
 17 The physical risks is risk of surgery,
 18 hormones, cancers. Any kind of medical problems
 19 that could come.
 20 Q Do you believe that there are any patients at the
 21 end of this process that you propose, that the
 22 provision of gender-affirming care, the benefits
 23 will outweigh the risks?
 24 A Yes. Could I qualify since we have not gone on
 25 yet? I think you are asking me to opine on an

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1 unknown that I would not say that I have a -- I'm
 2 saying yes based on that I think those who have
 3 gone through, you know, a proper process and are
 4 adults, you know, I think that that is a, that
 5 it's unknown, it's unknown still overall about the
 6 risks and benefits of these transitions. I think
 7 we do need more evidence on it. But that is my
 8 qualified answer. Go ahead.
 9 Q Would you support a ban on this kind of care for
 10 adults?
 11 A You would have to tell me what you mean by ban.
 12 Q Well, you are familiar with Senate Enrolled Act
 13 480, which we are talking about in this case as
 14 pertains to minors.
 15 A Yes.
 16 Q Would you support a law like Senate Enrolled Act
 17 480 if it applied to adults?
 18 A You are saying starting at what age?
 19 Q Let's start with for anybody of any age, would you
 20 support a ban on this kind of care?
 21 A I mean, I think you can reasonably say there must
 22 be some, there could be an age limit. There could
 23 be a process that people have to go through.
 24 Yes. I mean, it may be in the current
 25 climate that you need some legislative safeguards

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1 in order to ensure that there is a proper process.
 2 Q I am asking two questions then.
 3 The first question is so you believe that
 4 after some kind of proper evaluation process the
 5 provision of this care may be appropriate in
 6 adults, correct?
 7 A Correct.
 8 Q Setting aside what that process is, do you believe
 9 that there is any age limit that should exist for
 10 folks who are even eligible to go through that
 11 process to then receive this kind of care?
 12 A Well, I don't have a formulated opinion on what
 13 would be the pluses and minuses of a particular
 14 age limit.
 15 But I do think, in general, we understand
 16 that people are growing and developing and, you
 17 know, in other circumstances people are often, oh,
 18 the brain develops until twenty-five or until
 19 twenty-one.
 20 You know, there is an active debate about the
 21 age where someone sort of becomes, you know, a
 22 fully developed complete person and, you know,
 23 when their identity of any type, you know, would
 24 have solidified.
 25 I think you can have -- I don't think we have

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1 had enough quality discussion and debate in the
 2 literature regarding those things to give me a
 3 sense of what would be a, you know, how to
 4 approach that.
 5 Q In the interim while this debate is continuing or
 6 not, do you believe that there should be a ban on
 7 this kind of care for folks who are over
 8 eighteen?
 9 A A blanket ban for over eighteen? Well, as I was
 10 saying, I just think my belief would be with some
 11 process and with some age bar which might be more
 12 than eighteen could be appropriate.
 13 Q Okay. Well, I guess, earlier when we were talking
 14 about how you think that there is not sufficient
 15 research or there has not been sufficient debate
 16 with respect to folks under eighteen so you
 17 support a ban in the interim.
 18 I am asking the same question for over
 19 eighteen. Do you think there should be an age ban
 20 above eighteen in the interim?
 21 A I have not given it -- I think that it could be
 22 reasonable to have an age ban over eighteen,
 23 correct.
 24 I don't know what exactly, I've not given it
 25 a lot of thought, nor have I seen in the

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1 literature what would be a proper way to approach
2 this. What process would people have to go
3 through. I mean, whenever you make an age limit
4 like sixteen for driving, or twenty-one for
5 drinking, there are always problems with those
6 strict age limits. There are those trade offs.
7 There is a lot of complex calculation that would
8 go into any such trade off.
9 And so I've not really seen any analysis of
10 exactly what would be the best trade off in these
11 situations.
12 MR. SELDIN: We have been going for a
13 little bit at this point. How would a five minute
14 break sound?
15 (OFF RECORD AT 11:09 A.M.)
16 (AT THIS TIME A SHORT RECESS WAS HELD OFF
17 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS
18 WERE HAD:)
19 (ON RECORD AT 11:15 A.M.)
20 BY MR. SELDIN:
21 Q Dr. Kaliebe, welcome back.
22 MR. SELDIN: Joel, will you pull up
23 Exhibit 1 for us?
24 Q Dr. Kaliebe, I would like to talk a little about
25 your declaration.

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1 A Okay.
2 Q Dr. Kaliebe, in your declaration in Paragraph 25
3 you say, "Current discussions regarding
4 transgender care take place in the context of an
5 unexplained and remarkable rise in minor patients
6 reporting gender dysphoria."
7 Do you see where you wrote that?
8 A Yes.
9 Q Would you agree that gender dysphoria is a real
10 condition that requires treatment?
11 A Well, that is one of the things I was talking
12 about before in my preamble about things I was
13 asked before.
14 So is it a real disorder? Correct. But
15 the "requires treatment" part is a complicated
16 matter. So I would say, no. Even though before I
17 sort of automatically said yes, that sounds
18 reasonable. Lots of times in our business there
19 are problems people have that they mostly work
20 through on their own and do not get treatment for.
21 So that is the standard, you know, mental
22 health, most of the things that people have that
23 might meet criteria for a disorder or a problem do
24 not usually get solved by therapy or the medical
25 community.

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1 So, no. I would not say that I would agree
2 with that statement in that it does not, it seems
3 to reflect a it must be treated part. So I can't
4 agree with that.
5 MR. SELDIN: Joel, will you pull up
6 Exhibit 7? We will be at Page 157 of the PDF.
7 Q Dr. Kaliebe, earlier I showed you Exhibit 7, which
8 was your testimony at trial in Decker.
9 Do you recall us talking about that?
10 A Yes.
11 Q Okay. You will see on this Page 1119 of the
12 transcript starting at Line 11 you are asked
13 questions.
14 "Q. Dr. Kaliebe, you would agree that gender
15 dysphoria is a real condition that requires
16 treatment?
17 A. Correct."
18 Do you see that?
19 A Yes, I do.
20 Q Was the testimony that you provided at trial in
21 Decker that I just read truthful?
22 A Yes. In that I -- if you remember at the
23 beginning when you asked about did I make any
24 changes, as I looked at it and saw the wording of
25 this in both my previous, you know, as I was

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1 questioned, this is exactly what I was talking
2 about that now that I see how that was worded,
3 that I, in some ways, misunderstood about
4 "requires treatment" because you can talk about
5 that in different ways.
6 Is it, do we normally -- would we like to
7 treatment something? Is it good if something is
8 treated? Sometimes that is what you mean by
9 requires treatment.
10 I just want to clarify there are lots of
11 disorders and problems that do not require
12 treatment that for most people most of the time
13 they solve their problems without medical or
14 psychiatric treatment.
15 Now that I have had time to think about it
16 and looked at it in print, that is what I was
17 mentioning that I think I was, you know, I believe
18 that "requires" is a word that I was misreading.
19 And now I can see that if that is the, if
20 that is how you are asking it, "must be treated",
21 no, I don't, I want to add some nuance to that
22 question.
23 Q So, Dr. Kaliebe, earlier you were talking about
24 your deposition in Decker, which was like this,
25 just lawyers, no court.

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1 We talked about how you reviewed your
2 transcript for errata. In that case you pointed
3 out misquotes, but not sot of substantive changes
4 that you were thinking about after reflecting upon
5 the testimony.
6 What we just read was testimony that you
7 provided live in court from Decker a few weeks
8 ago. Are you saying the testimony I just read
9 that you provided to the court in Florida is, in
10 fact, not true?
11 A I'm saying that I would add nuance to it because
12 the word "requires" can be seen in different ways.
13 I don't want to be boxed into a corner of saying
14 something that I didn't.
15 Now that I read it, as I said about the
16 deposition, I am now reflecting an opinion that
17 the word "requires" can mean different things in
18 different contexts. So I'm just clarifying.
19 Q Do you feel like given what you have just told me
20 you will need to correct your testimony in Decker?
21 A I don't know what you mean by correct my
22 testimony.
23 Q Well, in Decker you said in court in front of a
24 judge, just like the judge that we have in our
25 case in Indiana, you were asked "You would agree

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1 that gender dysphoria is a real condition that
2 requires treatment?"
3 You said, "Correct."
4 Then you moved on being questioned. So the
5 judge in that case heard you say that it's
6 correct.
7 Do you think that judge needs to know that,
8 in fact, you want to add nuance to that because
9 it's not the answer that you wanted to give?
10 MR. PATTERSON: Objection.
11 You can answer.
12 A I think the judge is plenty intelligent to siphon
13 out these things himself. He saw the rest of my
14 testimony. I'm pretty sure that he was capable of
15 coming to conclusions about what I felt and how I
16 approached treatment.
17 So I think, I don't think it's necessary for
18 me to go and, you know, try to have something
19 amended. I don't see it as a matter that would
20 reach that level of importance.
21 But, once again, since I noticed it and I
22 have evolved or became more mindful of exactly how
23 the words are asked to me to, you know, and could
24 be perhaps used to twist or change what my opinion
25 is, I wanted to make sure here I'm on the record

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1 accurately with what my opinion is.
2 Q So you believe that your views have evolved since
3 May 18 when you provided this testimony?
4 MR. PATTERSON: Objection.
5 Mischaracterizes his testimony.
6 You can answer.
7 A I don't think, I think, you know, my views have
8 not changed on it. I just, the word "requires" is
9 an overly strong word that now I'm realizing I had
10 agreed to and now would be, I would add nuance. I
11 should have at that time added the nuance to my
12 answer.
13 Q All right. Further down on this page, you know,
14 right after this question I will read you part of
15 this testimony.
16 On Line 14 you were asked the question, "You
17 provided some testimony just earlier about the
18 number of people presenting for care. Do you
19 recall that?"
20 You said, "Correct."
21 Then you were asked, "You previously
22 testified that the fact that more people have been
23 showing up in clinics could be, could be explained
24 by, (a), that the care is more available; and,
25 (b), that more people feel comfortable seeking

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1 care; is that correct?"
2 And you said, "Yes."
3 A Correct.
4 Q Do you have any nuance that you want to add to
5 that testimony?
6 A Well, I would assume if you have specific
7 questions, you could ask me. So I think that that
8 speaks for itself.
9 Q So when I asked you correct -- when we were
10 talking earlier you said you had some nuance to
11 add to your answer in Line 16 of "Correct."
12 So I'm asking the same question here, which
13 is, did you understand the question then and
14 answer truthfully, I guess? Then, is there
15 anything that you need to change now to make that
16 the case?
17 A No. I mean, I think that those are factors which
18 are involved. So I still would believe -- I
19 believed at the time and I still believe the --
20 no, that's -- I will stick with that.
21 Q In your report or your declaration you talk about
22 how you had not seen any patients for gender
23 dysphoria between 2005 and 2016.
24 Do you recall that?
25 A Yes.

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1 Q Okay. And you are aware that there was at least
2 one clinic in the United States as early as 2007,
3 correct?
4 A Yes.
5 Q Is there a particular reason you didn't include
6 that fact in this declaration?
7 A I don't understand the question.
8 Q Okay.
9 MR. SELDIN: Joel, will you pull up
10 Exhibit 4?
11 Q Look at Paragraph 102. We were earlier talking
12 about the report that you provided in Decker.
13 This was filed with the court on April 7.
14 In Paragraph 102 if you read maybe two-thirds
15 of the way down the paragraph you said, "The first
16 gender clinic in the United States just opened in
17 2007."
18 Do you see that?
19 A Correct.
20 Q So is there a particular reason that you did not
21 include that fact in your declaration in this
22 matter?
23 A No.
24 Q Earlier we talked about how Decker was the first
25 case you had been an expert in that involved

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1 gender dysphoria, correct?
2 A Yes.
3 Q You said you had not held yourself out as having
4 any particular expertise in gender dysphoria prior
5 thereto, correct?
6 A Well, other than I have obviously testified on, in
7 many cases being a forensic psychiatrist. I have
8 repeatedly held myself out as an expert in
9 psychiatry and in child psychiatry.
10 So my expertise is as a psychiatrist and as a
11 child psychiatrist.
12 Q But you did not specifically hold yourself out as
13 having an expertise in gender dysphoria, is that
14 correct?
15 A Correct.
16 Q Okay. So turning back to Exhibit 1, Paragraph 26,
17 you will see in Paragraph 26 that you talk about
18 how from 2005 to 2016, that eleven year period,
19 none of the medical students or residents you
20 supervised presented you with cases involving
21 gender dysphoria.
22 Do you see where you wrote that?
23 A Yes.
24 Q It would not be surprising if no one came to
25 specifically ask you about gender dysphoria if you

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1 were not holding yourself out as having a
2 particular expertise on that topic, right?
3 A No. Because I work with residents and medical
4 students and primary care doctors on all sorts of
5 patients. So if we were seeing those patients
6 they would have brought them to me because I was
7 working with them as a supervisor under many
8 circumstances.
9 So, no, it would not have to be that I was an
10 expert. I was the expert as the attending
11 clinician or the person who ran the clinic or the
12 person doing the consultative service.
13 So I would disagree with that
14 characterization.
15 Q You would agree then that from 2005 to 2016 just
16 because you were not encountering patients with
17 gender dysphoria, that does not mean that no one
18 was encountering patients with gender dysphoria,
19 right?
20 A Well, I think I was very clear that it was just
21 nobody in my sphere that I worked in at all and my
22 personal interaction.
23 So I didn't ever claim that no one anywhere
24 ever saw a patient with gender dysphoria.
25 Q Okay.

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1 MR. SELDIN: Then, Joel, take to us
2 Paragraph 30, please.
3 Q You wrote, "Never before have there been large
4 cohorts of individuals seeking medical services to
5 alter their secondary sex characteristics."
6 Do you see that?
7 A Yes.
8 Q What do you base that statement on?
9 A Well, we are looking right at a graph of the
10 increases. I know that is Sweden. We could make
11 a similar graph in other places.
12 You know, as I mentioned in my report also,
13 you know, the base rate of gender dysphoria was
14 seen as very low even by the DSM-5, which I
15 believe is a pretty reputable source, two to
16 fourteen per 100,000.
17 So, you know, clearly there was not large
18 amounts of patients seeking services until
19 recently.
20 Q The question that I have is in that sentence you
21 say just seeking medical services to alter
22 secondary sex characteristics.
23 You are referring to a chart about gender
24 dysphoria children, adolescents in Sweden. I
25 guess what I'm asking is when you make that broad

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1 statement, are you considering the history of
2 cosmetic surgery and plastic surgery globally
3 which does often, in fact, alter secondary sex
4 characteristics?
5 A Okay. Yeah. I mean, I think point taken. People
6 do have voluntary surgeries for those things and
7 that has existed for a while. Yes.
8 Q So would it be fair to say that there have been
9 large cohorts of individuals seeking medical
10 services to alter their secondary sex
11 characteristics.
12 They just may not have had gender dysphoria
13 for that, correct?
14 A Well, you know, this report is related to gender
15 dysphoria. So I assume, you know, and these
16 charts are related to children.
17 So I would assume that it was understood that
18 we were talking about children presenting to
19 change their secondary sex characteristics to the
20 other gender, which is accurate.
21 You are correctly pointing out that there are
22 other circumstances where people have sought out
23 surgeries to change their sex characteristics.
24 Q In Paragraph 28 you talk about referrals to
25 certain gender clinics in England and elsewhere.

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1 Do you see that?
2 A Yes.
3 Q Would you agree that there is a difference between
4 having gender dysphoria and being referred to a
5 gender clinic?
6 A Yes.
7 Q Okay. So it's -- the base rate of gender
8 dysphoria and referrals to clinics is not apples
9 to apples, right?
10 A Well, you know, very likely they are related.
11 Q Very likely, but you were not certain?
12 A No.
13 MR. SELDIN: Joel, would you take us to
14 Paragraph 33.
15 Q In your third line of Paragraph 33 you say, "Yet
16 multiple lines of evidence point to direct social
17 influences and online and social media contagion
18 as major contributors to the remarkable rise in
19 gender dysphoria in adolescents."
20 Do you see where you wrote that?
21 A Yes.
22 Q What multiple lines of evidence are you referring
23 to here?
24 A Well, I go on in the report to talk about the
25 increase in presentations to child psychiatrists

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1 of other disorders or problems that are seemingly
2 acquired online or contributed to online which we
3 have, it has been shown that there is a
4 relationship between online viewing and
5 suicidality, self-harm, multiple personality
6 disorder, tic disorders.
7 So we have a significant literature that does
8 show the influence of online habits and
9 presentations to child psychiatrists for problems.
10 That whole idea of culture and disorders and how
11 the medical system's theories and naming of
12 disorders and treatments influence patient
13 presentations has gone back a long time.
14 I referenced the Shorter book which goes back
15 to the Victorian era. So we have known for a long
16 time that the way the medical establishment or
17 clinics see problems can bleed out into the
18 community and affect it.
19 In addition, there are currents in our
20 society that are, you know, reflect viewpoints or
21 ideologies that often are flowing through the
22 media. And those seem to, you know, have
23 influence on how people see themselves. That
24 could be any number of ways. And I don't think
25 that gender identity or gender dysphoria would be

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1 immune to any of those influences.
2 Q So the multiple lines of evidence you are
3 referring to then is by inference or analogy that
4 you would think that also applies to gender
5 dysphoria?
6 A Well, it would be a pretty incredible coincidence
7 that right at the same time that social media came
8 on the scene and became widely adopted by children
9 and adolescents and that the popularity of
10 influencer and ideology related to transgender and
11 gender dysphoria sort of came on the scene, that
12 that was right at the same time that we had this
13 large rise in presentations to gender clinics.
14 So it seems that there is very likely an
15 interaction between the two. Certainly we should
16 be skeptical and cautious when, you know, there is
17 such a change so quickly.
18 Q You would agree that is correlation and not
19 causation at this point?
20 A Correct.
21 Q When you say influencers, who were you referring
22 to.
23 A Well, I don't have specific names of people
24 online. Although over time we have heard many
25 names. There are TV shows. There are people that

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1 are online. There's a number of individuals who
2 are transgender who are well-known personalities.
3 There are also subgroups. You know,
4 influencers might be a strong word for this, but
5 there are a lot of people who are active on the
6 online communities, Reddit, and these type of
7 places where adolescents and children can be
8 influenced by what they encounter online.
9 Q Do you believe that a celebrity who is on social
10 media merely existing as openly transgender is a
11 source of social contagion?
12 A Well, they may be or may be not. I don't, I would
13 not say merely existing. Definitely it would
14 depend on how they present themselves and how they
15 are talking about themselves.
16 It could be -- no, not by merely existing.
17 Q When you say it would depend on what they said and
18 how they are presenting, what do you mean?
19 A Well, I think that we would have to be cautious
20 about the presentation of individuals who may have
21 a large influence over children and adolescents
22 who may take celebratory views regarding
23 transition.
24 That may have a large influence on minors.
25 And so I think that there's a potential for those

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1 who are celebratory to have an influence in a way
2 that, you know, can especially for minors who
3 already have mental health problems or are very
4 easily influenced, could lead them to believe or
5 develop a belief that transition is a solution to
6 the problems that they have, or that their gender
7 dysphoria, the solution to that would help them,
8 could contribute to the development of gender
9 dysphoria or contribute to the belief that a
10 transition would be, you know, a good source for
11 them.
12 Q Do you believe that to be the case even if there
13 is no mention by that particular celebrity about
14 any other co-morbid conditions?
15 You said celebratory. If someone really
16 celebrates the fact that they have medically
17 transitioned, do you believe that that is
18 sufficient to cause social contagion in youth such
19 that they will then believe that they also have
20 gender dysphoria?
21 A Well, I don't know that is sufficient. It could
22 be a contributor.
23 Q Is it possible that a celebrity who is celebratory
24 about their medical transition really creates a
25 more welcoming environment for people who already

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1 have gender dysphoria to be more open about it?
2 A Yes, it's possible.
3 MR. SELDIN: Joel, please take us to
4 Paragraph 52.
5 Q You wrote, "Yet most child and adolescent
6 psychiatrists I speak with admit to me that they
7 will not speak publicly on this subject due to how
8 sensitive the topic is, expressing fears of
9 hostilities from activists along with condemnation
10 and retributions from others with their
11 universities and organizations."
12 Do you see that?
13 A Yes.
14 Q Can you tell me which child and adolescent
15 psychiatrists have said this to you?
16 A Are you asking me to out the people who said they
17 do not want to speak publicly?
18 Q You represented to the court here that most of the
19 people you talk with have said this to you. I
20 would like to know who said this to you.
21 MR. PATTERSON: I object. There could be
22 First Amendment issues here.
23 At a minimum, we should go confidential on
24 this part of the transcript.
25 MR. SELDIN: I think it is presumptively

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1 confidential for two days so we can work it out.
2 Q Dr. Kaliebe, who said this to you?
3 A So this is confidential? Is that what you are
4 saying?
5 Q Yes. We can designate this portion as
6 confidential.
7 MR. PATTERSON: You will not object to
8 maintaining confidentiality of this portion,
9 correct?
10 MR. SELDIN: No, I won't.
11 Q Redacted
12 A Redacted
13 Redacted
14 Redacted
15 Redacted
16 Redacted
17 Redacted
18 Redacted
19 Redacted
20 Redacted
21 Redacted
22 Redacted
23 Redacted
24 Redacted
25 Redacted

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1 Redacted
 2 Redacted
 3 Redacted
 4 Redacted
 5 Redacted
 6 Q Let's start with the folks you just named. You
 7 first named, I think, you counted five or six
 8 people.
 9 Is that most of the psychiatrists that you
 10 have talked to? I'm trying to understand how you
 11 are coming to this conclusion of "most"?
 12 A I talk to many more. I talk to many, many more
 13 psychiatrists. When I go to the child psychiatry
 14 meetings I'm trying to talk to people about these
 15 issues so that we can come up with more.
 16 I just have not prepared a list to provide to
 17 out people who do not want to be outed during my
 18 deposition due to their fears of recrimination and
 19 hostility.
 20 That was not something I thought I would be
 21 asked to reveal. If you want me to make a list
 22 and give it to you later, you know, but like I
 23 said, as I am representing in my report, that it's
 24 many people.
 25 Q You were talking just a minute ago about a talk

Page 87

1 you gave in Puerto Rico. When was that?
 2 A May 2 or May 3 I would guess.
 3 Q What was the conference you were presenting at?
 4 A It was the Oasis Child Psychiatry Conference.
 5 Q What is the Oasis Child Psychiatry Conference?
 6 A A continuing medical education conference that is
 7 presented in different places. Basically people
 8 pay a fee and they travel to wherever it is. This
 9 one was in Puerto Rico.
 10 People like me who are experts provide talks
 11 on different things. I gave three talks at the
 12 Child Psychiatry Conference.
 13 You didn't ask me about presenting CMEs. I
 14 did present this CME talk on child, on gender
 15 dysphoria. So if you want to add that to my
 16 expertise, you can. But this was at the Oasis
 17 Child Psychiatry Conference.
 18 Q Who organizes that conference?
 19 A It's a larger, it's under the umbrella of a large
 20 organization that does many different, they have a
 21 psychiatry conference. They have a child
 22 psychiatry conference.
 23 They have many other things. I don't
 24 remember the name of the company. I don't
 25 remember the company of that organization.

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1 Q So it's, are they affiliated with a medical
 2 institution or association, or is this like a CME
 3 company?
 4 A It's like a board review CME company.
 5 Q Right. Was the topic of the conference you
 6 presented at specific to gender dysphoria?
 7 A No. The topic of the conference was specific to
 8 child psychiatry. I presented three topics.
 9 Gender dysphoria was one of the three topics.
 10 Q What were the other two?
 11 A Traumatic brain injury and social media.
 12 Q Had you presented any version of this presentation
 13 on gender dysphoria before?
 14 A No.
 15 Q Have you presented it again since May 2 or 3?
 16 A No.
 17 Q Have you presented other CMEs on gender dysphoria
 18 prior to May 2 or May 3?
 19 A No.
 20 Q Okay.
 21 A The date might be a little off. I'm not sure. It
 22 was May. It was early May.
 23 Q Okay. How many people attended your session on
 24 gender dysphoria?
 25 A There were probably sixty to eighty in the room.

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1 Q Okay. And about how many people attended the
 2 conference?
 3 A I would assume somewhere around that same number.
 4 It's also online.
 5 Q The entire conference you think was under one
 6 hundred practitioners?
 7 A Yeah. On site I would guess so. Yeah. I'm
 8 not -- it's a guess.
 9 Q Did you reach out to Oasis about this presentation
 10 or did they reach out to you?
 11 A I have spoken for them before. This was the third
 12 time that I have spoken for them. I spoke some at
 13 the adult psychiatry one contiguous with it.
 14 I have done it twice before for them for
 15 child. They have an adult and then a child
 16 conference. I spoke a little at the adult and
 17 then also the child conference this time. They
 18 request me as a speaker. They reached out to me.
 19 Q Did you discuss your involvement as an expert
 20 during your presentation?
 21 A No.
 22 Q I would assume when you say most of the
 23 psychiatrists that you speak with, and this may
 24 seem like a silly question, but you don't speak
 25 with most psychiatrists in the U.S. I take it,

Page 90

1 right?

2 A Correct.

3 Q You have stated you believe that it is

4 controversial to take the position that you take

5 regarding gender dysphoria, correct?

6 A Not controversial among psychiatrists or

7 physicians, yet controversial in the public

8 sphere. Yes.

9 Q So would it surprise you then that once you

10 express some receptiveness to this view of gender

11 dysphoria, would it surprise you then that what

12 appears to be an unusually large number of folks

13 would come to you expressing the same one?

14 A Well, mostly these are regular private

15 conversations from people that I know. It's not

16 like I was approached by the names that I gave you

17 or the people that I'm speaking about when I say

18 that child psychiatrists are afraid to talk about

19 this, but feel supportive of my approach.

20 Q Dr. Weiss, let's go to Paragraph 53 of your

21 declaration. We will scroll down a little bit.

22 MR. PATTERSON: Did you say Dr. Weiss?

23 Q Sorry. My mind is still in last week.

24 Dr. Kaliebe, you will see in this paragraph

25 you talk about social media as an influence

Page 91

1 regarding teenagers.

2 Do you think that heterosexuality is a sexual

3 identity?

4 A Could you repeat the question?

5 Q Is heterosexuality a sexual identity?

6 A Yes.

7 Q Do you believe that social media has an influence

8 in how teenagers who are heterosexual express

9 their identity?

10 A Identity, no.

11 Q You believe that teenagers who use social media

12 who are heterosexual or straight, the way they

13 express being straight is not influenced by social

14 media?

15 A It could be. It could be.

16 Q Are you familiar with the movie genre of the teen

17 rom com?

18 A Is that romantic comedy?

19 Q Right. You are generally familiar with the fact

20 that a decent amount of media television or movies

21 revolve around teenagers in high school who date.

22 Is that a fair description of a certain part

23 of American media?

24 A Yes.

25 Q Do you think that those movies and TV shows when

Page 92

1 they show straight teenagers dating, do you think

2 that that has an influence on how American

3 teenagers date or their expectations of dating as

4 straight teenagers?

5 A It could, yes.

6 Q All right. For teenagers who are not straight,

7 who have a different sexual identity, do you think

8 that media influences their expression more or

9 less than heterosexual teenagers?

10 A I would not have an opinion more or less. I'm not

11 sure.

12 Q Okay. And then do you think everyone has a gender

13 identity?

14 A I think that is an open scientific question. I'm

15 not, I would not say that that is a settled

16 question. That has been an assumption that most

17 people are going on.

18 That seems to be a common assumption. I'm

19 not sure that it is a settled scientific question.

20 Q Do you think that most people have an internal

21 sense of whether they are male or female or

22 something else?

23 A I think we are getting into nuance about internal,

24 what you mean by internal sense. Most people can

25 identify themselves as either male or female. So

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1 I would say that is correct because that does

2 exist in their brain. Yes.

3 Q When you say sense of themselves you mean as male

4 or female? We will start there.

5 A Correct.

6 Q Okay. Do you think that -- okay. In Paragraph 54

7 of your declaration you talk about the -- I'm

8 sorry. I lost my place here.

9 Yes. In Paragraph 53 you talk about

10 Dr. Weigle's publication in the Psychiatric

11 Times.

12 Do you see that about three lines up from the

13 end of Paragraph 53?

14 A Yes.

15 Q Is the Psychiatric Times a peer reviewed journal?

16 A No.

17 Q Dr. Kaliebe, in Paragraph 54 you say -- in

18 Paragraph 55 you say in my opinion --

19 MR. SELDIN: Joel, can you scroll down to

20 Paragraph 55, please.

21 Q You say, "In my opinion, technological,

22 ideological, and social factors underlie much of

23 the recent increase in gender dysphoria in

24 adolescents."

25 Do you see that?

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1 A Yes.
2 Q We will take a look at your report in Decker.
3 MR. SELDIN: Joel, will you pull that up?
4 That is Exhibit 4, Paragraph 44. You say there,
5 "It is plausible and probable that ideological and
6 social factors underlie the increase in gender
7 dysphoria."
8 Do you see that?
9 A Yes.
10 Q My question is in this earlier report in Decker
11 you said it's plausible and probable that
12 ideological and social factors underlie the
13 increase.
14 Then in your declaration here you say, "In my
15 opinion technological, ideological, and social
16 factors underlie much of the recent increase in
17 gender dysphoria in adolescents."
18 My question is, is this two ways of saying
19 the same thing? Or are you holding this opinion
20 to a different degree of certainty from April to
21 now?
22 A I guess it was just the -- it seems to me that I'm
23 pretty much saying the same thing on both
24 occasions. I'm just perhaps fine tuning it. I
25 don't know that it really adds more or less

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1 certainty, the change.
2 Q All right. In the Decker report you said it is
3 plausible and probable that ideological and social
4 factors underlie the increase in gender dysphoria.
5 Is it fair to say then that you are not sure,
6 but this could be true?
7 A Well, I'm saying it is probable. So, yeah, I
8 mean, I think in either case, you know, if it's my
9 opinion, I think the -- I mentioned it is
10 plausible because of it's so, you have had such
11 panic in the academic community when there has
12 been talk of social contagion that it's, you know,
13 it has been really remarkable how people have
14 fought against the idea that there possibly are
15 social or online influences driving these things
16 or having a large influence.
17 That is why I put in the word plausible there
18 because there are academics who are saying that
19 it's not plausible. But I think it is an
20 extraneous word, so I did not use it in the next
21 report.
22 Q As a general matter, would you expect teens who
23 had something in common to find each other online?
24 A Yeah, they could. Yes.
25 Q And would you generally expect that small

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1 populations that tend to otherwise be isolated
2 would find each other online?
3 A Yes.
4 MR. SELDIN: Joel, will you take us to
5 Paragraph 57, please.
6 I'm sorry. Can you take us back to
7 Exhibit 1 and then go to that Paragraph 57. I
8 apologize.
9 Q Dr. Kaliebe, in Paragraph 57 you provide what you
10 call, "A prescription for open exchange and
11 deliberate consideration regarding gender
12 dysphoria treatments..."
13 Do you see that?
14 A Yes.
15 Q Where does that prescription come from?
16 A Well, I don't know exactly where it comes from. I
17 feel like it's an amalgam of thoughts that come
18 from John Haidt, who I cited just below. He is a
19 public intellectual who has commented about group
20 think, the squashing of opinions within academia.
21 He is a social scientist. That is in part from
22 him.
23 It is in part from Jonathan Rauch, who
24 wrought a book called The Constitution of Ideas,
25 which is a quite thoughtful recent book that lays

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1 out, I think, even a list of something similar.
2 This could come from Jonathan Rauch.
3 Steven Pinker has written extensively on this same
4 topic and the importance of rationality and the
5 importance of a dialogue of ideas.
6 You could take this as far back as
7 John Stuart Mill, who was originally one of the
8 originals who sort of brought forth a lot of our
9 ideas that underpin what some people call liberal
10 science or scientific exchange today.
11 So this list is a time tested list and it's
12 reflecting of much of the underpinning of how we
13 have achieved, you know, science and moved
14 knowledge forward.
15 As Jonathan Rauch talked about in his book,
16 there is no one person who has a monopoly on the
17 truth. We get to the truth by exchange, which is
18 conflict, and we need that in order to understand
19 both our opinions better and the opinions of
20 others. And each of us, hopefully, with this
21 conflict will help us all get closer to the
22 truth.
23 So I know that was a long answer for where
24 that list comes from. I'm pretty sure if I looked
25 in those sources I could find a list that is

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1 similar. I don't know exactly where it comes
 2 from.
 3 Q Have you evaluated any other areas of medicine
 4 that you believe have a credible evidence base to
 5 assess whether this prescription was followed?
 6 A Well, I believe in a lot of medicine these things
 7 are broadly followed. So, yes, I believe in many
 8 places we have a rigorous scientific exchange on
 9 multiple matters within medicine. Yes.
 10 Q I guess, have you personally examined any
 11 particular treatment in the field of medicine to
 12 say I wonder if they follow this prescription and
 13 have done this analysis?
 14 A Yes. I think that the best example -- there are
 15 many examples, but I think the scholarly exchange
 16 regarding antidepressant medications is really a
 17 prime example of how we have a robust exchange of
 18 ideas.
 19 Q At the end of that robust exchange of ideas that
 20 you believe took place with antidepressants, did
 21 any state ban the use of antidepressants in
 22 minors?
 23 A No.
 24 Q Okay. Do you think they should have?
 25 A No.

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1 Q Is that an area with what we know now about
 2 antidepressants where you think individual
 3 clinicians have sufficient guidance to make
 4 decisions about their particular patients?
 5 A I think that we still are affected by some
 6 distortions of that scholarly dialogue in the
 7 past.
 8 It's in my report regarding undue influence
 9 of pharmaceutical companies which have swayed
 10 people in a different direction. Thankfully,
 11 there was enough rigor and enough people took
 12 interest, although, it took outside pressure
 13 because it was the lawsuit asking for a release of
 14 full information that helped lead to that.
 15 But, yes, at this point those who are looking
 16 can find a rigorous dialogue of ideas and make
 17 decisions for themselves.
 18 Q Do you think that that evolution would have
 19 benefited from a ban on the use of antidepressants
 20 in any population while it took place?
 21 A No.
 22 Q In Paragraph 58 you say, referring to this
 23 prescription, "This framework would depersonalize
 24 the search for truth and esteemed empirical
 25 dialogue, which has been in short supply on

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1 numerous topics within academia."
 2 Do you see that?
 3 A Yes.
 4 Q What are the other numerous topics you are
 5 referring to here?
 6 A I think in general many of our academic
 7 institutions and professional organizations
 8 included have gotten behind ideas of social
 9 justice.
 10 I think social justice ideas at some point,
 11 you know, may or may not reflect the truth. So if
 12 your goal is social justice, it can bump up
 13 against rigorous science.
 14 So I would say that in general that would be
 15 the one good example.
 16 Q Which social justice topics do you think are
 17 bumping up against empirical science?
 18 A Well, it could be any number of them. I think
 19 this is a case in point. So I think this is part
 20 of why it's in my report.
 21 Rather than being seen as a dialogue related
 22 to what is the science and ensuring a rigorous
 23 scientific dialogue, it has been treated as if
 24 it's a social justice issue rather than an issue
 25 of what is good medical practice.

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1 But I think, you know, the issues related to
 2 hot button topics, race would be one.
 3 Q In what way?
 4 A Well, I think that when -- I think that after
 5 George Floyd's murder and other events that there
 6 has been, but that in particular, there was a call
 7 for a special influence on matters of race. Which
 8 is a great thing for people to be more attune to
 9 and to have scholarly dialogue.
 10 But they asked for a certain viewpoint. I
 11 think a good example is Ibram Kendi's, you know,
 12 antiracism sort of viewpoint on it to be put
 13 forward as the way that we are supposed to handle
 14 it.
 15 So a lot of our journals, in fact, the Child
 16 Psychiatry Journal, they declared itself an
 17 antiracist journal, which is joining an ideology
 18 on how to approach race, rather than calling for
 19 more open and rigorous dialogue about race, which
 20 would have been the more appropriate viewpoint for
 21 a medical journal.
 22 Q I think you just described antiracism as a
 23 particular ideology about race.
 24 What are the other ideologies about race that
 25 you believe exist?

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1 A Well, like I said, I don't have a countervailing
2 ideology of it. Like I said, the journal in our,
3 in child psychiatry declared itself to be an
4 antiracist journal, which is an affiliation with
5 that ideology.
6 I'm actually against affiliations with
7 ideology. I don't know that there is a
8 counter-ideology. We prefer it to just be a
9 rigorous scientific dialogue about important
10 issues. That is what we would be aiming for if
11 you follow the prescription that I've laid out
12 here.
13 Q Are there any particular principles in antiracism
14 as an ideology that you think are antithetical to
15 the search for the truth or scholarly dialogue
16 that you think that journal should have
17 undertaken?
18 A Well, I didn't, you know, I'm not prepared to go
19 into a, you know, in depth into that. I would say
20 there's a, there are some broad narratives about
21 the world included in that, which is that certain
22 groups are oppressors and other groups are
23 oppressed.
24 That would be a primary narrative that is,
25 can be accurate. But yet we would have to be

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1 nuanced about how we approached those things and
2 that we should be very careful to make
3 generalizations especially in the realm of
4 science.
5 The more broad your generalization, the more
6 likely that you are over inclusive and
7 overgeneralizing. And so that would be the
8 oppressor versus oppressed narrative, that would
9 be a good example.
10 Another example of that would be the whole
11 idea of race being codified into a more important
12 marker of people's identity. Whereas, it's not
13 actually a very scientific idea. It is a really
14 complex idea.
15 People come from different backgrounds and
16 origins. You know, where do you draw the line?
17 How do we sort of determine this? And what do you
18 do about mixed race couples? What do you do about
19 people who look like they are one race, but they
20 are the other? I mean, it's very complex.
21 So the broader narratives embraced are
22 problematic when you come to, when you come to
23 science. Then, also, it's a call for, I mean,
24 when editors call for a certain viewpoint, once
25 again, I just think that that is not what any job

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1 of an editor or a journal would be.
2 They can call for more viewpoints and
3 discussions which would be great, but not to call
4 out or prefer a certain viewpoint.
5 Q Do you think there are any viewpoints about race
6 that journals should not seek to include?
7 A Well, I think that there, I think that certainly
8 you are not going to, you know, considering where
9 the dialogue is and who would be writing to
10 psychiatry journals, you are only going to have
11 thoughtful academics writing in and trying to talk
12 about a nuance.
13 So not within the, not that I, not that a
14 psychiatrist would write into a journal. I find
15 it would be highly unusual that there would be any
16 idea written in or someone who would submit for an
17 article that would be outside of the bounds of
18 what would be acceptable dialogue.
19 I would say maybe, you know, in theory there
20 could be. In practice, there is not.
21 Q Do you believe that there is, as a normative
22 matter, a view on race that a psychiatrist could
23 seek to present to a journal that without
24 hampering the search for truth the journal could
25 say that is actually outside of the bounds of

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1 discussion?
2 A Well, if they were overgeneralizing, which is
3 exactly what I'm talking about. Yes, so. I'm
4 against people overgeneralizing.
5 So a journal editor should knock down any
6 article that overgeneralizes.
7 Q Dr. Kaliebe, in the middle of Paragraph 62 in your
8 declaration you say, "Supporters of
9 gender-affirming treatment want to believe they
10 have found an ethical and evidence based
11 solution."
12 Do you see where you wrote that?
13 A Yes.
14 Q What do you think is unethical about
15 gender-affirming treatment?
16 A Well, gender-affirming treatment as an actual
17 clinical treatment can do harm. So I think it is
18 unethical to do harm.
19 Q What harm do you think it does?
20 A Well, when you are asked to evaluate a child or an
21 adolescent, they need to be seen in the context of
22 a total individual and their total environment.
23 You would have a biopsychosocial formulation.
24 They are in the process of identity development.
25 So to see someone through just the lens of

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1 affirming can be harmful and can turn the
2 discussion just towards gender identity or gender
3 dysphoria rather than away from the traditional
4 way that you would approach a patient.
5 So it's trying to, it is, I believe it's poor
6 medical care to move to affirming automatically
7 patients who present with gender identity issues
8 or gender dysphoria.
9 Q So is the harm from the diagnosis of gender
10 dysphoria, or from the possibility that the
11 evaluation process does not discover other
12 co-morbid conditions?
13 A There is not a problem with the diagnosis of the
14 gender dysphoria. But there is a problem with an
15 overemphasis on one component of people's identity
16 and a turning away from the typical therapeutic
17 approach which we have always used which does not
18 jump towards affirmation, but lets a person
19 develop in their own way and would be broadly
20 based and notice what is the context, what other
21 disorders, what else is going on, what traumas
22 have occurred, you know. What other family issues
23 are going on?
24 So, yes, I feel like that when this is
25 proposed as a way to approach these patients, that

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1 it distorts care away from what would be a proper
2 and traditional psychiatric approach.
3 Q Do you think that the care can be ethical if all
4 of the traditional psychiatric or
5 psychotherapeutic approaches that you are
6 referencing had already happened or are happening
7 concurrently?
8 Could then treatment that is gender-affirming
9 be ethical?
10 A Well, if you are -- yes, it could be. It could be
11 if they have had a proper workup and have, you
12 know, that that is the approach that the clinician
13 has decided after working with the patient for a
14 long period of time.
15 But I'm talking about a psychotherapy
16 approach. I assume that is what you are talking
17 about, too. When you say gender-affirming care
18 that can include medicalized care.
19 I want to be clear. I'm not talking about
20 medicalized care. I think we are talking about
21 therapy and therapeutic approaches.
22 Q I think we will talk about both. For
23 psychotherapeutic approaches you believe it is
24 possible to provide gender-affirming
25 psychotherapeutic approaches to minors who are

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1 experiencing gender dysphoria, is that fair?
2 A Well, you could get to it after providing
3 appropriate care, you know. Would there be a
4 place down the road where you could decide that,
5 you know, and I'm not quite sure what exactly you
6 are meaning by affirmative care, but I assume you
7 mean for, like, going along with the patient's
8 conceptualization of what is going on, which would
9 not be what we usually do in mental health.
10 We usually remain neutral about what is going
11 on rather than joining a patient's
12 conceptualization.
13 If at the end of the day, you know, would
14 that mean is it okay for a clinician to use the
15 pronouns that are requested by a patient, then I'm
16 saying, yes. You know, that is perfectly
17 reasonable and under certain circumstances, you
18 know, yes.
19 But is it appropriate to ever completely go
20 along with the patients' narratives or views of
21 the world so that is, you know, a clinical
22 decision that maybe you could get to.
23 MR. SELDIN: We have been going for
24 another hour. I think most of the folks here are
25 on East Coast time.

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1 Do we want to take a short break now and
2 then go for an hour and then do lunch? How are
3 folks feeling?
4 Dr. Kaliebe, will you be okay with a five
5 minute break and then another hour?
6 A I will do whatever the group wants.
7 MR. SELDIN: Let's do that. We will come
8 back at 12:27 Eastern.
9 (OFF RECORD AT 12:21 P.M.)
10 (AT THIS TIME A SHORT RECESS WAS HELD OFF
11 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS
12 WERE HAD:)
13 (ON RECORD AT 12:27 P.M.)
14 BY MR. SELDIN:
15 Q Dr. Kaliebe, welcome back after that short break.
16 In Paragraph 65 you describe a dynamic, "In
17 fact, sophisticated language skills enable
18 virtuosity in creating and promoting false
19 narratives."
20 Then you go on to say, "These dynamics have
21 arisen before in medicine, and it is my assessment
22 this has occurred again with regards to medical
23 interventions to treat gender dysphoria in
24 minors."
25 Do you see that?

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1 A Yes.
 2 Q What is your methodology for assessing that that
 3 has happened here?
 4 A Well, I think if you look at a lot of the journal
 5 articles, the press releases from national
 6 organizations, the sort of what I would call
 7 cheerleading for affirmative care, that it seems
 8 to be that it's like a, more of a tribal dynamic
 9 than an actual usual discussion, a very complex
 10 nuanced evidence based and a new treatment
 11 population.
 12 Within that environment clearly there is some
 13 who are, I believe, very caught up in a group
 14 think regarding these issues. So I can give you
 15 more details. But basically, the things that I
 16 put in my report sort of speak for themselves.
 17 The way the professional organizations are
 18 framing their arguments, the way the people write
 19 the guidelines all speak to a moralized type of
 20 environment rather than the usual dialogue
 21 regarding medical evidence.
 22 Q Is your primary concern the consensus or the
 23 enthusiasm?
 24 A Well, the false consensus is definitely a problem
 25 because they are, without really undergoing the

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1 standard academic debate, they are sort of
 2 pretending like there is a consensus and this is
 3 all settled science.
 4 Then the level of enthusiasm is also very
 5 problematic because the level of enthusiasm should
 6 be proportional to your confidence in your
 7 argument and the safety of your argument.
 8 So when people are coming out very
 9 enthusiastic for something that, you know, is not
 10 settled and unclear clinically, that then,
 11 those -- so I would believe those are both
 12 problems.
 13 Q Then you say that these dynamics have arisen
 14 before in medicine.
 15 When have they arisen before?
 16 A Well, when for a time lobotomies were popular and
 17 were sort of celebrated as curing a very difficult
 18 patient population with serious problems.
 19 The person, you know, won the Nobel Prize for
 20 lobotomy. In retrospect it sounds horrible, but
 21 that is an example.
 22 I think your, I mean, I think whenever you
 23 have intermixing of moralized environments -- on
 24 the flip side you could also say, like,
 25 pronunciations against, you know, making

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1 heterosexuality a disorder in the DSM would rise
 2 from moralized environments where people took what
 3 should be a scientific or medical issue and turned
 4 it into a disorder based on social or cultural
 5 elements.
 6 Q So with your homosexuality example, do you think
 7 the moralizing environment led to its inclusion in
 8 the DSM or its removal from the DSM?
 9 A Inclusion in the DSM.
 10 Q Do you agree with its removal from the DSM?
 11 A Yes.
 12 Q Okay. In Paragraph 66 you talk about emotional
 13 reasoning. In the last sentence you say that it
 14 "helps explain opinion cascades, partisanship, and
 15 group think."
 16 Do you see that?
 17 A Yes.
 18 Q Those are terms that come from sociology, is that
 19 correct?
 20 A I mean, there's a, they -- I'm not sure exactly.
 21 They jump from field to field. So you can get
 22 those terms in a number of different fields.
 23 Behavioral economics is a field that uses
 24 those terms. You know, we do talk about them some
 25 in medicine, too. Yes, I believe sociology and

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1 behavioral economics would be the, would be where
 2 I found them.
 3 Q Is it fair to say these are not conditions that
 4 you diagnose as a psychiatrist?
 5 A Behavioral economics was sort of founded by a
 6 psychologist. The only psychologist who won the
 7 Noble Prize, Daniel Kahneman, so it's within the
 8 realm of people who are experts in how the mind
 9 works and how we make decisions.
 10 Is it directly psychiatric? I think it's
 11 important for you to size up the person in front
 12 of you and where they get their information and if
 13 they have cognitive distortions related to groups,
 14 you know, and the information that comes to them
 15 in groups they affiliate with.
 16 I think modern psychiatrists should
 17 understand and know these things.
 18 Q Do you think you have expertise beyond that of a
 19 well-trained psychiatrist to assess whether
 20 opinion cascades, partisanship, and group think
 21 are occurring?
 22 A Well, I think I was mentioning that I would hope
 23 that all psychiatrists should understand these
 24 phenomenon and be able to see when they may apply.
 25 Q Do you, yourself, believe above that level that

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1 any psychiatrist should have, do you believe you
2 have particular expertise in identifying when
3 these things are happening?
4 A Well, I put in a lot of work. As I mentioned in
5 my report, I did present on misinformation at the
6 child psychiatry conference. If you look at some
7 of my articles, like my article on child obesity,
8 I bring in a lot of the ideas related to
9 behavioral economics and how to approach the world
10 and how we, how human beings tend to fool
11 themselves.
12 Yes, I probably put in more work than other
13 psychiatrists on these matters.
14 Q Okay.
15 A I will say I read a lot. So, you know, I probably
16 read a lot more than almost any psychiatrist that
17 you will talk to.
18 So, yes. I do pull from lots of different
19 things, but I think that what I'm pulling from
20 here is important and most psychiatrists
21 understand these dynamics.
22 Q Doctor, look at Paragraph 79. Dr. Kaliebe, in
23 this paragraph you are talking about the opioid
24 epidemic.
25 On the bottom of Page 27 there is a sentence

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1 that starts, "While a small number of patients may
2 have achieved better pain control as a result, it
3 came at the cost of creating legions of addicts."
4 Do you see where you wrote that?
5 A Yes.
6 Q And so is it fair to say that you have identified
7 opioid prescription as an area in which providers
8 were practicing either outside of the guidelines
9 or recklessly?
10 A Well, what I was saying was, in fact, the
11 guidelines were pushing them towards, they were
12 exerting pressures on them to prescribe
13 inappropriately.
14 So, no, you know, this was my whole point.
15 You get, you get ideas that come from, you know, a
16 small group, yet then can get taken up and become
17 popular. Especially when you have the idea of you
18 are being more compassionate so this is the right
19 thing to do. You are a bad person to ignore
20 someone's pain without realizing at the end of the
21 day these are complex matters and you can do harm
22 by opioid prescribing.
23 I believe that was pretty clear in what I
24 wrote.
25 Q Do you believe that the treatment of gender

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1 dysphoria like the treatment of pain is a complex
2 area?
3 A Yes.
4 Q Okay. And in response to the opioid epidemic, the
5 states have implemented greater controls, is that
6 fair to say?
7 A Yes.
8 Q But they have not banned them entirely?
9 A Correct.
10 Q Dr. Kaliebe, before the break we sort of talked
11 about, we touched on this and I want to dig a
12 little deeper.
13 So you say in Paragraph 83, you talk about
14 "affirmative treatment." You put that in quotes.
15 What is affirmative treatment?
16 A Well, I believe it has two major components. I
17 mean, one would be the idea that when someone
18 presents with -- well, specifically we are talking
19 children and adolescents here.
20 If a child presents and declares a gender
21 identity that the clinician should agree with that
22 identity. That is one component.
23 And then the other part of affirmative
24 treatment is medicalized treatment such as puberty
25 blockers, hormones, and surgeries.

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1 Q Where do you get that definition from?
2 A Of affirmative treatment?
3 Q Yes.
4 A I mean, I have seen much more complex descriptions
5 of affirmative treatment. I think that is what it
6 boils down to.
7 Q You say in Paragraph 83 there is a push for
8 affirmative treatment.
9 How do you think the groups that you list in
10 this paragraph are pushing the treatment?
11 A Well, if you look at the guidelines from WPATH, I
12 think those are clear. The Endocrine Society and
13 the American Academy of Pediatrics came out with
14 guidelines that specifically advocate for them.
15 American Psychiatric Association has, I
16 believe, they didn't come out with treatment
17 guidelines, but they have come out in support of
18 it in multiple ways, press releases, stuff on the
19 website, publicity things and in their journals.
20 So there's, you know, the way that they
21 selected articles and the articles that they
22 publish all, they all seem to reflect an idea that
23 those are the, that this is the approach that they
24 favor as institutions.
25 Q When you say push for affirmative treatment, do

Page 118

1 you mean just the organizational support around
2 the existing guidelines?
3 Or do you mean push for affirmative treatment
4 at the individual level?
5 A Well, it seems clear to me that they want us to
6 adopt this as treatment.
7 Q And what is your basis for saying that this kind
8 of care is politicized?
9 A Well, I think, for one, if you look at a survey,
10 opinions about these matters tend to clump in
11 lines that go along political affiliation.
12 So for one, it's just a fact that is based on
13 the surveys. There has been a number of surveys.
14 It tends to be that people who are in, you know,
15 in one political party have certain feelings about
16 this and people in another political party have
17 certain feelings about this.
18 So I cited a Regenerist article that did
19 questions after people came out of polls. That
20 was sort of a direct peer view published line of
21 that evidence. There have also been a number of
22 opinions polls.
23 The political parties, you know, have, I
24 don't know that the, I don't know if the, to what
25 degree the Republican party has come out, you

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1 know, with strong statements or push for these
2 things. But if my memory serves me correctly,
3 their administrative, I mean, political parties,
4 whoever is in political power has some control
5 over administrative issues.
6 So, I mean, I think that some aspects of the
7 general idea or rights for transgender individuals
8 is a politicized idea. So I think that that is
9 where I say that. I would also say that if you
10 look at the organizations -- I put some data in
11 there.
12 These organizations, particularly the
13 psychiatric ones, and the American Academy of
14 Pediatrics, I could say that for sure, too, tend
15 to be a left-leaning organization. They tend to
16 support politics that are, you know, to the left
17 of the center.
18 And also it's true if you will look at just
19 even polls of who in what medical specialty aligns
20 with what political party. One of the polls I saw
21 had psychiatry was second to the most left-leaning
22 of all of the specialties with only public health
23 being more left-leaned.
24 So not surprising that the professional
25 organizations follow the politics of the members

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1 that tend to lean in one direction. That is -- I
2 put examples in my report.
3 Q Based on that definition of certain kinds of care
4 being politicized, do you think that as a
5 clinician that is a reason to provide or not
6 provide certain kinds of care?
7 A Well, I think that it is not a reason you should
8 be providing care based on what is good care. But
9 it could make you more skeptical of these
10 professional organizations' support for certain
11 care because you know that they come out and
12 support things that happen to lean in their
13 political or within their, you know, thought
14 level. They are very accepting of things that
15 are, in that case, left-leaning.
16 Therefore, they are susceptible to
17 confirmation bias, group think, group dynamics
18 that would lead them to move away from a
19 scientific, more clinical approach towards an
20 ideological approach.
21 Unfortunately, I put in my report that is
22 what I feel has occurred.
23 Q Are there other areas of psychiatry where you
24 think the political alignment of psychiatrists or
25 their organizing groups has negatively influenced

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1 care?
2 A Yes and no. I mean, there are different
3 priorities that the organizations have. I mean,
4 my priority and what I was trying to push for
5 within the American Academy of Child and
6 Adolescent Psychiatry and the American Psychiatric
7 Association with some of the articles that I wrote
8 and, you know, supporting in meetings, was a
9 collaborative care, particularly working in
10 federally qualified health centers.
11 So what I would love to see is for them to
12 put an emphasis on getting primary care support to
13 deal with mental health issues. Getting an
14 emphasis on us growing more federally qualified
15 health centers which are primary care clinics that
16 provide like WIC and dental and, you know, mental
17 health care to communities. You can only open an
18 FQHC if you are an underserved or disadvantaged
19 community.
20 So that is what I was pushing for us to do.
21 We do do that some as an organization, push for
22 that. I just feel like that would be a much
23 better priority for an organization. So
24 unfortunately, you know, they seem to be more at
25 times interested in other things rather than what

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1 I think would be the most helpful approach.
2 It seems that sometimes the other things that
3 they are interested in are things that are hot
4 button political items rather than the actual, a
5 great thing you can do like supporting primary
6 care in disadvantaged neighborhoods.
7 Q So relative ranking of priorities aside, is there
8 any individual kind of care in psychiatry that you
9 think is being provided and should not be because
10 of the political alignment of psychiatrists or the
11 organized medical groups?
12 A No. I think gender medicine has been the first
13 time that this type of ideological care has
14 actually come in and affected, you know, patient
15 care on a wide level. Yeah. I have never seen
16 that before.
17 Q In Paragraph 84 you say in the third sentence, "I
18 have directly observed over the last decade, but
19 particularly the last 5 years, that these
20 organizations have prioritized a politicized,
21 narrow vision of social justice advocacy."
22 Do you see where you wrote that?
23 A It is kind of cut off at the bottom. Yes. I
24 remember writing it.
25 Q Other than what you just called gender medicine,

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1 what else have you directly observed in the last
2 five years that falls into this category?
3 A Well, I think we talked about race, so I think
4 that is an issue that, you know, while an
5 important issue and I'm glad that they want to
6 emphasize it, the way that they have emphasized
7 that has also has been very, it has been
8 politicized. And the sort of policing of, or the
9 curation of what goes in the journal, at least of
10 the psychiatric organizations, does seem to be
11 very narrow.
12 But that would be the other main thing that I
13 can think of. There are probably more. That is
14 what I can think of right now.
15 Q When you referenced just now narrow curation, are
16 you talking about articles regarding the treatment
17 of gender dysphoria or something else?
18 A Something else. I'm saying I do believe they do
19 that. But since I was asked about what else is
20 sort of politicized and the social justice, we
21 spoke before about how they have come out with
22 becoming antiracist journals rather than just
23 saying we would like to focus more on race. Race
24 is a really important topic. It is an important
25 component of what goes on in society.

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1 Q Let's look at Paragraph 85 and 86 together.
2 Dr. Kaliebe, you talk about your time
3 co-chairing -- is AACAP the way you say that?
4 A Yes. People say AACAP.
5 Q When you co-chaired AACAP's media committee, it
6 seemed like in Paragraph 86 you characterize that
7 as a committee of content experts, is that fair?
8 A Yes. Yes.
9 Q And then in Paragraph 85 you are talking on the
10 second line about special interest groups. You
11 put that in quotes.
12 Do you see where you wrote that?
13 A Correct.
14 Q Is there a difference between special interest
15 groups and content committee and content?
16 A Well, I was trying to differentiate that there are
17 groups of people that do, that are attracted
18 towards certain approaches. And so they could be
19 a group of people that are not officially a
20 committee.
21 So you could self-select in more ways than
22 one. The committees are vehicles within the
23 professional organizations.
24 Q What I'm trying to get at, your concerns about
25 group think and opinion cascades, do you think

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1 that was in affect when you were co-chairing the
2 AACAP committee on media?
3 A Yes and no. I think in the media committee we
4 were always mindful to bring in diverse opinions
5 of people. So we didn't want -- there are a lot
6 of people who are generally negative about the
7 media. They would want to present or talk about
8 media in negative ways.
9 We were very conscious that humans seem to
10 have a negativity bias and negative stuff gets
11 noticed more. There are also positives with
12 media. We are trying to cultivate in our
13 presentations and in our output a balanced look.
14 So, you know, I don't think by any estimation
15 anyone would think that our committee became
16 one-sided or too, you know, too negative. But
17 once again, you deal with clinical issues. So
18 there is always some bias towards negative. That
19 is something that we were cognizant about.
20 Q Are there other committees in AACAP that you feel
21 didn't do as good a job providing that kind of
22 balanced view other than the ones dealing with the
23 treatment of gender dysphoria?
24 A Well, I think I had mentioned previously that at
25 one point those who wrote -- or had in my

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1 report -- that those who wrote the pharmacology
 2 guidelines were overly enthusiastic, influenced,
 3 or excited or however you want to say it,
 4 regarding psychopharm.
 5 So I think at times any of these committees
 6 can be somewhat overconfident or have opinions
 7 that lean towards interventionalism towards
 8 whatever intervention that the committee is about.
 9 So I think that, yes, you know, the
 10 psychopharmacology committee would tend to be too
 11 much focused on psychopharmacology from the
 12 perspective of a regular psychiatric practitioner
 13 that has to take the different patients and use
 14 all sorts of different modalities and not just
 15 pharmacology.
 16 The group dynamics have some affect on the
 17 other committees. I mean, I would probably guess
 18 that, or it is possible that there is some other
 19 committees that they also may interact with. I
 20 have not been to the, I think it's, like, I will
 21 probably mess up the name. I think there is,
 22 like, a race and diversity committee.
 23 Is it possible that they would be, you know,
 24 could that committee be overly politicized? It is
 25 possible.

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1 Other than the gender committee I have never
 2 seen it affect clinical care in this way.
 3 Q Dr. Kaliebe, at the end of Paragraph 87 you
 4 characterize the group that works in the area of
 5 gender dysphoria as "a well-intentioned but
 6 homogenous group of supporters."
 7 What do you mean by homogenous?
 8 A I am talking about at the beginning of the
 9 paragraph, they have self-selected into providing
 10 this type of care and are enthusiastic about it.
 11 And so when you have a group of like-minded
 12 individuals that support it without really a --
 13 more skeptical people end up not being on that
 14 committee. So that is my impression.
 15 Q Just to describe a similar dynamic, the
 16 psychopharmacology committee, that they would have
 17 bias toward intervention using certain kinds of
 18 medication, is that also what you mean by -- would
 19 homogenous be a way to describe that as well?
 20 A Yes.
 21 Q Okay. Would you generally agree that a group of
 22 people that have a special interest in a topic
 23 is -- I guess, what I'm trying to ask you is when
 24 you were the chair of AACAP's media committee, did
 25 that committee benefit from the fact that its

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1 members had a special interest in media issues?
 2 MR. PATTERSON: Objection. Assumes facts
 3 not in evidence.
 4 You can answer.
 5 A Yes.
 6 Q Generally speaking, in your evaluation of group
 7 dynamics, if you have a small committee you would
 8 prefer folks who were interested in the topics
 9 rather than disinterested, correct?
 10 A Well, no. I would give some nuance to that. I
 11 mean, I would really love to see -- I actually
 12 thought that it probably would be really quite
 13 helpful for -- let's go back to the
 14 psychopharmacology committee -- for there to be
 15 some, like, regular bread and butter practitioners
 16 on that committee so that the committee would be
 17 mindful of what is happening in the real world and
 18 how, you know, their proclamations on, you know,
 19 medications play out.
 20 You know, especially as I've served in
 21 disadvantaged and underserved communities, you
 22 know, the idea that there is a medication solution
 23 for people's problems, you know, the guidelines
 24 were very heavy into pharmacologic, you know,
 25 solutions. And it just is not, it's just

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1 unrealistic on a massive level.
 2 No, I think it would be best if there was a
 3 way to make sure that there is broad inclusion of
 4 people. But in reality, that is not how
 5 committees are formed. It is people that tend to
 6 be enthusiasts.
 7 So I think there is some advantage to people
 8 being enthusiasts, but I think there are
 9 disadvantages, too. You know, as I mentioned the
 10 psychopharmacology example, you know, it would be
 11 nice for there to be a counterbalance of people in
 12 the field who are not so enthusiastic.
 13 Q Do you think that is true for every field?
 14 A Yes.
 15 Q Dr. Kaliebe, in Paragraph 89 you talk about
 16 watchful waiting.
 17 What do you -- is watchful waiting the
 18 approach that you prefer for treating minors with
 19 gender dysphoria?
 20 A Well, I think a component of the approach,
 21 regarding certainly medicalization-wise I would
 22 say yes. I think that would make the most sense
 23 to let people grow up and then once they, you
 24 know, are adults to make decisions about hormones
 25 and surgeries when they are fully developed

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1 humans.

2 So medicalization-wise, yes. But I think as

3 I mentioned before, I believe that it is ideal for

4 people to get other types of, you know, to have a

5 well-rounded approach to life which would include

6 a number of things and potentially psychotherapy.

7 Q And so you, in this paragraph you say that the

8 policy statement at issue from the AAP contained

9 citation errors, overstatements, and

10 mischaracterizations of the -- sorry -- you say it

11 mischaracterized the long-standing and

12 well-regarding clinical approach of watchful

13 waiting.

14 How do you think they mischaracterized it?

15 A Well, they say it right there. "Watchful waiting

16 is based on binary notions of gender."

17 I mean, to translate, that sounds like saying

18 well, those people who do watchful waiting, they

19 are just those old rubes who don't know any

20 better.

21 We're the sophisticated new people that want

22 to do this intervention. We are going to get rid

23 of that approach is what we want to do because we

24 know better now.

25 And I think that that right there kind of

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1 shows that they are failing to appreciate the

2 nuance and difficult realities of when you have a

3 developing situation and you don't know where it's

4 going to go, it's often better to not intervene

5 than to intervene and potentially do harm.

6 Q Do you agree that there are instances where not

7 intervening can actually also cause harm?

8 A Are we talking about with gender dysphoria or just

9 in general?

10 Q First, we will start in general. Do you agree

11 there are situations where the choice not to

12 intervene can also cause harm?

13 A Correct. Yes.

14 Q Do you think that there are instances in the

15 treatment of gender dysphoria in minors where

16 declining to intervene can cause harm?

17 A I would not frame it as causing harm. So I would

18 not use those words.

19 Q What words would you use?

20 A Well, I would say that the not intervening would

21 allow a patient to grow and develop. And then

22 once they have a sort of fully developed self,

23 then they can make decisions about medicalization

24 of their body.

25 So I don't, I just, I think you have got --

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1 that would be a better way to say it.

2 Q So are you aware that some of the original

3 proponents of the watchful waiting approach were

4 the Dutch and Ken Zucker in Toronto?

5 A I mean, I would step back and just say, you know,

6 watchful waiting is a term that we use in medicine

7 all of the time. It was used for decades before

8 it was adopted by gender medicine.

9 So I would say this is an old term that has

10 lots of uses in medicines. So, yes, I would, I am

11 aware that both Ken Zucker and those in the

12 Netherlands have used that approach.

13 Q Both the Amsterdam Clinic and Zucker's Toronto

14 clinic both treated adolescents with blockers

15 and hormones once they reached puberty, is that

16 right?

17 A Yeah. I mean, I don't have data about Zucker's

18 treatment protocol or what was going on there. I

19 can't speak to what treatment they were getting in

20 the clinic. The Dutch clinic has published a lot

21 of articles so we are familiar with that.

22 Q So in that respect, watchful waiting would apply

23 to prepuberty at those clinics?

24 A Correct.

25 Q And so even those proponents of watchful waiting,

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1 they still recommended medical interventions when

2 the incongruence of distress persisted into

3 puberty?

4 A Yes, I know the Dutch did. I don't know that

5 Zucker's protocol, I have not seen exactly how it

6 was treated or what his approach was.

7 Q Do you oppose social transition for minors with

8 gender dysphoria?

9 A Well, I think it's a complex subject. I think,

10 yes, in that children with gender dysphoria it

11 seems would be wise for them to be thought of as

12 children with gender dysphoria, not transgender

13 children.

14 We don't know what their, in the end

15 development is going to be, so why not, I think

16 it's most wise to keep them developing within

17 their biological sex, be honest that they are a

18 person with gender identity issues with gender

19 dysphoria.

20 They may grow up to be a transgender

21 individual as an adult. They may also grow up to

22 be not transgender as an adult. Since we don't

23 really know, why don't we more conservatively

24 approach this and not socially transition them

25 when they are young. That would be my

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1 recommendation.
2 That being said, you know, families can
3 decide to do whatever they want to do and, you
4 know, I don't know that there could not be some
5 exceptions to that recommendation. But that would
6 be my recommendation.
7 Q It sounds like you would agree that individual
8 families might decide that for their particular
9 child the appropriate way to address their gender
10 dysphoria would be to allow them to socially
11 transition?
12 A Well, they do decide that. Yes. I mean, like I
13 said, I don't think that is a wise decision. But
14 once again, that is a family decision. Whatever a
15 psychiatrist says cannot change what a family
16 does.
17 Q Would you support a ban on social transition among
18 minors?
19 A Well, I do think that the society has always used
20 biological sex as the main marker of what a minor,
21 you know, how a minor is classified.
22 So I don't see a compelling reason to stop
23 using biological sex as the marker which we --
24 especially considering these are children with
25 gender dysphoria. They are not transgender

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1 children. Right? We don't know what the end of
2 their trajectory will be so why are we going
3 through this at this point?
4 Like I said, through human history the marker
5 of biological sex has some, it has trade offs, but
6 it has generally worked well for us. I would say
7 that is the most sensible approach right now.
8 Q So my question was, I guess, do you think that
9 there should be a ban on parents taking the
10 approach of allowing their children to socially
11 transition prepuberty?
12 A I don't know that I have an answer to that
13 question because I've not thought about a ban. I
14 have a clinical impression or what I would
15 recommend. But I've not gone through the
16 implications of that.
17 Q You said that some of the children who have gender
18 dysphoria you believe may grow up to be
19 transgender and some may not be transgender, is
20 that right?
21 A Correct.
22 Q For the children who do grow up and are
23 transgender, do you think they will have been
24 harmed by not being allowed to socially transition
25 while they were children?

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1 A My guess is that we, since we never know about
2 what will happen with any one child we can't
3 really say if any individual would have been
4 better or would have been worse.
5 I would not frame it in terms of harm.
6 Children have been growing up all through human
7 history. We have generally not been socially
8 transitioning them and it has not been a major, I
9 think in general societies they have decided that
10 not transitioning is the better trade off.
11 So continuing with that approach seems wise
12 until we know better.
13 Q What do you base that statement on, that
14 assessment of the trade off?
15 A Well, for one, through all of human history we
16 have used biological sex as a main marker where
17 we, how we divide children.
18 Children with gender dysphoria do have a
19 harder time and are going to have significant
20 problems. I think it's one of those issues of,
21 like we often have in medicine where there is
22 only difficult choices. There is no easy choice
23 and no, like, clear that this is going to lead to
24 some great solution.
25 However, since we know so many of these kids

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1 will grow up to be -- like I said, I consider them
2 children with gender dysphoria. I do not consider
3 their identity to be fixed. I would like everyone
4 to have the opportunity to grow up and then become
5 an adult and then decide about what their identity
6 is.
7 Q What do you base that statement on that most of
8 the children with gender dysphoria do not grow up
9 to be transgender?
10 A That has been traditionally the data, that most
11 childhood onset gender dysphoria children grow up
12 and are typically, more likely the adult outcome
13 is being a same sex attracted adult.
14 Q Is that a particular study you are thinking of
15 when you say that?
16 A I have seen it referenced many times.
17 MR. SELDIN: Joel, will you take to us
18 Paragraph 91.
19 Q Dr. Kaliebe, in this paragraph you talk about
20 political activisms around laws pertaining to
21 gender-affirming care.
22 Do you see that?
23 A Yes.
24 Q You characterize it as political activisms.
25 Do you think it's political advocacy for

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1 endocrinologists who treat diabetes to take a
 2 position on the affordability of insulin?
 3 A No.
 4 Q Why not?
 5 A Well, that is not an issue that aligns with any
 6 particular politics. I have not seen any data
 7 that makes me think that Republican
 8 endocrinologists and Democrat endocrinologists see
 9 that differently. So, once again, it would not be
 10 a political issue because that seems to be a
 11 general medical care issue.
 12 Q And so when you say political, do you mean
 13 measurable difference in opinion by a political
 14 party?
 15 A Yes. Well, I don't -- I'm saying political saying
 16 these organizations seem very willing to get
 17 involved with political activism from a certain
 18 viewpoint. There could be any number of things
 19 where they -- you would think at least once maybe
 20 they would get, have some issue that is not from
 21 that same viewpoint, but it does not seem very --
 22 they seem very willing to make things more
 23 political than they really are.
 24 I believe that questions about
 25 gender-affirming care are clinical questions. And

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1 so I don't think that these organizations should
 2 be condemning people who see the evidence
 3 differently or want to be cautious.
 4 But it seems like that is in the press
 5 releases where they would want to approach it. So
 6 I can't think it's anything other than political
 7 because they usually, let's say, the American
 8 Academy of Pediatrics would be respectful of
 9 people who want a cautious approach or parents
 10 that do not agree with this approach.
 11 So, yes, I believe the way that they are
 12 approaching seems that it must be political.
 13 Q Earlier you were talking about how you wish some
 14 medical organizations prioritized things like
 15 access to primary care through federally funded
 16 health centers.
 17 Do you remember when we were talking about
 18 that?
 19 A Yes.
 20 Q Do you believe that that is a political issue?
 21 A Not so much because it has bipartisan support. So
 22 I believe that would be an issue that would not be
 23 politicized because I think individuals on both,
 24 on both on the left and the right could get behind
 25 those things. So it's a less politicized issue.

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1 Q Do you think an endocrinologist who testifies
 2 before a legislative body about a particular bill
 3 is engaged in political advocacy?
 4 For example, if there were a bill to make
 5 insulin free and an endocrinologist testified in
 6 favor of that bill, do you think that
 7 endocrinologist is engaging in political advocacy?
 8 A It would depend on how they testified and in what
 9 way and exactly what the bill was. I could not
 10 say. I would not make a blanket statement that it
 11 was or wasn't.
 12 Q So you think that the content of the opinion
 13 determines whether it is political advocacy or
 14 not?
 15 A That is one component of how I would decide, yes.
 16 Q What other components would help you decide
 17 whether that was political advocacy?
 18 A Well, depending on the issue. Right? The issue
 19 at hand here is an issue that does have clumpings
 20 of political support in different parties and
 21 different sides.
 22 So clearly, whenever you are talking about an
 23 issue that does have clear political implications,
 24 then that would make you at least be skeptical or
 25 consider that there is something political going

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1 on.
 2 Q Do you think clinicians who provide legislative
 3 testimony about bills like Senate Enrolled Act 480
 4 are engaged in political advocacy?
 5 A It would depend on the testimony they are giving.
 6 So possibly or possibly not.
 7 Q What would make their testimony political
 8 advocacy?
 9 A Well, I don't know if you are asking me about are
 10 they providing, you know, references to studies?
 11 Are they talking about -- you know, I'm not sure
 12 what they are bringing up.
 13 If they are trying to portray evidence as
 14 more than it really is or kind of, you know, if
 15 they use political language. I mean there are any
 16 number of ways that someone can reveal that they
 17 are more interested in advocating for a certain,
 18 you know, tribal political viewpoint than an
 19 actual sober discussion of what is the situation
 20 at hand.
 21 I think most clinicians who would get up and
 22 testify should be able to remain respectful about
 23 the other side of the opinion and realize the
 24 trade offs and difficulties and nuances.
 25 So if that is what they are doing and getting

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1 up and admitting all those things, then I would,
 2 you know, lean towards it not being so political.
 3 If that is not what they are doing, then I'm
 4 leaning in towards it being more political.
 5 Q In Paragraph 91 you are talking about this press
 6 release. You say, "Yet the press release frames
 7 these limits as discrimination based on gender
 8 identity, a moralized characterization of
 9 restrictions on care."
 10 Why do you think that is a moralizing
 11 statement?
 12 A Well, if I accuse you of discriminating I think
 13 that is a morale accusation. Right?
 14 Whereas, normally when you are talking about
 15 medical care you would be talking about what is
 16 the evidence base for this medical care. Or let
 17 me show you this study that strongly supports my
 18 opinion.
 19 That is what I would think that a medical
 20 organization would be doing, rather than claiming
 21 that this is discrimination.
 22 Q So back to my example of an endocrinologist and
 23 insulin. If I am an endocrinologist and I testify
 24 before a legislative body, I treat a lot of people
 25 with diabetes. They need insulin. The cost of

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1 insulin means some of them don't get it. That is
 2 a negative outcome. I think this bill should pass
 3 because it will make insulin free.
 4 Do you think any of that is political and
 5 moralizing?
 6 A No. Because they are talking about a clear-cut
 7 medical, you know, situation that seems
 8 apolitical.
 9 Q What if they then say, And I think it's
 10 discrimination against people with diabetes not to
 11 make insulin free? What then?
 12 A I mean, they could say that. I think that that
 13 would be a, I mean, they would be trying to
 14 moralize the argument. I don't think it would be
 15 a compelling argument.
 16 I'm guessing that people who are deciding
 17 about what could be paid for and not paid for are
 18 mostly working on economic arguments and not on
 19 discrimination arguments.
 20 MR. SELDIN: Joel, in Paragraph 92 about
 21 two-thirds of the way down, if you could show us
 22 Paragraph 92. Thank you.
 23 Q You are critical of the American Academy of
 24 Pediatrics. You say, "As such, a more appropriate
 25 perspective from a medical organization would be a

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1 call for reasoned dialogue to evaluate the moral
 2 claims on each side and examine the logic and data
 3 behind these moral frameworks and treatments."
 4 Do you see where you wrote that?
 5 A Yes.
 6 Q Is your issue that, I guess, do you think the
 7 competing moral frameworks in this particular
 8 instance are equally worth debating?
 9 A Well, I think there are multiple moral frameworks
 10 so you would have autonomy of patients. You would
 11 have parental decision rights. You would have
 12 whether an analysis of an evidence base is a moral
 13 one or a discriminatory one.
 14 So there's multiple moral issues at play.
 15 There would be the moral issue of can someone
 16 consent or not consent? Is it moral to allow
 17 those things?
 18 So there are just a number of ethical and
 19 moral issues that could be wrapped into any
 20 discussion.
 21 Q So in the realm of pediatrics generally you have
 22 issues of assent and consent, is that fair to say?
 23 A Yes.
 24 Q So in that respect, every decision about pediatric
 25 medicine involves the moral issue of assent and

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1 consent, right?
 2 A Yeah. I mean, you know, I would not quite -- I
 3 would say there's almost no moral issue for many
 4 or most regular pediatric treatment issues.
 5 Whether to get an antibiotic or whether to brace
 6 an arm after it's broken, you know, this is what
 7 most medical decisions are.
 8 Most of them do not have difficult competing
 9 moral frameworks like permanent treatments to
 10 minors with gender dysphoria. That is a lot more
 11 complex.
 12 Q Let's talk about some other medical interventions
 13 in pediatrics.
 14 Are you familiar with Cochlear implants?
 15 A Somewhat.
 16 Q Do you think that there is any moral valiance to a
 17 decision about whether to provide those to a
 18 child?
 19 A Well, not being my area of expertise, I don't know
 20 what the statistics are and how successful they
 21 are and how established they are.
 22 There may or may not be on different
 23 treatments depending on all those things. If it's
 24 a well established treatment and they have a great
 25 evidence base on, then the amount of the moral

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1 dilemma is small.
2 When you have unknowns in a treatment or it's
3 an experimental treatment, that is much more of a
4 moral dilemma. I don't know Cochlear implants
5 enough to tell you where I fall on that.
6 Q Do you believe then that the level of moral
7 dilemma is inverse to the evidence base?
8 A Well, the less evidence base and the more
9 potential harm would raise the moral implications.
10 Yes.
11 Q Okay. So then in any area of medicine where there
12 is an uncertainty about the evidence base or
13 outcomes you believe there is a moral issue?
14 A Well, specifically, I mean, yes. Especially when
15 we are talking about lifelong changing of
16 characteristics of a developing adolescent.
17 So, yes. I mean, yes. But there is, you
18 know, we are talking about something quite
19 significant.
20 Q Well, are you familiar with ear pinning as a
21 medical intervention in children?
22 A I mean, not very.
23 Q Well, I will represent to you that for children
24 whose ears stick out there is a surgical
25 intervention where you can pin their ears back so

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1 they stick out less.
2 Are you familiar with that?
3 A Okay. Yes.
4 Q Okay. Have you heard of such a thing?
5 A I have heard of it. Yes.
6 Q Okay. Do you think that that has moral
7 implications?
8 A Not -- I don't know. But it sounds like that is a
9 low risk surgery. So to me, I'm guessing that
10 it's a low risk procedure which, you know, seems
11 to be well received or work out the way that
12 individuals who have gotten in the past want. I
13 don't know how long it has been around for.
14 So it could be a significant moral issue if
15 it's the first patient that it's ever been done on
16 and there are some potential downfield negative
17 effects that could be serious.
18 If it's a standard procedure that is done all
19 of the time without much problem, then that makes
20 it less of a moral issue.
21 Q Even though it permanently alters the appearance
22 of the child you don't believe that that by itself
23 raises a moral issue?
24 A Well, is the outcome -- you know, if this is an
25 established procedure that has a known good

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1 outcome, then it reduces the moral or ethical
2 dilemma.
3 Q You don't believe that all interventions that
4 alter the bodies of minors involve moral dilemmas?
5 A I just said there are degrees. There would be a
6 degree.
7 Q In terms of what should inform moral
8 considerations around the provision of treatment
9 to minors, we have talked about evidence based.
10 We have talked about assent and consent.
11 Are there any other things that you think
12 should factor into that moral calculus?
13 A Evidence base. Assent and consent. Family and
14 parental viewpoints. There are any number of
15 possible other inputs.
16 Q What do you mean by family?
17 A I think if a family -- in a family there may or
18 may not be agreement with procedures. I think
19 that is something to take into account.
20 Q Would that fall under assent and consent?
21 A I guess it could. Yeah.
22 Q In Paragraph 93 --
23 A I could say there is some -- you are asking about
24 what moral dilemmas possibly you would have. I
25 think, you know, we talked about the evidence

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1 base. But, also, you know, we don't really have
2 an evidence base about a, you know, human
3 developing identity, which is also something that
4 we are treating. I just want to throw that out
5 there. We are sort of fiddling with something
6 which that is important and fundamental in human
7 beings.
8 I just think that also raises caution beyond
9 what a typical discussion of evidence base would
10 be.
11 Q Are you offering an opinion in this case about the
12 evidence base?
13 A Regarding gender-affirming care?
14 Q Yes.
15 A Well, I mean, yes. I've put, I did not
16 concentrate on that in my report, but I think I
17 make it clear in my report my assessment of the
18 evidence base.
19 MR. SELDIN: Joel, can you pull up
20 Exhibit 4. Take us to Paragraph 4, please. I'm
21 sorry. Can you scroll up to the first page so we
22 can see the caption.
23 Q Dr. Kaliebe, this was your report in the Decker
24 case that we were talking about.
25 Do you see the case caption?

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1 A Yes.

2 Q Then Paragraph 4 (b) and (c), Dr. Kaliebe, in your
3 Decker report you offered the opinion at 4 (b),
4 "There is no consensus in the field regarding the
5 treatment of gender dysphoria, nor is there an
6 evidence base sufficient to lead to any confident
7 recommendations."
8 Do you see where you wrote that in your
9 Decker report?

10 A I don't. Okay. Yes. Yes, I do.

11 Q Then in 4 (c) you said, "Multiple reviews of the
12 evidence base regarding treatment of gender
13 dysphoria indicate that the evidence for
14 affirmative treatment is low quality."
15 Do you see where you wrote that in the Decker
16 report?

17 A Correct. Yes.

18 Q There do not appear to be corresponding opinions
19 of this nature in your declaration in this case.
20 That is why I'm asking, are you offering
21 these opinions in this case here?

22 A Well, yeah. I'm not sure how to answer that in
23 that I believe there are other experts in this
24 case that are reviewing the evidence base.
25 Those are my opinions. But my -- in terms of

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1 this case, I wrote in my report the things that I
2 was emphasizing.

3 Q So is it fair to say that you, Dr. Kaliebe, the
4 individual, hold these views, but you,
5 Dr. Kaliebe, Indiana's expert in this case, are
6 not offering yourself as an expert on these two
7 points?

8 A I would not commit to that. Since I have put this
9 in my report even though it's not exactly these
10 same statements, I have mentioned the low quality
11 evidence base.
12 Since I have mentioned that in my report and
13 I am already speaking as an expert and I've gone
14 on the record, I think I am affirming that this is
15 my opinion and this opinion is in my report.

16 MR. SELDIN: I wonder if now is a good
17 time to take a little longer break for lunch.
18 Dr. Kaliebe, Mr. Patterson, would that work
19 for you?

20 MR. PATTERSON: Fine with me.

21 A Fine with me.
22 (OFF RECORD AT 1:31 P.M.)
23 (AT THIS TIME A SHORT RECESS WAS HELD OFF THE
24 RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE
25 HAD:)

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1 (ON RECORD AT 2:15 P.M.)

2 BY MR. SELDIN:

3 Q Dr. Kaliebe, welcome back.

4 MR. SELDIN: Joel, could you pull
5 Exhibit 1 back up for us.

6 Q This is your declaration that we have been talking
7 about in this case.

8 MR. SELDIN: Joel, can you take us to
9 Paragraph 121.

10 Q Dr. Kaliebe, in Paragraph 121 of your declaration
11 you have some criticisms of SOC-8. I take it that
12 is WPATH's Standards of Care 8?

13 A Correct.

14 Q And in Subsection A you say, "SOC-8 makes no
15 analysis for why it prioritizes affirmation of
16 gender identity over affirmation and acceptance of
17 the physical sexed body."
18 Do you see where you said that?

19 A Yes.

20 Q What is affirmation and acceptance of the physical
21 sex body?

22 A Well, it would be the concept that it is important
23 for people to come to accept and work with the
24 body that they have, which is a time tested
25 approach, you know, in individuals who have

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1 challenges and disorders, distress related to
2 their body.

3 Q When you say time tested, what do you mean?

4 A Well, I mean in many other psychiatric disorders
5 we have patients that are uncomfortable or
6 distressed by the body that they have.
7 Someone with anorexia will starve themselves
8 in order to, you know, not go into development or
9 because they don't want to, because they have a
10 distorted view of themselves, a body dysmorphic
11 disorder.
12 During development, of course, many people
13 are uncomfortable or distressed by the body that
14 they have.

15 Q In prior declarations you refer to this as body
16 affirmation.
17 Is affirmation acceptance of the physical sex
18 body the same as body affirmation?

19 A Yeah. I mean, I think they are part of the same
20 concept, yes.

21 Q Did you come up with this distinction between body
22 affirmation and gender affirmation?

23 A Did I come up with it? Well, I think that this is
24 a noticeable discrepancy by the way that we are
25 asked to approach gender dysphoria compared to

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1 other disorders like I was, like I was mentioning
 2 previously.
 3 So, yes. I don't have a clear source from
 4 where that comes from. It's just that I've noted
 5 that this is a very different approach to affirm
 6 and emphasize, you know, a psychological concept
 7 about self over the physical body.
 8 Q Is there any literature where researchers
 9 discussed this distinction between gender
 10 affirmation and body affirmation?
 11 A There probably is. You know, since we are in such
 12 a new field right now, you know, I don't think
 13 that there has been much on this regarding
 14 particularly this issue.
 15 But I think there is significant literature
 16 in other disorders regarding patients, healthy
 17 patients, learning to come to peace with or love
 18 the body that they have or reducing their distress
 19 about the body that they have.
 20 Q So it sounds like you are not aware of any studies
 21 on body affirmation versus gender affirmation as
 22 it pertains to gender dysphoria, is that correct?
 23 A Correct.
 24 Q In Paragraph 121, Subsection (d) another one of
 25 your criticisms is that, "SOC-8 downplays concerns

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1 related to detransitioning."
 2 Do you see where you wrote that?
 3 A Correct.
 4 MR. SELDIN: Joel, can you please pull up
 5 Exhibit 14.
 6 Q Dr. Kaliebe, have you seen this document before?
 7 A Yes. It's the Standards of Care for the Health of
 8 Transgender and Gender Diverse People, Version 8.
 9 I was referring to that in my report as the
 10 SOC-8.
 11 MR. SELDIN: Joel, can you take us to
 12 Page 43 of the PDF, please.
 13 Q Dr. Kaliebe, do you see where it says
 14 Statement 5.7?
 15 A Yes.
 16 Q Do you see, "We recommend health care
 17 professionals assessing adults who wish to
 18 detransition and seek general-related hormone
 19 intervention, surgical intervention, or both,
 20 utilize a comprehensive multidisciplinary
 21 assessment that will include additional viewpoints
 22 from experienced health care professionals in
 23 transgender health and that considers, together
 24 with the individual, the role of social transition
 25 as part of the assessment process."

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1 Do you see that?
 2 A Yes.
 3 Q There is a whole section of SOC-8 that talks about
 4 detransition, correct?
 5 A Correct. I think if you look at the amount of
 6 pages devoted to it, and I do see 260 pages on the
 7 document, that is why I was saying underemphasized
 8 the component.
 9 Q What would be an appropriate emphasis in the SOC-8
 10 for detransition?
 11 A Well, I think a more realistic approach in
 12 regarding the new patient population, which has
 13 recently emerged. And we do not know what the
 14 rates of detransition will be in this new
 15 different patient population.
 16 And so I think while it generally downplays
 17 it, reporting it to be rare, which I think, you
 18 know, once again, we are not totally clear on, the
 19 data is not so clear on how rare it really is.
 20 But, secondly, it's especially pertinent
 21 considering the large rise in these treatments
 22 among minors and minors that are very different
 23 than the minors that were in the Dutch protocol or
 24 other early interventions.
 25 MR. SELDIN: Can you take us back to

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1 Exhibit 1, please.
 2 Q In Paragraph 122, Doctor, in Paragraph 122 you
 3 say, "There have been several other episodes I
 4 have learned about that have caused me to conclude
 5 that I do not feel comfortable relying on WPATH or
 6 its U.S. affiliate, USPATH, to guide my care of
 7 gender dysphoric patients."
 8 A Yes.
 9 Q What do you rely on to treat your gender dysphoria
 10 patients?
 11 A My experience as a child psychiatrist. And I
 12 think patients are all human beings. They all
 13 share a lot of qualities. We have a wealth of
 14 clinical and other research data, which gives us a
 15 general approach on how to approach patients.
 16 And so when a new population and a new
 17 treatment model comes in and asks you to do
 18 something a different way and you see that it has
 19 flaws and it's not, it has not, it does not have
 20 the evidence base that it claims to have, then you
 21 have to use your, you have to use what you know
 22 about other treatments, which are, of course, you
 23 know, which are generalizable in order to approach
 24 that patient population.
 25 Q Earlier we talked about how in total you have

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1 treated maybe sixteen or seventeen patients with
 2 gender dysphoria.
 3 How many of those are you currently treating?
 4 A I would guess half that number.
 5 Q Are they aware you are not using USPATH or WPATH
 6 standards of care in their treatment?
 7 A I don't know that patients are ever aware of what
 8 guidelines or treatments or what approaches that
 9 you use as a clinician.
 10 That would be no regarding any of my patients
 11 with any of my approaches.
 12 Q Do you think a patient would want to know if you
 13 were intentionally not using consensus guidelines
 14 to treat their condition?
 15 A Well, I don't believe these to really be consensus
 16 guidelines. So, you know, there is no reason to
 17 inform patients exactly where you are getting your
 18 clinical approach from.
 19 You take it from all sorts of places. So I'm
 20 not -- no, I don't think it's necessary. I never
 21 inform my patients in other circumstances what
 22 guidelines I use or don't use. I don't think
 23 these patients are really any different.
 24 Q Are any of the patients you are currently treating
 25 for gender dysphoria minors?

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1 A Yes.
 2 Q Do you think their parents would want to know that
 3 you were not using WPATH and USPATH guidelines to
 4 treat them?
 5 A Once again, parents have never ever in the past
 6 asked me about what guidelines I use for my
 7 treatment. So I think that it would be a
 8 discussion to have perhaps if there is a
 9 discussion about medicalization. So in those
 10 situations I'm more than happy to tell them what
 11 my perspective is.
 12 But, once again, you know, you really don't
 13 usually go into treatment guidelines when you are
 14 discussing matters with parents or with patients.
 15 Q Are you treating these particular patients with
 16 what you call body affirmation?
 17 A Well, as I mentioned before, I think whenever you
 18 are referring people for things like physical
 19 activity, exercise, mindfulness approaches, those
 20 all have some elements of coming to peace with and
 21 using the body, appreciating the body that you
 22 have.
 23 I think that approach is known because those
 24 are things that I talk about. I think it would
 25 be, I don't think I talk about my philosophy of

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1 treatment with any of my patients. I just provide
 2 recommendations and treatment.
 3 Q Is it fair -- have you ever had a conversation
 4 with these patients or their parents in which you
 5 have explained what you explain here, that there
 6 is gender affirmation and there is body
 7 affirmation and you are going to prioritize body
 8 affirmation?
 9 A I have, in a manner, yes. I think that as I have
 10 spoken with parents they have -- I have
 11 communicated to them what my approach is. I don't
 12 use those words. I will tell parents what I
 13 emphasize and don't emphasize in my treatment.
 14 Once again, these are not the conversations,
 15 I mean, this is not usual -- you know, out in the
 16 community as a treater or in the clinics that I
 17 work in, I mean, this is not the level of
 18 conversation that you are typically having.
 19 So I am not usually talking about which
 20 guidelines I use or what approach I use with
 21 patients. This is quite unusual.
 22 Q Doctor, you have not told them there is no
 23 research about body affirmation versus gender
 24 affirmation?
 25 A Well, hold on. Because you are claiming that

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1 there is some research, which is not accurate.
 2 There is research in all sorts of things. You are
 3 just saying in the exact specific condition of
 4 gender dysphoria, which we have almost no research
 5 on anything in regard to any kind of therapy with
 6 gender dysphoria.
 7 It's such a new condition with this
 8 population with this large amount that we only now
 9 are starting to be able to roll out studies.
 10 Once again, you are mischaracterizing what is
 11 going on. But, yeah. So, no, I don't have
 12 exactly that conversation because that is not an
 13 appropriate framing of it.
 14 Q Well, have you had the conversation with parents
 15 or patients where you have said there is not any
 16 specific research on the use of body affirmation
 17 to treat your condition, gender dysphoria, but
 18 there is research for other conditions?
 19 So what I will recommend in the absence of
 20 that research on your specific condition is that
 21 we use body affirmation instead of gender
 22 affirmation.
 23 Have you had any kind of conversation like
 24 that with your patients?
 25 A Well, you know, once again, I think we are talking

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1 about these large, you know, concepts rather than
2 talking about specifics.
3 I mean, you know, you could still be
4 affirmative, meaning use the pronouns the person
5 was working with, and be affirmative in that you
6 are supporting them. But, also, want to work with
7 them in coming to peace with the body that they
8 have.
9 Q Is that your general practice with your minor
10 patients that have gender dysphoria, to use the
11 pronouns that they want to be known by?
12 A Yes.
13 Q Earlier you were talking about how you treat
14 patients given your desire not to use WPATH or
15 USPATH guidelines.
16 Is it fair to say then that you consider your
17 clinical practice sufficient to sort of establish
18 guidelines for yourself?
19 A Well, I think when you are a child psychiatrist
20 and you treat all of the different conditions that
21 could come in, people come in with autism. People
22 come in with psychosis. People come in with
23 bipolar disorder. They come in with PTSD. They
24 come in with all number of different problems.
25 And then they have problems in development.

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1 They have problems of identity that are not
2 related to gender. They have problems
3 academically. They have neurocognitive problems.
4 They have problems related to school. They have
5 problems relating to getting into fights. They
6 have family conflict.
7 So when you approach a patient clinically,
8 you are putting together a treatment plan and an
9 assessment that speaks to them specifically. So
10 I'm using what, you know, is the, I would say,
11 mainstream psychiatric approach with all these
12 patients, including the patients with gender
13 dysphoria.
14 Q So your description then of your clinical
15 experience, that is sufficient you think to
16 establish good clinical practices?
17 A I don't think that patients with gender dysphoria
18 are that different than other patients that I
19 should throw out all my training for everything
20 else I do and do something that WPATH has
21 determined to be the right approach even though my
22 assessment of the evidence is that it's not the
23 right approach. So, correct.
24 MR. SELDIN: Joel, will you take us to
25 Paragraph 129, please.

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1 Q Dr. Kaliebe, in Paragraph 129 you are discussing
2 Dr. Shumer.
3 Do you recall writing this paragraph?
4 A Yes.
5 Q In this paragraph at the very end you say, "This
6 virtuous sense of self must at least raise
7 concerns as to whether Dr. Shumer and other
8 advocates engage in sober reviews of the
9 evidence."
10 Do you see where you wrote that?
11 A Yes.
12 Q Would you generally agree that patients should
13 receive competent and compassionate care, medical
14 care?
15 A Yes.
16 Q Do you generally agree that transgender people are
17 emerging and demanding specific kinds of care?
18 A Emerging and demanding specific types of care?
19 Yeah. I mean, this is, I think some of the
20 questions that we have is a child, you know, a
21 transgender person, or are they a child with
22 gender dysphoria? Or is this a teenager with
23 gender dysphoria or a transgender person?
24 So I think, you know, as your identity is
25 still developing I think it's important for us to

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1 step back and look that we are not necessarily
2 dealing with someone who at the end of the day
3 should be best conceptualized as a certain person.
4 And that the fact that someone, that there
5 are some demands for care, once again, is detailed
6 elsewhere in my report. Yes, people should be
7 compassionate and we should be competent.
8 But often the type of care that patients
9 request is often not the best type of care for
10 them. So, you know, I am somewhat agreeing with
11 your characterization. But I think there is some
12 nuance there.
13 Q We talked about this a little bit earlier. I
14 wanted to clarify.
15 You said you prefer to treat, to consider
16 children with gender dysphoria as children with
17 gender dysphoria and not as what you called
18 transgender children, is that accurate?
19 A Correct.
20 Q You would agree, though, that some, that at least
21 some children with gender dysphoria are, in fact,
22 transgender, right?
23 A No. Because we don't know what their identity
24 really is or what it will be at the end. I don't
25 think we are, I mean, putting a label on a child

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1 that is still developing, I mean, that's not, I
 2 don't think it's a wise practice.
 3 So I would not call them transgender as I
 4 have stated. I would call them a child with
 5 gender dysphoria.
 6 Q And would you agree that some children with
 7 gender dysphoria come to identify as transgender
 8 adults?
 9 A Yes.
 10 Q Earlier we were talking about your concerns about
 11 some of the moralizing language that you think
 12 exists in discussions about the treatment of
 13 gender dysphoria.
 14 Do you remember us talking about that earlier
 15 today?
 16 A Correct.
 17 Q And it seems like based on Paragraph 129 that you
 18 have some concerns about folks who use what you
 19 term, folks who use what you characterize as
 20 moralizing language that they can't soberly review
 21 the evidence.
 22 Is that fair to say?
 23 A Well, they may or may not be able to. It would
 24 raise, it would raise a level of skepticism.
 25 MR. SELDIN: Joel, will you pull up

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1 Exhibit 11.
 2 Q Dr. Kaliebe, this is a printout of a website for
 3 an organization called Do No Harm.
 4 Have you heard of Do No Harm before?
 5 A I have heard the name. I'm not familiar with it,
 6 no.
 7 Q You will see in the "About Us" section it says,
 8 "We are a diverse group of physicians, health care
 9 professionals, medical students, patients, and
 10 policymakers united by a moral mission: Protect
 11 health care from a radical, divisive, and
 12 discriminatory ideology."
 13 Do you see where I read that?
 14 A Yes.
 15 Q Do you consider this the kind of moralizing
 16 language that gives you pause about an ability to
 17 soberly review the evidence?
 18 A Well, I think they are using language similar to
 19 Turban and Karasic and Shumer. Yeah. I would
 20 think that those who look at any sort of group
 21 that has a mission, you know, you would have to
 22 be, you have to be skeptical and understand that
 23 they are potentially a part of a group.
 24 MR. SELDIN: Joel, scroll down, please, to
 25 Page 6 of the PDF.

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1 Q Dr. Kaliebe, you will see at the bottom there is a
 2 photo of Dr. Daniel Weiss, Senior Fellow.
 3 Do you see that?
 4 A Yes.
 5 Q And I think we were talking earlier today, are you
 6 aware that Dr. Weiss is one of Indiana's experts
 7 in this case?
 8 A I am now that you are asking me that question.
 9 Q Would his membership in this group give you some
 10 pause about his ability to soberly review the
 11 evidence?
 12 A No. I mean, I think that your, you know, the fact
 13 that someone has joined a group which is calling
 14 for cautious care under the circumstances would
 15 not necessarily, you know, give me pause.
 16 So, no, I think, I mean, yes, is it possible
 17 that this could also have some group think or
 18 group identity issues, you know, distorting their
 19 viewpoint, it's possible.
 20 I, you know, as I said before, it just means
 21 that you should look at what the person says and
 22 examine the evidence and the idea about ideas
 23 competing with each other.
 24 Rather than personally attacking the person,
 25 you should identify the idea and evaluate the

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1 quality of the evidence or the idea.
 2 Q And so for clinicians like Dr. Shumer, do you
 3 think the same applies, that rather than simply
 4 judging him by his participation or any kind of
 5 group or gender clinic you should look at his
 6 ideas and evaluate them on the merits?
 7 A Correct.
 8 Q Okay.
 9 MR. SELDIN: Joel, will you take us back
 10 to Exhibit 1, please.
 11 Q Look at Paragraph 130. Dr. Kaliebe, in
 12 Paragraph 130 you talk about what you perceive to
 13 be a chilling effect on scholarly dialogue.
 14 Do you see where you wrote that?
 15 A In 130? I don't use those words there.
 16 Q Sorry.
 17 A It's not in Paragraph 130.
 18 MR. SELDIN: Joel, are you on Exhibit 1?
 19 JOEL SCHERER: Yes, this is Exhibit 1.
 20 MR. SELDIN: Okay. I have something wrong
 21 with my pagination.
 22 Q You do recall that there is some scholarly
 23 dialogue missing, right?
 24 A Yes.
 25 Q What specific articles do you think should have

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1 been published that have not been?

2 A Well, I think I say in the report there are many

3 articles that should be published and many issues

4 to be explored. We are in the infancy of medical

5 and hormonal treatments for young people and we

6 don't really have good long-term outcome data. We

7 don't have any control data.

8 So, you know, we should be still debating

9 what is the right approach considering the actual

10 level of the evidence. We should be careful about

11 promoting one type of care or the other and,

12 obviously, be talking about what evidence base

13 supports it.

14 I think specifically in the, in the arena of

15 gender-affirming care what we should talk about,

16 we should have articles in major medical journals

17 about informed consent in relation to that. We

18 should have articles regarding psychotherapy. We

19 should have articles regarding special populations

20 like traumatized individuals, personality

21 disorders, autism.

22 I mean, we have so much to explore. There is

23 so much more we don't know than what we do know.

24 To, you know, to only sort of allow one type of an

25 article or one perspective on this seems quite

Page 171

1 misguided.

2 Q Just to make sure we are talking about the same

3 thing, in your declaration you list some specific

4 instances of some specific articles that you

5 believe should have been published that were not.

6 Just in your answer now you are talking more

7 broadly about kinds of papers you wish you had

8 seen.

9 Were you referring to anything specific?

10 A I don't know exactly what has been submitted that

11 has not been published. So it is impossible for

12 us to know what articles were rejected. I'm not

13 quite understanding the question.

14 Q Well, fair to say you don't know if these, you are

15 not sure if maybe these articles don't exist at

16 all or they are being submitted and just not being

17 published?

18 A Correct. Other than my letters to the editor

19 which I know were rejected.

20 Q Do you know the rejection rate for letters to the

21 editor?

22 A No.

23 MR. SELDIN: Joel, can you take us to

24 Paragraph 142, please.

25 Q Dr. Kaliebe, in Paragraph 142 you talk about, "A

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1 colleague told me about a difficult experience

2 with editors of the American Academy of Psychiatry

3 and the Law Newsletter."

4 Do you see that?

5 A Correct.

6 Q Who is the colleague that --

7 A Josh Sanderson.

8 Q Okay. Do you know if he tried to get this article

9 published anywhere else?

10 A It got published. He just, they just asked him to

11 remove the actual behavior of the transgender

12 individuals on the inpatient unit.

13 So the whole, you know, part of the article

14 was to communicate that these are difficult

15 situations that we are having on the inpatient

16 unit with individuals who identify as transgender.

17 They forced him to take out the part about

18 what was actually happening on the inpatient unit,

19 thereby, stopping clinical exchange of information

20 related to caring for individuals on inpatient

21 units.

22 Q Did this colleague try to get his unedited article

23 published somewhere else?

24 A I'm not aware.

25 Q In Paragraph 144 at the end you say, "Former sex

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1 researchers have left the field due to the

2 harassment and intellectual bullying they

3 received."

4 Do you see where you wrote that?

5 A Yes.

6 Q Who has left the field?

7 A I gave the one example of Debra Soh. I don't

8 have a list in front of me. She is not the only

9 one.

10 Q Who else do you think has left the field?

11 A I don't have that in front of me. I think you

12 could read Debra Soh's book and it would provide a

13 lot of detail about the harassment and

14 anti-scientific atmosphere in which she endured.

15 Q Other than Soh, there is no one you can

16 specifically remember?

17 A There are examples in her book. And if I could

18 add on, I mean, it's not just about leaving the

19 field. It's about staying away from areas of

20 scholarly exploration, which there are plenty of

21 examples. Right?

22 So, for one, it's difficult to get grants or

23 to then be able to study things that are

24 controversial in universities, especially

25 controversial and related to gender dysphoria or

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1 transgender care.
 2 So, unfortunately, that is, you know, we are
 3 reducing the amount of information flow due to
 4 these things.
 5 MR. SELDIN: Joel, will you take us to
 6 Paragraph 145, please.
 7 Q Dr. Kaliebe, in Paragraph 145 you talk about your
 8 personal interactions with psychiatrists.
 9 Do you recall writing this paragraph?
 10 A Yes.
 11 Q Would you agree that your personal interactions
 12 with psychiatrists is a form of anecdotal
 13 evidence, right?
 14 A Correct.
 15 Q In Paragraph 145 you use the term automatic
 16 affirmation.
 17 A Yes.
 18 Q What is automatic affirmation?
 19 A As I mentioned earlier, when a patient comes to
 20 you and has a certain perspective on something, it
 21 is not typical within mental health for you to
 22 automatically agree with their perspective.
 23 So that is not what we do in any other
 24 situation, but for whatever reason with gender
 25 dysphoria we have been asked to, or there seems to

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1 be pressures that if someone says that they have a
 2 certain gender identity that we are obligated to
 3 agree with that. That is just a departure from
 4 typical mental health care.
 5 Q Where does the term automatic affirmation come
 6 from?
 7 A Well, that seems to be the approach which is being
 8 pushed. I don't know that term, I'm
 9 characterizing the affirmative approach as
 10 automatic or some component of it. I'm sure that
 11 there are people who consider themselves
 12 affirmative who do not automatically affirm or do
 13 not consider their affirmation automatic, yet it
 14 seems that there is some pressure to automatically
 15 affirm. So that is why I put that in there.
 16 It seems very unusual that you would
 17 necessarily agree with a patient when in mental
 18 health care we don't affirm or agree with patients
 19 in general.
 20 Q So automatic is your descriptive modifier based on
 21 your experience --
 22 A Well, yes. It is one of the fundamental problems
 23 with gender-affirming care. So it's an
 24 underlying, you know, unstable base that
 25 gender-affirming care has in my assessment.

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1 Q Earlier in one of your answers you said clinicians
 2 were obliged to accept gender identity.
 3 What did you mean by obliged?
 4 A Well, as I have said before, we typically in
 5 mental health -- let's say you are working with an
 6 adult client and they come in and say I want to
 7 have a divorce.
 8 You know, you are usually not going to be, I
 9 mean, any reputable therapist would be, like,
 10 let's sit down. Let's talk about it. Let's see
 11 what is going on. Let's understand your history
 12 and your current situation. Let's, I mean, let me
 13 hear more about this.
 14 You don't, you know, a mental health provider
 15 would not be yes, you should get a divorce, or no,
 16 you should not. Right? I mean, that would be
 17 inappropriate. Certainly we would not offer
 18 anything like suggestions in matters of, you know,
 19 major life choices like a divorce.
 20 At some point by getting to know a person you
 21 may get a sense of whether that would be a wise
 22 course for them or not. I'm just bringing that up
 23 as an example of what normally, how normally you
 24 would approach a patient in mental health when
 25 they say I have this situation.

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1 So you don't, you would not necessarily say
 2 yes, do something, or no, don't do something.
 3 Q Are you aware of any clinicians who are not asking
 4 follow-up questions when patients present
 5 themselves saying I think I have gender dysphoria
 6 or I might be transgender?
 7 A Yeah. If you look at the Hannah Barnes book, Time
 8 To Think, or you look at the whistleblower
 9 report, you can see that there is sufficient,
 10 significant evidence that within gender clinics
 11 there are a lot of pressures to automatically, and
 12 there are people in the community who say the
 13 first thing that you should do is immediately
 14 affirm. You have to go with it. This can never
 15 be challenged.
 16 So, yes, I feel that clinicians, therapists,
 17 have a lot of pressure, especially if they are,
 18 if, especially probably in places like gender
 19 clinics to automatically affirm.
 20 Q Based on your secondhand review of the literature
 21 you believe this is happening?
 22 A Well, based on what I read in WPATH guidelines,
 23 and based on what I have read in Hannah Barnes'
 24 book, and based on my experience talking with
 25 other psychiatrists, and based on my experience

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1 going to meetings and listening to child
 2 psychiatrists who are presenting on gender
 3 dysphoria, yes, I believe this is what is
 4 happening.
 5 Q If a patient presents themselves and says, you
 6 know, I think I have gender dysphoria or I think
 7 I'm transgender and I want you to use male
 8 pronouns for me, do you think it is automatic
 9 affirmation to begin using male pronouns for that
 10 person?
 11 A It may or may not be. It depends on the
 12 circumstance.
 13 Q In what circumstance would it not be automatic
 14 affirmation?
 15 A Well, if you are, if their request to use male
 16 pronouns is in a situation where you, you know,
 17 there has been a long history of gender dysphoria
 18 or issues related to it and this is a well thought
 19 out process that emerges in therapy, or someone
 20 has already done a bunch of therapy work, if they
 21 are older, I mean, there are all sorts of factors
 22 that you may consider whether to go with that.
 23 Or the next question might be why do you feel
 24 that way? What's going on? Tell me about that.
 25 Usually in therapy you are asking questions

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1 regarding what is the experience of the patient
 2 and why they feel a certain way.
 3 Q Would you agree that it's possible to do both? To
 4 say great, thank you, I will use male pronouns.
 5 Can you tell me a little more about that?
 6 A That would be one choice, yes.
 7 Q Would you consider that automatic affirmation?
 8 A It could be. Yeah. If you are going to go with
 9 it, right, at the first request of a patient I
 10 would consider that automatic affirmation.
 11 Q What do you think you should do instead?
 12 A Once again, it depends on the clinical situation.
 13 I mean, I have written that in the report.
 14 Someone, you know, if someone comes up and they
 15 were just sexually assaulted and now they say, I
 16 want to, I want to use male pronouns. I'm going
 17 to change to this male name.
 18 I would be, like, hold on. What's going on?
 19 You know, let me hear more about this. Let me
 20 hear what's behind your decision.
 21 Yes, we want to talk about it because we want
 22 to know, and I would want to explore what exactly
 23 is happening.
 24 Q That example that you just referred to about a
 25 patient recently being sexually assaulted, is that

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1 based on a specific patient or a hypothetical?
 2 A Well, that is, that particular vignette would be a
 3 hypothetical.
 4 Q So you are aware of that happening. That is an
 5 example that you came up with --
 6 A There is evidence there is increased gender
 7 dysphoria after sexual assault. That is in my
 8 report. This is part of the concern that after a
 9 sexual assault there is evidence that there is
 10 more likely to be gender dysphoria.
 11 Q That is a vignette that you came up with based on
 12 your reading of data, not a specific patient?
 13 A Correct.
 14 Q Okay. In Paragraph 145 you talk about some
 15 psychiatrists who are, many psychiatrists are
 16 "willing to use affirmative approaches
 17 selectively."
 18 Do you see where you wrote that?
 19 A Yes.
 20 Q Is that what we talked about just now where you
 21 said depending on the therapeutic history it might
 22 be warranted to affirm someone by using their
 23 pronouns?
 24 A Yes.
 25 Q Do you think in a patient that had that kind of

Page 181

1 long therapeutic history it would be warranted to
 2 provide them with gender-affirming care, medical
 3 care in the form of puberty blocks or hormones?
 4 A I think that we have already discussed this. I
 5 mean, if they are fully grown into adulthood that
 6 that would be worth considering.
 7 Yes, if they are done developing and they are
 8 still not in a process of identity development
 9 that could make sense.
 10 Q Do you think there are seventeen year olds who are
 11 sufficiently developed in their identity and have
 12 a long enough history that gender-affirming care
 13 in the form of hormones would be appropriate?
 14 A I don't think that we have enough data about if
 15 seventeen year olds will maintain their identity
 16 that they have in order to justify that.
 17 Q Can you imagine any circumstance in which it would
 18 be appropriate to provide hormones to a seventeen
 19 year old?
 20 A I don't think it is a good clinical decision. So,
 21 no, I don't. In my opinion, it would not be wise.
 22 MR. SELDIN: Joel, will you take us to
 23 Page 53, please. Can you scroll down a little
 24 bit. Go to Page 53. Thank you.
 25 Q Paragraph 131 appears out of order. It is on the

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1 bottom of Page 53.
2 Do you see where you are discussing here
3 Levine's list of assumptions misrepresented as
4 facts.
5 Do you see that?
6 A Yes.
7 Q Then the third bullet down says, "All gender
8 identity variations are biologically determined
9 and inherently healthy."
10 Do you see that?
11 A Yes.
12 Q Do you believe that there are some gender identity
13 variations that are inherently unhealthy?
14 A Do I believe there are some -- well, yeah. I
15 mean, I think we have an open scientific question
16 if some patient's gender identities are unhealthy
17 for them, correct.
18 Q What do you mean by unhealthy for them?
19 A Well, we could go back to the data related to
20 trauma and increased gender dysphoria. I mean, is
21 the, you know, is this really an avoidance
22 strategy to shield someone, you know,
23 psychologically from the trauma that they had.
24 Right?
25 So if someone develops a transgender identity

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1 or gender dysphoria after a sexual assault, it
2 could be an unhealthy response to that. And that
3 could end up being a, you know, you know,
4 nonproductive, nonfunctional way for them to cope
5 or react to that.
6 Q Do you think having a transgender gender identity
7 is inherently unhealthy?
8 A No, not across the board. So I think that, you
9 know, in an adult with an established transgender
10 identity, the -- you would have a, a transgender
11 identity -- everything in life is -- you know, so
12 first of all, there are people that seem to just
13 feel this very strongly. And it comes, and it has
14 come from not a place of another disorder or
15 trauma and it has been persistent for a long
16 period of time.
17 So I think that is the group of patients
18 where we are saying that that does not seem so
19 much like this is an unhealthy or problematic
20 identity.
21 Q So you would agree then that there are at least
22 some transgender adults for whom there is no
23 traumatic etiology for their transgender
24 identities? It is just the way they are, correct?
25 A Correct.

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1 Q Do you feel that way about any minors?
2 A What I would prefer to conceptualize this as is
3 that a minor is a developing individual with
4 gender dysphoria. So I don't think clinically it
5 is the right approach to consider them a fixed
6 transgender individual.
7 And only time will tell if they end up being
8 an adult who, you know, does have that fixed
9 identity of a stable transgender identity. So,
10 you know, for any one individual teenager or
11 child, I mean, we don't know what their life will
12 bring them or how they will develop.
13 Q If you could predict with a hundred percent
14 certainty which children with gender dysphoria
15 would grow up to become transgender adults, would
16 you have the same objections to provision of
17 gender-affirming care, medical care to minors?
18 A If you could predict with a hundred percent
19 certainty?
20 Well, I guess I would have a number of
21 caveats with that. We are saying someone without
22 co-morbidities or other problems that possibly
23 could be a contributing factor to developing it.
24 So I think, yes, I think you are -- then we
25 would, you know, everyone would feel much more

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1 comfortable if we knew for sure or we knew what
2 the person's individual development trajectory
3 would be.
4 So, you know, I have never thought of that
5 question before exactly like that. But, yeah,
6 perhaps if we knew, if we knew a hundred percent.
7 Q Is there any other medical condition for which you
8 think we should have a hundred percent certainty
9 as to outcome before we provide it?
10 A You know, well, not that I know of. I do think
11 this is an exceptional case because of the
12 permanent changing of a person's, you know,
13 trajectory with a, you know, low quality evidence
14 base.
15 So that is the challenge here, is that we
16 don't really know who is going to have what type
17 of identity as an adult. We don't know the
18 long-term outcomes. Yes, other situations where
19 we were talking about things that do not have this
20 risk level, sure, we don't demand such a high
21 certainty.
22 I'm not saying that I'm demanding a hundred
23 percent certainty. I'm saying I am demanding a
24 lot more certainty than we have with the current
25 patient population that we have.

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1 Q Would you support studies that would bring us
2 closer to certainty about the, about what you
3 believe would be --
4 A Yes. Yes.
5 Q You are aware that Senate Enrolled Act 480 does
6 not include any carve outs for research?
7 A Yes.
8 Q Do you think that that is a mistake?
9 A I don't know all of the factors that go into
10 making the bill. I would say, in general, I wish
11 we would be studying things more. Especially if
12 we were studying one pool of patients with
13 psychotherapy and psychosocial treatments.
14 As long as we are actually studying
15 alternatives, then I think studies are great. If
16 all you are going to study is medicalized
17 treatments, then we are going to be in the same
18 boat down the road because we are not going to
19 really know what treatments are better.
20 Q If I understand, you have opinions about study
21 design.
22 Generally speaking, you would support
23 studies?
24 A Correct.
25 Q Okay.

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1 MR. SELDIN: Joel, will you take us to
2 Page 55, please.
3 Q Dr. Kaliebe, you will see in Paragraph 151 you
4 talk about in the third sentence, "Psychotherapy
5 involves getting patients to recognize their own
6 thought patterns, disturbed emotions, and, when
7 appropriate, includes challenging irrational,
8 self-defeating, and harmful beliefs."
9 Do you see that?
10 A Yes.
11 Q Do you think gender dysphoria is an irrational,
12 self-defeating or harmful belief?
13 A I believe that what I have seen in many patients
14 with gender dysphoria is that it includes those
15 types of beliefs, yes.
16 So when you have a patient who is saying, you
17 know, who is so fearful of puberty, and they are
18 saying this will be the worst thing. This will be
19 so horrible. They are predicting a future that
20 they don't know. They are assuming the worst.
21 Right?
22 That is a classic assuming the worst
23 cognitive distortion. Right? They don't know
24 what will happen, but they feel it's bad. They
25 have thoughts related to that.

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1 A lot of patterns in gender dysphoria are
2 classic patterns that you have in all psychiatric
3 disorders. If they seem quite amenable to
4 treatment and if you can get patients to engage in
5 such treatment, then they could be less disturbed.
6 Yes.
7 Q So you were talking about the dreaded puberty as a
8 potentially irrational self-defeating or harmful
9 belief?
10 A Yes.
11 Q But you believe there are some children with
12 gender dysphoria who do grow up to be transgender
13 adults, right?
14 A Correct.
15 Q So for those youth, their fear of puberty is not
16 irrational, right?
17 A Well, it may be irrational because it may be out
18 of proportion. So just because a possible outcome
19 is that puberty will be bad, I mean, you know,
20 puberty may be good.
21 That person does not know until they
22 experience it. So they are assuming the worst and
23 making themselves suffer more. This is a lot of
24 what you do in therapy, is help people to have
25 realistic and flexible thought patterns and accept

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1 what they have to accept and not making things
2 worse for themselves.
3 You don't want people catastrophizing the
4 worst and focusing on negatives. That is amenable
5 to therapy. I think those could be quite helpful
6 in patients with gender dysphoria.
7 Q You might disagree with the amplitude of their
8 distress, but it would not be irrational to be
9 worried about going through puberty that didn't
10 match your gender identity, right?
11 A It is not all about rational. That is one
12 component of it. An overfocus on negative things
13 makes people more upset and causes them to do
14 worse.
15 So there are many different components of how
16 your thought patterns contribute to suffering. So
17 we want to minimize suffering from people having
18 flexible thoughts, alternative seeking, remaining
19 realistic.
20 And so just the overfocus itself, even if it
21 is rational, can be a harmful approach.
22 Q You talk about minimizing suffering as a generally
23 good goal. We talked about, you know, children
24 with gender dysphoria, minors with gender
25 dysphoria who grow up to be transgender adults.

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1 Would you agree that it's good to minimize
2 their suffering of going through puberty that does
3 not match their identity?
4 A I don't know that we know enough right now to say
5 whether that is -- even for the ones who end up
6 being adults, I don't know that we know that it's
7 not a better path, even if it's difficult, to go
8 through puberty, become an adult, have a
9 solidified identity and then make a choice to
10 transition when you have gone through that even if
11 it was painful or difficult or there was suffering
12 involved.
13 So while, yes, we want to minimize suffering,
14 I don't know that in your hypothetical that we
15 would be. I think that is one of the many
16 unknowns.
17 MR. SELDIN: Joel, will you take us to
18 Paragraph 154 on the next page, please.
19 Q Five lines down you say, "Yet, the false binary of
20 affirmative psychotherapy versus conversion for
21 gender dysphoria is being used to push therapists
22 away from consideration that acceptance of one's
23 biological sex or resolution of gender dysphoria
24 is a positive event."
25 Do you see where you wrote that?

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1 A Yes.
2 Q This false binary, what do you base that on?
3 A Well, a lot, there have been many attempts to call
4 different types of therapy for gender dysphoria or
5 approaches to people who are transgender as
6 conversion therapy.
7 Conversion therapy usually was thought of as
8 attempts to force changes in sexual orientation.
9 Those are not any -- I mean, in the distant past
10 those occurred. They were rejected by the mental
11 health community a long time ago. They may exist
12 in certain religious sects or in other parts of
13 society.
14 But to then associate regular, you know,
15 psychotherapy with conversion I think has done a
16 lot of damage in that people don't want to engage
17 in deep regular therapy with patients because for
18 fear of this.
19 And because patients hear that therapy is not
20 the solution to their problems. That they really
21 just need to be affirmed and get medical
22 treatments. So that can also interfere with the
23 patient's willingness to do therapy when therapies
24 are called conversion therapy.
25 Q So I'm trying to understand the distinction

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1 between this regular psychotherapy that you are
2 talking about and affirmative therapy.
3 Earlier you said it would not necessarily be
4 affirming for a therapist or psychiatrist to say,
5 Great, I'll use those pronouns. Can you tell me
6 more about that?
7 I mean, what is the difference between
8 regular psychotherapy and affirmative therapy in
9 that instance?
10 A Well, that would be fine. It's fine to choose
11 that approach. But as long as we are getting to
12 the, Can you tell me more about that, and we are
13 really truly going down that road it seems like
14 many proponents of medicalized transitions for
15 youth are not emphasizing how important it is for
16 there to be a true process of actual exploration
17 and a completion of identity development before
18 medicalized treatment.
19 And I just think that, you know, the, calling
20 therapies for gender identity or addressing
21 elements of gender identity conversion therapy is
22 an inappropriate attempt to, it's, it makes
23 therapy a pejorative and it argues against therapy
24 for kids who really could benefit from therapy.
25 MR. SELDIN: Joel, will you take us to

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1 Paragraph 168.
2 Q Dr. Kaliebe, in Paragraph 168 you say in the
3 second sentence, "Beyond standard psychotherapies,
4 more specific and nuanced approaches for gender
5 dysphoria exist, such as Exploratory Therapy."
6 Then you include the URL for
7 genderexploratory.com.
8 Do you see that?
9 A Yes.
10 Q Have you studied Gender Exploratory Therapy?
11 A I don't know what you mean by "studied." But I've
12 looked at the site and the approach, yes.
13 Q What is the evidence base for this approach?
14 A Well, it's based on long-standing principles of
15 psychotherapy. And as I note in other parts of my
16 report, the evidence base in general for
17 psychotherapy is quite good.
18 So since we are using lots of the techniques
19 from standard therapy, my guess is that it would
20 generalize and be quite good. Just like
21 everything else, there are very few studies as we
22 have a very new patient population.
23 Q You have a hypothesis that can work, but there is
24 not an evidence base specifically for gender
25 dysphoria?

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1 A There is a huge evidence base for psychotherapy.
2 I don't see any reason that patients with gender
3 dysphoria would be so different from all of the
4 other patients. So we can look at the massive
5 evidence base that there is for psychotherapy and
6 assume that all human beings with struggles and
7 problems and distress could benefit from talking.
8 People have been fine tuning and honing
9 therapy for quite a while and there are lots of
10 really well proven techniques. I have cited
11 cognitive therapy in my report.
12 I mean, there is a really strong substantial
13 base for this being a very effective tool. So I
14 don't see any reason why it would not work in
15 gender dysphoria.
16 Q You think you have a really good hypothesis, but
17 there is not a study showing that --
18 A Yes. Yes. There is no study showing it does not
19 work, right. There are a lot of studies that show
20 it works for everything else. But, no, we do not
21 have a specific study in this.
22 Q Right. Would you agree that gender dysphoria is
23 distress based on the existence of psychological
24 characteristics that don't align with their gender
25 identity?

Page 195

1 A That is a complex question. I'm not sure that
2 that is the primary driver for most of or --
3 Q Doctor, I don't mean to cut you off. I think
4 maybe you misunderstood my question. I'm not
5 talking about etiology. I'm just talking about
6 what it describes.
7 As a descriptive matter, gender dysphoria as
8 a distress because of having psychological
9 characteristics that don't align with your gender
10 identity, is that fair to say that is a
11 descriptive matter?
12 A I'm not sure. I mean, I think those are elements
13 of what is going on. But, in totality, we are not
14 really sure what the children and teens, what
15 factors are causing them to have the, you know,
16 thoughts and feelings that they have.
17 But, yes, I mean, I would agree to that, you
18 know, that part of the criteria is that there is
19 distress about their physical characteristics.
20 So I think that there are some qualifications
21 and that we really sort of have not fully
22 developed theories and knowledge about what is
23 driving gender dysphoria.
24 But, yes, I would agree that just by the
25 criteria, you are talking about someone who has

Page 196

1 distress related to their secondary sex
2 characteristics and physiology.
3 Q And even though you have talked about evidence for
4 things like cognitive behavioral therapy as a
5 treatment for other conditions, you are not aware
6 of any studies regarding the effectiveness of CBT
7 for the treatment of gender dysphoria, is that
8 correct?
9 A Yeah. I'm not aware of any studies that don't say
10 it treats it. But I'm not aware of any studies
11 that say it does treat it.
12 There are lots of studies that say it works
13 for a lot of things. It just has not been
14 studied, correct.
15 MR. SELDIN: Joel, will you take us back
16 to Page 56, please.
17 Q Dr. Kaliebe, in Paragraph 154 you say, "It is
18 surely reasonable and compassionate for a
19 psychotherapist to prefer a patient no longer to
20 suffer with gender dysphoria."
21 Do you see where you wrote that?
22 A Yes.
23 Q It's your belief that gender dysphoria can
24 resolve? Or it's your belief that gender
25 dysphoria can possibly be resolved by a person

Page 197

1 accepting their biological sex, is that fair?
2 A I believe that a component of resolution of gender
3 dysphoria could be in many cases, and maybe in all
4 cases, that acceptance. So yes, that could be one
5 component of it.
6 Q Would you agree that gender dysphoria can also be
7 resolved by treatments that bring a person's body
8 in line with their gender identity?
9 A I'm not so -- I think when you talk about the
10 patient population of adolescents that we are
11 treating, I'm not, I don't think that the evidence
12 is overwhelming that that does resolve their
13 gender dysphoria.
14 There's mixed evidence on that. So I would
15 not say that that is a uniform response to gender
16 affirming treatment. I would agree it does seem
17 there is evidence in some cases it resolves gender
18 dysphoria.
19 Q So I guess my question is if it's -- and we can
20 disagree about the frequency. But if it's
21 sometimes resolution through accepting their
22 biological sex, or through changing physical
23 characteristics to match gender identity, is it
24 ethical to totally ban one of those two?
25 A Well, I would add there is a third that sometimes

Page 198

1 these would just resolve on their own.
2 So, yes, I think that we also have to
3 understand and consider that gender dysphoria
4 could just resolve without treatment. So we don't
5 necessarily have to do a medicalized treatment for
6 all individuals with gender dysphoria.
7 So would it appropriate? Well, I think in
8 the case of developing minors, I think it is
9 proper to argue that they should wait until
10 complete development, and then have sufficient
11 psychotherapy and other supports that would help
12 them get to a place as an adult and with enough
13 time that they have stayed gender dysphoric before
14 moving on to medicalized treatments.
15 MR. SELDIN: Joel, will you pull up
16 Exhibit 7. Take us to Page 1130, which is
17 Page 168 of the PDF.
18 Q And so, Dr. Kaliebe, we were talking earlier about
19 your testimony in the Decker trial that took place
20 recently.
21 Do you remember we were talking about that?
22 A Yes.
23 Q This is going to be a long portion of me reading.
24 My question at the end will be did I read that
25 correctly.

Page 199

1 A Okay.
2 Q So you know where we are going. So on Page 1130
3 of this transcript at Line 11 the Court said -- or
4 rather we will start at Line 9.
5 "THE WITNESS: Yes, I do not believe that we
6 should be doing hormones and surgeries for
7 developing adolescents."
8 "THE COURT: My question was therapy. And I
9 think I take it from your answers that you don't
10 think therapy that would make an adolescent
11 comfortable with gender identity different from
12 the sex assigned at birth is ever appropriate.
13 Did I misunderstood it?"
14 "THE WITNESS: I would say a little bit. I
15 think that we wouldn't have a goal of trying to
16 change someone's gender identity in therapy. I'm
17 not trying to get to one particular result. It's
18 more you want to -- so if that's the end result
19 that they have a, you know, a gender identity
20 opposite from their natal sex, I am fine with
21 that. I'm not opposed to that.
22 "I do think that you would have a leaning
23 towards or it is sort of a better outcome for most
24 kids most of the times, considering the
25 co-morbidities and everything going on, that they

Page 200

1 come to peace with their natal sex because then
2 they don't have all the problems that come from
3 not having that, and the distress from not having
4 that. But I'm okay with -- obviously, there are
5 going to be people that are going to go on and be
6 transgender and not be comfortable with their
7 natal sex, so you could support that."
8 Did I read that correctly?
9 A Yes.
10 Q Do you still agree with that testimony that you
11 provided in Decker?
12 A Yes, I think that was very similar to the
13 conversation that we just had.
14 Q Earlier we talked about a situation in which you
15 were comfortable with the certainty of the
16 prediction.
17 For those children, for minors with gender
18 dysphoria who go on to be transgender adults there
19 may be a role for medical gender-affirming care
20 for those people, would you agree?
21 MR. PATTERSON: Objection. It has been
22 asked and answered several times.
23 You can answer again.
24 A You are saying as adults?
25 Q Yes. We will start with as adults.

Page 201

1 A Repeat the question then before I answer it.
2 Q So we talked about before those minors with gender
3 dysphoria who go on to be transgender adults.
4 Do you believe that there is a role for
5 gender-affirming medical care in the form of
6 hormones for those individuals?
7 A Yes.
8 Q Is it your belief it is ever appropriate to
9 provide that kind of medical care to someone who
10 is under eighteen?
11 MR. PATTERSON: Objection. Objection
12 asked and answered.
13 You can answer.
14 A My belief is that there is no evidence base to
15 support that practice.
16 MR. SELDIN: Joel, will you take us back
17 to Exhibit 1.
18 Q Dr. Kaliebe, we were talking earlier and you were
19 talking about conversion therapy in the context of
20 sexual orientation.
21 Do you remember that?
22 A Yes.
23 Q You said it was rare. Do you recall saying that?
24 A Yes. I qualified that conversion therapy was, if
25 it is carried out these days, it's typically

Page 202

1 carried out within parts of our society that are
2 not related to mental health care or medical care.
3 Q What do you base that statement on?
4 A That in all of my experience I've not encountered
5 medical or mental health professionals who would
6 attempt to change anyone's sexual orientation.
7 Nor have I ever seen any compelling evidence of it
8 in any of our medical journals.
9 Q Any evidence of it happening, you mean?
10 A Correct. Within the medical community or mental
11 health community, correct.
12 Q We will look at Page 59.
13 Dr. Kaliebe, earlier you had mentioned that
14 you thought trauma might have a role in gender
15 dysphoria in some minors.
16 A Correct.
17 Q For minors who have no history of trauma this
18 hypothesis would not be applicable, right?
19 A Correct.
20 Q And would you agree, or rather, do you think that
21 there are people who have gender dysphoria who
22 separate and unrelated have had some kind of
23 trauma in their life?
24 A Correct. You can see if something occurred before
25 the development of the gender dysphoria or at the

Page 203

1 same time as the development of the gender
2 dysphoria.
3 We would call that a co-occurring disorder if
4 it occurred at the same time or around the same
5 time, but after the trauma.
6 Q Would you agree then that -- once someone's trauma
7 has been adequately addressed it is possible that
8 that person could still have gender dysphoria?
9 A Yes.
10 Q Okay.
11 MR. SELDIN: We have been going a little
12 over an hour. Is now a good time for a five
13 minute break for folks? Let's come back at 3:37
14 Eastern.
15 (OFF RECORD AT 3:31 P.M.)
16 (AT THIS TIME A SHORT RECESS WAS HELD OFF
17 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS
18 WERE HAD:)
19 (ON RECORD AT 3:37 P.M.)
20 BY MR. SELDIN:
21 Q Let's look at paragraph -- sorry.
22 MR. SELDIN: Joel, will you bring up
23 Exhibit 15. Click us through to that link.
24 Q You recall earlier you mentioned this conference
25 you spoke about. Oasis.

Page 204

1 A Yes.
2 MR. SELDIN: Joel, will you scroll down.
3 Keep going.
4 Q I believe this is -- does this look like the
5 agenda from the conference that you were talking
6 about?
7 A Okay. Hold on. This is the adult conference.
8 Q Okay. The adult conference. Okay. There was a
9 separate child conference?
10 A Correct.
11 Q Well, let's stay here for a moment. So,
12 Dr. Kaliebe, you said that you provided three
13 different CME lectures at this weekend in
14 Puerto Rico, is that right?
15 A Of the child. Two for adult and three for child.
16 Q Okay. So are these the two for the adult that you
17 were talking about?
18 A Correct. Yes.
19 Q So the agenda would be listed separately for the
20 child conference?
21 A Yes.
22 Q I'm asking because I only saw two of the three. I
23 was not sure where the third had gone. We will
24 take a look at that in a second.
25 MR. SELDIN: Joel, will you pull up

Page 205

1 Exhibit 16.
2 Q Earlier you said you had a Twitter account. Is
3 that your handle?
4 A It must be ancient. Maybe I just joined to read
5 some things. I don't know that I have a handle.
6 I don't ever tweet anything. Maybe when I logged
7 in it connected to me through Google or some other
8 way. Like I said, I have gone on to read things.
9 Q Is that photo there --
10 A That is me in the photo.
11 Q Is that a New Orleans Saints jersey?
12 A It is a Saint's jersey, yes.
13 Q So that is you. The bio says "psychiatrist and
14 sceptic."
15 Does that sound like something you would
16 write?
17 A It is. I don't remember -- anyway. Yeah. I
18 would write that. I don't remember.
19 Q Okay. You don't have any reason to believe this
20 is a different Kristopher --
21 A That is me.
22 Q Okay. All right. And then we will scroll down.
23 You said you used Twitter to read some things.
24 It looks like that this profile liked this
25 tweet by Dr. Jordan B. Peterson that says, "Why

Page 206

1 can't we tell the truth about Lia Thomas?"

2 It links to an article on spiked-online.com.

3 Do you see that?

4 A Yes.

5 Q Do you recall liking this tweet?

6 A I believe that is accurate that I probably did.

7 Q Do you recall reading this article?

8 A I don't know that I ever read the article, no.

9 Q Okay.

10 A I may have. I may not have.

11 MR. SELDIN: Joel, scroll down.

12 Q You liked another tweet on March 28, 2022. This

13 was posted by komunik8e to Jordan Peterson. It

14 says, "The Party told you to reject the evidence

15 of your eyes and ears. It was their final, most

16 essential command."

17 That is a George Orwell quote from 1984

18 superimposed on a photo of Lia Thomas.

19 Do you recall liking this tweet?

20 A No. I don't doubt that I did if it showed up in

21 my profile.

22 Q What do you think this graphic means?

23 A What does the graphic mean? Well, I think there

24 is, the graphic means that there seems to be a

25 problem with inclusion of biological males in

Page 207

1 women's sports and that we, you know, that this is

2 an issue that seems, I think, important and that

3 we should have an honest proper discussion about

4 it.

5 And my opinion is that it's important to keep

6 women's sports to those who are biologically

7 female with whatever, you know, definition that

8 you have. Yes, I would agree that is the main

9 part.

10 The bigger part, though, is the, you know,

11 there is an Orwell quote. As I was mentioning

12 regarding, regarding, you know, silencing of

13 debate, it seems like that we have not had any

14 sort of proper dialogue, especially in the medical

15 journals and within medical societies about how we

16 are going to handle these complex issues.

17 So, you know, therefore, the George Orwell

18 quote I think is, you know, part of why I tweeted

19 it. Or why I liked it. I have never tweeted

20 anything as far as I know.

21 MR. SELDIN: Joel, scroll down to the last

22 page.

23 Q You will see you liked a tweet from Andre MCato on

24 March 28, 2022. The tweet that you are liking

25 says, "Who has the courage to interview Thomas and

Page 208

1 ask him how he justifies winning among women? In

2 a free society, that interview would have already

3 happened."

4 Do you see that?

5 A Okay. Yes.

6 Q Do you recall why you liked that tweet?

7 A No. I think it speaks for itself.

8 Q What do you mean?

9 A Well, I think that we should have a close look at

10 what is going on. And, you know, to me this is a

11 problematic issue when someone swims as a

12 biological male for three years in college and

13 then transitions and then swims as a female.

14 So, once again, this is something that I

15 think is challenging, but there is a clear answer

16 that most people would support. And I support

17 that biological sex when it comes to sports is

18 very important.

19 It is quite unfair for female participants if

20 someone who is a biological male and gone through

21 biological puberty is then allowed to compete with

22 biological females.

23 Q You would agree that Senate Enrolled Act 480 has

24 nothing to do with sports?

25 A Correct.

Page 209

1 Q Okay. And you will see that this tweet uses male

2 pronouns to refer to Lia Thomas.

3 Do you think that is appropriate?

4 A You know, once again, I don't think it's a big

5 deal. I don't know that I noticed whether it used

6 male pronouns or not. I mostly was liking things

7 that brought up this issue of fairness and, you

8 know, basically allowing women to compete fairly

9 in women's sports, which I think is an important

10 issue.

11 MR. SELDIN: Joel, I'm dropping into the

12 chat a link which I will call Exhibit 17 for

13 purposes of this exercise. If you can take us

14 there.

15 Q Is Exhibit 17 the agenda for the child portion of

16 the Oasis conference?

17 A Yes. You would have to scroll down to see the

18 rest.

19 Q You will see -- Dr. Kaliebe, do you see there are

20 two CMEs listed with your name next to them?

21 A Yes.

22 Q "Social Media and Cyberbullying: Prevention."

23 A Yes.

24 Q The second one is, "Cannabinoid: New Forms and

25 New Problems."

Page 210

1 A Yes.

2 Q I guess my question is earlier you talked about

3 presenting on gender dysphoria specifically at the

4 child portion of this conference.

5 I'm just wondering why it's not listed here?

6 A Yeah. Well, that's a good question. I've not

7 accessed this before. This is also garbled

8 because the presenters do not match up. I did not

9 represent on cannabinoids. I did present on the

10 social media. Some of this is messed up.

11 Q Okay. Did you present one or two CMEs?

12 A Three. I presented three.

13 Q Are the three that you did listed here?

14 A No. So only one is listed here. I presented the

15 social media one. I'm not sure if the other ones

16 are wrong or what is wrong on this. I presented

17 on the three. It was Social Media and Cyber

18 Bullying. It was Traumatic Brain Injury and

19 Gender Dysphoria. What is listed there is

20 incorrect.

21 Q Do you recall what the title of that CME would

22 have been on gender dysphoria?

23 A I know gender dysphoria. It was Reviewing the

24 Evidence or something like that.

25 MR. SELDIN: Joel, will you please bring

Page 211

1 up Exhibit 3.

2 Q Earlier today we talked about this as the C.V.

3 that you attached to your report in Boe v.

4 Marshall.

5 A Yes.

6 Q Look at Page 107 of this PDF. You will see,

7 Dr. Kaliebe, on Page 21 it says at the top that

8 you were a member of Zero To Three from 2017 to

9 2021.

10 Do you see that?

11 A Yes.

12 Q What is Zero To Three?

13 A Zero to Three is an organization devoted to young

14 children. So this is, there's a field, sometimes

15 people call it infant psychiatry or infant mental

16 health.

17 The first few years of life are incredibly

18 important. This is an organization devoted

19 towards supporting children, infants, young babies

20 and also their caregivers, especially their

21 mothers.

22 So Zero To Three is a professional

23 organization of those devoted to trying to promote

24 support for moms and babies.

25 Q Why did you stop being a member after 2021?

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1 A I had presented a couple times at their

2 conference. I do a lot of different things. So

3 that was not totally, or, you know, I didn't feel

4 like it was -- I just do so many things. I had to

5 give some things up. It's a great organization.

6 I would be happy to join or contribute again in

7 the future.

8 Q And then we will look at Exhibit 8 next. This is

9 an article on the Zero To Three website dated

10 December 15, 2021.

11 It says, "Embracing Diversity: Developing a

12 Gender Identity."

13 Do you see this article?

14 A Yes.

15 Q Have you seen this article before?

16 A No.

17 MR. SELDIN: Joel, scroll down to

18 "Supporting Healthy Development."

19 Q I will read something. My question will be did I

20 read that correctly.

21 Under Supporting Healthy Development it says,

22 "Make sure your child knows they have your

23 support. Gender identity is a central part of a

24 child's identity and well-being. Parents don't

25 make their children cisgender or transgender.

Page 213

1 This is also not a choice children make - it is

2 simply who they are. To grow up healthy, every

3 child needs to know that they are fully accepted,

4 loved, and supported."

5 Did I read that correctly?

6 A Yes.

7 Q Do you agree with that?

8 A Yeah.

9 Q Dr. Kaliebe it says, "Read stories that feature

10 all kinds of families, as well as stories that

11 include transgender, non-binary, and gender

12 expansive characters. Shared reading is a

13 powerful way for all families to nurture an

14 inclusive worldview and challenge stereotypes from

15 the start."

16 Then it links to some suggested titles.

17 Did I read that correctly?

18 A Yes.

19 Q Do you generally agree with that advice?

20 A You know, I don't, I'm not sure that if we are

21 talking about Zero To Three, you know, which is

22 really like, you know, very, very young children.

23 I think, you know, it's debatable what positive

24 influence you would have in a very, very young

25 child introducing these different characters.

Page 214

1 I don't think, you know, I'm not necessarily
2 opposed to it. But I'm also not thinking that
3 this is a, you know, that this is necessarily
4 important.
5 I mean, yeah, I mean, once again, I think I
6 would honestly, I personally would have a somewhat
7 different emphasis. I don't think there is
8 anything wrong with reading stories that include
9 transgender or nonbinary, or gender expansive
10 characters.
11 Q Dr. Kaliebe, further down there is a section that
12 says, "Build an inclusive community."
13 It says, "This is important for all kids, and
14 it's especially important for kids who may later
15 identify as LGBTQ. In the past, one of the
16 toughest things for kids discovering that their
17 sexual orientation or gender identity was
18 different than those around them was a feeling of
19 being alone. Actors, politicians, teachers,
20 sports stars, family, and friends who are upfront
21 about their identities help make the world more
22 comfortable for questioning kids. Make it clear
23 that all people are welcome in your community and
24 in your household. Living your values in this way
25 shows your child that they will be loved however

Page 215

1 they show up and whoever they become."
2 Did I read that correctly?
3 A Yes.
4 Q Do you agree with that?
5 A Yes. It is important for us to have broad roles,
6 or a broad range of how what, of how children can
7 act. I do think it is important that we accept
8 boyish girls and girlish boys and don't try to
9 pigeonhole kids into my particular gender
10 expression.
11 So I would definitely agree that allowing a
12 wide range of gender expression is important.
13 Q Do you think that extends to people who are
14 transgender?
15 A Well, I think we have had this conversation
16 already. Children with gender dysphoria I would
17 not categorize as transgender. I would say they
18 are a child with gender dysphoria because I don't
19 think it is appropriate to place an identity on a
20 child.
21 So within their life we should make room for
22 children to express themselves in any way,
23 including gender nonconforming ways.
24 So, yes, we are in agreement that we need to
25 make space for all children, including gender

Page 216

1 nonconforming children. And that it is important
2 for society to create space for gender
3 nonconforming children.
4 Where I think we are not on the same page or
5 there is some difference of viewpoint is that I
6 think it's important to emphasize that what we are
7 talking about in, you know, we are saying gender
8 nonconforming could be fine and not gender
9 dysphoria.
10 But if we are talking about a gender
11 dysphoria child, I'm not for labeling that child a
12 transgender child. I think that we can label them
13 a child with gender dysphoria.
14 Q In the middle of this paragraph it says, "Actors,
15 politicians, teachers, sports stars, family, and
16 friends who are upfront about their identities
17 help make the world more comfortable for
18 questioning kids."
19 Do you see that?
20 A Yes.
21 Q Earlier today we were talking about whether
22 celebrities who are openly transgender are a
23 source of social contagion. You thought they
24 might be.
25 Do you remember us talking about that?

Page 217

1 A Yes.
2 Q Do you think these two, this sentence and that
3 belief are in tension with each other?
4 A Well, I think there's a lot of nuance. As I said,
5 I think we have to be careful about anything that
6 may encourage children to want to change their
7 body prior to them fully developing as
8 individuals.
9 So I think that there is a challenge there in
10 wanting to accept a child as they are whether that
11 is gender nonconforming or not. So making space
12 for all children, but not having children feel
13 pressured that they would need to change their
14 body prior to them fully developing.
15 Q But per this paragraph just about people being
16 upfront about their identities, do you think just
17 being upfront about identity as a transgender
18 adult, that that is a source of social contagion?
19 A No, that is fine.
20 MR. SELDIN: Dr. Kaliebe, Mr. Patterson,
21 it may be that I'm able to wrap up soon. I think
22 another break might help me determine that.
23 Would you be opposed to a longer break,
24 about ten minutes until 4:13?
25 MR. PATTERSON: Fine.

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1 (OFF RECORD AT 4:02 P.M.)
 2 (AT THIS TIME A SHORT RECESS WAS HELD OFF
 3 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS
 4 WERE HAD:)
 5 (ON RECORD AT 4:09 P.M.)
 6 MR. SELDIN: Dr. Kaliebe, thank you for
 7 the conversation today. Unless Mr. Patterson has
 8 questions that I want to follow up, I think we are
 9 at an end.
 10 MR. PATTERSON: I don't have any
 11 questions. I think we are done.
 12
 13
 14 AND FURTHER DEPONENT SAITH NOT
 15
 16
 17 _____
 18 KRISTOPHER KALIEBE, M.D.
 19
 20
 21
 22
 23
 24
 25

Page 219

1 STATE OF INDIANA)
) SS:
 2 COUNTY OF BOONE)
 3
 4 I, Wendi Kramer Sulkoske, Notary Public in and
 5 for said county and state, do hereby certify that
 6 KRISTOPHER KALIEBE, M.D., the deponent herein was
 7 by me first duly sworn to tell the truth in the
 8 aforementioned matter;
 9 That the foregoing deposition was taken on
 10 behalf of the Plaintiffs at the time and place
 11 heretofore mentioned with counsel present as
 12 noted.
 13 That the deposition was taken down in
 14 Stenograph notes, reduced to typewriting under
 15 my direction, is a true record of the testimony
 16 given by said deponent, and was thereafter
 17 presented to the deponent for signature.
 18 That this certificate does not purport to
 19 acknowledge or verify the signature hereto of
 20 the deponent.
 21 I do further certify that I am a
 22 disinterested person in this cause of action;
 23 that I am not a relative or attorney of any of
 24 the parties or otherwise interested in the event
 25 of this action, and am not in the employ of the

Page 220

1 attorneys for the respective parties.
 2 IN WITNESS WHEREOF, I have hereunto set my
 3 hand and affixed my notarial seal this _____
 4 day of _____ 2023.
 5
 6 *Wendi K. Sulkoske*
 7
 8 _____
 9 Wendi Kramer Sulkoske, Notary Public
 10
 11 Commission Number NP0661030
 12 My commission expires December 1, 2030.
 13 My County of residence is Boone.
 14
 15
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 25

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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-JPH-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)

CIRCLE CITY REPORTING
 135 North Pennsylvania, Suite 1720
 Indianapolis, Indiana 46204

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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.)

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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1

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 Circle City Reporting

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1 Pursuant to the Indiana Supreme Court Case 20S-MS-236
 2 signed March 31, 2020,
 3 J A M E S M. C A N T O R, P H. D., having been first
 4 duly sworn or affirmed to tell the truth, the whole truth
 5 and nothing but the truth relating to said
 6 matter, was examined and testified as follows:
 7 DIRECT EXAMINATION
 8 QUESTIONS BY CHASE STRANGIO:
 9 Q Good morning, Dr. Cantor. How are you today?
 10 A I'm good. Thank you.
 11 Q My name is Chase Strangio. I am a lawyer with the
 12 ACLU representing the plaintiffs in this case. And
 13 I'll be asking you some questions today.
 14 As I mentioned, there are also some law
 15 student interns sitting in, as well as my
 16 colleagues, Gavin Rose and Stevie Pactor, from the
 17 ACLU of Indiana.
 18 Can you start by just stating your full name
 19 for the record, please.
 20 A I'm Dr. James Michael Cantor, C-A-N-T-O-R.
 21 Q And you've had your deposition taken before; yes?
 22 A Yes, I have.
 23 Q So you, generally speaking, know how this process
 24 goes?
 25 A Yes, I do.

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1 Q Okay. Still going to run through a few of the
 2 ground rules just to make sure we're on the same
 3 page.
 4 So as you know, there's a court reporter here.
 5 When answering my question, I ask that you respond
 6 verbally out loud so that Dana can hear you. And
 7 to please wait for me to finish asking my question
 8 before you begin your response. Does that sound
 9 okay?
 10 A Yep.
 11 Q And if you don't understand my question, which is
 12 very possible, please let me know and I can try to
 13 word it differently. Is that okay?
 14 A Yep.
 15 Q And if you do answer my question, I will assume
 16 that you understood it. Does that make sense?
 17 A I understand, yep.
 18 Q And are you feeling okay today?
 19 A Yes, I am. Thank you.
 20 Q Okay. And are you on any medication that would
 21 impair your ability to truthfully and accurately
 22 answer my questions?
 23 A No, I am not.
 24 Q And is there any reason you don't feel able to give
 25 complete and truthful testimony today?

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1 A Nope.
2 Q Okay. Great. I think we can get started. And, as
3 you know, at any point if you need to take a break,
4 please let me know. I imagine we'll also break for
5 lunch at some point. But if -- the only thing I
6 ask is to just answer the question we're discussing
7 before we break.
8 A I understand.
9 Q All right. So just starting with a little
10 background. You have been retained by the
11 defendants as an expert in this case; is that
12 right?
13 A Yes, I have.
14 Q And how did you come to be retained as an expert in
15 this case?
16 A Oh, goodness. I'm involved in several very similar
17 cases. And it's difficult for me to remember
18 exactly which one -- which way I got what e-mail
19 from who for which case.
20 So I could speak in general, I don't -- as I
21 say, I don't remember exactly how the first e-mail
22 started, "Hi, Dr. Cantor, I was referred to you
23 from," but it was essentially along those lines.
24 Q So someone in the State of -- someone at the State
25 of Indiana Attorney General's Office contacted you

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1 and you didn't contact them; is that right?
2 A Yes, that's correct.
3 Q And do you remember who that was?
4 A As I say, because several of these offices often
5 involve, you know, several different people, I
6 can't remember exactly which e-mail came from which
7 without going through my own e-mails to see who
8 said -- who came in at what point in the
9 conversation.
10 Q And do you remember approximately when that was?
11 A Within the past four or five months, I think.
12 Again, as I say, there's a cluster of them. I'm
13 not good on people's names to begin with.
14 So I hesitate to, again, without checking
15 through my own e-mails, but it was roughly in
16 that -- within the past couple of months. But
17 without checking my e-mails, I can't be --
18 Q Understood.
19 A I know better than to depend on my memory when
20 there are several very similar things all standing
21 next to each other.
22 Q Understood. You said you were an expert in similar
23 cases currently. What cases are those?
24 A On my CV, I listed all of the current cases. The
25 states themselves would be Kentucky, Indiana,

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1 Montana, Arizona, Florida, Texas, Tennessee. And,
2 again, without checking my list, I'm very probably
3 leaving one or two out.
4 Q And Oklahoma?
5 A Yes. Thank you.
6 Q So that's in addition -- including -- excuse me.
7 Including Indiana, that's one, two, three,
8 four -- at least eight states currently in cases
9 involving similar issues to the one here?
10 A Yes, that sounds about right.
11 Q And just so we're grounded in this case, are you
12 aware that this case concerns an Indiana law called
13 Senate Enrolled Act 480?
14 A Yes, I am.
15 Q And when this law was pending in the Indiana
16 legislature, did you take a public position on the
17 bill?
18 A No. The only testimony I had, and the only
19 interest I've ever had, really, is in the content
20 of the science.
21 So whenever I'm asked by the media, you know,
22 representatives in any state or any country,
23 members of the public, random e-mails I get, I'm
24 always happy to share whatever I can about the
25 science, but -- oh, and if somebody asks me a

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1 particular opinion about it, I'm perfectly happy to
2 show, you know, whatever points -- where the
3 science seems to contradict or match up with any
4 given proposal.
5 But I haven't in this state, and I don't think
6 in any state, given any particular support or
7 detraction from any particular proposal. The only
8 one I can think of where I did, I was specifically
9 invited to come and appear in Ontario, none in the
10 U.S.
11 Q So did you testify in support of Senate Enrolled
12 Act 480?
13 A No, I did not.
14 Q Have you ever spoken with a member of the Indiana
15 legislature about Senate Enrolled Act 480?
16 A No, I haven't.
17 Q Did you speak with anyone about Senate Enrolled Act
18 480 while it was pending?
19 A Not in any kind of professional capacity. But with
20 so many states and so many conversations just
21 amongst my colleagues and friends, I can't say that
22 I've never had a comment about it in general. But
23 I've never taken any public stance or given any,
24 you know, public commentary on any of the -- on any
25 specific proposal.

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1 I tend very specifically -- I do my best very
2 specifically to speak, again, just to the science
3 and to the general ideas and what ideas in general
4 match what -- or fail to match up with whatever
5 point in the science.
6 Q Understood. So have you -- other than the Ontario
7 example, have you ever testified in any state
8 legislature in the United States over pending
9 legislation concerning transgender people or the
10 treatment of gender dysphoria?
11 A No, I have not.
12 Q What did you do to prepare for your deposition
13 today?
14 A Lots and lots of re-reading. I re-read, of course,
15 the case files that I had, my comments, my
16 responses to the other experts who submitted
17 declarations. Re-read my own CV in case those
18 relevant questions are asked. And I'm always
19 keeping up with the literature, so there's always
20 something I need to read, re-read.
21 Q You mentioned your case files. What are those?
22 A Oh, no, I meant because I'm involved in several
23 different of the legal cases, in order to help me,
24 you know, as much as possible keep straight which
25 one is which, pardon the pun, just keeping track of

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1 which ones are involving which subset of issues and
2 in what order things are happening, just to, again,
3 keep my -- help me, as best as my aging memory can,
4 which one is which.
5 Q So when you say your case files, you mean your
6 files for this particular case?
7 A Yes.
8 Q And did you meet --
9 A Well, I shouldn't say this particular case, but
10 they're in clusters. And so, it helps me, you
11 know, keep a cognitive map of what's going in which
12 direction.
13 But by case files, I don't mean patient cases.
14 I mean the various set of legal cases and the
15 various, you know, documentation that's available
16 for each one. And some of the cases pertain to
17 events that happened years ago and what was -- what
18 the state of the science was at the particular time
19 before.
20 So, again, keeping track of a rough timeline
21 of what was available to whom and when.
22 Q So what is the cluster that this case would fall
23 in?
24 A Oh, bans to medicalized transition of minors. The
25 other clusters are the athletics-related bills and

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1 a set of bills that I would describe more generally
2 as free speech bills, under what circumstances, you
3 know, what person has a -- that somebody's comments
4 which others are offended by, you know, to what
5 extent the actual content of their comments
6 actually line up with what the science and what the
7 evidence itself has. I would say roughly those
8 three main clusters.
9 Q So you --
10 A Oh, and I should add -- I'm sorry --
11 detransitioners. Now there are groups of
12 detransitioners who are taking actions against
13 their clinics and care providers.
14 Q So you're currently serving as an expert in cases
15 involving medical care, athletics, what you explain
16 as free speech and detransition. Is that a fair
17 summary?
18 A Yes. My hesitation really is that my involvement
19 in all of them is the same regardless of the
20 application to which it's being put, the question
21 is to me or I'm a scientist --
22 Q Understood.
23 A -- and, as I say I, I will tell anybody of any
24 political angle or view whatever I can about the
25 existing science. What we know, what we don't know

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1 and how to interpret science and the scientific
2 method.
3 So those are the clusters, the topics to which
4 that information is being put. But the information
5 from me is the same regardless of who and how it's
6 being put.
7 Q So just to simplify, you are offering your
8 scientific opinion in cases involving medical care,
9 athletics, free speech and detransition; is that
10 right?
11 A Yes. I'd say that's a fair way to put it, sure.
12 Q And did you meet with counsel in preparation for
13 today's deposition?
14 A Yes, I did.
15 Q How many times?
16 A Once.
17 Q And for how long?
18 A A full day, a long day.
19 Q So you met with counsel for one long day?
20 A Yes. Everything else has been mostly
21 organizational e-mails, a few short Zoom calls.
22 But specifically aimed at preparation for today was
23 one full day.
24 Q What were the few short Zoom calls?
25 A Oh, again, reviewing the documents that have been

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1 submitted, you know, the basic process, the
2 context.
3 Q Yes, I would only -- so I didn't know if you
4 meant -- is that part of your meeting with counsel,
5 or is that a separate part of your preparation? I
6 don't need to know what you did with counsel.
7 A Oh, yeah, the e-mails and Zoom calls were
8 background kinds of organization. The only
9 preparation specifically for today was the one full
10 day pre-prep -- or prep.
11 Q And who was present for that prep meeting?
12 A John Ramer and Roger Brooks.
13 Q Roger Brooks from ADF?
14 A Correct.
15 Q Is ADF involved in this case?
16 A I don't know the details of the arrangements, but
17 the sequence of events was the first substantive
18 case that I was involved in for which I was
19 preparing a sizeable review of the scientific
20 literature was a case in Alabama.
21 After that preliminary hearing -- preliminary
22 injunction hearing, Alabama, the state, then again
23 I want to use the word retained, but I don't know
24 if that's actually the proper arrangement, but they
25 then began to -- they took on Roger Brooks in order

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1 to help them coordinate the subsequent features --
2 not features, events, processing of that case --
3 Q Does Roger --
4 A -- and --
5 Q Sorry. Go ahead. You can continue.
6 A Then several other states, as I say, with very,
7 very similar cases going on, same questions, same
8 needs, also wanted to retain me.
9 They similarly began to coordinate with
10 Alabama in order to, you know, minimize, overlap,
11 you know, maximize the efficiency between each of
12 the cases. They signed common interest agreements
13 with each other.
14 So Roger then, in turn, became involved in
15 helping to coordinate, you know, these -- they're
16 not coordinated cases in any way that I'm aware of,
17 but in order to help, you know, streamline
18 everything, there is an amount of, you know, trying
19 to use the best resources available across each of
20 these various states and each of the people
21 available to them.
22 MR. RAMER: Yeah, and --
23 A All of that to say I'm not aware of a direct
24 relationship between Roger Brooks and Indiana, but
25 through this set of coordinations, he is therefore,

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1 you know, at least indirectly involved because of
2 his experience through all of it. You know, many
3 people take his input and advice, you know, very
4 seriously.
5 MR. RAMER: Yeah, sorry, I'll just -- I'm
6 going to object and instruct the witness not to
7 answer about the substance of conversations,
8 obviously, with me as counsel in Indiana and Roger
9 Brooks who is counsel in Alabama, subject to the
10 protections there and also the common interest
11 privilege and protections here, so --
12 MR. STRANGIO: Yes, understood. Not trying in
13 any way to get at the substance of what was talked
14 about, just who was there.
15 MR. RAMER: Right.
16 BY MR. STRANGIO:
17 Q Is Roger Brooks often present for your deposition
18 preps subsequent to your involvement in Alabama?
19 A This was the only one. And he wasn't involved in
20 the prep for Alabama. He became involved after the
21 preliminary injunction hearing.
22 Q Got it. Do you have a relationship with ADF?
23 A No.
24 Q Did you speak with anyone other than your counsel
25 and Roger Brooks about your testimony today?

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1 A Not other than in any logistical sense.
2 Q What do you mean by logistical sense?
3 A Making sure that I had a quiet place in order to
4 be, clearing out my calendar for the day. You
5 know, just old-fashioned logistical kind of, oh,
6 this is happening.
7 Q Understood. And you talked about reviewing case
8 documents and your report and the other expert
9 reports in this case.
10 Any other documents that you recall reviewing
11 in anticipation of today's deposition?
12 A Not specific documents, no.
13 Q Okay. And is there anything with you on your desk
14 in front of you at the moment?
15 A I cleared my desk. I gave myself a blank pad of
16 paper in case I need it, a clean copy of my report
17 itself. But I didn't have time to print out a copy
18 of my CV in case there was something I needed in
19 reference to that. Other than that, it's coffee
20 and water.
21 Q Understood. Okay. So the only printed document is
22 your clean copy of your report in this case. So
23 when we talk about that, you will have it in front
24 of you; is that correct?
25 A Exactly, yes.

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1 Q Great. Thank you for doing that, spare us some of
2 the difficulties of the electronics.
3 A I don't know even if Lieutenant Uhura could have
4 handled this much paper.
5 Q All right. Well, we will just jump right in, then.
6 So I want to start by just marking a few exhibits,
7 just for ease as we go along, starting with your
8 declaration in this case.
9 MR. STRANGIO: So, Joel, if you can go ahead
10 and pull up what's premarked as Exhibit 1, that
11 would be great.
12 BY MR. STRANGIO:
13 Q And that's what, Dr. Cantor, you have in front of
14 you, I gather.
15 Doctor, do you -- oh, wow, maybe I can
16 actually move this -- do you recognize this
17 document, Doctor?
18 A Yes, I do. It looks like the declaration submitted
19 for this case.
20 Q And you understand this to be a true and accurate
21 copy of the declaration that you submitted in this
22 case?
23 A As best I can see, yes.
24 Q I can go down to the list of appendices, the
25 bibliography. So, yes, it does appear to be that?

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1 A As best as I can tell, yes.
2 Q And who wrote this declaration?
3 A I did.
4 Q Anyone help you?
5 A No. Again, the legal team, you know, did some
6 proofreading, gave me heads-up with some formatting
7 issues. The American Foreign Law Association uses
8 a different bibliography method than I'm accustomed
9 to. In my profession, we use the APA standards.
10 So, as I said, you know, technical details
11 like that.
12 Q And did you discuss this declaration with anyone?
13 A Again, with the legal team to help ensure the
14 topics that needed coverage would be included.
15 Q Anyone else?
16 A Not specifically that I can recall. As I say,
17 because I'm involved in several cases, and the
18 science that they need input on is the same
19 science, using the same basic report updated, you
20 know, as necessary, and, again, with feedback from
21 the various groups in order -- various parties to
22 make sure -- sometimes just a clarification of a
23 sentence or to ensure that it includes the
24 information that they need it to include.
25 So I don't want to say blanketly that nobody

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1 else has, you know, had any input to it, but
2 everybody who has had input, it's been on that same
3 kind of basic back-and-forth, make sure it's clear.
4 And what I can only describe as formatting things
5 in the opposite way than we do in science.
6 In science, I'm accustomed to here's what we
7 know. Here's the project I did, and here are our
8 conclusions. Where legal documents tend to be
9 organized in the opposite order. Here is my
10 conclusion, then I'll get to subsequently the
11 backup for how I got there.
12 Q Other than the various legal teams involved in all
13 of the cases where you're currently serving as an
14 expert, did you discuss the contents of this with
15 anyone else?
16 A Outside of that, no, not that I recall.
17 Q And did you discuss the contents of your
18 declaration with the other experts retained by the
19 defendants in this case?
20 A No, I did not.
21 Q Does this declaration represent a complete
22 statement of the opinions you intend to provide in
23 this matter?
24 A Yes, it does, which isn't to say, you know, if
25 asked a question about something else in the

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1 research that I happened not to have covered in my
2 report, or if somebody presents an argument making
3 an error in scientific thinking, you know, other
4 information can become relevant. But this is -- it
5 summarizes my intention of everything I plan to be
6 able -- I plan to be expressing.
7 Q So up until -- up to the point of today, this
8 represents a complete statement of the opinions you
9 intend to provide?
10 A Yes, that is correct.
11 Q Are you aware of any inaccuracies in the
12 declaration that you submitted in this case?
13 A No, other than, as I say, I found missing half of a
14 pair of parentheses, because the editor in me.
15 Again, as soon as I submit something, that's
16 exactly when I find a typo.
17 Q Yes, I understand this. Anything you would --
18 other than the parentheses, anything you would like
19 to amend or correct in the declaration you
20 submitted in this case?
21 A No. I found no factual or content error.
22 MR. STRANGIO: And let's go ahead, Joel, and
23 pull up what's premarked as Exhibit 2.
24 BY MR. STRANGIO:
25 Q And just for your awareness, Doctor, this is going

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1 to be your CV. Do you recognize this document?
2 A Yes, I do. It looks like my CV.
3 Q And is this a current and complete version of your
4 CV, 32 pages?
5 A The only -- and there's -- yes, it's complete, with
6 the caveat that I would have updated it with any
7 additional cases that I've become involved with.
8 Q So the only thing that might be missing from this
9 would be the addition of cases in which you've
10 become involved as an expert witness; is that
11 right?
12 A Yes, to the best of my recollection. I don't think
13 there's been anything else that's changed since I
14 submitted it.
15 Q So in 2022, you testified at a hearing in Alabama
16 in a case concerning a law similar to SEA 480; is
17 that right?
18 A Yes, that is correct.
19 MR. STRANGIO: And let's, Joel, go ahead and
20 pull up what's premarked as Exhibit 3.
21 BY MR. STRANGIO:
22 Q And, Dr. Cantor, at the time this was the case
23 called Eknes-Tucker; is that correct?
24 A Yes, that's my memory of it.
25 Q Doctor, does this appear to be a copy of your

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1 testimony from that hearing? You can take a close
2 look.
3 A As best as I can tell, that's what it looks like.
4 The sentences that jump out at me match the --
5 match what I recall.
6 Q And did you testify truthfully in that hearing?
7 A Yes, I did.
8 Q Great. So that's all I have to premark for now.
9 So let's go back to your CV, which is Exhibit 2.
10 MR. STRANGIO: If you could, Joel. Thanks.
11 BY MR. STRANGIO:
12 Q And before we have that in front of us, in
13 paragraph 1 of your declaration in this case, you
14 describe yourself as a sexual behavior scientist.
15 What is that?
16 A That's a good question. It is a relatively small
17 field in numbers of people. Because of the import
18 of the issues to so many people in so many
19 circumstances, it is like a very, very highly
20 followed field.
21 I say that only because there isn't a very
22 simple universally-agreed-upon term, like if I said
23 I were an epidemiologist or endocrinologist or
24 something, very many of us would simply refer to
25 ourselves as sex researchers. But because sex

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1 research is itself such a highly interdisciplinary
2 field, saying one is a sex researcher describes the
3 questions that we're pursuing and the kind of
4 issues we're investigating, but within that one
5 could be anything from a psychologist to a
6 neuroscientist, an epidemiologist. It doesn't
7 refer to the academic field referring to the tools
8 that we use in order to address those questions.
9 So I usually would use a phrase like sex
10 researcher or sexual behavior scientist in order to
11 indicate the kind of questions in which I've spent
12 my career investigating.
13 Q And when you say sex researcher, what are you
14 referring to with respect to sex?
15 A Well, over the course of my career, I've handled,
16 you know, many, many different kinds of questions.
17 In general, because I have a more technical
18 background than most other sex researchers do, I've
19 been able to apply, you know, much more
20 sophisticated tools for doing those investigations.
21 For example, a lot of studies including, you
22 know, many of the studies that the public are most
23 aware of, really involve interviewing people or
24 surveys or questionnaires or other relatively
25 simple, relatively straightforward methods, but

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1 they don't answer questions in the kind of way that
2 have a great deal of weight.
3 For example, you know, is somebody born gay,
4 or does somebody, you know, become gay is a
5 question that very often comes down to, you know,
6 some very technical, very biological studies. But
7 because so many people who themselves call
8 themselves sex researchers are just interviewing
9 people, they just get a pile of what everybody
10 thinks the answer should be.
11 So as I say, when I use the term, I'm refer --
12 when I use the term to describe myself, I'm
13 refer -- using sexual behavior scientist because
14 I'm investigating, you know, the motivations and
15 the basis behind or supporting people's sexual
16 behaviors, but I don't want to limit it technically
17 to behaviors either.
18 For example, if there's somebody who's
19 uncomfortable or trying to deal with being gay
20 living in a straight world, you know, some of the
21 questions are, "Doc, why am I different from other
22 people?" Well, we're not talking about his
23 behavior. We're not talking about some -- yeah,
24 doing therapy with somebody in order to help them,
25 you know, gain the self-confidence that they need

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1 in order to live a happy gay life.
2 But for the research itself, again, now we're
3 talking more, you know, fundamental -- I don't know
4 if I want to say traditional kinds of science, but
5 we're applying the tools to sexual behaviors or
6 sexual desires, sexual experiences, sexual intents,
7 sexual fantasies, masturbatory fantasies.
8 Some of these, you know, are not visible
9 behaviors, although they, you know -- some of these
10 don't reflect external behaviors. They reflect,
11 you know, what we infer to be internal states. And
12 there is no one-to-one correspondence between
13 external observable, objective characteristics and
14 what people report being their internal
15 experiences. That's especially true for people
16 whose sexual interests are, you know, something
17 that's stigmatized. They hide it, feel like they
18 need to hide it. They hide it in different ways
19 from different people in different circumstances,
20 including to the themselves.
21 Q And what is your current job?
22 A I'm in private practice.
23 Q What kind of private practice?
24 A It's in clinical psychology as a clinical
25 psychologist. My hesitation is, of course, as

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1 these cases became, you know, more and more
2 frequent, it's now a larger and larger proportion
3 of my time.
4 The majority of my career, as my CV says, is
5 as a full-time scientist and member of the medical
6 faculty. When I left CAMH, it was to go into
7 private practice. And then as these various cases,
8 again, came to -- started coming up, I was devoting
9 more and more time to the cases.
10 So I'm in private practice and continue to see
11 patients, but a larger portion of my time, again,
12 is in consultation, expert witness testimony, and
13 in summarizing the existing science for the needs
14 of the various cases.
15 Q So let's take each piece separately. What
16 percentage of your time currently would you say is
17 occupied by your private practice?
18 A I guess my question is a little bit different if
19 we're talking about corporate structure versus
20 hours per week.
21 So far as the accountants are concerned, you
22 know, everything I do is part of my private
23 practice. If one means by private practice, you
24 know, one-to-one therapy and seeing patients in a
25 traditional clinical psychology kind of role --

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1 Q Yeah, that's --
2 A -- or used in a therapy kind of role --
3 Q What percentage of your week is spent seeing
4 patients as a clinical psychologist?
5 A Roughly 20 percent of my time.
6 Q And what percentage of your time is spent serving
7 as an expert witness?
8 A Roughly 80 percent, two-thirds of my time.
9 Q And are you regularly compensated \$400 an hour for
10 your expert witness time?
11 A I am now, yes.
12 Q And approximately how many hours per week do you
13 spend serving as an expert witness?
14 A Oh, goodness. It's really hard to nail that down.
15 Although I'm now doing it, I'll say,
16 professionally, I'm still a scientist at heart. My
17 thinking is still what my thinking always is, I
18 want to know the right answer. I'm just genuinely
19 curious, and I want to know how all of this stuff
20 works.
21 So I will, for example, be posed a question
22 which, you know, whatever lawyer has about whatever
23 particular person's situation or case. I'll spend
24 whatever, half an hour answering an e-mail or
25 supplying whatever materials back up whatever the

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1 answer to their question is, but that then leads
2 to, oh, wait a -- that leads me to start thinking
3 about if that's true, wouldn't that mean. And now
4 I'm reorganizing my own notes, and I'm, you know,
5 reading and catching up on, you know, some obscure
6 statistic that was used in whatever set of
7 analyses.
8 And I'm, you know, now spending several
9 hours -- I don't know if self-educating is exactly
10 the right term, but scratching the itch of my own
11 curiosity for which, you know, I became a scientist
12 in the first place. And then later in the week I
13 will get another e-mail from another person in an
14 unrelated case asking a similar question, and I can
15 now give them a more fulsome answer.
16 So I still only, you know, spent a limited
17 amount of time working with either particular case,
18 but I will have spent several hours, you know,
19 investigating, thinking about and forming my own
20 thoughts about whatever a given issue is.
21 Q So understanding that it's combined somewhat across
22 cases, how many hours, approximately, per week
23 would you say you spend serving as an expert
24 witness?
25 A Typically, over the past few months, perhaps the

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1 past year, actually, might be a better guideline,
2 over the past year anywhere from just two or three
3 hours in bookkeeping and miscellaneous, you know,
4 admin tasks up through full-time, up through 40ish
5 hours, as an average, 10 to 15.
6 But, again, with the caveat that it runs
7 anywhere from practically zero for a long period of
8 time to, you know, almost obsessive because the --
9 some deadline is approaching with very little
10 notice, or I got caught up with, you know, my own
11 curiosity just leading me to that much more reading
12 and thinking.
13 Q Understood. And so, you said for the past year it
14 could range from anywhere between zero, two to
15 three hours, up to full-time. Did I get that
16 right?
17 A Yes, that would be about right.
18 Q And over the past year, about how much of your
19 income would you say derived from serving as an
20 expert witness?
21 MR. RAMER: Objection to the form.
22 A So if I'm remembering today's process correctly, I
23 do still answer a question even though there's an
24 objection in a deposition, even though --
25 Q Yes, sorry. Yes.

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1 A Got it. I'm just checking. Roughly 80 percent.
2 Q And on your CV, you're listed as the Director of
3 the Toronto Sexuality Centre from 2017 through the
4 present.
5 What is that position?
6 A When I left my hospital appointment, as I say it
7 was to go into private practice. My intent was to
8 begin a sex therapy clinic, which I did with
9 several staff people, you know, also clinical
10 psychologists, when I incorporated that group and I
11 began that clinic, I named it the Toronto Sexuality
12 Centre. And the legal designations appear just
13 automatically titled me, therefore, as Director.
14 As time went on and it became apparent -- a
15 bit clearer that a more substantial amount of my
16 own time was going to be involved with legal cases
17 rather than with clinical situations, I rebalanced
18 what was going on in the clinic so that I am
19 essentially just a solo private practitioner, but I
20 still have the name of the clinic as the corporate
21 entity.
22 Q So the Toronto Sexuality Centre signifies your
23 private practice; is that right?
24 A Yes. That's an accurate summary, yes.
25 Q And when you say you left your hospital appointment

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1 to begin your private practice, when was that?
2 A In 2017.
3 Q And before 2017, what was your job?
4 A I was a senior scientist at one of the large
5 psychiatric teaching hospitals -- well, the largest
6 psychiatric teaching hospital up here in Canada, in
7 Toronto, called the Centre for -- now called The
8 Centre for Addiction and Mental Health.
9 Q And when you were at the -- when you were a senior
10 scientist at that centre prior to 2017, did you
11 have a clinical practice?
12 A No, other than in the last year of it, as I was
13 preparing to leave it, I was, you know, building
14 my -- I was sewing together my parachute before I
15 jumped.
16 Q And in that role as a senior scientist at The
17 Centre for Addiction and Mental Health, what were
18 your responsibilities?
19 A They changed over the course of time. And as my
20 career advanced with them -- again, also as my CV
21 indicates, I began there as an intern the final
22 year of my doctoral studies, then a postdoctoral
23 fellow and so on progressing up the pretty
24 traditional ladder for academic researchers.
25 My duties as a senior scientist then were I

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1 was in charge of my specific research projects. I
2 was in charge of -- including obtaining the funding
3 in order to, you know, pursue those projects
4 itself.
5 I was then training and supervising the next
6 line of junior scientists, plus my own students
7 engaged in academic publications for the various
8 studies that I was running. And, also, in its
9 eccentric way as an ambassador to the field itself,
10 I was one of the higher profiled scientists in that
11 institution, largely due to my own, you know,
12 success and standing within my own field.
13 And because the issues that I was studying are
14 not just attention grabbing, but of the size of
15 legal weight or size of social import where the
16 results were not mere scientific curiosities, they
17 had very, very obvious and very, very important
18 potential implications for public health and public
19 safety.
20 So my media -- social media, and as I say
21 almost ambassadorial role itself became a large --
22 I don't know if I should call it official or
23 unofficial portion of my career, of my work --
24 Q When -- sorry. Continue.
25 A Of my career there.

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1 Q And when you say ambassador to the field, what
2 field is that that you're describing?
3 A Sex research, several different fields. Again,
4 that's the nature of being part of an interdis--
5 such an interdisciplinary field.
6 Part of it was to sex research itself. Part
7 of it was to the field of psychiatry. Even though
8 I was not myself a psychiatrist, I was, you know, a
9 member of the faculty of the Department of
10 Psychiatry in the University of Toronto Medical
11 School.
12 So helping the public appreciate the role of
13 mental health, mental health research, psychiatry
14 within the public health system, and to help people
15 appreciate the potential benefits of scientifically
16 oriented, evidence-based mental health treatment.
17 So a chunk, as I say, was to psychiatry. A
18 chunk was to sex research. And a large chunk, as I
19 say, to public welfare and public safety. I was
20 specifically within the law and mental health
21 program of the -- the abbreviation to the
22 hospital -- again, it was the Center for Addiction
23 and Mental Health, or C-A-M-H, it's pronounceable
24 nickname is CAMH.
25 Q CAMH. Understood.

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1 A So --
2 Q How -- sorry. Continue, you can.
3 A Lost the train -- oh, so because my specific role
4 was within their law and mental health program, a
5 lot of -- a large chunk of the group for which I
6 was -- you know, had an ambassadorial role was the
7 integration of psychiatry and the law or mental
8 health and the law.
9 What are the appropriate ways, what are the
10 most effective ways, what are the most
11 evidenced-based ways to ensure that people who were
12 engaged in the legal system in various capacities,
13 how does mental health interact with that.
14 So mental health issues not just in consent --
15 capacity to consent, but also people who break the
16 law. People who break the law, you know, during a
17 psychotic episode or people who break the law, you
18 know, as motivated by some mental illness. And
19 what's the correct way to get the right resources
20 to the right person, not only to help the patient,
21 but to also protect the health and safety of the
22 people around the patient.
23 Q Understood. I think that's probably a good
24 description of the field and your ambassadorial
25 role.

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1 Going back to your clinical practice, your
2 current clinical practice. What is the average age
3 of the patients that you see?
4 A I don't think -- as we would say in statistics,
5 nothing can mislead as much as the mean group,
6 because you really need to know how dispersed they
7 are. If I calculated a number, it would be --
8 Q Do you primarily see adults in your clinical
9 practice?
10 A Yes.
11 Q Do you see any adolescents in your clinical
12 practice?
13 A Yes.
14 Q How many?
15 A Oh, goodness. Today I think it's just down to two.
16 As I say, I see very few people of any age, you
17 know, currently.
18 Q Got it. And so you see about two adolescents. And
19 how many adults?
20 A Roughly eight currently.
21 Q And any prepubertal children?
22 A No.
23 Q Has the -- oh, sorry, no. Just one more thing on
24 your CV here. You have psychologist 2004 --
25 May 2004 to December 2011.

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1 Were you a clinical psychologist during that
2 period?
3 A Yes, that's correct. But the term clinical
4 psychologist isn't part of the formal title that
5 the institution gave.
6 Q Did you see patients during that period?
7 A Yes, I did.
8 Q And were the majority of your patients during that
9 period adults?
10 A Yes, they were.
11 Q Any adolescents?
12 A Yes.
13 Q What percentage of your patients during that period
14 were adolescent, would you say?
15 A Roughly 5 percent, perhaps.
16 Q And has the entirety of your professional career as
17 a psychologist been in Canada?
18 A Predominantly in Canada. I would hesitate to say
19 all. The gray part of the line would be I was
20 still in the U.S. while doing my master's degree.
21 And I was employed as a research assistant
22 specifically in neuroscience and in neuropsychology
23 for several years.
24 The topics were -- had no direct relationship
25 with the topics I study now, but it, of course,

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1 involved the same kinds of tools that are how to
2 assess somebody's brain health, neuropsychological
3 functioning, right down to the brain anatomy
4 itself.
5 So the tools include several of the tools I
6 still use today, but the topics and the behavioral
7 syndromes that the people were exhibiting are
8 different from the ones I study now. So I --
9 Q Have you had -- sorry. Go ahead, you can finish.
10 A So I was employed especially in a research context
11 within psychology for a few years in the U.S.
12 before I became Canadian.
13 Q Any clinical practice in the United States?
14 A Again, these overlap. The functions I was doing
15 then was to help analyze on the research end
16 information we were gathering from psychological
17 and neuropsychological assessment and clinical
18 assessment.
19 So it was clinical research, whether one
20 counts that as research or clinical reasonably and
21 appropriately checks both boxes. You can't do
22 research -- the kind of research we were doing was
23 based on the clinical work that we were doing. So
24 the same task is legitimately described as both.
25 Q And was that between 1990 and 1992?

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1 A Yes, that is correct.
2 Q And going back to your clinical psychology practice
3 or work from May of 2004 to December of 2011, you
4 said about 5 percent of your practice was
5 adolescent patients. Any prepubertal children?
6 A No.
7 Q You're not a medical doctor; correct?
8 A That is correct.
9 Q Not a psychiatrist?
10 A That is correct.
11 Q Not an endocrinologist?
12 A That is correct.
13 Q Have you ever prescribed puberty blockers to any
14 individual?
15 A No, I have not.
16 Q Hormone therapy?
17 A No, I have not. I'm wondering -- I guess I have a
18 question about your question.
19 How are you using hormone therapy to be
20 different from a specific hormone? To me those
21 are -- one is the subset of the other.
22 Q Well, do you prescribe medications?
23 A No, I do not.
24 Q So you've never prescribed puberty blockers to any
25 individual?

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1 A That is correct.
2 Q And you have never provided gender-affirming
3 hormone therapy to any individuals?
4 A That is correct.
5 Q Do you have any formal education or training
6 related to the treatment of gender dysphoria?
7 A Yes. The Canadian training model is different from
8 the American training model, however. So it's
9 difficult to compare them one to one.
10 Also, it's not -- clear is not the right
11 word -- to the extent that people who say that
12 they're offering training models, it's not clear,
13 and I don't want to take for granted that they are
14 legitimate training models.
15 They are usually a list of information, people
16 give it a title every -- and people in different
17 circumstances or context will accept it as that,
18 but these are not the kind of established,
19 validated testing programs where anybody's, you
20 know, tried to see what kind of outcomes and what
21 the appropriate content of such programs are.
22 But to get to your question more specifically,
23 the training model used up here in Canada is much
24 more similar to the European models than to the
25 American models. Where the American models, as I

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1 say, are, you know, here's a folder with a correct,
2 you know, title and description to it, and here's
3 the test at the end, that's that, we now call you
4 qualified, Canadian and European models apply a
5 much more apprenticeship-oriented model where here
6 are the readings, here are the patients. Let's go
7 over it all and start talking about it all and
8 develop a more comprehensive way of integrating all
9 of the information, acknowledging all of the
10 unknowns that we have.
11 So, as I say, in Canada we don't have the kind
12 of -- I don't know if credential-oriented is the
13 right description, but, you know, on-paper method
14 which is much more of the American model.
15 Q Well, when --
16 A I think there's also --
17 Q When did you have the Canadian model of formal
18 training related to gender dysphoria?
19 A I would divide that into two pieces, a clinical
20 portion and the research portion.
21 Q And when was the clinical portion?
22 A It was during my internship here. The final year
23 of my training as a clinical psychologist.
24 Q And what year was that?
25 A Oh goodness.

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1 Q I can look on your --
2 A '98/'99, I think it was.
3 Q And when was your research module of training?
4 A Again, it's hard to nail it down within those
5 terms, because it doesn't fit that kind of a model
6 quite -- it doesn't fit that way of thinking about
7 how the training works.
8 It's not like a plumbing or Calculus I where,
9 you know, it's a pretty set, known, widely used set
10 of material where people know what you get in
11 Calculus I.
12 A great deal of the relevant research,
13 research methods would have been over the course of
14 my postdoctoral study -- over the course of my
15 postdoctoral studies, which would have been, you
16 know, in the first few years of 2000.
17 But, again, these -- because of the nature of
18 the model up here, because of the particular places
19 and people that I was training with, there's much
20 more of a blend across clinical and research.
21 I was in a research science facility in a
22 clinical research program where the difference
23 between clinical work and research is just how good
24 your documentation is. If you see a bunch of
25 people and have a rough memory, and you're only

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1 reflecting on your own recollections of it, you
2 know, calling it clinical experience or anecdotal
3 evidence, people would accept that as clinical
4 work.
5 But if you then write down exactly how many
6 people you saw, exactly how many people ended up
7 with exactly what kind of situation, and you do it
8 in a systematic way, now it's research, even though
9 the functions themselves are the same.
10 Q So taking aside the how, this blended process,
11 let's say, occurred between 1998 and the early
12 2000s; is that right?
13 A It's correct for timeline. But, again, I don't
14 mean to be evasive, but to leave enough, you know,
15 blurriness around the boundaries that there was no
16 end of -- as of June, you are now qualified or you
17 are no longer going to be doing any of this after
18 this semester, none of it was that kind of a
19 program.
20 Most training, as I say, is much more an
21 apprentice kind of model where, "Oh, you're good at
22 math. Could you give us a hand with" whoever it is
23 doing whatever kind of a study. And so, now we're
24 studying this kind of sexual or gender behavior
25 instead of that kind of sexual or gender behavior.

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1 MR. STRANGIO: I'm about to sort of move into
2 a slightly different section of the CV. Do you
3 want to take a break, John, for five or --
4 MR. RAMER: I'd welcome a break, but it's up
5 to Dr. Cantor, if he would welcome one.
6 THE WITNESS: Oh, more specifically, my
7 coffee's empty. So yes.
8 MR. STRANGIO: Okay. Let's do five minutes
9 and we'll come back in five. Thanks.
10 (A recess was taken.)
11 BY MR. STRANGIO:
12 Q On your website, Doctor, you describe the main
13 focus of your research as being on the role of the
14 brain and human sexual interests, especially
15 atypical sexualities; is that right?
16 A Yes, that sounds right.
17 Q So the majority of your work, as you describe it,
18 has been focused on what you describe as atypical
19 sexualities?
20 A That's the best all-encompassing phrase I can think
21 of to capture it quickly, but, yes.
22 Q What are atypical sexualities?
23 A As I say, I use the term specifically to be broad,
24 but it's not an official term. To break it down
25 into pieces, I would say it breaks down into sexual

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1 orientations other than, you know, predominant
2 heterosexuality.
3 So it would include, you know, the various
4 homosexualities, bisexualities, more recently
5 people referring to themselves as asexual, some
6 people adopt terms like hypersexual and so on.
7 For gender identity, you know, of course, it
8 includes identifying originally as male or female.
9 But now people, of course, identifying with, you
10 know -- again, adopting very many different terms,
11 describing it in very many different ways. And, of
12 course, in the group of atypical sexualities that
13 are called the paraphilias.
14 And, again, there's no concrete objective,
15 clear demarcation for what counts as a paraphilia
16 or not. In general, the phrase is used for people
17 with a sexual interest pattern or sexual
18 interest -- a sexual interest pattern either in
19 people, kinds of people, or in activities that are
20 not merely atypical, not merely statistically
21 unusual, but that they experience that interest
22 pattern as profoundly and as deeply as sexual
23 orientation.
24 To them, you know, if the thing that they're
25 attracted to is not involved in the situation, it

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1 to them is not a sexual situation at all.
2 Q Is being transgender an atypical sexuality as you
3 describe it?
4 A As I describe it, I would include it among -- I
5 would include gender identities and gender
6 dysphoria within the term as I use those terms, but
7 I also have to acknowledge that, again, these are
8 not official terms with very specific lines. There
9 are other people who would use, you know, these
10 terms in different ways. And as long as we clarify
11 who we're talking about, you know, we can have a
12 perfectly productive conversation.
13 But I don't want to say, you know, I use the
14 term one way; and, therefore, you know, if somebody
15 else says it counts or it doesn't count that there
16 even is a right or wrong to it. But I use the term
17 because of its breadth in order to include things
18 like gender identity.
19 Oh, and also in the atypical sexualities, I
20 would also include the various kinks. And, again,
21 what's a kink versus what's a paraphilia is not
22 very clear. One blends into the others. There are
23 kinksters for whom, you know, if the thing that
24 they're into, yeah, some sexual encounters will
25 include it, others not. But for others if it

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1 doesn't include whatever thing it is that they're
2 into, it doesn't count at sex.
3 So it's tough to come up with a -- there's no
4 good objective, definite, uniformly accepted
5 boundary between them.
6 Q And have you done any research relating to
7 transgender people and/or gender dysphoria?
8 MR. RAMER: Objection to the form.
9 A I have.
10 Q What was that research?
11 A I've done research on various relatively technical
12 aspects, including, you know, how to develop, you
13 know, formal questionnaires and the psychometric
14 properties of those questionnaires.
15 I guess by psychometric I mean the statistical
16 properties of how to form a test in order to make
17 sure that the test is testing what you want it to
18 be testing and not merely just asking the same
19 question over and over and over again 10 different
20 ways, but not providing 10 different pieces of
21 information.
22 I've also done research on the role of the
23 brain and age of puberty and how going through
24 puberty at different ages affects, you know, the
25 course of brain development.

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1 Q Any research on the mental health outcomes of
2 people with gender dysphoria?
3 A No. I don't think I've done any direct work on
4 clinical outcomes.
5 Q On page 10 of your CV, which is up here, I just
6 want to ask you about a few things. You have here
7 listed under your "Funding History" a five-year
8 grant September 2015 entitled "Effects of sex
9 hormone treatment on brain development: A magnetic
10 resonance imaging" -- oh, no, sorry, is someone
11 moving this? Okay. Sorry.
12 MODERATOR: It said you didn't have access to
13 move it. So I was trying to give you control
14 again. I think it's Zoom messing up. Sorry about
15 that.
16 MR. STRANGIO: Oh, no, it's okay.
17 THE WITNESS: Oh, we need Lieutenant Uhura
18 again.
19 MR. STRANGIO: I thought it was me.
20 BY MR. STRANGIO:
21 Q I'm going to start that over. So we have here
22 under "Funding History" on your CV a five-year
23 grant from September of 2015, "Effects of sex
24 hormone treatment on brain development: A magnetic
25 resonance imaging study of adolescents with gender

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1 dysphoria."
2 Do you see where I'm looking?
3 A Yes, I do.
4 Q And what is this grant?
5 A It was essentially as it sounds. It was an attempt
6 to investigate what happens -- you know, what
7 happens in the brain, doesn't happen in the brain.
8 You know, in what patterns does the brain develop
9 amongst people who are being treated and receiving
10 different kinds of treatment, whether medical or
11 nonmedical, over the course of puberty.
12 Q And you were not the principal investigator in
13 this -- was it a study?
14 A It was a -- well, is a research grant. And so, it
15 was the request for the government funding in order
16 to conduct the study --
17 Q Did the government --
18 A -- studies, I should say.
19 Q Did the government provide the funding for this
20 particular research question?
21 A Yes, it did.
22 Q And you were not the principal investigator for
23 this grant?
24 A That is correct. That one was done by
25 Dr. VanderLaan.

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1 Q What was your role?
2 A Again, I handled the technical parts. I was the --
3 I don't want to say the expert on brain anatomy,
4 but I was the connective tissue between the, you
5 know, neuroanatomists and the other sex researchers
6 involved in the project.
7 Especially then, I was one of the very few
8 people in the world at that time that had a foot in
9 each of those camps and was able to help everybody,
10 you know, coordinate and cross these various fields
11 helping the sex researchers, you know, asking these
12 questions, helping them understand how MRI research
13 works. How, you know, brain analysis works. How
14 the statistics are done. Why things are done the
15 way that they're done. The strengths and
16 shortcomings and different methodological
17 principles available -- procedures available to
18 them.
19 As I say, it's a highly, highly
20 interdisciplinary field. And in order to use
21 really these, you know, very, very high-end
22 research techniques, you know, there are only a few
23 people who can at the same time talk to both the
24 sex researchers and the statisticians and the
25 neuroanatomists.

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1 Q And this was a grant for a five-year period; is
2 that right?
3 A Yes, that's correct.
4 Q Were your findings published?
5 A I hesitate to say mine, because those, of course --
6 that was before I actually left the academic world.
7 But, yes, it's been published.
8 Q And where is it published?
9 A Oh, goodness. I don't remember. I'd have to look
10 it up.
11 Q Is it in your CV?
12 A No, I didn't participate. As I say, once I left
13 the academic world, then -- I was going to say left
14 the project, but that makes it sound a bit more
15 dramatic than true.
16 I'm, you know, in regular e-mail contact with
17 several of these people and answer questions where
18 I can here and there, but I wasn't dedicating --
19 Q But you didn't stay on as a co-investigator on this
20 particular grant?
21 A Yes, in the sense that I didn't have the kind of
22 active, ongoing, you know, regular input attending,
23 you know, the weekly meetings and so on. But I --
24 at the same time, it wouldn't be fair to say that
25 there was some kind of formal resignation process.

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1 It was just we all moved on, and that's that --
2 well, I moved on, I guess I should say.
3 Q And you're not listed in any of the papers that
4 were published as a result of this grant?
5 A That's correct.
6 Q And there's a second grant listed at the top. That
7 is from July of 2018 for five years. And this was
8 "Brain function and connectomics" --
9 A Connectomics.
10 Q -- "connectomics following sex hormone treatment in
11 adolescents experience gender dysphoria."
12 Was this a grant that was also received by
13 your -- by this research team?
14 A Yes.
15 Q And you were not the principal investigator on this
16 grant?
17 A That's correct.
18 Q Do you remain a co-investigator on this one?
19 A The situation is the same. This one, you know,
20 was -- it was awarded in 2018, but, of course, the
21 design and the submission was ahead of that.
22 My involvement was the same. I was
23 essentially the consultant, you know, helping
24 everybody communicate to each other, helping them
25 figure out, you know, what are the kinds of brain

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1 features they should be looking at as the next
2 logical steps.
3 Q And in what year did you leave -- or let's just --
4 I'll rephrase that.
5 In what year did you move on from this
6 particular academic position and, therefore, this
7 grant?
8 A I'd have to look through my e-mails to find the
9 actual date of my formal letter of resignation from
10 CAMH, but all of this was happening roughly around
11 2017, 2018.
12 Q And so you will not be an author on any of the
13 published findings out of this grant?
14 A I've learned never to say never. It's not my plan
15 and intent, but that isn't to say that if they come
16 to me with, "James, we found, you know, this
17 strange thing that we thought you'd find
18 interesting, or we need your input on, or we ran
19 into some piece of the mathematics we can't figure
20 out," again, I have no -- I'm still a scientist at
21 heart. I still enjoy the material. And I would do
22 my best to try to fit it in.
23 Q For the two pieces of grant funding listed in your
24 CV under "Funding History," you don't anticipate
25 being involved in the published findings of either

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1 of them?
2 A That's correct.
3 Q How were the study participants recruited for these
4 two grants?
5 A Through the clinics that see kids with gender
6 dysphoria.
7 Q And do you know approximately how many individuals
8 were enrolled in each?
9 A No.
10 Q More than 50?
11 A Again, I don't know. There are oftentimes changes
12 in design that would have happened, you know, once
13 the project itself got going.
14 As I say, I'm not involved in the day-to-day
15 running of the project. So I wouldn't be apprised
16 of progress or changes.
17 Q And how would you describe the study design of
18 these two grant projects?
19 A Case control.
20 Q And what does that mean?
21 A A group of people who are undergoing one set of
22 circumstances and series of brain scans, and we
23 come up with what's essentially an average brain,
24 if it could be called -- average brain image, if
25 one could be called that. And then compared to

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1 people as matched on as many variables as we can,
2 you know -- or they can, I should say, match them
3 on similarly developed and equivalent average brain
4 of the control group. And then through an
5 exquisitely bizarre set of statistics use what's
6 more like image analysis than, you know,
7 traditional statistics in order to identify
8 patterns in the averages of the images and connect
9 that back to what are those differences in the
10 images and the patterns, you know, tell us about
11 the structure of the brain itself.
12 And then in turn, what do those changes in the
13 structure of the brain tell us about the
14 developmental processes that led to those
15 differences.
16 Q And the control groups, were those study-enrolled
17 participants, or was that a control developed from
18 data of the general population?
19 A I'm sorry, could you ask that again? I'm not sure
20 those are different groups.
21 Q Was the -- were there particular individuals
22 enrolled in the study who were not receiving
23 treatment that represented a control group?
24 A The control group would be people not receiving any
25 kind of gender-related treatment, yes.

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1 Q And they also had a diagnosis of gender dysphoria?
2 A No, these would be -- depending on the question,
3 each of these, again, were grants, you know, that
4 were enabling the funding of several different
5 research projects all boiling down to neuroimaging,
6 but it wasn't like the final research paper which
7 reported a single set of analyses, you know, to
8 answer a specific question.
9 Different parts of the grant were aimed at
10 answering different questions, each using different
11 kinds of methods. Some would compare the gender
12 dysphoric kids to non-dysphoric kids. Some would
13 compare the gender dysphoric kids to their
14 non-dysphoric siblings.
15 Q Got it.
16 A And in early pilot studies, we would even do it
17 versus what I can only call stock brains, you know,
18 there exist large databases, you know, of images
19 that have been accumulated over many years, you
20 know, and are just available as gen -- I hesitate
21 to use the word generic, but generic-controlled
22 samples because -- especially because getting MRIs
23 on someone is so expensive that if we can get just
24 a group of healthy controls that anybody can use,
25 you know, with socioeconomic status already

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1 reported and controlled and age already reported
2 and controlled that they, you know, can be used as
3 a generic set of -- a generic control sample for
4 just about any study. Typically that would be done
5 early in development -- early in the development of
6 a study.
7 Q But for these particular studies, you had at least
8 two variables, one of which was experiencing gender
9 dysphoria and one of which was receiving sex
10 hormone treatment?
11 A My hesitation is a quibble in that, you know, those
12 are not necessarily separate variables, you know,
13 so they wouldn't get chopped apart so easily. But
14 the issues, the features, you know, being
15 investigated sometimes were the gender dysphoria
16 itself and sometimes were the effects of the
17 medications and treatments that they were receiving
18 or potentially receiving.
19 Q But your controls neither had gender dysphoria, nor
20 were receiving sex hormone treatment?
21 A That's my recollection of the plan, yes.
22 Q Okay.
23 A As I say, my involvement was in the design of --
24 was in the grant application which proposed the
25 design of the studies. And it's not unusual for,

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1 you know, studies to need to be adjusted according
2 to whatever's going on, you know, once the feet hit
3 the laboratory ground.
4 So I couldn't say that, you know, as the
5 studies were conducted and after my involvement was
6 completed, I'll say, I can't speak to the current
7 status of the programs and whether any changes were
8 made, but the original plan was to do it as we
9 described.
10 Q So going back to your clinical practice, you're an
11 adult clinical psychologist; is that right?
12 A Yes, that's correct.
13 Q And as we discussed, you currently are treating
14 approximately 10 patients in your private practice?
15 A Yes.
16 Q Are any of those patients transgender?
17 A They're not. No one is transgender in the way that
18 most of the public uses the term currently. But,
19 as I say, especially the public use the term in
20 relatively vague ways that don't always match up
21 with the science.
22 But I do have one at the moment for whom
23 identity issues in general are a topic of their
24 concern but -- a topic of their concern. So it
25 really would depend on to whom I'm talking and in

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1 what context would this person's situation count is
2 a legitimate question. And it depends on how
3 people are using whatever terms and whatever ideas.
4 So if somebody, you know, gave me a
5 description or said, you know, is this a person
6 concerned with this, you know, we could say yes or
7 no. But whether the person, you know, counts as
8 gender dysphoric, counts as transsexual and so on
9 depends on how the person is using those terms.
10 Q Is that person an adult?
11 A Yes.
12 Q And you have never treated a prepubertal
13 transgender child; is that right?
14 A Yes, that is correct.
15 MR. RAMER: Objection to the form.
16 Q And you've never treated a transgender adolescent
17 under the age of 16; is that correct?
18 A Yes, that's correct.
19 Q Have you treated anyone under the age of 16?
20 A No, I have not.
21 Q And as I understand from previous testimony, the
22 extent of your clinical experience with transgender
23 adolescents has been providing counseling to eight
24 transgender patients between the ages of 16 and 18
25 in your career; is that right?

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1 A For being a formal clinician for cases, that number
2 sounds about right, yes.
3 Q And that was the number you gave in your testimony
4 in Alabama in May of 2022. So has that changed
5 since then?
6 MR. RAMER: Objection to the form.
7 A No, I don't think there's been anybody else in that
8 age range since that time.
9 Q Have you ever diagnosed a child with gender
10 dysphoria?
11 A No. Diagnosis, of course, is a subset of clinical
12 activities. So it's the same -- it's within the
13 same boundaries.
14 Q Since you've never treated a child, you've never
15 diagnosed a child with gender dysphoria it would be
16 fair to say?
17 A That is it exactly. Lovely when logic lines up.
18 Q It's rare.
19 A A rare pleasure we can call it.
20 Q Have you ever diagnosed an adolescent with gender
21 dysphoria?
22 A Not that I recall.
23 Q Have you ever monitored an adolescent patient with
24 gender dysphoria who was being treated with hormone
25 therapy?

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1 A That would depend on what one means by monitored.
2 I wouldn't have followed such a person or monitored
3 their medical treatment, for example. You know,
4 looking out for or interviewing regarding, you
5 know, physical side effects, that would have been
6 done by one of the physicians on the person's
7 clinical care team.
8 But I would have been involved in, you know,
9 progress and effects and so on on the person's
10 mental health status and development while they
11 were undergoing physical transition.
12 Q Well, you would have. Were you ever involved?
13 A I was involved in such cases, yes. I meant
14 hypothetically to be the different hypothetical --
15 to be the different ways to interpret the question,
16 not my role in the case.
17 Q So that would have been with the eight patients
18 that you have seen between the ages of 16 and 18,
19 some of those patients were on hormone therapy?
20 A Yes, that's correct.
21 Q And how were you monitoring their well-being on
22 hormone therapy?
23 A Oh, regular mental health assessment. As people
24 were going through, you know, transition, you know,
25 part of that, you know, during the clinical

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1 standards, especially of that time, you know,
2 checking in regularly with their -- with
3 psychologists and mental health professionals, you
4 know, was part of the process.
5 So it was a combination of reviewing the
6 various documents such as from schools and
7 employers where relevant. And a lot of it, of
8 course, face-to-face interviews and with the
9 clients themselves.
10 Q And when was this?
11 A This would have been over the course of my -- while
12 I was at CAMH for my internship and a few years
13 after -- several years after.
14 Q Can you give me those particular range of years?
15 A Oh, 1998 through probably roughly 2005.
16 Q So you have -- since 2005, have you provided
17 clinical treatment to any transgender adolescent?
18 MR. RAMER: Objection to the form.
19 A Of the eightish, a small -- twoish, perhaps, were
20 between 2005 and today.
21 Q And when was the most recent adolescent patient
22 with gender dysphoria that you saw as a clinical
23 psychologist?
24 A Three years ago, four years ago. Again, depending
25 on, you know, who counts which way, there are

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1 people who come in periodically for -- to check in
2 or catch up or somebody is now later experiencing,
3 you know, an unrelated issue, but because they know
4 who I am and we have a developed relationship, you
5 know, we can continue consultation or therapy or
6 whatever's appropriate, or there will be somebody,
7 again, not currently concerned with a
8 gender-related issue, but had gender-related issues
9 earlier in their lives.
10 So it's integrated as part of a comprehensive
11 assessment in getting to know the person, but not
12 necessarily the topic that brings them into therapy
13 to begin with or brings them into therapy to see me
14 specifically.
15 Q So just to summarize, in your career you have seen
16 approximately eight transgender adolescents as a
17 clinical psychiatrist -- excuse me.
18 In the course of your career, you've seen
19 approximately eight transgender adolescents between
20 the ages of 16 and 18, six of those were between
21 1998 and 2005?
22 MR. RAMER: Objection to the form.
23 A That sounds basically correct, yes. My, you know,
24 knowledge and expertise and the material, of
25 course, is about the science itself, not in the --

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1 when I see these people, this is what I do, as I
2 say. I'm relying on the evidence itself, not my,
3 you know, personal anecdotal experience with them.
4 Q And for the eight patients that you saw as a
5 clinical psychologist, what was the nature of the
6 counseling that you provided?
7 A The nature of the therapy and counseling with them
8 really depended on whatever it was that was going
9 on in their lives.
10 The research demonstrates that the people who
11 do best are the ones who have -- who are able to
12 navigate and who have the support in order to
13 navigate typical, I'll say, life stretches and
14 developmental courses.
15 So for many of these people, it was dealing
16 with usual, you know, what do I do with my life, or
17 I'm upset about or I'm having difficulty finding
18 educational experiences or friendship groups or,
19 you know, significant others.
20 So they were often -- I don't want to use the
21 word generic, but they were, you know, very similar
22 issues to what, you know, other people attending
23 therapy would be experiencing. But the potential
24 role that these other indicators had was greater
25 for most of these people because they had

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1 additional stressors to be going through; and,
2 therefore, needed that much more strength in order
3 to be able to handle the stresses that accompany
4 transition.
5 So the content of the therapy with them
6 usually would be the same content as with anyone
7 else, but there were -- there was for many of these
8 people more on the line, for a lot of people a
9 decision, for example, about what -- in the U.S.
10 you say college, in Canada we say university -- in
11 decisions about what university to attend would be
12 attached to social engagements, social
13 opportunities. The pressure on somebody who, of
14 course, is not just gender dysphoria, sexual
15 orientation often can have a similar impact, being
16 in urban versus rural environments, conservative
17 versus liberal environments. There's more on the
18 line for somebody -- for youth experiencing gender
19 dysphoria in planning or undergoing transition.
20 So the particular issues are the same. I'm
21 sorry, I'm repeating myself, but the circumstance
22 and context in which they're doing it is more
23 complicated or there's more involved in it.
24 So it's often very useful for them to
25 double-check their thinking or to receive, you

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1 know, feedback from somebody who's, you know,
2 familiar with and experienced with, you know, other
3 people going through similar issues.
4 Q So in some sense, you are providing to these eight
5 adolescent patients counseling comparable to what
6 you would provide to other patients?
7 A Predominantly. For some people it was specific
8 questions or curiosities or questions or their own
9 concerns about transitions, possibilities of
10 transitions, possible futures for them. But they
11 were not defined by their gender dysphoria or trans
12 status. They had all the regular issues that, you
13 know, very many youth have.
14 Q I want to talk for a minute about your appearance
15 in other cases as an expert. So I'm going to just
16 go right down to this last page here.
17 I'm trying to think, you mentioned a few
18 states that aren't listed here at the beginning.
19 So I guess my first question is: To the best of
20 your recollection, is this a complete list of the
21 cases in which you have been retained as an expert
22 witness?
23 A No. I think there have been some new ones since
24 then.
25 Q Can you tell me what those ones are?

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1 A I'm looking over, because on my bookshelf I have a
2 three-ring binder for each one, because that's my
3 list.
4 Q Why don't we do this, because you said -- is one
5 additional case Kentucky?
6 A Yes.
7 Q Is one additional case Montana?
8 A Yes. My hesitation with that is that it's going to
9 happen. They sent me the contract, but I haven't
10 signed it and returned it yet. But by the end of
11 business tomorrow, the answer will be yes.
12 Q Okay. So let's just say there's two or three
13 others that are in the works in which you have not
14 yet necessarily submitted any form of testimony.
15 Is that accurate?
16 A Again, perhaps I'm quibbling on the phrasing, but
17 for submitting testimony for Kentucky, I submitted
18 my declaration 48 hours ago, I think.
19 Q Okay. Understood. And for Montana, you have not
20 submitted anything yet?
21 A Correct. As I say, that -- you know, we're all
22 anticipating it about to happen. And I would not
23 be at all surprised if you're even more familiar
24 with my deadlines on this one than I am. But it
25 hasn't -- I'm waiting for the -- there's a funny

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1 old expression, dot and tittle. People used to dot
2 the "I" and cross the "T." Turns out that there
3 are words for those. The dot over the "I" is
4 called the jot, and the cross on the "T" is called
5 a tittle.
6 Q So that is where we are with respect to that.
7 Understood.
8 Among these cases listed, can you tell me
9 which ones you were deposed in?
10 A The Indiana case, A.M. versus. I would have to
11 check my notes for BPJ.
12 Q Anything else you recall?
13 A No, not that I recall, because several of the
14 cases -- well, a little less than half now were
15 Frye hearings, they don't involve depositions.
16 Q Those are the criminal cases -- or, sorry, civil
17 commitment cases?
18 A Yes. Again, I wasn't involved in the civil
19 commitment itself. I was involved in the Frye
20 hearing which, you know, was going to then get used
21 in the -- the questions to those were whether the
22 person was subject to civil commitment in the first
23 place, hence the Frye hearing in order to
24 investigate the scientific issues to decide whether
25 the civil commitment regulations pertained at all.

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1 Q So let's -- we'll say -- we will continue to update
2 as your testimony changes in these various cases
3 and call it an ongoing process. Does that sound
4 fair?
5 A That, yes, indeed sounds fair. As I say, the
6 nature of these particular set of cases, it's, you
7 know, me versus various combinations of, you know,
8 people from the AR office versus various subsets
9 of, you know, the same group of experts.
10 So it's, as I say, a rather bizarre, I don't
11 know if I can say unusual, but eccentric, novel
12 situation.
13 Q Well, going back to the cases involving transgender
14 people, did you ever reach out and offer yourself
15 as an expert in any of those cases?
16 A No, they all came to me.
17 Q And one of the cases you have listed here on your
18 CV, No. 5, is Dekker, et al. v. Florida Agency for
19 Health Care Administration. Do you see that?
20 A Yeah.
21 Q What was the nature of your involvement in that
22 case?
23 A They needed a -- well, my basic involvement was the
24 same as with the other cases. They needed, you
25 know, to know what the science said and, you know,

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1 what the -- and feedback on the experts -- what the
2 other experts have written and then, you know,
3 comparing their claims against the content of the
4 scientific literature again.
5 So the basic content of my involvement in that
6 case was exactly the same as my involvement with
7 each of the cases, is here are a bunch of claims,
8 which ones match up with the science.
9 Q And you wrote a declaration in that case?
10 A Yes.
11 Q But you were not called to testify at trial in
12 Dekker; is that right?
13 A That's my recollection, yes. I don't think it's
14 gone to trial yet.
15 Q I can represent to you that it has gone to trial.
16 So --
17 A Oh, okay.
18 Q -- if you haven't -- if you didn't testify there, I
19 gather you didn't testify at that particular trial.
20 A That would make sense. My amnesia gets me, but not
21 that bad.
22 Q So, yes, you did not unknowingly testify at the
23 Dekker trial we're going to say.
24 A I almost want to say, can I testify in my sleep?
25 Does that happen?

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1 Q I mean, you're the psychologist.
2 A Perfect answer.
3 Q And, yeah, so that was my only question on Dekker.
4 So in your declaration in this case, you write
5 about the practices of a selection of your European
6 countries with respect to treatment of adolescents
7 with gender dysphoria; is that right?
8 A Yes.
9 MR. STRANGIO: And, Joel, could we pull up
10 Exhibit 1, which is Dr. Cantor's declaration in
11 this case. I think I am -- am I in control?
12 That's a great question, but --
13 THE WITNESS: Is this another you're the
14 psychologist?
15 MR. STRANGIO: Yeah, I'm about to start asking
16 for advice over here, but for now I think I can
17 actually use this Zoom mechanism.
18 BY MR. STRANGIO:
19 Q Okay. So you do not provide a comprehensive
20 summary of all the practices of country -- excuse
21 me, you do not provide a comprehensive summary of
22 the practices of all of the countries in Europe; is
23 that correct?
24 A Correct. Again, my content was not about the, you
25 know, political situation, policy situation. My,

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1 you know, comments are about the science itself.
2 So I included -- what I included were the
3 systematic reviews that were available, all of the,
4 you know, comprehensive systematic reviews that
5 were available.
6 And so, the countries that I mentioned are the
7 countries that have used them, that have engaged in
8 them, but I haven't -- didn't attempt to make a
9 review of the political policy orientations of any
10 countries -- well, set of countries.
11 Q So England, Finland, Sweden, France and Norway are
12 the only countries that have done systematic
13 reviews of the evidence with respect to the
14 treatment of adolescents with gender dysphoria?
15 A That I am aware of. France didn't conduct its own.
16 They conducted a review, but not the -- but not a
17 systematic review of the original research.
18 Q Then why did you include France?
19 A They conducted a non -- a review, but not a formal
20 systematic review of the evidence as they were, you
21 know, evaluating their own set -- oh, actually,
22 that would be a better way of phrasing it.
23 That I included the countries that have, you
24 know, engaged in reviews of their policies, but, of
25 course, the ones that I deal with, you know, in its

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1 own section emphasizing are, of course, the
2 systematic -- the ones that conducted systematic
3 reviews.
4 Q So there are no other countries in Europe that have
5 engaged in reviews of their own policies other than
6 these five countries?
7 A I don't think I can claim negative in that I
8 haven't looked at every single country that did.
9 Essentially these are the ones who have done it,
10 who have conducted the kinds of reviews and then,
11 you know, made conclusions and asserted policies on
12 the basis of those reviews.
13 But I couldn't say that no other country has
14 done it more than feasible -- it's theoretically
15 possible, especially because they don't all publish
16 everything in English, it's certainly possible that
17 others have that I haven't become aware of.
18 Q But these were the ones that did reviews and came
19 to conclusions with respect to the evidence similar
20 to your own?
21 A Well, the ones that I reviewed, the ones that I
22 included would -- included their conclusions,
23 period. They happened to have come to the same
24 conclusions about the science that I've come to
25 about the science, but there was no -- I wouldn't,

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1 in fact I would work very hard to avoid, you know,
2 the kind of cherrypicking where I would only cite,
3 you know, or pick the ones who come to a particular
4 conclusion in any direction.
5 Q But you're just not sure whether there are other
6 countries in Europe that have done different
7 reviews?
8 MR. RAMER: Objection to the form.
9 A Again, I haven't attempted a country-by-country
10 search, you know, each in their various languages
11 to see if there's something that's been less
12 publicized or less internationally released.
13 So I can't say with any kind of certainty that
14 none exist, but these are the -- so I can't say
15 that none exist. I can only say that I'm not aware
16 of any.
17 Q So you didn't do a systematic review of all of the
18 countries' policies?
19 A Of countries' policies, correct.
20 Q On page 7, paragraph 16, you write here at the
21 bottom -- towards the bottom of paragraph 16
22 speaking about the European policies, "These range
23 from medical advisories to outright bans on the
24 transition of minors." Did I read that correctly?
25 A Those sounds like my words. I'm just squinting to

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1 take the --
2 Q Yeah, here we go.
3 MR. RAMER: And, Doctor, you have your -- am I
4 correct you have your blank printout as well?
5 Chase, is it okay if he consults that?
6 MR. STRANGIO: Yes, absolutely. I was about
7 to get my reading glasses, but I also made it
8 larger if that's helpful.
9 A Both are good, as I say. And here's my three-ring
10 binder for this one.
11 Q So, again, we're in paragraph 16, page 7. "These
12 range from medical advisories to outright bans on
13 the medical transition of minors."
14 A Yes.
15 Q Which of the countries that you identified in your
16 declaration have outright bans on the medical
17 transition of minors?
18 A The UK, Sweden, Finland. Am I forgetting somebody?
19 Q So is it your opinion --
20 A Yes, those three.
21 Q It's your opinion that the UK, Finland and Sweden
22 have outright bans on the medical transition of
23 minors?
24 A People can certainly quibble over the definition of
25 ban, but they have essentially, you know, reversed

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1 course from the wide availability that they had
2 restricting it only to specific formal approved,
3 you know, research studies.
4 Q So you consider accessing treatment in a formal
5 approved research study to be an outright ban on
6 medical transition?
7 MR. RAMER: Objection to the form.
8 A There's something funny embedded in that question.
9 That one is that they are restricted to research
10 studies which in turn select only particular people
11 under particular circumstances -- in particular
12 circumstances when they fit the -- whatever the
13 inclusion criteria are for the study. I don't
14 think it would be accurate to refer to that as
15 access.
16 It's not access. You know, what they would be
17 participating in, what they would be volunteering
18 for is participation in a research study as a
19 research subject, which is in turn medically
20 supervised and so on, which is -- again, especially
21 in countries -- this is one of the main
22 distinctions between the U.S. and the rest of the
23 world is that, you know, it's a public healthcare
24 system. Access means access.
25 And, you know, so participating in or

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1 volunteering for studies that involve, you know,
2 physical transition is not part of the you go to a
3 doctor and you show your health card and you get
4 access. That's -- as I said, that term does not
5 accurately depict their situation.
6 Q We're not talking about access. We're talking
7 about --
8 A I'm sorry, I thought you used the word.
9 Q -- outright bans on the medical transition of
10 minors.
11 So my question was: Do you consider
12 enrolling -- limiting treatment to a research study
13 to be an outright ban on the medical transition of
14 minors?
15 MR. RAMER: Objection to the form.
16 A Again, the use of the word treatment has some
17 assumptions built into it that don't very
18 accurately fit.
19 What the results of the systematic reviews of
20 the science and, you know, to the best of my
21 reading the science itself, says is that these are
22 not ready to be called treatments. These are
23 experiments. We're not sure when, for whom, under
24 what circumstances and in which way, you know,
25 these kind -- these interventions are helpful

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1 versus harmful and how to weigh the potential risks
2 with the potential benefits.
3 It's not yet ready for prime time. To refer
4 to it as a treatment would insinuate at least that,
5 you know, it has already, you know, been subject to
6 the kinds of analyses that we apply in providing
7 evidence-based medicine.
8 Q Okay. Well, let's ask more specifically. None of
9 the European countries that you mention in your
10 report have restrictions comparable to the one that
11 was passed in Indiana; right?
12 MR. RAMER: Objection to the form.
13 A Again, it's -- I can tell anybody, to the extent of
14 my knowledge, what the content of the science is.
15 And when I -- and to the extent that, you know, any
16 given, you know, legal proceeding or law is written
17 in lay language that a non-politician, non-lawyer
18 can read, I can, you know, compare it against the
19 content of the science.
20 The only distinction -- but I can't say that I
21 know the details of all the European various
22 regulations or those particular states within the
23 U.S. The only distinction I'm aware of is whether
24 research purposes are permitted exemption within
25 the ban. But I don't think it would be legitimate

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1 to say that if there's an exception to it then it's
2 not a ban.
3 Q So you would call it an outright ban even if it had
4 an exemption?
5 MR. RAMER: Objection to the form.
6 A It would depend on the nature of the exception.
7 Q So if there was an exception for research, for
8 example, you would call it an outright ban on
9 treatment? Sorry, excuse me.
10 If there was an exception for research, you
11 would call it an outright ban on the medical
12 transition of minors?
13 MR. RAMER: Objection to the form.
14 A I would hesitate to make a blanket statement in
15 case -- you know, I can imagine other at least
16 theoretical, you know, reasons that I would or
17 wouldn't call it. But I don't think that having an
18 exception -- for this particular situation, you
19 know, permitting -- again, we're not even talking a
20 particular research study that's ongoing in any of
21 these.
22 Such laws were -- regulations in Europe were
23 going on despite that there was no research going
24 on. That was one of the, you know, almost
25 ubiquitous criticisms, was the lack of research.

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1 And research programs have not been initiated in
2 these places yet.
3 So if a law, you know, permits -- in theory,
4 in the future if somebody else comes up with this
5 thing that doesn't yet exist, the current situation
6 is still such that it's not available, but we're
7 leaving room in the law just in case for the
8 future?
9 It's difficult -- in that circumstance, yes, I
10 think the word ban is including outright ban as a
11 perfectly legitimate descriptor.
12 Q So in the UK currently, can an adolescent with
13 gender dysphoria access puberty blockers as part of
14 an approved research protocol?
15 A That's my -- as I say, I don't study closely the
16 public policies of it. I can testify only to the
17 content -- really only to the content of the
18 science. But the way you describe it is roughly
19 what I recall of their current policy. But I don't
20 think that they have yet designed any such research
21 studies.
22 So even though it, you know, maintains and
23 reserves the potential, and as best as I can tell
24 the intent in the future to do that, the process
25 today, still for kids today, is that it's going to

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1 be a ban for the moment.
2 Things may -- as I say, exceptions, you know,
3 they're leaving room for potential exceptions in
4 the future, but they haven't happened yet.
5 Q So in paragraph 16 you talk about the various
6 policies and details about the policies.
7 Is it now your position that you're not
8 qualified to talk about the various policies in
9 these different European countries.
10 MR. RAMER: Objection to the form.
11 A I refer to the content of their reviews of the
12 science. And I, you know, share, re-review their
13 conclusions of the science. And I demonstrate not
14 their policies, but their changes to their policies
15 in response to their evaluations of the science.
16 Q But you might not be that familiar with how those
17 reviews are implementing the practice with respect
18 to the delivery of healthcare in these countries.
19 Is that fair?
20 MR. RAMER: Objection to the form.
21 A That's a bit overstated, I think. I haven't taken,
22 and I have no current plans to take thorough -- and
23 I speak as a scientist when I say thorough, I mean
24 almost obsessive -- investigation of the ins and
25 outs of the details. But on a relatively high

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1 level, I'm generally aware of their application or
2 of applications of science and how it's getting
3 used or misused in public policy.
4 But, as I say, I'm not a public policy expert.
5 I haven't, you know, gone into the details of, you
6 know, countries that are changing. I'm only
7 investigating, you know, the individual groups as
8 they are trying to gather the science for the
9 application of their policies.
10 I think it would be fairer to say that I've
11 spent some time and attention on the use of science
12 in policy -- or the uses of this present body of
13 science in policy, but I haven't studied, you know,
14 policy in and of itself.
15 Q So is it your position that no adolescents with
16 gender dysphoria are currently receiving puberty
17 blockers to treat their gender dysphoria in the UK?
18 A No, that doesn't sound correct to me. Exactly
19 because they're aware -- pardon the pun -- but
20 because their policies are in a transitional
21 status, there were, of course, you know, youth who
22 were already receiving medical transition services.
23 And that, as best as I recall, has been
24 grandfathered in. I don't think that they, you
25 know, stopped, you know, anybody who was already

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1 receiving treatment. So it wouldn't be fair to say
2 that nobody is currently receiving treatment.
3 What they say they're aiming to put
4 limitations on are the unnecessary or excessive or
5 over availability where medicalized transition
6 looks like is being used to displace other
7 interventions that very, very feasibly could be
8 better matched to these kids' needs and without the
9 sacrifices and risks that are associated with
10 physical transition.
11 Q So there are youth in the UK currently receiving
12 puberty blockers for gender dysphoria?
13 MR. RAMER: Objection to the form.
14 A Again, I hesitate to say that, you know, flat out
15 as a matter of fact, because that's not the --
16 they've already -- that's no longer a piece of --
17 you know, they've already completed their review of
18 the science. And so, that kind of completes how --
19 you know, that level of how closely I'm
20 following -- or that section of what I'm following
21 of what they're doing.
22 They're now -- the implementation or what --
23 the policies to which they're applying the science
24 is, you know, less a focus of what I follow than
25 the application of the science itself. Their

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1 review of the science is largely complete.
2 Q So at least as to individuals who had been
3 previously receiving puberty blockers for gender
4 dysphoria, that treatment -- or, excuse me, that
5 care is ongoing?
6 MR. RAMER: Objection to the form.
7 A My basic recollection is that they didn't cut off
8 from treatment people who were -- medical treatment
9 people who were already receiving medicalized
10 transition services or at least while a minor.
11 Q That would be true for hormone therapy as well?
12 A I'm including hormone therapy or what most people
13 call hormone therapy under medicalized transition,
14 yes.
15 Q And in your report you also reference Finland. And
16 just right now you referenced Finland as well; is
17 that right?
18 A Yes, that sounds right.
19 Q And do you read and write in Finnish?
20 A No, I do not.
21 Q Do you have a certified translation of the COHERE
22 2020 document regarding their review?
23 A Not of the full document, no, I don't think.
24 Q So you're basing your understanding of the Finnish
25 review on an uncertified translation?

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1 A No, that's not exactly true either. As a matter of
2 fact, I was due to go to Finland in the next couple
3 of weeks, but had -- you know, for a conference
4 that they're holding, you know, bringing together
5 the experts on exactly these topics.
6 And, of course, I'm in regular communication,
7 you know, with people all over the world within my
8 field and more and more commonly with this one.
9 You know, they've also been, you know, discussing
10 the issues themselves regularly in the media in
11 English and Finnish.
12 And, you know, to the extent that they have
13 also been, you know, releasing statements and
14 conversations with other people within the program
15 have been, again, in English. And all of it is
16 exactly consistent with each other. Nobody's
17 identified and nobody's, you know, claimed that
18 there have been any contradictions in any of the
19 available translations in any of the statements
20 that the scientists involved with it -- you know,
21 what they have said in English versus what they
22 have said in Finnish.
23 There have been no contradictions between the
24 conclusions that they came to versus the
25 conclusions that have been produced by scientists

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1 in other countries.
2 Q But typically are the only systematic review an
3 outline of the medical practices in Finland -- the
4 only official versions of the systematic review for
5 the Finnish medical authorities are in Finnish?
6 MR. RAMER: Objection to the form.
7 A I would have to check through my files to see if
8 that's still true. Another publication -- by
9 coincidence, not soon after I submitted this
10 declaration -- again, I would have to look through
11 and check to see if those were Sweden or Finland,
12 recently published in English a peer-reviewed
13 document, you know, summarizing the content of what
14 was originally in their native language.
15 And, again, I keep mixing up several of the
16 Scandinavian states, Finland and Sweden, and which
17 one contained within itself, you know, English
18 language summaries.
19 English is -- of course, you know, despite the
20 original languages that many reports are published
21 in, you know, throughout all of science, English is
22 still the lingua franca. The circulation of the
23 materials, the abstracts of the materials and so on
24 are still circulated in English.
25 And my conversations with the scientists

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1 themselves, including the ones who publish the
2 relevant studies, you know, we're in regular
3 contact with each other who, you know, certainly
4 have confirmed our whole conversations were based
5 on, you know, the idea of what the studies said --
6 of what the studies resulted. Also --
7 Q And by studies, you don't mean studies, you mean
8 systematic reviews; right?
9 A I'm kind of blending -- your mind is going exactly
10 where mine was headed. These two are blended. The
11 content of these systematic reviews -- of
12 systematic -- the content of systematic reviews is
13 largely the list of the papers getting reviewed.
14 So even though -- you know, and it is not at
15 all difficult to determine in any language Appendix
16 A is the list of studies included, you know, the
17 list of studies in Appendix B are the studies that
18 were not included. And those list of studies, you
19 know, have English titles published in English
20 journals and so on. And I'm very, very familiar
21 with every one of those studies.
22 So they have produced, you know, what are
23 entirely transparent lists of what was included and
24 what was not included. This was not a dense text
25 in which one needs a translation in order to

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1 identify subtle potential differences between how
2 something was originally written versus described.
3 The differences between what is included and what
4 is not, what was determined to be useful versus
5 not. And the result is very, very easy to
6 determine.
7 And, as I say, the studies themselves are
8 exactly the same studies that I'm very, very
9 familiar with to begin with.
10 MR. RAMER: Chase, if you have a good breaking
11 point, we've been going a little over an hour,
12 but --
13 MR. STRANGIO: I think if it's okay with you
14 both, I'd like to just finish up this section, and
15 then we could even break for lunch around noon, or
16 what are you thinking?
17 MR. RAMER: Over to Dr. Cantor, how he --
18 MR. STRANGIO: Yeah, are you --
19 THE WITNESS: That's fine with me.
20 MR. STRANGIO: Okay.
21 BY MR. STRANGIO:
22 Q So let's just take a step back. Finland has not
23 cut off puberty blockers and hormone therapy for
24 patients who had previously been receiving those
25 interventions, have they?

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1 A To the best of my knowledge, Finland has grand-
2 fathered people already receiving medical
3 treatments, and that the ban is for additional
4 cases.
5 They're attempting to stave off the -- or halt
6 the flood of new cases for which it is not at all
7 clear that the exist -- that the prior research
8 applies to the new demographic and to the new
9 phenomena that we're observing.
10 Q And for people prospectively seeking puberty
11 blockers and hormone therapy for gender dysphoria,
12 those interventions are available through clinical
13 trials?
14 A Again, I don't think it's accurate to refer to --
15 the word access and the word treatment, you know,
16 assumes that -- come with several assumptions that
17 I don't think are valid. For example --
18 Q Well, I think I said interventions and available.
19 Do you disagree with those formulations?
20 A Yes, for next-door neighbor kinds of reasons. That
21 is it assumes a current situation that is allowed
22 for, but is not assumed in the procedure itself --
23 policy itself. If, for example --
24 Q Let's pull up the Finnish policy, just so we are
25 talking about the same thing.

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1 MR. STRANGIO: So that's Exhibit 7. Joel, you
2 do that part; right? Thanks. Exhibit 7.
3 A Again, this looks ouija boardish from over here.
4 You talk and magic happens.
5 Q Well, let's not go that far.
6 Is this the document that you're referring to
7 from Finland?
8 A Yes, that looks like it.
9 Q Okay. And I just want to go first to -- so this is
10 under the current care in Finland, "In clear cases
11 of prepubertal onset of gender dysphoria that
12 intensified during puberty, a referral can be made
13 for an assessment by the research group at TAYS or
14 HUS regarding the appropriateness for puberty
15 suppression." Did I read that correctly?
16 MR. RAMER: Chase, can you zoom in a little
17 bit?
18 MR. STRANGIO: Yeah, sorry about that.
19 A What you read was the content of that sentence, but
20 interpreting what that sentence means requires a
21 little more information -- well, chunks of
22 significant information.
23 That text indicates that that would be the
24 process and that they are leaving permission for
25 that to happen, except they leave permission for

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1 that to happen. Missing from that sentence is that
2 neither -- I'm saying this in a backwards kind of
3 way -- they are limiting the permission to do that
4 to those two hospitals. But when that sentence is
5 isolated, it seems to suggest that, you know, those
6 two hospitals are engaged in such research
7 programs, and I don't believe they are.
8 It's, as I say, in the text of the policy it
9 leaves permission for them to do that, but they
10 have not set up the infrastructure to do it.
11 Also --
12 Q And you know that definitively?
13 A No, I don't know that --
14 MR. RAMER: Objection to form.
15 A -- definitively.
16 Q So they may have set up research program --
17 proto -- excuse me, they may have set up research
18 groups at the two hospitals listed?
19 MR. RAMER: Objection to the form.
20 A Again, some things are getting left out there. You
21 know, when this first came through, you know, the
22 best of my understanding in conversations with
23 these people was that there was no -- that there
24 did not then exist such a situation. But as, you
25 know, we've tripped over several times, these

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1 things are changing quickly. People are making
2 plans, and I -- you know, the exact details of
3 every policy are not what I follow.
4 So I necessarily need to leave room for the
5 possibility that they have come up with one since
6 the last time I happened to have heard from anybody
7 there, but I -- they haven't received any kind -- I
8 don't want to say they've received no publicity,
9 they at least have not crossed my desk.
10 Also, in the establishment of their policy,
11 you know, the intention of the policy is put in
12 place and then the government structure is move on.
13 If they conduct a study, find that, oh, it
14 doesn't actually help these kids so we shouldn't do
15 it anymore, the study wraps up and the rest of the
16 ban remains in place. It leaves, again, in theory
17 the opportunity for there being research, but it
18 would not be fair to say that the situation is more
19 limiting than it was meant to be.
20 They leave a loophole such that it can be used
21 if it can lead to potential changes in the future,
22 but none of those -- there's nothing in it that it
23 assumes that it will be this everliving alternative
24 way to receive medicalized transition services. It
25 just gives permission as just in case, but there's

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1 no indication that -- no reason to interpret it
2 either as permanent or as current.
3 Q So based on your understanding, those who had
4 previously been receiving medicalized transition as
5 adolescents can continue to receive it; is that
6 right?
7 A So far as I know, they haven't cut off people
8 already in a medicalized pipeline.
9 Q And that there is -- they have left open the
10 possibility of future treatment through research.
11 Is that fair?
12 MR. RAMER: Objection to the form.
13 A Again, for the same reasons as before, I hesitate
14 to say treatment. They've left the door open
15 through research, and then it will be open to the
16 researchers, you know, whether to investigate
17 whatever kind of interventions, changes, whether
18 that counts as treatment, whether that cancels the
19 type of treatment we're envisioning now is unknown.
20 Q And that's the same as in Sweden; correct? They
21 have not -- in Sweden they have not cut off
22 treatment for those who had previously been
23 receiving medicalized transition, as you call it?
24 A That -- to the best of my knowledge, that's true,
25 yes.

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1 Q And in Sweden they have left open the possibility
2 that these interventions may be provided through
3 research?
4 MR. RAMER: Objection to the form.
5 A Again, I would phrase it a different way, that they
6 have -- that the regulation enables research. And
7 then it's up to the researcher to know exactly what
8 it entails, including the researchers not doing it
9 at all.
10 Q Is it your view that there is no research in this
11 area happening at all in Sweden at this moment?
12 MR. RAMER: Objection to the form.
13 A I don't recall there currently being such a study,
14 no.
15 Q But you don't know?
16 A Again, I just reflexively leave myself some wiggle
17 room in that these things are changing quickly, you
18 know, they are of enormous interest. And I do not
19 take for granted that, you know, in the very recent
20 past that things have changed.
21 Q And you mentioned in our conversation Sweden,
22 Finland and the UK, and then you also discuss
23 France and Norway.
24 But France and Norway would not be examples of
25 places that have, quote, outright bans on

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1 treatment; is that right?
2 A They have instead, you know, issued policy
3 statements and advisories, you know, indicating
4 their conclusion that medicalized transition is
5 being overused too quickly, too often without
6 sufficient consideration of less-risky
7 alternatives, but they have not implemented -- they
8 have not used the same policies strategies, I guess
9 is the best term I can come up with, that the other
10 countries have.
11 Again, I'm not a medical policy expert. And
12 each of these countries, you know, is run different
13 ways, and they have different tools available to
14 them -- each of these governments has different
15 tools available to them in the way that they
16 regulate medicine, all of which are, you know,
17 entirely unlike the American lack of government
18 control over -- in the U.S. I hesitate to call it a
19 medical system, it's more like a medical industry.
20 Q So these are all countries with medical systems
21 that are fundamentally different from the U.S., you
22 would say?
23 MR. RAMER: Objection.
24 A They have --
25 Q What was that?

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1 A Yes, each of these countries has an entirely public
2 healthcare system, you know, very -- relative to
3 which the U.S. remains a big international outlier.
4 Q Medicalized transition, as you call it, is
5 available in France for adolescents?
6 A It has not reached the level of -- it has -- the
7 documents they've released have not suggested the
8 level of restriction that other countries have.
9 But I don't know, and I don't recall any reports
10 discussing what portions of that, you know,
11 reflect, you know, local political interests or, as
12 I say, the methods by which each of these countries
13 controls -- manage is a better word, manage their
14 healthcare system.
15 I don't know what the alternative strategies
16 or controls the government had, how they get
17 implemented or the extent to which they're issuing
18 policy guidelines or advisories. You know, does
19 that reflect a difference in their conclusion
20 result of the science or just the political
21 facility and speed with which they can produce such
22 changes.
23 Q So based on your knowledge, neither France nor
24 Norway have outright bans on either puberty
25 blockers or hormone therapy for adolescents with

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1 gender dysphoria?
2 A It would be fair to say that current -- that
3 although they have, you know, reversed course, you
4 know, and they have scaled way back from the easy
5 facilitation of medicalized transition, they
6 haven't issued any language that suggests a yank as
7 far back as strongly as the other countries have.
8 Q Well, I'm not asking for such a descriptive answer,
9 just simply yes or no -- well, I'll say it this
10 way, just is medicalized transition, as you call
11 it, banned in either France or Norway?
12 A I'm not sure the question can be answered very
13 accurately in just a yes or no, but I think it
14 would be fair to say that the statements available
15 are not as definitive as the ones in Scandinavia,
16 for example.
17 Q Going back to the --
18 MR. RAMER: Hey, Chase --
19 MR. STRANGIO: Yes.
20 MR. RAMER: -- do you --
21 MR. STRANGIO: This will be my last question
22 on this topic, and then I was thinking we could
23 break for lunch.
24 MR. RAMER: Okay.
25 MR. STRANGIO: Yeah, sorry. I'm not going to

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1 take us down -- I'm not going through every
2 country, I promise, John. I was going to pull up a
3 map, actually, of the whole world, and we're
4 just --
5 THE WITNESS: I was just going to say and now
6 for Latvia.
7 MR. STRANGIO: Yeah. If we could just pull up
8 what I have premarked as Exhibit 6.
9 BY MR. STRANGIO:
10 Q And before it comes up, Dr. Cantor, you reference
11 in your discussion of the UK something called the
12 interim report from Dr. Cass; is that right?
13 A Yes.
14 Q And this is a document that Dr. Cass put together
15 that informed -- is this the document?
16 A Yes, it looks like it.
17 Q And what is this document?
18 A This was -- there were several documents that were
19 released as a bulk. And I can't remember just from
20 the particular date of this one exactly which one
21 was which.
22 This was part of the series of reports and
23 documents where she was indicating the basic
24 results of the systematic review and the
25 comparisons against -- comparisons of its

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1 conclusions of what the science said with their
2 what was then current policy and why those policies
3 needed substantial revision.
4 Q And then I just want to turn to page 9 here. And
5 this is "A letter to children and young people"
6 from presumably Dr. Cass. Is that a fair
7 assessment?
8 A So far as I can -- so far as I know, yes. Oh, I
9 should also add that I don't think it's fair to say
10 that this is a document that she put together.
11 Q Fair enough.
12 A This was a very -- she was a leader of a very
13 large, very substantial, very talented team. You
14 know, she provided the leadership, and she was
15 selected specifically because she was close enough
16 to the material in order to understand the science,
17 what was going on in the basic field, but not so
18 close as to being a part of it and receiving money.
19 You know, she wasn't making her living from it
20 either.
21 Q Who is the -- who made up the team that she was
22 leading?
23 A Oh, goodness, I couldn't name the particular
24 people. I couldn't name the particular people.
25 Q You said it was a substantial team. How many

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1 people?
2 A Oh, that's a good question. I remember running
3 across, you know, lists in which they were
4 provided, but I -- these were not -- as I say,
5 these aren't people who are regularly part of the
6 sex research community where I would have run into
7 them over the course of my career.
8 Q So you don't know exactly sitting here today the
9 nature of the team that Dr. Cass led?
10 A No, that's not fair either. The nature of the team
11 were people, you know, with expertise and
12 background in assessment and public healthcare
13 policy. They were, you know, people with the
14 appropriate backgrounds in order to conduct the
15 review. But I don't recall their names, and
16 they're not -- I would have to go through the names
17 to double-check. I don't think any of them was a
18 sex researcher.
19 These are, you know, experts in medical
20 outcomes and medical outcomes research and in its
21 application to public healthcare policy.
22 Q And so, on this page here in this interim report
23 authored by Dr. Cass, the second paragraph she
24 writes, "I have heard that young service users are
25 particularly worried that I will suggest that

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1 services should be reduced or stopped. I want to
2 assure you that this is absolutely not the case -
3 the reverse is true. I think that more services
4 are needed for you, closer to where you live."
5 Is that correct? Did I read that correctly?
6 A That's the sentence that she wrote. But, again, in
7 its context -- when removed from the context
8 surrounding it, it would seem to be saying
9 something other than what it seems to say when put
10 back into that context.
11 I mean, you know, when isolated like that, you
12 know, it almost sounds like she's saying that she
13 wants to create more gender clinics so that people
14 didn't all have to go to the same clinic in London.
15 That's not what she was saying.
16 In the context of the fuller report and all
17 the other changes, she was putting as
18 diplomatically as a person can in such a polarized
19 cultural situation that the services -- that they
20 need more services, but not necessarily the exact
21 kind of services that they were requesting. I'm
22 even being ambiguous about this myself.
23 She wasn't saying that these people need more
24 gender clinics, and we're going to put more gender
25 clinics in more cities in order to facilitate your

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1 access to medicalized transition. She was
2 recognizing that these people are, and they are,
3 suffering from very substantial mental health
4 issues that are getting unaddressed. Those are the
5 services that she wanted to distribute, make more
6 available. And she was recognizing that these
7 people had great unmet needs, but that the --
8 Q So is it your -- finish. I'm sorry.
9 A But that medicalized transition was not necessarily
10 the best, most-appropriate balance of the potential
11 risks and potential benefits of the alternatives
12 that were available to them.
13 So she wanted better access to services that
14 would help the kids, but one can't isolate that
15 sentence in order to say that she was taking for
16 granted that the service that they needed was
17 medicalized transition.
18 Q So is it your understanding that in England --
19 excuse me, is it your understanding that in England
20 they are not expanding access to services including
21 medical services outside of the central gender
22 clinic?
23 MR. RAMER: Objection to the form.
24 A I'm not sure I'm following your question. When she
25 says -- in general where she says services, she is

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1 referring broadly to mental health services and
2 social services and help because these kids are in
3 distress.
4 Q And excluding gender transition -- including
5 medicalized transition services?
6 MR. RAMER: Objection to the form.
7 A Again, she's saying what she can say and leaving
8 open possibilities acknowledging the large number
9 of remaining unknowns. And that there are
10 possibilities that things may change in the future
11 as we get better evidence or if research produces
12 something that we're not currently predicting.
13 So she's using carefully crafted language, in
14 my judgment, to leave open the possibilities, but
15 to not make particular promises or to lead anybody
16 down a -- to mislead people down a particular path.
17 It is conceivable that, you know, future
18 research may demonstrate that, okay, this is --
19 that this may indeed, at least for some number of
20 these cases, perhaps that it would be possible that
21 medicalized transition might be the best option,
22 but we can't take that for granted.
23 What is very, very clear is that these kids
24 are in genuine distress, and they're not receiving
25 the supports they need for that distress. And

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1 although she didn't say it, the research is
2 indicating that -- does suggest very, very strongly
3 that these people are -- that very many of these
4 youth are expecting that a physical gender
5 transition would help them meet their psychological
6 needs when it's not the best balance of potential
7 risks and potential benefits -- risks and benefits
8 for what they're aiming. So she --
9 Q She didn't say that, you're saying that?
10 A Correct. That would be -- that last part is my own
11 assumption -- are my own words, you know. It is --
12 you know, what she said is consistent with it, but
13 I can't say that that is exactly what she's saying.
14 I point out only that when take -- removed
15 from the rest of the context around it, you know,
16 it sounds like she's offering to expand medicalized
17 transition, but that's not at all the full story.
18 MR. STRANGIO: I think we can go ahead and
19 stop there. How long, John, and Dr. Cantor, do you
20 want for lunch?
21 MR. RAMER: Over to Dr. Cantor.
22 THE WITNESS: Oh, I'm from New York. I can
23 eat while talking.
24 MR. STRANGIO: I mean, same, but let's not do
25 that for the sake of the court reporter, at least.

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1 So 40 minutes? Do you want to come back at ten of
2 one Eastern Time?
3 MR. RAMER: 12:50 Eastern sounds good.
4 MR. STRANGIO: Okay. All right. See you
5 then.
6 (The deposition was recessed for lunch.)
7 BY MR. STRANGIO:
8 Q So coming back to a conversation we started a while
9 back, Doctor, just for the sake of this line of
10 questioning, so you're not a pediatrician; is that
11 right?
12 A Correct.
13 Q And you don't have any clinical expertise in the
14 treatment of children?
15 A I don't know if it's fair to phrase it that way. I
16 have no clinical experience in that I don't do the
17 activity itself. But, of course, the effects on
18 children and how it affects their development and
19 their sexualities and so on I have a great deal of
20 expertise in.
21 Q So you don't have any clinical experience in the
22 treatment of children?
23 A Correct.
24 Q And limited clinical experience in the treatment of
25 adolescents?

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1 MR. RAMER: Objection to form.
2 A Again, I don't know what limited means in the sense
3 that, you know, it's -- most people have absolutely
4 zero, and even a lot of the people who have
5 experience with it have no experience in any other
6 aspect of human sexuality and aren't able to
7 perform a proper differential diagnosis.
8 Q But, generally speaking, in your clinical practice
9 I think you said lasted -- or, excuse me, generally
10 speaking in your clinical practice, approximately
11 5 percent of your patients were adolescents?
12 A Those numbers are correct, yes.
13 Q And do you have experience in pediatric research?
14 A Yes, in the same sense that I published papers
15 regarding children -- the assessment of children,
16 the effects of development over the course of
17 childhood, or for that matter, you know, prenatal.
18 You know, I'm not a neonatologist, but by the
19 same token brain development and what happens in
20 the brain and during brain development even before
21 birth is the very center of my background and
22 expertise.
23 Q And that's -- you've published original research in
24 that regard?
25 A I'm sorry, in which regard -- which of the --

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1 Q Excuse me, so you -- let me rephrase that.
2 Have you done any research trials in the area
3 of pediatrics?
4 A What do you mean a research trial?
5 Q What does that mean to you?
6 A It doesn't mean anything to me.
7 Q So I don't know what a --
8 A Usually when somebody says trial they mean a
9 clinical trial.
10 Q Have you done any clinical trials in pediatric
11 research?
12 A No, I don't think so. Again, my hesitation is
13 that -- just without scanning through my CV, just
14 to make sure that there isn't one that I forget, as
15 I say, you know, very often my involvement in
16 projects is for the statistics or, you know,
17 whatever technical piece that's relevant to the
18 project that somebody on the team doesn't have.
19 My favorite analogy is with accounting. It
20 doesn't matter if you're doing the books for one
21 kind of an industry or the other kind of an
22 industry. You know the accountant, and you know
23 when the accountant is wrong. And it doesn't
24 matter if they're selling cars or beef.
25 Q Got it. Have you reviewed the evidence base

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1 supporting clinical guidelines for pediatric
2 conditions other than gender dysphoria?
3 MR. RAMER: Objection to the form.
4 A No, not that I recall.
5 Q So are you aware of whether other treatment
6 protocols for pediatric conditions are supported by
7 randomized controlled trials?
8 A Some are, some aren't. The question's a bit over-
9 restricted in the sense that each of these
10 questions requires several different aspects to be
11 investigated at the same time and compared against
12 each other.
13 Of course, the most relevant of those are the
14 risk-to-benefit ratio, and in the large majority of
15 investigations that are pertinent to children, you
16 know, there are relatively few instances that
17 are -- that make good comparisons to gender
18 dysphoria when they have to be applied to children
19 or when we're talking medical interventions
20 specifically to adolescents, not prepubescence.
21 Q And are you aware as a general matter as to whether
22 research is more limited in the area of pediatrics
23 as compared with adult medicine?
24 MR. RAMER: Objection to the form.
25 A I've never undertaken such a comparison myself, but

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1 as a matter of, you know, how research -- how
2 medical research is done, of course, I'm often
3 involved in investigating or reviewing grants and a
4 wide range of different topics.
5 It would be an error to isolate research on
6 adolescents and interpret it in -- it would be an
7 error to interpret the number of studies conducted
8 with adolescents as opposed to, you know, age 18
9 and up or, you know, age of majority in whatever
10 given state and jurisdiction, because very, very
11 many illnesses are age linked. Young people have
12 fewer diseases than older people.
13 So the priority is often, on average, lower
14 for children than adults, because on average
15 they're healthier, you know, they haven't had the
16 long-term effects of whatever situation they're in,
17 whether it's smoking, obesity and so on.
18 That isn't to say zero, and that isn't to say
19 if you're young you're healthy, it's just that the
20 difference of the people who suffer ill health, the
21 young people are necessarily un -- less is a better
22 word, less represented. So one has to be careful
23 in not accidentally asserting a pattern that isn't
24 associated with -- we can't take anything for
25 granted.

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1 Q And are you aware of whether there are randomized
2 controlled trials supporting medical treatment for
3 precocious puberty?
4 A I don't think that there have been randomized
5 trials for it, but it's not a fair comparison. But
6 it wouldn't be fair to compare precocious puberty
7 and puberty blockers for precocious puberty with
8 the use of those same drugs for gender dysphoria.
9 Q Well, I'm not asking about gender dysphoria. I'm
10 just saying just as to precocious puberty. There
11 are -- you're not aware of any randomized
12 controlled trials preventing medical treatments for
13 precocious puberty?
14 A I haven't conducted a search for them.
15 Q So you're not aware of any?
16 A Not offhand, no.
17 Q What about randomized controlled trials supporting
18 medical treatment for congenital adrenal
19 hyperplasia?
20 MR. RAMER: Objection to the form.
21 A No, I can't think of randomized -- I can't think of
22 a placebo-controlled randomized study. I would
23 have to search to see if there have been randomized
24 studies comparing different kinds of medicalized
25 treatments with each other.

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1 Q But you're not aware of any offhand?
2 A No, not offhand.
3 Q Do you have any reason to know -- actually, let me
4 rephrase that.
5 Do you know if pediatric conditions frequently
6 have the type of evidence supporting treatment as
7 available evidence for treatment of gender
8 dysphoria?
9 MR. RAMER: Objection to the form.
10 A Again, that's not really a meaningful comparison,
11 because there are very few issues that have the
12 same risk-to-benefit ratio. And the great majority
13 of disorders, especially with youth, we're talking
14 about, you know, objectively diagnosed.
15 You can take a blood test and you either have
16 it or you don't. It isn't a matter of, well, we'll
17 talk about it and kind of decide and the child is
18 telling you what their diagnosis is. So there are
19 really very few like apples-versus-apples
20 comparisons that can be made.
21 So if you just kind of add up how many are
22 there, again, the result is misleading, because the
23 population of related disorders are so small to
24 begin with.
25 Q Well, let's take CAH, congenital adrenal

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1 hyperplasia, and just the medical intervention
2 of -- surgical interventions on the genitals to
3 make them conform to a more typical female genital
4 presentation.
5 Are you aware of any data supporting the use
6 of that surgical technique on infants with
7 congenital adrenal hyperplasia?
8 MR. RAMER: Objection to the form.
9 A I'm sorry, am I aware of any --
10 Q Data on the efficacy of that surgical technique on
11 treatment of infants with congenital adrenal
12 hyperplasia?
13 MR. RAMER: Same objection.
14 A Not on mental health effects. There have been some
15 case studies on, you know, the physiological
16 outcomes, for whatever they're worth.
17 You know, does the cosmetic end point match up
18 with generic surgical success, I'm not aware of
19 such studies for mental health effects.
20 Q But it's possible, then, that that intervention
21 causes harmful mental health effects on individuals
22 with congenital adrenal hyperplasia. Is that true?
23 MR. RAMER: Objection to the form.
24 A It's certainly a fair hypothesis. In fact, there
25 have been case studies, I don't remember if it's

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1 the name of the patient or the name of the author
2 of the book, John Colapinto, who examined, you know
3 a series of, you know, interventions that were done
4 with children in order to make their physiology,
5 you know, better match whatever -- oh, that was it.
6 I'm thinking of the Reimer case. It wasn't a CAH.
7 Never mind.
8 Q So you don't know of any data studying the mental
9 health outcomes of surgical interventions on
10 intersex -- sorry, excuse me, on infants with CAH?
11 A Not quantitative studies, no. There have been, you
12 know, single case studies of people, you know,
13 describing individual people, but not on -- not
14 anything to which one would apply any statistics.
15 Q Do you have concerns about the impact of that
16 surgical intervention on infants with congenital
17 adrenal hyperplasia --
18 MR. RAMER: Objection to the form. Sorry.
19 MR. STRANGIO: No, no. Sorry, that was not a
20 good question. I'll rephrase.
21 BY MR. STRANGIO:
22 Q Do you have any scientific objections to the nature
23 of the evidence base supporting the surgical
24 interventions on infants with congenital adrenal
25 hyperplasia?

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1 MR. RAMER: Objection to the form. Beyond the
2 scope.
3 A The question's kind of -- has a foot in science,
4 and a foot in, you know, the related research
5 ethics. And where it's properly science versus not
6 is a legitimate conversation.
7 I have concerns in the usual medical and
8 clinical research concern that intervening puts us
9 in a position of responsibility, especially when
10 we're talking about, you know, surgical
11 interventions.
12 In all of medicine and medical researches -- I
13 don't want to say it in Latin, because I'll
14 mispronounce it -- but we're not going to -- we are
15 bound not to do anything until we have very good
16 evidence of its outcome.
17 So intervening surgically or medically at all
18 should be withheld until we have, you know, solid
19 objective evidence to demonstrate benefit.
20 So, again, I'm kind of -- you know, that's
21 kind of scientific and kind of not. But I have
22 concerns in that, you know, people were intervening
23 medically and surgically without having a
24 sufficient scientific research basis for dramatic
25 intervention at all.

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1 Q But the law in this case explicitly exempts from
2 prohibition those kinds of surgical interventions
3 on infants with CAH. Are you aware of that?
4 A Yes. But, of course, you know, my purpose and
5 testimony isn't about the law. It's about the
6 nature of science, what the science says. And how
7 any organization wants to implement it is up to
8 them. I don't mean either to attack or defend any
9 statute.
10 Q But you didn't weigh in as to the scientific base
11 supporting those exempted interventions in this
12 case?
13 A I didn't intervene at all. I --
14 Q I said weigh in.
15 A -- do have -- not exactly sure what the difference
16 is. But, again, for a specific statute, I haven't
17 said anything.
18 The only caveat I need to add is that it's
19 very possible, although I don't have a specific
20 recollection, it's very, very plausible that I
21 would have spoken publicly about the application,
22 again, of medical interventions in situations like
23 the John Colapinto book about John Reimer -- Dan
24 Reimer, John Reimer -- David Reimer, that was it --
25 about medically intervene -- about engaging in

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1 medical interventions without first having
2 objective evidence about its risk-to-benefit ratio.
3 Q So I'm going to pull us to, just if you want to
4 pull it up on your paper copy, page 46, paragraph
5 106 of your declaration, which is Exhibit 1.
6 A Got it.
7 Q Maybe I should have had that. Okay. And this is
8 at the bottom of the page, from 46 to 47. You
9 write, "Biologically, the sex of an individual (for
10 humans and almost all animal species) as male or
11 female is irrevocably determined at the moment it
12 is conceived. Terms such as 'assign' obfuscate
13 rather than clarify the objective evidence."
14 Did I read that correctly?
15 A That's the content of the sentence, yes.
16 Q What about infants with intersex traits?
17 A What about it?
18 Q Would this sentence apply to them?
19 A Yes. However, there's subtle and profound -- or
20 there's a distinction that can be both subtle and
21 profound, you know, in how people are using the
22 word sex, especially in this context and in today's
23 context, about what it means as a definition of sex
24 and in what ways, you know, exceptions can and
25 should be made.

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1 There are relatively few characteristics for
2 which there don't exist, again, details,
3 atypicalities for which not everything can be taken
4 for granted, but they do not -- but these are often
5 examples that prove rather than disprove the rule.
6 Q So what is the definition of sex that you're using
7 here?
8 A That is exactly one of those profound and subtle --
9 distinctions that are both profound and subtle. In
10 the context of gender dysphoria, it's a mistake to
11 be saying that there is a definition of and that's
12 that.
13 And then with people picking either
14 chromosomes or hormones or, you know, subjective
15 experiences, sex itself in science would be -- let
16 me say this a different way. People are confusing
17 definitions with construct validity.
18 In mathematics, we have a definition, and it
19 will apply to the definition of the real numbers is
20 the definition of the real numbers and there are no
21 exceptions.
22 In science, we have what's called construct
23 validity. There's -- although we will use the word
24 fact, there is no such thing as a fact. We only
25 have the best explanation we have for the

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1 observations we've made. And it remains eternally
2 possible for some future exception to be made, and
3 we just haven't seen it yet. There is no such
4 thing as settled science as popular as the phrase
5 has become.
6 Sex is not like defining a real number versus
7 irrational number versus an imaginary number for
8 which there exists no exceptions. Sex is, again,
9 in science or in statistics what we would -- what
10 is the overlap amongst each of the pieces,
11 including all of chromosomes and genetics and so
12 on, all of which overlap and match the great,
13 great, great majority of the time.
14 Sex is that overlap, not the individual
15 ingredients that are put into the very -- the
16 overlap. So the identification of exceptions do
17 not break the rule.
18 In most situations, you know, at birth visual
19 inspection of the genitals is, you know, a
20 perfectly convenient, if I can use that term, way
21 to go about, you know, identifying the sex of the
22 kid, because it matches up with all of the other
23 features in the great, great, great majority of
24 instances.
25 But phrases such as the one that I was talking

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1 about here assigned at birth, well, if the mother
2 got a sonogram when she was six months pregnant,
3 she knew what the sex of the kid was going to be in
4 the great, great, great majority of cases months
5 before the birth happened.
6 So, as I say, but that -- so the presence of
7 exceptions in a long complicated chain of events
8 going from conception, and in some cases even
9 before conception for some, you know, chemical
10 interactions with the mother's body, you know,
11 through life experiences, you know, some of them
12 chemical, some of them biological, some of them
13 social, again, these are a large, large complicated
14 set of interrelated factors which are irrelevant in
15 the great majority of the time, but we only have an
16 issue when there is some exception.
17 So then we need to look more deeply into the
18 situation in order to decide what, if anything,
19 would be the most helpful to the person in
20 question. But as I say, these are all questions
21 about construct validity. And, you know, if I ask
22 a person what a house is, they can give me, you
23 know, a rough idea that will fit in the great,
24 great majority of the time. But then we can ask,
25 you know, "Well, is this an exception? Does this

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1 cave count as a house? Does this hut count as a
2 house? Does a hotel that you're living in" -- I'm
3 just making these up. And one can come up with,
4 well, there can be certain exceptions to certain
5 pieces of it, but what makes the house the house is
6 the consistent overlap of each of these
7 characteristics. But that there can be an
8 exception to one of the useful rules of thumb that
9 we use does not mean the overall concept -- that
10 the entire structure itself is wrong.
11 Q Well, I'm not asking if it was right or wrong. And
12 I think in some sense maybe you're trying to
13 respond to why I'm asking, not what I asked,
14 because I am just focused on these words in your
15 declaration, "The sex of an individual as male or
16 female."
17 What did you mean by "The sex of an individual
18 as male or female"?
19 A The overlapping set of -- again, because of the
20 context in which I wrote the sentence, it isn't so
21 easy to just lift the sentence out from the others.
22 By the sex of the individual, I mean the
23 overall set of characteristics, you know, ranging
24 from and including, you know, the multiple
25 biological features which are mostly -- again, it's

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1 the exceptions that are hitting my head -- that are
2 mostly determined at the point of conception and
3 the chromosomal combination.
4 Q Mostly, but not always determined at the point of
5 conception?
6 MR. RAMER: Objection to form.
7 A I wouldn't say always. Again, I'm leaving room for
8 there are certain, you know, chemical interactions
9 between the chromosomes, the mother's body, the
10 potential zygote and so on which can influence
11 what's going on biologically. They're rarely of
12 interest to very many circumstances, situations,
13 but they exist.
14 Q And so, coming back to your previous discussion,
15 you would say that overall sex is a set of --
16 sorry, the overlapping set of characteristics,
17 including multiple biological factors?
18 MR. RAMER: Objection to the form.
19 A Close. I would say it is the overlap --
20 Q Okay.
21 A -- amongst those biological features.
22 Q And what are those biological features?
23 A I don't know if they can be enumerated in full, but
24 the primary ones are, of course, chromosomes,
25 hormones. And biology, I'll say, from the neck

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1 down, you know, morphological form. And then
2 neuroanatomy, anatomy from the neck up.
3 Q And all of those biological features are part of
4 sex?
5 A Again, to say part of is to insinuate or the word
6 kind of involves a way by which they go together.
7 The best way I have -- I'm avoiding a mathematical
8 term, factor analysis, but it is the overlap itself
9 that forms the construct.
10 Science and biology don't work like
11 mathematics or law where you can write a definition
12 and then make all of your decisions based on that
13 definition and expect the result to be correct.
14 That's not how science works.
15 We give a best guess, and then we have to
16 check to see if we were correct by making -- you
17 know, designing a clever experiment to see if
18 something might be an exception. And we remain
19 tentative, because there remains always, at least
20 in theory, the possibility of something being
21 different.
22 Q Then in paragraph 107 regarding gender identity,
23 you write, "In science, a valid construct must be
24 both objectively measurable and falsifiable with
25 objective testing."

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1 Did I read that right, correctly?
2 A Yes.
3 Q What did you mean by that?
4 A Well, again, I was pitting it specifically against
5 trying to define or describe a concept according to
6 something that is none of, that doesn't fit --
7 well, specifically against claims of an inner
8 sense.
9 In science, there is no such thing as an inner
10 sense. The purpose of science was to replace
11 concepts based merely upon one's -- it's even more
12 ephemeral than inner sense, it's what one says is
13 their inner sense.
14 Q In medicine, though, there are phenomena that are
15 not objectively measurable beyond patient report;
16 right?
17 MR. RAMER: Objection to the form.
18 A Yes and no. There exists situations where when
19 it's low cost, consistent with other measures which
20 are objective and for which there are no major
21 risks, a convenient way to identify it could be
22 through something relatively subjective.
23 For example, you know, pain receptors in the
24 brain, fine and important and very relevant for
25 certain kind of research, but at the same time if

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1 there aren't enormous social pressures and enormous
2 risks, we don't need to send to a brain scan
3 everybody who comes in saying, "Doctor, my hand
4 hurts."
5 If, however, there are other situations where,
6 you know -- there also exists situations like
7 phantom limb pain. Now all of a sudden we're
8 looking at an exceptional circumstance and we can't
9 take for granted what the person says their
10 individual experience is.
11 So just saying that there exists exceptions,
12 again, we can't from that say -- those exceptions
13 don't disprove any such rule. There is a balance
14 of risks and benefits.
15 If it's low cost and pretty low risk, then we
16 can afford, we have the luxury of just going along
17 with the subjective self-report. If, however,
18 we're talking about something -- if that subjective
19 self-report is now in contradiction with the
20 objective available data, now we have a question.
21 We can't so easily take for granted the accuracy of
22 that subjective self-report.
23 Q But subjective self-report is often the basis for
24 some medical interventions; is that correct?
25 MR. RAMER: Objection to the form.

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1 A They exist in certain circumstances, which as I say
2 are when they're low risk and not in conflict with
3 objective information we do have.
4 Q Do you think gender identity is real?
5 MR. RAMER: Objection to the form.
6 A That's a pretty philosophical question, if not
7 outright Cartesian. Different people, of course,
8 use that phrase, you know, to mean many different
9 things in many different circumstances.
10 So there are different senses in which that,
11 you know, can be a useful descriptor, but only
12 partially accurate. And there are situations in
13 which, you know, people completely either misuse
14 the term or misidentify their own experiences by
15 application of the term because they don't have a
16 better term. They haven't been exposed to a better
17 term, or they're under some kind of social or other
18 pressure to use that term or use another term, for
19 that matter.
20 So whether it exists really depends on what a
21 person means and in what context.
22 Q Do you mean -- excuse me, do you use the term
23 gender identity?
24 A The words will come out of my mouth in -- if we're
25 in a context where what I'm trying to say is --

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1 will be well understood. If one is asking, you
2 know, very detailed questions or very specific
3 questions, then I'll use terms that, you know, more
4 precisely and more accurately capture what a person
5 is trying to say in using the phrase gender
6 identity. It's even more --
7 Q What are some of those terms that people might --
8 that you think would be -- that would more
9 accurately capture what people are trying to say?
10 A Oh, it depends on whatever it is I can infer about
11 what they're trying to say, again, by the context
12 of it. Very many people use the word, for example,
13 to mean -- to assert their belief that they would
14 be happier in a different social role if people
15 treated them in a different way.
16 And the only -- and so they use the word
17 gender identity, because it's now such a ubiquitous
18 term. And in many parts of society, a lot of
19 people feel pressure to just nod their heads and
20 say uh-huh, even though they're not sure what it is
21 exactly that they mean. And both of them are
22 working from a series of assumptions, and each one
23 is completely miscommunicating.
24 Again, with my scientific hat on, that's not
25 an acceptable situation. That's not how

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1 information can, you know, be assessed or
2 self-corrected, and we can't help each -- we can't
3 help people that way. In fact --
4 Q How would -- excuse me. Go ahead, you can finish.
5 A In doing -- probably one of the most common
6 questions in doing any kind of therapy with
7 anything is, "What do you mean by that?" A person
8 says whatever emotion it is, or they feel whatever
9 emotion they're feeling about, you know, their
10 mother, their brother, their significant other,
11 whoever it is, "What do you mean you hate love?"
12 Like/dislike are confused by, and it's the what are
13 the criteria that led you to use whatever word or
14 concept is the important part.
15 There are so many social, political and
16 emotional pressures influencing gender issues now
17 that, again, the term itself -- so many people are
18 using the term in so many different ways, the term
19 itself is not useful. People are using it for its
20 cachet as much sometimes, if not more, for its
21 accuracy.
22 Q So let's say -- how would you describe someone who
23 40 years ago, as a natal boy, let's say, said, "I
24 am certain that I am a girl."
25 What is that -- what would you describe that

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1 certainty of being a girl?
2 MR. RAMER: Objection to the form.
3 A Again, there are a couple of things embedded in
4 that. It's that, you know, if a child says it, you
5 know, a child being certain is not reflective of a
6 child being certain, you know. Very often children
7 phrase things, you know, in dichotomous or
8 simplified ways, you know, just as part of their
9 not yet having developed more subtle understandings
10 of them.
11 They will often assert things strongly because
12 they feel emotionally strongly about them, so they
13 use terms that are strong, even though that doesn't
14 reflect actual certainty or evidence.
15 It's an almost ubiquitous experience for gay
16 men to say that they -- or including myself even in
17 this particular one -- to have memories or feelings
18 of not being a boy or I'm a girl on the inside.
19 But even though they will have used those terms,
20 it's not an accurate perception. It's a use of the
21 only vocabulary that they have available to them
22 with a child's perception and experience of it.
23 Q What about an adult, 30 years ago none of the same
24 social political context of now, who is a natal
25 male asserts understanding or certainty of one's

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1 self as female?
2 MR. RAMER: Objection to the form.
3 A I'm almost self-conscious about I don't have to
4 project I was there and listening to these people
5 and in a -- you know, working in a clinic helping
6 adults, you know, with gender dysphoria exactly to
7 transition. And we had exactly this conversation,
8 but not quite 30 years, closer to 25. And that's
9 not how they described it. That's one of the flags
10 that's -- you know, that increases my, you know,
11 critical thinking ear, if I can mix my metaphors.
12 25 years ago, people felt -- at least the ones
13 that I was encountering, people felt comfortable
14 admitting to their doubt and uncertainty and "I'm
15 not so sure, and I want to try this out and see how
16 it goes."
17 Where the people coming into clinics now
18 are -- the expression -- I'm losing the expression,
19 are reporting to the test. They're -- you know,
20 they think they know the right answer. And if they
21 express doubt, then they won't be permitted to
22 transition, so they don't express doubt. Or flip
23 side that, you know, they're afraid that whatever
24 services will be changed if they start describing,
25 you know, I feel depressed or whatever negative

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1 emotions, so they don't tell the clinician.
2 So people today are describing in much more
3 dichotomous, black-and-white terms things that to
4 those of us who have been in this field for a while
5 recognize as different. People were willing to
6 express their doubt a generation ago, and they're
7 not now.
8 Q What are you basing that on, your assertion about
9 what's happening when people present themselves to
10 clinics today?
11 MR. RAMER: Objection to the form.
12 A It's a combination of my own experiences, the
13 reports of clinicians on both sides of the issues,
14 those who, you know, basically see things, you
15 know, with a critical eye that I apply, as well as
16 clinicians who do not, you know, they also
17 describe, you know, very, very dichotomous reports
18 from their patients.
19 But there's a huge generational divide. The
20 clinicians I should -- the large, large majority of
21 clinicians, even calling themselves advocates and
22 activists, are all very young. They didn't
23 experience these clinics, these patients, these
24 populations, these problems, these difficulties
25 before the social media age.

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1 This is all they know. They didn't notice a
2 difference. So far as they're concerned, things
3 have always been like this, and this is a permanent
4 situation. It's only the people who have been
5 working in this field over a longer period of time
6 who are able to look back at it and say, this
7 doesn't match the evidence. These are not the
8 people on whom we gathered that evidence.
9 The situations that suggest that, again, for
10 the adults for whom this was a good idea, this is a
11 different profile of what we were seeing before.
12 And the research we gathered on that prior group
13 does not automatically translate to the group that
14 we're seeing now.
15 Q You said your experience with patients presenting
16 to clinics, but you aren't currently seeing
17 patients in clinics, are you?
18 A I'm not seeing the patients directly, no. Usually
19 these would be either individual people coming to
20 me, other clinicians coming to me to consult on
21 whatever cases that they're seeing, the public
22 discussions amongst, you know, groups fall along
23 the spectrum. I should use a better term than
24 spectrum, it's getting overused.
25 Q What clinicians have been coming to you to express

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1 this?
2 A I'm not sure what you mean by what clinicians. Are
3 you asking for names?
4 Q Yeah.
5 A I don't know if I'm comfortable giving particular
6 names. Usually these would be clinicians, again,
7 from all over the world, you know, the U.S.,
8 Canada, Europe, asking for input or a contrast or
9 observations that they have known -- that they have
10 noticed with subsets of their patients whose
11 stories are different, or they don't know how to
12 interpret the story because the models they used to
13 use don't seem to be fitting. They're not getting
14 feedback from their clients in the same way the
15 clients they used to see.
16 And, of course, you know, the clinicians and
17 other sex researchers, you know, at a sex research
18 and sex therapy clinic -- sex therapy conference
19 that I'm a regular member of -- again, these are,
20 you know, to me -- I've been going to these, I'll
21 say it again, 25 years, you know, and these are
22 common conversations among them. I feel like I
23 need to add a caveat to that, too.
24 Conversations have also become -- I don't know
25 if quieter is the right term. People now are

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1 almost ironically less comfortable now talking
2 about it than it used to be. When gender identity
3 and sexual orientation were more stigmatized, you
4 know, height of the HIV era, clinicians and
5 scientists would pride themselves on resisting the
6 social stigma in order to talk about the issues.
7 The mantra of those days was silence equals death.
8 It's reversed today. People now are often --
9 I shouldn't say moderates, the middle 80 percent
10 are less comfortable discussing the issue, because
11 people want to ask questions where they feel there
12 is a vagary or uncertainty. But they've seen so
13 many examples, and there exists -- again, since the
14 onset of social media especially -- so many
15 examples of where people are getting pilloried not
16 merely -- not because they said what somebody
17 thinks is the wrong thing, but for saying,
18 basically, that they agree, but not strongly enough
19 that they're leaving out another opportunity to be
20 still more extreme.
21 Q What's an example of that?
22 A I can really only talk about them in a family of
23 examples where somebody will talk about a point
24 about a particular study. Actually, Twitter
25 probably is the best example, because --

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1 Q So you're referring to things that happened on
2 Twitter, not in medical communities?
3 A They --
4 MR. RAMER: Objection to the form.
5 A The situations don't divide quite so easily. It's
6 because I'm, you know, a well-known member of that
7 professional community that many of my Twitter
8 conversations or Twitter threads are with other
9 people that I know, again, from conferences,
10 experts and the same background.
11 So it's not the same kind of a conversation
12 that, you know, a member of the lay public would
13 have --
14 Q Let me ask you this --
15 A -- with another, you know, stranger member of the
16 lay public. These would be two professionals and
17 experts in a topic having a conversation mediated
18 by Twitter, but it's not the same as just two
19 random nonexperts having a conversation.
20 Q Well, when you say -- when you referenced the
21 examples of being pilloried, is that on Twitter?
22 A It includes Twitter. And because the nature of the
23 medium allows for it, you know, happens like --
24 they happen louder and more often. But, no, these
25 kinds of examples happen in every venue in which

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1 sex researchers have conversations.
2 Q Do you have examples from outside Twitter of this
3 happening?
4 A Yes. Again, just about any conversation -- any
5 social gathering -- social gatherings, for example,
6 the social hours at conferences where usually, you
7 know, it's at the end of the day, you know,
8 whatever cocktail somebody is holding as people are
9 just chatting and catching up since, you know,
10 we're all old friends to each other -- most of us
11 are old friends, you know, and then new batches of
12 students and so on. But the conversations are now
13 followed by who's listening. People are looking
14 over their shoulders. People are adding phrases
15 and caveats to their conversations that didn't used
16 to be there.
17 Two specific examples come to mind. Again,
18 I'm running through my head, because I don't want
19 to, you know, be inappropriately naming other
20 people in the context where they wouldn't have me
21 do. Both of these happen to involve Ken Zucker by
22 coincidence.
23 One would be a talk that he was giving at the
24 Society for Sex Therapy and Research, SSTAR. And
25 it was, you know, very much like other talks that

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1 Ken Zucker gives describing -- you know, sometimes
2 he's giving talks about specific research that he
3 was doing at the time on gender-dysphoric kids and
4 their development.
5 And then, you know, when he was involved in
6 the DSM, you know, many of his talks were about the
7 ongoing negotiations in the formation of the
8 clinical criteria for the DSM-5 this was. But
9 rather than just raise their hand or disagree and
10 have a conversation, the conversation was how dare
11 you say whatever it is that the person disagreed
12 with. Unlike not very many years before, you know,
13 it wasn't agree to disagree, it wasn't even just
14 disagree. It was if all I have to do is declare
15 myself offended and now you're not allowed to say
16 it, which was anathema to sex research, sex
17 research is what it is exactly because of sex
18 researchers who were willing to say things that
19 were unpopular amongst whatever other groups.
20 Q But Dr. Zucker was the one giving the presentation
21 in this example?
22 A Yes.
23 Q So he was speaking?
24 A Yes.
25 Q And you're describing the reaction of someone in

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1 the audience?
2 A Yes, interrupting it, and essentially the word
3 cancellation hadn't yet existed, but were so upset
4 that they didn't think that he should be allowed to
5 complete his thought discussion, or said another
6 way, other people didn't have the right to hear it.
7 Q When was this?
8 A Early 2010s.
9 Q And your other examples that you can think of are
10 in social hours and conferences and on Twitter?
11 A Those are, of course, much more common, because
12 those, you know, kinds of conversations are, you
13 know, so very much more common than an annual
14 conference.
15 And the other one -- specific one involving
16 him, again, was at a conference -- that I was at a
17 conference. I'm trying to remember the name of the
18 researcher who did it. Again, Ken Zucker was
19 giving a presentation. She had just finished hers
20 and happened to have been sitting right behind me.
21 And she was at full voice, you know, continuing to
22 talk to herself, essentially, saying what she'd
23 like -- well, didn't like about his conversation,
24 until I finally turned around, you know, "Do you
25 mind, you know, he's talking?"

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1 To which her response was, "Oh, I don't need
2 to hear that."
3 Q So coming back to your --
4 A I couldn't --
5 Q -- declaration, just to ground us there. You write
6 in some sections about social transition in
7 prepubertal children.
8 What is your understanding of what social
9 transition is?
10 A I hesitate to say my understanding is -- I hesitate
11 to say my understanding in that my understanding is
12 that, you know, many people use that phrase to say
13 many different things.
14 So step number one is find out, you know, what
15 it is the person I'm communicating with is trying
16 to say even before we know if we're agreeing or
17 disagreeing over any particular point.
18 So my understanding is the range of different
19 definitions and applications people use. And then
20 if we're actually going to do any kind of research
21 or assert any kind of meaningful fact, we start
22 with, well, in this circumstance what do me and
23 whoever it is that I'm talking to or I and whatever
24 author of the paper I'm reading, how is it being
25 used in this instance so we can be talking about

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1 the concept -- the relevant concept.
2 Q So you don't have a singular definition of social
3 transition that you use?
4 A I don't think it's -- I don't think anyone could
5 say that there exists a singular definition.
6 Q And if you use it at various points in your
7 declaration, is that based on how it's used in
8 other places that you're referencing?
9 A Again, I would have to look through each time I
10 mentioned it, but I, as a matter of habit, try to
11 either make it explicit how I'm using it or make
12 explicit -- if I'm addressing somebody else's
13 comment, then I do my best to make sure that it's
14 clear that, you know, I'm using that person's
15 definition or I'm addressing whatever that person's
16 conceptualization is.
17 Q And in your table of contents here pulled up on the
18 screen, which I think it's IX.B.1, you have a
19 section on what in the table of contents is,
20 "Eleven cohort studies followed children not
21 permitted social transition, all showing the
22 majority to desist feeling gender dysphoric upon
23 follow-up after puberty."
24 A Yep.
25 Q What does social transition refer to there?

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1 A There I was referring to Olson's study, recently
2 out of California, which was the one exception
3 among -- well, I shouldn't say exception among,
4 exception in addition to that 11. Hers was the one
5 study that followed kids who had already begun
6 living as the other gender when they came into her
7 clinic.
8 So when she reported her results of relatively
9 few of these kids having desisted by puberty,
10 exactly the opposite as the first -- as the prior
11 11, then, of course, I needed to cleave that, you
12 know, there was an important difference between her
13 one study and the other 11. That difference was,
14 again using her words, I'm pretty sure, that they
15 had socially transitioned.
16 So in that context, the meaning was, you know,
17 that the relevant definition was the one that made
18 the sample she was reporting on so distinct from
19 the others, from the other studies.
20 Q Well, you describe all the others as following
21 children who were not permitted social transition.
22 So presumably there has to be a definition that
23 applies to those 11 to know that children were not
24 permitted to social transition.
25 MR. RAMER: Objection to the form.

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1 A Again, that's not a definition. These were
2 studies, you know, that predated the existence of
3 the term. So the studies themselves didn't say
4 these kids were not permitted to transition
5 socially. These were studies that did what the
6 studies did.
7 And so, here we are, you know, sometimes
8 decades later trying to summarize in an
9 understandable, accurate, but still pithy --
10 pithy's not the right word -- succinct or concise
11 way to capture what is it that made, you know,
12 these 11 different from that one.
13 And the, you know, most applicable, shortest,
14 easily -- hardest to misunderstand phrase would be
15 social transition. But those papers didn't use
16 that term at all, but they're meaningfully
17 described with that term.
18 Q So what does it mean that they're meaningfully
19 described with that term, since you're the one who
20 applied that term to these 11 cohort studies?
21 A Oh, I think anybody reading the studies, the
22 methods, the contents of them would very
23 immediately come to the same conclusion that I did.
24 As I say, I'm not asserting that there was a
25 specific definition with a set of criteria that

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1 says fit or not fit. There really is no overlap
2 between what the set of 11 did and what Olson's
3 recent one did.
4 It was an active part or it was an explicit
5 part of the original 11 studies where the kids were
6 not permitted to crossdress and adopt new names.
7 They were, you know, encouraged to be as
8 comfortable as possible in their biological selves,
9 which is in -- which is exactly opposite to what
10 Olson did, which was to let the kids -- I don't
11 think it would be fair to say encourage, but --
12 indulge probably isn't the right word either, but
13 the way she, basically, described it is that, you
14 know, the kids came in very often already living
15 socially as the other sex.
16 So because this was, you know, such a large,
17 large difference between the original 11, we're not
18 in a situation where subtle differences in wording
19 or definition would change. You know, maybe one of
20 these two 11 really were more like Olson -- the
21 Olson study, the people -- the treatments, the
22 therapies that kids who were coming into Olson's
23 study were night and day different from the
24 treatments being received by the first 11.
25 Q So the first 11 you have on this page 51; is that

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1 correct? This table?
2 A That sounds right. Just seeing what you have up
3 there, that looks right, yes.
4 Q And seven of those were from the 1970s and '80s?
5 A Yes. As I say, this was ubiquitous, I would say
6 since the '70s. It would be an error to say that
7 all studies are old and, therefore, wrong.
8 Q I'm just not asking you to say whether they're old
9 or not. I'm just asking a factual matter whether
10 seven of them were published in the 1970s and the
11 1980s?
12 A That looks right, yes.
13 MR. STRANGIO: I'm happy -- I can keep going.
14 It is an hour now if you want to take five.
15 MR. RAMER: Yeah, why don't we take five.
16 MR. STRANGIO: Okay.
17 (A recess was taken.)
18 BY MR. STRANGIO:
19 Q So I'm going to fill in this exhibit, which is
20 one -- I'm going to take us to another section. So
21 we're in -- here on paragraph 135, page 59 of your
22 declaration, Doctor. It's at the bottom of the
23 page discussing what you're referring to as
24 adolescent childhood -- sorry, "Adolescent-Onset --
25 A Yep.

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1 Q -- Gender Dysphoria." And so, you write, "This
2 group typically presents in adolescence, but lacks
3 the history of cross-gender behavior in childhood
4 like the childhood-onset cases have. It is that
5 feature which led to the term Rapid Onset Gender
6 Dysphoria (ROGD)," citing to Littman 2018.
7 Did I read that correctly?
8 A Yes, that sounds correct.
9 Q And rapid-onset gender dysphoria is not a
10 recognized diagnosis; is that right?
11 A Not in a diagnostic manual itself, but that
12 shouldn't be interpreted to mean that the
13 phenomenon doesn't exist.
14 Q And the paper that you cite, Littman 2018, was
15 corrected as you note; right?
16 A There was a change to it, but nothing that
17 meaningfully altered any of its actual conclusions.
18 Q On footnote 5 you reference, "After initial
19 criticism, the publishing journal conducted a
20 reassessment of the article. The article was
21 expanded with additional detail and republished.
22 The relevant results were unchanged."
23 Is that a correct reading of the footnote
24 there?
25 A Yes.

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1 MR. STRANGIO: If we could, Joel, pull up
2 Exhibit 8.
3 Q Does this appear to be the notice of republication
4 of the Littman 2018 article?
5 A It appears to be, yes.
6 Q And at the top it says -- and I can zoom in so we
7 can look more closely -- "After publication of this
8 article" -- sorry, do you see where it begins that?
9 A Yes.
10 Q And then going down to the next paragraph -- oh,
11 sorry. Under the second part of this corrected
12 republication, there's a heading that reads,
13 "Emphasis that this is a study of parental
14 observations which serves to develop hypotheses."
15 Do you see that?
16 A Yes.
17 Q And then here at the top, about four lines down,
18 "Rapid-onset gender dysphoria, (ROGD) is not a
19 formal mental health diagnosis at this time. This
20 report did not collect data from the adolescents
21 and young adults (AYAs) or clinicians and therefore
22 does not validate the phenomenon."
23 Did I read that correctly?
24 A That's what that text says, but it's very difficult
25 for a person to know what that means and what it

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1 doesn't mean without having a better idea of how,
2 you know, science publishing works.
3 Q Well, so you noted that there was correction to the
4 article, but did not reference that ROGD is not a
5 formal mental health diagnosis.
6 Why didn't you mention that?
7 MR. RAMER: Objection to the form.
8 A It's not pertinent to the decision or question --
9 to the decision -- to the clinical question and the
10 pertinent decisions that followed from it.
11 In the situation, the whole point of the
12 current difficulty is that the profiles of the
13 people coming to clinics and expressing profound
14 often discontent that they do not match what is in
15 the existing manuals and on which our existing
16 knowledge base sits, that's the point.
17 Whether this new profile of person is better
18 helped and better served by ROGD as a diagnosis
19 unto itself, or if they actually are suffering
20 other kinds of problems but we're just noticing the
21 ROGD part of it because it's what they're saying on
22 its face value, or if, you know, the previously --
23 you know, the well-characterized distinction
24 between the adult-onset gender dysphoria -- and
25 adult-onset gender dysphoria, if this is now just a

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1 new way of expressing one of those, well, we need
2 to know that in order to know what to do with these
3 kids. That this new presentation is not in the, in
4 this case DSM is usually what people are referring
5 to, that's the whole point.
6 This is new and we don't know what to do with
7 it. Therefore, the medically and clinically
8 appropriate thing to do is nothing until we have a
9 better idea of what the potentials are, the risks
10 and benefits are.
11 When we're talking the removal of healthy
12 functioning tissue, that's a method of last resort
13 until we've exhausted the other alternatives which
14 don't involve as much potential harm.
15 If, you know, after we've exhausted the other
16 possibilities and realize, yeah, this really is the
17 best balance of the potential risks and benefits,
18 okay, let's go ahead. But that entire set of
19 questions was skipped.
20 We don't know if this is an independent
21 phenomenon, a new subset of an old phenomenon, and
22 if it is which phenomenon. These are people coming
23 in, you know, in great emotional distress. Okay,
24 but that doesn't mean that it's automatically what
25 it is that they're saying out loud. We can't take

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1 for granted that they're like one of the other
2 forms of gender dysphoria.
3 Q But in this paper, they're not saying it out loud;
4 right? It's their parents?
5 A Oh, in studies of youth that is -- that's very
6 common. That is -- as I say, it's difficult to
7 interpret that sentence once lifted out of, you
8 know, the rest of how this research is done.
9 Interviewing parents and caregivers and so on is a
10 very, very routine method of studying minors.
11 Q Exclusively interviewing parents and not the minors
12 themselves is routine?
13 MR. RAMER: Objection to the form.
14 A For one particular study, absolutely. It's when
15 asking a question, you know, it is exquisitely,
16 exquisitely rare for any one study to be -- to
17 answer -- you know, to answer any question.
18 Usually what we need, and the only way we know
19 that we're on the correct path that we have the
20 correct answer is when several different
21 researchers working independently using different
22 kinds of methods keep coming to the same result
23 over and over. That's when we can be confident.
24 So in any research investigating or that's the
25 pursuit of any question including this one, we need

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1 studies that talk to the kids, that talk to the
2 parents, that talk to their psychologists, that
3 talk to the physicians and other studies that don't
4 talk to a person at all and stick to objective
5 measures, you know, of whatever is appropriate to
6 the question.
7 So this one particular study was the one that
8 interviewed parents. It is neither the beginning
9 nor the end. Is it one piece of the puzzle and an
10 important piece when we need, you know, and it goes
11 in the pattern of all the others.
12 So it's that, you know, contribution one piece
13 at a time, yes, that is absolutely a routine method
14 for investigations studying minors.
15 MR. STRANGIO: If we could go back, Joel, to
16 Exhibit 1. Sorry, Joel, did you hear that, Exhibit
17 1? Thanks.
18 BY MR. STRANGIO:
19 Q Okay. Still on paragraph 135, you write after
20 reference to the Littman article, "The patterns" --
21 and this, let me -- I can zoom in for you, although
22 I think you have this in front of you, Doctor.
23 "The patterns reported by Littman have now
24 been independently replicated by another study
25 which also found it to be a predominantly female

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1 phenomenon, associated with very high rates of
2 social media use, among youth with other mental
3 health issues, and in association with peers
4 expressing gender dysphoria issues." Citation to
5 Diaz 2023.
6 A Yes.
7 Q Is that right?
8 A That reading of the text is correct, yes.
9 Q And if we can pull up -- well, let's see if we can
10 do this without pulling up the exhibit for the sake
11 of our limited technological skills.
12 Are you aware of changes to the Diaz article
13 subsequent to publication?
14 A Yes, I am.
15 Q And you're aware that the second author of the
16 publication, Michael Bailey, has since made public
17 that the paper has been retracted?
18 A Yes. Of course, I need to add the caveat that arm
19 of the drama happened after I submitted this. So
20 it wasn't -- you know, I didn't have that knowledge
21 when I wrote and submitted it. But, yes, I know
22 that that's happened in the interim.
23 Q So the article that you cite further the prop --
24 the article that you cite for the proposition that
25 the patterns reported by Littman have now been

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1 independently replicated was retracted?
2 A Again, there are some nuances in that. There are
3 some nuances in that. The paper wasn't -- the
4 basis of the retraction of the paper, which is
5 itself now a means of enormous controversy, was not
6 actually about whether the contents were accurate.
7 No one has, you know, presented any demonstration
8 that the results that they reported were incorrect.
9 So to the extent that one is actually seeking
10 the truth in that if one wants to know what's going
11 on, as best as we could tell with these kids, you
12 know, the conclusions they came to are perfectly
13 valid and, again, exactly the same. They, you
14 know, completely independently come to the same
15 conclusion as the Littman paper.
16 To the best of my knowledge, the nature of the
17 controversy, I guess I can call it, which led to
18 the formal retraction was -- oh, goodness -- was
19 the database was pre-existing. The nature of the
20 data were already collected by the time -- I guess
21 it was Bailey became involved.
22 And in research ethics, there are different
23 criteria that they use for pre-existing databases
24 versus, you know, actively going and recruiting
25 people in order to participate in a study or

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1 whatever.
2 The way that these data came, it was
3 ambiguous. There are, you know, different groups
4 that have different policies and different
5 principles for, you know, under what circumstances
6 should people have undergone how thorough of an
7 informed-consent process.
8 In this particular one, the relevant
9 guidelines would be those of the publisher itself,
10 Springer who publishes the journal that this was
11 printed in.
12 The policy of Springer is that it was up to
13 the discretion of the editor in chief. And the
14 editor in chief which said that, yep, nope, fine
15 with him.
16 However, after the publication of the article,
17 you know, the nature of it and that people didn't
18 like the conclusions that it came to started a --
19 what I can only call a campaign to have it declared
20 unethical, because they don't think that the
21 editor's discretion was what they wanted it to be.
22 So, again, that became, you know, whatever
23 pressures. And then it goes, you know, behind
24 closed doors, and I don't know what's going on.
25 And then the publisher ultimately decided to --

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1 that the paper should be officially retracted. But
2 there were never any allegations, and there were
3 never any conclusions that the content or the
4 conclusions themselves were in error.
5 So whether that should be -- so does that
6 count or does that not count? It's hard for me to
7 come to any conclusion that people are going to
8 accept or reject the contents of that paper
9 according to whether they accept or reject its
10 implications. The content of the paper, however,
11 has not been in question.
12 Q But just as a factual matter, in this paragraph one
13 of the papers was corrected and one was retracted?
14 A I don't think -- such a characterization, again,
15 just kind of insinuates a situation that is the
16 opposite of the truth.
17 The correction -- again, in general publishing
18 a correction is the formal name of a post-
19 publication change. It is -- you know, but in the
20 context where people are, you know, liking or
21 disliking a finding, the word correction is getting
22 used to imply that one of the conclusions was wrong
23 or something in it was incorrect, which is not the
24 case.
25 The content that was changed to Littman was

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1 adding detail. None of the conclusions changed, no
2 errors in it were found. It's the decision was,
3 well, add the necessary detail in order to
4 demonstrate that nothing was skipped because this
5 particular audience isn't going to take anything
6 for granted.
7 So she added the detail, but the nature of
8 editorial publishing is that such changes are
9 called correction. So, again, to just take that
10 sentence out is to -- is easily mistaken as an
11 assertion that something was incorrect.
12 Same with the Diaz paper. To call it a
13 retraction without the, you know, details of what
14 led to the retraction is to insinuate or to kind
15 of, you know, leave a reader or listener the
16 impression that there was something wrong, that
17 there was an error in the conclusions of the paper,
18 and so its conclusions ought not to be given any
19 weight.
20 That's not the case. The conclusions were
21 never in question, and nobody's changed any of the
22 conclusion -- nobody's asked for any changes to the
23 conclusions or demonstrated that there was an
24 error.
25 People have been -- there were people who were

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1 upset and protesting about -- well, again, their
2 motivations are, you know, pretty -- are relatively
3 clear, but the content -- the rule that was being
4 contested was the method and amount of disclosure,
5 you know, of the people who participated in the
6 study. But there was never any question in the
7 accuracy of the study itself.
8 Q Is your view that it was only retracted because of
9 external pressures?
10 MR. RAMER: Objection to the form.
11 A I haven't seen any evidence, and I haven't -- I
12 don't think I've heard any accusations otherwise.
13 Q So you think that the journal just retracted it
14 because of external pressures, not concerns about
15 the informed consent as --
16 A The journal didn't retract it. The publisher did.
17 Q Excuse me, the publisher retracted it out of
18 concerns about a lack of informed consent, that was
19 not a true reason?
20 MR. RAMER: Objection to the form.
21 A I don't think the situation breaks down quite that
22 way. And it's essentially what the publisher
23 themselves said. They indicated that they were
24 receiving those kinds of communications. There
25 was -- I'd have to go back and read the original

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1 letter they sent. The policy that they have, you
2 know, it was entirely explicit that it was left up
3 to editor's discretion. So essentially they as
4 publisher overturned the editor's use of that
5 discretion.
6 Again, I don't think any of that is ambiguous.
7 And I'm not aware of anyone anywhere in that
8 pipeline -- at least the parts, you know, to which
9 I'm privy, I've not seen any communications or
10 evidence or discussion otherwise.
11 Q Going to page 62 -- uh-oh, what have I done? So
12 beginning on page 62 of your declaration, you
13 distinguish between suicide and suicidality; is
14 that right?
15 A Yeah, again, I hesitate to say that, you know, I
16 distinguish. I'm just, you know, orienting people
17 to the proper uses of the vocabulary. So people
18 who are, you know, not psychologists, you know,
19 reading this don't accidentally mistake one to mean
20 the other, which, again, especially in this context
21 very many groups are actively doing.
22 Q So, I mean, in essence you note that they're
23 distinct clinical phenomena; is that right?
24 A I know that these are distinct phenomena, yes.
25 Q You note, sorry. I know that you know that. You

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1 note?
2 A Oh, I note that, yes.
3 Q I don't actually know, so --
4 A And perfectly legitimately, the public doesn't.
5 That's not their job. You know, this isn't the
6 kind of stuff that people discuss. And that's what
7 leads so many people to misunderstand the content
8 of these studies, especially when things are being
9 lifted out of context.
10 So in order to understand the context of these
11 studies, you know, I have to start out with, as I
12 say I do, here are the definitions. Here's how I'm
13 going to use them. If you read these other, here's
14 how they use them. Which one we use, I don't care,
15 but as long as we're all using the same one, we can
16 have a productive conversation.
17 Q And so, understanding they're distinct clinical
18 phenomena, you would agree that both should be
19 clinically addressed?
20 MR. RAMER: Objection.
21 A Oh, yes, absolutely.
22 Q And that reducing suicide and reducing suicidality
23 are both positive outcomes?
24 A Yes, absolutely. The difficulty that society comes
25 to is that it is exactly because it is part of

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1 these being such different phenomena that the way
2 to deal with them effectively is very different.
3 So --
4 Q Understood.
5 A -- not merely a matter of -- you know, using
6 suicide when we mean suicidality, that's not
7 merely, you know, exaggerating. It's failing to
8 help get the right kind of help to the right group
9 of people. And so, you're disadvantaging them
10 both. And everybody's harmed or failed to be
11 helped.
12 Q In paragraph 142, and this is on page 63, you
13 write, "Social media voices today loudly advocate
14 'hormones-on-demand' while issuing hyperbolic
15 warnings that teens will commit suicide unless this
16 is not granted."
17 Did I read that correctly?
18 A Yes, that's the content of my sentence.
19 Q What are hormones-on-demand?
20 A With minimal assessment consideration of
21 alternatives, it's removing whatever safeguard one
22 can find an excuse to remove.
23 This is another one of the differences that
24 have changed over time, which is relatively
25 apparent to those of us who have been in this field

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1 for long periods of time and have watched the
2 removal of safeguards as opposed to people who have
3 recently come into the field and are only aware of
4 the current status and don't realize that this is a
5 change.
6 So people are often referring to, you know,
7 history's long-standing criteria. No, the current
8 criteria are not long-standing at all. These are
9 brand-new and untested.
10 The subset of studies which suggest success
11 use the relatively high standards that used to be
12 in place at that time. Today people have removed
13 the real-life testing requiring months, years in
14 some cases, of psychotherapy and expect still to
15 get the same results.
16 Q There's no citation on this sentence about
17 hormones-on-demand; right?
18 A Correct. And that's also why I put it in quotes.
19 I'm using it as a general description to capture
20 the basic idea of what's going on.
21 Q So that's not based on any specific practice?
22 MR. RAMER: Objection to the form.
23 A No, that's not true either. It's the -- you know,
24 the term itself is, you know, my own expression in
25 order to describe the situation. But the situation

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1 that I'm describing is, you know, quite concretely
2 real.
3 As I say, it's the -- I'm referring very
4 specifically to the removal of the safeguards that
5 were in place when the available data were first
6 gathered. And the reason why, that just because
7 we're -- that after removing those safeguards and
8 after removing the assessment procedures and so on,
9 that expecting different -- expecting the same
10 result after changing the -- after removing those
11 safeguards is what makes the current situation an
12 experiment, you know, without the knowledge of the
13 experimentees.
14 And I use the word hormones-on-demand to refer
15 to situations where -- and to clinicians who
16 believe that asking for hormones or medicalized
17 transition services is sufficient, and from that
18 point forward, the clinician's predominant duty,
19 now with only very rare exceptions, to find ways to
20 provide them. Rather than to accept it as one of
21 the possibilities, let's try the less potentially
22 risky ones first.
23 Q And what -- who are the social media voices?
24 A Oh, again, the ones whom I happen to run into
25 regularly. There's certainly no shortage of them,

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1 only because his name is forefront of my mind for
2 the moment, would be, for example, Jack Turban.
3 Q So you would consider Jack Turban to be a social
4 media voice?
5 A Yes, I think it would be fair to describe him that
6 way. I don't want to be unfair to him either. I
7 wouldn't say he's limited to being a social media
8 voice.
9 Q So you mean clinicians on social media?
10 A I would include clinicians on social media.
11 Q And you think that non-clinicians on social media
12 are relevant to your assessment of current clinical
13 practice?
14 MR. RAMER: Objection to the form.
15 A No, I wouldn't say that either. How I use that
16 phrase, and how I would still use that phrase,
17 really, is that that is the medium through which
18 one would run into, you know, such voices. I mean,
19 if one is looking to find, you know, how these
20 ideas are getting communicated, they're largely
21 getting communicated through social media.
22 It is hard to avoid the observation that it
23 was the onset of social media that changed, you
24 know, the public perception and treatment,
25 including professional treatment, of gender

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1 dysphoria is one of very many, very profound
2 changes that all started with identical timelines.
3 Among them is this sudden and exquisitely rapid,
4 literally exponential increase in rates of mostly
5 adolescents, mostly biological female reporting
6 gender dysphoria.
7 It's unfortunate, it is not helping that
8 generation at all. Gender dysphoria -- or that
9 enormous exponential increase in gender dysphoria
10 is only one of several dysphorias, all of which
11 have exponentially been increasing since the onset
12 of social media.
13 Q What are the other dysphorias?
14 A The other major ones are reports of depressions,
15 anxieties and, again, suicidality.
16 Q On page 91, paragraph 204 -- Joel never should have
17 given me control of this.
18 A Would it be inappropriate for me to say, oh, this
19 sounds like a significant other kind of a comment?
20 Q Okay. 204. Here, Doctor, you are talking about
21 sterilization without proven fertility preservation
22 options. You write, "Clinical guidelines for the
23 medical transition of gender among children include
24 the need to caution and counsel patients and
25 parents about what are euphemistically called

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1 'options for fertility preservation.'" And then
2 you cite the Endocrine Society Guidelines.
3 Is that -- did I read that correctly?
4 A That's that one sentence, yes.
5 Q Shouldn't clinicians counsel patients about options
6 for fertility preservation?
7 MR. RAMER: Objection to the form.
8 A Again, that's why I'm pointing it or was trying to
9 emphasize that what I'm pointing out is that
10 they're doing that euphemistically, where the term
11 they're using is sterilization, which is
12 essentially guaranteed for somebody who goes from
13 puberty -- or halted puberty with puberty blockers
14 to cross-sex hormones.
15 The very phrase "fertility preservation" works
16 under the assumption that you were fertile in the
17 first place. And the sequence of blocking puberty
18 and taking prepubertal gonads and putting them on
19 cross-sex hormones is the prevention of
20 ever-developing fertility. It's not preservation.
21 That's an adopting of the term -- adoption of
22 a term if, for example, a man with testicular
23 cancer is going to undergo chemotherapy, which,
24 again, would, you know, interfere with, if not
25 outright destroy, his ability to produce viable

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1 sperm. That would be a person who is fertile, and
2 we are trying to maintain, we're trying to preserve
3 his fertility. To say that --
4 Q So I understand that. This is a reference to the
5 clinical guidelines for medical transition
6 generally.
7 So taking aside puberty blockers, there are
8 fertility preservation options for persons who
9 undergo hormone therapy, are there not?
10 MR. RAMER: Objection to the form.
11 A Again, that to me is why I referred to this as
12 you've -- as a euphemism. There exists a range of
13 interventions and a range of their harms.
14 To pick the mildest phrase which describes the
15 mildest harm, and then generalize that to apply to
16 the entire range where the controversy is at the
17 other extreme where there is again sterilizing
18 these children, you know, we end up with a
19 situation where the terminology is being used in
20 accordance with the person's political or other
21 views rather than my automatic preference as a
22 scientist make the word -- make the phrase precise
23 and accurate.
24 And fertility preservation is amongst the
25 terms that is, again, being a euphemism and not

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1 accurately describing the risks and potential harms
2 in a way that would allow for a legitimate and
3 meaningful calculation of the risk-to-benefit
4 ratio.
5 Q But you don't think that counseling a patient that
6 there are no options for fertility preservation in
7 some instances, and then counseling a different
8 patient that there are some options for fertility
9 preservation in other instances is an appropriate
10 way to describe a range of medical intervention?
11 MR. RAMER: Objection to the form.
12 A I haven't seen a document that does that. I don't
13 believe the Henbury policy did that. It consisted
14 only of the use of the mildest terms.
15 I also think it's an error to use, again, an
16 all-encompassing term like patient. We are talking
17 a prepubescent child and having an adult
18 conversation about whether they want to have
19 children. That conversation is not comparable in
20 any meaningful way to a 30-year-old adult male,
21 with in this example testicular cancer, who is able
22 to come to an adult brain decision over children,
23 not children, the potential for his own future
24 fertility.
25 Asking a prepubescent that is using a global

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1 all-encompassing term like patient is another
2 example of obscuring the most, you know, severe and
3 dramatic of these situations using exactly the same
4 term that we should use, you know, in describing
5 the most mild of the range of issues and the
6 risk-to-benefit ratio.
7 Q In that paragraph you write, "The decision to
8 undergo medicalized transition also represents the
9 decision never to have biological children of one's
10 own."
11 Do you think that might be the most extreme
12 interpretation of a range of potential outcomes?
13 MR. RAMER: Objection to the form.
14 A Oh, again, the same. When somebody is giving one
15 extreme, I'm pointing that out to -- you know, I'm
16 red flagging it by pointing out the missing part of
17 the extreme, which requires me to name the missing
18 part of the extreme. The whole point is that this
19 is a wide range.
20 Q But someone who, say, undergoes a double mastectomy
21 can still have biological children of one's own?
22 MR. RAMER: Objection to form.
23 A The situation, at least in theory, can exist. But
24 there are no reliable numbers, I think either in
25 the U.S. or Europe, about the proportions and

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1 overlap of, in your example biological women,
2 undergoing mastectomy versus cross-sex hormones
3 versus puberty suppression.
4 Of course, you know, sterility and decisions
5 about the sterility being made by a prepubescent
6 brain comes from people who are on puberty blockers
7 pretty much as puberty starts and then going on to
8 cross-sex hormones.
9 Q So you're describing a subset of the people who
10 undergo medicalized transition in this sentence?
11 MR. RAMER: Objection to the form.
12 A Hang on, I was still stuck on the prior part.
13 Again, the sterility is for people who are on
14 puberty blockers followed by cross-sex hormones.
15 A biological female put on puberty blockers
16 and then put on cross-sex hormones doesn't develop
17 the breasts for which a double mastectomy would be
18 required in the first place.
19 Q So, I'm sorry, your phrase undergoing a medicalized
20 transition only refers to people who go from
21 puberty blockers to gender-affirming hormones?
22 MR. RAMER: Objection to the form.
23 A I didn't mean my sentence to be a complete review
24 of, you know, several different potential
25 combinations of the several different variables.

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1 Again, my purpose was to demonstrate that it
2 is inappropriate to the point of misleading for a
3 professional medical society of all groups to use
4 only the mildest and most euphemistic of language
5 ignoring -- again, in a document meant for
6 physicians, not meant for the patients themselves,
7 describing, you know, only the most optimistic
8 balance of risk-to-benefit ratio as opposed to
9 recognizing the full range of varying situations.
10 And, again, in the case specifically of the
11 Endocrine Society statement, in complete absence of
12 the consideration -- I shouldn't say complete
13 absence, but at the same time as failing to
14 integrate the large number of complete unknowns and
15 still unexplored alternatives before we get to the
16 most dramatic of the options.
17 Q I'm just trying to understand this sentence that
18 you wrote --
19 A I'm sorry.
20 Q -- which is, "The decision to undergo medicalized
21 transition also represents the decision never to
22 have biological children of one's own."
23 In that sentence, medicalized transition only
24 refers to patients who go from puberty blockers to
25 hormone therapy; is that right?

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1 MR. RAMER: Objection to form.
2 A No, my one sentence cannot be considered on its own
3 without the other sentences that I purposefully put
4 it together with.
5 Q So you're not willing to say -- you're not willing
6 to accept that someone who only undergoes a
7 mastectomy, for example, could still have
8 biological children of their own?
9 MR. RAMER: Objection to the form.
10 A In its context, my sentence doesn't contest that.
11 I'm filling in the missing pieces. So the one
12 sentence taking out just, you know, ends up leaving
13 different pieces missing. It takes the whole set
14 of them where I'm pointing out, you know, the
15 pieces of the puzzle are missing. So I'm alerting
16 the reader to the missing pieces.
17 Well, it's true that I am not alerting people
18 to the not missing pieces. I only need to alert
19 people to the missing pieces.
20 So the one sentence on its own is what, in my
21 view, is one of the missing pieces. There's no
22 purpose to that sentence to point out the pieces
23 that were already there to begin with.
24 Q Do you think that testosterone impairs fertility
25 for every natal female who takes it?

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1 A For everyone? No. The most -- the powerful
2 effect, the essentially sterilizing issue happens
3 with the combination -- that happens from the
4 combination essentially applying cross-sex hormones
5 to gonads that still have prepubertal cells.
6 Q Got it.
7 A So the automatic sterilization goes from the --
8 goes to people who essentially were going from
9 puberty blockers to cross-sex hormones without time
10 in between to develop adult quality viable gonad
11 tissue, that I don't remember if it was in this
12 report, but it was exactly that error for which I
13 was faulting several of the other experts, as they
14 report, you know, some of the relatively mild side
15 effects of one or the relatively mild side effects
16 of the other where the actual danger is in the
17 combination, and nobody mentions the combination.
18 Q Understood. Earlier you were talking about
19 prepubertal children making these decisions about
20 fertility, but in the United States it's their
21 parents consenting to treatment; right?
22 MR. RAMER: Objection to form.
23 A I don't think -- that doesn't really describe the
24 full sentence. It's not like the parents are
25 deciding -- the parents aren't talking with each

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1 other should we have grandchildren. The parents
2 are trying to figure out, you know, what would
3 help, you know, increase the mood or discomfort of
4 the profound unhappiness of their child.
5 And so, from their point of view, they're
6 doing their best to do what they think their kid
7 wants or what they imagine their kid would want or
8 will have wanted when the kid is later an adult and
9 looking back on the whole thing.
10 So the parents generally are trying to guess
11 what the kid would want is -- what the kids would
12 want. It's also, I think, unfair to describe the
13 parents' decision-making process as consent as if
14 it's a cognitive process, when the consent is in
15 the legal meaning they are providing on paper what
16 we deem to be consent. But it's a misleading use
17 of the term to equate legal consent with making the
18 kid's decision for the kid, when the basis of what
19 the parent's legal decision is going to be is their
20 best guess for what they think the kid would want
21 if the kid were an adult, which the kid isn't.
22 Q And that's the nature of pediatric medicine as a
23 general matter?
24 MR. RAMER: Objection to form.
25 A This isn't like pediatric medicine as a general

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1 matter. That's the whole problem. In pediatric
2 medicine in general, we have objective evidence of
3 an objective process for which we can give -- I'm
4 making this part up -- a blood test to verify that
5 the kid has -- you know, to use a usual example,
6 whatever intersex condition.
7 This is exactly the opposite condition. We
8 have zero objective evidence, only subjective
9 self-report from a prepubescent kid which conflicts
10 entirely with all of the available objective
11 evidence. That is entirely unlike the rest of the
12 pediatric medicine -- or that is entirely unlike,
13 if I can talk in italics, the process of general
14 pediatric medicine.
15 Q On page 109 --
16 A I'm there. Speak of the devil.
17 Q Okay. So this is in paragraph 259. You write of
18 Dr. Turban, "Dr. Turban's employment as director of
19 a gender program in child and adolescent psychiatry
20 represents a significant conflict of interest: The
21 income he derives from his medical treatment of
22 these children would be directly affected by the
23 outcome of this case."
24 Did I read that correctly?
25 A Those are the sentence -- that's the sentence I

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1 wrote, yes.
2 Q And Dr. Turban is a psychiatrist; correct?
3 A Yes, so far as I know.
4 Q And he is employed in a child and adolescent
5 psychiatry program?
6 A Yes. Is it up to a year yet? Recently, but, yes.
7 Q But you maintain that his income is derived from
8 endocrine treatments?
9 A Did I say endocrine?
10 Q You said his medical treatment. I don't know what
11 you're referring to there.
12 A I meant it relatively broadly. It's -- again, I
13 don't know details about how the specific hospital
14 works. But the usual procedure, and I don't recall
15 him ever pointing out an exception, is to engage in
16 these procedures as a multidisciplinary team.
17 As a psychiatrist, he would ultimately be
18 responsible for the mental health assessment or
19 lack of mental health assessments used in deciding
20 who would go on to endocrinological treatments.
21 And the endocrinologist would be responsible then
22 for ensuring the physical ability of the child to
23 respond to the medications as desired, but not the
24 decision whether to.
25 Q Do you think that everyone who works in a

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1 multidisciplinary gender clinic has a conflict of
2 interest in these cases?
3 MR. RAMER: Objection to the form.
4 A I don't see any way around the idea that when the
5 legality of providing a service is in question that
6 there is a conflict of interest for the people
7 providing that service.
8 Q Well, Dr. Turban doesn't provide any of the
9 services directly that are the subject of the
10 Indiana law; right?
11 MR. RAMER: Objection to the form.
12 A I don't know what director would -- I don't know
13 what you mean by direct. If one is in charge of --
14 I don't mean to equate the situations, but if one
15 is the manager of a McDonald's, just because you're
16 not serving the hamburgers doesn't mean that you
17 are not affected if they shut down the whole
18 restaurant.
19 Q So if they ban puberty blockers and hormones and
20 surgery, it's your view that not only are the
21 endocrinologists and the surgeons conflicted --
22 possessing a conflict of interest, but the
23 psychiatrists are as well?
24 MR. RAMER: Objection to the form.
25 A Yes, everybody involved in the provision of the

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1 service. And if the -- to the extent that the
2 provision of the service is multidisciplinary, and
3 he is the doctor -- he is the director directing
4 the entire process, he is ultimately responsible
5 for it.
6 And it would be that entire -- it would be the
7 entire service he is directing that would be
8 switching to the other use of the term directly
9 influenced by regulations and findings that limit
10 or ban or restrict the provision of that very
11 service.
12 Q So is it just the directors of the program or every
13 physician who works at a gender program?
14 MR. RAMER: Objection to the form.
15 A I don't think I necessarily need to allow for the
16 possibility that there could be an exceptional
17 situation that doesn't immediately come to mind,
18 but to -- it's I can't think of a situation in
19 which one can be a specialist in providing a
20 specialized service that -- for which one would not
21 be in a conflict of interest if that service is
22 prevented.
23 The only exceptions, and I'm not even sure
24 they count as exceptions, depending on -- again, in
25 different hospitals in the U.S. is the

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1 international outlier in this again, there can be,
2 or I can imagine there existing a situation in
3 which, for example, a nurse is simply assigned a
4 department. And if one department is restructured
5 or canceled, then he, she, or they are reassigned
6 to another clinic so that it's, you know,
7 relatively invisible to them, I can imagine the
8 possibility for certain circumstances like that.
9 I cannot imagine such a situation from the
10 person -- from a person legitimately holding the
11 title director.
12 Q Do you believe that the physicians who treat
13 patients at gender clinics would not have jobs if
14 puberty blockers and gender-affirming hormones were
15 banned?
16 A I would be surprised certainly if they became
17 unemployed. But, again -- but they would be, you
18 know, in any meaningful way highly impacted.
19 Q They couldn't practice other aspects of their
20 specialties?
21 MR. RAMER: Objection to the form.
22 A They would be forced to. As I say, they would be
23 impacted, but I would be surprised if they ended up
24 unemployed.
25 Q So their income wouldn't necessarily be impacted?

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1 MR. RAMER: Objection to the form.
2 A I don't think that fairly describes the situation.
3 It's -- I don't think that fairly describes the
4 situation, no.
5 Having one's means of income being required,
6 you know, against one's will to have to change what
7 one does for a living in order to maintain one's
8 income represents a significant conflict of
9 interest.
10 Q So based on that, are the only legitimate experts
11 those who do not treat adolescents with gender
12 dysphoria?
13 A That's --
14 MR. RAMER: Objection to form.
15 A That's a different question. And as I enumerated
16 within my report, it is a standard procedure in
17 producing a systematic review in order to get
18 people who do not have a direct interest in the
19 outcome of it.
20 And that's exactly how Vivienne Cass in the UK
21 was chosen. And that's how all of the other groups
22 in all of the other countries were selected. To
23 pick an odd example, if one wanted to know if
24 reading fortune tea leaves were scientifically
25 valid, you could not do it by asking only the

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1 fortune tea leaf readers.
2 One needs to be able to -- in order to be
3 without a conflict of interest, one needs to be one
4 step further away than receiving income from the
5 provision of the service in question.
6 Q So you believe Dr. Turban is biased because you
7 think his compensation is tied to a certain
8 clinical outcome?
9 MR. RAMER: Objection to the form.
10 A I don't think I said biased. I'm, you know,
11 acknowledging he's in a conflict of interest. The
12 nature --
13 Q So you -- okay. Go ahead. Sorry.
14 A The nature of his writings suggest that, you know,
15 he has very, very strong beliefs about the
16 situation. But, again, the term bias is for me to
17 engage in some mind reading that I'd hesitate to.
18 It is perfectly legitimate, and it's a matter of,
19 you know, objective evidence to indicate that this
20 is a legitimate conflict of interest.
21 Bias is more cognitive -- is a more cognitive
22 situation, which is, I think, a legitimate
23 accusation, but I couldn't say that I have an
24 objective means of demonstrating it unlike conflict
25 of interest.

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1 Q So you think that compensation can have an improper
2 influence on a clinician's perspective?
3 MR. RAMER: Objection to the form.
4 A That's not a reference to the proper audience. The
5 people who are in need of protection, and the
6 people who are meant to be protected by
7 conflict-of-interest principles are not the
8 providers of the service, but the recipients of the
9 service.
10 Q What are conflict-of-interest principles?
11 A Oh, I don't mean them -- as I said, I mean them
12 generically. If I were going to receive, you know,
13 any medical service, I expect of the institutions,
14 whether it's government or medical boards depending
15 on one's jurisdiction, that if I'm going to be
16 receiving what I expect to be evidence-based
17 medicine, I expect that evidence to be evaluated by
18 people other than the person actually providing me
19 the service.
20 If I knew that the only person reviewing my
21 provider was my provider, I would be in a very
22 different situation of confidence in making my own
23 healthcare decisions than if a person at arm's
24 length were in charge of reviewing the procedures
25 my provider provides.

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1 Q Do you think being paid by an advocacy organization
2 might have an improper influence on a clinician's
3 opinion?
4 MR. RAMER: Objection to the form.
5 A I can imagine situations where it would, and I can
6 imagine situations where it wouldn't. So I
7 wouldn't automatically -- it would be a legitimate
8 conclusion, but it doesn't have the automatic
9 people provided -- the quality of service provision
10 or the -- tenability's not the word. The safety
11 and effectiveness of providing a service has to be
12 conducted by people at arm's length from it.
13 If one is at a -- is in a position where one
14 is advocating a particular view, then it's
15 completely transparent that one is, you know, of
16 that view or advocating for whatever that situation
17 is.
18 That's entirely unlike healthcare where one is
19 expected to be -- expected and depended upon to be
20 entirely objective, but it's not -- the
21 expectations and the people who were meant to be
22 protected by it are of a different kind.
23 Q Were you aware that Indiana's expert, Daniel Weiss,
24 testified before multiple state legislatures in
25 favor of laws like SEA 480?

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1 MR. RAMER: Objection to the form.
2 A I'm not even sure who that is.
3 Q And that he was compensated by Do No Harm for that
4 testimony?
5 MR. RAMER: Objection to the form.
6 A Same, I don't think I know who that is.
7 Q Is that a conflict of interest to testify before a
8 state legislature regarding a law and be
9 compensated by an advocacy organization?
10 MR. RAMER: Objection to the form.
11 A I'm still missing a piece. I don't know who or
12 what it is that we're talking about.
13 Q Well, I don't think you even have to know who he
14 is. He's one of Indiana's experts in this case, an
15 endocrinologist. But he testified regarding a law
16 like SEA 480, and for that testimony was
17 compensated by Do No Harm, an advocacy
18 organization.
19 I'm just trying to understand under your
20 framework for conflict of interest, would that be
21 one?
22 MR. RAMER: Objection to the form.
23 A No, I don't think so. Acting in a political
24 capacity advocating for a political view doesn't
25 have the same expectations of neutrality as would a

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1 physician -- as a patient coming to a physician
2 expecting to receive objective feedback and advice
3 from the physician.
4 In a governmental situation, there will --
5 there would generally be people advocating on one
6 side, people advocating on the other side. And the
7 influence of whatever money for whatever decision
8 it is, is almost, I don't know how cynical -- one
9 could be -- it would be perfectly fair to be
10 cynical. But that is not the same decision-making
11 process or position of vulnerability that a patient
12 has in expecting the advice they get from their own
13 doctors to be.
14 Q So is the conflict of interest you describe with
15 respect to Dr. Turban about a conflict of interest
16 with his patients, not as an expert in this case?
17 MR. RAMER: Objection to the form.
18 A The conflict I'm referring to is the combination of
19 them.
20 Q Page 124 --
21 MR. RAMER: Hey, Chase, we've been going
22 for --
23 MR. STRANGIO: So the question I have is, I'm
24 close to the end. Do you want to sort of go 20
25 more and try to wrap it up, or do you want to take

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1 a break and then finish? We can take a break, I
2 can check in with my side, and then we'll just
3 finish up after the break?
4 MR. RAMER: I'd appreciate the break.
5 MR. STRANGIO: Yeah, yeah, yeah, let's do it.
6 Let's do it. I was trying to get us done, but
7 understood.
8 MR. RAMER: No, I appreciate that, too.
9 MR. STRANGIO: Yeah, it's fine. It's fine.
10 Five minutes?
11 MR. RAMER: Works for me.
12 Doctor?
13 THE WITNESS: Okay. See you in five.
14 (A recess was taken.)
15 BY MR. STRANGIO:
16 Q Okay. I'm on page 124, paragraph 299 regarding
17 Dr. Shumer, you write, "Despite his use of dramatic
18 terms, Dr. Shumer is not a mental health expert
19 qualified to assess mental health outcomes, and he
20 cites no evidence to justify any predictions of
21 suicidality or other predictions of outcomes."
22 Did I read that correctly?
23 A Yes.
24 Q Do medical doctors not typically assess their
25 patient's mental health?

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1 A Not in the manner -- not in that manner, no.
2 Again, not -- they're generally, unless they have
3 specific training, again, specifically for
4 assessment of such mental health concerns, it tends
5 to be limited to what a brief screening and
6 standardized questions of, in general, things to be
7 on the lookout for. But that's not the context or
8 situation that he's describing or -- that he's
9 describing period -- semicolon. Nor is it the
10 basis for predicting what future situations that do
11 not currently exist will bring, you know, on the
12 basis of no evidence whatsoever.
13 Q And in the previous paragraph you write,
14 "Dr. Shumer's report provides a highly misleading
15 discussion of the risks of GnRH agonists and
16 cross-sex hormones."
17 Did I read that correctly?
18 A Yes.
19 Q And are you an endocrinologist qualified to make
20 assessments of the risks of GnRH agonists and
21 cross-sex hormones?
22 MR. RAMER: Objection to the form.
23 A That statement doesn't require an endocrinological
24 background.
25 Q Do you use social media?

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1 A A little bit.
2 Q Twitter as we've been discussing?
3 A Yeah, I try to keep it to roughly, you know, a
4 tweet or two a day. Usually I'm working on
5 something else and it occurs to me, oh, people
6 would be interested to hear that and I'll post it,
7 or there's a precious pithy thing that, ooh, that
8 kind of crystallizes it, so I'll release that.
9 Q And is your handle @JamesCantorPhD?
10 A Yes, that's correct.
11 MR. STRANGIO: Can we pull up what's marked as
12 Exhibit 11.
13 BY MR. STRANGIO:
14 Q On February 23 of this year, do you recall
15 tweeting, "The only ones who crave affirmation more
16 than trans teens are their doctors"?
17 A I recall that tweet, yes.
18 Q What did you mean by that?
19 A The interactions that I've had with them, with the
20 ones who in turn discuss or refuse to discuss the
21 relevant issues on social media are unlike the
22 healthcare providers I interact with in any other
23 aspect of human sexuality and unlike the scientists
24 I interact with on any other issue. There's much,
25 much less discussion of the content and much, much

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1 more discussion of how it's going to look.
2 Q And when you're talking about the interactions,
3 you're talking about interactions on social media?
4 A Not just. Of course, you know, it is exactly
5 because the bar for entry into social media is so
6 low that, you know, the proportion of the publicly
7 available statements, it takes up so much more than
8 it. But, no, it's not limited to social media.
9 Q Do you think that doctors who treat transgender
10 adolescents are doing so for reasons other than
11 concern for their patients?
12 MR. RAMER: Objection to the form.
13 A As happy as I am to call out what I think is an
14 unhealthy influence of one's personal
15 characteristics in one's professional practice, I
16 wouldn't dichotomize it either.
17 I would not say as a general rule that -- I do
18 believe, or I have every reason to believe, that
19 they genuinely believe that they are helping, but
20 the set of cases, situations, willingness to take
21 on risks, willingness to disagree with a popular
22 idea in the face of evidence suggests that there
23 is, as I say, an unhealthy or disproportionate
24 balance of the several inputs and motivations to
25 behavior.

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1 And, again, I don't mean to isolate people
2 involved with this issue versus rest of world so
3 much as I've been involved with very many, you
4 know, controversial issues. That's not only the
5 nature of sex research, but it's the nature above
6 all the other branches, even of sex research, it's
7 much more a part of the study and of atypical
8 sexualities.
9 So relative to other care providers and other
10 scientists involved with providing professional
11 care to people with other atypical sexualities, the
12 cluster of personalities, the type of conversations
13 that are had and not had, the unwillingness to
14 respond to the most legitimate, even published
15 criticisms, this group of people are unlike those
16 working in any other area of atypical sexuality.
17 Q And what is -- who is this group of people?
18 MR. RAMER: Objection to the form.
19 A People publicly advocating. I really want to say
20 extremists, I think I want -- I have a hard time
21 finding a different word than extremists, but
22 people with an un -- with a disproportionate
23 conviction of what they're doing is correct without
24 having balanced it against the enormous number of
25 unknown potential alternatives -- or potential

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1 alternatives.
2 Q And is that description one that you would apply to
3 all doctors that treat trans teens?
4 MR. RAMER: Objection to the form.
5 A No, I would automatically hesitate to -- I would
6 automatically -- I would reflexively refuse to --
7 Q What about would you apply that description to most
8 doctors that treat trans teens?
9 MR. RAMER: Objection to the form.
10 A I don't think there's a meaningful way -- no, I
11 would have to couch it more than that. Again, I'm
12 speaking, you know, on social media referring to
13 the other people involved in the discussion on
14 social media. And today, more than ever, the
15 number of people that -- I think I was making this
16 point earlier, that people with relatively moderate
17 or relatively balanced or nuanced perspectives are
18 silencing themselves for fear of being attacked by
19 either extremists on one side or extremists on the
20 other side for not being far enough to that given
21 extreme.
22 So it's because they've self-silenced. Again,
23 outside of the people who were speaking publicly,
24 and I mean to be speaking of the people who are
25 speaking publicly, I would not reflexively

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1 generalize that to people who are keeping quiet --
2 publicly quiet.
3 Q Including those people who are keeping quiet
4 publicly and continuing to treat adolescents with
5 gender dysphoria with medical interventions?
6 MR. RAMER: Objection to the form.
7 A Well, again, the continuing to treat is to assume
8 that there was a baseline against which to compare
9 them that doesn't exist. This really wasn't
10 getting done in the way and by the numbers of
11 people and without the supervision or tracking or
12 external review that --
13 Q I wasn't referring to the temporal in the way
14 you're responding. I just meant someone who's
15 currently prescribing, let's say, gender-affirming
16 hormone therapy to adolescents but isn't speaking
17 publicly on the matter.
18 Would this tweet apply to them?
19 MR. RAMER: Objection to the form.
20 A No. Again, I pretty much mean it to be people who
21 were speaking -- other people who were
22 participating in the same forum.
23 Q And so, when you refer to extremists, are
24 extremists those who support the provision of
25 hormone therapy to adolescents with gender

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1 dysphoria?

2 MR. RAMER: Objection to the form.

3 A Not necessarily. There are -- what's missing are

4 the people who merely support. There are very --

5 there are few speakers who merely support.

6 The people I would call extremists would be

7 those for whom there exists no alternative. There

8 is that -- the person asked for it has sufficient

9 basis to do everything you can to make sure that

10 they get it. Rather than cover bases, let's try

11 other things first. Let's not start with the most

12 dramatic of alternatives. Let's skip all of the

13 many unknowns and we're not so sure and use it as

14 a method of first resort. And any resistance is

15 immediately dismissed as politically anathema

16 rather than we're not so sure, let's be more

17 careful until we can be more sure.

18 Q Is the Endocrine Society Clinical Practice

19 Guideline on treatment of gender dysphoria with

20 respect to adolescents an extremist's position?

21 MR. RAMER: Objection to the form.

22 A I don't have an objective way to differentiate

23 extremists from going farther than it should

24 relative to the quality of evidence available.

25 Q Have you treated any of the individual plaintiffs

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1 in this case?

2 A No, I have not.

3 Q Have you ever practiced as a clinical psychologist

4 in Indiana?

5 A No, I have not.

6 Q And do you have any personal knowledge of how

7 treatment for gender dysphoria is provided to

8 adolescents in Indiana?

9 A Not in any direct way. Again, the nature of my

10 expertise is not the specifics of the policy or the

11 patients involved, but on the science according to

12 which the legal system and legislatures are

13 attempting to establish policy.

14 MR. STRANGIO: Just one sec. I'm going to --I

15 don't have anything else on my end.

16 THE WITNESS: That was a fast 20 minutes.

17 MR. STRANGIO: So I'll pass -- it was slightly

18 less. I'll pass the witness.

19 MR. RAMER: And I have no questions for the

20 witness. And we'd just like to review and sign.

21 AND FURTHER THE DEPONENT SAITH NOT.

22

23 _____

24 JAMES M. CANTOR, PH.D.

25

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1 STATE OF INDIANA)

2) SS:

3 COUNTY OF BOONE)

4 I, Dana S. Miller, RPR, CRR, a Notary Public in

5 and for the County of Boone, State of Indiana at

6 large, do hereby certify that JAMES M.

7 CANTOR, PH.D., the deponent herein, was by me first

8 duly sworn to tell the truth, the whole truth, and

9 nothing but the truth in above-captioned cause.

10 That the foregoing deposition was taken on

11 behalf of the Plaintiffs, appearing remotely from

12 Toronto, Canada, on the 7th day of June, 2023,

13 pursuant to the Applicable Rules.

14 That said deposition was taken down in

15 stenograph notes and afterwards reduced to

16 typewriting under my direction, and that the

17 typewritten transcript is a true record of the

18 testimony given by said deponent; and thereafter

19 presented to said deponent for his/her signature;

20 That the parties were represented by their

21 aforementioned counsel;

22 I do further certify that I am a disinterested

23 person in this cause of action; that I am not a

24 relative or attorney of either party, or otherwise

25 interested in the event of this action, and am not

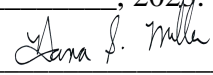
in the employ of the attorneys for either party.

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1 IN WITNESS WHEREOF, I have hereunto set my hand

2 and affixed my notarial seal this _____ day of

3 _____, 2023.

4 

5 _____

6 Dana S. Miller

7 Commission Number 0675790

8 My Commission Expires:

9 January 17, 2024

10

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12

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25

1 (Originating Party)
2 Chase Straffio, Esq.
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6 New York, NY 10004

7 NOTICE OF DEPOSITION FILING
8 UNITED STATES DISTRICT COURT
9 SOUTHERN DISTRICT OF INDIANA
10 INDIANAPOLIS DIVISION
11 CASE NO. 1:23-cv-00595-JPH-KMB

12 K.C., et al.,)

13 Plaintiffs,)

14 -vs-)

15 THE INDIVIDUAL MEMBERS OF THE)
16 MEDICAL LICENSING BOARD OF)
17 INDIANA, in their official)
18 capacities, et al.,)

19 Defendants.)

20 In compliance with the Indiana Rules of
21 Procedure, Federal Rules of Civil Procedure and/or
22 the Rules of the Industrial Board, you are notified
23 that the signed original deposition of JAMES M.
24 CANTOR, PH.D., taken on the 7th day of June, 2023,
25 has been sealed and submitted to the originating
party, along with the attached Errata Sheet(s), if
applicable.

26 ~~(Date received by Circle City Reporting)~~

27 CIRCLE CITY REPORTING
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30 Indianapolis, IN 46204
31 (317) 635-7857

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1 MS. EAGAN: No, Your Honor.

2 THE COURT: All right. State's case.

3 MR. DAVIS: Your Honor, the State calls Dr. James
4 Cantor when you are ready.

10:39:28 5 THE COURT: I'm ready.

6 JAMES CANTOR, MD,

7 having been first duly sworn by the courtroom deputy clerk, was
8 examined and testified as follows:

9 DIRECT EXAMINATION

10:39:46 10 BY MR. DAVIS:

11 Q Good morning, Dr. Cantor.

12 A Good morning.

13 Q Would you state your full name?

14 A James Michael Cantor.

10:40:02 15 Q What is your profession, Dr. Cantor?

16 A I am a clinical psychologist and neuroscientist.

17 Q What degrees do you have? Academic degrees.

18 A Bachelor's degree in computer science and mathematics, a
19 master's degree in applied psychology, and a Ph.D in clinical
10:40:17 20 psychology.

21 Q Where do you work?

22 A I am currently in private practice in Toronto, Canada.

23 Q And what is the nature -- are there any particular focuses
24 of the counseling you provide or the research that you have
10:40:32 25 performed?



1 A Human sexuality and atypical sexualities.

2 Q Would that include studies of gender identity?

3 A Yes, it is. Yes, it does.

4 Q Are you knowledgeable about the research surrounding
10:40:47 5 gender dysphoria?

6 A Yes, I am.

7 Q Have you analyzed research concerning the benefits and
8 harms of different ways of treating gender dysphoria?

9 A Yes, I have.

10:40:54 10 Q Do you have skills and expertise assessing the strengths
11 and weaknesses of scientific studies?

12 A Yes, I do.

13 Q And do these skills and expertise include judging what
14 those studies do and do not prove as a matter of science?

10:41:13 15 A Yes.

16 Q Have you treated people who presented with gender
17 dysphoria?

18 A Yes.

19 MR. DAVIS: Your Honor, we proffer Dr. Cantor as an
10:41:25 20 expert on psychology, human sexuality, research methodology,
21 and the state of the research literature on gender dysphoria
22 and its treatment.

23 THE COURT: Any objection?

24 MS. EAGAN: No, Your Honor.

10:41:37 25 THE COURT: All right. He will be accepted for that

1 purpose.

2 BY MR. DAVIS:

3 Q Dr. Cantor, there is a notebook in front of you with a
4 blue cover. Would you please turn to the second tab?

10:41:51 5 A I'm sorry. It just occurs to me I didn't bring my reading
6 glasses. They're in my brief case.

7 MR. DAVIS: Your Honor, can the witness get his
8 glasses?

9 THE COURT: Absolutely.

10:42:43 10 THE WITNESS: Part 2, you said?

11 BY MR. DAVIS:

12 Q Yes. Tab 2, which is Defendants' Exhibit 2.

13 Can you identify that document, Dr. Cantor?

14 A Yes. That is my report, which I submitted for these
10:42:54 15 proceedings.

16 Q Thank you.

17 I think actually, since we just heard Dr. Antommara, I
18 would like to begin with addressing some things that we heard
19 this morning.

10:43:02 20 Did you have the opportunity hear this morning's testimony
21 by Dr. Antommara?

22 A Yes, I did.

23 Q Did you understand Dr. Antommara to testify that randomly
24 controlled studies are not available in this area of medicine?

10:43:16 25 A Yes.

1 Q Did he then say, if you understand -- as you understand,
2 that because the randomly controlled trials are not available,
3 we can rely on observational trials?

4 A That is roughly what I understood him to say, yes.

10:43:33 5 Q Do you have any response to that?

6 A Yes. That's not -- it is true that none of the existing
7 studies are randomized, but it is entirely untrue that we
8 therefore can rely -- can make decisions based on the least
9 reliable kinds of studies.

10:43:48 10 There is a wide, wide range of studies in between, and
11 there's a wide, wide, range of different scientific
12 methodologies that we can employ in order to minimize the laws
13 that we get from completely randomized studies.

14 It's also actually possible if we wanted to conduct such
10:44:09 15 studies such as by allowing people to undergo different parts
16 of a treatment at different times, so we can compare the
17 differences between them when one group has started on that
18 type of treatment and the other hadn't yet.

19 Q Okay. So the randomized trials would be considered like
10:44:29 20 the gold standard, the top-tier level of scientific research?

21 A Randomization is one factor in determining how high
22 quality a study is. It is not a -- it's neither an all or
23 nothing.

24 Q I understand. But did I understand you to say that if you
10:44:47 25 assume that's not available, that's no reason to drop down to

1 the lowest quality of evidence?

2 A That is correct.

3 Q I understood Dr. Antommaria to testify that the level of
4 evidence supporting the WPATH and Endocrine Society guidelines
10:45:05 5 is comparable to the level of evidence supporting other
6 treatments in pediatrics. Can you respond to that?

7 A I am not aware, of course, of all the other treatments in
8 pediatrics. However, there are no studies yielding positive
9 effects of either the Endocrine Society standards or the WPATH
10:45:24 10 standards.

11 The studies which have shown effects have used the Dutch
12 model, which uses a higher set of standards than either the
13 Endocrine Society or the WPATH group.

14 Q Speaking of the Dutch study, I also understood
10:45:42 15 Dr. Antommaria to say there is no high quality evidence
16 supporting the use of psychotherapy alone for gender dysphoria.
17 Do you agree with that?

18 A No, I do not.

19 Q What would you say in response? What's the countervailing
10:45:56 20 evidence?

21 A There exists roughly 15-ish studies following up these
22 kids at all. All of the studies, which without exception that
23 used medical interventions also used psychological --
24 psychotherapy at the same time. So all of the studies which
10:46:17 25 could seem to show a benefit for medical interventions are

1 unable to distinguish that it was the medical intervention
2 causing the benefit, versus the psychotherapy causing the
3 benefit.

4 Of those studies, two were designed in a way that it was
10:46:33 5 possible to peel apart the effects of psychotherapy versus
6 medicine -- the Costa study and the Achille study. The full
7 references are in my report.

8 In the Costa study, there was a -- there were two phases.
9 There was a phase that people went through when they received
10:46:52 10 psychotherapy alone. And then in the subsequent phase, they
11 received both psychotherapy and medical interventions.

12 There were no significant differences between the group.
13 Both groups improved, and there were no significant differences
14 between the group that received psychotherapy alone and the
10:47:08 15 group that received psychotherapy plus medical interventions.

16 The other study, the Achille study, used a statistical
17 method to control for the effects of psychotherapy. That group
18 also improved after medical intervention, but when the effects
19 of psychotherapy were statistically controlled, there was no
10:47:28 20 additional benefit of the medical interventions after that.

21 Q I want to break some of that down. You mentioned studies
22 where all the participants were receiving both psychotherapy
23 and medical-affirming care at the same time, right?

24 A Correct.

10:47:48 25 Q Is that the Dutch -- oh, is the Dutch protocol, the Dutch

1 study an example of such a study?

2 A Both Dutch studies, the 2011 and the 2014, yes.

3 Q If, at the end of that trial, you look and see the people
4 that were receiving both psychotherapy and medical-affirming
10:48:06 5 care at the same time, improved in mental health at the end of
6 the trial, can you as a scientist tell whether the improvement
7 is the result of the pharmaceuticals or the psychotherapy?

8 A Not in the design of those studies, no. That's what in
9 science is called a confound.

10:48:27 10 Q Confound?

11 A Correct.

12 Q What does that mean, confound?

13 A It describes exactly that situation. When two things are
14 done at once, when you see the result, you can't peel apart
10:48:37 15 which -- which of those two interventions was responsible or
16 the interaction between those two interventions was
17 responsible.

18 Q Okay. But the Costa and Achille study, on the other hand,
19 they do provide scientific evidence that psychotherapy alone is
10:48:53 20 helpful, did --

21 A That's correct.

22 Q Okay.

23 A That psychotherapy is helpful and not the medical
24 interventions.

10:49:01 25 Q I also understood Dr. Antommaria to say that he had not

1 read studies about detransitioning. But if it ever became
2 relevant, he would make an effort to review such studies.

3 You are familiar with the body of the literature
4 concerning gender dysphoria, correct?

10:49:21 5 A Yes.

6 Q In your opinion, are the studies of detransitioning
7 relevant to someone trying to assess the benefits and harms of
8 these treatments?

9 A Yes, of course. It's very difficult -- detransition would
10:49:35 10 be the situation that one is trying to avoid. The best way to
11 avoid a situation is to understand that situation.

12 Q Dr. Antommaria said that there are prospective
13 observational trials that demonstrate the efficacy of puberty
14 blockers in gender-affirming care, and then later said the
10:49:59 15 trials he is referring to were primarily the Dutch group
16 studies.

17 Are those the studies you just mentioned, the 2011, 2014
18 studies?

19 A Those are the Dutch studies that usually we use. I can't
10:50:12 20 know if he is referring to some other study that I didn't make
21 a specific reference to.

22 Q That's fair.

23 In this area of medicine, when someone's talking about the
24 Dutch studies, the Dutch group studies, is it your
10:50:25 25 understanding they're generally referring to these 2011 and

1 2014 studies from the Dutch project?

2 A Almost always, yes.

3 Q Okay. And those are the studies you just mentioned that
4 have the confound problem, right?

10:50:36 5 A Correct.

6 Q You can't unpack whether it's the psychotherapy or -- not
7 from that study, you can't unpack whether it is the
8 psychotherapy or the pharmaceuticals that are making the
9 difference?

10:50:47 10 A That's correct.

11 Q Okay. More generally, I'd like to read for you a
12 statement from the plaintiffs' brief in support of their
13 preliminary injunction motion.

14 For the record, it's Doc 8 at page 18.

10:51:07 15 Dr. Cantor, the plaintiffs wrote in that brief, For more
16 than four decades, medical organizations have studied and
17 created an evidence-based standard for the medical treatment of
18 transgender patients. This standard confirms that transition,
19 including puberty blockers and hormone therapy where
10:51:26 20 appropriate, is the only safe and effective treatment for
21 gender dysphoria?

22 Dr. Cantor, does the research literature support that
23 statement?

24 A No, it does not.

10:51:37 25 Q Do you understand the plaintiffs primarily to be pointing

1 to the guidelines of medical organizations such at WPATH and
2 the Endocrine Society and the American Academy of Pediatrics to
3 support their positions that wish to continue giving these
4 treatments to children?

10:51:52 5 A Yes. They cited those repeatedly.

6 Q Okay. What observations have you had about the WPATH
7 guidelines and whether they have support in evidence?

8 A The WPATH guidelines and the Endocrine Society guidelines
9 have been tested among the set of -- as I say, roughly 15
10 outcome studies, some of them have used the WPATH guidelines or
11 Endocrine Society guidelines instead of the Dutch protocol.
12 And those studies demonstrated that there was no improvement at
13 all.

14 I shouldn't say none at all. One of them used several
10:52:36 15 kinds of measures of improvement, and I think it was all but
16 one demonstrated no differences at all. And one small one gave
17 an indication that suggested the possibility.

18 Q Have these organizations acknowledged anything about
19 desistance rates -- these organizations, I'm referring
10:52:57 20 specifically to WPATH and the Endocrine Society?

21 A I can't say that they've never addressed it, but to the
22 extent if it was ever addressed, they are grossly, grossly
23 minimized.

24 Q Can I refer you to paragraph 12 of your report on page 4?

10:53:33 25 A I got it.

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1 Q You say in that paragraph that the plaintiffs'
2 documentation -- and I assume by documentation, you mean
3 their -- the pleadings in this case and the briefs that you had
4 seen?

10:53:50 5 A That's correct.

6 Q You said the plaintiffs' documentation misrepresents the
7 contents of the associations' policies themselves.

8 Which associations were you speaking of there?

9 A They mentioned several other societies which made short
10:54:04 10 statements in general support of sexual diversity, but without
11 actually issuing specific standards about how to treat people
12 in that community with what or at what ages.

13 Q And what inconsistencies did you see between what those
14 organizations have said and the arguments you saw in
10:54:23 15 plaintiffs' briefing?

16 A The plaintiffs referred to the societies as if they were
17 providing very specific support for very specific policies
18 rather than general recommendations to provide, for example,
19 respect and values for diversity, but no specific guidelines.

10:54:48 20 Q Okay. Well, looking at paragraph 12, is one of your
21 points here looking at the bullet points that even WPATH and
22 Endocrine Society acknowledge as you write, that desistance of
23 gender dysphoria occurs in the majority of prepubescent
24 children?

10:55:04 25 A That is correct.

1 Q And then turning the page, were there other issues you saw
2 that the statements -- that these organizations believed and
3 plaintiffs' briefing was inconsistent with what the
4 organizations had stated?

10:55:16 5 A That the issue of mental health and that mental illnesses
6 and similar concerns need to be resolved before considering
7 transition rather than depending on transition to be the
8 resolution of, for example, depression and anxiety.

9 Q And have any of these organizations acknowledged that
10:55:42 10 puberty-blocking medication is an experimental not a routine
11 treatment?

12 A Yes, they have used that phrase.

13 Q Which organization?

14 A Again, I would have to look up to see exactly who used
10:55:52 15 which word. I believe it was WPATH, but I again have to go
16 back and check to make sure that it was they.

17 Q And let's turn to the American Academy of Pediatrics. And
18 I will refer you to your appendix.

19 And, Dr. Cantor, if you look at the top of the page, you
10:56:12 20 will see a line of blue figures. And it's page X out of 106.
21 The appendix I am referring to is page 100 out of 106.

22 A Got it.

23 Q What does the American Academy of Pediatrics or AAP, what
24 do they recommend in this area of care?

10:56:42 25 A They recommend what I can best describe as affirmation on

1 demand.

2 Q Okay. Did you review their recommendation when it came
3 out?

4 A Specifically I reviewed the sources on which they based
10:56:58 5 their recommendations.

6 Q Okay. Did you write about that?

7 A Yes, I did.

8 Q And does that appear as an appendix to your report
9 beginning at page 100 of that pdf?

10:57:09 10 A That is correct. I summarized all of my comments. I
11 submitted them to a journal where they underwent peer review.
12 And it's an official published peer-reviewed paper.

13 Q This is not a letter to the editor?

14 A That is correct. This is part of a scientific -- now part
10:57:22 15 of the scientific literature.

16 Q What did you comment upon?

17 A I really just checked what the authors of the AAP policy,
18 Dr. Rafferty, what their claims were, what they said was in
19 their references versus what was actually in their references.

10:57:43 20 And not only did their sources not contain what they were
21 alleged to have obtained, they often contained the very
22 opposite of what the AAP policy said they contained.

23 Q Did you have an agenda to disprove -- to prove or disprove
24 anybody when you undertook that review of the evidence?

10:58:01 25 A I wouldn't say an agenda other than to set the record --

1 pardon the pun -- straight.

2 This was a situation where these sources I had known for
3 many years. I had read them when they had first come out.

4 And when AAP came out with its policy, I was stunned by
10:58:21 5 its content. And as I read what they were basing it on, my
6 recollection was immediately this is not what those sources
7 said.

8 So immediately I just started double checking myself. Did
9 I misread something? Am I misremembering something?

10:58:36 10 And as I just checked in my own files with copies of these
11 papers -- most of these papers already in it, my memory was
12 correct. They said as -- the kinds of things I recalled them
13 to be saying.

14 Because we were now talking a major medical association
10:58:51 15 rather than an individual other scientist. This was different
16 from just one scientist like me disagreeing with another
17 scientist. This was now -- now had the potential to cause a
18 great deal of damage to a great number of people.

19 So because I had the ability to do it, I simply summarized
10:59:11 20 the contents of the original paper and contrasted point by
21 point the claims being made by AAP and simply quoting verbatim
22 what was in the original studies.

23 That entire thing was published, and the AAP has never
24 responded. They were approached by the media, and they just
10:59:33 25 would refuse to talk even to the media. They have yet to have

1 any response.

2 Q So to date, the AAP has not responded to the criticisms
3 that you raised?

4 A That is correct.

10:59:42 5 Q I will refer you now to page 6 of your report. Going by
6 the numbers at the bottom of the pages.

7 A Yep.

8 Q As you noted in your review of the plaintiffs' expert
9 report -- well, first off, did you review the expert reports
11:00:08 10 submitted by the plaintiffs by Dr. Hawkins and Dr. Ladinsky?

11 A Yes, I did.

12 Q And did you note that they studied a 2016 Olsen study
13 claiming that it proves that transition reduces the risk of
14 mental illness? That that was their claim?

11:00:23 15 A Correct.

16 Q Does the Olsen study show that?

17 A Just referring to my own report. Ultimately, no, it did
18 not. There was several statistical errors in the Olsen study.
19 The data were obtained then by the -- they -- upon request, and
11:00:45 20 Olsen provided their data to another author who reanalyzed -- I
21 should say, correctly analyzed the Olsen data, who demonstrated
22 that Olsen's data did not contain evidence of improvement. In
23 fact, it contained evidence of deterioration.

24 Q So in your opinion, does the 2016 Olsen study support
11:01:04 25 plaintiffs' position that children need these affirming --

1 these medicalized affirming treatments in order to improve
2 their mental health?

3 A No, it does not. Making such a claim is a half truth. It
4 would ignore the subsequent entries in the scientific
11:01:20 5 literature.

6 Q And what about the de Vries study that plaintiffs cited in
7 which you address on page 9 of your report? And does it show
8 that medical transition of minors improves mental health?

9 A No. It contains part of the confound. The de Vries study
11:01:43 10 as part of a Dutch group also included psychotherapy during
11 transition. So it is not possible to differentiate which type
12 of therapy, medical or psychotherapy, is responsible for the
13 benefits reported in that study.

14 Q I see. So participants in that study did have improved
11:02:00 15 mental health, correct?

16 A Yes.

17 Q But it's just not possible scientifically to tell what
18 caused the improvement?

19 A Correct.

11:02:06 20 Q And what about the Greene and Turbin studies plaintiffs'
21 experts cited which you discuss in paragraph 24 of your report?

22 A Yep.

23 Q Do those studies show that medical transition improves
24 mental health?

11:02:25 25 A No, they do not. These are retrospective correlational

1 studies. They are not able of describing any causal effect
2 coming to any causal conclusion.

3 Q Okay. Now, you mentioned there that -- you say this very
4 pattern is what one would predict from clinical gatekeeping.

11:02:43 5 What do you mean by clinical gatekeeping?

6 A One of -- across the various clinical standards are to
7 prevent somebody with mental illness from undergoing
8 transition. So such people are being held back. They're being
9 filtered out of groups who do undergo transition.

11:03:03 10 So when a clinic then compares the people who underwent
11 transition to the people in their files who did not undergo
12 transition, they are necessarily comparing a group of people
13 from whom the mental illness was removed and comparing them to
14 a group of people from whom the mental illnesses were not
11:03:22 15 removed.

16 So when you see better mental health amongst the people
17 who had transitioned, the improvement is not because of the
18 transition, the improvement is because you have removed the
19 people with the worst mental health from the group in the first
11:03:40 20 place.

21 Q Okay. So is it correct, then, that one thing you might
22 see in these studies is by picking out the people with the best
23 mental health, and giving them the treatment, then comparing
24 them to the people with lower mental health, then, of course,
11:03:57 25 the people who went through the study would do better?

1 A That is correct.

2 Q Did you review any of the other studies that plaintiffs
3 have submitted into evidence such as the Allen study, the
4 Turban articles, the Biggs (phonetic) study, the Lopez de Lara
11:04:24 5 study, Tordoff?

6 A Yes, I have.

7 Q Do you have any comments on those studies and whether they
8 support plaintiffs' position?

9 A They suffered from the same methodological problems as the
11:04:35 10 other studies.

11 Q Did any of those studies support the position that medical
12 transition improves mental health?

13 A No, they did not.

14 Q In minors with gender dysphoria?

11:04:47 15 A Correct. No, they do not.

16 Q Oh. What has been called the Yale study by Brouware,
17 B-R-O-U-W-A-R-E, was the first named author. Did you review
18 that one?

19 A Yes, I did, but it wasn't a study.

11:05:07 20 Q What was --

21 A Apparently, that was a report submitted by those authors
22 for another -- or for a combined set of court cases.

23 Q Okay. But you would not refer to that document as a
24 scientific study?

11:05:21 25 A From the Yale group with -- again, the name I don't -- I

1 hesitate to try to pronounce, but, no, it was not a study at
2 all. It was those authors' report reviewing the literature and
3 providing their opinions.

4 Q Okay. As a matter of fact, Dr. Ladinsky was asked about
11:05:39 5 that study yesterday. And for the record, that testimony
6 appears on page 116 of the rough transcript.

7 The question was: In this document, do the authors also
8 cite a number of peer-reviewed studies that contradict some of
9 the supports or the principles that the State articulated as
11:06:00 10 the reasons for SB 184? And Dr. Ladinsky responded, They do, a
11 considerable compendium of them.

12 Is she right? Did those authors show that there are
13 studies that contradict the State's position in this case?

14 A There was such a statement. There was no meaningful way
11:06:21 15 to try to put together what claim went together with what
16 source. Rather than -- what's done more typically either in
17 science or in pause, best as I understand, is here the claim
18 and here is the source justifying it. Here is next claim, here
19 the source justifying it.

11:06:38 20 Instead, that document made a long series of unsourced
21 claims and then provided a long series -- a series of very
22 large footnotes with 20 and 30 references. And there was just
23 no way to see what fact was alleged to have come from what
24 source.

11:06:56 25 Q So we've talked about whether the literature the

1 plaintiffs' -- the studies that plaintiffs cite to support
2 their position. Let's talk about whether the literature
3 supports the State's position. But a little background first.

4 Could you describe from your review of the literature just
11:07:17 5 what's the difference between adult onset gender dysphoria,
6 child onset, and adolescent onset? And I know this is a broad
7 question, but I just mean like age groups.

8 A Usually we would be referring to these as a prepubescent
9 onset. Then the literature is very, very long, but reported on
11:07:37 10 adult onset. And by adult, on average, these were people in
11 their 20s and in their 30s and 40s. It was very, very
12 distinct. It was not, you know, a bell-shaped curve with some
13 midpoint around 18 or 19 years old.

14 It's only within the past --

11:08:02 15 THE COURT: Hold on one second.

16 Go ahead. Sorry.

17 THE WITNESS: It's only within the past ten years or
18 so that a different profile has begun to emerge and was noticed
19 by clinicians. And that now is being called either adolescent
11:08:20 20 onset or rapid onset.

21 Now, all three of these groups have in common that they're
22 complaining about the same thing. Doc, I feel like I am in the
23 wrong body. Doc, I am the brain of one, but in the body of the
24 other.

11:08:34 25 So the way that they describe it is similar. But every

1 objective way we have of measuring these people shows that
2 these are independent phenomena. They are not related except
3 in the way that people describe the situation, describe what
4 they're experiencing.

11:08:50 5 The best analogy I have would be if somebody came to a
6 doctor saying I have a headache. Okay. I got it. Got that's
7 a symptom. I have some more questions. But we cannot from
8 that say that a migraine headache is the same thing as a
9 tension headache is the same thing as having just suffered a
11:09:08 10 head injury.

11 The causes are different. How we respond to them is
12 different. And the other characteristics about each of these
13 are different. They only resemble each other in the most
14 superficial ways.

11:09:19 15 Childhood onset or prepubescent onset gender dysphoria
16 appears to be entirely unrelated to adult onset gender
17 dysphoria. And the two of those appear to be entirely
18 unrelated to the rapid onset or adolescent onset gender
19 dysphoria.

11:09:40 20 BY MR. DAVIS:

21 Q Well, let's break that down. Adult onset, typically
22 people who present with what you're referring to adult onset
23 gender dysphoria, what age are they when they come into the
24 doctors' office and say, something's wrong?

11:09:50 25 A On average, in their 30s and 40s.

1 Q Okay. Has there been research considering whether
2 those -- that universe, the adult onset universe does well
3 after transitioning?

4 A Those who are mentally healthy by and large do, do well
11:10:08 5 after transition.

6 Q Can you apply those studies to consider whether someone
7 with child onset gender dysphoria is going to do well after
8 transitioning?

9 A No. Because these are independent phenomena. The
11:10:23 10 information from one does not -- from one group does not
11 generalize to the other.

12 Q Comparing the adult and the child onset, what is the
13 difference that makes the studies of one, you know, it's not
14 apples to apples?

11:10:35 15 A Correct.

16 Q Okay. What is the difference between those patients?

17 A The -- they -- as I say, differed in just about every
18 objective measure we've been able to apply to them.

19 There are, of course, the ages themselves. Something --
11:10:53 20 the sex ratios in them are different. The adults are almost
21 100 percent biological male. There's more of a mix amongst the
22 childhood onset.

23 The adults are almost always attracted to females. That
24 is to say, relative to being biological male, they are almost
11:11:13 25 always heterosexual.

1 The childhood onset almost always are attracted to the
2 same biological sex. They are almost always homosexual.

3 Q Talking about the child onset, is that a new phenomenon,
4 child onset gender dysphoria?

11:11:31 5 A I wouldn't say new. It's been systematically studied for
6 20 to 30 years'ish.

7 Q From the literature that you reviewed, do most of these
8 kids, if not socially transitioned and given hormones, will
9 they want to transition after reaching puberty?

11:11:52 10 A Generally not.

11 Q And page 36 -- excuse me -- paragraph 36 of your report,
12 Dr. Cantor, what statistics do you provide about the rates of
13 desistance among those presenting with childhood onset gender
14 dysphoria?

11:12:15 15 A The exact numbers are between 61 to 88 percent of them
16 desist. In the appendix in my report, I list all of the
17 studies that have ever been conducted with that group, all the
18 outcome studies that have been conducted with that group.

19 Q We probably both need to slow down just a little bit
11:12:37 20 for...

21 A I'm from New York. It just happens.

22 Q We'll do our best.

23 Dr. Hawkins was asked about your paragraph 36 yesterday.

24 And I will represent that on page 30 of the rough transcript,
11:12:54 25 she said that when the study such as the ones you're citing

1 offers this elevated rate of desisters, quote, what we tend to
2 find is that the initial cohort that was given the diagnosis of
3 gender dysphoria is actually false.

4 My question, Dr. Cantor, is: Does the research literature
11:13:15 5 support Dr. Hawkins's statement?

6 A No. As I say, I listed every single such study.

7 Q Do we have any tools today that reliably tell us which
8 kids will desist and which kids will persist?

9 A No, we do not. There have been some attempts to develop
11:13:34 10 such a test, but they have never been able to find a good
11 characteristic, a feature, a pattern, a test result in which
12 the majority continued to want to persist.

13 The best that they have ever been able to do was find a
14 tool which distinguished unlikely to want to persist versus
11:13:54 15 even less likely to want to persist.

16 Q There's been testimony about something called the DSM-5.
17 Do you know what that is?

18 A Yes, I do.

19 Q What is it?

11:14:04 20 A The full name is the Diagnostic and Statistical Manual of
21 Mental Illnesses, published by the American Psychiatric
22 Association.

23 Q If someone were to claim that now that we have the DSM-5
24 we may be able to do a lot better with identifying who's the
11:14:24 25 desister and who is the persister, is there any research on

1 that?

2 A No. Nobody's ever tried to differentiating any of the
3 DSMs from DSM-I through its various versions to the current
4 one.

11:14:38 5 Q So there have been at least five?

6 A There was a I, a II, a III, III-R, IV, IV then had a text
7 revision. They switched some of the commentary around the
8 diagnoses, but they didn't change any of the diagnostic
9 criteria themselves. There was then the 5. And there is as of
11:15:01 10 last month a 5 again with a text revision, but no changes to
11 any of the actual diagnostic criteria.

12 THE COURT: Mr. Davis, how much longer do you think we
13 will be?

14 MR. DAVIS: Your Honor, direct will take us up to
11:15:14 15 about noon, I would predict. There's just a lot to cover with
16 Dr. Cantor.

17 THE COURT: I am not rushing you. I am just trying to
18 get a road map of that.

19 So how long do we think cross might be?

11:15:25 20 MS. EAGAN: It's difficult to predict because I am not
21 sure what else he may say, but maybe an hour, hour or less, I
22 would think.

23 THE COURT: All right. I am leaning toward an earlier
24 lunch than we did yesterday. So maybe -- if it's okay with
11:15:45 25 you, let's just go ahead and find a stopping point at your

1 leisure, and we will just pick back up after lunch.

2 MR. DAVIS: Thank you, Your Honor. This is as good as
3 any.

4 THE COURT: Is it?

11:16:00 5 MR. DAVIS: Yes. We have just talked about DSM-5.
6 Going to watchful waiting next. This is as good a place as
7 any.

8 THE COURT: Okay. Good. Good. With that said, then
9 are we still on target with your last witness?

11:16:17 10 MR. DAVIS: Yes, Your Honor. Ms. Wright is here. I
11 don't know if she is in the courtroom yet or not, but she is in
12 Montgomery, and she will be ready to go when we finish with
13 Dr. Cantor.

14 THE COURT: We think the length of that witness would
11:16:30 15 be what?

16 MR. DAVIS: Oh, I would say direct would be well under
17 30 minutes, but I don't know about cross.

18 THE COURT: Okay. All right. Okay. Well, I think
19 we're on target.

11:16:38 20 Let's take a good long lunch today. Let's see here.
21 Let's come back at 12:45.

22 MR. DAVIS: Thank you, Judge.

23 THE COURT: Thank you.

24 MR. DOSS: Judge?

11:16:54 25 THE COURT: Yes?

1 MR. DOSS: Closing, how long would you like?

2 THE COURT: You know, I mean, this is important. I'm
3 not going to, you know, jack everybody up on this, but to the
4 extent you can hold it to around 25, I think would probably be
11:17:07 5 a good thing.

6 And in your openings, I think you really road mapped it
7 very well, both sides did.

8 So, you know, again, I know the arguments. I'm really
9 interested in, you know, some analysis with case law. And I am
11:17:22 10 going to be directly asking about a few cases. I'm very
11 interested to know parallels between the Arkansas decision and
12 that law. And then I may give you some hypotheticals that you
13 won't like.

14 See you after lunch.

11:17:40 15 (Recess.)

16 THE COURT: All yours, Mr. Davis.

17 MR. DAVIS: Thank you, Judge.

18 BY MR. DAVIS:

19 Q Welcome back, Dr. Cantor.

12:51:00 20 We spoke earlier about the Dutch protocol. Did the
21 participants in those Dutch studies have psychotherapy before
22 beginning treatment? Before that study?

23 A They were receiving treatment as part of their
24 participation in the study. I don't think they reported
12:51:21 25 whether anybody happened to have attempted psychotherapy before

1 approaching the clinic at all.

2 Q Okay. Forgive me if I'm mistaking which study is which.

3 I was reading about a study that described the psychotherapy

4 that was available to the participants as extensive. And that

12:51:40 5 that extensive psychotherapy was at least two years. Which

6 study am I thinking of?

7 A That wouldn't have been a particular study so much as what

8 they use in their process in general.

9 And then the Dutch group was reporting the results, you

12:51:56 10 know, of -- periodically over the course of the study.

11 Q I see.

12 A But by the time the first set of results, their earlier

13 study, the 2011 study, the participants in it will have already

14 been through a substantial amount of therapy.

12:52:13 15 Q Okay.

16 A They also emphasize that in assessing the children that

17 it's a very extensive assessment, and the assessment itself was

18 also ongoing over the course of the study.

19 So even before deciding who might be eligible for

12:52:30 20 hormones, they have now many, many months to years' experience

21 with the particular case even with a particular child even

22 before making a decision. That's very, very different from

23 just having an appointment, taking a test, and then having a

24 diagnostic decision an hour later.

12:52:46 25 Q That is exactly what I was meaning to ask you about. I

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1 was using sloppy language.

2 So this extensive assessment that happened before some of
3 these children began treatments, they were assessed, you said,
4 over a course of a couple of years?

12:52:59 5 A Correct.

6 Q Okay. So does literature support having such an extensive
7 assessment period before subjecting someone to these
8 treatments?

9 A I don't know if I would say support it, but all of the
12:53:16 10 conclusions that come from the literature depend on it.

11 Q Thank you.

12 Is there a way of treating gender dysphoria that some
13 practitioners refer to as a watchful waiting approach?

14 A Yes. Watchful waiting usually refers specifically to
12:53:40 15 withholding any decision about medical interventions until they
16 have a better idea or feel more confident for a particular case
17 about whether that kid is going to be a persister or desister.
18 It is given the knowledge that that's available that the
19 majority of these kids do desist. Nobody wants to make a
12:54:00 20 decision upon first appointment.

21 And so -- so they tend to provide psychotherapy, whatever
22 kind of care, whatever is appropriate to the individual kid
23 until enough time has gone by to give -- to suggest is this a
24 kid whose feelings like they're feelings are slowing down and
12:54:19 25 they just need more time, are they building up, or are they

1 staying steady?

2 So the watchful waiting period would be postponing any
3 decision about medical interventions until the clinicians had
4 some confidence.

12:54:31 5 Q While you are watching and while you are waiting, are you
6 just leaving him alone, or her?

7 A No. That would be the time during which one would be
8 supplying a therapy for whatever else is going on in the kid's
9 life.

12:54:42 10 Q Okay.

11 A Usually they're associated with -- there's a great deal of
12 what we call comorbidity. They're also suffering from other
13 problems at the same time, either depressions, anxieties, early
14 evidence of personality disorders, for example. And it's never
12:55:00 15 clear whether their gender dysphoria is a result of those other
16 psychological problems.

17 So by helping them develop the tools to deal with those
18 other problems, if they remain dysphoric afterwards, we know
19 that the dysphoria wasn't the result of those other problems.
12:55:17 20 So rather than just leaving them alone, they're still receiving
21 support, and the family is still receiving support over that
22 period.

23 Q So I believe you pointed out in your report that clinical
24 guidelines suggest that mental health issues such as the
12:55:33 25 comorbidities you mentioned should be resolved before

1 transition; is that correct?

2 A Yes.

3 Q Okay. Why?

4 A Because it's never clear what's causing what. We cannot
12:55:44 5 from a correlation conclude anything about a causation. It's
6 very possible, and it's been frequently observed that a lot of
7 these kids are using gender issues as an explanation for the
8 unhappiness that they're experiencing elsewhere in their life.

9 So rather than developing the skills to -- for example --
12:56:04 10 better social skills. If a person feels awkward and they're
11 withdrawing from kids their own age, we are not sure if they
12 want to transition because they're blaming gender dysphoria for
13 why they feel unpopular or uncomfortable, and we're not --
14 versus we can't tell if anxiety or depression is a result of
12:56:27 15 how they're being treated by the rest of society.

16 So it's only by helping them deal with and by giving them
17 the skills to overcome those other disorders that we can see if
18 the gender dysphoria itself resolves just as a result of that.

19 Q So if a person is suffering from depression, or is
12:56:48 20 struggling with their own sexual identity, or some type of
21 abuse, or any of these other comorbidities, explain how this
22 psychotherapy process would work, how a psychotherapist such as
23 yourself would try to dig down into the issue and see if that
24 is something that's generating these feelings that are being
12:57:08 25 mistaken as gender dysphoria, or whether the gender dysphoria

1 is its own thing.

2 A Just to be specific, I'm specifically an adult clinical
3 psychologist. I see clients ages 16 and up. So it wouldn't be
4 me personally.

12:57:23 5 What the literature shows about these kids is that they
6 can be very, very diverse. It certainly is feasible that they
7 are experiencing, for example, depression or anxiety as a
8 result of social transphobia, but that doesn't explain the
9 other things that we're observing.

12:57:41 10 For example, a transphobia doesn't cause autism, which is
11 another very, very common disorder in that group. Transphobia
12 wouldn't cause the development of borderline personality
13 disorder, which we're seeing in very, very, large proportions
14 among the teenagers.

12:57:58 15 So although certain symptoms like anxiety and depression
16 can feasibly be the result of social reactions to being trans,
17 but that does not explain the overall phenomenon. What does
18 better explain the overall phenomenon is that there is some
19 thing troubling this kid, and it is resulting in both the
12:58:20 20 psychological symptoms, depression, anxiety in someone, and
21 also producing the gender dysphoria, that discomfort with being
22 their natural sex.

23 Q I would expect this could vary wildly from patient to
24 patient, but if you -- and I recognize and thank you for
12:58:37 25 clarifying that you deal with a more adult-age group.

1 But if you're helping someone, an adolescent, work through
2 some of these issues, how often do you think a psychotherapist
3 would want to see the patient and over what period of time?

4 A It does vary widely. And the kind of disorders that
12:58:57 5 they're reporting do tend to be the kinds that require very
6 long-term interventions.

7 As I say, autism, and related Asperger's syndrome, and
8 also very, very high rates of borderline personality disorders,
9 which, again, is a very, very long-term disorder to help
12:59:14 10 somebody deal with.

11 Q Fair to say this would not be two or three sessions?

12 A Correct. This would be over the course of months or
13 years.

14 Q Does the research literature show that there are risks
12:59:30 15 associated with medical transitioning?

16 A Yes, quite substantial, including both loss of --
17 primarily loss of function, and depending on the person's point
18 of view, whatever the cosmetic effects are.

19 Q What are the risks of the watchful waiting approach in
12:59:48 20 providing psychotherapy in helping the child deal with any
21 underlying emotional issues?

22 A There don't appear to be any, at least any concrete.

23 Q I will refer you to paragraph 68 of your report,
24 Dr. Cantor.

13:00:06 25 Tell me what the advantages there are to a patient, what

1 opportunities it opens up to him or her if any emotional issues
2 are dealt with before the decision to transition.

3 A If a person fails to deal with whatever emotional issues
4 before it transition, and then transitions and discovers that
13:00:30 5 they continue with whatever psychological issues are pervading
6 them, they have gone through the entire transition process
7 entirely unnecessarily. They haven't been helped. They have
8 now lost whatever -- they have now been sterilized, lost
9 whatever sexual -- or other functions, but it hasn't actually
13:00:49 10 resulted in any improvement in their psychological function.

11 If you go the other way around and you help the person
12 deal with psychologically whatever it is that's going on, they
13 still retain the option for transition after that. And it's
14 that situation that the professional societies have
13:01:05 15 repeatedly -- that the standards of care have repeatedly
16 pointed out.

17 Q So watchful waiting approach does not eliminate a person's
18 ability to transition to the opposite sex later in life if they
19 so choose?

13:01:19 20 A Correct.

21 Q Does the research literature show there's any relationship
22 between children who present with gender dysphoria and those
23 who later in life turn out to identify as gay?

24 A Yes. The large majority of the ones who believe that they
13:01:42 25 were born the wrong sex turn out to be gay or lesbian.

1 To a prepubescent child who doesn't yet have a sex drive,
2 they have no way to interpret why they feel different from
3 other boys or other girls their age. It's only with the onset
4 of sex drive that they start -- and start developing crushes
13:01:58 5 and physical attractions that they now have the information
6 they need to realize why they're different. But to an eight
7 year old or to prepubescent children, the only explanation they
8 have for why they're not like other boys or not like other
9 girls is they must be the wrong sex. They're misinterpreting
13:02:18 10 their feelings.

11 THE COURT: Let's take a quick time out.

12 So, you know, I guess I'm wondering how both sides are
13 wanting me to use all this expert testimony. I mean, the
14 Eleventh Circuit has said more than one time that, you know,
13:02:31 15 medical psychiatric professionals are in a far better position
16 to make decisions about medical and psychiatric issues than
17 judges are.

18 So I guess I want to know from each side real quickly, how
19 do y'all envision that I use these experts? I mean, are you
13:02:48 20 asking me to say, well, this guy's science is junk and this
21 guy's science is perfect; or something in between? What am
22 I -- tell me how you envision me using this.

23 MR. LACOUR: May I?

24 THE COURT: Perfect. Absolutely.

13:03:05 25 MR. LACOUR: Your Honor, as we began the opening

1 statements, when there's an area of medical uncertainty, the
2 State has wide discretion to regulate. So if it's not so clear
3 to you as to which side's experts have it right, if you see
4 that uncertainty, then under Supreme Court precedent, the State
13:03:29 5 is allowed to regulate.

6 The State has to think about all 5 million Alabamians. We
7 have to take all that into account when regulating in these
8 areas where it is not certain.

9 The judge has an important but a limited role in our
13:03:45 10 federal system to see whether those judgments the State has
11 reached in those areas of uncertainty somehow conflict with the
12 Constitution.

13 And we submit we have come forward with evidence to at
14 least put into question whether there is this consensus that
13:04:03 15 has been proclaimed by the plaintiffs here.

16 Again, I think the bar on the plaintiffs is quite high, to
17 show an absence of uncertainty, or to show some great
18 certainty.

19 And when you look at the international studies and the
13:04:19 20 literature reviews, when you hear from very qualified experts
21 like Dr. Cantor, who have applied great rigor to these studies
22 that are being relied upon by the plaintiffs, by their experts,
23 by the AAP, for example, then I think that is enough to create
24 that doubt to create that space for uncertainty. And when that
13:04:45 25 is there, the State can step in.

1 So that's how we see it. We don't think that you sit here
2 as an independent medical board to assess whether a particular
3 treatment is going to be the best for any particular
4 individual. The role of the federal courts in our federal
13:05:01 5 system, the laboratories of democracy is to see if we have done
6 something that is somewhat inexplicable.

7 I think there is ample evidence to explain why the State
8 has done what it's done in addition to the lengthy legislative
9 findings in SB 184.

13:05:22 10 We have come forward with multiple experts from fields of
11 endocrinology, psychology, and pediatrics, and have brought
12 forward substantial amount of other peer-reviewed research and
13 literature reviews to show that this very novel area of the
14 law -- keep in mind the UAB clinic didn't open until
13:05:44 15 seven years ago. This is a novel area of medicine, rather --
16 is just, in the State's judgment, too risky. And if that's a
17 reasonable judgment for the State to make, then that's the end
18 of the case.

19 THE COURT: All right. Mr. Doss.

13:06:03 20 MR. DOSS: Your Honor, I'm unaware of a case that
21 establishes that principle that's so long as there's
22 uncertainty and a reasonable judgment, then that alone is
23 sufficient for the State to violate constitutional protections.

24 The standard of review is what I think helps frame some of
13:06:23 25 this testimony. So, for example, if strict scrutiny applies,

1 it is the State's burden to establish a compelling state
2 interest. And that its infringement on the constitutional
3 protection has been narrowly tailored.

4 And I guess to preview Your Honor for closing, that is a
13:06:40 5 key focus that I plan to spend some time with in closing on why
6 this testimony we've heard yesterday and today, number one,
7 does not establish a compelling State interest. But number
8 two, even if you assume that it does establish some interest by
9 the State, the interest that the State has identified and the
13:06:58 10 regulation that it has imposed are mismatched. It's not
11 narrowly tailored for the very reasons offered by the State
12 through its witnesses.

13 And based on the standard of review, it is not a reasoned
14 judgment. That's not the test for when a constitutional
13:07:13 15 violation has occurred. The test is whether there is
16 satisfaction of this demanding standard for the law's
17 viability.

18 And so as I mentioned in opening, I don't think that Your
19 Honor's job for the purpose of this hearing is deciding
13:07:31 20 ultimately maybe even who is right. It's to show that there is
21 scientific -- there are standards of care that exist, there are
22 approved approaches to dealing with these issues. These are
23 real medical diagnoses. These are real medical treatments.

24 And though the State may disagree them, that's not enough
13:07:50 25 to establish the violation of the constitutional rights, Your

1 Honor.

2 THE COURT: And on that note, at least from what I can
3 tell from both sides, State and government, and original
4 plaintiffs, am I correct to say that everybody agrees that
13:08:07 5 these are real diagnoses? Or no?

6 MR. LACOUR: Your Honor, could you --

7 THE COURT: And I am going to say this one more time.
8 I don't need head nods. It is out of hand. This is not
9 entertainment. This is the real world and the law. So we're
13:08:25 10 not in a movie theater. I don't need head nods. I don't need
11 approval or disapproval. If you want to do that, take it
12 outside.

13 Go ahead.

14 MR. LACOUR: Your Honor, I think -- Your Honor, we
13:08:46 15 agree that gender dysphoria is a psychological diagnosis, but
16 as we have shown in both our written evidence and through
17 witness testimony from both defense witnesses and plaintiffs'
18 witnesses, we don't know whose gender dysphoria is likely to
19 persist. And that's very important.

13:09:07 20 Even Dr. Antommara this morning said that if you -- the
21 level of certainty you have --

22 THE COURT: You are giving me more detail than I want.
23 I just need you to answer my question.

24 MR. LACOUR: Okay. Can I respond to something
13:09:21 25 Mr. Doss said before?

1 THE COURT: Very quickly.

2 MR. LACOUR: He is unaware of the standard. We cited
3 it multiple times in our P.I. response. It's Gonzales vs.
4 Carhart, a 2007 decision from the Supreme Court where the
13:09:32 5 federal government had regulated partial birth abortion. That
6 was an area of medical uncertainty.

7 There were -- I will go back and I will look at the
8 filings in that case, but I would be shocked if the AMA did not
9 chime in, in favor of the plaintiffs who were challenging the
13:09:46 10 ban on partial birth abortion there saying that it was a safe
11 or necessary -- medically necessary treatment for some people.

12 It was enough that Congress found medical uncertainty
13 there. And there were values, as well, in unborn life that
14 Congress was able to promote even though there were medical
13:10:04 15 organizations.

16 I will confirm this before closing, but I am fairly
17 certain there were medical organizations who were not fans of
18 Congress's action there.

19 Even so, and even in an area like abortion where there is
13:10:16 20 more law at least for the last 49 years in that space,
21 addressing some right to abortion, even then, that ban was
22 upheld by the Supreme Court.

23 THE COURT: And I'm sure you can get into that on
24 closing.

13:10:31 25 Let's go back to my original question. Just answer it

1 succinctly for me.

2 MR. LACOUR: And that would be are these real
3 diagnoses?

4 THE COURT: Yes. Just answer my question in two
13:10:41 5 sentences.

6 MR. LACOUR: Gender dysphoria is a diagnosis. I think
7 the debate is how should it be treated. And SB 184 is
8 expressed in Section 6.

9 There's no ban on psychotherapy whatsoever. The ban only
13:10:58 10 applies to these novel risky potentially long-term
11 harm-inducing or causing medications.

12 THE COURT: So no argument from the State on status,
13 diagnosis, any of that? You are only -- your only issue is
14 treatment; is that correct?

13:11:17 15 MR. LACOUR: Correct, Your Honor.

16 THE COURT: Got it. Thank you.

17 Anything else, Mr. Doss? And I will give the government a
18 shot --

19 MR. DOSS: No, Your Honor.

13:11:25 20 THE COURT: -- if they want to be heard.

21 MR. CHEEK: Nothing else to add that hasn't already
22 been said, Your Honor. Thank you.

23 THE COURT: Okay. All right.

24 Mr. Davis, I have gotten right in the middle of your
13:11:34 25 witness again. Sorry. Pick it back up.

1 MR. DAVIS: I certainly understand, Judge.

2 BY MR. DAVIS:

3 Q Okay. Dr. Cantor, we to try to pick up where we were.

4 Let's take two young boys, eight years old, say. So
13:11:52 5 puberty hasn't started yet. They both have gender dysphoria,
6 even though they may not really understand it yet.

7 And I know I'm asking you to assume some things that an
8 outside observer may not be able to confirm just by looking at
9 that child.

13:12:06 10 And let's assume that both those young boys would, if not
11 intervened with transitioning care, would both grow up to
12 identify as gay.

13 So the boy who is left alone to go through natural
14 puberty, what does he come to understand once puberty kicks in?

13:12:24 15 A Once he -- as puberty kicks in, of course, sex drive comes
16 in as a part of that, and he starts experiencing sexual
17 attractions and sexual arousal.

18 That, then, because he is experiencing it towards other
19 men, teachers, peers, whoever it is, he can now -- he now has
13:12:41 20 the opportunity to understand the nature of his experiences and
21 why he doesn't feel quite like other boys, why he doesn't feel
22 as masculine, and why he doesn't feel as masculine.

23 Now, in otherwise healthy circumstances, he will grow up
24 to be a healthy gay man.

13:12:57 25 Q Now, the other boy is given puberty blockers. What

1 happens in his case?

2 A Such a person who does not develop sexual -- the capacity
3 for sexual arousal and sexual attractions because the very
4 biological features which produce that have been held from him,
13:13:14 5 he never experiences an orgasm. He never experiences sexual
6 arousal, and doesn't have the opportunity to understand the
7 other potential explanations for why he feels the way he does,
8 and go from a child's understanding of why he doesn't feel like
9 other boys, to an adult's understanding of why he doesn't feel
13:13:36 10 like other boys.

11 By blocking puberty, you are blocking the very information
12 that he needs to understand his own situation.

13 Q And you are not claiming to describe every person who is
14 experiencing gender dysphoria, I take it?

13:13:49 15 A Correct.

16 Q Does the evidence show that sexual orientation changes
17 after a person identifies as gay or lesbian?

18 A No. There is no evidence to suggest that sexual
19 orientation is unstable or changes.

13:14:05 20 Q What does the evidence show about whether a person's
21 gender identity can change?

22 A That shows the very opposite. Among the children, it
23 changes in the majority of them.

24 They're even people who identify and describe themselves,
13:14:19 25 for example, as being fluid, the very definition of which is

1 that their gender identity changes on a constant basis.

2 Q Are you familiar with the argument that if we do not allow
3 minors to transition medically, the result will be increased
4 suicides within these group of young people?

13:14:38 5 A I've heard that said, yes.

6 Q Does the research literature support the argument that
7 denying these treatments will lead to an increase in
8 suicidality?

9 A No, it does not.

13:14:50 10 Q Are you familiar with what other countries are doing, with
11 respect to treatment of gender dysphoria?

12 A Yes, I am.

13 Q Are there any changes going on in recent years?

14 A Very much. In fact, things -- it's almost as if the
13:15:10 15 pendulum has reached its far point, and it's now coming back to
16 a much more moderate evidence-based tone.

17 There was really -- sparking off of the social media age
18 more than anything else, we're able to identify a greatly,
19 greatly accelerated, great and greatly expanded number and type
13:15:31 20 of person who was potentially going to go through transition
21 entirely, unlike the groups which we had previously studied.

22 Several countries, especially in Europe, permitted them
23 with lower and lower standards. And then once the reports
24 started coming out that that was failing greatly, they're now
13:15:53 25 restricting very, very quickly and very, very greatly.

1 The two most substantial bans have been in Sweden and in
2 Finland. And there are also now very, very strong statements
3 urging the medical field to pull things back in the UK and in
4 France.

13:16:08 5 Q Dr. Ladinsky testified yesterday that -- I don't have her
6 exact words in front of me -- but she said that what's going on
7 in the UK and Sweden and Finland isn't as relevant here because
8 those countries have a centralized health-care system, whereas
9 we have a less centralized health-care system, and all these
13:16:35 10 experts unrelated can see the same child.

11 That's a poor paraphrase. The record will speak for
12 itself. But assume she made that type of testimony. Would you
13 agree with her?

14 A No. I can't see the logic of it. It's certainly
13:16:53 15 feasible, in fact, more than likely that decisions are made
16 differently when there are centralized boards and a centralized
17 authority charged specifically with reviewing the evidence that
18 will be the basis of the medical procedures of that country,
19 and the U.S. lacks that.

13:17:11 20 But there's no reason to think that that situation would
21 change the actual outcomes of the actual children getting the
22 actual interventions.

23 Q So is it possible, then, that a more centralized
24 health-care system may provide the ability -- an even greater
13:17:24 25 ability to study and evaluate the risks and benefits of

1 gender-affirming care?

2 A That's demonstrably true. That is exactly the process
3 they have gone through. They have published the results of
4 exactly their reviews, and that is how their health-care
13:17:40 5 systems -- that is what their health-care systems are
6 responding to.

7 The American professional associations have not gone
8 through such a comprehensive process. They're merely coming up
9 with policies and citing only individual pieces of studies that
13:17:54 10 appear to support it, rather than a comprehensive review.

11 Q I want to close a loop on adolescent onset gender
12 dysphoria. We talked about ways different groups are
13 different.

14 What's unique about this group of adolescent onset, or you
13:18:11 15 referred to it also as rapid onset gender dysphoria?

16 A Yeah. It's been called both.

17 Where both the childhood onset and the adult onset are
18 primarily male, the adolescent -- the adult onset and childhood
19 onset are primarily male. The adolescent onset is primarily is
13:18:28 20 female. They present with a different set -- it's a different
21 epidemiological set of characteristics, and the evidence that
22 we have about both adults and children don't seem to apply to
23 that middle group.

24 Q Does this group of people presenting with gender dysphoria
13:18:45 25 in their adolescence -- you said primarily female?

1 A Yes.

2 Q Do they tend to have any issues or comorbidities in common
3 with each other?

4 A The most common one of those would be borderline
13:18:57 5 personality disorders and other difficulties with integrating
6 socially into their environments. As I say, such as autism and
7 Asperger's syndrome.

8 Q You are not saying that's true for everyone presenting
9 with gender dysphoria for the first time in their adolescence?

13:19:13 10 A Correct.

11 Q But many?

12 A Correct.

13 Q What does the research literature show about the
14 desistance or detransition rates of people who transition after
13:19:25 15 first presenting with gender dysphoria in their adolescence?

16 A There has never been any such study.

17 Q Did you review the plaintiffs' reply brief, Dr. Cantor?

18 A Yes, I did.

19 Q Did you see any response to your report in plaintiffs'
13:19:41 20 reply?

21 A Not a single comment. My name was never mentioned. None
22 of the studies that I cited were referred to. None of the
23 arguments were addressed. I don't believe I was quoted
24 anywhere in it, unlike the other experts.

13:19:56 25 Q I did note a line that the plaintiffs criticized the

1 defendants' experts in general for relying on older studies.

2 A Yes. I saw that claim. I was a bit confused by it.

3 In my report, I provided a comprehensive list of every
4 single study. There were 11 in total. So the old studies were
13:20:18 5 listed, the new studies were listed. It was comprehensive.

6 It was also a tangential argument. As I said, the 11
7 studies which have been conducted were unanimous in their
8 findings. They all found the same thing. The majority
9 desists.

13:20:33 10 So it doesn't matter even if one did rely only on the
11 older studies, the newer studies showed exactly the same thing
12 as the older studies.

13 Q We spoke a little bit about some of the things we heard
14 from Dr. Antommara this morning. I want to turn to some of
13:20:55 15 the things in his report.

16 You reviewed his written expert report, did you not?

17 A Yes, I did.

18 Q He -- Dr. Antommara wrote on -- in paragraph 17 of his
19 report -- and I will find a copy if you need it, but this is
13:21:07 20 one sentence.

21 Quote, gender-affirming medical care is supported by
22 clinical studies. Is he right?

23 A That's true for adults, but that's not true for the other
24 groups.

13:21:21 25 Q And Dr. Antommara spoke about how if a drug is FDA

1 approved in one area, it's okay to use it off label in another
2 area?

3 A That's what he said, yes.

4 Q What does the research literature say, or what opinion do
13:21:44 5 you have about using the same drug, a puberty-blocker in the
6 case of a person who's six, seven, eight, the purpose is to --
7 precocious puberty, what about the cases of precocious puberty
8 and using puberty-blockers to help someone medically transition
9 at the beginning of normal puberty?

13:22:03 10 A Well, the ability to use a medication off label is not a
11 blanket permission to give any drug you want for any reasons
12 you want or for any conditions you want.

13 Ultimately, it's going to depend on what the scientific
14 literature itself says, which in turn is what the various
13:22:22 15 regulatory bodies use to make their decisions to decide what's
16 off label or on label to begin with.

17 So because a medication would be useful for some people in
18 some situations and some circumstances, does not mean it's
19 automatically going to be useful for other people in other
13:22:37 20 circumstances. Indeed it could be deleterious.

21 If you use a puberty-blocker in somebody with precocious
22 puberty, you are pushing somebody who is far below the average
23 age of puberty, and you are bringing them closer to the
24 species-typical range of puberty.

13:22:55 25 If you give that same drug to somebody who is already

1 having a typical age of puberty, you are now pushing them
2 outside of the species-typical age.

3 Q Thank you, Dr. Cantor.

4 I am going to sum up. Does the research literature
13:23:21 5 support plaintiffs' claims that we need to treat children and
6 adolescents with gender dysphoria with social transition
7 puberty-blockers and cross-sex hormones?

8 A I'm sorry. Could you say that -- I missed the first half
9 of that sentence.

13:23:33 10 Q My apologies.

11 Does the research literature support plaintiffs' claims
12 that we need to treat children and adolescents with gender
13 dysphoria with social transition, puberty-blockers, and
14 cross-sex hormones?

13:23:46 15 A No. That's terrible overstatement.

16 Q Does the research literature support Alabama's description
17 of these treatments as experimental?

18 A Yes. They're fairly called experimental.

19 Q When does a drug or a course of treatment stop being
13:24:02 20 experimental?

21 A That's an excellent question. There is no real test for
22 it. There is no objective way to decide something is one
23 versus the other.

24 Science is never finished. It's always possible for there
13:24:14 25 always to be some future piece of information that changes what

1 we know.

2 There are, of course, you know, different situations --
3 drugs, issues under active investigation, where it's very clear
4 that it's still experimental, and others where, you know, there
13:24:32 5 is only very little question left.

6 For this particular situation, we have a very small number
7 of studies that in certain situations might look like they
8 might be helping, but a much larger body of better performed
9 studies showing that the improvement is not actually coming
13:24:47 10 from the transition itself.

11 Indeed, there were other areas of the report that were
12 referred to already ongoing studies testing exactly these
13 interventions. Well, that there exists ongoing tests of these
14 interventions is pretty much the definition of calling
13:25:05 15 something experimental.

16 Q If scientists are eventually able to replicate the same
17 results under the same conditions over and over again, can you
18 then pretty much say something is established?

19 A Yes.

13:25:17 20 Q Has anybody been able to replicate the results of, say,
21 the Dutch study that showed at least some positive results with
22 a combination of treatments?

23 A No. Most of the studies have demonstrated no improvement
24 in these children from medical transition.

13:25:32 25 Q Do you understand plaintiffs to argue that Alabama is out

1 of step with groups like the American Academy of Pediatrics?

2 A Yes, I've heard them say that.

3 Q What's your response?

4 A Well, it's actually the American Academy of Pediatrics
13:25:54 5 which is out of step with the international standards.

6 Q Is there a consensus, a medical consensus internationally
7 in support of these treatments?

8 A There is now a very quickly developing one. It is still
9 ongoing debate, so I would hesitate to describe it -- describe
13:26:12 10 that there is a solid consensus.

11 As I say, really what we have seen is a pendulum swing
12 which is overswung and now is substantially and very quickly
13 correcting itself.

14 Q Is the pendulum swinging in favor of medical transition
13:26:27 15 use of puberty-blockers and cross-sex hormones for children and
16 adolescents?

17 A No. It's swinging now against that.

18 Q Is there a medical consensus in the United States for the
19 best way to treat gender dysphoria?

13:26:39 20 A No, there is not.

21 MR. DAVIS: Thank you, Dr. Cantor.

22 THE COURT: So I do have a question myself.

23 Dr. Cantor, you said that an adult should be affirmed in
24 their transgender status.

13:26:58 25 THE WITNESS: An otherwise mentally healthy adult,

1 yes.

2 THE COURT: All right. So make it clear to me, then,
3 when should an adolescent or a child be affirmed in that
4 status?

13:27:10 5 THE WITNESS: That, to me, is an empirical question.

6 We are not sure actually when the best time do that is.
7 Every time we check, we keep finding that, no, that's not
8 exactly the right way. No, that's not exactly quite working.

9 And when we do think we have run into a clue that gives us
13:27:26 10 an idea of when, we are not able to recreate that situation.

11 THE COURT: Is that case by case, then?

12 THE WITNESS: I would hesitate to say case by case
13 exactly because --

14 THE COURT: Let me rephrase it. Under what
13:27:44 15 circumstances would you affirm a child or an adolescent?

16 THE WITNESS: I can't say that there's a situation --
17 all of the situations will be gray. I can't think of any
18 evidence that would give us the kind of certainty in any case
19 that would outweigh the potential risks.

13:28:19 20 THE COURT: So you would never affirm a child or an
21 adolescent?

22 THE WITNESS: Not with the current evidence available,
23 no.

24 THE COURT: Okay. All right. Cross?

13:28:28 25 CROSS-EXAMINATION

1 BY MS. EAGAN:

2 Q Good afternoon, Dr. Cantor.

3 A Good afternoon.

4 Q Dr. Cantor, you are an adult clinical psychologist,

13:29:15 5 correct?

6 A Yes.

7 Q You are not a medical doctor?

8 A Correct.

9 Q Your private practice -- in your private practice in

13:29:22 10 Toronto, the average age of your patients is 30 to 35 years
11 old?

12 A Average, that would be about right, yes.

13 Q You've not ever provided clinical care to transgender
14 prepubertal children?

13:29:39 15 A Correct.

16 Q You have not provided care to a transgender adolescent
17 under the age of 16?

18 A Correct.

19 Q The extent of your experience, Dr. Cantor, working with

13:29:52 20 transgender adolescents consists of counseling six to eight
21 transgender patients between the ages of 16 and 18; isn't that
22 correct?

23 A Yes.

24 Q So your clinical experience with gender dysphoria really

13:30:09 25 lies in the counseling of adult patients?

1 A Correct.

2 Q And you acknowledge that gender dysphoria in children does
3 not represent the same phenomenon as adult gender dysphoria,
4 correct?

13:30:24 5 A Correct.

6 Q And, in fact, to use your words, they differ in every
7 known regard, from sexual interest patterns to responses to
8 treatments?

9 A Correct.

13:30:36 10 Q Dr. Cantor, you have never diagnosed a child or an
11 adolescent with gender dysphoria?

12 A Correct.

13 Q Never treated a child or an adolescent for gender
14 dysphoria?

13:30:48 15 A Correct.

16 Q You have no experience personally with monitoring patients
17 who are undergoing puberty-blocking treatment?

18 A Correct.

19 Q You don't know what type of monitoring is typically done
13:31:04 20 or not done on those types of patients; isn't that fair?

21 A No.

22 Q No, that's not fair?

23 A Well, you -- I personally didn't do it, but I am aware of
24 the procedures that are done.

13:31:15 25 Q Okay. But you have no experience with that?

1 A That's correct.

2 Q Similarly, you have never monitored -- or you have not
3 monitored an adolescent or teenage patient on hormone therapy?

4 A Correct. Until -- well, I wouldn't be monitoring the
13:31:34 5 status in any case, so, yes, that's correct.

6 Q I am going to switch to UAB Children's, the gender clinic
7 here in Alabama.

8 Have you ever spoken to a child or adolescent who was
9 treated at the gender clinic here in Alabama?

13:32:00 10 A No.

11 Q Have you ever spoken to any former patients of the clinic?

12 A No.

13 Q You weren't here yesterday to hear Dr. Ladinsky talk about
14 the treatment protocols they have at children's UAB, were you?

13:32:12 15 A Correct.

16 Q You weren't here to listen to the results of treatments
17 provided to adolescent patients at UAB's Children's in the
18 gender clinic; fair?

19 A Yes. They have never published them.

13:32:27 20 Q And you weren't here to hear them?

21 A Correct.

22 Q Dr. Cantor, you have no personal knowledge of the
23 assessment or the treatment methodologies that are used here in
24 Alabama at UAB Children's Hospital, correct?

13:32:42 25 A Correct. Correct.

1 Q You do not know the disciplines of the medical providers
2 who are part of the treatment team involved in that assessment
3 at UAB Hospital?

4 A Correct.

13:32:56 5 Q Now, I heard your opinion that it's important to assess
6 the mental health issues of an adolescent patient to see
7 whether that is a potentially contributing factor to gender
8 dysphoria and whether there's a need to address. That's a fair
9 statement of your opinion?

13:33:17 10 A I'm sorry. Would you repeat that, please?

11 Q Sure. It's your belief that mental health issues need to
12 be assessed and addressed before a transition occurs?

13 A Correct.

14 Q Do you know what assessment protocols at UAB Children's
13:33:31 15 are to address mental health issues before a child is put on
16 any transitioning medication?

17 A No, I do not.

18 Q Do you have any idea or do you know what the doctors at
19 UAB Children's discuss with their adolescent patients about the
13:33:48 20 risks and the benefits of medical treatments at UAB?

21 A No.

22 Q Wouldn't you agree -- well, never mind. I am going to
23 move on.

24 Dr. Cantor, I want to talk with you a minute about -- or a
13:34:18 25 little bit about your criticisms of the various studies

1 regarding the efficacy of puberty blockers and hormone
2 treatments, okay?

3 A Yep.

4 Q As I understand your report and your testimony today, one
13:34:36 5 of the criticisms you have of some of those studies is that it
6 relies on participant's self-assessment I believe is the
7 language that you used.

8 Essentially, it is based upon what socially transitioned
9 youth and their family is reporting about their mental health
13:34:53 10 in these studies?

11 A I would say that's incomplete. My criticisms would be
12 relying on such subjective accounts entirely for all the
13 decision making rather than using it as one part of the
14 decision making.

13:35:08 15 Q In other words, basing your study based upon what the
16 participants in the study tell you how they're feeling at
17 different points in the study?

18 A Being limited to that is a problem, yes.

19 Q And I believe the way that you phrased it, you said,
13:35:22 20 subjective self-reports about how one is doing may not be
21 reflecting reality objectively.

22 A Correct.

23 Q But, Dr. Cantor, self-reports about how one is doing may
24 reflect reality, fair?

13:35:38 25 A That's correct.

1 Q So when somebody says, I am doing well, my mental state is
2 better, that very well may be the case?

3 A May be the case, yes.

4 Q Another complaint that you have, I believe, is what you
13:35:58 5 call confounded data. And I believe you referred to the de
6 Vries study for that?

7 A The two de Vries's studies, yes. As a matter of fact,
8 it's all but two of all papers in that set of literature.

9 Q And by confounded data, the way that I am understanding
13:36:13 10 it, what you're saying is that you are not able to tell because
11 the data is, quote, confounded, whether one's improved mental
12 health for a minor who has socially transitioned, whether that
13 came from the actual medical services, whether it came from the
14 psychotherapy, or whether it came from the combination of both?

13:36:34 15 A Correct.

16 Q But one thing, Doctor, that you do have to admit is when
17 adolescents with gender dysphoria have transitioned through a
18 combination of medical services and psychotherapy, you have to
19 admit that based upon the studies, their mental health
13:36:55 20 improved, correct?

21 A No. There were several studies that showed no improvement
22 even though -- even though they were receiving both. I've
23 listed them in my report.

24 Q Can you direct me to where in your report those are,
13:37:11 25 please, sir?

1 A Sure.

2 THE COURT: While he is looking, did you say your
3 target is an hour; is that right?

4 MS. EAGAN: Yes, sir. I believe I should be able to
13:37:33 5 be done in an hour.

6 THE WITNESS: Page 20, footnote 40.

7 BY MS. EAGAN:

8 Q I'm sorry, sir?

9 A Page 20, footnote 40. The Carmichael study, the
13:37:48 10 Hisle-Gorman, et al, study, and Kaltiala.

11 My full sentence was, New studies continue to appear at an
12 accelerating rate, repeatedly reporting deteriorations or lacks
13 of improvement in mental health, footnote 40 -- or again, those
14 were the specific studies -- and then or lack of improvement
13:38:23 15 beyond psychotherapy alone, footnote 41.

16 Q Certainly, Dr. Cantor, though, there are many study -- or
17 there are studies that indicate when adolescents with the
18 combination of medical service and psychotherapy transition,
19 their mental health has improved. You agree with that
13:38:40 20 statement?

21 A I would have to check to see if the number is zero or a
22 handful. There have been reports of there having been such
23 improvement, such as the Branstom study, which once it was
24 reanalyzed, discovered to have problems, and the finding was
13:39:00 25 withdrawn.

1 So there -- again, I would have to go through and check to
2 be sure that it's not zero. It would be fair to say that there
3 might have been a study which found such a thing. But the
4 majority of studies are finding either no improvements or
13:39:17 5 deteriorations, or it's a situation that we call a failure to
6 replicate.

7 Q Sir, I am a little bit confused, because I want to go to
8 two of your studies that you have actually talked about today,
9 the Costa study and the Achille study.

13:39:33 10 Now, as I understand your testimony today, in those
11 studies, there was -- the studies reported that there was an
12 improvement in mental state for adolescents who were treated
13 with medication and psychological treatment in transition that
14 there was an improvement, but in those, you said you can't tell
13:39:58 15 whether it's from the medication or from the psychological
16 treatment?

17 A No. The Costa study and the Achille study associated the
18 improvement specifically with the psychotherapy and ruled out
19 that the effects were due to the medical interventions.

13:40:13 20 Q Okay. Well, let's pull those studies, Doctor, and let's
21 look at those.

22 If you could, there should be a notebook up there that has
23 plaintiffs' exhibits in it. Is that one plaintiff, sir?

24 If you could please, sir, turn to Plaintiffs' Exhibit 34.

13:40:55 25 A Yes.

1 Q All right. Plaintiffs' Exhibit 34, is this the -- do you
2 say Costa or Costa?

3 A I'm sorry?

4 Q Do you say Costa?

13:41:05 5 A My guess is Costa. I have never met the person.

6 Q All right. Exhibit 34 that you have in front of you, is
7 that the Costa study?

8 A Yes, it is.

9 Q All right. So, Doctor, I first want to focus in on --
13:41:18 10 well, let me ask this: This study was aimed at assessing
11 gender dysphoric adolescents' global functioning after
12 psychological support and after puberty suppression, correct?

13 A Yes.

14 Q Bear with me. I am going to take this out so I can put it
13:41:42 15 up on the Elmo, sir.

16 All right, sir. I am going to direct your attention to
17 results that I have highlighted on my copy. Okay? According
18 to the abstract here, the results?

19 A Yes.

13:42:18 20 Q At baseline, gender dysphoric adolescents showed poor
21 functioning with -- it defines the mean scores. So baseline
22 means at the start of the study, correct?

23 A Usually it does. I would have to check that that's
24 exactly how they used the term.

13:42:35 25 Q All right. We will get to the details of that in a

1 minute.

2 Okay. Gender dysphoric adolescents' global functioning
3 improved significantly after six months after psychological
4 support. And then it goes on to say, Moreover, gender
13:42:49 5 dysphoric adolescents receiving also puberty suppression had
6 significantly better psychosocial functioning after 12 months
7 of puberty suppression compared to when they had received only
8 psychological support.

9 Did I read that right, sir?

13:43:07 10 A Yes.

11 Q Do you remember the methodology that was used for this
12 study, sir?

13 A Roughly.

14 Q Pardon?

13:43:14 15 A Yes. Roughly.

16 Q Sorry. I meant to -- all right. And do you recall that
17 the methodology was everybody started at baseline. For the
18 first six months all of the adolescents received psychological
19 counseling. And then for the next 12 months beyond that, one
13:43:36 20 group received puberty blockers, and one group just continued
21 to receive psychological counseling. Do you recall that?

22 A Yes.

23 Q All right. And then I am going to direct you, sir, to
24 page 2211 of the -- if you look at the blue writing on the top,
13:44:12 25 it's page 6 of 9.

1 A Yes.

2 Q All right. And I am going to direct you, sir, to on the
3 CGAS on follow-up?

4 A Yes.

13:44:32 5 Q All right. And I am going to start at the second
6 paragraph where it says delayed eligible. Do you see where I
7 am talking about?

8 A Yes.

9 Q This is talking about there were three follow-ups, right,
13:44:43 10 at 6 months, at 12 months, and at 18 months for this study; is
11 that correct?

12 A That sounds familiar to me, yes.

13 Q And let's read through that together.

14 Delayed eligible gender dysphoric adolescents, who
13:44:55 15 received only -- and gender delayed, GD adolescents, is your
16 recollection that those were adolescents who were eligible to
17 receive puberty blockers, but they delayed them for six months
18 so that they had everybody at a -- doing psychological study?
19 Do you remember this is the group that gets the puberty
13:45:17 20 blockers?

21 A Yes, that sounds correct.

22 Q Okay. The delayed eligible gender dysphoric adolescents
23 who received only psychological support for the entire duration
24 of the study -- excuse me -- I take that back.

13:45:29 25 This was actually the group that just got the

1 psychological -- had significantly better psychosocial
2 functioning after six months of psychological support, okay?

3 However, despite scoring better at the following
4 evaluations, they did not show any further significant
13:45:47 5 improvement in their psychosocial functioning.

6 Did I read that right?

7 A Yes.

8 Q Also, the delayed eligible group continued to score lower
9 than a sample of children adolescents without observed
13:46:04 10 psychological psychiatric symptoms even after 18 months of
11 being in psychological support.

12 So what that's saying is after 18 months, they were still
13 below a group that did not have psychological therapy or
14 issues, correct?

13:46:20 15 A Yes.

16 Q On the contrary, the immediately eligible group, who at
17 baseline had a higher, but not significantly different
18 psychosocial functioning than the delayed eligible group, did
19 not show any significant improvement after six months of
13:46:40 20 psychological support. However -- and this is the key --
21 immediately eligible adolescents had a significantly higher
22 psychosocial functioning after 12 months of puberty suppression
23 compared to when they had received only psychological support.

24 Did I read that correctly?

13:47:03 25 A Yes.

1 Q Then you see at the top of this, there is a chart. And
2 when you look at this chart, the bottom is actually the three
3 different check-ins. Time zero is baseline, when the study
4 started, right?

13:47:18 5 A Yes.

6 Q Time one is the six-month check-in, correct?

7 A Yes.

8 Q And during that six months, both groups are getting just
9 psychotherapy, correct?

13:47:31 10 A Yes, I believe so.

11 Q The rest -- and just to orient us.

12 The red group, the red line is the group of adolescents
13 who only got psychotherapy or psychotherapy through the entire
14 18-month study, right?

13:47:46 15 A Yes.

16 Q The green line that you see that goes up -- goes up and
17 keeps going up, that is the line of adolescents who receive
18 puberty blockers; fair?

19 A Yes.

13:47:59 20 Q And so, Doctor, to get to the ultimate conclusion of this
21 study that you say shows that puberty blockers don't work or
22 don't give any improvement in mental condition over
23 psychotherapy, the conclusion, this study confirms the
24 effectiveness of puberty suppression for gender dysphoric
13:48:37 25 adolescents. Recently, a long-term follow-up evaluation of

1 puberty suppression among gender dysphoric adolescents after
2 that CSHT, which is hormone therapy and GRS, which is puberty
3 blockers, has demonstrated that gender dysphoric adolescents
4 are able to maintain a good functioning into their adult years.

13:49:00 5 This present study, together with this previous research,
6 indicate that both psychological support and puberty
7 suppression enable young gender dysphoric individuals to reach
8 a psychosocial functioning comparable with their peers.

9 Did I read that conclusion correctly?

13:49:17 10 A Yes.

11 THE COURT: Ms. Eagan, when you reach a comfortable
12 spot, let's take a post-lunch break.

13 MS. EAGAN: Perfect. We're good, Judge. We can go
14 ahead and break now.

13:49:35 15 THE COURT: Okay. I will see you in 15 minutes.

16 (Recess.)

17 THE COURT: Go ahead, Ms. Eagan.

18 MS. EAGAN: Thank you, Your Honor.

19 BY MS. EAGAN:

14:09:00 20 Q Dr. Cantor, my understanding from paragraph 63 of your
21 declaration is that the other study that you point to in
22 support of your assertion that testing revealed that puberty
23 blockers did not improve mental health any more than mental
24 health does on its own is the Achille study you mentioned
14:09:29 25 earlier today; is that right?

1 A Yes.

2 Q If you, please, sir, could turn to Plaintiffs' Exhibit 42
3 in that binder in front of you, and this would be the
4 plaintiffs' exhibits that we were looking at earlier.

14:09:42 5 A Yep. Got it.

6 Q All right. Is Plaintiffs' Exhibit 42 the Achille study
7 that we just mentioned?

8 A Yes.

9 Q All right.

14:09:59 10 MS. EAGAN: Your Honor, do you mind if I take this off
11 of this?

12 THE COURT: That's fine.

13 BY MS. EAGAN:

14 Q All right. I am going to -- so this is Plaintiffs'
14:10:15 15 Exhibit 42.

16 And the Achille study, again, was -- in this case if we
17 look at the abstract, the background of the study or the
18 purpose of the study was to examine the associations of
19 endocrine intervention puberty suppression and/or cross-sex
14:10:35 20 hormones therapy with depression and quality of life scores
21 over time in transgender youths.

22 That was the purpose of the study, correct?

23 A Yes.

24 Q And looking down to the results section, between 2013 and
14:10:56 25 2018 -- so this went over a five-year period, right?

1 A Yes.

2 Q And there were 50 participants in the study, correct?

3 A That sounds right, yes.

4 Q All right. And that they received endocrine intervention
14:11:17 5 both -- some were in the form of puberty blockers, and some
6 were in the form of cross-sex hormones, but endocrine -- and
7 over that time period and completed three waves of
8 questionnaires.

9 Is that your recollection of this study?

14:11:30 10 A Yes, roughly.

11 Q Okay. And when that was -- with those treatments, mean
12 depression scores and suicidal ideation decreased over time,
13 which means their depression was -- went down, or they got
14 better. Suicidal ideation went down, which is improvement,
14:11:50 15 correct?

16 A Yes.

17 Q While mean quality of life scores improved over time.

18 And then it goes on to say, When controlling for
19 psychiatric medications and engagement in counseling,
14:12:03 20 regression analysis suggested improvement with endocrine
21 intervention. And then it goes on to say that this reached
22 significance in male to female participants. And the male to
23 female participants, those are ones that were receiving hormone
24 therapy, correct?

14:12:23 25 A I believe they were both receiving hormone therapy. It

1 was not significant in one group, and so they're just reporting
2 the successful in the other and not reporting the nonsuccessful
3 group.

14:12:39 4 Q Well, let's talk about that. Let me pull up paragraph 63
5 of your declaration.

6 When you're discussing this study, here is what you said.
7 You said that upon follow-up, some incremental improvements
8 were noted; however, after -- so, in other words, upon
9 follow-up, they saw improvements.

14:13:07 10 But after statistically adjusting for psychiatric
11 medication and engagement and counseling, quote, most
12 predictors did not reach statistical significance.

13 And that's your basis -- that statement is your basis to
14 say there was not a statistical significance of difference
14:13:26 15 between just counseling versus with meds; is that right?

16 A I'm sorry. Could you say that part again?

17 Q The language that you seize onto, to say that puberty
18 blockers did not improve mental health more than mental
19 healthcare did on its own --

14:13:43 20 A Right.

21 Q -- was the statement in the study that most predictors did
22 not reach statistical significance.

23 A Well, I wouldn't say that I derived that just from that
24 sentence. It's just easier to convey that idea to readers by
14:13:56 25 using the sentence. My evaluation of the study is by those

1 statistics directly.

2 Q All right. Let's go to the language in the study that
3 they talk about, the regression analysis that you were just
4 referencing there.

14:14:11 5 Okay. And this is here in the regression analysis.

6 Let me first say this: The mean changes over time. And
7 it does say, Mean depression scores decreased. Quality of life
8 improved, but did not reach statistical significance.

9 But then when you go on to the regression analysis, here
14:14:39 10 is what it says. It says, Given our modest sample size --
11 which in this case was 50 people, right?

12 A Yes.

13 Q Given our modest sample size, particularly when stratified
14 by gender, most predictors did not reach statistical
14:14:57 15 significance.

16 So one of the contributing factors to that, of course, was
17 the size of the number of participants, correct?

18 A Yes. In statistics, that's a truism. The precision of
19 the statistics is the direct -- direct result of the sample
14:15:20 20 size.

21 Q Okay. And then it goes on to say, That being said, effect
22 sizes values were notably large in many models. In the male to
23 female participants, only puberty suppression reached a
24 significance level. And it gives the number in one of the
14:15:43 25 sample -- one of the tests, and associations with the two other

1 scores approached significance.

2 And then it goes on to say, For female to male
3 participants, only cross-sex hormone therapy approached
4 statistical significance.

14:15:57 5 All right. Statistical significance are not -- on all
6 planes, the numbers improved, correct?

7 A No. That's -- the very meaning of determining --
8 factoring in whether something is statistically significant or
9 not.

14:16:15 10 Q Ultimately, the writers of this study stated, if you look
11 at the next paragraph -- or look on the discussion part if you
12 want -- can you see the screen up here?

13 A Oh, I have the same thing on this screen.

14 Q Oh. You have got one. Okay, good.

14:16:31 15 Our results suggest that endocrine intervention is
16 associated with improved mental health among transgender youth.

17 Did I read that right?

18 A Yes. Those are their words.

19 Q Doctor, to be clear, you agree that the U.S.-based medical
14:17:15 20 association guidelines and position statements are in support
21 for the use of medical treatment combined with mental health
22 treatment for adolescents with gender dysphoria, correct?

23 A I don't think I would phrase it quite that strongly. Most
24 of the associations are using relatively vague terms. And it's
14:17:35 25 not clear when they're talking about adults or children, when

1 they're talking about transition, medical services versus
2 psychotherapy, or a relatively blanket statement of
3 demonstrating respect. I can only accept that they're
4 endorsing a particular treatment when they're endorsing a
14:17:54 5 particular treatment.

6 So is there a specific association or specific statement
7 you have in mind?

8 Q The major medical associations that were involved in this
9 space endorse the use of medications to treat gender dysphoria
14:18:08 10 in children -- excuse me -- gender dysphoric adolescents once
11 they reach puberty when appropriate?

12 A I can think of two medical associations, one
13 interdisciplinary association, and the other -- and all of the
14 others are, as I say relatively, vague words of support, and
14:18:44 15 it's not clear exactly what it is that they're recommending.

16 Q Well, my understanding is what you like to look at is the
17 international standards. That's what you're talking about
18 today in support of your opinions?

19 A Oh, I looked at each of them, and I think I described each
14:18:59 20 of them. I did my best not to leave any out.

21 Q So, and according to you, the Dutch approach is
22 internationally the most widely-respected and utilized method
23 for the treatment of children who present with gender
24 dysphoria?

14:19:13 25 A Yes.

1 Q And the Dutch approach is also, I believe, what you call
2 that watchful waiting approach?

3 A No.

4 Q Okay. The Dutch approach is what is accepted -- I have
14:19:24 5 already said what you said.

6 The Dutch approach says social transition can happen at
7 age 12, puberty blockers may be prescribed at age 12, hormones
8 at age 16, and then resolve other mental health issues before
9 transition. That's the Dutch method?

14:19:43 10 A Yes.

11 Q Do you know how that approach aligns with protocols that
12 are utilized at UAB Children's in Alabama?

13 A I don't know.

14 Q In any event, what you say is internationally the most
14:20:03 15 widely-respected and utilized method for treatment of children
16 who present with gender dysphoria, you would agree that that
17 approach would be a felony in Alabama with this new law,
18 correct?

19 A Yes. It's true that the Alabama law didn't leave an
14:20:26 20 exception for research purposes.

21 Q Okay. So let's talk about the European countries that you
22 mentioned very briefly, the UK, Finland, Sweden and France.

23 When you look at those four European countries, Doctor,
24 not one of them has enacted a ban to puberty blockers and
14:20:46 25 hormone treatments as Alabama has done here, correct?

1 A No.

2 Q That's not correct?

3 A Correct. That is not correct.

4 Q UK has not fully banned puberty blockers and hormone
14:21:00 5 treatments in youth 18 and younger?

6 A That's correct.

7 Q Finland has not banned -- let me ask it this way: Has
8 Finland banned blockers and hormone treatments in youth ages 18
9 and under for gender dysphoria?

14:21:16 10 A Yes, I believe it has.

11 Q It has?

12 A I believe so.

13 Q A blanket ban? Should I refer you to paragraph 131 of
14 your declaration, sir?

14:21:47 15 A Hang on. That's just where I am now.

16 Q Okay.

17 A Oh, yes, they did leave an exception for hormones. The
18 total ban was on surgery.

19 Q Thank you, sir.

14:22:05 20 Sweden, has Sweden put an absolute ban on puberty
21 blockers?

22 A Yes.

23 Q And bear with me. Have they put a ban on puberty blockers
24 and hormone treatments in youth ages 18 and under for gender
14:22:23 25 dysphoria in Sweden?

1 A 18 and under?

2 Q Yes, sir.

3 A No. They allowed exceptions for 16 year olds -- 16 year
4 olds within research circumstances.

14:22:32 5 Q Has France banned the use of puberty blockers and hormone
6 treatments for adolescents ages 18 and under?

7 A No.

8 Q Can you point me to a single country, Doctor, in Europe
9 that has put a blanket ban on the use of puberty blockers or
14:22:50 10 hormone treatments for youth ages 18 and under for gender
11 dysphoria?

12 A Blanket ban in the way you're describing it, no.

13 THE COURT: How about any country?

14 THE WITNESS: No, not that I know of.

14:23:04 15 BY MS. EAGAN:

16 Q I want to turn very briefly to the subject of -- I will
17 use your word desistance.

18 If you turn to paragraph 36 of your declaration.

19 A Yes.

14:23:36 20 Q In that -- you state, Among prepubescent children who feel
21 gender dysphoric, the majority cease to want to be the other
22 gender over the course of puberty ranging from 61 to 80 percent
23 desistance across the large prospective studies.

24 I know that's a point that you also raised earlier today.

14:23:59 25 So I want to ask this question: Of those that number, do

1 you know, Doctor, what percentage of those kids cease to want
2 to be the other gender -- that's using your words -- before or
3 as they enter puberty, in other words, before they actually get
4 into puberty? Do you know how many of those desisters are in
14:24:27 5 that window?

6 A I must not be understanding your question, because it
7 makes me want to say the same number that's in the report, 61
8 to 88 percent. What's different from what I said and what
9 you're asking?

14:24:39 10 Q The 61 to 88 percent, is that children that realign with
11 their birth sex before -- or as they're entering into puberty,
12 that's that number?

13 A Yes.

14 Q Okay. All right. So I want to focus on a different
14:25:01 15 category of youth. Let me ask you this: The medications in
16 the United States, puberty blockers and hormone treatments
17 cannot be given to kids for gender dysphoria until after
18 they've actually entered into puberty, correct?

19 A Very many clinics are doing it as close to the beginning
14:25:23 20 as soon as puberty starts as they are able.

21 Q But it's once they have entered puberty?

22 A Yes.

23 Q So let me ask you about that category of youth.

24 And that is adolescents who have entered into puberty,
14:25:38 25 okay, and who have been -- have suffered from gender dysphoria

1 persistently, consistently, and insisently in childhood
2 leading up to puberty, okay?

3 A Okay.

4 Q Do you have any data regarding what percentage of those
14:25:58 5 individuals desist after they enter into puberty?

6 A No. I don't think that level of follow-up has yet been
7 conducted.

8 Q And, Doctor, in fact, it's your belief that the
9 majority -- that while the majority of prepubescent kids cease
14:26:35 10 to feel trans, you know, to puberty or during puberty, in other
11 words, as they enter into puberty, the majority of kids who
12 continue to feel trans after puberty rarely cease?

13 A That does seem to be the case, yes.

14 Q Okay. Doctor, are you being paid to be here to testify
14:27:10 15 today?

16 A Yes.

17 Q What's your rate?

18 A 400 an hour.

19 Q Who is paying your fees?

14:27:14 20 A The Alabama state -- State of Alabama.

21 Q Okay. Dr. Cantor, have you attempted to recruit parents
22 in Alabama whose children have gender dysphoria and were
23 prescribed or referred to gender-affirmative treatments, have
24 you tried to recruit them to give a witness statement in this
14:27:38 25 case that they believe the treatments are harmful?

1 A No.

2 Q Do you tweet?

3 A Yes.

4 MS. EAGAN: Your Honor, may I approach?

14:27:49 5 THE COURT: Yes.

6 BY MS. EAGAN:

7 Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet
8 Dr. James Cantor retweeted. And it's -- let me say this: Is
9 this a tweet that you actually did?

14:28:40 10 A No. I --

11 Q You retweeted?

12 A Retweeted, exactly.

13 Q From a group called Genspect, or what's -- I don't tweet.
14 Would you call that a group? I guess it's a group called
14:28:56 15 Genspect?

16 A It's there is a group called Genspect, and this is their
17 Twitter account.

18 Q All right. And then you retweeted it?

19 A Yes.

14:29:03 20 Q And it says, Urgent. Attention. Alabama parents, if your
21 child experienced gender dysphoria and was prescribed or
22 referred to gender-affirmative treatments and you believe these
23 treatments are harmful, please direct message, e-mail us at
24 once. We are looking for witness statements. Can be anon.

14:29:26 25 By anon, I guess that means anonymous, correct?

1 A That would be my reading, yes.

2 Q All right. Doctor, have you seen a sworn statement under
3 penalty of perjury for any Alabama parent whose kid received
4 puberty blockers or hormones and the parent said the

14:29:50 5 medications hurt their kid more than they helped them?

6 A I'm sorry. Did you ask have I seen such a statement?

7 Q Yes, sir.

8 A Not that I recall.

9 MS. EAGAN: Nothing further.

14:30:05 10 THE COURT: Any redirect?

11 MR. DAVIS: Short.

12 THE COURT: Ms. Eagan, did you intend to offer that
13 into evidence or no?

14 MS. EAGAN: Oh, yes. Thank you, Judge. I offer

14:30:37 15 Plaintiffs' Exhibit 45.

16 THE COURT: It will be admitted.

17 REDIRECT EXAMINATION

18 BY MR. DAVIS:

19 Q Dr. Cantor?

14:30:51 20 A Hi.

21 Q Is it true as a clinician you are not treating anyone who
22 has presented with gender dysphoria as an adult or as a child?

23 A I treat adults with gender dysphoria, not children.

24 Q You are not treating them while they are adolescents or

14:31:09 25 children, you are not currently treating someone who is like

1 under age 16?

2 A Correct.

3 Q Okay. But you are familiar with the research literature
4 on these issues, correct?

14:31:19 5 A Yes, quite.

6 Q And even those that are studying -- or children in
7 adolescents?

8 A Of course.

9 Q You're knowledgeable about the treatment they're
14:31:29 10 receiving?

11 A Yes, very.

12 Q And are you knowledgeable about what the research shows
13 about the efficacy of these treatments?

14 A Yes.

14:31:35 15 Q You had an exchange with Ms. Eagan where you admitted that
16 a fact that is self-reported by a participant may be true?

17 A Correct.

18 Q What's the rest of that sentence?

19 A It is certainly not necessarily true. We need something
14:31:53 20 objective before we can make any decisions upon it.

21 Q Let's turn to the Costa study. That's at Tab 38 of the
22 book of plaintiffs' exhibits.

23 MR. DAVIS: Your Honor, I'm sorry. I left a notebook.

24 May I step over?

14:32:40 25 THE COURT: Certainly.

1 THE WITNESS: I'm sorry. You said Tab 38?

2 BY MR. DAVIS:

3 Q I was mistaken, Dr. Cantor. It was 34.

4 A 34 of the defendants'?

14:33:02 5 Q No. Of the plaintiffs' book.

6 A Yes. Now I'm back there.

7 Q Okay. Now, you have a line in your report in paragraph 57
8 of your report that I will just read to you.

9 It says, Both groups improved in psychological functioning
14:33:25 10 over the course of the study, but no statistically significant
11 differences between the groups was detected at any point?

12 A Correct.

13 Q Okay. Are the three groups represented by the three
14 colored lines -- the three groups you're talking about, the
14:33:41 15 three groups on the three colored lines on this chart I'm
16 showing you?

17 A Part of the information is contained in that graph, yes.

18 Q Okay. Does this table tell us more about the statistical
19 significance or lack thereof shown in the Costa study?

14:34:02 20 A Yes, it does. The results of this table, although much
21 harder to read, indicate that there was no statistical
22 significance between the groups.

23 Q Okay.

24 A What was changing in the groups was change over time
14:34:13 25 within the group relative to the same group previously. But

1 there were no changes -- no significant differences between the
2 groups themselves.

3 Q Okay. What does it mean in a study if a finding lacks
4 statistical significance?

14:34:29 5 A That there was a substantial probability of getting a
6 pattern like that just by random chance.

7 Q And are there any reasons other than puberty suppression
8 that the delayed group did not have the same change over time
9 as the immediately eligible group?

14:34:45 10 A It's not exactly clear if they didn't change just as much.
11 That's one of the ambiguities that, again, comes from
12 statistics. When you look at it in different ways, you can see
13 different aspects, different aspects of it.

14 Q And the authors actually noted statistical significance or
14:35:11 15 lack thereof, did they not, in the language that are bracketed
16 there? It says, this difference failed to reach significance
17 possibly because of sample size?

18 A That is correct.

19 Q Have you said anything about the Costa study in your
14:35:24 20 report that you need to withdraw after your exchange with
21 Ms. Eagan?

22 A No. Everything I said is accurate.

23 Q Okay. Is the same true for everything that you have said
24 about the Achille study?

14:35:39 25 A Yes. Everything I said was accurate. Nothing in the

1 prior discussion changed it.

2 Q The UK is still reviewing these treatments, are they not?

3 A They are in the middle of deciding what to do with what
4 they have now discovered from their comprehensive review of the
14:35:57 5 literature, which showed what they were doing was wrong.

6 Q What did they discover?

7 A They discovered that they said exactly what I said, that
8 there is no evidence to support the medical transition of these
9 children.

14:36:09 10 Q And they have not yet decided how to respond to that
11 revelation, correct?

12 A Correct. They have now taken that report, and they're now
13 reorganizing and deciding exactly what it is that they're going
14 to do.

14:36:21 15 Q And in France, is it not correct that they've said about
16 hormones that the greatest reserve is required for their use?

17 A That is correct.

18 Q And is it true that, quote, they have said that speaking
19 of hormones, they're irreversible nature must be emphasized?

14:36:38 20 A That is correct.

21 Q And in Sweden, is anyone under 16 getting puberty blockers
22 or hormone treatments?

23 A No. That is banned.

24 Q And what about over 16? Youth -- like --

14:36:51 25 A Between 16 and 18, they're permitted to do it, but only

1 within recognized research programs. A regular physician
2 can't.

3 Q And how many such research programs are going on at
4 present?

14:37:04 5 A Oh, in Sweden?

6 Q Are you aware of any?

7 A I am aware of one lab that has two locations. I don't
8 know what its current status is with its current research
9 program.

14:37:20 10 Q Okay. Can you say whether a single child under 18 is
11 currently receiving hormones for the purpose of transitioning
12 in Sweden?

13 A I don't know.

14 MR. DAVIS: Thank you, Dr. Cantor.

14:37:39 15 THE COURT: Any recross?

16 MS. EAGAN: No, Your Honor.

17 THE COURT: May this witness be excused?

18 MR. DAVIS: Yes, of course, Your Honor.

19 THE COURT: All right. You can step down, sir.

14:37:48 20 THE WITNESS: Thank you.

21 THE COURT: All right. Call your next witness.

22 MR. DAVIS: Your Honor, the State calls Ms. Sydney

23 Wright.

24 THE COURT: All right.

14:37:54 25 SYDNEY WRIGHT,

← **Tweet**



James Cantor
@JamesCantorPhD



The only ones who crave affirmation more than trans teens are their doctors.

8:02 AM · Feb 15, 2023 · **4,734** Views

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 Wales, Australia, on the 30th day of May, 2023, pursuant to the Indiana Rules of Trial Procedure.

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1 Pursuant to the Indiana Supreme Court Case
2 20S-MS-236 signed March 31, 2020, PROFESSOR
3 DIANNA T. KENNY, having been first duly sworn to
4 tell the truth, the whole truth and nothing but
5 the truth relating to said matter, was examined
6 and testified as follows:
7 DIRECT EXAMINATION,
8 QUESTIONS BY GAVIN M. ROSE:
9 Q Good morning, Doctor. How are you today?
10 A I'm fine. Thanks.
11 Q Can you state your name for the record, please.
12 A It's Dianna Theadora Kenny.
13 Q That's Dianna with two Ns; correct?
14 A Yes, and Theadora with an O, not an A, so
15 T-h-e-a-d-o-r-a, and Kenny there's no E,
16 K-e-n-n-y.
17 Q And I heard you before we went on the record say
18 that you would prefer to be addressed as Dianna;
19 is that correct?
20 A That's fine, yeah.
21 Q If I fall into old habits, do you prefer doctor
22 or professor?
23 A Professor.
24 Q Dianna, have you ever had your deposition taken
25 before?

Page 5

1 A Not in America, no.
2 Q Have you in Australia?
3 A Yes. Well, I mean, you don't call them -- it's
4 not exactly the same process, but yes.
5 Q You've been asked questions under oath for
6 purposes of a court case?
7 A That's right, yes.
8 Q I, obviously, know nothing about the rules of
9 depositions or their equivalent in Australia, so
10 I will go over the rules real quick with you.
11 You understand that this is a formal asking and
12 answering of questions under oath; correct?
13 A Yes.
14 Q Okay. The court reporter has asked me to remind
15 you, which I would have done anyway, that
16 because she is writing down everything that we
17 say it is very important that you wait until I
18 finish my question before providing your answer.
19 A Okay.
20 Q And I will try to give you the exact same
21 courtesy; is that fair?
22 A Yes, it is. Could I get you to sit back a
23 fraction because I can only see that much of
24 your face?
25 Q I'm sorry. Is this better?

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1 A That's better, yes.
 2 Q Can you still hear me okay?
 3 A Yes, I can.
 4 Q Okay. We had an issue with Zoom not long ago
 5 where I had it set to the wrong microphone so
 6 I'm used to leaning over something and I don't
 7 have to now that it's set correctly, so I
 8 apologize.
 9 A Thank you.
 10 Q The court reporter has also asked me to remind
 11 you that because of the distance between you and
 12 us there very well may be a lag time in the
 13 video or in our communication, so, for that
 14 reason, too, it's important for you to wait
 15 until I finish to begin your answer, okay?
 16 A Okay.
 17 Q In other depositions in this case we have been
 18 taking a short break every hour or so. My plan,
 19 if everybody is tolerating it, is to go a little
 20 longer than that, at least for the beginning,
 21 simply because we're already in the evening
 22 hours right now, but if at any time you feel
 23 like you need a break to stretch your legs, get
 24 a drink of water, use the restroom, please,
 25 speak up and we can certainly make that happen.

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1 Is that okay?
 2 A I'm perfectly happy to go for -- I'm used to
 3 doing long stretches. I have a long attention
 4 span. I know it's going to get very late over
 5 there, so it's fine with me to just, yeah,
 6 extend those breaks.
 7 Q Well, I have a short attention span and horrible
 8 knees so, please, forgive me if I'm the one that
 9 needs a break.
 10 A Okay.
 11 Q Do you have any questions about the process?
 12 A No.
 13 Q Okay. What did you do to prepare for today's
 14 deposition?
 15 MR. FISHER: I'm going to object to the
 16 extent it calls for communication with counsel.
 17 Q Without telling me the content of anything you
 18 spoke with your attorneys about today's
 19 happenings, did you speak with your attorneys in
 20 advance of today's deposition?
 21 A Yes.
 22 Q And when did you speak with them?
 23 A Over the course of the last month. Well,
 24 speaking means communicating, documents, you
 25 know, going through what was required in my

Page 8

1 report, things like that.
 2 Q Did you have a meeting or conversations
 3 specifically for the purpose of preparing you
 4 for today's deposition?
 5 A A brief meeting.
 6 Q When did that take place?
 7 A I think that was last Thursday morning, my time.
 8 Q Of course. Did you speak with anyone other than
 9 the attorneys for Indiana to prepare for today's
 10 deposition?
 11 A No.
 12 Q Did you review any documents in advance of
 13 today's deposition?
 14 A Yes.
 15 Q Which documents did you review?
 16 A The primary documents that I reviewed are listed
 17 on the front of my declaration. Do you want me
 18 to go through them? You'll have them in front
 19 of you, but I have them here if you need them.
 20 Q That was going to be my next question. Do you
 21 have any documents in front of you that you plan
 22 on referencing during the deposition?
 23 A I have my declaration.
 24 Q Okay. Is that the only document you have in
 25 front of you?

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1 A I was advised that that was the only document I
 2 was permitted.
 3 Q That's perfectly fine with me. I just want to
 4 make sure.
 5 The declaration that you have in front of
 6 you, does it have the attached exhibits, I think
 7 A through E?
 8 A Yes, A through E. The ones you just sent like
 9 10 minutes ago?
 10 Q The declaration that your attorneys provided to
 11 us have, I think, five attachments. The first
 12 was your CV and then the other four were medical
 13 records pertaining to each of the plaintiffs.
 14 Do you have those attachments in front of you?
 15 A No, I don't, no.
 16 Q And it sounds like you have received copies of
 17 several exhibits that I e-mailed to your
 18 attorneys a short while ago?
 19 A Yes, I received them about three minutes before
 20 this call.
 21 Q Okay. And is anyone else in the room with you?
 22 A No.
 23 Q And are you physically located in your home?
 24 A Yes, in my office, yes.
 25 Q Your home office?

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1 A My home office, yes.
 2 Q And you said this while we were off the record,
 3 but that's in Sydney, New South Wales,
 4 Australia?
 5 A That's right.
 6 Q While we're talking today, Doctor, I have
 7 several exhibits that I am going to show you.
 8 Unlike the other attorneys in this case, I have
 9 decided to go out on a limb and explain to the
 10 court reporter that I will try to use the
 11 share-screen function to show them myself.
 12 Because of how that works, you will only be able
 13 to see one page or part of one page on your
 14 computer. I promise I'm not trying to trick
 15 you. If you need me to scroll down or anything
 16 like that, please, just let me know and I'm more
 17 than happy to do so. Is that fair?
 18 A Yes, that's fine.
 19 Q You will also notice as we go through some of
 20 them that I have highlighted portions of the
 21 exhibits. The only reason for doing so -- and I
 22 freely admit that that was me that did so -- is
 23 to try to direct my eyesight so that I don't
 24 waste your time as I try to find what I'm
 25 looking for, but that's why some portions will

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1 be highlighted.
 2 MR. FISHER: Gavin, can I interject for a
 3 second?
 4 MR. ROSE: Of course.
 5 MR. FISHER: To the extent that she needs
 6 full context for any of those documents, do you
 7 have an objection if she opens the full document
 8 that she received by e-mail?
 9 MR. ROSE: Of course not.
 10 Q Okay, Doctor, I'm going to pull up using the
 11 share-screen function what I have marked as
 12 Exhibit 1. And do you see that in front of you
 13 right now?
 14 A Yes.
 15 Q And I can scroll down if you need for me to;
 16 although, I can tell you that it's 14 pages
 17 long. I assume you recognize this as your
 18 curriculum vitae?
 19 A Yes.
 20 Q And this is the version that your attorneys
 21 provided to us just over the weekend. I assume
 22 that it's still current; is that correct?
 23 A Yes, that's correct.
 24 Q Okay. And you're currently employed, I
 25 understand?

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1 A Yes.
 2 Q And it looks from your CV like you're employed
 3 as a consultant presently?
 4 A That's right.
 5 Q And that's for a business called DK Consulting?
 6 A Yes.
 7 Q And I assume the DK is you?
 8 A Yes.
 9 Q Are you the -- I'm sorry, I talked over you.
 10 A That's okay. I just said it's not very
 11 original. No symbolism in that at all, yeah.
 12 Q Are you the only employee of DK Consulting?
 13 A I have an assistant, like an administrative
 14 assistant.
 15 Q Okay. Is that the only other employee?
 16 A Yes.
 17 Q And has this been your only employment since
 18 2019?
 19 A Yes.
 20 Q And by "since 2019," I mean since you retired
 21 from being a professor.
 22 A That's right, yes.
 23 Q Do you currently have any patient care
 24 responsibility?
 25 A I'm in full-time private practice, so yeah.

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1 Q Is that through DK Consulting or just separate?
 2 A No, no, that's through DK Consulting.
 3 Q Okay. And I assume that you provide
 4 psychotherapy to your patients?
 5 A Yes, I provide psychotherapy; I provide marriage
 6 and family therapy; I do child and adolescent
 7 assessments; and I do mediation and family
 8 dispute resolution.
 9 Q When you do child and adolescent assessments, is
 10 that for anyone in particular?
 11 A Well, in recent times, it's children being
 12 brought for gender dysphoria, so a large part of
 13 my practice currently are children and families
 14 with a young person who is declaring themselves
 15 transgender.
 16 Q And when you say that you work full time in
 17 private practice, is that more or less 40 hours
 18 a week that you see patients?
 19 A It's more like 60 hours a week.
 20 Q And approximately what percentage of that would
 21 you say are for patients who have identified
 22 themselves as transgender?
 23 A I'd say two-thirds, but they're not all patient
 24 contacts, the 60 hours, because I include
 25 preparing depositions for Indiana among the

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1 hours that I spend working. So, in my clinical
 2 hours, I would say at the moment two-thirds.
 3 Q And, I'm sorry, that was just a bad question
 4 then. About how many hours each week are you
 5 working as a clinician?
 6 A About 30.
 7 Q Okay. So about 20 hours or so each week you're
 8 treating or assessing patients for gender
 9 dysphoria?
 10 A Yes.
 11 Q And are all the patients with gender dysphoria
 12 that you see minors?
 13 A Yes, I specialize in minors.
 14 Q I'll come back to your clinical practice in just
 15 a little bit. It looks from your CV like you
 16 served as a professor at the University of
 17 Sydney in various capacities from 1988 through
 18 2019. Is that accurate?
 19 A That is.
 20 Q Your last position was as an honorary professor
 21 of psychology and a professor of music?
 22 A Yes.
 23 Q I'm just curious, but why music?
 24 A Sorry?
 25 Q I said I'm just curious, but why music?

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1 A Why music? It's a very long story and it's
 2 probably for another time, but I, you know --
 3 Q Let me ask you this because I couldn't tell from
 4 your CV. Is it teaching music or is it teaching
 5 the psychology of music or performance anxiety
 6 or what have you?
 7 A I established a research center at the Sydney
 8 Conservatorium of Music which is a faculty of
 9 the University of Sydney. So, when the Sydney
 10 Conservatorium of Music amalgamated with the
 11 university, it was a freestanding tertiary
 12 institution, and then there was a lot of
 13 legislative changes to reduce the number of
 14 tertiary institutions and the Sydney
 15 Conservatorium amalgamated with Sydney
 16 University and became a faculty, but we were a
 17 research-led university and it didn't have any
 18 research as a tertiary institution. It was
 19 primarily concerned with training young
 20 musicians.
 21 And they were looking for somebody who had
 22 research expertise and who knew about music and
 23 how the university structures ran, applying for
 24 research grants, setting up a research
 25 laboratory, so the magic finger was pointed at

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1 me. And, for those years, I had two
 2 professorships that I had to juggle and get this
 3 search established. So I didn't do any
 4 undergraduate lecturing in that position. It
 5 was all as a director of research center and I
 6 was primarily supervising Ph.D. students but
 7 also doing a lot of research, applying for
 8 grants, writing papers, and so forth, yeah.
 9 Q Thank you. In your role as a professor of
 10 psychology or I guess before that a lecturer in
 11 psychology, were there specific subjects that
 12 you taught?
 13 A Yes, I was specifically hired for my expertise
 14 in developmental psychology and so I was
 15 primarily responsible for both the undergraduate
 16 and the postgraduate teaching in subjects like
 17 infant and child psychology, developmental
 18 psychology, developmental psychopathology. What
 19 else? Current issues in adolescent psychology,
 20 all those kinds of subjects, child and
 21 adolescent assessment.
 22 Q Of the psychology courses that you taught, did
 23 any of them concern treating gender dysphoria or
 24 providing gender-affirmative care?
 25 A There was no such thing when I started at the

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1 university and there were no courses anywhere in
 2 Australia because the incidence and prevalence
 3 of that condition was estimated to be minutely
 4 small and we, therefore, focused on the much
 5 more prevalent conditions that children present
 6 with in childhood. So it wasn't on the radar.
 7 Let me put it that way.
 8 Q Did you teach any courses about that subject
 9 toward the end of your career with the
 10 University of Sydney?
 11 A No. Towards the end of my career as a
 12 professor, I was primarily supervising Ph.D.
 13 students and executing research grants,
 14 conducting research, and generally organizing
 15 the research program that I've described before.
 16 Q Have you taken any courses pertaining to gender
 17 dysphoria?
 18 A Well, there aren't any formal courses even now
 19 that I'm aware of in Australia and I would have
 20 to vet them very carefully before I book any of
 21 those courses because Australia has
 22 unquestioningly, and without due thought and
 23 consideration, adopted what we call here as
 24 gender ideology and as soon as I see the
 25 contents of the description of gender ideology,

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1 I become, you know, quite twitchy and disturbed
 2 by the scientifically fallacious information
 3 that's being propagated, particularly in our
 4 entrance primary and secondary schools.
 5 So I have engaged in a very detailed
 6 undertaking to educate myself based on my
 7 thorough training and many, many years of
 8 clinical experience developing my own model and
 9 my own clinical practice approach to these young
 10 people.
 11 Q In the middle of your answer there you used the
 12 phrase "what we call here as gender ideology,"
 13 and I'm just curious who "we" is in that
 14 sentence.
 15 A Well, it's generally referred to in that way in
 16 the media and media who are somewhat less than
 17 supportive of things like gender-affirming care,
 18 for example, and all the new lexicon, the new
 19 terminology, you know, that's being propagated
 20 by the machinery of the trans advocates.
 21 Q Okay. And I asked if you had taken any courses
 22 pertaining to gender dysphoria and maybe I
 23 didn't ask the question in the right way. Other
 24 than your personal investigation and review of
 25 the literature and certain materials, do you

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1 have any professional training specific to
 2 gender dysphoria or its treatment?
 3 A As I explained, there are no such courses.
 4 People have just adopted practices from
 5 overseas. And, I mean, there are courses within
 6 courses, so, for example, in cultural studies
 7 there's a subcourse called gender and sexuality
 8 and within that course they would cover the
 9 discourses, the current discourses, but it's
 10 more in the area of sociology or critical
 11 studies. And my field is psychology so there's
 12 not really any intersection unless I choose to
 13 read some literature in that field, but there's
 14 no such discrete course as gender-affirming
 15 care.
 16 Q Okay. During your time as a professor for, if
 17 I'm doing the math right, 30, 31 years, did you
 18 have patient care responsibilities at the same
 19 time?
 20 A Yes, I had rights to private practice throughout
 21 my academic career.
 22 Q And about how many hours each week were you
 23 seeing patients? And I'm sure --
 24 A About 10.
 25 Q Okay. And was that more or less consistent

Page 20

1 throughout your time teaching?
 2 A Yeah. I mean, it varied according to, you know,
 3 circumstances, but, on average, I would say that
 4 would be about right.
 5 Q So, prior to your time in private practice
 6 following your tenure with the University of
 7 Sydney, were any of the patients that you saw
 8 diagnosed with gender dysphoria?
 9 A Do you mean when I was at the university?
 10 Q Yes. I'm sorry.
 11 A No. I only kind of became involved in about
 12 2019 when a colleague of mine, who is an
 13 adolescent psychiatrist, called me and said a
 14 few psychiatrists are getting referrals of these
 15 young children who are gender dysphoric and
 16 wanting to transgender and none of them had very
 17 much experience with child and adolescent
 18 psychology or psychiatry. And he asked me if I
 19 would review a couple of cases that he had been
 20 referred and have a case conference, a peer
 21 consultation. And it was from that point that I
 22 started to take on cases myself and to really
 23 intensively educate myself about what was going
 24 on and what was happening in this field, so it's
 25 really been for the last coming into five years.

Page 21

1 Q And do you remember what time of the year in
 2 2019 you left the University of Sydney?
 3 A July.
 4 Q So would it be after that time that you began
 5 looking into gender dysphoria?
 6 A Yes.
 7 Q Okay. And then it looks from your CV like from
 8 '86 through '87 you were a psychologist in
 9 private practice?
 10 A Yes, I was.
 11 Q During this time did you see or treat any
 12 patients with gender dysphoria?
 13 A No. I might say that they didn't exist in
 14 Australia in 1986/'87.
 15 Q Okay. Then I want to, if it's okay, just
 16 briefly focus on your clinical experience after
 17 you left the University of Sydney where you've
 18 been seeing patients and looking into gender
 19 dysphoria. Is that okay?
 20 A Yeah.
 21 Q Approximately how many patients with gender
 22 dysphoria or gender identity issues did you see
 23 over this period or have you seen over this
 24 period?
 25 MR. FISHER: I'm going to object to the

Page 22

1 form of that question. It's unclear whether
 2 those are two separate categories or you're
 3 conflating them together?
 4 MR. ROSE: That's a perfectly fair
 5 objection and if Tom had not called me, I would
 6 have rephrased it myself.
 7 Q How many patients diagnosed with gender
 8 dysphoria have you seen since you left the
 9 University of Sydney, more or less?
 10 A Well, it depends on whether you're talking about
 11 seeing them for assessment or seeing them for
 12 therapy. If I just counted the young people
 13 that I had seen for assessment, it would be in
 14 the vicinity of 150 to 180, and, of those, I
 15 would have taken probably 50 to 60 into
 16 long-term therapy.
 17 Q And pretend I know almost nothing about the
 18 practice of psychology, but what is, I guess,
 19 the assessment? A patient gets referred to you
 20 from some source and what happens then when
 21 you're assessing them?
 22 A Well, I always meet with the parents first and I
 23 get a full developmental history because there's
 24 a great deal of dispute about onset and I want
 25 to get a very clear picture from the parents

Page 23

1 about when their child first expressed ideas
 2 about being transgender and so forth. So I do a
 3 very careful historical overview of their
 4 developmental milestones. I also want to
 5 understand how they're performing at school. I
 6 also want to review any of the previous
 7 assessments that they've had for intellectual
 8 ability, any intellectual disabilities, learning
 9 disabilities, have they had an assessment for
 10 autism spectrum disorder, ADHD, have they ever
 11 been diagnosed with depression and anxiety, are
 12 they on any medications. So that is quite an
 13 extended interview with the parents.
 14 And during that time I'm also assessing the
 15 marital and parental dynamic so I'm looking for
 16 power imbalances in the marital diet, I'm
 17 looking for whether there's a lack of respectful
 18 interactions between the parents, and I'm also
 19 looking for whether there's any disagreement
 20 about how they should proceed with their child.
 21 And quite often you'll see one parent who is
 22 more supportive of allowing the transition and
 23 another parent who is not approving. So all of
 24 these things are extremely important.
 25 And then I will see the child on his or her

Page 24

1 own and that might go from one to three sessions
 2 depending on what I'm exploring with the child
 3 and what I think is happening in terms of this
 4 child's life.
 5 After that assessment of the child, I meet
 6 again with the parents and I give them an
 7 overview of my opinion and how we should proceed
 8 or how I recommend that the family proceed.
 9 Q Just a couple of questions about that.
 10 MR. FISHER: Gavin, I'm sorry to interrupt
 11 you. I just want to alert you. Because you're
 12 sharing your screen, when people are sending you
 13 text messages they're popping up on my screen.
 14 I'm doing my best to ignore them and not look at
 15 them, but I noticed at least one of them was
 16 from Chase so I thought I'd better alert you
 17 because probably you don't want me to see those.
 18 MR. ROSE: I appreciate that. Thank you.
 19 Can we go off the record for just a second?
 20 (A discussion was held off the record.)
 21 QUESTIONS BY GAVIN M. ROSE:
 22 Q Okay. Doctor, you just explained the assessment
 23 process when you see a patient for the first
 24 time for gender dysphoria, and my question to
 25 you is going to be whether there is an age range

Page 25

1 of the children that you assess.
 2 A I've seen children as young as three to four and
 3 I usually -- I have seen some young adults in
 4 their 20s, but the majority are under 18 years
 5 of age or around. You know, I've seen quite a
 6 few like 17, 18-year-olds.
 7 Q Would you say the majority are in their
 8 adolescence?
 9 A Yes, I would.
 10 Q Approximately how many children preadolescence
 11 have you assessed for gender dysphoria?
 12 A I think it would be less than a quarter of the
 13 presentations.
 14 Q So, if I'm doing the math, maybe 30-ish?
 15 A Yeah. I mean, it depends on whether you count
 16 the peripubertal children, you know, the 11 and
 17 12-year-olds because some children are reaching
 18 puberty at younger than average ages. So a
 19 child might be pubertal at 10 and so it would be
 20 a question of whether you would count that child
 21 as a child or as an emerging adolescent, so it
 22 gets a little bit gray if you wanted to strictly
 23 categorize them. The majority, I would say,
 24 would be between 10 and 18.
 25 Q Okay. And of the 150 to 180 patients you've

Page 26

1 assessed, how do you decide which ones will
 2 become the 50 or 60 that you accept for
 3 longer-term treatment?
 4 A I make an assessment about whether the young
 5 person is capable of entering into a
 6 psychotherapeutic process. That's one
 7 criterion.
 8 Another is whether it is more (inaudible)
 9 to work directly with the parents and, quite
 10 often, I will choose to do that in the first
 11 instance. So I will meet with the parents more
 12 regularly than the child and I will -- I suppose
 13 the word is coach, you know, coach them about
 14 parenting and how to manage, you know, the
 15 child's behavior generally and how to manage the
 16 statements or, you know, gender sort of related
 17 issues, so that's another way that I work.
 18 And, in some cases, I'll work with the
 19 family, usually the young person and the parents
 20 together. In most cases I don't include
 21 siblings. If I do do family therapy, it's just
 22 with the identified child.
 23 So I have a very broad perspective on the
 24 kinds of interventions that I undertake and
 25 they're based on very careful assessment of the

Page 27

1 dynamics of the family, the capacity to engage
 2 in particular psychotherapeutic processes, and
 3 that involves a capacity for insight and
 4 reflective function. And, you know, if not, I
 5 step it down to psychoeducation, behavioral
 6 management. But I do find that an open
 7 exploratory psychodynamic/psychotherapy approach
 8 is more effective if it's suitable for that
 9 young person and the family.
 10 Q And you began that answering by saying that one
 11 of the things you look at in determining whether
 12 to accept a patient for longer-term treatment is
 13 whether they're capable of entering into the
 14 psychotherapeutic relationship or possibly the
 15 process. What type of patient is not capable of
 16 doing that?
 17 A Well, you have to be very careful about young
 18 people with autism spectrum disorder. In the
 19 early days and even now, I did take some of
 20 those into individual therapy because they were
 21 extremely distressed young people. And, because
 22 of their cognitive rigidity, cognitive
 23 immaturity, their literal interpretation of the
 24 world, and some of them display quite
 25 obsessional features in both their behavior and

Page 28

1 their thinking, you come to a point where it
 2 does not seem to be the best intervention for
 3 that type of young person and so I seek other
 4 methods, usually primarily working intensively
 5 with the parents.
 6 Q And when you assess a patient are you attempting
 7 to -- are they coming to you with a diagnosis or
 8 are you attempting to diagnose them?
 9 A I'm not primarily focused -- I presume you're
 10 meaning a diagnosis of gender dysphoria?
 11 Q Sure.
 12 A Yeah. The parent will usually tell me in the
 13 first assessment interview what their child is
 14 saying and doing with respect to gender and what
 15 their demands are and expectations. When I see
 16 the child, I'll ask them why they've come to see
 17 me, what is their understanding of why they've
 18 visited with me today, and I usually take the
 19 assessment from that point. And you would be
 20 amazed at how many of them don't start with
 21 gender.
 22 Q How many minor patients have you diagnosed with
 23 gender dysphoria, if any?
 24 A I think one.
 25 Q And how old was that patient?

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1 A Four.
 2 Q And when you diagnosed that patient with gender
 3 dysphoria, what diagnostic criteria did you use?
 4 A Well, I mean, the only acceptable one in current
 5 situation is DSM-5 that you will see from my
 6 declaration that I have great concerns about the
 7 DSM-5 as do a large number of my colleagues.
 8 Q Are those the criteria that you used in
 9 diagnosing that one patient, though?
 10 A I look at those criteria, but I primarily am
 11 concerned with the behavior of the child.
 12 Q What, if any, criteria other than the DSM-5 did
 13 you consult in diagnosing that patient?
 14 A I look at their general adaptation, whether
 15 they're meeting developmental milestones,
 16 whether they're capable of expressing an
 17 independent idea about themselves because quite
 18 often there are subtle communication dynamics
 19 happening between parents and children, and, you
 20 know, I mean, of course, the simplest one is
 21 that mother speaks for the child and that's why
 22 it's important to spend some time with the child
 23 alone. And, often, because I do a lot of work
 24 for the family court in Australia and for the
 25 Office of the Department of Public Prosecutions

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1 where there are allegations of child sexual
 2 abuse, they're really, really, you know, very
 3 damaging custody disputes and so on.
 4 Q I'm sorry for interrupting, but I was going to
 5 ask: Did the tools or criteria that you used in
 6 addition to the DSM-5, do they come from any
 7 publication? Are they written down anywhere?
 8 A Well, they come from the development psychology
 9 literature and also the literature on dynamic
 10 psychotherapy.
 11 Q But there's no specific one page, two-page list
 12 of criteria that you can point me to for these?
 13 A Well, I have been a coauthor of two clinical
 14 guides for the management of children with
 15 gender dysphoria. One of them was an
 16 international consortium that I contributed a
 17 very significant portion of that document. I've
 18 also contributed in a major way to the clinical
 19 guide published by the National Association of
 20 Practicing Psychiatrists, and I've also written
 21 some therapeutic treatment guides for clinicians
 22 that I've presented at meetings and conferences
 23 for consideration.
 24 Q You described this one patient that you
 25 diagnosed with gender dysphoria. Were any of

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1 the other patients that you saw for gender
 2 dysphoria diagnosed with gender dysphoria by
 3 another professional?
 4 A By and large, my practice involves what's called
 5 tertiary referral, so a lot of these young
 6 people come to me when the parents have been
 7 horrified by what's been going on in the gender
 8 clinics.
 9 So one of the typical ways that it happens
 10 is that the child declares him or herself
 11 transgender. The mother takes the child to the
 12 general practitioner. That's the family
 13 treating doctor. The doctors will then refer
 14 these children to either gender-affirming
 15 (inaudible) pediatricians or to the gender
 16 clinics. And once you're on that, as the
 17 Swedish call it, the "trans train," there's
 18 almost only one stop and that's transition.
 19 And, so, when the parents go to these
 20 establishments, they're actually excluded from
 21 the process. They're being made to wait
 22 outside. If the parent wants to contribute
 23 their perceptions of their child and their
 24 worries about their child and maybe transition
 25 isn't the right thing for them, they're taken

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1 off and told that they're the problem and to get
 2 out of the child's way. And, you know, as soon
 3 as this child starts the transition process, all
 4 of these serious psychological problems up to
 5 and including self harm and school refusal and,
 6 you know, the old standards of depression and
 7 anxiety, they're all going to magically
 8 disappear if you start pumping the child with
 9 puberty blockers and cross-sex hormones.
 10 Q I'm sorry, Doctor.
 11 A I'll finish my answer.
 12 Q I'm sorry, Doctor. You've actually gone well
 13 beyond the question that I've asked so I'd like
 14 to turn back to the question that I asked which
 15 is: Other than the one patient that you
 16 diagnosed with gender dysphoria, had any of the
 17 other patients that you've seen for gender
 18 dysphoria been diagnosed with that condition by
 19 some other professional?
 20 A Well, I was about to finish my answer when you
 21 cut me off. So the answer is yes and I'm
 22 telling you the root by which they've been
 23 diagnosed after maybe one half-hour session by
 24 the gender clinic.
 25 Q And the reason I ask that question is I'm trying

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1 to hone down on, I guess, whether you believe
 2 that you have only had one patient with an
 3 accurate diagnosis of gender dysphoria or
 4 whether you believe you've had a number of
 5 patients with an accurate diagnosis of gender
 6 dysphoria.
 7 A Well, I was attempting to answer that question
 8 in your previous question which is I am a
 9 tertiary referral source. So the parents who
 10 become horrified at what's going on at the
 11 gender clinics are the people who are most
 12 likely to come to see me so they're already
 13 convinced that the diagnosis of gender dysphoria
 14 is inaccurate and inappropriate for their child,
 15 and, so, that would be the patient group that I
 16 see. I'm not seeing the captured parents.
 17 They're staying at the gender clinics.
 18 Q Okay. And, other than that one patient that you
 19 diagnosed with gender dysphoria, did you agree
 20 with the assessment of the parents that every
 21 other patient you saw for gender dysphoria had
 22 been inaccurately or inappropriately diagnosed
 23 with that condition?
 24 A I don't make definitive statements of that kind
 25 until I've worked with the parents and with the

Page 34

1 child. It's an open question that has to be
2 explored very carefully as well as all of the
3 other comorbid presentations that the child
4 usually presents with. I can tell you one thing
5 for sure and that is I haven't seen a child
6 without a comorbid presentation who comes
7 telling me that they're gender dysphoric, so
8 there's usually serious pathology in the child
9 and the family.
10 Q Have any patients come to you with a diagnosis
11 of gender dysphoria where your assessment and
12 prolonged treatment, if it goes that way,
13 confirms the diagnosis?
14 A I don't confirm the diagnosis.
15 Q Okay. You keep medical records for each of your
16 patients; is that correct?
17 A Of course.
18 Q And on the medical records that you keep, do you
19 have a list of diagnoses for which the patients
20 have presented or been confirmed? Do you have a
21 list of diagnoses for each patient?
22 A Yes.
23 Q And how many patients of the 50 or 60 that
24 you've accepted into long-term treatment do your
25 records reflect a diagnosis of gender dysphoria?

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1 A Zero.
2 Q And what about the one person that you diagnosed
3 with gender dysphoria?
4 A I didn't make a definitive statement. I said it
5 was likely a diagnosis that needed to be
6 considered seriously, but because of the child's
7 age and, you know, cognitive immaturity, I
8 suggested that the parents engage in active
9 watchful waiting for a significant period of
10 time before taking any action.
11 Q And do you continue to see that patient?
12 A I see the parents. I don't see the patient at
13 this point.
14 Q Have you ever seen a patient who was taking
15 either puberty blockers or gender-affirming
16 hormones?
17 A Yes.
18 Q And were those subsequently discontinued?
19 A No. Oh, well, I mean, one has to look at each
20 case individually, but there's only a small
21 number that I'm seeing who had already started
22 that process and, to date, they have not
23 discontinued and I'm not pressuring them to
24 discontinue. You know, these young people on
25 cross-sex hormones around 16, 17, 18, so I

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1 engage in an exploratory process with them, but,
2 once they do start taking the cross-sex
3 hormones, the landscape changes because these
4 medications, of course, affect the total body
5 and the way they think about themselves and
6 their neurological as well as physical
7 functioning.
8 Q And, please, correct me if I'm wrong because I
9 might have just misheard a word. Did you say
10 that you've only seen one patient taking
11 hormones?
12 A No, I've seen three or four.
13 Q Okay. And were those three or four patients
14 patients that you simply assessed or were they
15 accepted into longer-term treatment?
16 A I have one in long-term treatment. I've been
17 seeing him for two years, and when I started to
18 see him he wasn't taking hormones. The others
19 have turned 18 during their therapy and decided
20 that they were going to proceed to cross-sex
21 hormones. And, yeah, I don't know if that
22 answers your question.
23 Q It does. Thank you. And I didn't ask it right
24 the first time and I apologize for that, but
25 same questions about puberty blockers. How many

Page 37

1 patients have you seen who are taking puberty
2 blockers?
3 A Probably not many, two or three.
4 Q And, again, same question. Were those patients
5 that you accepted into longer-term treatment?
6 A Well, I did attempt to, yes.
7 Q Attempt but did not ultimately?
8 A Well, when the decision was made, you know, that
9 puberty blockers were the magic bullet, that
10 kind of foreclosed any further discussion.
11 Q Why did it foreclose any further discussion?
12 A Well, they found the magic solution.
13 Q A short while ago in talking about the one
14 patient who you diagnosed with at least likely
15 gender dysphoria, you said that you told the
16 parents to wait and evaluate for I think you
17 said a considerable amount of time. Does that
18 sound right?
19 A Yes.
20 Q How long do you consider to be a considerable
21 amount of time?
22 A It varies with different patients, but I was
23 very mindful if I communicated this to the
24 parents that one of the only robust studies that
25 looked at childhood onset of gender dysphoria

1 and followed them for 20 years, 88% of them
2 desisted by like adulthood and I think it was
3 60% identified as gay young men. And I
4 communicated that developmental trajectory to
5 the parents and said that they needed to
6 exercise extreme caution in allowing the child
7 to follow his natural developmental trajectory
8 and that any social transition or prescription
9 of puberty blockade would derail that
10 developmental trajectory.
11 Q And, I'm sorry, how are you defining social
12 transition?
13 A Where the child changes his or her names or
14 pronouns. They start to dress in the
15 stereotypically style of the opposite sex where
16 they grow their hair long or cut their hair
17 short, that kind of thing.
18 Q When you have a patient that presents to you as
19 transgender, do you use particular pronouns in
20 referring to that person?
21 A I avoid pronouns altogether because I'm having
22 first person conversation with a young person
23 and I do not use --
24 Q Well, you talk about the patient with their
25 parents, though; right?

1 A Not often, no. I usually separate the
2 consultations with parents and children.
3 Q I'm so sorry for the misunderstanding, Doctor.
4 I did not mean you talk about the patient with
5 the parents in the same room. I meant you have
6 a separate conversation with the parents about
7 the patient; correct?
8 A Yes.
9 Q And when you're speaking to the parent do you
10 use pronouns to refer to the child?
11 A I follow the parent and, in the majority of the
12 cases that I see, the parent is insisting on the
13 child's birth name and natal pronouns.
14 Q Are there cases where the parent has referred to
15 their child using their non-natal pronouns?
16 A Yes, I had one last night and, I mean, it wasn't
17 her first session. I've seen her before and she
18 is now using her daughter's preferred name and
19 masculine pronouns. And I have discussed that
20 with her, you know, why is she doing that and
21 how does she think it's helping her child, and I
22 then seek permission from the parent to call the
23 child by his or her given name and pronouns.
24 Q And I assume your medical records use the sex
25 the child was assigned at birth when they have

1 to?
2 A Yes. I need to do that for clinical purposes
3 because I need to get a picture in my own mind,
4 a template of this child, and quite often I have
5 to do file reviews and case reviews and you will
6 notice in my declaration that I have referred to
7 these four young people using pronouns of their
8 natal sex and their given name except in one
9 case where the given name has been expunged
10 completely, but that is my clinical practice.
11 Q Okay. Doctor, in your CV, which should still be
12 in front of you, Page 2 lists your membership in
13 various professional organizations; is that
14 correct?
15 A Yeah.
16 Q And I assume you remain a member of each of the
17 organizations you list here?
18 A No, I said that I -- well, in my CV, obviously,
19 it doesn't say that, but somewhere I said, I
20 think it was in the bio, you know, preceding
21 this, I was a member or eligible for membership
22 if I let the membership lapse and in some cases
23 I have let the membership lapse because the fees
24 are ridiculous and you have to be very
25 selective.

1 Q Okay. Of the professional societies you list on
2 your CV, which of these societies or
3 organizations do you remain a member?
4 A Only the Australian Psychological Society, but I
5 have at one time or another been members -- oh,
6 and the International Association of Relational
7 Psychoanalytic Psychotherapy. Oh, and I'm a
8 member of the Australian Dispute Resolution
9 Association, yeah.
10 Q And when was the last time you were a member of
11 the American -- or an international affiliate,
12 it looks like, of the American Psychological
13 Association?
14 A I let those go after I left the university.
15 Q So 2019 or so?
16 A Yeah.
17 Q Is that because the university was paying your
18 membership dues?
19 A Oh, no. No, we have to pay our own membership
20 dues.
21 Q Why did you let your membership lapse then?
22 A There's just so much available on the Internet
23 now. It just wasn't value for money. I mean,
24 the Australian Psychological Society, the fees
25 are \$1,000 a year and you just have to be

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1 selective.

2 Q And what does it mean to be an international

3 affiliate of the American Psychological

4 Association? I just don't know what that means.

5 A That means that if you're not American, you

6 can't be a full member.

7 Q Gotcha. Other than the organizations that you

8 list here on Page 2 of your CV, are you

9 currently a member of any other professional

10 organizations?

11 A Yes, I'm a council member of the University of

12 Sydney Association of Professors and I'm a

13 council member of the Australian Association of

14 University Professors. I'm a member of the

15 Society for Evidence-Based Gender Medicine.

16 Q And if I refer to that organization just as

17 SEGM, S-E-G-M, you'll know what I mean?

18 A I will.

19 Q How did you become a member of SEGM?

20 A I was invited.

21 Q By whom?

22 A There were two founding directors and I think

23 one of them is Australian and he put my name up

24 to the American cofounder and they invited me

25 together.

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1 Q And when did you first become a member?

2 A I'd say maybe three to four years ago.

3 Q Have you ever held a leadership position with

4 the organization?

5 A No, I avoid administration and hierarchies and,

6 you know, political positions like the plague.

7 I'm a clinician, I'm a researcher, I'm a writer,

8 and I don't have time for that and I'm not

9 interested in that, yeah.

10 Q Have you ever been compensated by SEGM for any

11 reason?

12 A Yes, I have been on one occasion.

13 Q I assume this was for giving a talk or

14 presentation to a meeting?

15 A I wrote some extensive material for their

16 clinical guide.

17 Q I'm sorry, I missed a word there. Wrote some

18 what material?

19 A Extensively. I wrote some very long documents

20 for them when we were putting together the

21 clinical guide and it was an honorarium. I

22 didn't ask for payment, but they appreciated the

23 amount of time and effort that I devoted to

24 that. And I was perfectly prepared to do it

25 voluntarily so it was just a gesture rather than

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1 -- it wasn't a contract. It was an honorarium.

2 Q Does SEGM hold meetings or conferences?

3 A Yes.

4 Q How often?

5 A I believe about once a month there's a Zoom

6 meeting and from time to time, you know, people

7 get together in person but it's very difficult

8 when you're in Australia. You have to be very

9 selective where you travel.

10 Q Do you have to be invited to become a member?

11 A I believe so.

12 Q Are you aware that statements by SEGM have been

13 cited in support of a formal opinion in Texas

14 that took the position that the provision of

15 certain gender-affirming care to a minor

16 constitutes child abuse?

17 A Yes.

18 MR. FISHER: I was just gonna object. I

19 wasn't sure what formal opinion. Could you

20 maybe --

21 MR. ROSE: I can state for the record, Tom,

22 but when Attorney General Paxton issued his

23 formal opinion declaring the provision of

24 certain care to be child abuse under Texas law

25 he cited SEGM, I think, a couple times.

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1 MR. FISHER: Paxton did, okay. Thank you.

2 MR. ROSE: And I didn't see a point to

3 bring that up and I apologize, bringing the

4 actual document up.

5 Q And I guess my question to you, Doctor, is

6 whether you believe that providing

7 gender-affirming care to minors in the form of

8 puberty blockers or hormones constitutes child

9 abuse.

10 A I would prefer to avoid a motive language. I do

11 believe it's very poor medicine to derail a

12 child's natural developmental trajectory

13 precipitously when the drugs that have been

14 prescribed have known demonstrated (inaudible)

15 to the human body.

16 Now, child abuse in this country, and I'm

17 sure in yours, carries with it a legal

18 definition and so I don't think it's helpful to

19 use a motive language when trying to discuss the

20 best treatment and management of young people

21 who are declaring themselves gender dysphoric.

22 Q And, I'm sorry, Doctor, I would know the answer

23 to this question if you were a psychologist in

24 America. As a psychologist in Australia, are

25 you authorized to prescribe medications?

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1 A No.
2 Q Are you a member of any advocacy or political
3 organizations?
4 A No.
5 Q Have you been in the past?
6 A You mean advocacy for gender-affirming care?
7 Q I meant in general and we can narrow it down
8 from there.
9 A No, I'm not a member of any political party.
10 I'm not a member of any religious organization.
11 I'm not a member of any gender or
12 sexuality-based organization. I am a completely
13 free agent.
14 Q Okay. My understanding is that you have
15 testified before several legislatures and other
16 decision-making bodies concerning transgender
17 persons or the provision of gender-affirming
18 care; correct?
19 A Well, only one formally in America and that was
20 in Alabama.
21 Q And I'll do that one first. Do you mean that
22 you played a role in the Alabama bill similar to
23 Indiana's before that bill was passed?
24 A Yes.
25 Q You, I assume, submitted written comments

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1 advocating for it to be passed?
2 A The original bill, yes.
3 Q And have you testified before legislatures or
4 other decision-making bodies in Australia about
5 the issue?
6 A I have provided written and oral submission to
7 the New South Whales Parliament and the
8 Queensland Parliament and written submissions to
9 the National Parliament in Canberra on various
10 bills associated with gender.
11 Q Let me take those one at a time, I'm sorry,
12 because I just don't understand how broad your
13 answer was. For the parliament in New South
14 Whales, was there more than one bill that you
15 submitted comments on?
16 A Just scroll down so I can see and just remind
17 myself.
18 Q I apologize.
19 A Just keep going. Keep going down to the
20 submissions. Okay. Stop. The submission to
21 the New South Whales Parliamentary Inquiry for
22 the Education Legislation Amendment of Parental
23 Rights, I had a written submission and appeared.
24 I was invited to appear to the parliamentary
25 inquiry. Then there was the submission and

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1 invited presentation to the Queensland
2 government inquiry into the Health Legislation
3 Bill in 2019 to outlaw conversion therapy. And
4 the submission to the ACT -- that stands for
5 Australian Capital Territory -- government into
6 the proposed amendments to outlaw conversion
7 therapy. And I believe I submitted a similar
8 submission to the Victorian Parliament on
9 conversion therapy as well and I've just
10 neglected to put that in.
11 Q Okay. And other than -- maybe this would have
12 been a better way to do this. Other than the
13 possible submission to the Victorian Parliament,
14 is every time you have testified or submitted
15 written testimony to a decision-making body in
16 Australia about gender-affirming care, is that
17 contained on Page 6 of your CV here?
18 A Yes.
19 Q And the one to the Victorian Parliament was also
20 on conversion therapy?
21 A Yeah.
22 Q Have you been compensated for your testimony to
23 any of these bodies?
24 A Only Alabama and Indiana. The other have been
25 all pro bono.

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1 Q And, by your compensation in Alabama and
2 Indiana, you mean after a lawsuit was filed?
3 A I don't understand.
4 Q I'm sorry, Doctor. I'm trying to figure out
5 whether you were paid for submitting testimony
6 to the legislatures while a bill was being
7 contemplated or whether you're just talking
8 about being paid to serve as a witness after a
9 bill was passed and challenged in court.
10 A I think they -- the Alabama and Indiana
11 situations are similar, so, yeah, a bill was
12 passed, now there's an appeal, and I have
13 written a report. Tom will be able to explain
14 that a lot better than me. I don't want to say
15 the wrong thing.
16 MR. FISHER: I'm of no use to Gavin in any
17 of this.
18 Q I understand. Thank you. Page 3 of your CV
19 describes some of your activities for
20 court-referred clients. Do you see that?
21 A Yeah.
22 Q And when did you assume these responsibilities?
23 A Oh, I've been doing that kind of work 10 to 15
24 years.
25 Q You mean you have over the past 15 years?

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1 A Yeah.
2 Q And I assume these are cases where a court in
3 Australia, for one reason or another, wants a
4 child to be evaluated; is that fair?
5 A Yes, and they can also be referred for
6 court-mandated therapy.
7 Q In your responsibilities for court-referred
8 clients, did any of the issues arising from that
9 concern gender dysphoria?
10 A No, because the work that I've done for courts
11 related to gender dysphoria have been written
12 review and literature review and clinical
13 practice documents, so these court-referred
14 clients are usually to do with parental
15 capacity, custody, time with, and, you know, any
16 assessment that would make it necessary for the
17 child or the family to enter into a therapeutic
18 process.
19 Q Okay.
20 A I'll say no to that in terms of gender
21 dysphoria. This work, more or less, preceded my
22 work on gender issues.
23 Q Okay. And then Page 4 of your CV indicates that
24 you also consult for the Tribunal of the
25 Catholic Church; correct?

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1 A I have, yeah.
2 Q Is that something you currently do?
3 A The last case I did was probably about a year
4 ago, maybe more, but I have been doing it for a
5 very long time but I've kinda pulled back
6 because I've just got too much work in other
7 areas.
8 Q And, just very briefly, what did your
9 consultancy for the church or does it entail
10 when they refer something to you?
11 A Usually cases of marriage where one party is --
12 one or both parties is seeking an annulment of
13 the marriage, and it's a very arcane system and
14 it actually behaves very much like a court of
15 law. There's a defender of the faith and a
16 defender of the couple so it's quite
17 adversarial, it can be, and, extraordinarily,
18 the Catholic Church will sometimes find that
19 there are no grounds for annulment. And usually
20 people who go and seek annulments, they're
21 devout Catholics and they wanted to remarry in
22 the Catholic Church, but they can't remarry in
23 the Catholic Church. They can only have a civil
24 marriage unless their previous marriage has been
25 annulled, and so they're the people who seek

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1 annulments.
2 So I do a marriage assessment and I see the
3 couple and, you know, I do all the normal things
4 that I would normally do as a psychological
5 assessment of these couples to assist them and
6 support them in -- you know, it's usually a very
7 fraught and stressful time for these couples.
8 Q Okay. And then I'm going to scroll through this
9 real quick. And, I'm sorry, Doctor, did you say
10 that you have a copy of your CV in front of you?
11 A No, I don't, no.
12 Q Okay. Then I will scroll through real quick.
13 I'm going to scroll through Pages 5 through 8 of
14 your CV real quick, and my question to you is
15 going to be whether this, as it purports to, the
16 articles, reports, presentations that you have
17 given specifically concerning gender
18 dysphoria-related issues is going to be my
19 question. Spoiler alert.
20 Look through to the bottom there. Is that
21 an accurate description of what you identify in
22 Pages 5 through 8?
23 A Yeah, pretty much.
24 Q Okay. The very last entry under that subheading
25 related to gender dysphoria appears to be a

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1 radio interview that you gave in 2015. Do you
2 see that?
3 A Yes.
4 Q I've read the transcript to this interview.
5 It's my assumption it was mistakenly placed
6 here, but I will just ask you. Did this
7 interview specifically concern gender dysphoria
8 or any issues related to it?
9 A I'm sorry about that. Let me just turn my phone
10 off. It is misplaced, I'm afraid to say,
11 because the date of 2015 is prior to my work in
12 the gender dysphoria area, so I apologize for
13 that error.
14 Q That was my assumption. I just wanted to make
15 sure the record reflected that. And if that's
16 the only error you make in a 14-page CV, you
17 have done quite well for yourself.
18 Okay. The date you've given for when you
19 started focusing on gender-related issues of
20 2019 you've indicated, more or less, coincides
21 with when you left the University of Sydney.
22 I'm wondering, first and foremost, why you left
23 the University of Sydney.
24 A Well, after 31 years, I'd had enough and I was
25 wanting to get back into clinical work and the

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1 tertiary system in this country is somewhat less
 2 than conducive to genuine academic work. It's
 3 just turned into a corporate bazaar and I no
 4 longer felt the affinity that I've always felt
 5 for academic life and my academic institution in
 6 particular, but it was time for a change.
 7 I wanted to work clinically and I wanted to
 8 be free to express my firmly-held positions on
 9 certain topics. And you, no doubt, are very
 10 aware that there have been several academics
 11 around the world who have been sacked from the
 12 universities for expressing a contrary view, but
 13 that didn't motivate me. I have to be very
 14 clear about that because I hadn't really written
 15 or published anything or even formed my opinions
 16 firmly in 2019, but I did note with interest how
 17 other academics were being treated around the
 18 world if they dared to express a contrary view
 19 and I wouldn't find that acceptable.
 20 Q Was there anything specific at the University of
 21 Sydney that indicated to you you would not be
 22 allowed to express your opinions related to
 23 gender dysphoria?
 24 A Oh, absolutely. You just had to look at the new
 25 policies and, you know, colleagues using -- you

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1 know, you can see our names up here on the Zoom
 2 and suddenly putting in preferred pronouns and
 3 there were all sorts of indications that, you
 4 know, the opinions were only going one way and
 5 there was no room for academic debate, but I do
 6 stress that that was not a motivator for me
 7 personally.
 8 Q Okay. I'm going to scroll back up to Page 5 of
 9 your CV. Toward the bottom of the page is an
 10 article with the lead author R. D'Angelo that
 11 you coauthored titled One Size Does Not Fit All.
 12 Do you see that?
 13 A Yeah.
 14 Q Other than this publication, have any of your
 15 writings concerning gender dysphoria or its
 16 treatment been published in any peer-reviewed
 17 journals?
 18 A No, not at this point.
 19 Q But this D'Angelo article was published in a
 20 peer-reviewed journal?
 21 A Yes, it was.
 22 Q And it's my understanding from looking at the
 23 article that it's a direct response to an
 24 article that had been published by Jack Turban
 25 and others?

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1 A Correct.
 2 Q Pages 7 through 8 of your CV identify keynote
 3 and invited presentations and podcasts that you
 4 have given pertaining to gender dysphoria. Do
 5 you see that?
 6 A Yes.
 7 Q Is this a complete list of the presentations
 8 that you have given concerning gender dysphoria?
 9 A Look, it might not be complete. I, you know,
 10 was under extreme time pressure to get all the
 11 materials prepared for this deposition and I did
 12 focus very much on the content, you know,
 13 reviewing the literature, writing, and then I
 14 had to focus an enormous amount of attention on
 15 doing the case file reviews of the four
 16 plaintiffs so it may not be an exhaustive list.
 17 Q Is it fair to say that you intended it as an
 18 exhaustive list but there might have been some
 19 presentations that simply slipped your mind as
 20 you were preparing this?
 21 A Quite possibly, yes.
 22 Q Are there any presentations that you
 23 intentionally left off?
 24 A No.
 25 Q Okay. First of all, we've been going for about

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1 an hour and a half. Are you still good to go
 2 for a while?
 3 A Yes, I'm fine.
 4 MR. ROSE: Please, if anyone needs a break,
 5 feel free to speak up, but, as I say, I'm more
 6 than happy to keep talking as long as anyone
 7 will let me.
 8 THE WITNESS: I just wonder if I could have
 9 a one-minute adjournment. I'll be back in one
 10 minute.
 11 MR. ROSE: That's perfectly fine.
 12 (A recess was taken.)
 13 DIRECT EXAMINATION CONTINUING,
 14 QUESTIONS BY GAVIN M. ROSE:
 15 Q My understanding is that you have been retained
 16 by the State of Indiana to offer expert
 17 testimony in this case. Is that your
 18 understanding as well?
 19 A Yes.
 20 Q And you understand that this litigation
 21 generally challenges a complete ban on providing
 22 certain gender-affirming care to minors
 23 diagnosed with gender dysphoria?
 24 A Yes.
 25 Q In order to become involved in this case, did

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1 you reach out to Indiana or did Indiana or its
2 attorneys contact you?
3 A The latter.
4 Q And you're being compensated at an hourly rate
5 of \$400 U.S.?
6 A Yes.
7 Q Do you know approximately how many hours you've
8 devoted to this case so far?
9 A I've kept a running total, but it's well over
10 100. Well over, yeah.
11 Q How does the hourly rate of \$400 compare with
12 the rate that you charge to clients for
13 psychotherapy?
14 A It's extremely generous.
15 Q What is your hourly rate to provide
16 psychotherapy?
17 A I work on a sliding scale so people who are in
18 financial hardship I work for what's called the
19 Medicare rebate, which is the amount that is
20 covered by the nationalized healthcare cover in
21 Australia, and for people who own planes, boats,
22 and tennis courts I charge about, depending,
23 250.
24 Q I'm sorry, did you say 350? 250?
25 A 250. And that's a lot less in American dollars

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1 because our Australian dollar is only worth
2 about \$.68 to your dollar at the moment.
3 Q And that's what I was going to ask. That's in
4 Australian dollars?
5 A Yeah. Yeah.
6 Q Okay. At the outset of this deposition you
7 indicated that you had your expert declaration
8 in front of you?
9 A Yes.
10 Q Is that still the case?
11 A Yes, it is.
12 Q Okay. I'm going to share my screen just very
13 quickly right now and pull up what I marked as
14 Exhibit 2. And I assume that you recognize this
15 as the expert declaration you have submitted?
16 A Yes.
17 Q And I will tell you at the outset that I did not
18 include any of the attachments that your
19 attorneys provided to us. If it's okay with
20 you, I am going to stop the share of this and
21 both you and I can reference our hard copies and
22 I assume that will be much quicker than me
23 scrolling up and down through this. Is that
24 okay?
25 A That's okay.

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1 Q Okay. Did you draft your declaration yourself?
2 A Yes.
3 Q Did anyone other than you draft any portion of
4 it?
5 A No.
6 Q Did anyone other than Indiana's attorneys review
7 or comment on it before you finalized it?
8 A No.
9 Q Have you conferred with any other professionals
10 about this litigation?
11 A No.
12 Q Are you familiar with -- and by familiar, I just
13 mean do you know who they are. Are you familiar
14 with the other individuals that Indiana has
15 designated as expert witnesses in this case?
16 A No, I don't think I am. I haven't been
17 specifically advised, no.
18 Q And my only question to you is whether you have
19 conferred with any of them about this case.
20 A No.
21 Q Okay. I'm pulling up just very quickly what I
22 have marked as Exhibit 3. Do you see that?
23 A Yes.
24 Q Have you seen this document before?
25 A Yes.

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1 Q It's my understanding that this is a summary
2 prepared either by Indiana's attorneys or by you
3 in conjunction with Indiana's attorneys
4 indicating which medical records you have
5 attached to your declarations as Exhibits B, C,
6 D, and E. Is that correct?
7 A Yes.
8 Q Since leaving the University of Sydney, are
9 there any conditions or diagnoses other than
10 gender dysphoria that you consider yourself
11 specialized and emphasize your practice in?
12 A I'm best known for developmental and educational
13 psychology type diagnoses, but I also have an
14 international reputation in the treatment of
15 music performance anxiety and I have many
16 peer-reviewed international publications and
17 have developed a completely new theory about
18 music performance anxiety so that would be an
19 expertise I'm well known for.
20 The other well-known area is the area of
21 sexual offending and I've written extensively on
22 child sexual abuse and juvenile sex offending.
23 So they would be kind of super specialties
24 that I have, but, in general, in the field of
25 developmental and educational psychology.

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1 Q Okay. You indicate in your expert report -- and
2 I don't think you have to look at it, but I
3 think it's Paragraph 9 -- that you have become a
4 tertiary referral source and you mentioned that
5 here as well.
6 A Yeah.
7 Q What does that mean, becoming a tertiary
8 referral source?
9 A Well, it means people have gone through other
10 steps before they get to me.
11 Q Okay. And are there particular persons or
12 entities from whom you receive a significant
13 number of referrals?
14 A I get most of my referrals directly from parents
15 who have spoken with each other. There are some
16 parent support organizations who will recommend
17 parents to me and so they'll come through that
18 route as well.
19 Q Okay. In your declaration you indicate that you
20 are one of only a few clinicians practicing
21 exploratory psychotherapy with persons with
22 gender dysphoria because of so-called conversion
23 therapy bans that have been passed in some
24 Australian states. I assume you're familiar
25 with that.

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1 A Yes.
2 Q What Australian states have passed a ban on
3 conversion therapy?
4 A Queensland, Victoria, the ACT, and I think one
5 in Tasmania is about to go through. And, yeah,
6 I think that they're the four, yeah.
7 Q And I assume you've reviewed the laws that were
8 being proposed and then passed in these states?
9 A Yes.
10 Q Are they all, I guess, functionally identical,
11 for lack of a better word?
12 A Yeah. Yeah, I would say.
13 Q I'm going to pull up what I have marked as
14 Exhibit 4. Do you see that document in front of
15 you?
16 A Yes, but I can't read it.
17 Q That's perfectly fair. I will represent to you
18 that the, I guess, fifth page of the PDF, which
19 has an internal pagination No. 1, says "The
20 Parliament of Victoria enacts:" And I'm just
21 wondering if you recognize this as Victoria's
22 ban on conversion therapy.
23 A Yes, I recognize it, yes.
24 Q And my assumption is that you, yourself,
25 practice in New South Whales?

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1 A That's right, yes.
2 Q Is there a conversion therapy ban that has been
3 enacted in New South Whales?
4 A Not a legal ban, but there's a huge amount of
5 pressure against therapists who are not
6 practicing gender-affirming care.
7 Q And, I'm sorry, I just didn't understand from
8 your declaration. Are you saying that the
9 psychotherapy that you perform to patients with
10 gender dysphoria would be illegal if you did the
11 same thing in Queensland, Victoria, or the ACT?
12 A Yes.
13 Q My understanding is that Australia is at least
14 considering a nationwide ban. Is that your
15 understanding?
16 A Yes, that's my understanding.
17 Q Has it been passed yet?
18 A No.
19 Q Okay. In Paragraph 10 of your declaration you
20 indicate that you're unable to list the
21 Australian cases in which you've testified as an
22 expert because of laws protecting the identity
23 of minors; correct?
24 A Yeah.
25 Q But there have been approximately 100 of those

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1 cases?
2 A That includes my child sexual abuse cases.
3 They're not all related to gender dysphoria.
4 And it also includes the family court cases and
5 the children's court cases. They involve
6 custody disputes but not related to gender
7 dysphoria.
8 Q And that was going to be my question is we
9 looked at the court-referred clients portion of
10 your CV. Is that what those 100 cases refer to?
11 A No, no, no. That's post the court process, the
12 court referred. These are assessments for or
13 expert witness regarding the actual call of
14 matter.
15 Q Of those 100 cases, approximately how many
16 concern gender dysphoria or related issues?
17 A Oh, I think only about three.
18 Q And I assume those were in the last few years?
19 A Yeah.
20 Q And then the one American case you identify is
21 the case challenging a ban similar to ours in
22 Alabama?
23 A Yes.
24 Q And you identify the case as Bowman, but I
25 assume, if you know, it's the same case that I

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1 know as Eknes-Tucker?
2 A I'll take your word for that.
3 Q Okay. Doctor, I am ready to move into slightly
4 more substantive matters. Thank you for your
5 patience as I went through that.
6 I want to be perfectly clear from the
7 outset. Do you consider gender dysphoria to be
8 a valid medical diagnosis?
9 A No.
10 Q Are there any circumstances under which you
11 believe a patient may accurately be diagnosed
12 with gender dysphoria?
13 A Let me put it this way. I think there is a
14 phenomenon that one could describe as gender
15 dysphoria, but the diagnostic process is what
16 I'm referring to as lacking validity. So, in
17 answer to your first question -- could you just
18 repeat your first question about gender
19 dysphoria?
20 Q My first question was whether you consider
21 gender dysphoria to be a valid diagnosis.
22 A Diagnosis, no. I have major diagnostic concerns
23 with the way in which gender dysphoria is being
24 diagnosed, but I'm not challenging the existence
25 of a phenomenon, a clinical phenomenon, that can

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1 be described as gender dysphoria.
2 Q What does that mean, a clinical phenomenon?
3 A Well, you know, if a patient comes to you and
4 says, "Look, I've got very low mood, I'm not
5 sleeping, I've lost my appetite, I've got no
6 motivation," you'll say, "Well, you know, that
7 sounds like a depressive process," and I need to
8 explore that further with the patient.
9 Similarly, with gender dysphoria, you know,
10 children will come with their narrative about
11 I've always wanted to be a boy and I've always
12 wanted to play with boy things and, in the
13 extreme cases, they want to cut off their sexual
14 organs and so forth. So, of course, one has to
15 be alert to the possibility that there is a
16 clinical process in which the child is
17 uncomfortable in his or her own body and that
18 needs to be explored.
19 Q Do you believe that there are any circumstances
20 under which a child who presents with that
21 clinical phenomenon should be allowed to receive
22 puberty blockers or gender-affirming hormones?
23 A Under almost no circumstances would I think that
24 is a valid approach to take.
25 Q You qualify that with "almost no." What are the

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1 circumstances where you think that might be a
2 valid approach?
3 A Well, if you look at the historical literature
4 and, you know, the amount of writing that
5 occurred, you know, pre sort of 2005 to '10,
6 this was a vanishingly rare diagnosis,
7 vanishingly rare. For example, some of the
8 population figures given for the prevalence of
9 gender dysphoria pre the common era of gender
10 dysphoria, let's put it that way, Sweden was
11 reporting one in one million. The DSM-5
12 reported 1 in 27,000 females and one in 10,000
13 males. So, you know, these figures are
14 extremely low so I'm not going to be absolutist
15 and say there is no circumstance under which
16 it's not an appropriate diagnosis, but the
17 degree to which it's being diagnosed today is of
18 great clinical concern.
19 Q And, Doctor, my question was: How would a child
20 have to present to you for you to believe it to
21 be appropriate for that child to receive puberty
22 blockers or gender-affirming hormones or is that
23 just off the table entirely?
24 A It's very close to being off the table.
25 Q How about for adults? Do you think adults

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1 should have the ability to receive
2 gender-affirming hormones or even
3 gender-affirming surgery?
4 A Under very special circumstances. Under the
5 original treatment protocol for an adult seeking
6 transgender surgery was that they had to live in
7 their chosen sex for two years and undergo
8 intensive psychotherapy before they would be
9 cleared for surgery. None of those safeguards
10 are in place for young people.
11 Q If they were in place, would you believe it
12 would be appropriate for them to receive this
13 sort of gender-affirming care?
14 A In vanishingly rare cases.
15 Q And can you imagine a child who presents who has
16 consistently over a number of years presented as
17 a sex different than the birth sex who has been
18 in therapy for years and who is presenting with
19 no comorbidities and a certain level of
20 distress, can you imagine yourself thinking it
21 appropriate for that person to receive
22 gender-affirming medications?
23 A I don't think such a person exists.
24 Q Okay. I want to turn, at long last, to social
25 contagion and your description of social

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1 contagion. My understanding is that you
2 separate your declaration into two chapters;
3 correct?
4 A Yes.
5 Q And will you flip to Paragraph 21 of your
6 declaration on Page 11?
7 A Okay. So I'm going to have to change glasses
8 frequently when I'm looking at my declaration.
9 So you said 21?
10 Q 21.
11 A Alright.
12 Q Are you there?
13 A Yes.
14 Q You don't have to do so out loud, but will you
15 read Paragraph 21 to yourself real quick?
16 A Yeah, I've read it.
17 Q Okay. We'll get to the specifics momentarily,
18 but my first question is if this paragraph
19 provides a fair summary of the conclusion that
20 you offer in the first chapter of your
21 declaration.
22 A Yes.
23 Q You use the language "social contagion may have
24 a major role" to play, and I'm curious about
25 your use of the word "may" in that sentence.

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1 A Well, I'm not absolutist or prescriptionist
2 because I am not omnipotent and my paper is
3 based on very careful analysis and inference.
4 And the reason that it is based on analysis and
5 inference is that there has been no
6 empirically-driven epidemiological study to test
7 my hypotheses and that's why I say "may."
8 Q And you're familiar, I assume, with an article
9 and ultimately a correction to that article that
10 was published by Dr. Lisa Littman who was then
11 with Brown University?
12 A Uh-huh.
13 Q I'm sorry. Yes?
14 A Yes.
15 Q And you're aware, I assume, that she describes
16 her work as "generating hypotheses, not
17 conclusions"?
18 A Yes.
19 Q And you just used that word, too. Is it fair to
20 say that you are describing to us a hypothesis?
21 A Yes, it is fair to say that, but some hypotheses
22 are more robust than others and I believe this
23 to be a very robust hypothesis.
24 Q Will you turn to Paragraph 108 of your
25 declaration?

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1 A Did you say 108?
2 Q 108 on Page 55.
3 A Yes.
4 Q Are you there?
5 A Yes, I am.
6 Q And in that paragraph you describe a "core group
7 of 'actual' cases," I assume of gender
8 dysphoria. Do you see that?
9 A Yes.
10 Q And by "core group of 'actual' cases," you meant
11 actual cases of gender dysphoria?
12 A Yes.
13 Q And it appears to me that you're indicating in
14 this paragraph that social contagion may affect
15 some "actual cases" of gender dysphoria but may
16 also affect some other, I assume, nonactual
17 cases. Is that a fair statement?
18 A Yes, that's a fair statement.
19 Q And how does the social contagion affect the
20 actual cases?
21 A Well, it's the disinhibition effect that if --
22 you see, I'm trying to cover all my bases here
23 because all of the literature that I've read,
24 all the epidemiological literature available on
25 gender dysphoria, will identify a case. It

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1 might be 1 in 84,000. It might be 1 in 1
2 million. It might be 1 in "twenty-two hundred
3 and fourteen thousand." There's data predating
4 2010 that shows, you know, very consistently
5 that there are cases but they're vanishingly
6 rare. It wouldn't even qualify for -- well, an
7 orphan diagnosis qualifies because --
8 Q Let me stop you there because I think you've
9 gone well beyond the --
10 MR. FISHER: Gavin, let her finish the
11 answer, please. You keep doing this. You gotta
12 let her answer. She's trying to provide you an
13 answer.
14 MR. ROSE: I think she keeps stepping well
15 beyond my questions, Tom.
16 A I'm sorry. I'll be very specific. It's okay.
17 It's okay. The answer is: Yes, there are some
18 actual cases. We don't know how many. And of
19 those actual cases, the current (inaudible) of
20 transgender affirming everything would help that
21 vanishingly rare case who had not yet enacted or
22 done anything about their genuine gender
23 dysphoria to come forward for treatment.
24 Q And I think you referred to that at the outset
25 as a disinhibition effect. Is that fair?

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1 A Yeah. Yeah.
2 Q It might make some people just feel more
3 comfortable coming forward?
4 A Yes.
5 Q Okay. I want to make sure I understand
6 generally now what types of things might serve
7 as the social contagion you described as capable
8 of causing persons to mistakenly identify as
9 transgender. You describe, first and foremost,
10 influences from peers, celebrities, social
11 media. Is that a fair statement?
12 A Yeah. It obviously goes way beyond that, but,
13 yes, they are factors that are included.
14 Q And I guess my question is: If a celebrity or
15 other influential person does nothing more than
16 openly identify themselves as being transgender,
17 is that something that you think can have this
18 social contagion effect?
19 A Yes.
20 Q There does not need to be any attempt at overt
21 coercion of any sort?
22 A No.
23 Q What if a public library or a school library
24 chooses to either carry or display books
25 pertaining to gender-related issues, is that

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1 something that can have a social contagion
2 effect?
3 A Absolutely. Particularly as they're universally
4 full of misinformation.
5 Q What if a person is simply subjected to a book
6 with a transgender protagonist, can that have a
7 social contagion effect?
8 A Yes, it can. The Internet site Anime was
9 recently boasting that it now had 279 characters
10 that were known cisgender.
11 Q Do you know how many cisgender characters it
12 has?
13 A Half a dozen.
14 Q And the Internet site Anime, is that anime.com?
15 A I presume.
16 Q You know throughout your declaration that in
17 recent years there have been significant
18 increases in persons identifying as transgender
19 or in seeking care from gender clinics. I
20 assume you agree that's a fair summary?
21 A Yeah.
22 Q I assume you agree that there are other factors
23 in addition to social contagion that might also
24 cause an increase in persons identifying as
25 transgender?

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1 A Well, you have to go back to my paragraph that
2 tries to explain the statistical complexity. I
3 would argue that what explains the exponential
4 increase in young people presenting as
5 transgender is primarily accounted for by the
6 phenomena of social contagion.
7 Q And I understand that and you used the word
8 "primarily." I'm just wondering what other
9 factors might also account for that.
10 A Well, the other factors I see as secondary
11 factors. So gender dysphoria has become a
12 vehicle for young people who are very distressed
13 about themselves in some way that something has
14 gone wrong with their development, so they're
15 unhappy, they're discontent, they don't have a
16 peer group, they're lonely, they may be in
17 conflict with their parents, they may have and
18 they will have significant comorbid conditions.
19 So gender dysphoria has become, you know, the
20 overarching umbrella on which disturbed young
21 people are hanging their hats, so to speak,
22 because they get such a receptive response to
23 declaring themselves transgender, whereas if
24 they said, oh, I'm depressed or I'm anxious,
25 well, that's very garden variety and it doesn't

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1 get above the threshold of concern, whereas
2 young people presenting with gender dysphoria
3 have this whole machine around them now. It
4 really gets their parents' attention. It really
5 gets them noticed and, you know, managed and so
6 forth. So these are secondary things.
7 But, I mean, I have parents coming to me
8 who show me thousands of text messages that
9 their child had received from groomers and
10 predators on the Internet trying to convince
11 young people to transition. You're really
12 trans. If you say this about yourself, it means
13 that you're really trans. And some of them have
14 gone to the point of actually sending minors
15 cross-sex hormones through the Internet as a
16 gift to the young person.
17 Q Do you believe that better understanding of
18 gender dysphoria has played any role in the
19 increase in the number of persons identifying as
20 transgender?
21 A I don't think there's any better understanding
22 that I've noticed in the last 10 years.
23 Q Do you think increases in the availability of
24 treatment have led more persons to come forward
25 as transgender?

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1 A Absolutely, but in a socially contagious way.
2 Q Are you aware of studies indicating that more
3 persons will seek care for a condition when that
4 condition becomes destigmatized?
5 A You know, the destigmatized argument has a small
6 amount of merit, but it can't possibly account
7 for the numbers and the trajectories on graphs
8 that we're seeing with gender dysphoria.
9 Q Are you familiar with a body of professional
10 literature specifically concerning increased
11 numbers in patients seeking treatment for HIV as
12 the condition became destigmatized?
13 A Sure.
14 Q And you agree that there were significant
15 increases in persons seeking treatment for that
16 condition?
17 A Yes, because they had a diagnosable medical
18 condition that could be treated with
19 scientifically evidence-based medications.
20 Q In your opinion, can social contagion work the
21 other way around if someone is subjected to
22 messages that being transgender is wrong or
23 simply does not have access to any books with a
24 transgender protagonist? Can that cause a
25 transgender person to remain in the closet, so

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1 to speak?
2 A There is absolutely no evidence for that
3 assertion one way or the other, but if you want
4 me to give an educated guess, it's possible but
5 it would be extremely unusual.
6 Q In the report that you submitted in the Alabama
7 case -- and I didn't print it out or pull it up
8 for you -- you noted that the "ominous trend"
9 whereby more persons are identifying as
10 transgender has "rarely been systematically
11 studied" either theoretically or empirically. I
12 understand you might not recall the precise
13 verbiage, but do you recall expressing
14 sentiments similar to that?
15 A Yes.
16 Q And I assume that's still an accurate statement
17 of your beliefs?
18 A Well, it's not my beliefs. It's an empirical
19 fact.
20 Q Are you aware of any peer-reviewed studies at
21 all that attempted to systematically study
22 whether social contagion has led to increases in
23 transgender identification?
24 A Did you use the word "peer-reviewed" or -- what
25 was the wording exactly?

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1 Q Sorry, I will repeat the question. Are you
2 aware of any peer-reviewed studies at all that
3 attempted to systematically study whether social
4 contagion has led to increases in transgender
5 identification?
6 A Well, Jack Turban actually claims that he's
7 systematically and emphatically disconfirmed
8 social contagion, but, given that I only deal
9 with robust scientific literature that uses a
10 scientific method, I will say no because his
11 study does not fall into that category.
12 Q Are you aware of any peer-reviewed studies at
13 all that attempted to determine what proportion
14 of the increase in transgender identification
15 over recent years can be attributed to social
16 contagion?
17 A I have stated at the outlet that my conclusions
18 are inferential and deductive. I looked at
19 social contagions in a range of other adolescent
20 psychopathologies and the same mechanisms and
21 the same dynamics and the same upward swings in
22 prevalence have occurred in at least six
23 adolescent psychopathologies that have been
24 systematically studied. Now, there's no will to
25 systematically study social contagion and gender

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1 dysphoria and the reason for that is that it
2 will disprove the basic tenant of gender
3 ideology.
4 Q Doctor, I'm sorry to cut you off. I don't mind
5 that you're trying to explain your answer, but
6 the question I asked you first was a yes or no
7 question. We do need to make sure the record is
8 complete and clear so I do want to make sure I
9 get a yes or no to the question about whether
10 you're aware of any peer-review studies that
11 attempted to determine what proportion of the
12 increase in transgender identification can be
13 attributed to social contagion.
14 A I've already answered that question and then I
15 tried to qualify it and was unable to finish my
16 answer.
17 Q Is it fair to say that there are no
18 peer-reviewed studies that attempt to determine
19 what proportion of the increase in transgender
20 identification over recent years can be
21 attributed to social contagion?
22 A Yep.
23 Q I'm sorry. Did you say yes or no?
24 A I said yep.
25 Q Is that a yes?

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1 A Yes, it's a yes.
2 Q Okay. I'm going to pull up for you real quick
3 what I have marked as Exhibit 5. And do you see
4 that in front of you?
5 A Yes.
6 Q Beginning in -- and you can go there if you
7 want, but in Paragraph 81 of your declaration
8 you describe an article that was written by
9 Dr. Littman who we mentioned.
10 A Yes.
11 Q And I understand that there was ultimately a
12 correction to that article, but you recognize
13 what I have in front of you as the original
14 article that Dr. Littman authored?
15 A Yes.
16 Q And both you and Dr. Littman discuss
17 "rapid-onset gender dysphoria"; correct?
18 A Yes.
19 Q Prior to Dr. Littman's article in 2018, are you
20 aware of any professional literature that used
21 that term?
22 A No.
23 Q Is rapid-onset gender dysphoria a diagnosis
24 listed in the DSM-5 or its text revision?
25 A No.

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1 Q Is it identified in the International
2 Classification of Diseases, ICD-9?
3 A No.
4 Q Is there an objective measure that you or
5 Dr. Littman are using to determine when or
6 whether the onset of gender dysphoria is
7 "rapid"?
8 A It's adolescent onset as opposed to early
9 childhood onset.
10 Q And that was going to be my question. Is the
11 term saying anything other than that a person
12 first identified themselves as transgender
13 during their adolescence rather than earlier?
14 A Well, it's the timing but also the rapidity of
15 the onset so it becomes manifest in a very short
16 period of time during adolescence.
17 Q Do you have a way of distinguishing between
18 someone with "rapid-onset gender dysphoria" and
19 someone who had dysphoria for a longer period of
20 time but simply delayed in coming out through
21 pressures or family dynamics or what have you?
22 A That would be very unusual, but the way that I
23 assess it is through very detailed clinical
24 interview.
25 Q Do you have any patients that you've diagnosed

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1 with rapid-onset gender dysphoria?
2 A Well, I don't tend to be beholden to diagnoses,
3 but the majority of my caseload would, if you
4 wanted to use that term, would fit into that
5 categorization.
6 Q Okay. It's my understanding that for her study
7 Dr. Littman posted a survey on three different
8 websites where parents had reported sudden or
9 rapid onsets of gender dysphoria in their
10 children; is that correct?
11 A That's my understanding, yes.
12 Q And then I understand they were subsequently
13 reposted to a fourth website, a Facebook group?
14 A Uh-huh.
15 Q Sorry. Yes?
16 A Yes.
17 Q And of the three websites that Dr. Littman
18 originally posted the survey, are you aware that
19 they have all taken a position on the provision
20 of gender-affirming care to transgender youth?
21 A The parents?
22 Q The websites.
23 A Oh. No, I don't think I was completely clear
24 about that.
25 Q Do you have an understanding that all three of

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1 those sites have taken a position that was
2 "unsupportive" of gender transition?
3 MR. FISHER: I'm going to object. I'm not
4 sure that the meaning of that is clear or where
5 it's coming from.
6 MR. ROSE: Why don't I get an answer first
7 and then I can explain, if that's okay.
8 Q Do you need me to repeat the question, Doctor?
9 A Yes.
10 Q Do you agree that all three of the sites on
11 which Dr. Littman posted the survey have taken a
12 position that is "unsupportive of [gender]
13 transition"?
14 MR. FISHER: Same objection. You may
15 answer.
16 A Okay. Concerned and questioning.
17 Q Would it surprise you to know that in her notice
18 of correction to this article Dr. Littman
19 characterized all three of these websites as
20 being "unsupportive of [gender] transition"?
21 A Look, I probably read it, but I've been reading
22 hundreds of papers since then and details will
23 sometimes escape one's attention.
24 MR. ROSE: And, just for the record since
25 I'm speaking instead of writing, the "gender"

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1 there is in brackets. The quote is
 2 "unsupportive of transition" and the "gender" is
 3 taken from context.
 4 Q One of the websites that Dr. Littman indicates
 5 the survey was posted to is called Youth Trans
 6 Critical Professionals. Are you familiar with
 7 that website?
 8 A Yes.
 9 Q Have you ever visited it?
 10 A I tend not to spend a lot of time visiting
 11 websites.
 12 Q Have you ever visited it?
 13 A I've clicked to it.
 14 Q The reason I ask is that if you go right now,
 15 you pick up a language saying that the website
 16 is now private and it cannot be accessed, and
 17 I'm wondering if you were aware of that.
 18 A No.
 19 Q Okay. And you understand that Dr. Littman
 20 directed her survey toward the parents of
 21 transgender youth, not the youth themselves;
 22 right?
 23 A Yes.
 24 Q When you provide psychotherapy to one of your
 25 patients, are there any circumstances at all

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1 where you would rely exclusively on a parent's
 2 report about what was going on with their child?
 3 A No, I do what's called triangulation and I
 4 include in my case formulation information from
 5 every possible source that is available to me.
 6 Q And one of those sources is obviously speaking
 7 with the child themselves; correct?
 8 A Of course.
 9 Q And I assume in speaking with the child you
 10 would want to know not just what they're going
 11 through but also if there were any reasons that
 12 their parents would not be aware of what they're
 13 going through; is that fair?
 14 MR. FISHER: I'm going to object. I'm not
 15 sure what is meant by "what they're not going
 16 through."
 17 THE WITNESS: Yeah, I know. Thank you.
 18 Q Do you understand the question, Doctor?
 19 A I think you'll have to reword it.
 20 Q Let me just ask this more generally. In your
 21 field of psychotherapy, I assume that
 22 self-reporting provides a useful and sometimes
 23 vital source of information; is that fair?
 24 A Yes.
 25 Q Okay. And you're aware, I assume, that the year

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1 after Dr. Littman first published her article
 2 she published a corrected version of the same
 3 article along with a notice of correction?
 4 A There was a (inaudible) after the publication of
 5 her article and it was taken down after it had
 6 already gone through a rigorous peer-review
 7 process, so, to please the naysayers, a couple
 8 of sentences were added and so I wouldn't call
 9 it a substantive correction. The data remained
 10 unchanged and the conclusions remained
 11 unchanged.
 12 Q Okay. But there was a corrected version
 13 published; correct?
 14 A Well, there was a slightly altered version
 15 published.
 16 Q And at the same time of that publication there
 17 was also a separate notice of correction
 18 explaining the reasons for the revision that was
 19 published in the same journal?
 20 A Yes.
 21 Q I'm going to click over to Exhibit 6. Do you
 22 see that in front of you?
 23 A Yes.
 24 Q And you recognize this, I assume, as the notice
 25 of correction?

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1 A Yes.
 2 Q In this notice, Dr. Littman says that "This
 3 report ... does not validate the phenomenon,"
 4 and it appears from context that the phenomenon
 5 is rapid-onset gender dysphoria. Do you see
 6 that in the middle of the --
 7 A Yeah. Yeah.
 8 Q Do you agree that Dr. Littman's study does not
 9 validate of phenomenon of rapid-onset gender
 10 dysphoria?
 11 A Absolutely. It was a very preliminary early
 12 notice of something interesting, and all new
 13 discoveries are made through noticing changes in
 14 patterns in the environment and that can lead to
 15 all sorts of astounding new discoveries. So it
 16 would be foolish, and nor did she do so,
 17 claiming that this study proved anything other
 18 than the report of this group of parents.
 19 Q Okay. Do you know Dr. Littman personally?
 20 A No.
 21 Q Okay. And I'm going to click over to Exhibit 7.
 22 And do you see that in front of you?
 23 A I do.
 24 Q A short while ago, you mentioned a study by
 25 Dr. Turban and others that sounded like you took

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1 issues with, and am I correct that this is that
2 study?
3 A Yes, it is.
4 Q This was published in a journal called
5 Pediatrics?
6 A Yeah.
7 Q And that's a peer-reviewed journal; correct?
8 A Let's just say they have a peer-review process
9 that has been degraded in recent times.
10 Q Has the process itself changed to your
11 knowledge?
12 A No, the process is still the same.
13 Q If it had not been for the article's publication
14 of Dr. Turban's article or others like it, would
15 you believe that the peer-review process of
16 Pediatrics had been degraded in recent years?
17 A I would have to judge that article by article,
18 but it's astounding to me that some of the
19 papers that I see published on the subject have
20 actually got through a peer-review process if it
21 was truly anonymized and objective.
22 Q I understand that you might take issue with some
23 of the data or the source of the data, but you
24 understand that Dr. Turban and others analyzed
25 data from several states that was collected by

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1 the Centers for Disease Control and Prevention;
2 correct?
3 A That one, I believe from memory, is from the
4 Youth Risk Behavior Survey.
5 MR. ROSE: Okay. Doctor, if you don't
6 mind, my bladder is desperately requesting that
7 I call a break. I'm okay with just five
8 minutes. If anyone needs a longer break, I'm
9 more than happy with that, too.
10 THE WITNESS: Five minutes is fine with me.
11 (A recess was taken.)
12 DIRECT EXAMINATION CONTINUING,
13 QUESTIONS BY GAVIN M. ROSE:
14 Q Doctor, do you still have your declaration in
15 front of you?
16 A Yes, I do.
17 Q I will have you turn to Paragraph 85 on Page 41
18 if you don't mind.
19 A Yeah.
20 Q In this paragraph, you mention an August 2021
21 statement by the Coalition for Advancement &
22 Application of Psychological Services or CAAPS
23 calling for the elimination of the use of
24 rapid-onset gender dysphoria; correct?
25 A Yes.

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1 Q It's my understanding that CAAPS, with two As to
2 our court reporter, is a nonprofit coalition of
3 various professional organizations involved in
4 the science of mental health. Is that a fair
5 summary?
6 A I guess so, yes.
7 Q Well, I took it directly from their website, so
8 I hope it is. Okay. I am going to show you
9 what I've marked as Exhibit 8. Do you see that
10 in front of you?
11 A Yes.
12 Q And you, I assume, recognize this as the
13 statement to which you were referring in
14 Paragraph 85 of your declaration?
15 A That's right, yes.
16 Q And you understand, I assume, that numerous
17 other -- I won't count them, but numerous other
18 organizations also signed on to the statement?
19 A Yes.
20 Q Including both the American Psychological
21 Association and the American Psychiatric
22 Association, I think?
23 A Yes.
24 Q I'm looking, I guess, generally at Paragraph 87
25 of your declaration. I don't know, Doctor, if

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1 you will need to look at it for this series of
2 questions, but I certainly invite you to if it
3 would be useful to you. In this paragraph --
4 A Sorry for interrupting. It's very hard. I've
5 got a visual impairment and it's very hard for
6 me to go from screen to page, back and forward,
7 and I'm just wondering if you would be able to
8 quickly put that up on the screen for me.
9 Q I can certainly do that. I can't promise it
10 will be quickly, but I can certainly do that.
11 A Okay.
12 Q Do you see that in front of you?
13 A Yeah.
14 Q It's Paragraph 87 of your declaration; correct?
15 A Yes.
16 Q And I'm not going to get into precise numbers,
17 but it sounds here like you're describing, I
18 guess, differences in the share of persons
19 identifying as transgender between adolescents
20 and younger children over several decades; is
21 that fair?
22 A Yes.
23 Q I think you say that prior to 2000, children age
24 3 to 12 years identifying as transgender greatly
25 outnumbered adolescents?

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1 A Yes.
2 Q And my understanding of your report is that you
3 believe the increase in the percentage of
4 adolescents identifying as transgender is
5 because that group, and particularly persons
6 assigned female at birth in that group, are
7 particularly susceptible to social contagion; is
8 that fair?
9 A Yes.
10 Q Is it fair to say that you think that social
11 contagion played a minimal role before the year
12 2000 in causing persons to identify as
13 transgender?
14 A Yes.
15 Q Is there an age at which you think persons
16 assigned female at birth have matured enough
17 that they're less likely to be susceptible to
18 social contagion?
19 A Could I register my disagreement with the phrase
20 "assigned female at birth"? Could you, please,
21 just say "a natal female" because sex is not
22 assigned at birth. Sex is determined at
23 conception by the presence of X and Y
24 chromosomes. It is not assigned at birth, so I
25 would appreciate if you could just use the

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1 phrase "a natal female" or "a natal male."
2 Q Why don't I just state for the record that when
3 I use the phrase "assigned female at birth," I
4 am referring to what you would refer to as a
5 "natal female," okay?
6 A But I don't want any more documents than
7 necessary to reflect flawed and fallacious
8 scientifically-lacking gender ideology of which
9 the phrase "assigned female at birth" is a major
10 contributor.
11 Q Do you understand what I mean when I say
12 "assigned female at birth"?
13 A I understand what you mean, but you're
14 expressing it incorrectly.
15 MR. FISHER: I'm concerning along these
16 lines that it's gonna end up putting words in
17 her mouth that she doesn't want, and I think
18 that that's probably part of her concern, too.
19 MR. ROSE: Well, she can certainly answer
20 however she feels comfortable, but I am going to
21 use the verbiage with which I feel comfortable.
22 Q And, as I stated for the record, when I use the
23 phrase "assigned female at birth," I'm referring
24 to what you would refer to as "a natal female."
25 Is that fair?

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1 A Yes.
2 Q Okay. The question that precipitated this was
3 whether there is an age at which you believe
4 that persons assigned female at birth have
5 matured enough that they are less susceptible to
6 social contagion?
7 A There's a clear set of studies that shows that
8 susceptibility decreases with increasing age and
9 cognitive maturity, so children are more
10 susceptible, in general -- we're talking in
11 population figures here but there's a lot of,
12 you know, variation at an individual basis, but,
13 statistically, in general, at a population
14 level, children tend to be more susceptible than
15 young adolescents; young adolescents tend to be
16 more susceptible than older adolescents; and
17 older adolescents tend to be more susceptible
18 than young adults, onwards.
19 So there's not a cut-off. There's not, you
20 know, 15 is the cut-off at which you're
21 susceptible and then after 15 you're not
22 susceptible. It's a gradient rather than
23 categorical, but that, from a statistical
24 perspective, is what the findings have been.
25 Q And I apologize for repeating you. I really

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1 just think I missed a word. It sounded like you
2 were saying that children are the most
3 susceptible, young adolescents next, older
4 adolescents next, and adults are the less
5 susceptible; is that fair?
6 A From a population statistically, a generalized
7 perspective, yes.
8 Q I understand there may be variants with
9 particular individuals; correct?
10 A Well, one variation that has been noted is that
11 children who are securely attached to their
12 parents are less susceptible compared with
13 children who were not securely attached and that
14 could occur anywhere from early childhood to
15 late adolescence, so there's very important
16 modifiers of that statement.
17 Q I had asked the initial question about whether
18 there was an age at which persons assigned
19 female at birth are mature enough, and you gave
20 me that hierarchy and that's perfectly fine. I
21 assume the same hierarchy exists for persons
22 assigned male at birth?
23 A The natal males, yes, the same hierarchy exists.
24 Q And we were talking in general, but as it
25 relates to the social contagion effect of

1 transgender identification, it's the same
2 hierarchy, right, children most susceptible,
3 then young adolescents, then older adolescents,
4 then adults?
5 A Well, when you look at the literature on uptake
6 of behavioral phenomenon in different age
7 groups, you find this effect across the board
8 whether it's substance abuse, self harm,
9 suicidality, and so forth, so it's a fairly
10 robust finding.
11 Q Okay. I'm going to scroll up on your
12 declaration again to Paragraph 84. Do you see
13 that?
14 A Yes.
15 Q And in this paragraph you're describing, at
16 least for most of it until the last sentence, a
17 study published by Indremo and others?
18 A Yes.
19 Q And this was a study that tracked a number of
20 referrals to clinics providing gender-affirming
21 care after positive or negative media coverage?
22 A Yes.
23 Q And it sounds to me from your language like
24 you're describing in this paragraph increases in
25 referrals following positive media coverage and

1 decreases following negative media coverage; is
2 that fair?
3 A That's fair.
4 Q And the study you cite concerning the negative
5 media coverage is the Indremo, the Swedish study
6 from 2020?
7 A Yes.
8 Q I'm flipping over to Exhibit 9 now. And do you
9 see that in front of you?
10 A Yes, I do.
11 Q And I assume that you recognize this as the
12 Indremo and others study?
13 A I know where you're going with this and it's a
14 question of emphasis, but the results are the
15 results. Indremo is trying to present it as,
16 you know, let's get all the media coverage
17 positive, but his study is, in fact, a perfect
18 example of social contagion. Negative coverages
19 reduces clinic numbers and positive coverage
20 increases them and so it's really quite a robust
21 demonstration of social contagion.
22 Q I'm sorry, Doctor, my question was literally
23 just do you recognize Exhibit 9, the Indremo
24 study that you cite?
25 A Yes, I do. I do recognize it, but I was

1 anticipating where you were going with it.
2 MR. FISHER: Doctor, let me just suggest
3 let's not anticipate. We'll get through it
4 faster.
5 THE WITNESS: Thank you. Okay. I'm sorry.
6 Q You're perfectly fine. I don't mind at all. I
7 just wanted to make sure the record was clear on
8 that front.
9 A Okay.
10 Q And my understanding is that the Indremo study
11 actually studied the relationship between three
12 different media events and referrals to gender
13 clinics; correct?
14 A Yes.
15 Q One positive media event and two negative media
16 events?
17 A Well, the two negative were connected. They
18 were Part 1 and Part 2 of the same series.
19 Q And then there was also one positive media
20 event?
21 A Yes.
22 Q And do you understand that for the positive
23 event and for the first of the negative events
24 the Indremo study actually found no relationship
25 between media coverage and transgender clinic

1 referrals?
2 A Say that again. Sorry.
3 Q You understand, don't you, that for both the
4 positive media event and the first of the
5 negative media events the study actually found
6 virtually no change in the number of referrals
7 to gender clinics following the media coverage;
8 correct?
9 A It's been some time since I've read the details
10 of the article. It's just not my memory of it.
11 I thought -- let me just see that conclusion.
12 Q I've moved you down to the results section. Do
13 you see that on the --
14 A Yeah.
15 Q And you agree that the majority of this section
16 describes the changes in referrals following the
17 second negative media event; correct?
18 A Okay. So we're looking at time-specific
19 changes. So in the three months following the
20 event, referrals decreased by 25% overall, by
21 32% for individuals being natal females, and by
22 25% for those aged 13 to 18.
23 Q And you understand that those statistics that
24 you just recounted relate to the changes in
25 referrals following the second negative media

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1 event; correct?
2 A Yeah. Yeah.
3 Q Do you see the last line of the results section
4 that says for the other two media events no
5 changes in referral counts or time trends were
6 observed?
7 A Yes, I do see that and I actually forgotten that
8 part of it.
9 Q Is it fair to say that in your expert report you
10 only described one of the three events studied
11 in the Indremo study?
12 A I was reporting the three-month follow-up data,
13 so I'd have to go back and just revisit that.
14 Q Okay. Then flipping back to your expert report
15 still on Paragraph 84, the last sentence of that
16 paragraph after you talk about the Indremo study
17 says, "On the contrary, increased positive media
18 coverage of trans issues resulted in an increase
19 in referrals to gender clinics." Do you see
20 that?
21 A Yeah.
22 Q The study you cite for that is Pang and others?
23 A Yes.
24 Q And, just for the record, I think you cite the
25 same study earlier in your report for a similar

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1 proposition.
2 A Yes.
3 Q Just proving to you that I read the entire
4 thing.
5 A I'm very impressed.
6 Q I was gonna say I could write my memoirs three
7 times over and end the night with your report
8 here.
9 Okay. I'm flipping over to Exhibit 10.
10 And, again, my first question to you is whether
11 you recognize this as the Pang report that you
12 cite.
13 A Yes.
14 Q And I will just tell you the page numbers on
15 this exhibit do not line up with page numbers
16 that you cited elsewhere in your report simply
17 because of where I got it from, I assume.
18 Okay. My understanding is that Dr. Pang
19 and others studied referral rates to gender
20 clinics in Australia and the UK following media
21 coverage related to transgender issues. Is that
22 your understanding?
23 A Yes.
24 Q Okay. I'm going to flip over to the PDF Page 5
25 where I have highlighted a portion beginning

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1 with "The search strategy." You don't need to
2 do so out loud, but can you read the highlighted
3 portion to yourself?
4 A Yes, I'm familiar with it, yes.
5 Q And this describes the search criteria or terms
6 that Pang and others used to find media items to
7 study in their report?
8 A Yes.
9 Q And you agree that these criteria included any
10 media coverage that contained the words gender,
11 transgender, or gender dysphoria as well as
12 child or adolescent; correct?
13 A Yes.
14 Q If there had been stories in the UK or Australia
15 during the relevant time period similar to the
16 negative media events that were covered in the
17 Indremo study, do you agree that they would
18 almost certainly have fallen within the search
19 criteria?
20 A It would only be a surmise, but it's likely.
21 Q It would have been very difficult to write about
22 that without using the words transgender and
23 either child or adolescent; right?
24 A Sure.
25 Q Okay. I'm going to scroll down to Page 9. And

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1 at the bottom of that carry-over paragraph at
2 the top, Pang and others write, "Testing whether
3 negative media coverage is associated with
4 reduced referral rates (and conversely whether
5 positive coverage is associated with increased
6 referral rates) would thus be a useful next
7 step." Did I read this correctly?
8 A Yes.
9 Q Would it surprise you to learn that this is the
10 only sentence in the entire study where media
11 coverage is referred to as either negative or
12 positive?
13 A Could you go back up to the top of the article?
14 Q Tell me where to stop.
15 A I just want to see the abstract. Okay. Keep
16 going. Okay. Just stop there. Come back down
17 actually. No, go up.
18 Q Sorry.
19 A There. Stop there. Okay. And you're saying
20 that he's talked about media coverage generally
21 as opposed to positive or negative media
22 coverage.
23 Q And do you agree with that?
24 A What in particular?
25 Q Do you agree that the study authors are talking

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1 about media coverage in general and not media
2 coverage as either positive toward transgender
3 issues or negative toward transgender issues?
4 A Well, saying it's positive or negative is kind
5 of drilling down, but the fact that he showed a
6 strong association between media coverage and
7 increased referrals is a demonstration of social
8 contagion.
9 Q I'm going to flip back over to Exhibit 2 where
10 you say, "On the contrary, increased positive
11 media coverage of trans issues resulted in an
12 increase in referrals to gender clinics," and I
13 want you to explain to me where you got that
14 "increased positive media coverage" language.
15 A I'd probably have to read the whole paper again
16 to tell you where I got it. I hope it wasn't an
17 overstep inference on my part, so I presume,
18 obviously, that I inferred from the paper, but I
19 would have to review the paper again to identify
20 how I drew the conclusion that it was positive
21 media coverage as opposed to any media coverage.
22 Q Prior to today, when was the last time you
23 looked at that study?
24 A Oh, it was some time ago.
25 Q Okay. I'm going to scroll down still on your

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1 declaration to, I think, Paragraph 129. Do you
2 see that in front of you?
3 A Yes, I do.
4 Q And do you see at the bottom of that paragraph
5 you state, "The authors, however, did concede
6 that ... increased media content (specifically
7 via social media) might act as a ... means of
8 social contagion"?
9 A Uh-huh.
10 Q I'm sorry. Yes?
11 A Yes.
12 Q And you underlined "might act as a ... means of
13 social contagion"; correct?
14 A Yes.
15 Q And that was still in reference to the Pang
16 study; correct?
17 A Yes.
18 Q I'm going to flip back over to Exhibit 10 and
19 scroll down to Page 9. And you will see at the
20 top of the paragraph immediately above the
21 Limitations heading, Pang and others begin their
22 statement with, "However, we are also mindful
23 that others have speculated that increased media
24 content (specifically via social media) might
25 act as a double-edged sword or a means of social

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1 contagion." Did I read that correctly?
2 A Yes.
3 Q And that is the language from which you are
4 quoting?
5 A Yeah.
6 Q The declaration?
7 A Yeah.
8 Q And what I want to know is how the authors
9 saying "we are mindful that others have
10 speculated" in their article translated to "the
11 authors, however, did concede that" in your
12 expert declaration.
13 A The very fact that he mentioned it, you know,
14 implies that it has to be considered as a
15 serious hypothesis.
16 Q You think that him mentioning that others have
17 speculated about the effect of increased media
18 content means that he's conceding that it might
19 act as a means of social contagion?
20 A Yes, I think his disarming that possible
21 conclusion.
22 Q Okay. In Paragraphs 94 and 95 of your
23 declaration -- and, I'm sorry, it won't all fit
24 in on one page, but you understand that these
25 paragraphs generally concern various data from

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1 the United Kingdom and from Australia; correct?
2 A Yeah.
3 Q And, for much of this data, the citation is
4 provide is to either Kenny, DT 2021 or Kenny, DT
5 2022. Do you see that?
6 A Yep.
7 Q And these citations are obviously you; correct?
8 A They're obviously me, yes.
9 Q And are they referencing something that has been
10 published or simply data that you've collected?
11 A Well, it's been published on my website, but the
12 figures were provided by the gender clinics and
13 I converted them from either text or tabular
14 form into a graph.
15 Q Has this data been published in any
16 peer-reviewed journal?
17 A I think similar data has been used in
18 peer-reviewed publications. (Inaudible) had to
19 have used similar data to have done his study.
20 Q Your chart wherein you reference both referrals
21 to gender clinics in the UK and Australia
22 provides under it that Australian data was
23 provided by "gender clinics under freedom of
24 information applications." Do you see that?
25 A Yeah.

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1 Q Did the UK data come from similar requests?
2 A No, the UK data was published on the NIH
3 website.
4 Q And I understand that -- and I'm looking at
5 Figure 3 here. Do you see the entirety of
6 Figure 3 on this screen?
7 A Yeah.
8 Q I understand that the figure is in thousands so
9 you can't garner precise numbers from this, but,
10 from looking at the chart, it appears to me that
11 the Australian data shows either zero or roughly
12 zero referrals to gender clinics all the way
13 through 2013; is that correct?
14 A Yeah.
15 Q And the UK data shows roughly zero through 2006
16 or 2007 at which point it starts increasing
17 slowly?
18 A Yes.
19 Q Is this because there were simply no gender
20 clinics prior to these dates?
21 A My understanding is that the UK only had the
22 Tavistock gender service. Right up until it's
23 closure, I think it was the only service
24 offering so-called gender-affirming care, so it
25 was a sole referral agency.

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1 Q I'm sorry, I didn't mean to cut you off. Just
2 while it was fresh on my mind, I was going to do
3 it for the court reporter, but
4 T-a-v-i-s-t-o-c-k. Do I have that correct,
5 Doctor?
6 A Yeah. Yeah.
7 Q So my question was whether it's your
8 understanding that there were no gender clinics
9 in these countries during the periods of time
10 where the chart indicates that there were zero
11 or roughly zero referrals to clinics.
12 A Well, as I've just answered for the UK, that
13 there was a clinic, but it did receive a very
14 low number of referrals. In Australia there
15 would have been a couple of clinics but nowhere
16 near as many as there are now.
17 Q A couple of gender clinics even before 2013?
18 A Look, I can't give you the precise numbers and
19 dates of clinics. I believe that they were
20 incorporated into the pediatric departments of
21 the major children's hospital, so it would have
22 been people consulting about children who were
23 presenting with gender dysphoria, but they were
24 probably not called gender clinics and there
25 wasn't a specific service for that purpose until

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1 more recently.
2 Q So, when these charts indicate zero or near
3 zero, you agree it's likely because people were
4 receiving care through something other than
5 formal gender clinics; is that fair?
6 A Yes, it's probably fair, yeah.
7 Q And do you know when Tavistock opened?
8 A I know there's data before like 2000, I mean
9 back as far as 2000, but beyond that I don't
10 know.
11 Q Do you know when it closed?
12 A I think it's formally closing September 2023.
13 Q Okay. In Paragraphs 97 and 98 of your
14 declaration, we'll start here, but do you
15 generally see what these paragraphs are talking
16 about?
17 A Yes.
18 Q It looks to me like you're describing data
19 showing increased referrals to gender clinics in
20 certain Australian states. Do I understand that
21 right?
22 A Yeah.
23 Q And Figure 4 separates it out by each state?
24 A Yes.
25 Q And I think you describe in text that the

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1 increased referrals were primarily in three
2 states, Western Australia, Queensland, and
3 Victoria. Do I have that right?
4 A Yes.
5 Q I assume on your chart WA is Western Australia?
6 A That's right.
7 Q And VIC is Victoria?
8 A Yes.
9 Q And QLD is Queensland?
10 A Yes.
11 Q My understanding is that Melbourne is the
12 largest city in Victoria. Do I have that right?
13 A Sydney is the largest.
14 Q I'm sorry. Is Sydney not in New South Wales?
15 A Sydney is in New South Wales.
16 Q Sorry. I said Victoria. Is Melbourne the
17 largest city in Victoria?
18 A Oh, I see what you mean. , it is, yes.
19 Q Okay. I'm sorry. I have to admit my knowledge
20 of Australian geography is less than yours so I
21 would've been happy to be told I was wrong
22 there.
23 A Well, my knowledge of your 51 states is very
24 sparse in my mind as well, so we're even.
25 Q We're somewhere between Los Angeles and New

1 York. That's all you need to know.
2 A Okay.
3 Q Certainly that's all people in either Los
4 Angeles or New York care about.
5 Okay. My understanding, and please tell me
6 if I'm wrong, is that the first health clinic
7 catering solely to the needs of transgender
8 persons or gender diverse persons in Melbourne
9 was opened in 2016. Is that your understanding
10 as well?
11 MR. FISHER: I'm gonna object just because
12 there's lack of definition behind those
13 descriptions you just provided.
14 Q And you can answer the question, Doctor.
15 A I was just going to say a plane was flying
16 overhead and I missed the substantive issue in
17 your question.
18 Q Sure. My understanding is that the first health
19 clinic in Melbourne catering solely to
20 transgender and gender diverse persons opened in
21 2016. Is that your understanding as well?
22 MR. FISHER: Same objection. You can
23 answer.
24 A I couldn't give you the precise year, so, if you
25 have researched the question and found that it

1 was 2016, I will accept that answer.
2 Q You understand that it opened sometime in the
3 last 5 or 10 years; right?
4 A Yeah. Yeah.
5 Q And what's the name of that clinic in Melbourne?
6 A It's called the -- it's in the Royal Children's
7 Hospital -- the Adolescent Gender Service, I
8 think it's called, or something of that nature.
9 Q Okay. And then in Western Australia, the
10 capital and the largest city is Perth; right?
11 A Yeah.
12 Q I don't know why I didn't have an exhibit for
13 you for Victoria and I made you guess at that.
14 I'm sorry for making you do that, but I'm going
15 to pull up Exhibit 11 and see if there's a
16 rotate button.
17 MR. FISHER: You have to subscribe.
18 Q Okay. Why don't I flip to my own Exhibit 11 and
19 read you the highlighted portion that I have
20 taken there. And I will tell you that this is a
21 printout that I took from the web page of the
22 Government of Western Australia's Mental Health
23 Commission, and the portion I have highlighted
24 says that the gender identity service "was
25 created in 2015 to address the gap in services

1 available to young people in WA experiencing
2 problems with their gender identity."
3 Is it your understanding that the gender
4 identity service opened in Western Australia in
5 2015?
6 A Yes.
7 Q And I assume that that's the largest gender
8 clinic in Western Australia?
9 A Yes.
10 Q And then Exhibit 12 is another printout that
11 I've taken from the website of the Government of
12 Queensland wherein the article they published
13 has someone saying that there was no
14 multidisciplinary gender service in Queensland
15 before the establishment of the gender clinic at
16 Children's Health Queensland in 2017. And my
17 question to you is: Is it your understanding
18 that the gender clinic at Children's Health
19 Queensland first opened in 2017?
20 A Yes.
21 Q Okay. In Paragraph 105 of your declaration,
22 which spans two pages, but do you see the top of
23 Paragraph 105 there?
24 A Yes. Yep.
25 Q And you provide a citation here to Tegg, 2022,

1 personal communication?
2 A Yep.
3 Q And I assume that the citation is to something
4 that was just relayed to you by whoever Tegg is?
5 A Yes.
6 Q And Tegg, I assume, is Simon Tegg?
7 A Yes.
8 Q And are you aware that Mr. Tegg is part of a
9 group called Fully Informed?
10 A Yes.
11 Q Are you aware that that group has played an
12 active role in advocating in favor of policies
13 in New Zealand that would prevent children from
14 accessing gender-affirming medications?
15 A Of course.
16 Q To your knowledge, has the data you received
17 from Mr. Tegg been published in any peer-review
18 journal?
19 A Not to my knowledge.
20 Q Okay. I'm going to scroll down just as an
21 example to Paragraph 107. Do you see that
22 there?
23 A Yeah.
24 Q The citation that you provide at the end of that
25 paragraph is to a -- your guess is as good as

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1 mine on the pronunciation -- Respaut & Terhune,
 2 2022; correct?
 3 A Yep.
 4 Q This article here, Respaut & Terhune, is it
 5 published in a peer-review journal?
 6 A I'd have to look at the reference.
 7 Q I will just tell you that I found it and your
 8 references are at the end of your declaration,
 9 but Respaut & Terhune are actually reporters for
 10 Reuters. Does that refresh your recollection?
 11 A Well, I have quoted some journalistic pieces
 12 from reputable journals, yes, because they have
 13 access to information that's very difficult for
 14 people, you know, to obtain by any other means,
 15 so I have done that on a couple of occasions.
 16 Q And when you have relied on media stories for
 17 the information you provide in your expert
 18 report, you provide the citation in roughly that
 19 format, right, just the author and the year?
 20 A Yeah. Yeah. That is the accepted APA
 21 referencing convention.
 22 Q Is it fair to say that there are several other
 23 citations that you provide in your expert report
 24 that are just media stories?
 25 A There's a small handful out of 200 plus

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1 references and it's because I wasn't able to
 2 source the information from anywhere else.
 3 Q And every media story that you relied on, is
 4 that cited in the references portion at the end
 5 of your declaration?
 6 A Yes.
 7 Q I'm going to scroll down to Paragraph 131 real
 8 quick. And I don't know how every single
 9 paragraph I've chosen actually spans two pages,
 10 so I apologize for that, but do you see the
 11 beginning of Paragraph 131?
 12 A I do.
 13 Q And in this you are describing an article
 14 published by Dr. Turban and others in 2021?
 15 A Yes.
 16 Q I'm going to bring up Exhibit 13 and ask you,
 17 first and foremost, if Exhibit 13 is that
 18 article that you're citing.
 19 A Yep.
 20 Q And, generally speaking, in your expert
 21 declaration you're relying on Dr. Turban's
 22 article to describe the detransition rates
 23 amongst persons who had previously been
 24 diagnosed with gender dysphoria. Is that a fair
 25 summary?

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1 A No, because in this study Turban conflates
 2 transgender with gender diverse and that's a
 3 fatal flaw for any study to do that.
 4 Q Okay. And I apologize, that wasn't the portion
 5 that I was trying to focus on and that's just my
 6 verbiage, but you're relying on Dr. Turban's
 7 study to discuss the detransition rates. Is
 8 that a fair summary?
 9 A Not detransition rates generally but the
 10 detransition rates that he reports in that
 11 study.
 12 Q Okay. Do you understand that Dr. Turban's
 13 article did not just seek to collect data on the
 14 rate of so-called detransition but also sought
 15 to analyze why persons detransitioned?
 16 A I don't think he's capable of psychoanalyzing
 17 anything and I don't necessarily think he
 18 claimed to do so.
 19 Q Do you understand that the report itself
 20 purports to provide data on why persons
 21 detransitioned?
 22 A Yes.
 23 Q Do you understand that the data set that he
 24 relied on was of people who currently identify
 25 or identified at the time of the article as

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1 transgender?
 2 A Or gender diverse.
 3 Q Or gender diverse. I'm sorry. You understand
 4 that; correct?
 5 A Yes.
 6 Q So every person in the article who had
 7 "detransitioned" subsequently retransitioned.
 8 Is that your understanding of what the article
 9 purports to report?
 10 A It's very difficult to work out exactly what it
 11 purports to report.
 12 Q Okay. Well, you're relying on the article to
 13 talk about detransition rate and my question to
 14 you was whether you were aware that everyone in
 15 the article subsequently retransitioned;
 16 correct?
 17 A I'm not sure I'm aware of that now only because
 18 it's been some time since I read the paper.
 19 Q The article speaks for itself so if you're not
 20 aware of it, that's perfectly fine and I don't
 21 have to prolong the issue.
 22 Are you aware that the article also
 23 classified the reasons for "detransition" --
 24 A Yes.
 25 Q -- as either -- I'm sorry, I wasn't done with

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1 the question. Why don't we start there, though.
2 You're aware that the article also classified
3 the reasons for detransition; correct?
4 A Yes. Yes.
5 Q And it classified them, while having specific
6 categories as well, into external and internal
7 reasons. Is that your understanding?
8 A Yes.
9 Q And you're aware that the article found that the
10 overwhelming majority of persons with a history
11 of detransition cited at least one external
12 reason for that; correct?
13 A Yes.
14 Q Do you agree that that finding is consistent
15 with your social contagion hypothesis?
16 A Look, I'm afraid that I don't base any of my
17 inferences or conclusions on the work of Jack
18 Turban because it's almost all universally
19 flawed research, methodologically suspect, and
20 one cannot draw conclusions or make
21 generalizations from the purported conclusions
22 that he draws from his own research.
23 Q Well, imagine some professional other than
24 Dr. Turban who you respected. If they published
25 a scholarly article finding that of 100 persons

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1 who "detransitioned," 82.5% of them cited at
2 least one external factor as a reason for their
3 detransition, would you believe that that is
4 consistent with your social contagion
5 hypothesis?
6 A Well, that eventuality has never occurred. It's
7 never been reported before or since, so it would
8 be merely an assumption to say that a reputable
9 scientist had found those results. So, to take
10 the next leap and say whether it was consistent
11 or not consistent with social contagion, my
12 hypothesis, is really not appropriate.
13 Q Okay. I'm going to click over to Exhibit 14.
14 MR. FISHER: Gavin, can I interrupt for
15 just one second?
16 MR. ROSE: Of course.
17 MR. FISHER: I just want to point something
18 out. Please go off the record for just one
19 second.
20 (A discussion was held off the record.)
21 Q Doctor, I have in front of you right now what
22 I've marked as Exhibit 14, and I assume that you
23 are familiar with this?
24 A Yes.
25 Q This is an article that you authored and was

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1 published in 2021. Do I have that correct?
2 A Yeah.
3 Q I understand that there is significant, I guess,
4 elaboration in your expert declaration, but is
5 it fair to say that many of the opinions you
6 express in your expert declaration are also
7 expressed in this article Exhibit 14?
8 A Yes.
9 Q And my understanding is that this article was
10 published in a collection of articles by various
11 Australian professionals. Do I have that right?
12 A Yes.
13 Q And the collection was devoted to the
14 "transgendering" of children and adolescents; is
15 that right?
16 A Yeah.
17 Q Was your article published anywhere else?
18 A Not at this point, no.
19 Q Has it been published -- I'm sorry, I was
20 confused by your response. By "not at this
21 point," do you mean not currently or do you mean
22 not at the time that it was published in the
23 collection of articles?
24 A No to both questions.
25 Q Okay. My understanding is that the article

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1 collection was edited and published by a
2 sociologist in Australia named Geoffrey
3 Holloway. Do I have that right?
4 A Yes.
5 Q Were you compensated for writing or submitting
6 your article?
7 A No.
8 Q Okay. I'm pulling up Exhibit 15 and I will just
9 tell you before we get into this that I have not
10 taken the entire publication. What I have here,
11 I think, is the cover page, the table of
12 contents, and the editorial that appears as
13 Section 1 to the publication. Do you recognize
14 this as those portions of that collection in
15 which your article appear?
16 A Yes.
17 Q The editorial that appears indicates that one of
18 the key objectives of the publication was "to
19 promote the campaign for a national, public
20 inquiry into the transgendering of children and
21 adolescents." Do you see that?
22 A Yes.
23 Q Is that your understanding as one of the key
24 objectives of the publication?
25 A Yes.

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1 Q Is that one of the reasons that you submitted
2 your article for inclusion?
3 A Yes.
4 Q What is the transgendering of children and
5 adolescents?
6 A The transgendering refers to a process of
7 persuasion that children are "born in the wrong
8 body," that their gender identity, however
9 defined, does not align with their natal sex,
10 and the transgendering is the process whereby
11 medical professionals assist the child to bring
12 their sexed body into line with their reported
13 gender identity using means such as puberty
14 blockade, cross-sex hormones, and sex
15 reassignment surgery.
16 Q In your declaration you refer on several
17 occasions to the "trans activist lobby." You're
18 familiar with that, I assume?
19 A Yes.
20 Q Is the transgendering of children and
21 adolescents being accomplished or attempted by
22 the trans activist lobby?
23 A Absolutely.
24 Q Is there anyone other than the trans activist
25 lobby that is performing the transgendering of

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1 children and adolescents?
2 A Well, the lobby is an open social network that
3 has a number of means of propagation, one of
4 which is the Internet, social media, the
5 misteaching of children, schools using
6 curricular that is scientifically incorrect, so
7 they're being coquetted at very young ages, five
8 and six.
9 If you have a look at some of the
10 educational materials and curricula, children as
11 young as five and six are being told that girls
12 can have penises and boys can have vulvas and
13 there are crude drawings, anatomical drawings,
14 for which children are not really ready and
15 should not be exposed. They're also being told
16 that they can have whatever gender identity they
17 like.
18 And, furthermore, you know, there are other
19 means of propagation including this whole
20 movement of drag queen story time where drag
21 queens go into schools and libraries, community
22 libraries, and other public places where very
23 young children assemble and play and they're
24 read transgender story books about transgender
25 theories and transgender (inaudible) and a

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1 gender unicorn where further incorrect
2 information is disseminated and propagated.
3 That's what we call the transgendering of
4 children.
5 Q Your article, Exhibit 14, were you solicited to
6 submit an article to that publication?
7 A Well, the word "solicited" is slightly loaded.
8 I was invited to contribute an article.
9 Q And I wasn't trying to load anything. I was
10 asking whether they invited you or whether they
11 had an open call for articles and you just
12 happened to submit one. But they invited you to
13 submit an article?
14 A I believe so, yes.
15 Q Okay. Did you submit your article for
16 publication anywhere else?
17 A Not that particular article. I did attempt to
18 get it published in a peer-reviewed journal and,
19 unsurprisingly, it was not considered
20 politically correct enough and so I was unable
21 to get it published.
22 Q What journal was that?
23 A The Archives of Sexual Behavior.
24 Q And when did you submit it to that journal?
25 A A version of it was submitted about a year ago,

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1 maybe about that.
2 Q So after it appeared in this collection?
3 A Probably.
4 Q Other than that journal, did you submit it for
5 publication anywhere else?
6 A I've done versions of it under invitation to
7 other sources and publications and so forth.
8 It's never the same version. It's always
9 tailored and very much shorter than the
10 declaration. The declaration is probably the
11 longest and most detailed version of my work on
12 this topic.
13 Q Other than the one peer-reviewed journal from
14 which it was rejected, did you submit it to any
15 other peer-reviewed journals?
16 A I think I already answered that question and I
17 said no.
18 Q Oh, I'm sorry. I thought you had two. I'm not
19 trying to trick you up. I just don't have a
20 realtime transcript, so I apologize.
21 A The chapter that I submitted to the
22 Brunskell-Evans edited volume was peer-reviewed
23 and I just haven't really been focused on
24 peer-reviewed publications. (Inaudible) at the
25 moment having left the university to publish and

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1 most of my colleagues have had the experience of
2 putting a huge amount of work into a paper and
3 not even get past the first round of reviews, so
4 I haven't pursued that avenue of dissemination,
5 but I do have over 200 international
6 peer-reviewed journal articles. So I'm not
7 incapable of reaching a bar for peer review, but
8 it's almost impossible to get articles critical
9 of the current transgender position past a peer
10 review.
11 Q Okay. I'm back in your declaration right now
12 and I am going to bring up, I guess, the end of
13 Paragraph 140 and the beginning of Paragraph
14 141. Do you see that in front of you?
15 A Yep, I do.
16 Q It appears to me that Paragraph 140 ends with a
17 quote from a British neurosurgeon about
18 lobotomy; correct?
19 A Yep.
20 Q And then in Paragraph 141 you apply this quote
21 to the practice of transgendering children and
22 young people. Is that a fair summary?
23 A That's a fair summary.
24 Q And you have in that paragraph a statement that
25 "These young people are also 'totally ruined as

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1 social human beings." I assume that by "These
2 young people" there, you're referring to
3 transgender persons?
4 A I'm referring to young people who have had their
5 bodies medically and surgically altered in a
6 vain attempt to change their sex.
7 Q What does it mean to be totally ruined as a
8 social human being?
9 A It means that one suffers, as I say later on in
10 that paragraph, pervasive mistreatment and
11 violence, severe economic hardship and
12 instability, discrimination, significant
13 negative physical and mental health impacts, and
14 so forth.
15 Q Do you believe that the plaintiff children in
16 this case have been totaled ruined as social
17 human beings?
18 A I think they have suffered enormously. They're
19 very vulnerable young people and, I mean,
20 obviously, I wouldn't apply that phraseology to
21 very young children, you know, who still have
22 the opportunity to be rehabilitated if they
23 received the right care rather than the
24 one-size-fits-all care of gender affirmation for
25 which, you know, they are, in all likelihood,

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1 not appropriate.
2 Q Sorry. One second, please. I'm sorry, Doctor,
3 my co-counsel heard something that I didn't hear
4 and we're probably both wrong on one front or
5 another.
6 What role does whether or not a person has
7 had gender-affirming surgery play in your
8 determination as to whether they are totally
9 ruined as social human beings?
10 A What role does surgery play in ruining them? Is
11 that what you're asking?
12 Q Sure, let's start there.
13 A Okay. It's a significant traumatic insult on
14 the body to remove perfectly healthy organs, the
15 result of which will impair their sexual
16 function. Many of them suffer ongoing and
17 significant medical complications including
18 chronic pain, infection, fistulas, bleeding,
19 and, you know, in the case of male to female,
20 they have to constantly dilate which I'm told
21 causes significant pain. Many of them are
22 sexually dysfunctional or are not able to feel
23 comfortable enough to expose their naked bodies
24 to other people. So, to the extent that those
25 situations have eventuated from sex reassignment

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1 surgery, the answer to your question would be
2 yes.
3 Q Do you believe that children who have been given
4 access to gender-affirming medications, either
5 puberty blockers or hormones, but have not had
6 surgery, do you believe that they are totally
7 ruined as social human beings?
8 A I don't think it's fair that you characterize my
9 view as everybody who's had gender-affirming
10 care of some kind or another are totally ruined
11 human beings because it depends on the age of
12 the child, it depends on the nature of the
13 treatment, what age it was commenced at, and,
14 you know, the kind of support they got and what
15 was the final outcome, but if your question was
16 about puberty blockade -- is that correct? Were
17 they totally ruined human beings?
18 Q I said puberty blockers or gender-affirming
19 hormones, but if you have different --
20 A Okay.
21 Q -- for the two, please --
22 A Well, some of the adverse effects of puberty
23 blockade are -- I mean, I'm sure I'm not going
24 to be able to include everything right at this
25 moment, but the ones that come to mind are

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1 questions of future fertility, bone density and
2 bone grown and their final height. It carries
3 significant risks of weight gain and there are a
4 significant number of children who report
5 headaches and hot flashes and, more recently, a
6 phenomenon called pseudotumor cerebri which, if
7 not treated promptly, may cause blindness.
8 So this drug is not safe and, in some
9 respects, it's not reversible because what it,
10 in fact, does is delay puberty including the
11 growth of the sexual organs, and if the child
12 remains on puberty blockers for longer than two
13 years, the growth of their sexual organs may not
14 return to what they would have been had they
15 been allowed to mature without puberty blockade.
16 The other thing that happens with puberty
17 blockade is, of course, their peers are going
18 through puberty and so all of the factors that
19 made them feel different and gender dysphoric in
20 the first place are often exacerbated because
21 they remain in a prepubertal state while what
22 used to be their best friends and peers are all
23 moving into the next stage of development which
24 is sexual maturation. So there are the possible
25 problems caused by puberty blockade.

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1 So, if we move on to the cross-sex
2 hormones, some of the problems with prescribing
3 testosterone to women are, of course, well,
4 first of all, the suppression of menses, the
5 permanent infertility, and ovarian uterine
6 atrophy that occurs with longer-term use often
7 necessitating the removal of a young woman's
8 uterus and ovaries because they atrophy and
9 cause enormous pain. Then we have clitoral
10 discomfort, vaginal atrophy which, of course,
11 makes sexual intercourse very difficult. They
12 often have cyst formation on the ovaries, pelvic
13 pain, a condition called polycythemia which
14 means that they develop too many red blood cells
15 which carry medical risks. There's increased
16 dyslipidemia, acne, oily skin. Some of them
17 develop hypertension, some of them develop Type
18 2 diabetes, mood swings, increased frustration
19 and anger and aggression, a risk for deep vein
20 thrombosis.
21 That's what I can think of at the moment.
22 I'm sure there are more, but, you know, these
23 drugs are touted as being, you know, oh, wow,
24 this is really going to get you what you want,
25 but these issues are skated over, at best.

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1 So, if we move to the adverse effects of
2 estrogen on males, we see things like, again,
3 deep vein thrombosis, high triglycerides. Some
4 of them will get hyperprolactinemia which means
5 they will start to have discharge from their
6 nipples. They can develop a condition called
7 hyperkalemia which is excessive potassium which
8 can really upset the metabolic balance in the
9 body which can affect the heart. Again, Type 2
10 diabetes, hypertension, weight gain.
11 Yeah, these drugs are dangerous drugs.
12 They're synthetic dangerous drugs to be pumping
13 into young children and adolescents.
14 Q And, just to be clear, Doctor --
15 A I beg your pardon.
16 Q I'm sorry, I didn't mean to cut you off there.
17 I thought you were done.
18 A Well, I'm sure I've missed something, but that
19 will have to do for now.
20 Q And, just to be clear, Doctor, you're not a
21 medical doctor, are you?
22 A I'm not.
23 Q In your CV you make reference to what appears to
24 me to be a two-part podcast called The Medical
25 Scam of the Century. Do you know what I'm

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1 talking about?
2 A I do know what you're talking about.
3 Q Is it fair to say that you consider the
4 "transgendering of children and adolescents" to
5 be the medical scam of the century?
6 A Yes.
7 Q You're familiar, I assume, with the Australian
8 Psychological Society; correct?
9 A Of course.
10 Q And, I'm sorry, I just forget. Is this one of
11 the organizations you're still a member of or is
12 it something --
13 A Yes, it is. Yes, I'm still a member.
14 Q And you're aware that this organization has
15 published an information sheet recommending
16 mental health practices that affirm transgender
17 people's experiences?
18 A Yes.
19 Q And I'm pulling up Exhibit 16 for you. Do you
20 see that in front of you?
21 A Yes.
22 Q You recognize this as that information sheet?
23 A Yes, I do.
24 Q And you understand that, along with this, the
25 same organization published a one-page summary

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1 of its information sheet; correct?
2 A I do.
3 Q And I'm pulling up Exhibit 17. And you
4 recognize this as that summary; correct?
5 A Correct.
6 Q You previously mentioned the Royal Children's
7 Hospital in Melbourne; correct?
8 A Yes.
9 Q And my understanding is this is the largest
10 children's hospital in Melbourne?
11 A Yes, it is.
12 Q Is it the largest one in Australia? I just
13 don't know.
14 A No, there's the Westmead Children's Hospital and
15 the Prince of Whales Children's Hospital in New
16 South Whales.
17 Q But you're aware that it has published treatment
18 guidelines for the treatment of transgender and
19 gender diverse children and adolescents;
20 correct?
21 A Yes.
22 Q And what's the relationship, if you know,
23 between The Royal Children's Hospital and
24 AusPATH?
25 A Well, the director of the gender service at The

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1 Royal Children's Hospital is one of the
2 coauthors of AusPATH.
3 Q I'm pulling up for you what I have marked as
4 Exhibit 18. Do you see that in front of you?
5 A Yes, I do.
6 Q You recognize these as the treatment guidelines
7 that have been published by AusPATH for the
8 treatment of transgender and gender diverse
9 children and adolescents?
10 A Yes.
11 Q And these are the treatment guidelines that you
12 reference in your declaration occasionally as
13 the AusPATH guidelines?
14 A Yes.
15 Q And my understanding is that this is the
16 Australian body similar to WPATH?
17 A Yes.
18 Q We just briefly touched on this, but in your
19 declaration you repeatedly describe the
20 influence of the trans activist lobby and I'm
21 wondering -- and maybe I asked you this or
22 something close to this, but I'm wondering who,
23 in your estimation, comprises the trans activist
24 lobby.
25 A Look, I think in a footnote I said I'm using it

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1 as a summary term for the vast network of
2 individuals and organizations who are
3 propagating gender-affirming care.
4 Q Do you believe that the trans activist lobby has
5 a leader or a leadership structure?
6 A The trans activist lobby, which is my summary
7 term so that I don't have to list multiple
8 individuals and organizations, is an open system
9 network so it's got many, many influencers and
10 many networks and subnetworks that have, you
11 know, been -- it's been a very, very effective
12 marketing machine.
13 So it's got very great many modes, you
14 know, that can attract children, so we've got
15 TikTok, we've got Insta -- Instagram not so
16 much. What are the others? I'm having a mental
17 block about these websites, but there's many of
18 them that spend a great deal of time, you know,
19 attracting young people to these sites and, you
20 know, talking to them in very positive terms
21 about transgendering and they can be whatever
22 gender they like. And it often attracts young
23 children who are marginalized and who are
24 looking for a group, looking to belong, looking
25 to be important and special.

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1 And, yeah, so it's not any one individual,
2 but I did do a social network diagram for what's
3 going on in Australia and the network consists
4 of politicians, sadly the Australian Human
5 Rights Commission, the Commissioner for Children
6 and Young People, the eSafety Commissioner.
7 They're all singing the same song and there's no
8 capacity to (inaudible) the unanimous kind of
9 voice about gender-affirming care.
10 So, you know, I'm not being extremist or,
11 you know, it's not a conspiracy theory to call
12 it a trans lobby. It's a summary term for
13 what's happening in society currently and it's
14 very, very concerning.
15 Q And the deep dive that you said you took -- and
16 I'm sorry if I'm putting words into your mouth
17 -- into persons in power in Australia, it's my
18 understanding that that is available on your
19 website?
20 A What particularly?
21 Q I'm sorry, I will pull that up at the next break
22 and make sure we're talking about the same
23 thing.
24 I assume you believe that the trans
25 activist lobby is global and not limited to

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1 Australia; right?
2 A Oh, absolutely.
3 Q And The Royal Children's Hospital in Melbourne
4 is a member of the lobby?
5 A Look, I don't want you to put that kind of
6 notion into my mouth. I'm not kind of reifying
7 the transgender lobby as some, you know, star
8 chamber organization that's infiltrating the
9 world, but The Royal Children's Hospital acts as
10 a major harbor of this open social network
11 disseminating misinformation and advocating for
12 gender-affirming care very strongly, both
13 politically and in the courts. These are facts.
14 They're not part of a conspiracy theory.
15 The Australian standards of care have been
16 strongly influenced by the WPATH guidelines and
17 the WPATH guidelines have been strongly
18 influenced, so there's this mutual kind of
19 network of social influence to the point that
20 you would call it brute think because if you
21 have a look at the early documents like the
22 standards of care, you'll see the same authors
23 across different guidelines and standards of
24 care. So we've got Henriette van de Waal and
25 Peggy Cohen-Kettenis from the Amsterdam Clinic

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1 who were authors of the 2006 Dutch protocol and
2 we see their names appear repeatedly on these
3 standards of care compilations over the last few
4 years as well as the Endocrine Society. And
5 there are other names as well that keep coming
6 up like Louie Myer (phonetic) and so forth.
7 So there is this group think that has
8 developed around the guidelines including the
9 Australian Psychological Society. It's one
10 voice speaking and there's no room for doubt.
11 And, so, there is this collective
12 rationalization of thinking where there's a lot
13 of -- you know, there's no admission of any
14 other alternative point of view. They don't
15 survey the alternatives and every time an
16 alternative is offered like social contagion or
17 like the fact that many of these gender diverse
18 children will grow up to be gay adults if left
19 alone. They don't admit any other possible way
20 of helping and managing these young people, so
21 they do not appraise properly the risks of their
22 own preferred solution which is gender-affirming
23 care. They scoff at the idea of the
24 reversibility of some of their treatments. They
25 selectively choose information and they have

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1 this err of invulnerability that if you belong
2 to this group of gender-affirming care,
3 clinicians, politicians, teachers, et cetera,
4 then we have the truth. We have the absolute
5 truth. And all I'm saying, people outside of
6 that network are saying: Please think about
7 alternatives, please think about possible harm,
8 please think about irreversibility. And it's
9 not happening.
10 Q Is it fair to say that you believe that the
11 American Medical Association has been improperly
12 influenced by the trans activist lobby?
13 A Yes.
14 Q Is it fair to say that you believe the American
15 Psychiatric Association has been improperly
16 influenced?
17 A Yes.
18 Q How about the American Psychological
19 Association?
20 A Look, I've put a big list in my declaration and
21 if you have a look at all of their position
22 statements, there's very little variation, you
23 know, between them and it's --
24 Q I'm sorry, Doctor. We're gonna be here all
25 night if you don't just answer the question.

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1 A Okay.
2 Q The question was whether you believe the
3 American Psychological Association has been
4 improperly influenced by the trans activist --
5 A Yes.
6 Q And the same for the Endocrine Society?
7 A Yes.
8 Q Earlier in your deposition I showed you what was
9 Exhibit 8, the statement by the CAAPS
10 organization that had been signed by a couple
11 dozen other organizations. Do you remember that
12 document?
13 A Yes, I do.
14 Q Is it fair to say that you believe that each of
15 those organizations has been improperly
16 influenced by the trans activist lobby?
17 A Well, they're part of it so they influence each
18 other. It's a bidirectional influence.
19 Q And the various Australian state governments
20 that have passed bans on conversion therapy,
21 have they been improperly influenced by the
22 trans activist lobby?
23 A Well, I mean, I'm afraid I have to seriously
24 question their intellectual capacity to put a
25 bill like the banning of conversion therapy into

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1 parliament. It's an extremely poorly-worded
2 document and it's unlikely to catch anyone in
3 its net, but what it has done is scare off
4 therapists from treating these children in any
5 way whatsoever. So now there is an extreme
6 shortage of skilled child and adolescent
7 therapists to help these young people because
8 almost no one wants to touch this patient group
9 because of that legislation.
10 Q You understand, I assume, that a federal judge
11 in the Alabama case where you submitted an
12 expert report issued an injunction against the
13 statute banning certain types of
14 gender-affirming care for minors; correct?
15 A Issued an injunction against gender-affirming
16 care?
17 Q I'm sorry, that's lawyer talk. Issued an order
18 for preventing the statute from taking effect.
19 A Yes.
20 Q Is it your position that that judge was
21 improperly influenced by the trans activist
22 lobby?
23 A I don't have an opinion on that.
24 Q I'm pulling up for you what I have marked as
25 Exhibit 19. Do you see that document in front

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1 of you?
2 A Yes.
3 Q I assume you're familiar with this?
4 A Yes.
5 Q These are the informed consent standards that
6 AusPATH has promulgated for gender-affirming
7 hormone therapy?
8 A Yeah.
9 Q I'm popping Exhibit 18 back up for you and my
10 question to you is whether you use any portion
11 of this document, the AusPATH treatment
12 guidelines, when you provide therapy to
13 transgender persons or persons who identify as
14 transgender.
15 A Was your question: Is there any part of the
16 document that says children should have therapy?
17 Q My question was whether there's any portion of
18 this document that you rely on when treating a
19 patient who walks through your door.
20 A No.
21 Q And is the same true for Exhibit 19, the
22 informed consent standards?
23 A There are more general informed consent
24 standards that every practicing clinician must
25 adhere to, but the gender-affirming therapists

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1 don't even adhere to their own standards of
2 informed consent and most of them don't even
3 understand what constitutes informed consent.
4 MR. ROSE: Off the record for a sec.
5 (A discussion was held off the record.)
6 Q Doctor, you ready to power forward?
7 A Sure.
8 Q Chapter 2 of your declaration -- excuse me. You
9 have a separate what you call chapter of your
10 declaration that specifically concerns the named
11 plaintiffs in this case; is that fair?
12 A Yeah.
13 MR. ROSE: And, Tom, before we plow
14 forward, just a matter of housekeeping. We want
15 to make sure that Exhibits B, C, D, and E of the
16 doctor's declaration as well as I think they
17 will be Exhibits 20 and 21 of this deposition
18 and any testimony about those are maintained as
19 confidential. I assume that's not an issue and
20 we can obviously figure out how that needs to
21 work for the Court?
22 MR. FISHER: Right. Agreed. No objection
23 to that.
24 Q Okay, Doctor. Just very generally, have you
25 personally evaluated any of the plaintiffs?

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1 A As stated in my report, no, I haven't.
2 Q Have you interviewed them at any time?
3 A No.
4 Q Have you interviewed any of their parents?
5 A No.
6 Q Have you ever communicated in any fashion with
7 either them or their parents?
8 A No.
9 Q Have you ever communicated about the plaintiffs
10 with any professional who has evaluated or
11 treated any of them?
12 A No.
13 Q It's fair to say that your opinions about them
14 come exclusively from a review of the medical
15 records that you were provided; is that correct?
16 A As stated in my report.
17 Q Sorry. That's a yes?
18 A Yes.
19 Q Do you have an understanding as to whether each
20 of the plaintiffs received mental health therapy
21 before seeking or being prescribed either
22 puberty blockers or gender-affirming hormones?
23 A Did you say do I have an understanding?
24 Q Do you understand whether the plaintiffs
25 received mental health therapy before seeking or

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1 being prescribed gender-affirming medications
2 including puberty blockers?
3 A It wasn't entirely clear exactly what they
4 received by way of psychotherapeutic support
5 because, as I say, in the documents before me
6 only vague references were made. So I didn't
7 see any process notes, I didn't see any case
8 formulation, I didn't see any progress, goals,
9 or anything that one would normally see
10 documented in a clinical process.
11 Q Okay. I am bringing back up your expert report,
12 Exhibit 2. Do you see that in front of you?
13 A Yeah.
14 Q I am going to scroll down to Paragraph 198.
15 Okay. Do you see Paragraph 198 and the
16 associated footnote 34?
17 A Yes.
18 Q In this portion of your declaration you're
19 describing a visit that Plaintiff K.C. had with
20 the doctor managing her Type 1 diabetes. Do you
21 see that?
22 A Yeah.
23 Q And you underscore in your report that K.C. was
24 reported to have "no dysmorphic features." Do
25 you see that language?

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1 A Yes.
2 Q And you speculate in the footnote that it's
3 unclear whether the doctor meant dysphoric or
4 dysmorphic or was --
5 A Yes.
6 Q -- using the terms interchangeably; is that
7 correct?
8 A Yes.
9 Q I assume you understand that gender dysphoria
10 and body dysmorphic disorder are two entirely
11 separate diagnoses; right?
12 A They're not two entirely separate diagnoses, but
13 they have different emphases.
14 Q And they're listed separately in the DSM;
15 correct?
16 A Yes.
17 Q Do you have an understanding that persons with
18 diabetes are more likely to develop an eating
19 disorder that might lead to body dysmorphia?
20 A Yes.
21 Q So do you agree that for a doctor managing a
22 patient's diabetes whether a patient displays
23 dysmorphic features might be particularly
24 noteworthy?
25 A Yes.

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1 Q But you still think the diabetes doctor, despite
2 using the phrase "dysmorphic features," might
3 have been intending to reference K.C.'s gender
4 dysphoria?
5 A Well, he then goes on to say "sweet transgender
6 girl," so it's ambiguous.
7 Q Okay. I'm going to scroll down to Paragraph
8 229. Do you see that in front of you?
9 A Yes. Yes.
10 Q You're describing here an assessment of M.W.
11 that you indicate took place on January 4th,
12 2022. Is that a fair statement?
13 A Yes.
14 Q My review of the medical records, I'll just tell
15 you, does not reveal anything from January 4th
16 but does indicate that M.W. had an initial
17 evaluation at Riley Gender Health Connect on
18 April 14th, 4/14/22. Is it possible that you
19 simply got the dates wrong?
20 A Well, given that I had to scroll through
21 literally thousands of pages on Notepad
22 formatting, it is possible I got the date wrong.
23 And, also, Americans reverse the date and month
24 and it may have occurred for one of those two
25 reasons.

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1 Q I understand that and I'm not blaming you. And,
2 for the record, I did go through other portions
3 of your declaration to see whether you were
4 adopting the American style of month/day or
5 whether you were not. I'm certainly not blaming
6 you.
7 In your report of this encounter you
8 indicate that M.W. was neutral about certain
9 secondary sexual characteristics, satisfied with
10 other things, and also neutral about
11 characteristics such as hair, voice, and general
12 appearance. I understand that I'm not quoting
13 everything, but you see the language I'm
14 referencing; right?
15 A Yes. Yes.
16 Q And you underlined "voice"; right?
17 A Uh-huh.
18 Q Sorry. Yes?
19 A Yes.
20 Q Why did you underline "voice"?
21 A Because voice is one of the characteristics
22 around which young people claim extreme
23 dysphoria.
24 Q So is it fair to say that you underlined "voice"
25 because you thought M.W. being neutral about

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1 that was more noteworthy than some of the other
2 items reported?
3 A Yes.
4 Q I'm going to flip over to what I've marked as
5 Exhibit 20 which, as you will see, is the
6 encounter on April 14th, 2022. And I will
7 scroll down to, I guess, Page 3 of the document
8 using the PDF page numbers. I have highlighted
9 a couple aspects of the report there. Do you
10 see the portions I have highlighted?
11 A Yes.
12 Q And I will just tell you that this -- and I'm
13 not trying to trick you. I can scroll back and
14 forth if you want me to. The language I
15 highlighted matches almost verbatim the language
16 that you report in Paragraph 229 of your
17 declaration. Is it fair to say that this is the
18 document that you were looking at?
19 A Well, I didn't get it in that form. In that
20 form it's actually interpretable, but I got it
21 in incredibly narrow paragraphs and the average
22 scores were kind of above the text
23 interpretation so it was quite difficult for me
24 to make sense of it. I mean, presented like
25 that, it looks much more interpretable than the

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1 form that I got it in which was a Notepad
2 document.
3 Q So is it possible that you misinterpreted M.W.'s
4 medical records as you were going through them?
5 A I hope I didn't. I took great care not to, but
6 it looks as if I did not misinterpret anything
7 on this occasion.
8 Q Okay. And all of the medical records that you
9 reviewed, did you receive them all in the same
10 format that was difficult to read?
11 A Most of them were in Notepad format. I got a
12 couple that were scanned Word or PDF documents,
13 but they weren't like -- the text was fuzzy, and
14 they were the two primary forms in which I got
15 the records.
16 Q And the Notepad format was the one that you were
17 indicating was difficult to read?
18 A Yeah, and I had hundreds of those files to go
19 through.
20 Q Okay. I will scroll up just a little bit on
21 Exhibit 20 now to the top of that Page 3. It
22 looks to me like what Page 3 is doing here is
23 providing a summary of the intake paperwork that
24 M.W. and, under the caregiver's portion, M.W.'s
25 parents completed. Is that fair?

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1 A Yeah.
2 Q I assume you were provided a copy of that
3 pre-intake paperwork itself as well?
4 A As I said, but not in this form.
5 Q Okay. I understand the formatting might have
6 changed, but I'm flipping over to Exhibit 21 and
7 I will ask you whether this appears to you to be
8 the pre-intake paperwork for M.W. that is
9 summarized in Exhibit 20.
10 A I don't believe I've seen that document.
11 Q Okay. Is there a reason you would not have seen
12 it?
13 A I don't know. I would remember that if I had
14 seen it and I haven't seen it.
15 Q I'm going to scroll down just a little and I
16 will represent to you this is the self-report
17 portion and I'm on Page 6 right now. Do you see
18 the highlighted portion about how M.W. feels
19 about his breasts?
20 A Yes.
21 Q And you acknowledge that he indicates that he
22 was very dissatisfied with them?
23 A Yep.
24 Q I'm scrolling down just a little bit farther.
25 You see the same thing about voice and chest?

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1 A Yes.
2 Q And I'm looking at Page 7 now, but you see that
3 M.W. actually reported that he was very
4 dissatisfied with his voice?
5 A Yes.
6 Q So is it fair to say that the statement in your
7 declaration that M.W. was neutral about his
8 voice is inaccurate?
9 A According to the document that I reviewed, no,
10 it's not inaccurate because that was the
11 information in front of me, but, as I said in
12 the beginning of my Chapter 2, that had I been
13 presented with any information subsequent to my
14 report, it might cause me to change my opinion.
15 And just because a child says they're
16 dissatisfied with their breasts and voice, it
17 doesn't mean that you automatically jump into a
18 diagnosis of gender dysphoria and send them off
19 for gender-affirming care.
20 Q Okay. Well, we've established that Exhibit 20
21 which indicates "Tended to report feeling
22 neutral about characteristics such as hair,
23 voice, and general appearance" is what you were
24 looking at for that portion of your declaration;
25 correct?

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1 A Correct.

2 Q I'm going to scroll up on the same document then

3 to the top of Page 2 where it says that M.W.

4 "Reports feeling significant dysphoria related

5 to chest, voice, and menstrual periods." Do you

6 see that?

7 A Yep.

8 Q And do you still think it was accurate for you

9 to report that M.W. is neutral about his voice?

10 A From the documents that were in front of me, I

11 reported that accurately.

12 Q This is part of the same document, Doctor.

13 A Look, I would like you to have a look at the

14 Notepad files that I was sent. They were

15 disjointed. They didn't necessarily even follow

16 one sentence continuing on the next line.

17 Sometimes I had to scroll down several lines to

18 get the end of a sentence. I was under extreme

19 time pressure. I was given some medical records

20 two days before I had to file my report. I was

21 up all night for three nights in a row trying to

22 complete the work.

23 But, even under all of those circumstances,

24 even if a young child reports dysphoria in

25 relation to chest, voice, and menstrual periods,

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1 I do not jump to the conclusion that this child

2 is suitable for gender-affirmation care.

3 Q And the circumstances you described about your

4 difficulties reviewing the medical records, I

5 assume that applies to the medical records of

6 all four plaintiffs?

7 A Well, most of them were given to me in that

8 format, in Notepad format.

9 Q Is that a yes?

10 A Yes.

11 Q Okay.

12 A But I didn't just rely on those medical records.

13 I also was given the declarations of the parents

14 and I had the parent reports from their lawyers

15 as well, so it was multiple sources of

16 information.

17 Q I'm back in Paragraph 229 of your declaration.

18 In the middle of this paragraph you say "there

19 is no evidence of a marked incongruence between

20 M.W.'s experienced/expressed gender and (all)

21 primary and/or secondary sex characteristics."

22 Do you see the language that I have just quoted?

23 A Yeah.

24 Q Why is "all" in parentheses?

25 A Because, generally speaking, the child would

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1 need to express a global dissatisfaction with

2 their body overall. I mean, you know, quite

3 often children will not like something about

4 themselves. I don't like my hips or I don't

5 like my shoulders. That doesn't make them

6 either body dysmorphic or gender dysphoric.

7 So, perhaps, it would've been better to put

8 "most" rather than "all," but I was just drawing

9 that point so that people wouldn't misconstrue

10 that one dissatisfaction or a few

11 dissatisfactions would meet criteria.

12 Q Let me put it this way, Doctor. Is "all" in

13 parentheses because the rest of that sentence is

14 a direct quote from the DSM-5 criteria for

15 gender dysphoria?

16 A Yes, it is. I am quoting from the criteria from

17 DSM.

18 Q So you added the word "all" to the criteria?

19 A Well, I probably did add it, yes, for emphasis.

20 Q Okay. Doctor, I was reading an interview that's

21 linked from your website to a website called

22 xxxkidernet.com. Are you familiar with the

23 interview that I'm referencing?

24 A Yep.

25 Q And I don't have it up in front of me, but I did

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1 copy this quote. And I'm going to read this

2 quote to you and then the questions I'm going to

3 ask is going to be whether you recall making

4 this statement and whether it is an accurate

5 statement of your beliefs.

6 You were quoted as saying, "Transgender

7 advocates state that in transgenderism -- the

8 belief/assumption that one has been born in the

9 wrong body -- the body must be aligned to one's

10 gender belief, not one's belief to one's

11 biological body. They assume that the mind is

12 correct in its perceptions and beliefs and the

13 body is diseased and must be treated."

14 Do you recall making that statement or

15 something similar to it?

16 A Yes.

17 Q And is what I quoted an accurate statement of

18 your beliefs?

19 A Yes.

20 Q When you provide psychotherapy to a transgender

21 patient or a patient identifying as transgender,

22 is one of your methods to attempt to align their

23 belief to their biological body?

24 A This is a grave misunderstanding of the process

25 of exploratory psychodynamic psychotherapy. I

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1 don't try to do anything except provide a safe
2 space for the young person to know their true
3 feelings and to express them, and whatever
4 conclusion they draw at the end of the
5 psychotherapeutic process is not any attempt on
6 the part of the therapist to engineer a
7 particular outcome.
8 And what I find in the majority of cases is
9 that after the first few sessions the child just
10 stops talking about gender dysphoria and wanting
11 to transition and we start talking about their
12 emotional distress and pain in relationship to
13 what is happening in their primary attachment
14 relationships and also other issues that are of
15 great concern to them such as bullying and
16 discrimination, isolation, loneliness, a fear of
17 not meeting expectations. Many of them have
18 very deeply entrenched self-punty, internalized
19 self-punty xxthat need to be dealt with and
20 often we have to deal with how they manage their
21 emotional distress through self harm.
22 So every time a child or anybody comes into
23 an exploratory psychodynamic psychotherapy it's
24 what's on the mind of the patient, what the
25 patient brings to that session that the

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1 therapist focuses on. So, no, I do not have a
2 goal of aligning anything with anything else.
3 Q Okay.
4 A It's to support the young person to understand
5 themselves better.
6 Q Okay, Doctor. I'm going to pull up what I have
7 marked as Exhibit 22. Do you see that in front
8 of you?
9 A Uh-huh.
10 Q Sorry. ?
11 A Yes.
12 Q That's for the court reporter, not for me.
13 A I understand. I understand.
14 Q You recognize this as a presentation that you
15 gave in November 2021 to the organization that
16 we previously called SEGM?
17 A Yes.
18 Q And this presentation is not listed on your CV.
19 Does this refresh your recollection as to
20 whether there are presentations that you
21 omitted?
22 A Right. Okay. I'll be sure to add it next time.
23 Q Was this presentation given at a conference of
24 some sort?
25 MR. ROSE: You're on mute, Tom, if you're

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1 trying to talk.
2 MR. FISHER: Is there any reason you can
3 just make it bigger for the doctor?
4 MR. ROSE: Oh, I had no idea, Tom.
5 Q I'm sorry, Doctor, I didn't realize you were
6 leaning forward to try to read it.
7 A Right.
8 Q Is this better for you?
9 A Yes. Thank you. Yes.
10 Q Okay. I'm sorry, Doctor, let me repeat the
11 question. The question was whether this
12 presentation was given at a conference of some
13 sort.
14 A Yes, it was, yes.
15 Q Did you give it in person, online?
16 A Given that it's November '21, it was probably
17 online.
18 Q It would have been a conference of the Society
19 for Evidence-based Gender Medicine?
20 A No, not necessarily. I'm just characterizing --
21 I'm just situating myself as a member of that
22 organization.
23 Q Gotcha. And I don't know where I got this from,
24 but it's in my notes so I'll just ask you. Was
25 this given at a conference of the National

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1 Association of Practicing Psychiatrists?
2 A Oh, that's highly likely, yes.
3 Q I'm positive I saw it somewhere, but I don't
4 know where I got that from. Is that an
5 Australian organization?
6 A Yeah, it's a national organization, yes.
7 Q But the nation of Australia?
8 A The nation of Australia.
9 Q I assumed by how practicing was spelled.
10 Okay. And what we have here is the
11 PowerPoint, I assume, that accompanied this
12 presentation?
13 A Yes.
14 Q Did you create the PowerPoint yourself?
15 A Yes, I did. This is a presentation of a
16 distillation of my theory development of what is
17 required in assessment and therapy of young
18 people presenting with gender dysphoria, so,
19 yeah, it is a model that I've developed.
20 Q Okay. And on the very last page of your
21 presentation you included an image of what
22 appears to be a rose with the verbage "TRANS IS
23 NOT BEAUTIFUL," correct?
24 A Yes.
25 Q Do you consider this image to be a hateful one?

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1 A The image with or without the "NOT"?

2 Q As you presented it at the conference.

3 A Hate was not in my heart. Why didn't you show
4 more interest in the slides in between?

5 MR. ROSE: Doctor, I have no further
6 questions. Thank you very much for your time
7 this morning for you/this evening for us.

8 MR. FISHER: Can we take maybe 20 minutes?
9 (A recess was taken.)

10 CROSS-EXAMINATION,
11 QUESTIONS BY THOMAS M. FISHER:

12 Q Dianna, you were asked earlier by Mr. Rose about
13 -- and this was a while ago so I'm certainly
14 paraphrasing here, but I think the discussion
15 was treatment of children who had started
16 puberty blockers. Do you remember that
17 discussion?

18 A Yes.

19 Q And I think the question from Mr. Rose was
20 something along the lines of: Well, did you
21 continue treating them, that child? And you
22 said no. And then the follow-up, of course,
23 was: Well, why not? And your response was
24 something like: Well, they had found the magic
25 solution. And that was the end of the

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1 discussion. Do you remember that?

2 A Yes.

3 Q Okay. So I was hoping you could explain to us a
4 little bit more about what you meant when you
5 said that.

6 A What I meant was that families go through a lot
7 of heartache when a child declares themselves
8 transgender, not all but most, and parents have
9 difficulty tolerating their children's distress
10 and most parents want to do what's going to make
11 their children happy. And by "magic solution,"
12 I'm referring to a treatment that they've been
13 convinced is going to improve their child's not
14 only gender dysphoria but all the comorbid
15 presentations that the child has as well.

16 And there is, not always but very, very
17 often, a honeymoon period where everything seems
18 to settle down. It's like, you know, the child
19 is getting this almost magic treatment that's
20 going to take away all the gender dysphoria and
21 everybody then breathes a sigh of relief, but
22 they're really breathing a sigh of relief over
23 this very short-term period and all the
24 complications that may come in the future are
25 brushed aside because peace is being restored

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1 and the child appears happier in the short term.

2 But most studies show that pubic blockade
3 has no positive effect on mental health
4 presentations. It's just a placebo effect, but
5 it feels like magic at the time.

6 Q So, in that circumstance then, because there was
7 that honeymoon period, the family would
8 discontinue seeing you at that point?

9 A Yes. Yes, they would discontinue other forms of
10 therapy.

11 Q Okay. Alright. Later in Mr. Rose's questioning
12 he asked about so-called conversion therapy bans
13 in some of the Australian states. Do you recall
14 that discussion?

15 A Yes, I do.

16 Q And I think that the sum and substance was
17 pretty much all of those so-called conversion
18 therapy bans were materially identical. Is that
19 your recollection?

20 A Yes.

21 Q Tell us about what that means, the conversion
22 therapy bans that those Australian states have
23 enacted. What, in particular, are they trying
24 to ban?

25 A Well, they're actually based on a completely and

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1 utter red herring. I don't know if you know
2 that expression in America, but it means that
3 it's a (inaudible). It's just based on
4 shimmering sand because what they're claiming --
5 like conversion therapy is defined as trying to
6 change the sexual orientation of homosexual
7 individuals to heterosexual, and there was some
8 conversion therapy practiced many, many years
9 ago, decades ago, and maybe there are tiny
10 little pockets in religious groups and so forth
11 that is still trying to practice that but it's
12 certainly not accepted in mainstream medicine,
13 and it has never been practiced in its form,
14 which was created for homosexuality, on
15 transgender individuals. So there is no such
16 thing as conversion therapy for transgender
17 individuals.

18 And the definition of conversion therapy is
19 a question that Mr. Rose put to me about my
20 psychotherapy and that is: Do you aim to change
21 the child's perception of the gender identity to
22 align with their body? Now, that's conversion
23 therapy, but psychotherapy doesn't try to do
24 that.

25 So the only conversion therapy is

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1 gender-affirming care. It doesn't exist in any
2 other form and it's a defunct treatment. It's
3 proven to be inhumane, unethical, and medically
4 ineffective. So it's all part, I'm sorry to
5 say, you know, the transgender machinery,
6 building up straw men to attack and pull down,
7 and then there was so much dancing in the street
8 when these conversion therapy laws got through
9 parliament.
10 Q What can you do in your practice that
11 psychologists in those states with conversion
12 therapy bans cannot do when it comes to treating
13 gender dysphoria?
14 A Well, there's two ways of looking at it. One is
15 that anything that isn't gender-affirming care
16 may be interpreted as conversion therapy, but
17 you can only be prosecuted under that act if an
18 actual patient makes a complaint about you. So
19 a trans group or an advocacy group making a
20 complaint that they know you're practicing
21 something other than gender-affirming care
22 cannot bring a complaint, so the patient or the
23 patient's parent needs to directly complain
24 about you.
25 But, in reality, it carries 18 months jail

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1 and a \$30,000 fine if you're convicted under
2 this act, but I doubt very much whether anybody
3 could be convicted under that act because
4 conversion therapy is not even defined properly
5 in these new laws and it's never been practiced
6 to anybody's knowledge in the transgender space.
7 Q But, just to be clear, your understanding of
8 those laws is that they mean to say that
9 anything other than gender-affirming care is
10 conversion therapy?
11 A Yes.
12 Q Okay. Then at the end of Mr. Rose's
13 questioning, he brought up a slide at the end of
14 a long presentation that you gave, I think, and
15 -- well, first of all, do you recall what that
16 presentation was?
17 A Yes, I do. Yes, I was presenting my new model
18 of exploratory psychodynamic psychotherapy
19 starting with what I thought were essential
20 assessment examinations that need to be done at
21 the beginning, and then I outlined some of what
22 I believe underlies the genesis of gender
23 dysphoria and then how I work with the family to
24 resolve some of those issues.
25 Q Well, and when Mr. Rose was asking you about the

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1 last slide, you, I think, made a comment about
2 how you wished he would be more interested in
3 what came before that. Do you remember making
4 that comment?
5 A Yes, I do. Yes.
6 Q I was wondering what sparked that. What was it
7 that you had hoped Mr. Rose would have been more
8 interested in?
9 A Well, it was a very serious presentation
10 presenting a new model of therapy that has not
11 been presented before or outlined, you know,
12 actually put into a coherent form so that
13 clinicians can meet and discuss, compare notes,
14 and, you know, talk about the process of
15 psychotherapy. So it was the result of, you
16 know, four to five years of very intense study
17 on the subject and, you know, working constantly
18 with young gender dysphoric people, and to go to
19 the last slide, I mean, all we saw was the first
20 slide and the last slide, which I think is a
21 little bit cheap.
22 Q And what about that last slide that said, as I
23 recall, it had said "TRANS IS BEAUTIFUL" and you
24 put the word "NOT" in, "TRANS IS NOT BEAUTIFUL."
25 Do you remember that?

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1 A Yes, I do, yes.
2 Q What did you mean by that?
3 A Well, if you look at the foregoing slides, you
4 would see that the life of young people after
5 they transition is actually worse in so many
6 ways compared to before they transition. Yes,
7 they're already having difficulties, there are a
8 lot of problems, a lot of comorbidities, but
9 when you look at studies that show what happens
10 to these young people after they transition,
11 that's when the suicide rate increases.
12 A long-term Swedish study that followed up
13 people who'd had transgender surgery for 30
14 years showed that their suicide rate was 19
15 times higher than in the general population
16 matched for age and sex. So transgender
17 cross-sex hormones and sex reassignment surgery
18 does not cure suicidality. It actually
19 exacerbates it.
20 And the same goes for the other common
21 comorbidities that you see with young people
22 premorbid and that is vastly increased rates of
23 depression, suicide, self harm, acting out,
24 unemployment, homelessness.
25 And that was my summary way of saying

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1 becoming transgender is not beautiful. In other
 2 words, it's not la dolce vita, the beautiful
 3 life that people envisage/fantasize about
 4 because their previous life was so difficult and
 5 in some cases traumatic. So it was part of a
 6 whole kind of complex constellation of factors
 7 that I had been talking about previously.
 8 MR. FISHER: I don't have any further
 9 questions.
 10 MR. ROSE: Just another hour, hour and a
 11 half maybe, Doctor. Doctor, it's 11 o'clock at
 12 night here. My boss is in my office and I have
 13 been told that if I ask you a single question, I
 14 will be fired on the spot, so I have no further
 15 questions.
 16 MR. FISHER: We'll take signature.
 17 AND FURTHER THE DEPONENT SAITH NOT.
 18
 19
 20
 21
 22
 23
 24
 25

 PROFESSOR DIANNA T. KENNY

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1 STATE OF INDIANA)
) SS:
 2 COUNTY OF HAMILTON)
 3 I, Brandy L. Bradley, RPR, a Notary Public in
 4 and for the County of Hamilton, State of Indiana at
 5 large, do hereby certify that PROFESSOR DIANNA
 6 T. KENNY, the deponent herein, was by me first duly
 7 sworn to tell the truth, the whole truth, and nothing
 8 but the truth in the above-captioned cause;
 9 That the foregoing deposition was taken on
 10 behalf of the Plaintiffs at the remote location of
 11 the witness, Sydney, New South Whales, Australia, on
 12 the 30th day of May, 2023, pursuant to the Applicable
 13 Rules;
 14 That said deposition was taken down in
 15 stenograph notes and afterwards reduced to
 16 typewriting under my direction, and that the
 17 typewritten transcript is a true record of the
 18 testimony given by said deponent, and thereafter
 19 presented to said deponent for his/her signature;
 20 That the parties were represented by their
 21 aforementioned counsel.
 22 I do further certify that I am a disinterested
 23 person in this cause of action; that I am not a
 24 relative or attorney of either party, or otherwise
 25 interested in the event of this action, and am not in

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1 the employ of the attorneys for either party.
 2 IN WITNESS WHEREOF, I have hereunto set my hand
 3 and affixed my notarial seal this ____ day of
 4 _____, 2023.
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Brandy Bradley

 Brandy L. Bradley, RPR

Commission No. NP0682101
 My Commission Expires:
 April 13, 2024

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1 (Originating Party)
 2 Gaym M. Rose
 3 ACLU of Indiana
 4 1031 W. Washington Street
 5 Indianapolis, IN 46202

NOTICE OF DEPOSITION FILING
 UNITED STATES DISTRICT COURT
 SOUTHERN DISTRICT OF INDIANA
 INDIANAPOLIS DIVISION
 NO. 1:23-cv-00595-JPH-KMB

8 K.C., et al.,)
 9 Plaintiff(s),))
 10 -vs-))
 11 THE INDIVIDUAL MEMBERS OF THE))
 12 MEDICAL LICENSING BOARD OF))
 13 INDIANA, in their official))
 14 capacities, et al.,))
 15 Defendant(s).))

16 In compliance with the Indiana Rules of
 17 Procedure, Federal Rules of Civil Procedure and/or
 18 the Rules of the Industrial Board, you are notified
 19 that the signed original deposition of PROFESSOR
 20 DIANNA T. KENNY, taken on the 30th day of May, 2023,
 21 has been sealed and submitted to the originating
 22 party, along with the attached Errata Sheet(s), if
 23 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

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Change or Suppression (Conversion) Practices Prohibition Act 2021
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Part 1—Preliminary

- (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.

Change or Suppression (Conversion) Practices Prohibition Act 2021
No. of 2021
Part 1—Preliminary

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.

Change or Suppression (Conversion) Practices Prohibition Act 2021
No. of 2021
Part 1—Preliminary

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

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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;

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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**.

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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

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- (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.

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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.

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Part 2—Offences relating to change or suppression practices

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

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(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

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(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.

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- (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
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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;
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- (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.
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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.
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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.

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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.

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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.
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- (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.
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- (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
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- (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.
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- (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.
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- (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
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- (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.
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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.

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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—
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- (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;
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- (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;
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- (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—
-

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- (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—

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- (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.

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Part 4—General matters

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
-

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Part 4—General matters

- (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
-

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Part 4—General matters

- (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.

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Part 4—General matters

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.
-

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No. of 2021

Part 4—General matters

- (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
-

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Part 4—General matters

- (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.

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Part 5—Amendment of definitions in the Equal Opportunity Act 2010

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
-

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Part 5—Amendment of definitions in the Equal Opportunity Act 2010

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

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Part 5—Amendment of definitions in the Equal Opportunity Act 2010

- (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."

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Part 6—Consequential amendment of Acts

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;"

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Part 6—Consequential amendment of Acts

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."

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Part 7—Repeal of amending Parts

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**).

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Endnotes

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."

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



OPEN ACCESS

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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

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 under-reported 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 non-conforming 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.

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.

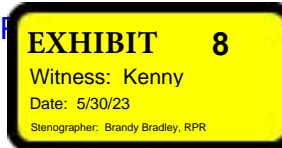
Supporting information

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

About CAAPS

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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

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CAAPS

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EXHIBIT 22

Witness: Kenny

Date: 5/30/23

Stenographer: Brandy Bradley, RPR

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.**



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

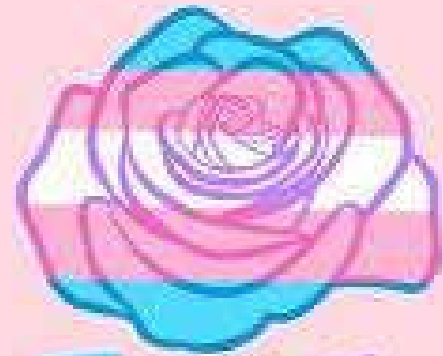
Conclusions

- **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

- related to a grievance against the parents and a struggle for autonomy/individuation
- related to an idea that one can create an ideal self
- protective against feelings of inadequacy, anxiety, jealousy, and disappointment
- a triumph over feelings of vulnerability
- 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

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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.

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Informed Consent for balancing hormones in Gender Diverse 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 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)

<i>Average timeline</i>	<i>Effect of Testosterone</i>
<i>1–3 months after starting testosterone</i>	<ul style="list-style-type: none"> • 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
<i>1–6 months after starting testosterone</i>	<ul style="list-style-type: none"> • menstrual periods stop
<i>3–6 months after starting testosterone</i>	<ul style="list-style-type: none"> • voice starts to crack and drop within first 3–6 months, but can take a year to finish changing
<i>1 year or more after starting testosterone</i>	<ul style="list-style-type: none"> • 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

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

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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)

<p>Average timeline</p> <p>1–3 months after starting estrogen</p>	<p>Effect of Estrogen</p> <ul style="list-style-type: none">• 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
<p>Gradual changes (maximum change after 1–2 years on estrogen)</p>	<ul style="list-style-type: none">• 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)

<p>Average timeline</p> <p>Testosterone 1–3 months after starting antiandrogens</p>	<p>Effect of blocking</p> <ul style="list-style-type: none">• 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
<p>Gradual changes (usually at least 2 years)</p>	<ul style="list-style-type: none">• 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.

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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.

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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.

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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.

<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES</p> <p>2 (All appearances via videoconference)</p> <p>3 FOR THE PLAINTIFFS:</p> <p>4 Kenneth J. Falk</p> <p>5 ACLU of Indiana</p> <p>6 1031 East Washington Street</p> <p>7 Indianapolis, IN 46202</p> <p>8 317.635.4059</p> <p>9 kfalk@aclu-in.org</p> <p>10</p> <p>11 FOR THE DEFENDANTS:</p> <p>12 Thomas M. Fisher</p> <p>13 Office of the Attorney General</p> <p>14 302 West Washington Street</p> <p>15 IGCS 5th Floor</p> <p>16 Indianapolis, IN 46204</p> <p>17 317.232.6255</p> <p>18 tom.fisher@atg.in.gov</p> <p>19 FOR THE DEPONENT:</p> <p>20 Kimberly C. Metzger</p> <p>21 MCCARTER & ENGLISH, LLP</p> <p>22 880 West Monon Green Boulevard</p> <p>23 Suite 101</p> <p>24 Carmel, IN 46032</p> <p>25 317.363.3232</p> <p>kmetzger@mccarter.com</p> <p>ALSO PRESENT:</p> <p>Zef Cota, concierge tech</p> <p>Julie Conrad, general counsel for Eskenazi</p> <p>Harper Seldin, counsel for plaintiff</p> <p>Melinda Holmes, counsel for defendant</p> <p>Gavin Rose, counsel for plaintiff</p>	<p style="text-align: right;">Page 4</p> <p>1 INDEX OF EXHIBITS</p> <p>2 Page</p> <p>3 Deposition Exhibit No.:</p> <p>4 Exhibit 1 - Complaint 6</p> <p>5 Exhibit 2 - Senate Enrolled Act No. 480 9</p> <p>6 Exhibit 3 - Document subpoena 11</p> <p>7 Exhibit 4 - Document subpoena attachment 12</p> <p>8 Exhibit 5 - Amended deposition subpoena 15</p> <p>9 Exhibit 6 - Amended deposition subpoena 15</p> <p>10 30(b)(6) attachment</p> <p>11 Exhibit 7 - Eskenazi Health's amended 16</p> <p>12 response</p> <p>13 Exhibit 8 - Gender Health Program brochure, . . . 18</p> <p>14 Eskenazi_000001 and 2</p> <p>15 Exhibit 9 - Gender Health Program Plan of 19</p> <p>16 care, Eskenazi_000087 through</p> <p>17 91</p> <p>18 Exhibit 10 - Informed consent document, 21</p> <p>19 Eskenazi_000003 through 16</p> <p>20 Exhibit 11 - WPATH Standards of Care, 24</p> <p>21 Eskenazi_000017 through 49</p> <p>22 Exhibit 12 - Endocrine Society treatment 25</p> <p>23 clinical practice guideline,</p> <p>24 Eskenazi_000052 through 86</p> <p>25 Exhibit 13 - Support Groups document, 28</p> <p>Eskenazi_000050 and 51</p>
<p style="text-align: right;">Page 3</p> <p>1 INDEX OF EXAMINATION</p> <p>2 Page</p> <p>3 DIRECT EXAMINATION 5</p> <p>4 Questions by Thomas M. Fisher</p> <p>5 CROSS-EXAMINATION 44</p> <p>6 Questions by Kenneth J. Falk</p>	<p style="text-align: right;">Page 5</p> <p>1 (Time noted: 12:39 p.m.)</p> <p>2 JANINE M. FOGEL, MD,</p> <p>3 having been duly sworn to tell the truth, the whole</p> <p>4 truth, and nothing but the truth relating to said</p> <p>5 matter, was examined and testified as follows:</p> <p>6</p> <p>7 DIRECT EXAMINATION,</p> <p>8 QUESTIONS BY THOMAS M. FISHER:</p> <p>9 Q Dr. Fogel, good afternoon. My name is Tom</p> <p>10 Fisher. I am a lawyer at the Attorney General's</p> <p>11 Office and I'll be taking the deposition of</p> <p>12 Eskenazi today. And as I understand it, you're</p> <p>13 the designated witness for Eskenazi today.</p> <p>14 Is that generally your understanding, what</p> <p>15 we're doing?</p> <p>16 A Yes.</p> <p>17 Q I hope not to take too long. We do have some</p> <p>18 questions to get through. We are going to start</p> <p>19 off by looking at some documents that have been</p> <p>20 produce in this case.</p> <p>21 So just make sure that we are all on the</p> <p>22 same page as to what this case is, let's mark as</p> <p>23 Exhibit 1, the complaint in this case. If I can</p> <p>24 show that on the witness?</p> <p>25 THE CONCIERGE: I'm introducing it. Please</p>

ESKENAZI HEALTH GENDER HEALTH PROGRAM

ESKENAZI
HEALTH



BE HEALTHY.
BE WELL.
BE ACCEPTED.

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0008**

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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](https://www.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 insurance.

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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.

COPY

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>.

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5/17/2023
FOGEL

Eskenazi_000003

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.
- Male 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.



1016D1 OF 3

Consent
Form# EH2562

ESKENAZI HEALTH CENTER OF EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH Indianapolis, Indiana

Rev. 3/16 INFORMED CONSENT FOR FEMINIZING HORMONE THERAPY - PAGE 2 OF 3

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.



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Consent Form# EH2562

ESKENAZI HEALTH CENTER OF
EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH
Indianapolis, Indiana

Rev. 3/16 INFORMED CONSENT FOR FEMINIZING HORMONE THERAPY - PAGE 3 OF 3

- 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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Consent
Form# EH2562

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	Polycythemia
	Gallstones	Weight gain
	Elevated liver enzymes	Acne
	Weight gain	Androgenic alopecia (balding)
	Hypertriglyceridemia	Sleep apnea
Likely increased risk with presence of additional risk factors ^B	Cardiovascular disease	
Possible increased risk	Hypertension	Elevated liver enzymes
	Hyperprolactinemia or prolactinoma ^A	Hyperlipidemia
Possible increased risk with presence of additional risk factors ^B	Type 2 diabetes ^A	Destabilization of certain psychiatric disorders ^C
		Cardiovascular disease
		Hypertension
No increased risk or inconclusive	Breast cancer	Type 2 diabetes
		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.



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Consent
Form# EH2563

Eskenazi_000010

ESKENAZI HEALTH CENTER OF
EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH
Indianapolis, Indiana

Rev. 2/16 INFORMED CONSENT FOR MASCULINIZING HORMONE THERAPY - PAGE 2 OF 3

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.



1016D2 OF 3

Consent
Form# EH2563

Eskenazi_000011

ESKENAZI HEALTH CENTER OF
EXCELLENCE IN WOMEN'S HEALTH

ESKENAZI HEALTH
Indianapolis, Indiana

Rev. 2/16 INFORMED CONSENT FOR MASCULINIZING HORMONE THERAPY - PAGE 3 OF 3

- 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



1016D3 OF 3

Consent
Form# EH2563

Eskenazi_000012

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. BOLDDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease ^A	Polycythemia
	Gallstones	Weight gain
	Elevated liver enzymes	Acne
	Weight gain	Androgenic alopecia (balding)
	Hypertriglyceridemia	Sleep apnea
Likely increased risk with presence of additional risk factors ^B	Cardiovascular disease	
Possible increased risk	Hypertension	Elevated liver enzymes
	Hyperprolactinemia or prolactinoma ^A	Hyperlipidemia
Possible increased risk with presence of additional risk factors ^B	Type 2 diabetes ^A	Destabilization of certain psychiatric disorders ^C
		Cardiovascular disease
		Hypertension
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

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.



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 Number317.880.6042

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

Exhibit

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5/17/2023

FOGEL

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