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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

Case No. 1:23-cv-00269-BLW

**PLAINTIFFS' NOTICE OF DEPOSITION
ERRATA AND COMPLETE
DEPOSITION TRANSCRIPT**

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PLEASE TAKE NOTICE that Plaintiffs respectfully submit the following documents in further support of their Motion for a Preliminary Injunction (Dkt. 32):

- 1) The signed errata sheet for the Deposition of Christine Brady, Ph.D., which was submitted as a complete transcript by the State Defendants as Dkt. 56-2 in support of their opposition to Plaintiffs' Motion;
- 2) The complete transcript of the Deposition of Jack Turban, M.D., M.S.H., of which excerpts were submitted by the State Defendants as Dkt. 72-2 in support of their surreply in further opposition to Plaintiffs' Motion; and
- 3) The signed errata sheet for the Deposition of Jack Turban, M.D., M.S.H.

Dated: November 2, 2023

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CERTIFICATE OF SERVICE

I hereby certify that on November 2, 2023, the foregoing document was filed via the Court's electronic filing system, which caused the same to be served by electronic service upon all counsel of record.

/s/ Philip S. May

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Counsel for Plaintiffs

Christine Brady, Ph.D. August 31, 2023

VERIFICATION

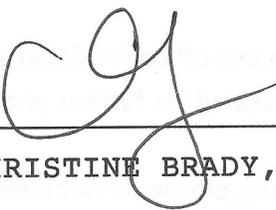
STATE OF California)

COUNTY OF Santa Clara)

I, CHRISTINE BRADY, Ph.D., being first duly sworn on my oath, depose and say:

That I am the witness named in the foregoing deposition taken the 31st day of August, 2023, consisting of pages numbered 1 to 204, inclusive; that I have read the said deposition and know the contents thereof; that the questions contained therein were propounded to me; the answers to said questions were given by me, and that the answers as contained therein (or as corrected by me therein) are true and correct.

Corrections Made: Yes X No


CHRISTINE BRADY, Ph.D.

Subscribed and sworn to before me this 3 day of October, 2023, at _____, Idaho.

Notary Public for Idaho
Residing at _____, Idaho
My commission expires: _____.

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UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

| | | |
|--------------------------------|---|-------------------|
| PAM POE, by and through her |) | Case No. |
| parents and next friends, |) | 1:23-cv-00269-CWD |
| Penny and Peter Poe; PENNY |) | |
| POE; PETER POE; JANE DOE, by |) | |
| and through her parents and |) | |
| next friends, Joan and John |) | |
| Doe; JOAN DOE; JOHN DOE, |) | |
| |) | |
| Plaintiffs, |) | |
| |) | |
| v. |) | |
| |) | |
| RAÚL LABRADOR, in his |) | |
| official capacity as the |) | |
| Attorney General of the State) |) | |
| of Idaho; JAN M. BENNETTS, in) |) | |
| her official capacity as |) | |
| County Prosecuting Attorney |) | |
| for Ada, Idaho; and the |) | |
| INDIVIDUAL MEMBERS OF THE |) | |
| IDAHO CODE COMMISSION, in |) | |
| their official capacities, |) | |
| |) | |
| Defendants. |) | |
| _____ |) | |

REMOTE VIDEOTAPED DEPOSITION OF JACK TURBAN, M.D., MHS
MONDAY, OCTOBER 16, 2023

Reported By: Amy E. Simmons, CSR, RDR, CRR, CRC

1 REMOTE VIDEOTAPED DEPOSITION OF JACK TURBAN, M.D., MHS
 2
 3 BE IT REMEMBERED that the remote videotaped
 4 deposition of JACK TURBAN, M.D., MHS was taken via Zoom
 5 videoconference by the attorney for the Defendants before
 6 Associated Reporting & Video, a Veritext company, Amy E.
 7 Simmons, Idaho CSR No. 685, California CSR No. 14553,
 8 Washington CSR No. 22012915, Oregon CSR No. 22-009, and
 9 Notary Public in and for the County of Ada, State of
 10 Idaho, on Monday, the 16th day of October, 2023,
 11 commencing at the hour of 9:06 a.m. Pacific time in the
 12 above-entitled matter.
 13
 14
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 16
 Also Present: Chris Ennis, Videographer
 17 Jocelyn Larsson,
 Court Reporting Intern
 18
 19
 20
 21
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 23
 24
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| <p>1 EXHIBITS (continued)</p> <p>2 NO. PAGE</p> <p>3 Exhibit 30. LGBT Health "Factors Leading to 299 4 'Detransition' Among Transgender and Gender Diverse People in the 5 United States: A Mixed-Methods Analysis" (8 pages)</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p style="text-align: right;">Page 7</p> | <p>1 MR. MAY: And Philip May from 2 Groombridge, Wu, Baughman & Stone on behalf of 3 Plaintiffs.</p> <p>4 THE VIDEOGRAPHER: And if the court 5 reporter will please swear the witness.</p> <p>6 THE REPORTER: I think we have a couple 7 more people that need to identify themselves 8 first. I've got Rafael Droz and Dina Flores.</p> <p>9 MS. FLORES-BREWER: Yes. This is Dina 10 Flores-Brewer. I'm one of the attorneys for ACLU 11 of Idaho. I am just listening in today.</p> <p>12 THE REPORTER: Thank you. And Mr. Droz 13 is for the State; is that correct? I'm thinking 14 he's just not on.</p> <p>15 MR. RAMER: That's right. He's with the 16 Idaho Attorney General's Office representing the 17 State defendants.</p> <p>18</p> <p>19 JACK TURBAN, M.D., MHS, 20 a witness having been first duly sworn to tell the truth, 21 the whole truth, and nothing but the truth, testified as 22 follows: 23 /// 24 /// 25 ///</p> <p style="text-align: right;">Page 9</p> |

| | |
|---|---|
| <p>1 EXAMINATION</p> <p>2 BY MR. RAMER:</p> <p>3 Q. (BY MR. RAMER) Good morning, Dr. Turban.</p> <p>4 A. Good morning.</p> <p>5 Q. My name is John Ramer. I'm from the law</p> <p>6 firm Cooper & Kirk representing the State</p> <p>7 defendants in this case.</p> <p>8 I know you've been deposed before, but</p> <p>9 just as a quick refresher for both of us -- more</p> <p>10 for me -- but for the benefit of the court</p> <p>11 reporter, we'll try not to talk over one another.</p> <p>12 And I'd just ask that you respond</p> <p>13 verbally when answering questions.</p> <p>14 If you don't understand anything about my</p> <p>15 question, please just let me know; otherwise, I'll</p> <p>16 assume you're answering the question asked.</p> <p>17 And I typically aim for a break every</p> <p>18 hour or so, but if you need a break at any point,</p> <p>19 just let me know. And my only request would be</p> <p>20 that you answer any question that's pending before</p> <p>21 we go on a break.</p> <p>22 Does that all sound good?</p> <p>23 A. Yes.</p> <p>24 MR. RAMER: And first, I'm just going to</p> <p>25 introduce and mark some documents that we'll</p> <p style="text-align: right;">Page 10</p> | <p>1 Q. (BY MR. RAMER) And then Turban</p> <p>2 Exhibit 3, does this document appear to be your</p> <p>3 signed errata sheet for your deposition in the</p> <p>4 Indiana case?</p> <p>5 A. Yes.</p> <p>6 Q. And, Dr. Turban, is anyone in the room</p> <p>7 with you besides Li Nowlin-Sohl?</p> <p>8 A. Sorry, no.</p> <p>9 Q. And do you have any documents open in</p> <p>10 front of you?</p> <p>11 A. Just the exhibits that you sent.</p> <p>12 Q. Great. Dr. Turban, are you familiar with</p> <p>13 the term "evidence-based medicine"?</p> <p>14 A. Yes.</p> <p>15 Q. And what is your understanding of that</p> <p>16 term?</p> <p>17 A. The broad term, that refers to using the</p> <p>18 existing published research literature when making</p> <p>19 decisions about medical care.</p> <p>20 Q. And do you practice evidence-based</p> <p>21 medicine?</p> <p>22 A. Yes.</p> <p>23 Q. And how does one practice evidence-based</p> <p>24 medicine?</p> <p>25 A. That's a big question that involves many</p> <p style="text-align: right;">Page 12</p> |
| <p>1 likely be referring to throughout the day. The</p> <p>2 first one Li should have. It's Turban Exhibit 1.</p> <p>3 I think the file name says "Tab A." When you have</p> <p>4 it, just let me know.</p> <p>5 (Deposition Exhibit No. 1 was marked.)</p> <p>6 THE WITNESS: I have it.</p> <p>7 Q. (BY MR. RAMER) And, Dr. Turban, is this</p> <p>8 a copy of the declaration you submitted in this</p> <p>9 case?</p> <p>10 A. Yes.</p> <p>11 Q. Okay. And attached to the declaration,</p> <p>12 is your CV attached?</p> <p>13 A. Yes.</p> <p>14 Q. And I assume there are not any major</p> <p>15 changes over the weekend from when this was filed</p> <p>16 on Friday?</p> <p>17 A. Correct.</p> <p>18 (Deposition Exhibit No. 2 was marked.)</p> <p>19 Q. (BY MR. RAMER) Okay. The next document,</p> <p>20 Turban Exhibit 2, does this appear to be the</p> <p>21 transcript of your deposition in the Indiana case,</p> <p>22 K.C. vs. The Individual Members of the Medical</p> <p>23 Licensing Board?</p> <p>24 A. It appears to be, yes.</p> <p>25 (Deposition Exhibit No. 3 was marked.)</p> <p style="text-align: right;">Page 11</p> | <p>1 years of medical school and residency and</p> <p>2 fellowship training, but as a general matter it</p> <p>3 involves having a patient in front of you and</p> <p>4 referencing the existing research literature to</p> <p>5 try to make the best decision for that patient</p> <p>6 based on the research that's been published.</p> <p>7 Q. Are you familiar with the term</p> <p>8 "systematic review"?</p> <p>9 A. Yes.</p> <p>10 Q. And what is your understanding of that</p> <p>11 term?</p> <p>12 A. Systematic review is when one predefines</p> <p>13 search terms that they are going to use when</p> <p>14 searching various research databases. Then they</p> <p>15 provide a review of the literature that they</p> <p>16 identify through that search method.</p> <p>17 Q. When you say "they provide a review of</p> <p>18 the literature," what do you mean by that?</p> <p>19 A. They would define search terms. They</p> <p>20 would put those search terms into the research</p> <p>21 databases. Many papers will come out of there,</p> <p>22 but then there's variation in how they may choose</p> <p>23 to include or exclude different studies, how they</p> <p>24 interpret them, and how they summarize their</p> <p>25 reading of those papers.</p> <p style="text-align: right;">Page 13</p> |

1 Q. And what does the practice of
2 evidence-based medicine say about the role of
3 systematic reviews in clinical decision-making?
4 MS. NOWLIN-SOHL: Object to the form.
5 THE WITNESS: Again, because systematic
6 reviews can be so broad, there would be systematic
7 reviews that would be very useful and there would
8 be some other systematic reviews that would be
9 less useful.
10 Usually in evidence-based medicine people
11 are talking about systematic reviews of clinical
12 trials or of non -- like, observational studies or
13 comparative studies, but there's not really a
14 straightforward answer. Systematic review is just
15 one way of collecting literature that you may then
16 use when working through evidence-based medicine.
17 Q. (BY MR. RAMER) And do you know how a
18 systematic review is conducted?
19 A. There are many different ways to conduct
20 a systematic review, but again, in general, one
21 would predefine their search terms to find the
22 databases they're going to use, put those search
23 terms into those databases, screen abstracts,
24 identify the abstracts that they feel are relevant
25 to their questions, and then summarize that

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1 literature.
2 Q. What is the value of a systematic review
3 over an alternative method of reviewing a body of
4 scientific literature?
5 A. Do you mean comparing a systematic review
6 to, say, a narrative review?
7 Q. Sure. Or any other -- I guess what other
8 types of reviews of the body of scientific
9 literature are there besides systematic review and
10 a narrative review?
11 A. Those are the two main ones that people
12 would discuss. So a narrative view is usually
13 written by an expert who knows the literature
14 broadly but they may not include in their
15 manuscript what specific search terms they used,
16 what specific databases they used, but they'll
17 summarize what's known about the research, and
18 they'll go through peer review where other experts
19 check that material also.
20 They would add additional literature if
21 that individual author has missed something. It
22 goes back and forth through the peer-review
23 process until the reviewer, the editor, and the
24 author feel that it's comprehensive.
25 A systematic review is different in that

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1 the manuscript will actually say "These are the
2 search terms that we used when searching our
3 literature databases, and these are the databases
4 that we used." So it makes it a little bit easier
5 for another researcher to repeat their search.
6 Q. Have you ever conducted a systematic
7 review?
8 A. Not as a first author, but I've been part
9 of a team that's conducted a systematic review.
10 Q. And what systematic review was that?
11 A. The systematic review of a broad category
12 of functional neurologic disorders among sexual-
13 and gender-minority people.
14 Q. Do you happen to know the name of that
15 paper?
16 A. I think the first author is Lerario,
17 L-e-r-a-r-i-o, I believe.
18 Q. And what was your role in that systematic
19 review?
20 A. I assisted the team with choosing our
21 search terms, choosing the databases, and also in
22 writing the manuscript, editing the manuscript.
23 Q. As you sit here today, are you able to
24 name any specific systematic reviews relating to
25 literature in your field that you have read?

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1 MS. NOWLIN-SOHL: Object to form.
2 THE WITNESS: I don't know that I would
3 have, like, a specific title that I could rattle
4 off, but there have been many systematic
5 reviews -- is there a specific part of my field
6 that you're referencing?
7 Q. (BY MR. RAMER) I guess what field are
8 you opining upon as an expert in this case?
9 A. The treatment of adolescents with gender
10 dysphoria.
11 Q. So then, yes, I guess I'll talk about
12 that field.
13 Have you -- as you sit here today, are
14 you able to name any specific systematic reviews
15 relating to literature in that field that you have
16 read?
17 A. I don't remember the exact titles, but I
18 know there was one, I believe, in the Journal of
19 Transgender Health a few years ago.
20 There have been a number of
21 non-peer-reviewed systematic reviews.
22 I believe there were systematic reviews
23 conducted as part of some of the guidelines that
24 were written.
25 Q. And I know you said you don't know the

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| <p>1 title, but the one that you first referred to in 2 the Journal For Transgender Health, can you 3 describe it so that we can at least try to 4 identify it? 5 A. It was a few years ago that it came out, 6 but it was I think generally looking at the mental 7 health impacts of different gender-affirming 8 medical interventions for adolescents with gender 9 dysphoria. 10 And, as a systematic review generally 11 does, goes through the strengths and weaknesses of 12 different studies that have been published. 13 Q. Do you remember any of the authors on it? 14 A. I don't recall. 15 Q. Of the systematic reviews you described, 16 did you study them in detail? 17 MS. NOWLIN-SOHL: Object to form. 18 THE WITNESS: Generally if you are in a 19 specific field where you know most of the research 20 papers, the thing that's most interesting about 21 systematic review is if it identifies a paper that 22 you didn't already know about. 23 The big thing about systematic review is 24 that it's using specific search terms and doing 25 this really comprehensive search of these large</p> <p style="text-align: right;">Page 18</p> | <p>1 So can you repeat that answer for me, 2 please? 3 THE WITNESS: Yeah, sorry. I'm trying to 4 see if I can turn up the microphone also. 5 THE REPORTER: Thank you. 6 THE WITNESS: I think the microphone is 7 up all the way. Is this better with it close? 8 THE REPORTER: Let's try it. 9 THE WITNESS: I think the question was if 10 I've had any coursework in using evidence-based 11 medicine? 12 Q. (BY MR. RAMER) That's right. 13 A. So certainly that would be part of -- my 14 undergraduate degree was in neuroscience from 15 Harvard College. 16 And then I received my medical school 17 degree from Yale School of Medicine where we 18 talked about evidence-based medicine both in our 19 preclinical classroom courses and through our 20 clinical courtships when we're working with 21 patients. 22 And then received a master's of health 23 sciences research from Yale also. 24 I did my adult psychiatry residency at 25 Harvard Medical School at MGH McLean where we had</p> <p style="text-align: right;">Page 20</p> |
| <p>1 databases, so it's values that can identify a 2 peer-reviewed research paper that you didn't know 3 about previously. 4 So probably what I would have done is if 5 there were any papers in there that I didn't know 6 about, I would have added it to my running list of 7 papers that I think are important for me to know 8 and for my fellows to know and others in the 9 field. 10 Q. (BY MR. RAMER) And this question may not 11 make sense, but have you taken any particular 12 courses on the evidence-based medicine? Or is it 13 more it's a set of principles that is infused into 14 all of medical education? 15 MS. NOWLIN-SOHL: Object to form. 16 THE WITNESS: Certainly there is some in 17 my undergraduate degree in neuroscience that was 18 from Harvard. Also my medical school courses -- 19 [indiscernible]. 20 THE REPORTER: Dr. Turban, I'm sorry to 21 interrupt. I'm having a hard time understanding 22 you a little bit. I don't know if you can get 23 closer to the microphone or maybe slow down a tiny 24 bit? Some of your words are just cutting out, and 25 I'm struggling with understanding them.</p> <p style="text-align: right;">Page 19</p> | <p>1 more courses on it as well as applying it 2 practically to seeing patients. 3 And then similarly in my fellowship in 4 child and adolescent psychiatry at Stanford. 5 MR. RAMER: Okay. And I'd like to 6 introduce what will be Turban Exhibit 4. And it 7 should be the Users' Guides to the Medical 8 Literature Third Edition. 9 (Deposition Exhibit No. 4 was marked.) 10 Q. (BY MR. RAMER) Do you see that? 11 A. Yes. 12 Q. And have you seen this document before? 13 A. I do not believe I have. 14 Q. Do you recognize the lead author's name, 15 Gordon Guyatt? 16 A. I do not. It looks like he is a 17 biostatistician in Ontario. 18 Q. Where are you getting that information? 19 A. From the first page. 20 Q. Oh, I see. And I'd like to go to page 4, 21 which I think is 33 in the PDF. 22 A. Okay. 23 Q. The second full sentence on this page, 24 I'll just read it and ask if I've read it 25 correctly.</p> <p style="text-align: right;">Page 21</p> |

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| <p>1 It says "Efficient and optimally 2 effective evidence-based practice dictates 3 bypassing the critical assessment of primary 4 studies and, if they are available, moving 5 straight to the evaluation of rigorous systematic 6 reviews." 7 Did I read that correctly? 8 A. Yes. 9 Q. And do you agree with that statement? 10 A. Yeah, I think this is similar to what I 11 was saying before, that it wouldn't be a good 12 practice to just look at one or two individual 13 studies. [Indiscernible] -- of a systematic 14 review is that it's going to identify more studies 15 that you may not find -- that a more, as they're 16 saying, quote, rigorous systematic review with a 17 certain search approach would potentially 18 identify. 19 It's basically saying that you don't want 20 to miss individual studies that might be important 21 for your interpretation. 22 Q. But it looks like it's discussing that 23 you need to bypass, quote, the critical assessment 24 primary studies, end quote, and instead proceed to 25 systematic reviews.</p> <p style="text-align: right;">Page 22</p> | <p>1 understand the very last part of what you just 2 said. 3 Could you say that again? 4 A. The word "bypass" is tricky because I 5 think -- correct me if I'm wrong, but I think you 6 were reading "bypass" as meaning you should not 7 read the individual studies and you should just go 8 to the systematic review. That's not my 9 interpretation. 10 I think they're saying that you shouldn't 11 just read individual studies because you might 12 miss other important studies. So you should read 13 the studies that you identified, but you should 14 also go to systematic reviews to make sure you're 15 not missing important information or studies that 16 you yourself didn't identify in your search. 17 Q. And then I'd like to go to page 14, which 18 I think is page 43 in the PDF. 19 A. Okay. 20 Q. And the first full paragraph on this 21 page, I'm just going to read the first two 22 sentences and ask if I read it correctly. 23 It says "Rational clinical decisions 24 require systematic summaries of the best available 25 evidence. Without such summaries, clinicians,</p> <p style="text-align: right;">Page 24</p> |
| <p>1 And that -- do you agree that seems to be 2 discussing something different than merely 3 identifying studies? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: I may have to read it in 6 context to see what they mean by "bypass," if you 7 give me a moment. 8 If read in context, this seems to talk 9 about how one could read individual studies. It 10 then goes on to say that there are times where an 11 individual study doesn't give you the full picture 12 because other studies may provide additional 13 information. 14 Then they're saying, you know, you should 15 bypass the individual studies and go to the 16 systematic reviews, but I think really what they 17 mean is don't only read individual studies because 18 that would put you at risk of missing other 19 studies that are important for understanding the 20 body of research as a whole is how I read that 21 sentence. I don't think they're saying to ignore 22 individual studies or to not consider reading them 23 in depth when they're identified in the systematic 24 review. 25 Q. (BY MR. RAMER) I'm sorry. I didn't</p> <p style="text-align: right;">Page 23</p> | <p>1 expert or otherwise, will be unduly influenced by 2 their own preconceptions and by unrepresentative 3 and often lower quality evidence." 4 Did I read that correctly? 5 A. Yes. 6 Q. And do you agree with those statements? 7 A. Again, I think what this is saying is 8 that if you only knew some of the research 9 literature and you were missing several research 10 studies, then you wouldn't have the complete 11 picture of the evidence. And I believe that is 12 true. 13 Q. What do you take them to be referring to 14 when they discuss "lower quality evidence"? 15 MS. NOWLIN-SOHL: Object to form; 16 foundation. 17 THE WITNESS: They don't -- I don't know 18 if they provided a specific definition earlier, 19 but it's a subjective term relevant to others. It 20 would depend on what you were comparing, 21 presumably something lower quality than the other 22 papers you had not identified in some way. But I 23 don't think they're specifying a specific way in 24 which one paper is lower quality than another, 25 just highlighting that some papers may be higher</p> <p style="text-align: right;">Page 25</p> |

1 quality than others.
 2 Q. (BY MR. RAMER) How can one paper be
 3 higher quality than another?
 4 A. Oh, I would need to give you an entire
 5 course on clinical research and statistical
 6 approaches.
 7 Q. Okay. So your point -- just to kind of
 8 summarize here, your point is that the value of
 9 the systematic review is really just the value of
 10 identifying relevant studies; is that fair?
 11 A. The major goal of systematic review is to
 12 collect the best you can. Systematic reviews are
 13 never perfect. There are intricacies in what
 14 search terms you use, which databases you use, how
 15 you choose to include and exclude different
 16 studies, so there are many ways that systematic
 17 review can be high quality or low quality itself.
 18 But in general the goal, if it's done
 19 well, is that you would identify all the relevant
 20 research, that you could really be making your
 21 summaries of the literature based on a complete
 22 picture, that you're not missing important
 23 studies.
 24 Q. So it's just about locating studies; is
 25 that right?

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1 MS. NOWLIN-SOHL: Objection;
 2 mischaracterizes prior testimony.
 3 THE WITNESS: It's about in a systematic
 4 way, identifying relevant papers and then one
 5 generally summarizes them as well.
 6 Ideally, a critical reader of a
 7 systematic review would go back to those studies
 8 and read them as well, if it were feasible.
 9 MR. RAMER: And I tried to send what I'll
 10 call Turban Exhibit 5. Did you receive that, Li?
 11 MS. NOWLIN-SOHL: I have not.
 12 MR. RAMER: Okay.
 13 Q. (BY MR. RAMER) Let's do it this way.
 14 Dr. Turban, have you ever heard of the pyramid of
 15 evidence?
 16 A. Broadly speaking.
 17 MR. RAMER: Hey, Li, do you mind if we go
 18 off the record for just one second to discuss a
 19 technical issue?
 20 MS. NOWLIN-SOHL: Yeah, that's fine.
 21 THE VIDEOGRAPHER: Okay. So the time is
 22 9:32 a.m. Pacific time, and we are off the record.
 23 (Brief pause in the proceedings.)
 24 THE VIDEOGRAPHER: All right. So we are
 25 recording. The time is 9:33 a.m. Pacific time,

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1 and we are back on the record.
 2 MR. RAMER: Okay. I just tried hitting
 3 send again the compressed version. So if that
 4 shows up, Li, just let me know.
 5 Q. (BY MR. RAMER) While we're waiting,
 6 Dr. Turban, have you ever heard the term the
 7 "hierarchy of evidence"?
 8 Sorry. Did you hear me?
 9 MR. RAMER: Amy, can you hear me?
 10 THE WITNESS: Something just happened
 11 with our A/V system.
 12 MS. NOWLIN-SOHL: Can you hear us, John?
 13 MR. RAMER: I just said while we're
 14 waiting --
 15 MS. NOWLIN-SOHL: Okay. We cannot hear
 16 you.
 17 MR. RAMER: Okay. Let's go off the
 18 record again.
 19 THE WITNESS: Try again now, please.
 20 MR. RAMER: Can you hear me? All right.
 21 THE VIDEOGRAPHER: Okay. I'll take you
 22 guys off here. One second.
 23 So the time is 9:35 a.m. Pacific, and we
 24 are off the record.
 25 (Brief pause in the proceedings.)

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1 THE VIDEOGRAPHER: Okay. So we are
 2 regarding. The time is 9:37 a.m. Pacific, and we
 3 are back on the record.
 4 (Deposition Exhibit No. 5 was marked.)
 5 Q. (BY MR. RAMER) Okay. Dr. Turban, do you
 6 have Turban Exhibit 5, which says "The Cass
 7 Review" at the top in front of you?
 8 A. Yes. February 2022.
 9 Q. And have you seen this document before?
 10 A. Yes.
 11 Q. Have you read it?
 12 A. Yes.
 13 Q. And when did you first read it?
 14 A. I don't recall. Many months ago.
 15 Q. Do you recall what you thought when you
 16 read it?
 17 A. My main takeaways were that they --
 18 there's a lot of news coverage of it also.
 19 My understanding is there were very long
 20 wait lists for the central gender clinic in the
 21 U.K. And because of those long waits, there was
 22 concern that the physicians weren't able to
 23 provide comprehensive care and be able to see the
 24 number of patients they had on their very long
 25 wait list.

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| <p>1 So I think the review went in and 2 ultimately determined it would be better to close 3 that centralized clinic and open several regional 4 clinics where they'd be able to provide more 5 comprehensive individualized care. 6 Q. Okay. And I'd like to go to page 62 of 7 this document. 8 And just let me know when you're there. 9 A. We're there. Figure 3? 10 Q. Yes. And so Figure 3 is entitled 11 "Pyramid of Standards of Evidence"; is that right? 12 A. Yes. 13 Q. And have you seen this image before? 14 A. I've seen images like this one before. 15 Q. And have you ever heard the term 16 "hierarchy of evidence"? 17 A. In a general sense, yes. 18 Q. And what's your understanding of that 19 term? 20 A. Just a broad reference to the fact that 21 some research studies may have fewer potential 22 interpretive pitfalls than others. 23 Q. And can you explain why this figure has 24 "Systematic reviews" at the top of the pyramid? 25 A. I think this is going to the point that</p> <p style="text-align: right;">Page 30</p> | <p>1 Q. And why is that of higher value? 2 A. Because you're looking at all of the 3 studies instead of looking at just one. 4 Q. And so again, you think that what this 5 figure is showing is that systematic reviews are 6 at the top of the pyramid because they identify 7 all the studies? 8 MS. NOWLIN-SOHL: Objection; 9 mischaracterizes prior testimony. 10 THE WITNESS: Yeah, I would say what's at 11 the top is "Systematic review and meta-analyses," 12 and that a systematic review with a meta-analysis 13 is summarizing to the best of its ability with 14 many caveats as much of the literature as 15 possible. 16 Q. (BY MR. RAMER) Okay. Can you explain 17 why cohort studies are below randomized controlled 18 trials on this pyramid? 19 A. So cohort studies are studies where you 20 have a group of patients and you follow them over 21 time. So the realm of gender-affirming medical 22 care, this would be something like having 23 adolescents with gender dysphoria who are treated 24 with testosterone, and you look before and after 25 and you see their mental health is better after.</p> <p style="text-align: right;">Page 32</p> |
| <p>1 knowing the body of literature as a whole is more 2 useful than just an individual study. 3 I think it's worth pointing out that it 4 actually says "Systematic reviews and 5 meta-analyses." 6 And meta-analyses are different. So 7 meta-analyses are when you actually take all the 8 research studies that have been done and conduct 9 statistical analyses to create a composite number 10 that really tells you in a quantitative way how to 11 put all the research together instead of some of 12 these systematic reviews where their description 13 is narrative; they're just kind of saying their 14 interpretation of the data. 15 That's different from a meta-analysis 16 where they actually apply statistical techniques 17 to summarize all of the research as a whole. 18 So systematic review and meta-analysis is 19 a specific kind of paper that's not just a 20 systematic review. 21 But generally what this figure is getting 22 at is that if you have a paper that has all of the 23 research literature, or as much as possible of the 24 research literature together and summarized, 25 that's of higher value than individual studies.</p> <p style="text-align: right;">Page 31</p> | <p>1 That's a cohort study. 2 If you were looking just at an individual 3 cohort study -- and again, this is why you 4 shouldn't look at just one paper -- you might ask, 5 "Okay. Did their mental health improve because of 6 the testosterone? Or was their mental health 7 going to improve anyway?" 8 Does that make sense? 9 So in the research, we have other studies 10 that compared those who had access to treatment to 11 those who didn't. We have parallel process 12 models. We have all these ways to answer that 13 question that aren't on this, like, very basic 14 teaching tool that's this pyramid. 15 The reason a randomized controlled trial 16 is above that is because a randomized controlled 17 trial in a single paper could answer two 18 questions. So it could tell you does mental 19 health improve before and after? And also do 20 people who get treatment do better than those who 21 don't do treatment, which approaches this question 22 of would their mental health have just gotten 23 better anyway? 24 So a randomized controlled trial can kind 25 of hit more things in one study than a cohort</p> <p style="text-align: right;">Page 33</p> |

1 study can.
 2 Q. Do you think this pyramid is saying that
 3 a randomized controlled trial is of higher quality
 4 than a cohort study?
 5 A. I think that's a broad
 6 oversimplification, but I think what it's saying
 7 is that if you had a single randomized controlled
 8 trial that was well conducted, it would likely
 9 give you more information than a cohort study.
 10 Q. Because it's of higher quality?
 11 A. Not necessary -- what do you mean by
 12 "higher quality"?
 13 Q. Because that study design is of higher
 14 quality than a cohort study.
 15 A. I would say because it has the benefit of
 16 having a control group, medical cohort study does
 17 not, which gives you additional information about
 18 whether or not your outcome would have improved
 19 whether or not the introduction was given. It
 20 gives you more information.
 21 A single randomized controlled trial,
 22 when well conducted, can give more information
 23 than a cohort study.
 24 Q. What about -- and I know this is -- I'm
 25 not -- this question is not about a specific

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1 study. It's more about methodology in theory.
 2 And so my question is looking at this, in
 3 theory you have a group of four cohort studies.
 4 And if you have a group of four randomized
 5 controlled trials, all else being equal, based on
 6 the design of those studies, are the randomized
 7 controlled trials of higher quality than the
 8 cohort studies?
 9 MS. NOWLIN-SOHL: Object to form.
 10 THE WITNESS: It's hard to say all else
 11 being equal because there are so many variables
 12 that go into how you design a cohort study or how
 13 you design a randomized controlled trial, so I
 14 would really need you to kind of give me specific
 15 studies to answer that question.
 16 Q. (BY MR. RAMER) Well, no. It's a
 17 hypothetical about the theory and the method of
 18 it, and so the hypothetical is all else being
 19 equal -- they have the exact same inputs, the
 20 exact same outputs, one is a randomized controlled
 21 trial; one is a group of cohort studies.
 22 And my question is is the group of
 23 randomized controlled trials of higher quality
 24 than the group of cohort studies?
 25 MS. NOWLIN-SOHL: Object to form.

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1 THE WITNESS: Again, with all due
 2 respect, I think your question is implying lack of
 3 understanding of how the studies are designed.
 4 You can't put the exact same inputs into a cohort
 5 study and a randomized controlled trial because
 6 they're different study designs.
 7 So when you're saying "all else being
 8 equal," I really don't know what you -- I need you
 9 to be more specific.
 10 Q. (BY MR. RAMER) And when you say they're
 11 a different study design, does the design of one
 12 lead to a higher quality study than the design of
 13 the other?
 14 MS. NOWLIN-SOHL: Object to the form.
 15 THE WITNESS: I believe I answered that
 16 question.
 17 Q. (BY MR. RAMER) Could you remind me what
 18 your answer was?
 19 MS. NOWLIN-SOHL: Same objection.
 20 THE WITNESS: So they're different study
 21 designs. A cohort study tells you whether or not
 22 an outcome changes before and after the
 23 intervention. It does not have a control group.
 24 So you could be left with the question of
 25 whether or not your outcome improved because of

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1 the intervention or because it was going to
 2 improve anyway over time.
 3 A randomized controlled trial generally
 4 has two groups. One group gets intervention; one
 5 group doesn't. So you can see maybe the treatment
 6 group improves and the other group, which could be
 7 many different groups -- let's say it's a placebo
 8 in this case -- does not improve, and then that
 9 would tell you, okay. It probably wasn't that
 10 they improved just because of time.
 11 So in that case, a randomized controlled
 12 trial can give you more information than a cohort
 13 study wouldn't. So it has the potential to give
 14 you more information certainly.
 15 Q. And on this pyramid, on the left side of
 16 it, the arrow that's adjacent that refers to
 17 quality, what do you think that's referring to?
 18 A. I think it's just a vague reference to
 19 the fact that -- these are all different study
 20 designs as you go up the pyramid.
 21 And as you go up the pyramid, you get --
 22 the study designs have the potential to answer
 23 other kinds of questions, right?
 24 So the cohort study can't tell you about
 25 whether or not mental health would have improved

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| <p>1 without the treatment. The randomized controlled 2 trial tells you that. 3 And then all randomized controlled trials 4 are going to have strengths and benefits, right? 5 They may have different patient populations. They 6 might have different study outcomes. They may 7 have different blinding procedures. 8 And so a systematic review and 9 meta-analysis would tell you instead of like, oh, 10 look, I only have this one study I'm looking at, 11 you would look at all of them, and that would give 12 you more and more richer information. 13 Q. Okay. I'd like to go back to Turban 14 Exhibit 4, which is the Users' Guide to the 15 Medical Literature. 16 And I would like to go to page 6 in the 17 document. I think it's 35 in the PDF. 18 A. Yes. 19 Q. And I'm just going to read the -- it's 20 the sentence at the very bottom that carries over 21 on to page 7. And I'll just read it and ask if I 22 read it correctly. 23 It says "In our discussions of systematic 24 reviews and guidelines, we introduce the GRADE 25 (Grading of Recommendations Assessment,</p> <p style="text-align: right;">Page 38</p> | <p>1 several other factors that would be important to 2 consider when -- whether or not to recommend a 3 treatment. 4 But it has two steps in that way. It has 5 kind of the grading of the evidence and then 6 determining strength of recommendations. 7 Q. And have you ever attempted to apply the 8 criteria specified by GRADE to assess a study? 9 A. It's generally recommended that one do 10 that as part of, like, a full research group. And 11 I've not been on one of those groups. 12 Q. And so then you -- you've also never 13 attempted to do that for any of the studies that 14 you cite in your declaration, correct? 15 A. No, not apply specific GRADE criteria. 16 Generally GRADE criteria is used when one is 17 writing guidelines. 18 Q. I'm sorry. Say that again? 19 A. GRADE is typically used when one is 20 writing clinical practice guidelines. 21 Q. Is GRADE ever used in a systematic 22 review? 23 A. Some people might. I have not. 24 Q. How many systematic reviews have you 25 done?</p> <p style="text-align: right;">Page 40</p> |
| <p>1 Development, and Evaluation) approach to 2 summarizing evidence and developing 3 recommendations, an approach that we believe 4 represents a major advance in EBM," parentheses, 5 cross-reference to chapter 15. 6 Did I read that correctly? 7 A. Yes. 8 Q. And are you familiar with the GRADE 9 approach that's referenced here? 10 A. Broadly, yes. 11 Q. And could you explain your understanding 12 of that approach? 13 A. Yes. So GRADE generally involves looking 14 at the research literature. And then there's some 15 subjectivity to it, but they provide you with 16 general guidelines about how you would -- like, 17 great level of confidence in the research itself. 18 Then there's a -- and then each of those 19 get GRADE scores. I think it's something like 20 low, very low, high, very high. I could be wrong 21 about the exact names of the categories. 22 And then there's a separate set of 23 factors that are applied about strength of 24 recommendation. So it takes into account both 25 what the research literature is, but then makes</p> <p style="text-align: right;">Page 39</p> | <p>1 A. Just one. 2 Q. Can you explain how those who would use 3 GRADE in a systematic review would use it in the 4 process of creating the systematic review? 5 MS. NOWLIN-SOHL: Object to the form; 6 foundation. 7 THE WITNESS: Yeah, I don't think they 8 would GRADE the systematic review. I think they 9 would have different research questions, and there 10 would be a body of literature they would identify 11 through their search that they would then look at 12 in their specific tables that give you, like, a 13 rough general sense of how to apply the GRADE 14 criteria to different conclusions. 15 Q. (BY MR. RAMER) And then sticking with 16 this document, I'd like to go to page 273, which 17 is 302 in the PDF, I believe. 18 Are you there? 19 A. Yes. 20 Q. Okay. And then the -- well, the only 21 full paragraph on the page, it's a little long, 22 but I'm going to read it and ask if I read it 23 correctly. 24 It says "In contrast to systematic 25 reviews, traditional narrative reviews typically</p> <p style="text-align: right;">Page 41</p> |

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| <p>1 address multiple aspects of the disease (e.g., 2 etiology, diagnosis, prognosis, or management), 3 have no explicit criteria for selecting the 4 included studies, do not include systematic 5 assessments of the risk of bias associated with 6 primary studies and do not provide quantitative 7 best estimates or rate the confidence in these 8 estimates. 9 "The traditional narrative review 10 articles are useful for obtaining a broad overview 11 of a clinical condition, but may not provide a 12 reliable and unbiased answer to a focused, 13 clinical question." 14 Did I read that correctly? 15 A. Yes. 16 Q. And then what is your understanding of 17 how systematic reviews differ from narrative 18 reviews with respect to systematic assessment of 19 the risk of bias associated with primary studies? 20 A. A systematic review may or may not 21 include an assessment of the risk of bias. 22 Also, as the paragraph that you skipped 23 over notes, it may or may not include, like, an 24 unbiased summary of the literature, like a 25 meta-analysis.</p> <p style="text-align: right;">Page 42</p> | <p>1 Q. (BY MR. RAMER) Well, let's suppose you 2 have a systematic review that does include a 3 systematic assessment of the risk of bias 4 associated with primary studies. 5 Do you agree that would be a valuable 6 consideration from that systematic review? 7 A. I believe that would be useful 8 information. 9 Q. And sticking with this document, I'd like 10 to go to page 275, which is just a couple pages 11 up. 12 And specifically Figure 14-2, which is 13 entitled "The Process of Conducting a Systematic 14 Review and Meta-Analysis." 15 Do you see that? 16 A. Yes. 17 Q. Do you see how this figure divides 18 between a systematic review and a meta-analysis on 19 the right-hand side? 20 A. Yes. 21 Q. And as part of the systematic review part 22 of this figure, do you agree that it includes the 23 bullet "Assess risk of bias, abstract data"? 24 A. Yes. I believe the point of this 25 textbook chapter is to tell you the best way --</p> <p style="text-align: right;">Page 44</p> |
| <p>1 So systematic reviews can have some of 2 these same problems that you're outlining. 3 Q. Do narrative reviews include systematic 4 assessments of the risk of bias associated with 5 the primary studies? 6 A. Neither a systematic review nor a 7 narrative review necessarily include that. 8 Q. Does a narrative review ever include 9 that? 10 A. It could. 11 Q. And for systematic reviews, can they 12 include systematic assessments of the risk of bias 13 associated with primary studies? 14 A. They could. 15 Q. Would that be a value -- 16 A. Yes. 17 Q. I'm sorry? 18 A. Yes. 19 Q. Well, let me ask this question: Would 20 that be a value that comes with conducting a 21 systematic review? 22 MS. NOWLIN-SOHL: Object to form. 23 THE WITNESS: Not necessarily. A 24 systematic review may or may not do that, and a 25 narrative review may or may not do that.</p> <p style="text-align: right;">Page 43</p> | <p>1 highest quality way to do a systematic review. 2 Q. Okay. 3 A. I think it's strongly implying you should 4 do the meta-analysis as well. 5 Q. So as part of the systematic review 6 process that's outlined here, authors would assess 7 risk of bias, correct? 8 A. I believe they're saying ideally you 9 would do that, yes. 10 Q. And how does one assess the risk of bias? 11 A. There are a lot of different ways. There 12 are formal ways in which I'm not a statistical 13 expert, but they can create these kind of summary 14 plots and run statistical analyses to try and, 15 like, quantitatively look at the risk of bias. 16 But then also just as you look at 17 individuals studies by study, there are a lot of 18 different types of bias. There's selection bias; 19 there's recall bias; there's social desirability 20 bias. So it's a broad area of technologic 21 analysis. 22 Q. And have you ever assessed risk of bias 23 as part of the systematic review that you 24 conducted? 25 A. I'd have to go back and look. What we</p> <p style="text-align: right;">Page 45</p> |

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| <p>1 were doing was specifically called a scoping 2 review. So that's more focused on identification 3 what has been looked at and what's not been looked 4 at. 5 And our main conclusion from that was 6 that there hasn't been much research on functional 7 neurologic disorders among sexual- and 8 gender-minority people, so there wasn't a lot of 9 literature to analyze the depth in that way. 10 Q. And what is this figure referring to when 11 it refers to the process of abstracting data? 12 A. I usually think of that as something more 13 for the meta-analysis where you're going into the 14 tables and pulling out summary statistics and 15 P-values and confidence intervals so that you can, 16 like, pull out the most relevant numbers and 17 statistics from the paper. 18 For a meta-analysis, you then feed that 19 into a different statistical analysis where you're 20 pulling the data all together. 21 But if they're saying just as part of the 22 systematic review of doing that, I think they're 23 more just broadly saying pulling out the key 24 findings of the research. Because if it's not a 25 meta-analysis, you wouldn't be feeding that</p> <p style="text-align: right;">Page 46</p> | <p>1 final two sentences of that paragraph. 2 A. Okay. I'm there now. 3 Q. Okay. I'll start again. 4 "Even if the results of different studies 5 are consistent, determining their risk of bias is 6 still important. Consistent results are less 7 compelling if they come from studies with a high 8 risk of bias than if they come from studies with a 9 low risk of bias." 10 Did I read that correctly? 11 A. Yes. 12 Q. So this is saying even if you have 13 numerous studies showing the same results, you 14 still should assess those individual studies for 15 risk of bias, correct? 16 A. Yes. I think we can broadly always agree 17 in medicine that anytime you have a research 18 study, you should assess it for risk and bias. 19 I think I'd also highlight that there are 20 many different types of bias. I don't know what 21 specific type of bias they're referencing here 22 without reading the full chapter and the context. 23 Q. And is some bias worse than others? 24 A. I don't know that I would say "worse." 25 They're different.</p> <p style="text-align: right;">Page 48</p> |
| <p>1 abstracted data into a more sophisticated 2 methodology of summarizing the data 3 quantitatively. 4 Q. And sticking with this document, I'd like 5 to go to page 283, which I think is page 312 in 6 the PDF. And just let me know when you're there. 7 A. Sorry. Which part of page 312? 8 Q. So it's page 283 in the book. Page 312 9 in the PDF. 10 A. Yes. We're on the page. 11 Q. Okay. And I want to look at the -- in 12 the middle of the page you see the blue header? 13 It says "Was the risk of bias of the primary 14 studies assessed?" 15 A. Yes. 16 Q. And the first full paragraph below that, 17 I'm just going to read the final two sentences of 18 that paragraph and ask if I read it correctly. 19 It says "Even if the results of different 20 studies are consistent, determining their risk of 21 bias is still important." 22 A. Sorry, I thought you were -- Sorry. 23 You're starting halfway down? 24 Q. So it's the first full paragraph after 25 the blue header. And I'm going to be reading the</p> <p style="text-align: right;">Page 47</p> | <p>1 Q. And for the studies that you cite in your 2 declaration, have you assessed them for risk of 3 bias? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: Yes. Any scientific 6 research paper you read is going to, likely in the 7 discussion section, talk about for that individual 8 paper what biases may come up or what limitations 9 there are to how you interpret that study in 10 isolation, which is why, back to your point of why 11 you want the systematic review and identifying all 12 of the research, that you always want to look at 13 all the research as a whole, because every 14 individual study is going to have strengths and 15 weaknesses. They're pointing out that's true even 16 for randomized controlled trials. 17 Q. (BY MR. RAMER) And so I think you 18 discussed that you read the discussion to see 19 where the bias is in the study. 20 And is that generally how you assess 21 studies for risk of bias? 22 A. That's a good starting point, because 23 often the author of the paper, in the peer-review 24 process, whatever peer reviewer identifies as a 25 limitation of the study, if that -- that's due to</p> <p style="text-align: right;">Page 49</p> |

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| <p>1 something like recall bias, et cetera, that that's 2 usually the part of the paper where that's going 3 to be written. 4 But I think most experts are also going 5 to read the full paper to see if they identify any 6 other limitations of the study that weren't 7 explicitly noted in the discussion section of the 8 paper. 9 Q. And this will for now be my last question 10 on this, and then maybe we can take a break. 11 But I'd like to go to page 182 in this 12 document. Just let me know if you're there. 13 A. We're there. 14 Q. Okay. And I'd like to look at the last 15 paragraph on the page in the first sentence. And 16 I'll just read it and ask if I read it correctly. 17 It says "In answering any clinical 18 question, our first goal should be to identify 19 whether there is an existing systematic review of 20 the topic that can provide a summary of the 21 highest quality available evidence (see the 22 summarizing the evidence section)." 23 Did I read that correctly? 24 A. Yes. 25 Q. And do you agree that the first goal in</p> <p style="text-align: right;">Page 50</p> | <p>1 wanted to be an expert, you would probably pull 2 the individual studies that are identified in the 3 systematic review, analyze them further, see what 4 additional information can be teased out that 5 maybe wasn't teased out by the person who did the 6 initial systematic review where likely their goal 7 was just to give you a sense of the whole of the 8 literature. 9 MR. RAMER: All right. I think maybe 10 we're at a breaking point here. Does that sound 11 good? 12 MS. NOWLIN-SOHL: Yeah, that sounds good. 13 Five minutes? 14 MR. RAMER: Yeah, works for me. 15 THE VIDEOGRAPHER: Okay. So the time is 16 10:06 a.m. Pacific time, and we are off the 17 record. 18 (Break taken from 10:06 a.m. to 10:12 a.m.) 19 THE VIDEOGRAPHER: So we are recording. 20 The time is 10:12 a.m. Pacific, and we are back on 21 the record. 22 Q. (BY MR. RAMER) Dr. Turban, I'd like to 23 go to your declaration, which is Turban Exhibit 1, 24 and specifically go to page 15 and paragraph 24. 25 And I just want to read the -- it's</p> <p style="text-align: right;">Page 52</p> |
| <p>1 answering any clinical question is to identify 2 whether there is an existing systematic review of 3 the topic? 4 MS. NOWLIN-SOHL: Object to the form. 5 THE WITNESS: I think what this is likely 6 referencing -- not having read the entire 7 textbook, but it looks like it's a textbook about 8 teaching clinicians how to conduct evidence-based 9 medicine -- I think they're saying when you first 10 come to a topic, so if you're not an expert in a 11 topic -- let's say I were going to treat someone 12 with -- let's just say it's a hypothetical 13 condition that I don't treat every day but I have 14 a patient who I need to help. 15 One of the first things I would look for 16 is yes, a systematic review. If I don't already 17 know that literature, that's going to be a really 18 fast way for me to find a summary of a lot of the 19 literature that I need to know for that given 20 situation. So yes, it would be a good place to 21 start. 22 I think if your aim is to be an expert in 23 the field, you wouldn't stop there. You would 24 read the systematic review. You would look at the 25 evidence that's in there but then if you really</p> <p style="text-align: right;">Page 51</p> | <p>1 toward the end of the paragraph on this page. 2 I'll read the sentence starting with the word 3 "but" and then just ask if I read it correctly. 4 It says "But all a systematic review 5 means is that the authors of the reports 6 predefined the search terms they used when 7 conducting literature reviews in various 8 databases." 9 And did I read that correctly? 10 A. Correct. There's a citation to the 11 Harvard Countway Library. 12 Q. And based on what we've discussed so far 13 today, do you agree that this sentence is wrong? 14 A. No. 15 Q. You maintain that all a systematic review 16 means is that the authors of the reports predefine 17 the search terms they used when conducting the 18 literature reviews; is that right? 19 A. Correct. 20 Q. Okay. 21 A. There are other things one may do as part 22 of a systematic review to add to it, but the label 23 at its face means that the review was systematic, 24 that you defined your search terms and your 25 databases for how you identified your literature.</p> <p style="text-align: right;">Page 53</p> |

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| <p>1 Different authors might do different things from 2 there. 3 Q. And so you do not think that a systematic 4 review includes the assessment of the individual 5 studies that make up the review? 6 A. What differentiates a systematic review 7 from a narrative review or a different type of 8 review -- all of those are going to talk about the 9 literature, but what distinguishes it is that it 10 defines its search terms and the bases that it 11 uses so that others can repeat that search. 12 Q. And so you do not think that the 13 assessment of individual studies for bias is a 14 component of a systematic review; is that right? 15 A. It may or may not be. Depends on the 16 systematic review. Ideally it would, but just 17 calling something a systematic review doesn't mean 18 it will do that. 19 Q. And so you're not speaking categorically 20 in that sentence; is that right? 21 MS. NOWLIN-SOHL: Object to form. 22 THE WITNESS: I'm saying the term 23 "systematic review" means that the authors of the 24 reports predefined the search terms they used when 25 conducting the literature reviews in various</p> <p style="text-align: right;">Page 54</p> | <p>1 predefined your search terms and the databases you 2 used for searching. 3 MR. RAMER: Okay. I'd like to go to -- 4 yeah, I'd like to go to what I'll call Turban 5 Exhibit 6 that I just sent. Let me know when you 6 have it. 7 (Deposition Exhibit No. 6 was marked.) 8 Q. (BY MR. RAMER) And is this the web page 9 you're citing in footnote 31? 10 A. Yes, it appears to be. 11 Q. Okay. And you cite this page in support 12 of the proposition that all a systematic review 13 means is that the authors of the reports 14 predefined the search terms they used when 15 conducting literature reviews in various 16 databases, correct? 17 A. Correct. This then goes on to say other 18 things went in to add to a systematic review to 19 make it a better systematic review, but again, 20 what the phrase "systematic review" means is that 21 you were systematic in how you collected your 22 literature for the review. 23 Q. You don't think that it also includes 24 being systematic in how you assess the studies 25 that form the systematic review?</p> <p style="text-align: right;">Page 56</p> |
| <p>1 databases. 2 Q. (BY MR. RAMER) Are there systematic 3 reviews where the authors also include an 4 assessment of the individual studies that make up 5 the systematic review? 6 A. Yes. 7 Q. So then isn't it wrong to say that all a 8 systematic review is is just predefining the 9 search terms? 10 MS. NOWLIN-SOHL: Object to the form; 11 argumentative, mischaracterizes prior testimony. 12 THE WITNESS: It says "but all a 13 systematic review means is that the authors of the 14 reports predefined the search terms they used when 15 conducting literature reviews in various 16 databases." 17 So if you're calling a paper a systematic 18 review, that is what the term "systematic review" 19 means. 20 It's not saying there's nothing else in 21 it but the search terms. There's the search terms 22 that the papers identify that they summarize in 23 the literature, but when you're using the term 24 "systematic review," what you're highlighting is 25 that -- exactly what I put there, that you</p> <p style="text-align: right;">Page 55</p> | <p>1 A. Not necessarily. Ideally it would be, 2 but I don't believe all systematic reviews reach 3 that level of rigor. 4 Q. Okay. So on this document, Turban 5 Exhibit 6, there is a -- on page 1 there is a bold 6 question that says "What is a systematic review?" 7 And I'm just going to read the first two sentences 8 under that and ask if I read them correctly. 9 It says "A systematic review is guided 10 filtering and synthesis of all available evidence 11 addressing a specific, focused research question, 12 generally about a specific intervention or 13 exposure. The use of a standardized, systematic 14 methods and preselected eligibility criteria 15 reduce the risk of bias in identifying, selecting, 16 and analyzing relevant studies." 17 Did I read that correctly? 18 A. Yes. 19 Q. What is your understanding of what this 20 page is describing when it mentions "analyzing 21 relevant studies"? 22 MS. NOWLIN-SOHL: Object to form. 23 THE WITNESS: So they're saying you use 24 standardized systematic methods in preselected 25 eligibility criteria, so those are all things to</p> <p style="text-align: right;">Page 57</p> |

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| <p>1 identify the studies you're going to look at. 2 They're saying that doing that reduces 3 the risk of bias in identifying, selecting, and 4 then reporting out the relevant studies. If 5 you -- if you didn't do a systematic review -- and 6 again, a systematic review doesn't guarantee that 7 your search methods are perfect, but it increases 8 the likelihood that you're not going to miss 9 important studies that need to be analyzed. 10 But I don't read this as saying that you 11 necessarily need to have a standardized systematic 12 method of analyzing the relevant studies, although 13 that would be ideal. 14 Q. (BY MR. RAMER) Well, in the first 15 sentence then, what is your understanding of what 16 it's referring to when it is discussing the 17 synthesis of all available evidence? 18 A. The general process of taking all the 19 studies that you identify and then reporting out 20 the summary. 21 Q. Would creating a synthesis of all 22 available evidence require analyzing the relevant 23 studies? 24 A. There are many ways you could go about 25 analyzing the relevant studies.</p> <p style="text-align: right;">Page 58</p> | <p>1 assessment of the validity or risk of bias. And 2 it does go on to tell you how ideally they would 3 be conducted. 4 But the term "systematic review" means 5 what I noted in my declaration. 6 Q. (BY MR. RAMER) But you think the meaning 7 of the term you note in your declaration comes 8 from what we're looking at right now? 9 MS. NOWLIN-SOHL: Object to form; 10 argumentative. 11 THE WITNESS: Yes. 12 Q. (BY MR. RAMER) What is this paragraph -- 13 let me rephrase. 14 What is your understanding of what this 15 paragraph is discussing in the sentence you were 16 reading where it says "an assessment of the 17 validity or risk of bias of each included study"? 18 MS. NOWLIN-SOHL: Object to form; asked 19 and answered. 20 THE WITNESS: Sorry. I'm not sure which 21 sentence you're referring to. 22 Q. (BY MR. RAMER) You were reading the 23 second-to-last sentence in this paragraph, and you 24 got to the point where it says "an assessment of 25 the validity or risk of bias of each included</p> <p style="text-align: right;">Page 60</p> |
| <p>1 Q. Like what? 2 A. You could read them and give your general 3 impression. 4 You could, if you were doing a practice 5 guideline, you might be able to create criteria. 6 Those are two examples. 7 You might look at the sample size of all 8 of that. 9 You might look at the inclusion and 10 exclusion criteria. 11 Q. Do you agree that this paragraph states 12 that a systematic review is something more than 13 predefining search terms used when conducting 14 literature reviews in various databases? 15 MS. NOWLIN-SOHL: Object to form. 16 THE WITNESS: I believe it explains that 17 the term "systematic review" means that one 18 defines the way that they're defining their search 19 terms and their databases. That's what a 20 systematic review as a whole means. 21 It goes on to say -- it says -- well, it 22 says halfway down a well-designed systematic 23 review includes clear objectives, preselected 24 criteria, an explicit methodology, a thorough and 25 reproducible search of the literature, an</p> <p style="text-align: right;">Page 59</p> | <p>1 study." 2 And my question is what is your 3 understanding of what that is referring to? 4 MS. NOWLIN-SOHL: Same objections. 5 THE WITNESS: Yeah. So again, that 6 sentence starts "A well-designed systematic review 7 includes," and it ends with "an analysis and 8 presentation of the findings of the included 9 studies." And before that, "an assessment of the 10 validity or risk of bias that each study 11 included." 12 Not all systematic reviews will be well 13 designed. 14 Q. (BY MR. RAMER) Why would a well-designed 15 systematic review include an assessment of the 16 validity or risk of bias of each included study? 17 A. Again, it's useful information. 18 Different -- analyses of different types of bias 19 provide different types of useful information. 20 But for instance, recall bias would be 21 important to know if people are asked questions 22 about the remote past. Right? Like, you'd want 23 to know if you were asking someone about their 24 childhood how long ago was that? What kind of 25 question was it? Is it likely that they would</p> <p style="text-align: right;">Page 61</p> |

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| <p>1 remember something that long ago given the nature 2 of the event? It's just one example of the many 3 types of bias we may examine. 4 Q. And why would a well-designed systematic 5 review look for bias in the individual studies? 6 A. Because it gets you more information 7 about what the study actually tells you. 8 Q. Do you agree that assessing bias in the 9 individual studies is an advantage of a systematic 10 review over a narrative review? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: No. I think both can do 13 that. 14 Q. (BY MR. RAMER) Do they both do it 15 systematically? 16 MS. NOWLIN-SOHL: Object to form. 17 THE WITNESS: Not necessarily. 18 Q. (BY MR. RAMER) And why not necessarily? 19 A. Both of them could do it unsystematically 20 based on general impression of the authors. 21 Q. And I'd like to go back to your 22 declaration and the same paragraph but on the next 23 page, so the run-over. And the second to last 24 sentence, I'll just read it and ask if I read it 25 correctly.</p> <p style="text-align: right;">Page 62</p> | <p>1 A. So I don't know that I would use this 2 specific citation. 3 Q. Okay. And then just going back to your 4 declaration page -- sorry, paragraph 24, but back 5 to page 15 and the sentence we were previously 6 discussing, and so the point of -- I'll just -- to 7 refresh, the sentence says "But all a systematic 8 review means is that the authors of the reports 9 predefined the search terms they used when 10 conducting literature reviews in various 11 databases." 12 And you would agree that the description 13 you give there does not define a well-designed 14 systematic review, correct? 15 MS. NOWLIN-SOHL: Object to form. 16 THE WITNESS: I think it's a 17 rectangle/square situation. I think my definition 18 will cover all systematic reviews. 19 Q. (BY MR. RAMER) I think where I'm getting 20 hung up with that answer is the beginning of the 21 sentence where you say, "but all a systematic 22 review means," which means to describe the full 23 universe of systematic reviews can be defined 24 strictly by the fact that the authors used 25 predefined search terms.</p> <p style="text-align: right;">Page 64</p> |
| <p>1 It says "The primary advantage to a 2 systematic review would be its potential, and no 3 guarantee, to identify research publications that 4 had not previously been identified in this 5 discussion." 6 Did I read that correctly? 7 A. Yes. 8 Q. And you do not cite anything for that 9 proposition, correct? 10 A. Correct. There's no citation on that 11 sentence. 12 Q. Do you think the documents we were 13 looking at, Turban Exhibit 6 from Harvard that you 14 cited in footnote 31, could support that 15 proposition? 16 A. Let me look. 17 Q. And if you don't know, that's fine. 18 Just so I can keep track of time, what 19 page are you on currently? 20 A. I went through -- I'm not seeing that 21 there is a section that explicitly is discussing 22 what the advantage of the systematic review is 23 over something else. It's mostly describing what 24 they are. 25 Q. Okay.</p> <p style="text-align: right;">Page 63</p> | <p>1 Is there -- 2 A. All systematic reviews will have 3 predefined their search terms. 4 Q. And will well-designed systematic reviews 5 only predefine their search terms? 6 MS. NOWLIN-SOHL: Object to form. 7 THE WITNESS: This is my rectangle/square 8 comment. 9 So when you're calling something a 10 systematic review, the piece of information you're 11 communicating is that they predefined their search 12 terms and the databases they used. So that term 13 is telling you that. 14 There are a million other things that the 15 term doesn't tell you, right? It doesn't tell you 16 the author list. It doesn't tell you how long it 17 is. It doesn't tell you how they went about 18 analyzing all the studies. 19 That term tells you that they predefined 20 their search terms in some way, and they tell you 21 what databases they used. It doesn't tell you 22 more than that. 23 Q. And can we return to Turban Exhibit -- 24 let's see -- Exhibit 4, which is the Users' 25 Guidelines to the Medical Literature?</p> <p style="text-align: right;">Page 65</p> |

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| <p>1 MS. NOWLIN-SOHL: What page, John? 2 MR. RAMER: Yeah, sorry. Database 3 page 275, which I believe is page 304. 4 MS. NOWLIN-SOHL: Okay. We're there. 5 Q. (BY MR. RAMER) And just looking at 6 Figure 14-2 again. 7 It seems as though you are defining a 8 systematic review to be something less than what 9 Figure 14-2 is defining to be a systematic review; 10 is that fair? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: Could you repeat the 13 question? 14 Q. (BY MR. RAMER) Is it fair to say that 15 you were defining systematic review differently 16 from how this is defining systematic review? 17 MS. NOWLIN-SOHL: Object to form; 18 mischaracterizes prior testimony. 19 THE WITNESS: I don't think that these 20 definitions are in conflict with each other. 21 Q. (BY MR. RAMER) Do you agree that this 22 figure defines a systematic review to include 23 reviewing the full text of possibly eligible 24 studies and then assessing risk of bias and 25 abstracting data?</p> <p style="text-align: right;">Page 66</p> | <p>1 expert in this case? 2 A. I'm not sure I understand the question. 3 Q. How did you -- 4 A. Sorry. Come to be an expert in the 5 field, or how did I get involved in the case? 6 Q. How did you become an expert witness in 7 this particular case? 8 A. I was asked by one of the attorneys on 9 the case. 10 Q. And who specifically asked you? 11 A. Leslie Cooper. 12 Q. And without going into anything that you 13 spoke about with counsel, when were you contacted 14 to serve as an expert witness in this case? 15 A. I don't recall. Sometime recently, 16 perhaps in the past month or so. 17 Q. Was it after August? 18 A. I believe so. 19 Q. Was it after September 5th? 20 A. I really have to look at my call logs. 21 I'm not entirely sure when. 22 Q. Do you know whether the Defendants in the 23 case had already submitted their brief opposing 24 the preliminary injunction when you were asked to 25 serve as an expert?</p> <p style="text-align: right;">Page 68</p> |
| <p>1 MS. NOWLIN-SOHL: Object to form. 2 THE WITNESS: Again, not all systematic 3 reviews would necessarily assess the risk of bias. 4 I think this is describing how you would ideally 5 conduct a systematic review. They will always 6 involve reviewing the text of the studies that you 7 identify. That's what a review is. 8 Q. (BY MR. RAMER) And so you think that in 9 this figure, the bottom two lines that make up the 10 systematic review are unnecessary for something to 11 be a systematic review; is that right? 12 MS. NOWLIN-SOHL: Object to the form; 13 mischaracterizes prior testimony. 14 THE WITNESS: I don't think all 15 systematic reviews are necessarily going to assess 16 the risk of bias. 17 Abstract data -- I'm not sure what 18 they're referencing specifically in this figure 19 since it's a vague term. I do think all 20 systematic reviews are going to review the studies 21 that they identify through their predefined 22 searches. 23 Q. (BY MR. RAMER) And we can kind of shift 24 gears a little bit and move off that document. 25 Dr. Turban, how did you come to be an</p> <p style="text-align: right;">Page 67</p> | <p>1 A. I know I received -- I'm not a lawyer. I 2 received -- what was it? -- a combined brief, I 3 believe, opposing preliminary injunction, 4 something, the second half of the goal of the 5 memorandum that I reviewed at some point. 6 But I don't remember when I received 7 that, so I don't know how the dates lined up. I 8 know I asked to see it at a certain point because 9 I think it's referenced in something. 10 Q. And do you know the other expert 11 witnesses supporting the Plaintiffs in this case? 12 A. If you named them I could tell you. 13 Q. Dr. Kara Connelly? 14 A. I know of Dr. Connelly but do not know 15 her personally. 16 Q. Did you read the declaration she 17 submitted in this case? 18 A. I did not. 19 Q. Do you know Dr. Christine Brady? 20 A. I do. Dr. Brady is a former supervisor 21 of mine from Stanford. 22 Q. Have you spoken at all with Dr. Brady in 23 this case? 24 A. I speak with Dr. Brady because we have 25 some shared patients. I don't recall if we</p> <p style="text-align: right;">Page 69</p> |

1 specifically talked about the case, but it
2 wouldn't have been anything more than in passing.
3 Q. Before you were asked to be an expert in
4 this case, did you know that Dr. Brady was serving
5 as an expert?
6 A. I think I knew that Dr. Brady -- I knew
7 of another case she'd done in Louisiana, and I
8 think I knew she was considering doing other
9 cases. But I don't know if I knew she was doing
10 this one specifically.
11 Q. What is the case in Louisiana you're
12 referring to?
13 A. I believe it was a case related to the
14 gender clinic that she worked in. Sorry,
15 what's -- was it Louisville? University of
16 Louisville, I think. I'm forgetting the details.
17 I talked to her about it years ago.
18 Q. And she was serving as an expert in that
19 case?
20 A. I don't know if she was an expert or
21 because she was in the clinic was deposed, but
22 there was some forensic component to it where I
23 think they were asking her about care for
24 adolescent gender dysphoria.
25 Q. Did I freeze?

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1 A. Yeah. You're back up, though.
2 Q. Okay.
3 MR. RAMER: Amy, could you read back the
4 last answer for me?
5 (The record was read by the reporter.)
6 Q. (BY MR. RAMER) And, Dr. Turban, before
7 you were asked to be an expert in this case, did
8 Dr. Brady ever contact you about the process of
9 serving as an expert witness?
10 A. We may have spoken about it, like the
11 general process of doing expert witness work when
12 I was at Stanford, but I don't remember specific
13 conversations.
14 Q. And what did you do to prepare for this
15 deposition?
16 A. I reviewed my own declaration. I earlier
17 reviewed the declarations of Dr. Cantor and
18 Dr. Weiss, and I read the State's memorandum that
19 I think was -- I keep forgetting. I think it was
20 a combined memoranda and opposition to preliminary
21 injunction, maybe motion to dismiss.
22 Q. Did you do any prep for the deposition?
23 A. I had two meetings with the lawyers from
24 the ACLU to go through my declaration and prepare.
25 Q. And who was in those meetings, without

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1 disclosing the contents of the discussion?
2 A. Li was with me here, Leslie Cooper, and I
3 believe Philip May.
4 Q. Anyone else?
5 A. No, not that I recall.
6 Q. And, Dr. Turban, what does it mean to be
7 transgender?
8 A. One has a gender identity different from
9 their sex assigned at birth.
10 Q. And what is gender dysphoria?
11 A. Gender dysphoria is a diagnosis in the
12 DSM-5 -- now DSM-5 text revision that involves
13 having a gender identity different from one's sex
14 assigned at birth, and then having clinically
15 relevant distress related to that that causes some
16 impairment in social, occupational, or other
17 functioning.
18 There are two sets of criteria. One set
19 for prepubertal children, and another set for
20 adolescents and adults.
21 Q. Can an individual be transgender but not
22 experience gender dysphoria?
23 A. Yes.
24 Q. Is gender dysphoria different from
25 anxiety?

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1 A. "Anxiety" is a very broad, untechnical
2 term. There are a series of anxiety disorders
3 that are specified in the DSM, like generalized
4 anxiety disorder or social anxiety disorder.
5 Q. And are those different from gender
6 dysphoria?
7 A. Those are different diagnoses, yes.
8 Q. And what is the difference between
9 generalized anxiety disorder and gender dysphoria?
10 A. In generalized anxiety disorder, one
11 typically has anxiety in several different
12 domains. So for instance, they might be anxious
13 about their health and anxious about their grades
14 and anxious about being late.
15 One classic thing we say in psychiatry is
16 people with generalized anxiety disorder sometimes
17 become anxious that they will become anxious, so
18 just highlighting that there are many, many
19 different types of things that they become anxious
20 about.
21 And then again, that needs to lead to
22 some sort of clinic-basing assent impairment. So
23 all of us have day-to-day worries, but that
24 wouldn't necessarily meet the criteria for
25 generalized anxiety disorder.

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1 Gender dysphoria is different in that the
 2 distress is specifically related to an
 3 incongruence, if you will, which means their
 4 gender identity and their sex assigned at birth.
 5 Q. And is gender dysphoria different from
 6 some form of clinical depression?
 7 MS. NOWLIN-SOHL: Object to form.
 8 THE WITNESS: Those are different
 9 diagnoses. So there's major depressive disorder,
 10 for instance, that requires two weeks of a number
 11 of symptoms related to depression. It would be
 12 different combinations of the symptoms, but
 13 generally depressed mood, loss of ability to enjoy
 14 things, disturbances in sleep, disturbances in
 15 appetite, delayed psychomotor movements,
 16 impairments of concentration.
 17 Then again separately, gender dysphoria
 18 is more about the psychological distress related
 19 to one's sex assigned at birth being different
 20 from their gender identity.
 21 Q. (BY MR. RAMER) And what is gender
 22 identity?
 23 A. Gender identity is one's psychological
 24 understanding of their gender broadly in terms of
 25 masculinity, femininity.

1 Q. Can gender identity change over time?
 2 A. So there's research showing that there's
 3 a strong innate biological basis for gender
 4 identity that forms kind of the base, if you will.
 5 That's what I think of as the person's gender
 6 identity.
 7 But in the same way that we, with other
 8 parts of ourselves, kind of describe language to
 9 that and conceptualize it, put words to it, that
 10 can evolve over time.
 11 Q. And so the latter that you just described
 12 can change over time, but can the former category,
 13 the gender identity itself, change over time?
 14 A. It seems no. It seems that there's -- we
 15 have twin studies, for instance, I think are the
 16 strongest piece of data that we have for that,
 17 that are usually what we use for determining if
 18 something has an innate biological determinate.
 19 And those show that gender identity has a strong
 20 biological component, particularly trans
 21 identities is what the studies looked at.
 22 But certainly we see patients where the
 23 language they ascribe to their gender identity or
 24 their understanding of it could evolve over time.
 25 Q. So is it fair to say that gender identity

1 does not change over time, but the language
 2 someone uses to describe it can change over time?
 3 A. That's how I conceptualize it given the
 4 biological literature that we have.
 5 Q. If an individual identifies as a male at
 6 age 16 and later identifies as a female at age 22,
 7 has that person's gender identity changed?
 8 A. It would be really difficult to know. So
 9 I think I cited in my declaration a paper we wrote
 10 in the Journal of the American Academy of Child
 11 and Adolescent Psychiatry about thinking about
 12 changes in the way people conceptualize their
 13 gender identity or people's evolution of interests
 14 in gender-affirming medical care. And in it, we
 15 describe that that could be due to internal
 16 factors or external factors.
 17 So what we often see -- we call this
 18 [indiscernible] -- is that if you are constantly
 19 told that your gender identity or you're harassed
 20 for being transgender or you're discriminated
 21 against, you can certainly internalize a lot of
 22 those messages and then -- which -- or state that
 23 you are now cisgender.
 24 We talked about it can also be an
 25 internal factor where without those external

1 negative pressures, you may evolve on your own to
 2 have a different conceptualization of your gender
 3 identity.
 4 The thing that's further complicated is
 5 minority stress framework explains the ways in
 6 which people internalize negative messages that
 7 might minoritize people from the commute. So you
 8 can imagine if you are a young trans person who's
 9 constantly told that trans people are invalid or
 10 being trans is a result of trauma or you're a
 11 danger to people on sports teams or you're a
 12 danger to people in bathrooms, they might start to
 13 internalize those negative views of trans people
 14 and then kind of push yourself to present as
 15 cisgender.
 16 I think it's similar to what we saw with
 17 the ex-gay movements in the past. But again, this
 18 is seeking broadly and I think we'd have to kind
 19 of look person by person because it's such a
 20 complex question.
 21 Q. But those examples that you just gave,
 22 those are examples of the way the language they're
 23 using to describe their gender identity changes.
 24 But their actual gender identity has not changed,
 25 correct?

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| <p>1 MS. NOWLIN-SOHL: Object to form; 2 mischaracterizes prior testimony. 3 THE WITNESS: Yeah, I think I gave 4 examples, both in which the language they used 5 changes but also the ways in which their 6 understanding of their gender identity has evolved 7 potentially through those internal or external 8 factors. 9 But I would go back to the fact that 10 there are these data showing this strong 11 biological determinate of our gender identities. 12 But obviously the human psyche is complex in how 13 it understands and evolves in its understanding of 14 itself. 15 Q. (BY MR. RAMER) So are you saying that 16 there are examples where because they have -- 17 individuals have. Let me rephrase. 18 Are you saying there are examples where 19 internal and external factors do in fact change 20 someone's gender identity? 21 A. The external factors can drive internal 22 factors, which can subsequently change one's 23 understanding of their gender identity. 24 Q. And is there a distinction between gender 25 identity and one's understanding of their gender Page 78</p> | <p>1 identity does not change over time, could alter 2 the answer to the question. 3 A. So I think your question was the person 4 had a gender identity at one point and then had a 5 different gender identity at the other points, but 6 I would want to know from you what you mean by 7 their gender identity was different at one point 8 in time or two. 9 Did their understanding change? Did 10 something happen? Were they told something? Or 11 even assessing this based on what they are telling 12 you? 13 Q. But so your view is, though, that at time 14 point 1 and time point 2, there is never a change 15 in gender identity, correct? 16 MS. NOWLIN-SOHL: Object to form; 17 argumentative, mischaracterizes prior testimony. 18 THE WITNESS: What I'm saying is there is 19 strong evidence of an innate biological 20 determinate of gender identity that appears to be 21 stable throughout time, but there is extreme 22 complexity in how people think about themselves, 23 and they ascribe language to that and feel 24 comfortable sharing it or not at various times. 25 Q. (BY MR. RAMER) So can you -- are you Page 80</p> |
| <p>1 identity? 2 A. I believe so. I think it's important to 3 differentiate with what we know about the brain 4 and these innate biological factors from the 5 influence of how people ascribe language and 6 understanding to themselves over time. 7 Q. And so when you're discussing examples 8 where an individual's understanding of their 9 gender identity has changed, that does not mean 10 that their gender identity has changed, correct? 11 A. That's how I would conceptualize it. I 12 think that's fair. 13 Q. And so just going back to my question, if 14 an individual identifies as a male at age 16 and 15 later identifies as a female at age 22, that 16 individual's gender identity has not changed, 17 correct? 18 MS. NOWLIN-SOHL: Object to form; asked 19 and answered. 20 THE WITNESS: Are you thinking of a 21 person that you have more detail where we can 22 discuss it in depth? 23 Q. (BY MR. RAMER) I don't understand. I 24 guess I don't understand how the question -- how 25 the answer, based on your view that gender Page 79</p> | <p>1 able to say that the evidence shows that gender 2 identity does not change over time? 3 MS. NOWLIN-SOHL: Object to form. 4 THE WITNESS: If you're defining "gender 5 identity" as those innate biological factors, then 6 yes, because they're innate biological factors, 7 that they would be unlikely to change over time. 8 And if you look at clinical experience, 9 I've not had any patients who identified as 10 transgender and then subsequently identified as 11 cisgender. 12 I have had patients who have kind of had 13 this core transgender identity but have kind of 14 shifted the way they conceptualize it between, 15 say, transmasculine or nonbinary. 16 I've had patients who moved somewhere or 17 studied abroad and felt that they weren't safe 18 being out as trans so they went into the closet. 19 To everyone around them, they presented as being 20 cisgender for that period of time. 21 I hope that helps provide context. 22 Q. (BY MR. RAMER) Do you ever think it 23 would be appropriate to provide puberty blockers 24 to a patient who was not formally diagnosed with 25 gender dysphoria under the DSM-5? Page 81</p> |

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| <p>1 A. Perhaps if they had central precocious 2 puberty. 3 Q. Would the exception of central precocious 4 puberty -- I'll just rephrase it differently. 5 Do you think it is appropriate to provide 6 puberty blockers as a treatment for gender 7 dysphoria to a patient who was not formally 8 diagnosed with gender dysphoria under the DSM-5? 9 MS. NOWLIN-SOHL: Object to form. 10 THE WITNESS: I guess I don't understand 11 how the patient has gender dysphoria if they don't 12 meet the criteria for gender dysphoria. 13 Q. (BY MR. RAMER) Well, would you -- do you 14 think it's appropriate to give puberty blockers to 15 a patient who meets the classification of gender 16 incongruence under the ICD-11? 17 A. But does not meet the criteria for gender 18 dysphoria? 19 Q. Correct. 20 MS. NOWLIN-SOHL: Object to form. 21 THE WITNESS: No. In the United States, 22 that would not be appropriate practice. 23 Q. (BY MR. RAMER) Is the primary purpose of 24 gender-affirming medical interventions to reduce 25 the distress associated with gender dysphoria?</p> <p style="text-align: right;">Page 82</p> | <p>1 Q. And have you read it? 2 A. Yes. 3 Q. Okay. I'd like to go to page S43, which 4 is page 45 in the PDF. 5 MS. NOWLIN-SOHL: So, John, we have an 6 excerpt that starts at S43, and it's only a 7 24-page PDF. 8 MR. RAMER: Yes. I apologize. So that's 9 my fault, so let's just stick with this. So page 10 S43, the page we're on. 11 MS. NOWLIN-SOHL: Okay. 12 MR. RAMER: Sorry about that. 13 Q. (BY MR. RAMER) And this chapter is about 14 adolescents, correct? 15 A. Correct. 16 Q. Okay. And I'd like to go down to S48, 17 which is page 6 in the PDF. 18 And these are WPATH statements of 19 recommendations regarding care for adolescents, 20 correct? 21 A. Yes. 22 Q. So about partway down this box, there's 23 an italics that says -- I'll just read it and ask 24 if I read it correctly. 25 It says "The following recommendations</p> <p style="text-align: right;">Page 84</p> |
| <p>1 A. Yes. 2 Q. And so a treatment that does not reduce 3 the distress associated with gender dysphoria 4 cannot be deemed an effective treatment for gender 5 dysphoria, correct? 6 MS. NOWLIN-SOHL: Object to form. 7 THE WITNESS: The caveat I would add is 8 that generally in actual history of gender 9 dysphoria is that it worsens over time. 10 So if there were a treatment that could 11 prevent the worsening of the distress, that would 12 be an improvement as well, and a notable goal. 13 Q. (BY MR. RAMER) Oh, I see. You're saying 14 like -- you're referring to, like, maintaining the 15 baseline is what you're saying? 16 A. Yeah. If you can prevent it from getting 17 worse, that would also be a good goal. 18 MR. RAMER: And, Dr. Turban, I'd like to 19 introduce what we'll call Turban Exhibit 7. 20 (Deposition Exhibit No. 7 was marked.) 21 Q. (BY MR. RAMER) And I'll just represent 22 to you that this is Chapter 6 of the WPATH 23 Standards of Care, Version 8. 24 And have you seen this document before? 25 A. Yes.</p> <p style="text-align: right;">Page 83</p> | <p>1 are made regarding the requirements for 2 gender-affirming medical and surgical treatment 3 (all of them must be met)." 4 Did I read that correctly? 5 A. Yes. 6 Q. And then I'd like to go to 6.12.C in this 7 box just a few lines down. And I'll read that and 8 ask if I read it correctly. 9 It says "The adolescent demonstrates the 10 emotional and cognitive maturity required to 11 provide informed consent/assent for the 12 treatment." 13 Did I read that correctly? 14 A. Yes. 15 Q. And am I right in thinking that as a 16 general matter, minors do not actually consent to 17 treatments but rather their parents provide 18 informed consent and then the minor provides 19 informed assent? 20 MS. NOWLIN-SOHL: Object to the extent 21 that it calls for a legal conclusion. 22 THE WITNESS: In general, that is 23 correct. I'll say this is a very conservative 24 area of medicine, and generally when assessing 25 capacity, which is kind of the medical version of</p> <p style="text-align: right;">Page 85</p> |

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| <p>1 ability to consent, we use something called the 2 Applebaum criteria for adults. 3 And I think I and many apply those 4 Applebaum criteria for being able to provide 5 informed consent to minors, but technically 6 because they are minors, even if they have -- they 7 meet those Applebaum criteria that we would use 8 for adults saying that they could give informed 9 consent, we would call it assent because of their 10 minor status. Their parents would need to provide 11 the consent for them to be able to access care. 12 Q. (BY MR. RAMER) Would you ever provide -- 13 let me rephrase. 14 Would you ever provide the treatment 15 described in Chapter 6 when a minor provides 16 informed assent but you do not have informed 17 consent from the parent? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: No, I can't imagine I would 20 do that. 21 And the latest guidelines I think have a 22 statement in there that you need informed consent 23 from parents. I think it says something like 24 unless that would be dangerous. I think that 25 means, you know, like a noncustodial parent or a</p> <p style="text-align: right;">Page 86</p> | <p>1 criteria that are kind of separate from the 2 consent criteria would likely make them unable to 3 be able to provide the consent. 4 Q. (BY MR. RAMER) Okay. Well, let's take 5 that and with respect to 6.12.b. 6 Do you think that if an individual has 7 not experienced gender diversity or incongruence 8 for a marked and sustained period of time that 9 they would not be able to provide informed assent? 10 A. Oh, sorry. I thought you were only 11 referencing the text within d and e. 12 Q. Sorry. Do you want me to back out? Can 13 I ask the question again? 14 A. Sure. 15 Q. All I'm asking is so we have this 16 requirement of informed consent/assent in 6.12.c. 17 And my question is simply based on this 18 list and the statement above it that says all of 19 these criteria must be met, doesn't that mean that 20 there can be a situation where adolescent can 21 provide informed assent or consent and thus 22 satisfy 6.12.c and yet nevertheless not be 23 eligible for treatment based on one of these other 24 requirements? 25 A. Yes.</p> <p style="text-align: right;">Page 88</p> |
| <p>1 parent who is physically abusive or a parent who 2 is not in the child's life that you would need a 3 legal guardian to provide the informed consent. 4 Q. (BY MR. RAMER) And I want to look still 5 in this box. I want to look at first read 6.12.b 6 and ask if I read it correctly, and then I'll read 7 d. 8 So 6.12.b says "The experience of gender 9 diversity/incongruence is marked and sustained 10 over time." 11 Did I read that correctly? 12 A. Yes. 13 Q. And then 6.12.d says "the adolescent's 14 mental health concerns (if any) that may interfere 15 with diagnostic clarity, capacity to consent, and 16 gender-affirming medical treatments have been 17 addressed." 18 And did I read that correctly? 19 A. Yes. 20 Q. So based on these guidelines, could there 21 be times where an adolescent is able to provide 22 informed assent for a treatment but a provider 23 still should not provide the treatment? 24 MS. NOWLIN-SOHL: Object to form. 25 THE WITNESS: I think most of these other</p> <p style="text-align: right;">Page 87</p> | <p>1 Q. And have you ever heard the terms 2 "assessment model" and "informed consent model" 3 used to describe a treatment protocol? 4 A. Yes. 5 Q. What is the difference between an 6 assessment model and an informed consent model? 7 A. They're not as clearly delineated as I 8 think one would like, but I can kind of describe 9 the two broad concepts. 10 So an informed consent model, this is 11 what we do pretty much in all of medicine where we 12 provide individuals with the risks of a treatment, 13 the potential benefits of a treatment, unknowns of 14 the treatment, just everything that's important to 15 know, like, when making a decision about the 16 treatment. 17 And then they decide -- in pediatric 18 medicine -- again, in the vast majority of the 19 cases it's not actually the adolescent deciding; 20 it's the parents deciding and the adolescent 21 agreeing -- but I think generally most doctors, 22 particularly for their adolescent patients, really 23 want the patients to have about as strong of an 24 understanding of the treatment as their parents 25 do.</p> <p style="text-align: right;">Page 89</p> |

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| <p>1 The assessment model is a little bit 2 ill-defined, but it involves still informed 3 consent because you're giving them all the 4 information. 5 But in particular for gender-affirming 6 medical interventions, the guidelines require the 7 biopsychosocial assessment, where in addition to 8 making sure that they have all the information 9 about the treatments to make the decision, you as 10 the provider want to know more so that you're 11 making sure you're supporting them in all the ways 12 that they need to be supported. 13 So you want to know their family history. 14 You want to know genetic predispositions they 15 have. That's kind of the bio -- you want to know 16 any medications they're on. You would want to 17 know any medical conditions they have, bio. 18 Psycho is understanding the way their 19 mind works. Do they have certain personality 20 characteristics? Do they have certain typical 21 thought patterns? We try and vary all psychiatry, 22 but it's safe to say there are many different 23 psychological dynamics that you can evaluate. 24 And then social is particularly important 25 for these kids because you want to understand</p> <p style="text-align: right;">Page 90</p> | <p>1 think these have elements of both models? Or do 2 you think this is better described as an 3 assessment model? Or how would you characterize 4 these particular guidelines? 5 MS. NOWLIN-SOHL: Object to form. 6 THE WITNESS: My understanding is that 7 they require a comprehensive biopsychosocial 8 assessment prior to initiating any 9 gender-affirming medical or surgical care for a 10 minor. 11 Q. (BY MR. RAMER) And if there are 12 requirements over and above informed consent or 13 informed assent such as the provider needs to 14 confirm the length of time of the gender 15 incongruence or the provider needs to address 16 particular comorbidities before providing 17 treatment, wouldn't those be aspects of an 18 assessment model? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: This is what I was saying. 21 The distinction is not always entirely cut and 22 dried in that way, because to be able to -- in my 23 opinion, to be able to give true informed consent, 24 you would -- you as the provider would need to 25 understand a lot of those dynamics about the</p> <p style="text-align: right;">Page 92</p> |
| <p>1 their family environment. You want to understand 2 their peer environment. You want to understand 3 how their teachers are treating them. You want to 4 know if there's potential for bullying or violence 5 or harassment, all of these things that can affect 6 mental health. 7 So you want to have the comprehensive 8 biopsychosocial assessment so you can know all the 9 ways you can help the person, right? So maybe 10 they need us to talk to their school to make sure 11 there's a bathroom where they feel safe. 12 Maybe we need them to talk to their 13 families, help their families understand their 14 experience. Or if there's communication breaking 15 down, getting everyone together to make sure 16 they're on the same page so everyone can feel 17 loved and respected. 18 And maybe in some of the those cases the 19 medical interventions will be in part to consider 20 also, but that assessment model takes a very broad 21 look at the young person, but ultimately does 22 involve a lot of the informed consent work as 23 well. 24 Q. And do you think Chapter 6, these 25 guidelines that we've been looking at, do you</p> <p style="text-align: right;">Page 91</p> | <p>1 person so that you could properly educate them on 2 how to make the decision and the relevant things 3 that they need to consider. 4 Q. (BY MR. RAMER) So I guess -- sorry. Go 5 ahead. 6 A. So I think, you know, informed consent is 7 not the model in pediatrics, I'll say, first and 8 foremost. But I think just the concept of 9 informed consent requires asking the person a lot 10 of questions in a focused assessment kind of way 11 because you need to understand them well to be 12 able to counsel them on informed consent. 13 Q. So you could not accurate -- let me 14 rephrase. 15 You could not accurately describe the 16 guidelines in Chapter 6 as an informed consent 17 model, correct? 18 MS. NOWLIN-SOHL: Object to form; asked 19 and answered. 20 THE WITNESS: I think they involved 21 informed consent, but I think they moved past that 22 into more of an assessment as well. But again, 23 they're not clean distinctions between those two 24 terms. 25 Q. (BY MR. RAMER) And I'd like to go to</p> <p style="text-align: right;">Page 93</p> |

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| <p>1 page S62, which is page 20 in the PDF. 2 And then in the right column it appears 3 there is a section discussing statement 6.12.d in 4 more depth; is that fair? 5 A. Yes. 6 Q. Okay. And I'd like to go to the next 7 page and the left column and specifically the 8 paragraph that is numbered 2. And I'll just read 9 this full paragraph and ask if I read it 10 correctly, and then we can go from there. 11 It says "Second, mental health can also 12 complicate the assessment of gender development 13 and gender identity related needs. For example, 14 it is critical to differentiate gender 15 incongruence from specific mental health 16 presentations such as obsessions and compulsions, 17 special interests in autism, rigid thinking, 18 broader identity problems, parent/child 19 interaction difficulties, severe developmental 20 anxieties, (e.g., fear of growing up and pubertal 21 changes unrelated to gender identity), trauma or 22 psychotic thoughts. Mental health challenges that 23 interfere with the clarity of identity development 24 and gender-related decision-making should be 25 prioritized and addressed." Page 94</p> | <p>1 So I had a patient once who came to me 2 wanting to better understand his gender identity. 3 He had autism and somewhat rigid thinking. And 4 really enjoyed -- is it okay if I change some of 5 the details to protected the patient's 6 confidentiality if the theme is the same? 7 Q. We can just say we're talking about a 8 hypothetical, but sure, go ahead. 9 A. So let's say he enjoyed ballet, like a 10 stereotypical female activity, and wondered if 11 that meant that he was trans. 12 The more we talked to him, we realized 13 that no, he just likes that particular activity, 14 but still very much identified as male and 15 certainly didn't actually have a disconnect 16 between his gender identity and his sex assigned 17 at birth. Certainly didn't have any problem with 18 his physical body or primary or secondary sex 19 characteristics. 20 And the more we talked through it, it 21 seemed clear, you know, he didn't have gender 22 dysphoria. But maybe at first glance he did have 23 suspicion for it because of how he was describing 24 this rigid thinking around gender roles' behavior. 25 Q. If -- and this is another hypothetical. Page 96</p> |
| <p>1 Did I read that correctly? 2 A. Yes. 3 Q. And what is diagnostic clarity? 4 A. Sorry, I'm just going to see where it 5 came up in that paragraph. 6 Q. Sorry. I think it's in -- let's see 7 here. It actually might be in the statement 8 itself. Yeah, sorry. 9 So going back another page -- going back 10 another page, right column, so this is S62, 11 Statement 6.12.d. 12 It says "The adolescent's mental health 13 concerns parentheses (if any) that may interfere 14 with diagnostic clarity." 15 And my question is just what is 16 diagnostic clarity? 17 A. I think in their instance, they're 18 referencing clarity around a gender dysphoria 19 diagnosis. 20 Q. And do you agree that mental health 21 concerns can interfere with diagnostic clarity? 22 A. Yes. 23 Q. How so? 24 A. In many of the ways listed. One example 25 that you gave was autism. Page 95</p> | <p>1 If the adolescent is at the beginning of 2 Tanner Stage II has been diagnosed with gender 3 dysphoria and wants puberty blockers, but the 4 adolescent is expressing suicidal ideation, in 5 your opinion, is that adolescent eligibility to 6 receive puberty blockers as a treatment? 7 MS. NOWLIN-SOHL: Object to form. 8 THE WITNESS: It depends. Suicidal 9 ideation is a broad construct. That kind of 10 ranges from what some people will call passive 11 suicidal ideation, something like, I'd rather not 12 be alive. I'm so miserable. But I don't have any 13 plan or intent to harm myself. 14 Another end of the spectrum might be, you 15 know, active suicidal ideation with intent to 16 plan, where somebody wants to die and they have a 17 plan to act on it and they plan to act on it soon. 18 If you were on that side of the spectrum, then 19 we're not going to start talking about puberty 20 blockers. We're going to work towards an 21 inpatient hospitalization to make sure that that 22 person is safe and stabilized, and then they could 23 potentially be a candidate in the future. 24 Another end of the spectrum I would 25 really want to understand the nature of the Page 97</p> |

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| <p>1 suicidality, you know, if it was not acute 2 suicidality, the person doesn't have a physical 3 safety risk but they're so unhappy that they're 4 expressing a desire not to live even though they 5 wouldn't act on that, and a lot of that is related 6 to gender dysphoria and the fear of puberty 7 progressing. And that's a patient where you might 8 do more work towards understanding if they would 9 be a candidate for pubertal suppression. 10 Q. (BY MR. RAMER) If the patient is 11 expressing passive suicidal ideation, are you 12 saying they would not be eligible until after 13 you've done the further assessment? Or are you 14 saying if the patient is expressing passive 15 suicidal ideation, they would be eligible? 16 A. If they're expressing passive suicidal 17 ideation, that wouldn't make them immediately 18 ineligible but they would need to go through the 19 full biopsychosocial assessment, meet all the 20 other criteria. 21 And if they had -- if their suicidality 22 was being driven by other things that aren't 23 gender dysphoria, we would want to treat those as 24 well. And we'd likely work on safety planning, 25 the standard approaches that we take for patients</p> <p style="text-align: right;">Page 98</p> | <p>1 MR. RAMER: Okay. 2 THE VIDEOGRAPHER: Okay. So the time is 3 11:17 a.m. Pacific time, and we are off the 4 record. 5 (Break taken from 11:17 a.m. to 11:23 a.m.) 6 THE VIDEOGRAPHER: All right. So we are 7 recording. The time is 11:23 a.m. Pacific, and we 8 are back on the record. 9 Q. (BY MR. RAMER) Dr. Turban, I'd like to 10 return to Turban Exhibit 7, which is Chapter 6, 11 the "Adolescents" chapter of the SOC8. And going 12 back to page S48, which is 6 in the PDF. 13 I want to look again at statement 6.12.B, 14 which requires that the experience of gender 15 diversity/incongruence is marked and sustained 16 over time. 17 And my question is based on your review 18 of the evidence, do you agree with that 19 requirement as a precondition for adolescent 20 receiving treatment? 21 MS. NOWLIN-SOHL: Object to form; 22 foundation. 23 THE WITNESS: Yes. 24 Q. (BY MR. RAMER) And then with 6.12.d, 25 same page, do you -- let me rephrase.</p> <p style="text-align: right;">Page 100</p> |
| <p>1 who are having suicidal thoughts. 2 Q. So is passive suicidal ideation, for lack 3 of a better term, less serious than active 4 suicidal ideation? 5 A. Do you have a better term? 6 Q. I'm asking you. You're saying you treat 7 people differently based on whether they have 8 passive suicidal ideation or active, and I guess 9 the question is how do you justify treating them 10 differently? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: So if a person has active 13 suicidal ideation with intent to plan, we need to 14 get them somewhere where they can be watched and 15 supervised and make sure they're not going to act 16 on that plan and die. 17 If the person is confident they're not 18 going to act on it; they don't have a plan, then 19 wouldn't necessarily need to be in that type of 20 restrictive setting. 21 MR. RAMER: I think we've been going just 22 a little over an hour. Do you want to -- could 23 you use a break? I could if you couldn't, but 24 either way, do you want to take a break? 25 MS. NOWLIN-SOHL: That sounds good.</p> <p style="text-align: right;">Page 99</p> | <p>1 Also based on your review of the 2 evidence, do you agree with that requirement as a 3 precondition for receiving treatment? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: Yes, as well as based on 6 clinical experience. 7 Q. (BY MR. RAMER) Do you think there's an 8 argument that a less rigorous mental health 9 assessment could be better because patients would 10 not have to go untreated for gender dysphoria as 11 long? 12 MS. NOWLIN-SOHL: Object to form. 13 THE WITNESS: I'm aware that argument has 14 increased. 15 Q. (BY MR. RAMER) And do you agree with 16 that argument? 17 A. I see the theoretical basis for it. That 18 being said, it wouldn't be in line with current 19 guidelines. It's a balance, right? Like, the 20 level of assessment, make sure someone's making a 21 very good, informed decision. 22 The longer the assessment is, 23 particularly for pubertal suppression, the longer 24 people are waiting and progressing through 25 puberty, which is worsening their gender</p> <p style="text-align: right;">Page 101</p> |

1 dysphoria. So it's a complex balance between
 2 those two factors.
 3 MR. RAMER: And I'd like to turn to
 4 Turban -- or introduce Turban Exhibit 8.
 5 MR. RAMER: Do you have that, Li?
 6 MS. NOWLIN-SOHL: Not yet.
 7 MR. RAMER: Okay.
 8 Q. (BY MR. RAMER) And I can start while
 9 we're waiting and just ask, Dr. Turban, have you
 10 appeared on an episode of the GenderGP podcast?
 11 A. Perhaps I'm not sure which podcast that
 12 is, but it sounds like a podcast I did appear on.
 13 MR. RAMER: And are you still waiting on
 14 it, Li?
 15 MS. NOWLIN-SOHL: We just got it.
 16 (Deposition Exhibit No. 8 was marked.)
 17 THE WITNESS: I see. Yes, I do recall
 18 this one.
 19 Q. (BY MR. RAMER) Okay. And I'll just
 20 represent to you that this is a transcript that is
 21 posted on GenderGP's website.
 22 And on page 1, is that your photo?
 23 A. That is quite the photo of me, yes.
 24 Q. I'd like to go to page 6. And at the top
 25 of this page, there is a response attributed to

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1 you. And I'll just read the first, the first part
 2 of this paragraph, and ask you a question about
 3 it.
 4 And it says "Yeah, I think that's a huge
 5 question that especially in pediatrics people are
 6 grappling with -- I think people have had an
 7 easier time in adult medicine kind of recognizing
 8 that these, like, assessment/gatekeeping were a
 9 little bit ridiculous and damaging. And it's
 10 interesting that not all of the lessons from that
 11 have made it into pediatrics yet because people
 12 don't trust kids to make decisions in the same
 13 way, obviously, but, like, things people are
 14 familiar with, right? Like, if you're -- if you
 15 set up this assessment, gatekeeping protocol,
 16 people are just going to figure out the answers
 17 and then tell you what you want to hear. And
 18 you've set up this really kind of like argument
 19 representative with your patient or client.
 20 (Unclear time stamped 1407). And you're like why?
 21 Why even bother? You know?"
 22 And do you think there's any reason to
 23 bother with an assessment model for
 24 gender-affirming medical interventions?
 25 MS. NOWLIN-SOHL: Object to form.

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1 THE WITNESS: So what I was referencing
 2 here -- and you'll see at the top I mentioned
 3 adult, quote, gatekeeping models, was that there
 4 was a history within psychiatry where there was an
 5 extensive assessment process prior to adults being
 6 able to start gender-affirming medical
 7 interventions, and some of the assessment criteria
 8 were not very reasonable. You know, if the
 9 psychiatrist felt that the trans woman's outfit
 10 was not particularly feminine or felt that her
 11 makeup was done well or that she didn't have the
 12 sexual orientation that the psychiatrist thought
 13 she should have, they would refuse to provide the
 14 person with care.
 15 And then also what happened was the trans
 16 community just learned the questions that some of
 17 those physicians were asking, and they would go in
 18 and address the way the person wanted and answer
 19 the questions the way they were [indiscernible]
 20 and it really stifled the relationship.
 21 You know the person wasn't actually
 22 answering the questions honestly to the physician
 23 because the things that were being asked weren't
 24 really so much about whether or not decision was
 25 right for the person, and was more about the

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1 therapist's views around what women should look
 2 like.
 3 I do think there's a role for assessment
 4 in pediatrics, but I think it shouldn't be that
 5 kind of thing. I don't think they should be
 6 sitting judging a patient's physical appearance,
 7 but rather really trying to understand them in a
 8 collaborative way so they feel comfortable
 9 speaking with me, so I really understand them, the
 10 whole spectrum of their lives, all the ways I can
 11 support them and guide them and their family
 12 through these decisions about whether they will
 13 benefit from puberty blockers or gender-affirming
 14 hormones.
 15 Q. Do you think that acquiring a diagnosis
 16 of gender dysphoria on the DSM-5 before an
 17 adolescent can obtain gender-affirming medical
 18 interventions is an assessment model?
 19 A. I think it's somewhat semantics, but
 20 determining the diagnosis is an assessment.
 21 You're doing a diagnostic assessment to come to
 22 that diagnostic conclusion.
 23 Q. Do you think there's a risk that
 24 individuals would be able to figure out the
 25 answers to obtain a diagnosis of gender dysphoria

Page 105

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| <p>1 on the DSM-5 and then tell the providers what they 2 want to hear? 3 MS. NOWLIN-SOHL: Object to form; calls 4 for speculation. 5 THE WITNESS: I think less so in minors 6 because we're usually interviewing their parents 7 and other people in their lives as well, so we 8 want to have fairly consistent answers between the 9 different members of the family. 10 And when answers seem to be discordant 11 with each other, we usually facilitate family 12 therapy sessions to try to come to a shared 13 understanding of what's going on to make sure we 14 have a clear understanding of the picture. 15 Q. (BY MR. RAMER) So you think parents' 16 observations or conclusions regarding the gender 17 identity of their children is relevant to this 18 assessment? 19 A. I think the parents' experience and 20 perception is a piece of the puzzle, yes. 21 Q. And are you aware of any providers in the 22 United States who use only an informed consent 23 model to provide gender-affirming medical 24 interventions? 25 MS. NOWLIN-SOHL: Object to form. Page 106</p> | <p>1 A. Correct. 2 Q. And you're talking about the diagnosis 3 for gender dysphoria here; is that right? 4 A. In the context of psychiatric 5 appointments. 6 Q. So what do you mean when you say, "The 7 only argument for the diagnosis existing is 8 insurance coverage"? 9 A. I believe this was in the context of 10 arguments about whether or not gender dysphoria 11 should be in the DSM. And there have been 12 arguments on both sides. Some people have 13 highlighted concerns that because gender dysphoria 14 is in the DSM, that the general public will 15 misinterpret that to think that trans identities 16 are a mental illness and that that will promote 17 stigma, which I think is something that we've 18 seen. 19 My philosophy on that is that we just 20 shouldn't stigmatize mental health conditions 21 broadly. I wouldn't stigmatize someone with major 22 depressive disorder in the same way that I 23 wouldn't stigmatize someone with gender dysphoria, 24 but I understand that stigma exists. 25 Another side of the spectrum, people have Page 108</p> |
| <p>1 THE WITNESS: For minors or adults? 2 Q. (BY MR. RAMER) Minors. 3 A. No. But again, it's this what do you 4 mean by informed consent? 5 So what I would say, which hopefully 6 answers the question, is that everyone I know 7 conducts this comprehensive biopsychosocial 8 evaluation prior to initiating care, and that that 9 biopsychosocial assessment involves ensuring the 10 patient can provide informed consent or assent and 11 that the parents can provide informed consent. 12 Q. In sticking with this same document, I'd 13 like to move to page 11. And on this page there 14 are two answers attributed to you. One is very 15 short. I'm looking at the second one further 16 down. 17 And in particular in that paragraph, I 18 just want to read the third to last sentence that 19 begins with the words "And right." And I'll 20 ask -- I'm sorry. Maybe the fourth to last -- the 21 sentence that begins with the words "And right," 22 and then I'll ask if I read it correctly. 23 It says "And right. The only argument 24 for the diagnosis existing is insurance coverage." 25 Did I read that correctly? Page 107</p> | <p>1 made arguments that it should be in the DSM, and 2 there are plenty of peer-reviewed publications 3 that highlight that for psychiatrists, the main 4 reason it's in the DSM is for insurance billing. 5 So that if I'm talking to someone about 6 gender-affirming medical care, for instance, and 7 doing that biopsychosocial evaluation, I need some 8 diagnostic code to put down, otherwise I wouldn't 9 be able to do that work theoretically. 10 Q. And here you say the only argument for 11 the diagnosis existing is insurance coverage. 12 Is that what you think? 13 MS. NOWLIN-SOHL: Object to form. 14 THE WITNESS: Again, I think that's in 15 the context of psychiatric events. Like, on a 16 broader level, it's a useful diagnosis for 17 establishing that somebody could be a candidate 18 for gender-affirming medical intervention. 19 But, you know, you could get at a similar 20 concept of gender dysphoria without using that 21 specific term that many find stigmatizing. 22 Q. (BY MR. RAMER) So, I mean, what do 23 you -- how would you do it without using that 24 term? You'd just call it something else? 25 MS. NOWLIN-SOHL: Object to form. Page 109</p> |

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| <p>1 THE WITNESS: I mean, you could describe 2 that the person has a gender identity that's 3 incongruent with their sex assigned at birth and 4 have for many years, and that's creating 5 clinically relevant distress. Maybe describe the 6 different elements of typical gender dysphoria 7 that they have. But the way insurance billing is 8 set up, you would need to actually generally bill 9 that kind of diagnostic code. 10 Similarly, a lot of insurance companies 11 won't cover, I think, some of the medical 12 appointments as well unless there's a diagnostic 13 code. 14 Q. (BY MR. RAMER) Do you think that an 15 individual who has distress resulting from -- 16 well, no, let me rephrase. 17 Do you think there are instances where an 18 individual can desire gender-affirming medical 19 interventions but not meet the criteria for a 20 diagnosis of gender dysphoria under the DSM-5? 21 A. It's theoretically possible. 22 Q. And do you think that those individuals 23 should receive gender-affirming medical 24 interventions? 25 MS. NOWLIN-SOHL: Object to form; calls Page 110</p> | <p>1 this end. 2 Did you say you could not picture a case? 3 A. I cannot picture a case where that would 4 be a reasonable practice. 5 Q. And I want to skip the next sentence and 6 then read the one after that and ask if I read it 7 correctly. 8 It says "Never once have I had a" -- 9 sorry. I'll start again. 10 "Never once have I had a treatment plan 11 for someone's, like, gender dysphoria. But I've 12 had treatment plans to help them with their 13 anxiety or their depression or trauma-related 14 symptoms." 15 Did I read that correctly? 16 A. Sorry. I'm just finding where you are. 17 Yes. 18 Q. And is it true that you have never once 19 had a treatment plan for someone's gender 20 dysphoria? 21 A. So again, this is talking in the context 22 of a psychiatric treatment plan. So I wouldn't 23 have -- there's no evidence psychotherapy is to 24 try and push someone to identify with their sex 25 assigned at birth. Page 112</p> |
| <p>1 for speculation. 2 THE WITNESS: No. That would be 3 practicing outside of guidelines. 4 Q. (BY MR. RAMER) Don't the guidelines 5 create exceptions? Or are they rigid rules? 6 A. They're a general set of guidelines for 7 care. 8 But that would be an extreme departure, 9 to provide the intervention to somebody in the 10 United States where we use the DSM who doesn't 11 meet the criteria for gender dysphoria. It's hard 12 for me to imagine that situation happening. 13 Q. And just as a -- you know, an expert in 14 this field, do you think the guidelines should 15 prevent those individuals from receiving 16 gender-affirming medical interventions? 17 MS. NOWLIN-SOHL: Object to form. Also 18 objection to the extent that it calls for a legal 19 conclusion. 20 THE WITNESS: Yeah, I mean, I'm hesitant 21 to make broad characterizations of all of medicine 22 not knowing, like, all the specific details of a 23 given case. But I can't picture a case where that 24 would be a reasonable practice. 25 Q. (BY MR. RAMER) I couldn't hear you at Page 111</p> | <p>1 I might try and work with their school 2 around bullying or work with their family around, 3 like, communication and validation skills or -- 4 what I'm getting at here is there's not an 5 evidence-based psychotherapy or psychiatric 6 medication that's evidence based for gender 7 dysphoria. 8 Q. I guess I thought we were just discussing 9 that the only reason for the diagnosis is so that 10 you can enter a code for health insurance 11 purposes. 12 And I guess I don't understand if you 13 don't have treatment plans for gender dysphoria 14 because you're a psychiatrist, what is the need 15 for the diagnosis? 16 MS. NOWLIN-SOHL: Object to form; 17 mischaracterizes prior testimony. 18 THE WITNESS: So for instance, if I were 19 doing the biopsychosocial assessment for somebody 20 to consider starting pubertal suppression for 21 gender dysphoria, I would conceptualize that as 22 the treatment is the pubertal suppression, and I'm 23 conducting the biopsychosocial assessment to 24 broadly support them in many areas of their life 25 and then also, you know, pass them on to the next Page 113</p> |

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| <p>1 step to actually get them treatment, which is the 2 pubertal suppression. So it's a bit of semantics 3 in that way. 4 I think another problem that comes up 5 sometimes -- and, again, with the insurance 6 issue -- is let's say I do an assessment and the 7 person doesn't meet the criteria for a gender 8 dysphoria, then you're also left with, you know, 9 what do we bill insurance in this instance? 10 But it's just kind of a technicality of 11 how insurance billing works. 12 Q. (BY MR. RAMER) So is the only thing that 13 you as a psychiatrist do for the treatment for 14 gender dysphoria is the initial biopsyo -- let 15 me rephrase. 16 Is the only thing that you, as a 17 psychiatrist, do for the treatment of gender 18 dysphoria the initial biopsychosocial assessment? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: Yes. In terms of the 21 distress the person's having related to their 22 physical body not aligning with their gender 23 identity, our primary role is to do that 24 biopsychosocial assessment. 25 If they had something else going on, if</p> <p style="text-align: right;">Page 114</p> | <p>1 describing there, there actually is a different 2 diagnostic code for purposes of health insurance, 3 right? You're treating anxiety or you're treating 4 depression? 5 MS. NOWLIN-SOHL: Object to form. 6 THE WITNESS: If I were treating someone 7 who had that. But not everyone who comes to see 8 me as part of gender-related care is going to have 9 those other diagnoses. 10 Q. (BY MR. RAMER) So do you see patients 11 who are receiving gender-affirming medical 12 interventions after you have conducted the 13 biopsychosocial assessment with them? 14 A. Like, do I continue to see them? 15 Q. Yes. 16 A. Yes. 17 Q. And what are you doing during those 18 meetings? 19 A. It depends on the patient. 20 Q. Can you provide me some examples? 21 A. If they also had -- generally if they -- 22 for someone who ultimately did start the 23 gender-affirming medical intervention, I would 24 check with them to see how they're feeling about 25 the intervention, making sure that they're</p> <p style="text-align: right;">Page 116</p> |
| <p>1 they had major depressive disorder or generalized 2 anxiety disorder, I would treat that as well. And 3 I'll also do general psychosocial intervention so 4 family therapy or working with the school or 5 trying to prevent bullying. 6 But those things don't work to get rid of 7 the fact that the person's distressed about their 8 body not aligning with their gender identity, 9 which is the gender dysphoria. 10 Q. (BY MR. RAMER) Are there individuals who 11 have gender dysphoria but do not have anxiety that 12 rises to the level of general anxiety disorder? 13 A. Generalized anxiety disorder is not 14 defined by the level of anxiety but rather the 15 types of things about which one has anxiety. 16 Q. So in this sentence when you say "But 17 I've had treatment plans to help them with their 18 anxiety or their depression," are you referring to 19 actual diagnoses of an anxiety disorder or a 20 depression disorder? 21 A. Yeah. Those are colloquialisms for 22 anxiety disorders, which there are many, or 23 depression which can have many different diagnoses 24 that cause it. 25 Q. And so for that treatment you're</p> <p style="text-align: right;">Page 115</p> | <p>1 comfortable continuing with it, seeing if they 2 have any questions or if there are any worries 3 that are coming up around it. 4 If they also had generalized anxiety 5 disorder, I might be offering an evidence-based 6 medication or an evidence-based psychotherapy for 7 generalized anxiety disorder like cognitive 8 behavioral therapy. 9 Q. Was there more? 10 A. I don't know how many examples -- 11 Q. That's fine. That's fine. Let's -- so 12 same page, toward the bottom, and just there's a 13 statement attributed to Dr. Helen Webberley. 14 In this paragraph she's discussing 15 Johanna Olson-Kennedy, correct? 16 A. Do you want me to -- 17 Q. Sure, you can. And just as a reminder, 18 my question is just simply if she is discussing 19 Johanna Olson-Kennedy. 20 A. Looks like she's referencing 21 Dr. Olson-Kennedy as well as -- I don't know who 22 Darlene Tando is. I don't know Aiden's last name, 23 but I believe Aiden is a psychotherapist who works 24 with trans youth. 25 Q. And do you know Dr. Olson-Kennedy?</p> <p style="text-align: right;">Page 117</p> |

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| <p>1 A. Yes.</p> <p>2 Q. And on page 12, Dr. Webberley -- so top</p> <p>3 of page 12, second and third full sentences,</p> <p>4 Dr. Webberley says, "And basically Johanna has</p> <p>5 just said, 'Look, if your kid -- if your kid tells</p> <p>6 you that they're trans, they most likely are.</p> <p>7 Just believe it.'"</p> <p>8 Did I read that correctly?</p> <p>9 A. Yes.</p> <p>10 Q. Do you agree that Dr. Olson's -- well,</p> <p>11 sorry.</p> <p>12 Do you agree that Dr. Olson-Kennedy's</p> <p>13 practice is that if your kids tell you that</p> <p>14 they're trans, you should just believe it?</p> <p>15 MS. NOWLIN-SOHL: Object to form;</p> <p>16 foundation.</p> <p>17 THE WITNESS: I think probably that's</p> <p>18 mostly glib. I don't think that's her actual</p> <p>19 practice.</p> <p>20 My understanding is that she conducts the</p> <p>21 biopsychosocial evaluation, and that Aiden --</p> <p>22 again, whose last name I forget -- is a therapist</p> <p>23 who similarly conducts those evaluations.</p> <p>24 Q. (BY MR. RAMER) And then same page down</p> <p>25 to your response which follows. And I'll just</p> <p style="text-align: right;">Page 118</p> | <p>1 mental health treatment.</p> <p>2 The good thing that's unique about their</p> <p>3 model versus other models is it's not necessarily</p> <p>4 like an LMFT or a social worker or a psychologist.</p> <p>5 It's this medical doctor who has special training</p> <p>6 in conducting biopsychosocial assessments, whereas</p> <p>7 other places it's more, you know, a psychologist</p> <p>8 or a psychiatrist.</p> <p>9 And then what they've told me is that if</p> <p>10 it is particularly complex and they feel that they</p> <p>11 need someone like a Ph.D. or psychologist, those</p> <p>12 individual patients they'll refer over. So if</p> <p>13 someone has complex autism or trauma or psychosis.</p> <p>14 Q. And you used an acronym, "LMFT."</p> <p>15 What is that?</p> <p>16 A. It's a licensed marriage and family</p> <p>17 therapist.</p> <p>18 Q. And at Brown University, you said -- did</p> <p>19 you say Dr. Forcier?</p> <p>20 A. Yes. F-o-r-c-i-e-r.</p> <p>21 Q. But in this passage, you say that, quote,</p> <p>22 they don't have a lot of mental health</p> <p>23 involvement, end quote.</p> <p>24 What did you mean by that?</p> <p>25 A. Yeah, that in their clinics, there are</p> <p style="text-align: right;">Page 120</p> |
| <p>1 read the first few sentences and ask if I read it</p> <p>2 correctly.</p> <p>3 It says "Yeah, I was really talking</p> <p>4 around it and not naming names, but that model</p> <p>5 does exist in the U.S., right? So Dr. Olson,</p> <p>6 that's her model. Brown University's clinic has a</p> <p>7 similar model. And I think we're now starting to</p> <p>8 have the conversations like, great. Those models</p> <p>9 have now been around for a little while where they</p> <p>10 don't have a lot of mental health involvement.</p> <p>11 They don't have a gatekeeping model. They have</p> <p>12 this informed consent model, and so far it seems</p> <p>13 to be going fine."</p> <p>14 Did I read that correctly?</p> <p>15 A. Yes.</p> <p>16 Q. And are you, in this response, accurately</p> <p>17 describing the model that Dr. Olson-Kennedy uses?</p> <p>18 A. Again, I think it's a little tricky</p> <p>19 between these terms, assessment and gatekeeping</p> <p>20 and informed consent being somewhat unclear.</p> <p>21 But my understanding, especially talking</p> <p>22 to Dr. Olson and -- Dr. Forcier is the one at the</p> <p>23 Brown University clinic -- is that they do conduct</p> <p>24 these biopsychosocial assessments as adolescent</p> <p>25 medicine physicians who are trained in doing</p> <p style="text-align: right;">Page 119</p> | <p>1 these adolescent medicine physicians who have kind</p> <p>2 of broader training. So they -- they can</p> <p>3 prescribe hormones and puberty blockers, but they</p> <p>4 also are the pediatric medical specialty that</p> <p>5 focuses the most on mental health. So they're not</p> <p>6 pure psychiatrists the way that I am, so there's</p> <p>7 not necessarily a psychologist or psychiatrist</p> <p>8 involved in every single case. Sometimes it's an</p> <p>9 adolescent medicine physician who has mental</p> <p>10 health expertise.</p> <p>11 Q. And so that model results in less mental</p> <p>12 health involvement; is that right?</p> <p>13 MS. NOWLIN-SOHL: Object to form.</p> <p>14 THE WITNESS: Yeah, I guess I'm saying</p> <p>15 less mental health involvement. I just mean that</p> <p>16 it's an adolescent medicine doctor who has mental</p> <p>17 health training that is different than, say, a</p> <p>18 psychiatrist or a psychologist who only has mental</p> <p>19 health training.</p> <p>20 So for them, it could be the same person</p> <p>21 doing the biopsychosocial mental health assessment</p> <p>22 and also providing the hormones, whereas in other</p> <p>23 models you have a specified, separate person.</p> <p>24 Q. (BY MR. RAMER) So are there patients</p> <p>25 receiving fewer mental health interventions as a</p> <p style="text-align: right;">Page 121</p> |

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| <p>1 result? 2 MS. NOWLIN-SOHL: Object to form; calls 3 for speculation. 4 THE WITNESS: No, I think it's fewer 5 practitioners that they're seeing but not 6 necessarily fewer mental health interventions. 7 Q. (BY MR. RAMER) And what's the benefit of 8 having fewer practitioners that they're seeing? 9 A. I think their logic is that it would be 10 more streamlined. So for instance, in our model, 11 a patient has to wait many months to be able to 12 come in to see me. You know, there's, like, the 13 delay going from provider to provider having more 14 and more appointments. 15 So in our model, we do often have 16 patients who are progressing through puberty while 17 their mental health is worsening while we try and 18 work on logistics of getting that biopsychosocial 19 assessment done. But in their model, because it's 20 the same doctor, it's more streamlined. 21 And again, I don't work in these clinics. 22 I'm giving you my understanding from talking to 23 them to the best of my ability. But take it with 24 a grain of salt, having not actually worked in 25 there or seen their exact protocols.</p> <p style="text-align: right;">Page 122</p> | <p>1 psychiatrist, so I am the one doing mental health 2 assessment, but I can't remember if there's 3 specific language in the old guidelines versus the 4 new guidelines that said whether it could be an 5 adolescent medicine physician doing the mental 6 health biopsychosocial evaluation versus another 7 type of medical professional. 8 Q. (BY MR. RAMER) And you don't know the 9 answer to that question with respect to the 10 current guidelines either? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: I believe the current 13 guidelines say "mental health professional," but I 14 would have to go back and look. It hasn't been 15 relevant since I am a mental health professional. 16 Q. (BY MR. RAMER) Yeah. Yeah. Okay. That 17 makes sense. 18 MR. RAMER: Li, did you receive Turban 19 Exhibit 9? 20 MS. NOWLIN-SOHL: No. 21 MR. RAMER: Still no? 22 MS. NOWLIN-SOHL: Still no. 23 MR. RAMER: Well, I'll just -- we can get 24 started and then we can confirm the document. 25 Q. (BY MR. RAMER) But what I'm going to be</p> <p style="text-align: right;">Page 124</p> |
| <p>1 Q. And at the beginning of this answer you 2 say you were talking around it and not naming 3 names. 4 Why were you not naming names? 5 A. I don't remember. I'd have to go through 6 the rest of the -- 7 Q. That's fine. If you don't know -- 8 A. Probably because I was just speaking in 9 general terms and not talking about the specific 10 clinics. 11 Q. And so it doesn't have something to do 12 with the fact that the type of model they're using 13 would somehow be controversial? 14 MS. NOWLIN-SOHL: Object to form. 15 THE WITNESS: I don't know what you mean 16 by "controversial." 17 Q. (BY MR. RAMER) Well, I guess that it 18 would be inconsistent with the WPATH guidelines. 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: I would have to go back and 21 look at when this interview was and look at how 22 the guidelines evolved, because I think it was 23 during Standards of Care 7. 24 And I can't remember -- it's something 25 that's irrelevant to me because I am a</p> <p style="text-align: right;">Page 123</p> | <p>1 bringing up, Dr. Turban, is your article entitled 2 "Pubertal" -- "Pubertal Suppression For 3 Transgender Youth and Risk of Suicidal Ideation," 4 which is published in Pediatrics. 5 MR. RAMER: You still do not have the 6 document? 7 MS. NOWLIN-SOHL: Just arrived. 8 THE WITNESS: Okay. 9 (Deposition Exhibit No. 9 was marked.) 10 Q. (BY MR. RAMER) And is this that 11 document, Doctor? 12 A. Yes. 13 Q. And where did the data for this article 14 come from? 15 A. This data is from the 2015 U.S. 16 Transgender Survey. 17 Q. And looking -- sticking with your 18 article, going to page 3 under "Methods," and just 19 at a high level of generality, I'm trying to 20 understand what the study does. And basically -- 21 tell me if I have this generally correct. 22 Basically the study takes two different 23 groups. The first group is individuals who wanted 24 puberty blockers and received them; and the second 25 group is individuals who wanted puberty blockers</p> <p style="text-align: right;">Page 125</p> |

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| <p>1 but did not receive them. 2 Is that fair? 3 A. Yes. 4 Q. And then you compared those two groups on 5 a number of different metrics, correct? 6 A. Yes. 7 Q. And on this page, moving down to "Study 8 Population," I just -- the second and third 9 sentences I'm going to read and ask if I read them 10 correctly. 11 It says that "Given that pubertal 12 suppression for transgender youth was not 13 available in the United States until 1998, only 14 participants who are 17 or younger in 1998 would 15 have had healthcare access to GnRHa for pubertal 16 suppression. We thus restricted the analysis to 17 participants who were 36 or younger at the time of 18 the survey resulting in a sample of 20,619 19 participants." 20 Did I read that correctly? 21 A. Yes. 22 Q. And the basic idea there is that it's 23 highly unlikely, if not impossible, that anyone 24 over the age of 36 at the time of the survey would 25 have had access to puberty blockers to treat</p> <p style="text-align: right;">Page 126</p> | <p>1 the sentence that says "P less than .05 defines 2 statistical significance." 3 Is that right? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: That's talking about one 6 specific -- but the way you build these models, 7 there are different statistical thresholds for 8 different parts in how you build the model. 9 Q. (BY MR. RAMER) And is a P-value of less 10 than .05, is that a standard P-value for a 11 threshold of statistical significance? 12 A. It depends on what you're doing. 13 Q. And so like what? What does it depend 14 on? 15 A. For instance, if you were running a study 16 that had, like, hundreds and hundreds of 17 comparisons, you'd want to do a correction for 18 multiple comparisons and do it using a lower 19 P-value. 20 If you were deciding which variables to 21 build into a logistic progression model, you would 22 probably use a higher P-value like the .2 that we 23 used. 24 Q. When you have a threshold of statistical 25 significance of less than .05, what do you make of</p> <p style="text-align: right;">Page 128</p> |
| <p>1 gender dysphoria; is that right? 2 A. I wouldn't say it's impossible. There 3 have been some historical studies done by Jules 4 Gill-Peterson, who I think is at the University of 5 Pittsburgh now, that found that individual 6 physicians were offering pubertal suppression in 7 the United States earlier than this. 8 But this is a rough guideline based on 9 what we knew from the published literature. This 10 was then in the published literature. The first 11 time it seemed to be offered was at the Gender 12 Management Service at Boston Children's Hospital, 13 it made a publication that -- roughly 1988 is when 14 they started. 15 Q. And then going to the next page, 16 statistical analysis, about three-quarters of the 17 way down the paragraph, it states that your 18 threshold for statistical significance was a 19 P-value of less than .05; is that right? 20 A. I believe that's just for when we were 21 comparing demographic differences. In the 22 multivariable logistic progression, we chose 23 anything with a P-value of less than .2 to include 24 in the model. 25 Q. Okay. That's fair. And I'm just reading</p> <p style="text-align: right;">Page 127</p> | <p>1 a finding with a P-value of .07 or .08 just as a 2 theoretical manner? 3 A. Theoretically it would tell you nothing 4 one way or another. 5 Q. Have you heard people use the term 6 "substantial finding" or "important finding" for 7 something like that where the P-value doesn't 8 fully reach the threshold of statistical 9 significance? 10 MS. NOWLIN-SOHL: Object to form. 11 THE WITNESS: I've heard people use the 12 term "trend" toward whatever the recitation 13 they're looking at is. I was trying not to do 14 that. 15 Q. (BY MR. RAMER) And sticking with page 4, 16 going up to the top, the first full paragraph but 17 then the last two sentences in that paragraph, 18 just read and ask if I read it correctly. 19 It says "Those who reported beginning 20 treatment after age 17 were excluded to only 21 include participants who likely had pubertal 22 suppression during the active endogenous puberty. 23 The vast majority of adolescents would have 24 reached Tanner 5, the final stage of puberty, by 25 age 17."</p> <p style="text-align: right;">Page 129</p> |

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| <p>1 Did I read that correctly?</p> <p>2 A. Yes.</p> <p>3 Q. Why would someone report receiving</p> <p>4 pubertal suppression after age 17?</p> <p>5 A. For birth-assigned males, estrogen alone</p> <p>6 is not strong enough to suppress your endogenous</p> <p>7 testosterone, so you often need a second</p> <p>8 medication on board. You could use a puberty</p> <p>9 blocker or GnRH agonist to do that. They're</p> <p>10 expensive, so generally they're not. Generally</p> <p>11 one uses something like spironolactone.</p> <p>12 But want to really be looking at it in</p> <p>13 people who are using it to suppress active puberty</p> <p>14 rather than, you know, suppress testosterone for</p> <p>15 someone who was already past the pubertal</p> <p>16 adolescent window.</p> <p>17 Q. So you excluded participants who reported</p> <p>18 beginning pubertal suppression after age 17</p> <p>19 because you didn't want to look at that particular</p> <p>20 treatment?</p> <p>21 MS. NOWLIN-SOHL: Object to form.</p> <p>22 THE WITNESS: Our clinical question here</p> <p>23 was pubertal suppression during adolescence rather</p> <p>24 than, you know, blocking endogenous testosterone</p> <p>25 as an adult.</p> <p style="text-align: right;">Page 130</p> | <p>1 like to go to page 100.</p> <p>2 And in the right column there's a blue</p> <p>3 header it says "See puberty blocking hormones,"</p> <p>4 and there's one paragraph below it. And the final</p> <p>5 sentence of that paragraph says "However, less</p> <p>6 than 1 percent of respondents reported ever having</p> <p>7 them." And then there's an endnote 12.</p> <p>8 Do you see that?</p> <p>9 A. Yes.</p> <p>10 Q. And then if we go to page 126, the left</p> <p>11 column is endnote 12. And I'd just like to read</p> <p>12 the middle sentences here and ask if I read them</p> <p>13 correctly.</p> <p>14 It says "While puberty-blocking</p> <p>15 medications are usually used to delay physical</p> <p>16 changes associated with puberty and youth ages 9</p> <p>17 to 16 prior to beginning hormone replacement</p> <p>18 therapy, a large majority, 73 percent of</p> <p>19 respondents who reported having taken puberty</p> <p>20 blockers in Q.12.9, reported doing so after age 18</p> <p>21 in Q.12.11. This indicates that the question may</p> <p>22 have misinterpreted by some respondents who</p> <p>23 confused puberty blockers with the hormone therapy</p> <p>24 given to adults and older adolescents."</p> <p>25 Did I read that correctly?</p> <p style="text-align: right;">Page 132</p> |
| <p>1 MR. RAMER: And, Li, do you have Turban</p> <p>2 Exhibit 10?</p> <p>3 MS. NOWLIN-SOHL: Yes.</p> <p>4</p> <p>5 (Deposition Exhibit No. 10 was marked.)</p> <p>6 Q. (BY MR. RAMER) And, Dr. Turban, is this</p> <p>7 the survey that you used for this paper?</p> <p>8 A. This looks like the report of the full</p> <p>9 survey, yes.</p> <p>10 Q. Fair. And I'd like to go to page 271 and</p> <p>11 specifically question 12.9 on that page.</p> <p>12 And is this the question that you used to</p> <p>13 determine the number of participants who received</p> <p>14 pubertal suppression?</p> <p>15 A. Yes.</p> <p>16 Q. And then they would have, for -- I guess</p> <p>17 let's go to 272 now.</p> <p>18 And then if they had selected puberty</p> <p>19 blocking hormones in 12.9, they would be sent to</p> <p>20 question 12.11; is that right?</p> <p>21 A. Yes.</p> <p>22 Q. And then they would have a drop-down and</p> <p>23 report their age; is that right?</p> <p>24 A. Correct.</p> <p>25 Q. Okay. Sticking with this document, I'd</p> <p style="text-align: right;">Page 131</p> | <p>1 A. Yes.</p> <p>2 Q. Would you agree that 73 percent is a</p> <p>3 large percentage of these respondents?</p> <p>4 A. Yes. And again, these are the</p> <p>5 respondents that we excluded from our study</p> <p>6 because we didn't want to look at those who</p> <p>7 potentially misinterpreted the question or had</p> <p>8 accessed puberty blockers later as adults.</p> <p>9 Q. Do you agree with the second statement I</p> <p>10 read that "Respondents may have misinterpreted</p> <p>11 this question and confused puberty blockers with</p> <p>12 the hormone therapy given to adults and older</p> <p>13 adolescents"?</p> <p>14 MS. NOWLIN-SOHL: Object to form;</p> <p>15 foundation.</p> <p>16 THE WITNESS: Potentially for those older</p> <p>17 respondents who we excluded. I think it's less</p> <p>18 likely for younger people who would be more aware</p> <p>19 of what pubertal suppression is.</p> <p>20 Q. (BY MR. RAMER) If that many people</p> <p>21 misunderstood the question, how can you assume the</p> <p>22 other 27 percent correctly understood the</p> <p>23 question?</p> <p>24 MS. NOWLIN-SOHL: Object to form.</p> <p>25 THE WITNESS: There is no way to be</p> <p style="text-align: right;">Page 133</p> |

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| <p>1 certain, but I think for younger people who are 2 closer to when pubertal suppression was around and 3 available and in conversation, they would know the 4 difference between the two. But there's no way to 5 be sure. 6 Q. (BY MR. RAMER) And so this error that's 7 described in footnote 12 does not give you pause 8 in relying on this data? 9 A. Not extreme pause again, because these 10 people were all excluded from the study, all of 11 the adults who would have said they accessed it 12 late. 13 Q. I'd like to go back to page 271, and in 14 the right column, question 12.8. 15 And this is the question you used to 16 define the group of people who have ever wanted 17 pubertal suppression, correct? 18 A. Correct. 19 Q. And did you adjust the results for this 20 question based on the same error that affected the 21 results for question 12.9? 22 MS. NOWLIN-SOHL: Object to form. 23 THE WITNESS: We similarly excluded all 24 older individuals who wouldn't have been able to 25 access them, which would have gotten rid of a lot</p> <p style="text-align: right;">Page 134</p> | <p>1 and after and find all that's improved after the 2 treatment, then there's the study that compares 3 those who did receive treatment to those who 4 didn't at a single time point. And this is one of 5 those latter studies. 6 MR. RAMER: I'm going to send now, see 7 when it reaches you, what I'll mark as Turban 8 Exhibit 11. And this will be -- 9 (Deposition Exhibit No. 11 was marked.) 10 Q. (BY MR. RAMER) This will be your article 11 in Plos One -- sorry, I guess clarification. 12 Do you say "Plos One"? 13 A. I do. 14 Q. Okay. This will be your article in Plos 15 One entitled "Access to Gender-Affirming Hormones 16 During Adolescence and Mental Health Outcomes 17 Among Transgender Adults." 18 And the method in this article is similar 19 to the article we just looked at, right? 20 MS. NOWLIN-SOHL: John, we don't actually 21 have the exhibit quite yet. Can we actually just 22 hang on a second? 23 MR. RAMER: I mean, does he not -- 24 Q. (BY MR. RAMER) Doctor, is the method you 25 used in accessing gender-affirming hormones with</p> <p style="text-align: right;">Page 136</p> |
| <p>1 of the older people who answered the question. 2 Q. (BY MR. RAMER) In the relevant time 3 periods -- I'm sorry. 4 First let's go back to your article, 5 which is Turban Exhibit 9. And it's page 4 where 6 it says "Outcomes." 7 And the relevant time periods for the 8 metrics in this paragraph were the past month, the 9 past year, and lifetime, correct? 10 A. Yes. 11 Q. And with respect to the time periods for 12 the past month and the past year, those dates are 13 from the date the survey was taken, right? 14 A. Correct. 15 Q. And so with you excluding anybody 36 16 years old and older, your data would still include 17 a 35-year-old who said he had suicidal ideation in 18 the last month, right? 19 A. Correct. 20 Q. And this paper does not report the change 21 in these metrics based on the purported inability 22 to access pubertal suppression, correct? 23 A. No. So as I explained in the 24 declaration, there are two types of studies 25 generally for this area, studies that look before</p> <p style="text-align: right;">Page 135</p> | <p>1 respect to the U.S. Transgender Survey similar to 2 what you did in the article we just looked at? 3 A. The methodology of the Plos One paper is 4 similar to the Pediatrics paper. 5 Q. And the major difference is this paper 6 that we're going to be looking at is focused on 7 cross-sex hormones, whereas the prior one was 8 focused on pubertal suppression; is that right? 9 A. Generally, yes. 10 MR. RAMER: And are we still waiting on 11 it, Li? 12 MS. NOWLIN-SOHL: Yes. 13 Q. (BY MR. RAMER) I guess I'll just ask you 14 a general question, Doctor, about what an odds 15 ratio is. And here's what I think it is, and 16 please tell me if I have this wrong. 17 Basically an odds ratio of one tells us 18 there is no relationship between an exposure and 19 an outcome. And an odds ratio of greater than one 20 tells us that the exposure is associated with 21 higher odds of that particular outcome. And an 22 odds ratio of less than one tells us that the 23 exposure is associated with lower odds of that 24 particular outcome. 25 Is that close to being right?</p> <p style="text-align: right;">Page 137</p> |

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| <p>1 A. Yes, with the caveat that you would also 2 want to look at the key value and the confidence 3 intervals. 4 MS. NOWLIN-SOHL: We have the document 5 now, John. 6 MR. RAMER: Okay. Great. 7 Q. (BY MR. RAMER) And just to confirm, 8 Doctor, is this your Plos One article titled 9 "Access to Gender-Affirming Hormones During 10 Adolescence and Mental Health Outcomes Among 11 Transgender Adults"? 12 A. It is. I would just be careful because 13 we published a correction on this paper later. 14 The overall conclusions didn't change, but some of 15 the numbers changed. 16 Q. And did the numbers change -- well, let's 17 go to page 9, Table 2. And if the numbers I'm 18 going to ask about did change, maybe we'll take 19 our longer break a little earlier. 20 But did the numbers change with respect 21 to the age 16 or 17 group? 22 A. I don't think so, but I would want to 23 look to be sure. 24 MR. RAMER: Okay. Well, we're almost 25 coming up on an hour, and then maybe I'll track</p> <p style="text-align: right;">Page 138</p> | <p>1 JAMA Psychiatry about association between exposure 2 to gender identity conversion efforts and mental 3 health outcomes. 4 Q. And on page 69, which I think is page 2 5 of the article, in the second paragraph, second 6 sentence, you say, "Gender identity conversion 7 therapy refers to psychological interventions with 8 a predetermined goal to change a person's gender 9 identity to align with their sex assigned at 10 birth." 11 Did I read that correctly? 12 A. Yes. Citation 8, so it looks like that 13 definition is from Byne, et al., but it's also the 14 general definition from the American Academy of 15 Child and Adolescent Psychiatry. 16 Q. And would a psychological intervention 17 with a predetermined goal of affirming a person's 18 gender identity constitute gender identity 19 conversion therapy? 20 A. What do you mean by the predetermined 21 goal of affirming their gender identity? 22 Q. I guess what do you mean by the 23 predetermined goal to change a person's gender 24 identity in this passage? 25 A. I guess make it different than it is, or</p> <p style="text-align: right;">Page 140</p> |
| <p>1 down the corrected version of that. 2 And so do we want to break until -- 3 what's good for you, Doctor and Li? 4 MS. NOWLIN-SOHL: Yeah, I think we need 5 to go get lunch, so 45 minutes would probably be 6 best. We can come back right around 1:00 Pacific 7 time. 8 MR. RAMER: Top of the hour? 9 MS. NOWLIN-SOHL: Yeah. 10 MR. RAMER: That sounds good to me. 11 THE VIDEOGRAPHER: Okay. So the time is 12 12:17 p.m. Pacific time, and we are off the 13 record. 14 (Break taken from 12:17 p.m. to 1:05 p.m.) 15 THE VIDEOGRAPHER: All right. So we are 16 recording. The time is 1:05 p.m. Pacific time, 17 and we are back on the record. 18 (Deposition Exhibit No. 12 was marked.) 19 Q. (BY MR. RAMER) Dr. Turban, I'd like to 20 introduce Turban Exhibit 12. If you'd let me know 21 when you have that in front of you. 22 A. Is it the JAMA Psychiatry paper? 23 Q. That's correct. And can you tell me what 24 this document is? 25 A. This is a research paper we published in</p> <p style="text-align: right;">Page 139</p> | <p>1 force it to change. 2 Affirming would be accepting the identity 3 they currently have. 4 Q. What about a psychological intervention 5 with a predetermined goal of consolidating a 6 person's gender identity? Would that constitute a 7 gender identity conversion therapy? 8 MS. NOWLIN-SOHL: Object to form. 9 THE WITNESS: I don't know what you mean 10 by "consolidate." 11 Q. (BY MR. RAMER) Is any psychological 12 intervention with a predetermined goal ethical? 13 MS. NOWLIN-SOHL: Object to form. 14 THE WITNESS: Yes. For instance, if the 15 goal was to make someone's major depressive 16 disorder go into remission, that would be 17 appropriate. 18 Q. (BY MR. RAMER) And are you familiar with 19 the term "exploratory therapy"? 20 A. Yes. 21 Q. And what is your understanding of that 22 term? 23 A. My understanding of exploratory 24 psychotherapy is working with a person in a 25 nondirective way to explore their gender identity</p> <p style="text-align: right;">Page 141</p> |

1 and help them understand it without having a
 2 predetermined goal in mind.
 3 So you wouldn't be doing therapy to try
 4 and make them be cisgender; you wouldn't be doing
 5 the therapy to try and make them transgender, but
 6 rather helping them explore to understand
 7 themselves.
 8 Q. And if you had a psychological
 9 intervention with a predetermined goal of making
 10 someone transgender, would that constitute
 11 transgender identity conversion therapy?
 12 A. Essentially, yes.
 13 Q. And do you engage in exploratory therapy
 14 with your patients?
 15 A. Yes.
 16 Q. And why do you engage in exploratory
 17 therapy with your patients?
 18 A. I think of it as part of the
 19 biopsychosocial evaluation to make sure the person
 20 has a clear understanding of their identity and
 21 the many ways in which they can exist in this
 22 world and understanding themselves.
 23 Q. Can exploratory therapy reduce stress
 24 related to an individual's gender incongruence?
 25 MS. NOWLIN-SOHL: Object to form.

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1 THE WITNESS: I'm not familiar with any
 2 evidence that that is the case.
 3 Q. (BY MR. RAMER) You're not familiar with
 4 any evidence that exploratory therapy can reduce
 5 stress related to an individual's gender
 6 incongruence?
 7 A. Correct.
 8 Q. Are you aware of any evidence that
 9 exploratory therapy -- I'll move on.
 10 The data for this article also came from
 11 the 2015 U.S. Transgender Survey, correct?
 12 A. Yes.
 13 Q. And then if we could go back to
 14 Exhibit 10, which is the report of the survey, and
 15 I'd like to go to page 273. And specifically
 16 question 13.2 in the left column.
 17 And is this the question you used to
 18 represent conversion therapy?
 19 A. We use the term "gender identity
 20 conversion efforts," but yes.
 21 Q. And if a provider informs a patient about
 22 the risks associated with gender-affirming medical
 23 interventions, do you think it's possible the
 24 patient would construe that information as the
 25 provider trying to stop the patient from being

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1 trans?
 2 MS. NOWLIN-SOHL: Object to form; calls
 3 for speculation.
 4 THE WITNESS: No. I think that would be
 5 a stretch.
 6 Q. (BY MR. RAMER) Why?
 7 A. I routinely talk to my patients about the
 8 risks and benefits of treatments. They never
 9 think that I'm trying to force them to stop being
 10 trans.
 11 They understand that I am informing them
 12 about important risks and benefits to consider
 13 about medical treatments they're considering.
 14 Q. If a provider tells a patient that the
 15 patient may not access gender-affirming medical
 16 interventions until the patient completes a
 17 biopsychosocial assessment, do you think it's
 18 possible the patient will view that limitation as
 19 the provider trying to stop the patient from being
 20 trans?
 21 MS. NOWLIN-SOHL: Object to form; calls
 22 for speculation.
 23 THE WITNESS: I do not.
 24 Q. (BY MR. RAMER) And why not?
 25 MS. NOWLIN-SOHL: Same objections.

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1 THE WITNESS: That's my routine practice,
 2 and I've never had a patient think that I was
 3 trying to force them to be cisgender when
 4 describing to them the treatment guidelines that I
 5 would follow.
 6 Q. (BY MR. RAMER) Do you think your
 7 patient -- if one of your patients thought that
 8 you were trying to stop them from being trans, do
 9 you think that they would tell you?
 10 MS. NOWLIN-SOHL: Object to form; calls
 11 for speculation.
 12 THE WITNESS: My patients don't usually
 13 hold back if they're unhappy with me about
 14 something. I think they would usually tell me.
 15 Q. (BY MR. RAMER) Do you think that belief
 16 holds true for the majority of adolescents
 17 expressing gender dysphoria?
 18 MS. NOWLIN-SOHL: Object to form;
 19 foundation, speculation.
 20 THE WITNESS: Could you repeat the
 21 question?
 22 Q. (BY MR. RAMER) I thought you said you
 23 don't believe that if your patients thought you
 24 were trying to stop them from being trans that
 25 they would tell you.

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| <p>1 I'm sorry. You said that -- in effect, 2 you said they would tell you; is that fair? 3 A. I believe they would tell me or their 4 parents would tell me. If they were really angry 5 and thought I was trying to force them to be 6 cisgender, they would probably not want to keep 7 seeing me, in which case the parents would 8 probably tell me if they didn't want to keep 9 seeing me, and I would ask why. 10 I think generally that would come to my 11 attention in some way. 12 MR. RAMER: And, Li, do you have Turban 13 Exhibit 13? 14 MS. NOWLIN-SOHL: Not yet. 15 MR. RAMER: Okay. Well, we'll stick with 16 this document and go to -- I think it's page 75. 17 MS. NOWLIN-SOHL: And this is still the 18 U.S. Trans Survey? 19 MR. RAMER: No, I'm sorry. Return to 20 Turban Exhibit 12, the -- Dr. Turban's paper. I 21 apologize. You can go to page 75 in that 22 document. 23 MS. NOWLIN-SOHL: Okay. We are there. 24 Q. (BY MR. RAMER) Okay. And in the left 25 column below "Strengths and Limitations," the</p> <p style="text-align: right;">Page 146</p> | <p>1 or internalized transphobia, which would have been 2 basically due to experiencing transphobia that 3 they start to internalize in terms of self-hatred, 4 that people who are exposed to these ideas that 5 they should be forced to be cisgender because 6 maybe trans is bad might be more likely to seek 7 out these conversion efforts than other types of 8 therapy that don't try and force them to be 9 cisgender. 10 But that would imply that a societal 11 rejection is leading to that internalized 12 transphobia and other bad mental health outcomes. 13 MR. RAMER: And, Li, do you have Turban 14 Exhibit 13? 15 MS. NOWLIN-SOHL: We do. 16 MR. RAMER: Okay. Let's bring that up. 17 (Deposition Exhibit No. 13 was marked.) 18 Q. (BY MR. RAMER) And, Dr. Turban, I'll 19 represent that this is an NBC news article 20 entitled "Transgender Conversion Therapy 21 Associated with Severe Psychological Distress." 22 And have you seen this article before? 23 A. Yes. 24 Q. And toward the top, do you see the date 25 and time -- or actually just the date.</p> <p style="text-align: right;">Page 148</p> |
| <p>1 third sentence says "It is possible that those 2 with worse mental health or internalized 3 transphobia may have been more likely to seek out 4 conversion therapy rather than non-GICE therapy, 5 suggesting that conversion efforts themselves are 6 not causative of these poor mental health 7 outcomes. 8 Did I read that correctly? 9 A. It's part of a -- I think the next 10 sentence would be important to read. 11 Q. Okay. But that sentence I read, I read 12 that correctly, for the record? 13 A. You read the words correctly without the 14 context, yes. 15 Q. Okay. And do you say -- do you say 16 "GICE"? Do you pronounce that or do you say 17 "GICE"? 18 A. I usually just say gender identity 19 conversion efforts. 20 Q. Okay. And here's an opportunity to add 21 context. 22 Can you just explain what you're saying 23 in that sentence? 24 A. Yes. The first sentence you read said 25 it's possible that those with worse mental health</p> <p style="text-align: right;">Page 147</p> | <p>1 Do you see the date that this article was 2 published? 3 A. Yes. 4 Q. And do you recall what day you published 5 the article we were just looking at in Turban 6 Exhibit 12? 7 A. I do not. 8 Q. If we go back to Turban Exhibit 12 and go 9 to the first page, which is page 68, and then 10 towards the bottom, do you see where it says 11 "Published online September 11, 2019"? 12 A. Yes. 13 Q. And so the news article in Turban 14 Exhibit 13 was published the same day that you 15 published this article in Turban Exhibit 12 16 online; is that correct? 17 A. That seems to be the case. That's 18 generally how news outlets cover new research 19 articles is they get them ahead of time while 20 they're under embargoes so they have time to read 21 them and conduct interviews so that they can 22 publish them around the same time that the paper 23 comes out. 24 Q. How do the news organizations become 25 aware of the article when it's embargoed?</p> <p style="text-align: right;">Page 149</p> |

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| <p>1 A. I'm not sure if they sign up for it or -- 2 but essentially most of the major high-impact 3 medical journals send out press releases about 4 articles that are coming out in their future 5 editions that aren't out yet to journalists so 6 that the journalists have a chance to request an 7 embargoed version of the article with the 8 agreement that they don't talk about it publicly 9 until the article is officially posted online. 10 Q. And then in this NBC article, which is 11 Turban Exhibit 13, I'd like to go to page 2 of the 12 PDF. And about halfway down before this blank 13 space, there's a quote attributed to you. 14 And it says "We hope our findings 15 contribute to ongoing legislative efforts to ban 16 gender identity conversion efforts." 17 Do you see that? 18 A. Yes. 19 Q. And do you think that's an accurate 20 quote? 21 A. Yes. 22 Q. And before you conducted this study, did 23 you want to ban gender identity conversion 24 efforts? 25 A. They were labeled dangerous and unethical</p> <p style="text-align: right;">Page 150</p> | <p>1 published in the Journal of Adolescent Health in 2 2023. 3 Q. And just as a general matter for me to 4 understand the method in this article, basically 5 you're identifying two relevant time periods. 6 And the first is when -- the first time 7 period is when participants realize their 8 transgender identity, correct? 9 A. Correct. 10 Q. Sorry? 11 A. Correct. 12 Q. And the second time point is when 13 participants share that identity with others, 14 correct? 15 A. Correct. 16 Q. And so you measure the period between 17 those two points. And as a general matter, if the 18 time period between those two points is longer, 19 that tends to undermine the ROGD hypothesis, 20 right? 21 MS. NOWLIN-SOHL: Object to form. 22 THE WITNESS: I wouldn't say the ROGD 23 hypothesis was a major part of this study. It's 24 been -- I don't think there are many people who 25 take that hypothesis seriously, and the American</p> <p style="text-align: right;">Page 152</p> |
| <p>1 by all major medical organizations, including the 2 American Psychiatric Association and the American 3 Academy of Child and Adolescent Psychiatry. And 4 there was broad consensus prior to this research 5 that they were dangerous and ineffective. 6 And anytime there's broad consensus that 7 the practice is harmful towards children in 8 particular, I would be in favor of children not 9 being exposed to that practice. 10 Q. And so yes, you did want to ban gender 11 identity conversion efforts before you conducted 12 this study, correct? 13 A. I am personally not in a position to ban 14 practices, but I was in agreement with the 15 position statements of the American Psychiatric 16 Association and the American Academy of Child and 17 Adolescent Psychiatry. 18 MR. RAMER: Let's turn to -- I'd like to 19 introduce Turban Exhibit 14. Do you have that? 20 MS. NOWLIN-SOHL: We do. 21 MR. RAMER: Okay. 22 (Deposition Exhibit No. 14 was marked.) 23 Q. (BY MR. RAMER) And, Dr. Turban, do you 24 recognize this document? And if so, what is it? 25 A. Yes. This is a research article we</p> <p style="text-align: right;">Page 151</p> | <p>1 Psychological Association has emphasized that it's 2 not a valid diagnosis and shouldn't be used in 3 assessment or clinical context. 4 So I think that's an interesting, like, 5 extra thing to think about with this paper, but I 6 think what was most interesting about this paper 7 was that a substantial proportion of trans adults 8 don't come to realize their gender identity until 9 later, after age 10, and that for those who 10 realize in childhood before age 10 that there is a 11 very long period of time before they tell someone 12 else, 14 years. 13 The reason that's interesting for that 14 survey from 2018 about rapid onset gender 15 dysphoria is the way they determined in that study 16 that the person's gender identity or gender 17 dysphoria was rapid in onset was based on when 18 parents came to know that the child had gender 19 dysphoria or a trans identity. 20 And this is just highlighting that there 21 are many years. The median was 14 years between 22 somebody knowing their gender identity and telling 23 it to another person when they realized as 24 children, highlighting that using parent report 25 alone the way that survey did is not reliable.</p> <p style="text-align: right;">Page 153</p> |

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| <p>1 Q. Yeah. And so the reason that the 2 findings here tend to undermine the ROGD 3 hypothesis is because of how long that -- in part 4 because of how long that time period was between 5 the point that the individual identified as 6 transgender and the point that the individual 7 disclosed that information, correct? 8 A. Yes. It undermines the notion, one of 9 many notions in the hypothesis that when a parent 10 comes to understand that their child is trans that 11 that coincides with when the child themselves came 12 to understand that. 13 Q. Right. Okay. And so yeah, the longer 14 the time period, the more it tends to undermine 15 the hypothesis. 16 And that's why the 14 years is relevant, 17 right? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: I don't know that I really 20 agree with that characterization that, you know, 21 if it were 16 versus 14, that would be a matter, 22 or if it would be 14 versus 30. Just the fact 23 that there is a substantial period of time I think 24 is what undermines it. 25 Q. (BY MR. RAMER) And for this study, the Page 154</p> | <p>1 gender identity after the onset of puberty that 2 they are less likely to continue to have that 3 identity in adulthood. 4 So it's interesting to see that among 5 trans adults. It's actually not an uncommon 6 experience. 7 Q. (BY MR. RAMER) Right. And the reason 8 it's interesting is it undercuts the idea that, 9 you know, late realization is some sort of new 10 experience, correct? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: I suppose, or that the 13 later realization, you know, is synonymous -- 14 [indiscernible]. 15 THE REPORTER: Dr. Turban, I'm sorry to 16 interrupt. I couldn't understand you. 17 THE WITNESS: Oh, sorry. How far back do 18 you want me to go? 19 THE REPORTER: Just repeat your answer, 20 if you wouldn't mind. 21 THE WITNESS: So just saying the thing 22 that's interesting to me is that there was this 23 notion, less so in the field, but sometimes out 24 among the general public, that if one comes to 25 understand their trans identity after puberty, Page 156</p> |
| <p>1 data you used again comes from the U.S. 2 Transgender Survey; is that right? 3 A. Yes. 4 Q. And so on page 1 here under "Results," 5 the first sentence says "Of 27,497 participants, 6 40.8 percent reported 'later realization' of TGD 7 identities." 8 Did I read that correctly? 9 A. Yes. 10 Q. And so you're saying there that -- I 11 mean, the upshot of this is that later realization 12 was common among the adult survey participants -- 13 MS. NOWLIN-SOHL: Objection. 14 MR. RAMER: I'm sorry. 15 MS. NOWLIN-SOHL: I'm sorry, go ahead. 16 Continue. 17 Q. (BY MR. RAMER) Okay. Well, I guess why 18 is that relevant with respect to the ROGD 19 hypothesis? 20 MS. NOWLIN-SOHL: Object to form. 21 THE WITNESS: It's not necessarily. I 22 think it's more relevant that there's the 23 misconception, I think, less within the field, but 24 more kind of in, like, media and public policy 25 debates that if one comes to understand their Page 155</p> | <p>1 that it will not persist into adulthood. 2 But here we saw that among adults, it was 3 actually a fairly common experience for them to 4 first come to understand their gender identity 5 after age 10, which is a rough cutoff for puberty. 6 Q. (BY MR. RAMER) Well, I guess if the 40.8 7 percent is relevant in the context of persistence 8 or desistance, wouldn't you need to know the 9 individuals who had later realization but then 10 did, in fact, come to identify as cisgender? 11 A. Yeah, I think you're pointing out there 12 are different studies that could be done. You 13 could follow people longitudinally and then you 14 could find a desistance rate, if that's the term 15 you wanted to use. 16 This study wasn't that since we didn't 17 follow people longitudinally. We didn't have that 18 data available. 19 So this was just showing that among trans 20 adults, this isn't an uncommon experience. But it 21 doesn't tell you how many people would continue to 22 identify that way longitudinally. 23 Q. And then still on the same page in the 24 same results paragraph, the second and third 25 sentences, you say, "Within the 'childhood Page 157</p> |

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| <p>1 realization' group, the median age of sharing 2 one's gender identity with another person was 20. 3 In this group, the median time between realization 4 of one's gender identity and sharing this with 5 another person was 14 years." 6 And did I read that correctly? 7 A. Yes. 8 Q. Did you also record the median age of 9 participants sharing their gender identity for the 10 later realization group? 11 A. We did. We didn't have room in this 12 paper because it wasn't the focus. But we 13 recently published a response to the letter to the 14 editor where we provided that additional data. I 15 would have to pull it up to get the numbers. 16 Q. What letter to the editor are you 17 referring to? 18 A. I forget the author of the letter, but 19 someone wrote in to the journal asking for more 20 information and analyses, and so we provided them. 21 Q. And so the -- and this is just a 22 clarification, not a trick question. 23 So in the last sentence here, you're 24 talking about the median time. That is only 25 referring to the childhood realization group; is</p> <p style="text-align: right;">Page 158</p> | <p>1 came to know. 2 So I think one author called it rapid 3 onset parental notification, like the parents 4 found out all of a sudden in adolescence, but that 5 it's actually pretty typical for children to 6 withhold this information from their parents for 7 many years, in my clinical experience, due to fear 8 that their parents won't accept them. 9 Q. And I'd like to go back to Turban 10 Exhibit 10, which is the U.S. -- the report of the 11 U.S. Transgender Survey. And go to page 259. And 12 left column, Section 3 -- 13 A. Yes, we have it. 14 Q. So question 3.1 says "At about what age 15 did you begin to feel that your gender was 16 'different' from your assigned birth sex?" 17 Did I read that correctly? 18 A. Yes. 19 Q. And this is the question you used to 20 collect data for determining when the participants 21 first realized their transgender identity, 22 correct? 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: Let me double-check. 25 Sorry. I'm looking at the underlying question</p> <p style="text-align: right;">Page 160</p> |
| <p>1 that right? 2 A. Correct. The letter author asks for what 3 you're asking, and so we had it published in the 4 letter response, but I don't have it in front of 5 me. 6 Q. Okay. And do you think it's fair to say 7 that -- granting that you disagree with any sort 8 of ROGD hypothesis, do you think it's fair to say 9 that people who think the ROGD hypothesis may be 10 worth investigating, that the hypothesis is 11 focused on adolescents and not children? 12 A. I think you're missing the point of it in 13 that the reason this childhood question is 14 relevant is that the rapid onset gender dysphoria 15 study survey used the time that parents heard 16 about their child's gender identity as when the 17 children came to recognize their gender identity. 18 What this paper is showing is that those 19 people where the parents first found out in 20 adolescence may have known 12 years earlier, 21 right? Because there's a mean 12 years between 22 realizing and telling another person. 23 So for what was, from the parents' 24 perspective, the onset of time was actually much, 25 much later potentially than when the young person</p> <p style="text-align: right;">Page 159</p> | <p>1 because I just want to make sure I'm telling you 2 correct. 3 Q. (BY MR. RAMER) I guess it's page -- in 4 your article, page 54, left column under "Age of 5 sharing" -- oh, no, that's the other one. Sorry. 6 Yeah, so page 853, right column, very 7 bottom. "Age of TGD identity realization." 8 And you say, "As outlined above, 9 participants were asked the age at which they felt 10 that their gender was different from societal 11 expectations based on their sex assigned at birth 12 and were provided with a drop-down list of integer 13 ages from 1 to 99 years." 14 A. Yes, question 3.1. 15 Q. And so returning to -- sorry, if you 16 can -- and so returning to Exhibit 10 in the same 17 page we were on, 259, and same left column, 18 Section 3, I'm going to read question 3.2 and ask 19 if I read it correctly. 20 It says, "At about what age did you start 21 to think you were trans (even if you did not know 22 the word for it)?" 23 Did I read that correctly? 24 A. Yes. 25 Q. So why did you use question 3.1 instead</p> <p style="text-align: right;">Page 161</p> |

1 of 3.2?
2 A. We thought that 3.1 was a bit broader,
3 even though they're quite similar.
4 Q. Why would you use the broader question,
5 then?
6 A. Because it captures -- they're really
7 similar questions. We did not design the survey.
8 We were doing secondary data analyses of the
9 surveys, so we were in a position to try and pick
10 which question we thought was best.
11 The second one says "When did you think
12 you were trans (even if you didn't have the word
13 for it)," and then 3.1 basically asks without the
14 word, the feeling of it.
15 So we felt that 3.1 was just a cleaner
16 question even though they asked quite similar
17 things. We felt like 3.2 was a little bit more
18 about, like, ascribing language to it, like the
19 word "trans" or maybe someone had a word like
20 "trans" whereas we thought 3.1 captured more like
21 the gender identity experience rather than the
22 language they were ascribing to it. But they're
23 very similar.
24 Q. Do you know how the data would have
25 changed if you had used question 3.2 instead of

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1 3.1?
2 A. No. We tried not to run a ton of
3 analyses in that way that we think are going to be
4 similar. Because when you do that, you're more
5 likely to find a statistical finding due to chance
6 called P-hacking that's commonly criticized in
7 statistical research. Usually the cleaner, fewer
8 comparisons you make, the better.
9 So we did not repeat the analysis with
10 3.2. One could do that.
11 Q. Would you agree that a component of the
12 ROGD hypothesis, as those individuals who suggest
13 it might be legitimate would view it, concerns the
14 effect of social media on adolescents?
15 MS. NOWLIN-SOHL: Object to form.
16 THE WITNESS: I don't have any colleagues
17 who are experts in the field who do believe in
18 that hypothesis.
19 Again, the American Psychological
20 Association has argued against using it
21 clinically, the correction on the paper
22 highlighted that it's not a formal valid mental
23 health diagnosis.
24 All I can go off of is that one paper
25 where that single author was describing her

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1 thoughts about it. And my reading of that paper
2 is that I think that she did think that it had
3 something to do with social media influence. But
4 I think you would have to ask her.
5 Q. (BY MR. RAMER) Would you agree that as a
6 general matter you would probably have to be born
7 in the 1990s to have grown up with social media as
8 an adolescent?
9 A. I don't know enough about the history of
10 social media to give you an answer.
11 Q. Do you think there's a chance that social
12 media existed in its current form before 1990?
13 MS. NOWLIN-SOHL: Object to form.
14 THE WITNESS: You're making me think back
15 to when I first got social media. To be honest, I
16 don't know. Was MySpace first? I honestly don't
17 know when social media began. I don't know that
18 this is within my area of expertise.
19 Q. (BY MR. RAMER) And what year was the
20 data collected for the U.S. Transgender Survey?
21 A. 2015.
22 Q. And an individual had to be 18 years old
23 to take the survey, correct?
24 A. Correct.
25 Q. All right. Sticking with your article,

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1 I'd like to go to page 855, Table 1.
2 MS. NOWLIN-SOHL: Sorry, we might have
3 gotten a little bit lost.
4 Which exhibit are we in right now?
5 MR. RAMER: Turban Exhibit 14, the "Age
6 of Realization" -- sorry, it's hard in the virtual
7 setting to keep track of what's pulled up. So
8 Turban Exhibit 14, the "Age of Realization" paper.
9 MS. NOWLIN-SOHL: Okay.
10 MR. RAMER: And page 855, which has
11 Table 1.
12 MS. NOWLIN-SOHL: Okay. We are there.
13 Q. (BY MR. RAMER) Okay. And for this
14 article, you included all age groups in the data,
15 correct?
16 A. Sorry. What do you mean by "all age
17 groups"?
18 Q. Did you exclude anybody from the data
19 based on their age?
20 A. Based on their age at the time of the
21 survey?
22 Q. Yes.
23 A. No.
24 Q. And so it looks like there's about
25 roughly 800 people in the dataset who are 65 and

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| <p>1 older, correct?</p> <p>2 A. Yeah. Looks like that would account for</p> <p>3 about 5 or 6 percent of the total study.</p> <p>4 Q. And then for 45 to 64, about --</p> <p>5 A. Maybe 27 percent of the study.</p> <p>6 Q. And I appreciate I'm having you do math</p> <p>7 on the fly, so I'm not looking for it precise.</p> <p>8 But and then from 25 to 44 it looks like</p> <p>9 it's -- I'll put myself up -- well, I guess I</p> <p>10 don't know. What percentage of the study?</p> <p>11 A. Were in the 25 to 44 group?</p> <p>12 Q. Yeah.</p> <p>13 A. About 77 percent.</p> <p>14 Q. Well, maybe this is why we shouldn't do</p> <p>15 math on the fly. Because you're just adding those</p> <p>16 parentheses, but I don't think that would --</p> <p>17 A. Oh, wait. Sorry, yeah.</p> <p>18 Q. Well, let's just step back. This is not</p> <p>19 the point of the question.</p> <p>20 A. To get to your whole point, the most were</p> <p>21 very young, so mostly the 18 to 24 group.</p> <p>22 Q. Okay. Yeah. Would you agree that it's</p> <p>23 highly unlikely if not impossible that individuals</p> <p>24 in the 45 to 64 age group used social media as</p> <p>25 adolescents?</p> <p style="text-align: right;">Page 166</p> | <p>1 mental health diagnosis. It doesn't have support,</p> <p>2 and the American Psychological Association</p> <p>3 recommended against using it. So we weren't</p> <p>4 designing the study around that hypothesis in a</p> <p>5 single paper.</p> <p>6 Q. (BY MR. RAMER) Sorry. I didn't mean to</p> <p>7 cut you off.</p> <p>8 And so for this -- sticking with this</p> <p>9 article and page 855, Table 1, you have two</p> <p>10 columns here with one for childhood realization</p> <p>11 and one for late realization, correct?</p> <p>12 A. Correct.</p> <p>13 Q. And starting with the 65-plus group, is</p> <p>14 it fair to say the vast majority fall into the</p> <p>15 childhood realization category?</p> <p>16 MS. NOWLIN-SOHL: Object to form.</p> <p>17 THE WITNESS: I'd have to -- I'd have to</p> <p>18 add the numbers and then divide it -- I don't want</p> <p>19 to do the math.</p> <p>20 Q. (BY MR. RAMER) Fair. I'll ask it this</p> <p>21 way.</p> <p>22 You would agree that 573 is larger than</p> <p>23 215?</p> <p>24 A. That, I can do in my head, yes.</p> <p>25 Q. And for the 45 to 64 group, you would</p> <p style="text-align: right;">Page 168</p> |
| <p>1 A. Probably, but they're a small portion of</p> <p>2 the study.</p> <p>3 Q. Would you agree it's highly unlikely, if</p> <p>4 not impossible, that the majority of the 25 to 44</p> <p>5 age group used social media as adolescents?</p> <p>6 A. We'd have to know the distribution of how</p> <p>7 many were closer to 25, how many were closer to</p> <p>8 44.</p> <p>9 Q. But it didn't occur to you to make an</p> <p>10 adjustment for that based on -- sorry.</p> <p>11 A. I mean, this paper was not --</p> <p>12 MS. NOWLIN-SOHL: Object to form;</p> <p>13 argumentative.</p> <p>14 MR. RAMER: I'll re-ask it. Let me</p> <p>15 re-ask it, and then we'll try again.</p> <p>16 Q. (BY MR. RAMER) It didn't occur to you to</p> <p>17 make an adjustment for that given the fact that</p> <p>18 the first sentence of the purpose in your paper is</p> <p>19 discussing rapid onset gender dysphoria?</p> <p>20 MS. NOWLIN-SOHL: Object to form;</p> <p>21 argumentative.</p> <p>22 THE WITNESS: Though it's the first</p> <p>23 sentence, I wouldn't say this paper was really</p> <p>24 primarily focused on the rapid onset gender</p> <p>25 dysphoria hypothesis. That, again, is not a valid</p> <p style="text-align: right;">Page 167</p> | <p>1 agree that 3,224 is significantly larger than 825,</p> <p>2 correct?</p> <p>3 MS. NOWLIN-SOHL: Object to form.</p> <p>4 THE WITNESS: Yes.</p> <p>5 Q. (BY MR. RAMER) And for the 25 to 44</p> <p>6 group, you would agree that 7,043 is much larger</p> <p>7 than 3,856, correct?</p> <p>8 MS. NOWLIN-SOHL: Object to form.</p> <p>9 THE WITNESS: Yes.</p> <p>10 Q. (BY MR. RAMER) But then when you get to</p> <p>11 the 18 to 24 group, do you see that it looks like</p> <p>12 the numbers flip for the first time?</p> <p>13 MS. NOWLIN-SOHL: Object to form.</p> <p>14 THE WITNESS: Yeah, I would caution</p> <p>15 against making any of the comparisons you're</p> <p>16 making because the statistics weren't applied in</p> <p>17 that way, and so we don't know the degree to which</p> <p>18 those would be meaningfully different.</p> <p>19 Q. (BY MR. RAMER) I guess why didn't you</p> <p>20 apply the statistics in that way?</p> <p>21 MS. NOWLIN-SOHL: Object to form.</p> <p>22 THE WITNESS: Our statistician elected to</p> <p>23 do these large kind of square analyses so that we,</p> <p>24 as I referenced earlier, wouldn't be running a ton</p> <p>25 of analyses that leads you to the potential of</p> <p style="text-align: right;">Page 169</p> |

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| <p>1 that P-hacking concern. Otherwise you would be 2 doing a statistical test on every single row in 3 this table, which you can see would progressively 4 become a large number of comparisons. 5 Q. (BY MR. RAMER) Did that data that we 6 were just discussing, the fact that is -- in the 7 18 to 24 group for the first time, based on these 8 raw numbers, that a majority of the group fell 9 into the later realization group, did that 10 interest you? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: It wasn't the focus of the 13 paper, and I wouldn't recommend drawing 14 conclusions based on raw numbers. 15 Q. (BY MR. RAMER) Yeah, I'm not drawing 16 conclusions or trying to say what the focus of the 17 paper was. I'm just -- I mean, as a non-expert 18 looking at that table, like, that struck me. I 19 found that striking. 20 And I'm curious if you found that 21 interesting and whether you're going to research 22 it more or, you know, you've seen enough. 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: You could go back and run 25 the individual T tests on those lines.</p> <p style="text-align: right;">Page 170</p> | <p>1 MS. NOWLIN-SOHL: Object to form; calls 2 for speculation. 3 THE WITNESS: I don't think they would 4 actually be in -- let me look. 5 Because the USTS isn't a sample of trans 6 people, if there were a cisgender person who was 7 just generally nonconforming, they wouldn't be in 8 this study. 9 Q. (BY MR. RAMER) Isn't gender expression a 10 major part of living out your gender identity? 11 A. It could be a major part, but there are 12 people who have gender expressions that you might 13 think of as feminine who would have cisgender 14 identities. 15 If you've ever seen a cisgender man wear 16 nail polish, you might think of that as a feminine 17 gender expression, but it doesn't mean that person 18 is transgender. 19 Q. I guess what I'm trying to understand is 20 for the second time point in this study, you 21 focused on when the individual's transgender 22 identity was, like, expressly disclosed to 23 somebody else, whereas it seems like much more 24 common that an individual is going to be living 25 out their transgender identity with their gender</p> <p style="text-align: right;">Page 172</p> |
| <p>1 Q. (BY MR. RAMER) Well, I could not because 2 I do not have the expertise you have. 3 A. I also would need to harass my 4 statistician to do it and give her time, but it's 5 a publicly available data set also, so anyone 6 would be able to request the numbers and run those 7 analyses. 8 Q. And stepping back from the table now, do 9 you think it's possible for a parent to observe 10 that their child is transgender before the child 11 expressly states it? 12 A. There can maybe be suggestions, but it's 13 hard to know somebody's internal experience 14 without them telling you. 15 For instance, I'd caution against making 16 assumptions that, you know -- I think we referred 17 to assigned male wanted to play with dolls or wear 18 dresses, that doesn't mean that the young person 19 is transgender. They could be cisgender and like 20 dolls and dresses. 21 So it's drawing the conclusions based on 22 observations without the person telling you their 23 experience is limited. 24 Q. Well, that example you just gave, how 25 would that person have answered 3.1?</p> <p style="text-align: right;">Page 171</p> | <p>1 expression and people are going to understand, or 2 like, for lack of a better term, have a hunch of 3 their gender identity -- 4 A. Absolutely. 5 MS. NOWLIN-SOHL: Hold on. Let him 6 finish. 7 Q. (BY MR. RAMER) Well, no, go ahead. I 8 was meandering. Please. 9 MS. NOWLIN-SOHL: Object to form. Was 10 there a question? 11 MR. RAMER: Well, he was going to give an 12 answer. So please. 13 THE WITNESS: I lost track -- I lost 14 track of the question, honestly. What was the 15 question? 16 Q. (BY MR. RAMER) I guess it's just isn't 17 the premise of your paper that parents would not 18 know that their child has a transgender identity 19 until the child expressly discloses it to them? 20 MS. NOWLIN-SOHL: Object to form. 21 THE WITNESS: I think that's very common, 22 that young trans people live in a world where they 23 know that trans identities are stigmatized, and 24 trans people are commonly bullied and harassed. 25 Often these kids when they're young have</p> <p style="text-align: right;">Page 173</p> |

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| <p>1 expressed some small amount of gender diverse 2 expression. So, say, the young kid who played 3 with dolls or played with dresses, and they're 4 usually yelled at or socially sanctioned -- I 5 think the message very early on is that's not 6 acceptable. So it's actually very common that 7 they go to great lengths to hide that for a long 8 time. 9 So no, it's usually not apparent to other 10 people because the kids are trying to hide it 11 because they're afraid of the consequences if 12 people were to know. 13 Q. (BY MR. RAMER) Right. And that was my 14 question. 15 Isn't the premise of your paper that 16 parents wouldn't know the child has a transgender 17 identity until the child expressly disclosed it to 18 them? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: I wouldn't say it's the 21 premise of the paper. I would say it's a finding 22 of the paper that the young people didn't feel 23 comfortable sharing it with another person for 12 24 years. Why would they not feel comfortable? 25 Q. (BY MR. RAMER) But the reason the paper</p> <p style="text-align: right;">Page 174</p> | <p>1 told another person. So the parents would have 2 found out 12 years after the young person knew. 3 And as I said earlier, you can't presume 4 someone's gender identity by observing their 5 gender expression, as many cisgender people may 6 like things that you may not consider gender 7 typical. Like a cisgender man who likes musicals, 8 I wouldn't recommend assuming that person is 9 transgender. 10 Q. (BY MR. RAMER) Switching gears a little 11 bit, how do you stay up-to-date on the literature 12 in your field? 13 A. A lot of ways. We have conferences. I 14 use Google Scholar notifications so when new 15 peer-reviewed papers are published they come to my 16 inbox. Conversation with colleagues. 17 Q. Are there any particular authors you 18 trust in the field? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: I'm not really sure what 21 you mean by, like, "trust" or "distrust." 22 Q. (BY MR. RAMER) Sure. Do you think that 23 Annelou de Vries is a leading expert in the field? 24 A. Yes. 25 Q. Do you think Diane Chen is a leading</p> <p style="text-align: right;">Page 176</p> |
| <p>1 is relevant to the ROGD hypothesis is the parents 2 didn't know until a later time, correct? 3 MS. NOWLIN-SOHL: Object to form. 4 THE WITNESS: Again, I think you're 5 over-indexing on how important that one survey 6 paper is about ROGD. And again, this paper isn't 7 a direct response to that 2018 single survey, but 8 if you want to tie it to that question of rapid 9 onset, then yes, the point of this paper is that 10 often young people don't tell another person for 11 many years. And so at the time point when parents 12 are being told, that does not necessarily coincide 13 with when the young person first realized. 14 Q. (BY MR. RAMER) Sorry to keep going back 15 to this, but the point is that the parents would 16 not know until they are told, correct? 17 MS. NOWLIN-SOHL: Object to form; asked 18 and answered. 19 THE WITNESS: I think I answered the 20 question. 21 Q. (BY MR. RAMER) And what was the answer? 22 MS. NOWLIN-SOHL: Same objection. Asked 23 and answered. 24 THE WITNESS: That the study found that 25 there were median 12 years before the young people</p> <p style="text-align: right;">Page 175</p> | <p>1 expert in the field? 2 A. Yes. 3 MR. RAMER: And, Li, if you have it, I'd 4 like to introduce Turban Exhibit 15. 5 MS. NOWLIN-SOHL: We are still waiting on 6 that. 7 MR. RAMER: Please just let me know when 8 it arrives. 9 MS. NOWLIN-SOHL: Still waiting. Is 10 it -- no, just got it. 11 (Deposition Exhibit No. 15 was marked.) 12 Q. (BY MR. RAMER) Okay. Dr. Turban, have 13 you seen this editorial before? 14 A. Yes. 15 Q. And when was the last time you read it? 16 A. Probably when it first came out. 17 Q. And this editorial is coauthored by 18 Annelou de Vries, correct? 19 A. Yes. 20 Q. And if you turn to page 277, which I 21 think is the third page in the PDF, and you look 22 at footnote 1 -- 23 A. Sorry. What page again? 24 Q. 277 in the pagination, but I think the 25 last page of the PDF. Or it's an endnote. Sorry,</p> <p style="text-align: right;">Page 177</p> |

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| <p>1 endnote 1. 2 A. The first citation? 3 Q. Yes. 4 A. Yes. 5 Q. And that is the Chen article that you 6 cite in your declaration, correct? 7 A. Yes. I think the exhibit you sent is an 8 editorial on that paper that came out at the time 9 the paper was published. 10 Q. And so I'd like to go back to -- back one 11 page to page 276, and left column and second full 12 paragraph. And I'll just read the first two 13 sentences and ask if I read them correctly. 14 It says "Yet the study leaves some 15 concerns unanswered. Although overall 16 psychological functioning in the study 17 participants improved, there was substantial 18 variation among participants. A considerable 19 number still had depression, anxiety, or both at 20 24 months, and two died by suicide." 21 Did I read that correctly? 22 A. Yes. 23 Q. And were you aware of these facts before 24 you cited the Chen article? 25 A. Yes.</p> <p style="text-align: right;">Page 178</p> | <p>1 would have provided more data along that same 2 line. I think they could have adjusted for that 3 variable the way some of the other studies have 4 that I cite in my declaration. 5 Q. Why would you need to adjust for that 6 variable? 7 A. So I think there's been this question 8 raised, like the experts' declarations of whether 9 or not the improvement that you see when 10 adolescents with gender dysphoria get medical 11 interventions is that improvement from the 12 medication like the puberty blocker or the 13 hormones? Or is it from therapy they're getting 14 at the same time? 15 So I cited, I believe, three studies in 16 my declaration that looked at that question. This 17 was one of them. The way they looked at it was by 18 this parallel process analysis that showed that 19 the improvement tracked with their physical gender 20 incongruence improving as opposed to it not being 21 related to the actual physical impact of the 22 hormones. 23 Q. So is the idea that de Vries is 24 discussing here the possibility that mental health 25 care could be a confounding variable in this</p> <p style="text-align: right;">Page 180</p> |
| <p>1 Q. And so same paragraph, two sentences 2 later, it says "However, other possible 3 determinates of outcomes were not reported, 4 particularly the extent of mental health care 5 provided throughout GAH treatment." 6 Did I read that correctly? 7 A. You skipped a sentence in between, but 8 yes. 9 Q. Yeah. And what is your understanding of 10 what de Vries is saying in that sentence I just 11 read? 12 A. So the sentence that you skipped, which I 13 explained in my declaration, is that they looked 14 at the correlation between appearance congruence 15 in mental health outcomes and found that degree of 16 physical congruence predicted the improvement in 17 mental health, which is suggesting that it was 18 actually the physical effects of the intervention 19 resulting in the mental health outcomes rather 20 than something like psychotherapy. 21 Then going to the sentence that you read, 22 they're highlighting that, so that that provides 23 evidence that it was from the intervention. It 24 would have been nice if they also collected data 25 about the degree of mental health involvement that</p> <p style="text-align: right;">Page 179</p> | <p>1 study? 2 MS. NOWLIN-SOHL: Object to form. 3 THE WITNESS: She's highlighting they did 4 a specific analysis to look at that, and it 5 suggested that the improvements were from not 6 mental health, especially how there's another 7 additional way they could have looked at it. 8 Q. (BY MR. RAMER) And so yes, it could be a 9 confounding variable? 10 MS. NOWLIN-SOHL: Object to form; 11 mischaracterizes his prior testimony. 12 THE WITNESS: Yeah, I think that's a 13 mischaracterization of what I just said. 14 Q. (BY MR. RAMER) No, I wasn't trying to 15 repeat what you were saying. 16 I was asking the question of is the 17 concerns that are unanswered that de Vries is 18 talking about in this paragraph where she 19 references that the extent of mental health care 20 provided throughout GAH treatment was not reported 21 have to do with the fact that mental health care 22 is potentially a confounding variable? 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: That line is pretty far 25 removed from when she uses that phrase</p> <p style="text-align: right;">Page 181</p> |

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| <p>1 "unanswered." 2 And again, they did the parallel process 3 modeling that found that the mental health 4 improvement tracked along with adherence 5 congruence, suggesting that it was the physical 6 effects of the gender-affirming hormones leading 7 the person phenotype to align more with their 8 gender identity that was driving the improvements 9 in mental health as opposed to it being from 10 therapy. 11 Q. (BY MR. RAMER) Why do you need to 12 control for mental health care, though, if it's 13 not a potentially confounding variable? 14 MS. NOWLIN-SOHL: Object to form. 15 THE WITNESS: You -- they looked at it in 16 a different way using this parallel process 17 monitoring to separate out the impact of the 18 physical effects of the hormones from other 19 potential things like therapy. 20 Q. (BY MR. RAMER) And I understand that 21 you're describing what they did. 22 I guess my question is why do you need to 23 control for mental health care -- 24 MS. NOWLIN-SOHL: Object to form. 25 THE WITNESS: The reason why --</p> <p style="text-align: right;">Page 182</p> | <p>1 are there separate from any impact of 2 psychotherapy. 3 And the Costa study that I cited gets at 4 that question as well. 5 Q. (BY MR. RAMER) So the answer is that -- 6 well, I guess I'm not totally clear. 7 Is the answer that mental health care 8 does not -- let me rephrase. 9 You can say that the evidence does not 10 support the proposition that mental health care 11 can improve the distress associated with gender 12 dysphoria? 13 A. Now I'm unclear with your question. So 14 the thing that is being brought up in this 15 editorial was brought up in some of the State's 16 expert reports in which they asked this question: 17 In these studies where people are receiving 18 gender-affirming medical interventions, they're 19 also often receiving therapy. So is their mental 20 health improving because of the therapy or it's 21 improving because of the gender-affirming 22 hormones? 23 This study, the Tordoff study, and the 24 Costa study provide evidence that their mental 25 health isn't just improving from the therapy.</p> <p style="text-align: right;">Page 184</p> |
| <p>1 Q. (BY MR. RAMER) Okay. Why do you need to 2 control for mental health care if it is not a 3 potentially confounding variable? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: The reason they did that is 6 to address the potential of it being a confounding 7 variable, that they wanted to see was the 8 improvement in mental health from the physical 9 effects of the gender-affirming hormones as 10 opposed to potential things like mental health, 11 like you're implying, or psychotherapy. 12 And they found that it was from the 13 physical effects of the hormones, answering this 14 question of whether or not it could have just been 15 from any psychotherapy they were receiving. 16 Q. (BY MR. RAMER) And in your view, given 17 the body of evidence, can we rule out mental 18 health care as a potentially confounding variable? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: So this study provides 21 evidence that it's not just from -- that the 22 improvements we see from gender-affirming hormones 23 aren't just from therapy provided in time. 24 The Tordoff study that I cited similarly 25 looked at that question and found that the effects</p> <p style="text-align: right;">Page 183</p> | <p>1 Their mental health is improving from the 2 gender-affirming hormones. 3 Q. And my question is about the word "just" 4 that you're using there in your answer. 5 Because you say, "It shows that it's not 6 improving just because of the mental health 7 therapy." 8 And my question is can you say that the 9 evidence shows that mental health care is not 10 effective in reducing the distress associated with 11 gender dysphoria? 12 MS. NOWLIN-SOHL: Object to form. 13 THE WITNESS: So that's not -- these 14 studies are looking -- are not asking that 15 question. 16 These studies are asking do 17 gender-affirming hormones improve mental health? 18 You're asking does what psychotherapy 19 improve gender dysphoria? 20 Q. (BY MR. RAMER) Say again. 21 A. What psychotherapy are you asking me if 22 it -- there's evidence that it improves gender 23 dysphoria? 24 Q. The psychotherapy that's a potentially 25 confounding variable that they're controlling for</p> <p style="text-align: right;">Page 185</p> |

1 in these studies.
2 A. Again, the de Vries study didn't take
3 that statistical approach of controlling for a
4 potential confounder of psychotherapy. They did
5 it through parallel process models.
6 Q. Do you mean the Chen study?
7 A. Yes.
8 Q. Why is it significant if you have a study
9 where the patients are receiving both
10 gender-affirming medical interventions and
11 psychotherapy to control for the psychotherapy?
12 MS. NOWLIN-SOHL: Object to form.
13 THE WITNESS: Because you want to know if
14 the improvement was from the hormones or from the
15 psychotherapy.
16 Q. (BY MR. RAMER) And my question for you
17 is does the evidence show that psychotherapy is
18 ineffective at reducing the distress associated
19 with gender dysphoria?
20 MS. NOWLIN-SOHL: Object to form.
21 THE WITNESS: So to say that something is
22 ineffective, you would need to do something like a
23 noninferiority study, which has not been done.
24 But I'm not aware of any research that
25 shows that psychotherapy is effective in

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1 alleviating gender dysphoria.
2 Q. (BY MR. RAMER) What about studies where
3 they are giving the patients both gender-affirming
4 medical interventions and psychotherapy and they
5 are not controlling for psychotherapy?
6 Do you think that those studies suggest
7 that the gender-affirming medical interventions
8 can reduce distress associated with gender
9 dysphoria?
10 MS. NOWLIN-SOHL: Object to form.
11 THE WITNESS: Sorry. Can you repeat the
12 question?
13 Q. (BY MR. RAMER) So maybe it's more of a
14 hypothetical about a theory, which is you have a
15 study. In the study, the patients are receiving
16 both gender-affirming medical interventions and
17 psychotherapy. The outcome of the study is
18 improvement on all scores.
19 What?
20 A. Scores on what?
21 Q. On all metrics that you're -- depression,
22 anxiety, distress associated with gender
23 dysphoria.
24 A. It would be hard to have a scale to
25 measure distress associated with gender dysphoria

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1 because there is not a clean measure for that.
2 Q. You can't use the UGDS?
3 A. Not really. You'd have to flip the
4 scores the way the Dutch have done it
5 intermittently, but it's not really a good measure
6 of those things, more measure the degree to which
7 you don't identify with your sex assigned at
8 birth. They're not really designed to track
9 improvements in the distress related to that over
10 time.
11 Q. Okay. Well, let's go back to the
12 hypothetical -- and if you'll just allow me to
13 finish, and then I'll give you the opportunity to
14 answer -- which is you have a study. The patients
15 are receiving both gender-affirming medical
16 interventions and psychotherapy. The outcome is
17 improvement in quality of life.
18 Do you think that that study provides
19 evidence that gender-affirming medical
20 interventions are effective in improving quality
21 of life?
22 MS. NOWLIN-SOHL: Object to form.
23 THE WITNESS: So you're describing the
24 Costa study from 2015 essentially which does
25 exist, which did show that pubertal suppression

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1 improved mental health, whereas for the group that
2 got six months of therapy and then got a year of
3 therapy plus puberty blockers, they did not
4 improve when they just got therapy, but when they
5 got therapy with the blockers, they improved,
6 suggesting that the blockers improved their
7 health --
8 Q. (BY MR. RAMER) Sorry, go ahead.
9 A. For that immediately eligible group they
10 got six months of therapy, but therapy did not
11 improve their mental health in a statistically
12 significant way with the caveat to not interpret
13 one statistical finding as valid. But then once
14 they got pubertal suppression with the therapy,
15 their mental health did improve.
16 Q. And so I'm not describing the Costa study
17 because in my hypothetical the study is not
18 distinguishing between patients who received only
19 psychotherapy and patients who received
20 psychotherapy and then proceeded on to
21 gender-affirming medical intervention.
22 My hypothetical is a study where the
23 patients received both for the entire time, and
24 they show improvement.
25 And my question is does that type of

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| <p>1 study in my hypothetical constitute evidence that 2 gender-affirming medical interventions are 3 effective in improving that quality of life 4 metric? 5 MS. NOWLIN-SOHL: Object to form. 6 THE WITNESS: In that study, you would -- 7 in that theoretical study, you would want to 8 disentangle what was from therapy and what was 9 from the pubertal suppression. If that were the 10 only study that existed and that was the study 11 that you were looking at and you had this question 12 of whether or not therapy alone was effective, 13 then you would want to separate it. 14 Q. (BY MR. RAMER) What if the question is 15 whether or not gender-affirming medical 16 interventions are effective? Is that study also 17 worthless in that context? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: I wouldn't call it 20 worthless. I think it would be interesting. But 21 I think it would be more informative if you 22 adjusted for -- separated out the impacts of 23 therapy from puberty blockers. 24 Q. (BY MR. RAMER) And so if you don't 25 separate it out, can you cite that hypothetical</p> <p style="text-align: right;">Page 190</p> | <p>1 correctly. 2 It says "Finally, benefits of early 3 medical intervention, including puberty 4 suppressions, need to be weighed against possible 5 adverse effects -- for example, with regard to 6 bone and brain development and fertility." 7 Did I read that correctly? 8 A. Yes. 9 Q. And you see where de Vries mentions 10 possible adverse effects on brain development? 11 A. Just in that sentence? 12 Q. In that sentence. 13 A. Yes. 14 Q. What do you know about the risk of 15 adverse effects on brain development from pubertal 16 suppression? 17 A. So there's only one study that looked at 18 potential impacts on effective functioning that 19 seemed to suggest no adverse impact. 20 I think Dr. de Vries mentions something 21 here, educational achievements are expected given 22 their pretreatment status is reassuring. 23 I'm not aware of any convincing clinical 24 data that says there's an adverse impact on brain 25 development.</p> <p style="text-align: right;">Page 192</p> |
| <p>1 study as evidence that gender-affirming medical 2 interventions are effective? 3 MS. NOWLIN-SOHL: Object to form; calls 4 for speculation. 5 THE WITNESS: It would be a piece of 6 evidence. I wouldn't recommend using it in 7 isolation but look at the full body of literature 8 where they've done some other things to try to 9 tease apart those two interventions. 10 MR. RAMER: Okay. I think we've been 11 going for just about an hour if you all want to 12 take a break. 13 MS. NOWLIN-SOHL: Yeah, that sounds good. 14 MR. RAMER: Let's go off the record. 15 THE VIDEOGRAPHER: Okay. So the time is 16 2:13 p.m. Pacific time, and we are off the record. 17 (Break taken from 2:13 p.m. to 2:19 p.m.) 18 THE VIDEOGRAPHER: All right. So we are 19 recording. The time is 2:19 Pacific time, and we 20 are back on record. 21 Q. (BY MR. RAMER) And, Dr. Turban, I'd like 22 to stick with the article we were just discussing. 23 And I'd like to look on page 276 and the right 24 column and the second full paragraph, first 25 sentence. And I'll read it and ask if I read it</p> <p style="text-align: right;">Page 191</p> | <p>1 Certainly the delay in bone density 2 accrual is well known with pubertal suppression, 3 but to be honest, I'm not sure what she's 4 referencing with brain development. 5 Q. Is adolescence associated with 6 significant neurodevelopment? 7 A. Yes. 8 Q. And do you agree that adolescence is 9 associated with an increase in capabilities for 10 abstraction and logical thinking? 11 A. Yes. 12 Q. And is puberty linked to developmental 13 changes in social and emotional processing? 14 A. I'm not an expert on the intricacies of 15 that research, but I can say as a clinical matter 16 in terms of cognitive development for my 17 patients -- I mean, I have a handful of patients 18 who are now at Ivy League universities who are 19 doing quite well, so there doesn't seem to be an 20 apparent, clear negative path on cognition. 21 Q. So you are not an expert on cognitive 22 development; is that right? 23 A. I am broadly, but I wouldn't be able to 24 dive into the depths of the study of -- like, 25 neuroimaging studies that look at different</p> <p style="text-align: right;">Page 193</p> |

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| <p>1 neuroimaging paths throughout adolescence. 2 Q. In this case are you opining as an expert 3 on cognitive development? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: At the level of being a 6 child in adolescent psychiatry, yes, but not at 7 the level of being somebody who spends my whole 8 career doing things like neuroimaging studies, 9 looking at neural pathway development. 10 MR. RAMER: And, Li, do you have Turban 11 Exhibit 16 yet? 12 MS. NOWLIN-SOHL: I do. 13 MR. RAMER: Oh, great. 14 (Deposition Exhibit No. 16 was marked.) 15 Q. (BY MR. RAMER) And, Dr. Turban, have you 16 seen this article before? 17 A. No. 18 Q. Do you recognize the lead author? 19 A. Yes. 20 Q. And I'd like to go to page 254 in this 21 article, and specifically the left column under 22 "Discussion," and the second sentence in that 23 paragraph following the discussion header. And 24 I'll read it and ask if I read it correctly. 25 It says "However, puberty is a major</p> <p style="text-align: right;">Page 194</p> | <p>1 But I think the sentence you read is too 2 vague to say a lot from. 3 Q. And what are the two studies you're 4 referencing? 5 A. I have to remember the -- I think the one 6 that was the meta-analysis looking among young 7 adults I believe was in the Journal of Psycho 8 Neurologic Chronology I think in 2021. 9 The executive functioning one I believe 10 was by the Dutch, but I don't know the name of the 11 first author. 12 Q. Is the executive functioning one the one 13 with the Tower of London test? 14 A. Yes. 15 Q. I'd like to go to page -- stick with this 16 article, go to page 249, and right column and 17 first full paragraph. And I'd like to just read 18 it and ask if I read it correctly. 19 It says "We employed a two-round Delphi 20 procedure to obtain expert consensus regarding the 21 most efficacious research design elements 22 addressing the following research question: What, 23 if any, real world impact does pubertal 24 suppression have on transgender children's 25 cognitive and neural development?"</p> <p style="text-align: right;">Page 196</p> |
| <p>1 developmental process. And the full consequences, 2 both beneficial and adverse of suppressing 3 endogenous puberty, are not yet understood." 4 Did I read that correctly? 5 A. Yes. 6 Q. Do you agree that the full consequences 7 of suppressing endogenous puberty are not yet 8 understood? 9 A. This is a somewhat vague sentence. I 10 think the thing that's difficult when talking 11 about the impact of any medication on cognition is 12 that there are really infinite cognitive domains 13 one could look at. So in many ways, it's an 14 unanswerable question. 15 People have looked at different 16 questions, for instance, impact on executive 17 functioning. It does not seem that there's an 18 adverse impact. 19 There is also a meta-analysis that looked 20 mostly at young adults, not adolescents, so 21 different, that did find an adverse impact on 22 several cognitive things they looked at. 23 They found an improvement in visual 24 spatial reasoning among people that took 25 testosterone.</p> <p style="text-align: right;">Page 195</p> | <p>1 Did I read that correctly? 2 A. Yes. 3 Q. Do you know the answer to that question? 4 MS. NOWLIN-SOHL: Object to form. 5 THE WITNESS: I think it's too broad of a 6 question to have a straightforward answer. I 7 don't know that I could answer any question for 8 any medical intervention. 9 Q. (BY MR. RAMER) Do you think that 10 question is unanswerable? 11 MS. NOWLIN-SOHL: Object to form. 12 THE WITNESS: I think it's too broad to 13 really be able to answer. It kind of would 14 involve nearly infinite subquestions. So it would 15 be interesting to see the results of this Delphi 16 procedure to see what they thought were the 17 important subquestions to be answered. 18 Q. (BY MR. RAMER) Do you agree that 19 learning the answer to that question could have 20 important clinical implications? 21 MS. NOWLIN-SOHL: Object to form. 22 THE WITNESS: Again, it's such a broad 23 question. I certainly could imagine that there 24 would be subquestions that come out of it that 25 would be interesting, but nothing this paper</p> <p style="text-align: right;">Page 197</p> |

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| <p>1 ultimately does. But I have not seen this 2 particular paper. 3 Q. (BY MR. RAMER) So are you -- just to 4 understand, are you criticizing the question 5 that's in italics there? 6 MS. NOWLIN-SOHL: Object to form; 7 mischaracterizes prior testimony. 8 THE WITNESS: I think it's a broad 9 question that is likely designed from more 10 specific questions. 11 Q. (BY MR. RAMER) Do you know -- can you 12 describe any impact -- let me put it this way: 13 What can you tell me about the effect of pubertal 14 suppression on transgender children's cognitive 15 and neural development? 16 MS. NOWLIN-SOHL: Object to form. 17 THE WITNESS: It appears to result in 18 improved anxiety, depression, and from the data we 19 have, not impact executive functioning in that 20 clinically these young people don't seem to have 21 major issues in academic functioning. 22 Q. (BY MR. RAMER) Would you agree that 23 anxiety, depression, executive functioning, and 24 academic functioning are not necessarily the same 25 thing as neural and cognitive development? Page 198</p> | <p>1 "In addition, cognitive/behavioral 2 flexibility, a component of executive functioning, 3 should be measured, given that studies in rodents 4 show ovarian hormones, acting during puberty, 5 program cognitive flexibility by exerting 6 long-lasting effects on excitatory and inhibitory 7 balance in the prefrontal cortex." 8 Did I read that correctly? 9 A. Yes. 10 Q. Do you agree that rodent studies have 11 shown that ovarian hormones can have long-lasting 12 effects in brain development? 13 MS. NOWLIN-SOHL: Object to form; 14 foundation. 15 THE WITNESS: Whether or not a research 16 finding from rodents is going to translate to 17 humans is always very up in the air. I'd have to 18 look at the specific citation to know the details 19 of this rodent study. 20 Q. (BY MR. RAMER) Well, I guess following 21 up on that, if a scientist is faced with animal 22 studies reporting that pubertal hormones have 23 long-lasting effects on brain development, 24 shouldn't that scientist conclude there was some 25 possibility that pubertal hormones may also have Page 200</p> |
| <p>1 MS. NOWLIN-SOHL: Object to form. 2 THE WITNESS: I think they're aspects of 3 cognitive development. Again, this is kind of my 4 overall point here, that cognitive neural 5 development is such a broad term that it could 6 encompass nearly infinite things. 7 Q. (BY MR. RAMER) So you think -- sorry. 8 So just to confirm that I understand, you think 9 that the question that was developed by these 10 researchers is so broad that it encompasses an 11 infinite number of things? 12 MS. NOWLIN-SOHL: Object to form; 13 mischaracterizes prior testimony. 14 THE WITNESS: I don't think this is the 15 question that came out of the Delphi procedure. 16 It looks like this is the question they used to 17 prompt their Delphi procedure to then see what 18 their more specific questions would be. 19 I haven't read this paper, but from the 20 section you showed me, that's what it looks like. 21 Q. (BY MR. RAMER) Let's go to page 253 in 22 this document. Right column, about halfway down 23 there's a sentence that begins with "In addition." 24 And I'll just read it and ask if I read it 25 correctly. Page 199</p> | <p>1 long-lasting effects on brain development in 2 humans? 3 MS. NOWLIN-SOHL: Object to form. 4 THE WITNESS: Not necessarily a high 5 probability because rodent studies often don't 6 translate into clinically meaningful measures in 7 humans, but potentially. 8 Q. (BY MR. RAMER) I'd like to go to -- 9 well, I guess before seeing this article, which 10 you said you've seen for the first time today, 11 were you aware of references in literature 12 regarding the effect of pubertal suppression on 13 brain development in animals? 14 MS. NOWLIN-SOHL: Object to form. 15 THE WITNESS: I believe there is one 16 study in sheep that's been referenced. 17 I mean, the way I think about this 18 clinically is that these medications have been 19 around for decades. And generally, anytime 20 there's a medication that's FDA approved and on 21 the market, there's market surveillance. 22 And we will often identify if there is a 23 really serious consequence, and there haven't been 24 any apparent serious -- when I say "apparent," 25 adverse consequences from pubertal suppression Page 201</p> |

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| <p>1 that I'm aware of. 2 But certainly it's reasonable to do 3 research to study this more in depth to see if 4 maybe there are finer, less clinically significant 5 or obvious impacts. 6 Q. (BY MR. RAMER) When you say the 7 medications have been around for a while -- I'm 8 paraphrasing -- but the use of puberty blockers in 9 particular, the FDA approval is for central 10 precocious puberty, correct? 11 A. Correct. 12 Q. And when treating central precocious 13 puberty, you will eventually cease giving the 14 patient puberty blockers and then the patient will 15 then proceed through endogenous puberty, correct? 16 A. Correct. 17 Q. And so if the question is suppressing 18 endogenous puberty permanently, and what effect 19 that has on cognition, the fact that puberty 20 blockers have been FDA approved for central 21 precocious puberty is irrelevant, correct? 22 MS. NOWLIN-SOHL: Object to form. 23 THE WITNESS: I wouldn't call it 24 irrelevant. I think in both circumstances people 25 are exposed to the medications for a period of</p> <p style="text-align: right;">Page 202</p> | <p>1 Q. Well, what about the second sentence that 2 says "any GnRHa-related difference in brain 3 structure is likely to be observed over the long 4 term rather than immediately"? 5 A. It's somewhat imprecise. I don't know 6 what they mean "over the long term" versus 7 "immediately," but I don't have any specific 8 objection to the sentence. 9 Q. And going to 255 in this document, left 10 column, second full paragraph about halfway down 11 that paragraph, there's a sentence that starts 12 with "Yet." And I'll just read these two 13 sentences in this paragraph and ask if I read them 14 correctly first. 15 "Yet, evidence suggests an 16 over-occurrence of neurodiversity characteristics, 17 (especially related to autism) among 18 gender-referred youth. The neurodevelopmental 19 impact of pubertal suppression on neurodiverse 20 gender-diverse youth might well be different than 21 in neurotypical gender-diverse youth given 22 variations in neurodevelopmental trajectories 23 observed across neurodevelopment conditions." 24 Did I read that correctly? 25 A. Yes.</p> <p style="text-align: right;">Page 204</p> |
| <p>1 time that puberty is suppressed. And then they go 2 through either estrogen or testosterone puberty. 3 Q. (BY MR. RAMER) Well, you're saying 4 estrogen or testosterone puberty. That is not the 5 same thing, necessarily, as endogenous puberty, 6 correct? 7 A. For any given person, yeah, their 8 endogenous -- or endogenous puberty, it would be 9 estrogen or testosterone puberty, depending on 10 their sex assigned at birth. 11 Q. I'd like to go to page 252 in this 12 document. And the left column just about over 13 halfway down the paragraph there's a sentence that 14 starts with the words "The effects." And I'll 15 read it and ask if I read it correctly. 16 "The effects of pubertal suppression may 17 not appear for several years. Any GnRHa-related 18 difference in brain structure is likely to be 19 observed over the long term rather than 20 immediately." 21 Did I read that correctly? 22 A. Yes. 23 Q. Do you agree with those statements? 24 A. I mean it says "may," so hard to argue 25 with the sentence.</p> <p style="text-align: right;">Page 203</p> | <p>1 Q. Are you aware of any studies researching 2 the effect of pubertal suppression on 3 neurodevelopment in adolescents with neurodiverse 4 characteristics? 5 A. Yes. So the research on the relationship 6 between autism and gender dysphoria has been 7 controversial about whether or not there is a true 8 relationship between the two. 9 So we published a paper in the Journal of 10 the American Academy of Child and Adolescent 11 Psychiatry a few years ago where we looked at the 12 different studies that looked at whether or not 13 there was a co-occurrence between gender dysphoria 14 and autism or vice versus, and pointed out that 15 there were a lot of issues with that research. 16 So for the research, looking at those 17 with gender dysphoria, they would often use 18 screening instruments like the social 19 responsiveness scale or the autism quotient. And 20 they found that trans youth with gender dysphoria 21 were more likely to score in the clinical range on 22 those instruments than youth without gender 23 dysphoria. 24 The problem, as you know, is those 25 instruments are very nonspecific, so as many as</p> <p style="text-align: right;">Page 205</p> |

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| <p>1 80 percent of the kids who just have social 2 anxiety will score in the clinical range. 3 So for that reason we didn't know are 4 these young people scoring in the clinical range 5 because they truly have autism? Or is it because 6 they have other conditions that they're screening 7 for in this range too. 8 So that prompted some people to wonder if 9 these, quote, autism results were truly a result 10 of autism or if they were a result of minority 11 stress or gender dysphoria. So it raised the 12 question of whether or not these supposed autism 13 symptoms would improve following gender-affirming 14 medical care. 15 And I know there was at least one study 16 that only looked at pubertal suppression for, I 17 forget how long, a year or two, and looked at how 18 the social responsiveness scale changed over time 19 after gender-affirming medical treatment. 20 Q. What is the social responsiveness scale? 21 A. Screening instrument for autism that 22 again is somewhat nonspecific, because people with 23 other conditions like social anxiety disorder will 24 often screen in the clinical range. 25 Q. So in your previous answer, what question</p> <p style="text-align: right;">Page 206</p> | <p>1 different cognitive outcomes. It could be the 2 social responsiveness scale that they looked it. 3 It can look at neuroimaging techniques. 4 Q. Okay. Exclude the social responsiveness 5 scale. 6 Are you aware of any study researching 7 the effect of pubertal suppression on 8 neurodevelopment in adolescents with neurodiverse 9 characteristics? 10 A. I have to look back at what other 11 outcomes that study looked at, but I can't recall. 12 Q. Okay. Let's go back to -- it was a while 13 ago -- Turban Exhibit 5, which I believe is the 14 Cass interim report. 15 And specifically I'd like to go to 16 page 38. And in the right column there is a 17 paragraph numbered 3.32. I'm just going to read 18 the first sentence and ask if I read it correctly. 19 MS. NOWLIN-SOHL: Can you give us one 20 second, John? 21 MR. RAMER: Oh, sorry. Yep. 22 MS. NOWLIN-SOHL: You said 3.32? 23 MR. RAMER: Yeah, so page 38, right 24 column, paragraph numbered 3.32. 25 MS. NOWLIN-SOHL: Okay. We are there.</p> <p style="text-align: right;">Page 208</p> |
| <p>1 were you answering? 2 A. You asked if I was aware of any studies 3 looking at the impact of gender-affirming medical 4 care among those with neurodivergent 5 characteristics like autism. 6 Q. Well, it was actually specifically are 7 you aware of any study researching the effect of 8 pubertal suppression on neurodevelopment in 9 adolescents with neurodiverse characteristics? 10 A. Autism is a -- neurodiversity is a 11 category that includes autism. People often use 12 "neurodiversity" to reference people who have 13 autism characteristics. And so that was a study 14 of looking at people who were neurodiverse and 15 that they had presumably autism. And they 16 followed them after pubertal suppression. 17 Q. And so I appreciate that "neurodiverse" 18 includes people who have autism. 19 My question is the study about the effect 20 of pubertal suppression on neurodevelopment 21 specifically in adolescents who are neurodiverse. 22 Aware of any study researching that? 23 A. What do you mean by "neurodevelopment"? 24 Q. What do you understand that term to mean? 25 A. It's a broad term that could look at</p> <p style="text-align: right;">Page 207</p> | <p>1 Q. (BY MR. RAMER) Okay. I'll read the 2 first sentence of that paragraph and ask if I read 3 it correctly. 4 It says "A closely linked concern is the 5 unknown impacts on development, maturation, and 6 cognition if a child or young person is not 7 exposed to the physical, psychological, 8 physiological, neurochemical, and sexual changes 9 that accompany adolescent hormone surges." 10 Did I read that correctly? 11 A. Yes. 12 Q. And do you agree that the impact of 13 puberty blockers on the child's developmental 14 cognition is currently unknown? 15 MS. NOWLIN-SOHL: Object to form. 16 THE WITNESS: There are elements of 17 neurocognition that have been studied, but we 18 don't know for every domain of neurocognition. 19 And I think the same is probably true for the vast 20 majority of medications. 21 Q. (BY MR. RAMER) What's your basis for 22 that conclusion? 23 A. That we don't routinely study every 24 medication for every way in which it could impact 25 every domain of neurocognitive development.</p> <p style="text-align: right;">Page 209</p> |

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| <p>1 You know, there's impact to their 2 functioning; there's visual/spatial reasoning; 3 there's verbal fluency; there's different measures 4 of mathematical ability. There's just so many 5 different ways you can measure neurocognitive 6 development, and we don't routinely -- we just 7 don't have research for the vast majority of 8 medications and how they impact all those 9 different domains because there are so many. 10 Q. In your testimony -- 11 A. If there were -- again, like a 12 post-medication surveillance signal that came up 13 from the FDA showing, wow, we have a lot of 14 patients who took this specific medication, and it 15 seems like they're having clinically significant 16 impairment in their neurocognitive domain, that 17 would probably prompt that research. 18 But that's not routinely done for every 19 medication. It would be nice if it were, but it's 20 a lot of research and really intensive research to 21 do. 22 Q. And so you're saying that for the vast 23 majority of medications, we do not know the 24 neurocognitive outcomes from taking those 25 medications; is that right?</p> <p style="text-align: right;">Page 210</p> | <p>1 hormones? 2 MS. NOWLIN-SOHL: Object to form. 3 THE WITNESS: I can say clinically most 4 patients who get pubertal suppression -- well, 5 essentially all of them, will later either stop 6 pubertal suppression and go through endogenous 7 puberty, or they'll start gender-affirming 8 hormones. 9 Generally clinical experience has been 10 that those patients do quite well, and we don't 11 see that they have major cognitive impairments 12 that are clinically significant, but I'm not aware 13 of a specific peer-reviewed study looking at that 14 question, and again would point out that this term 15 "brain maturation" is very vague and not a very 16 technical term. And so I'm not sure exactly what 17 metric of brain maturation you're referencing. 18 Q. (BY MR. RAMER) You read this when -- 19 well, when did you read this? 20 A. I don't remember. Many months ago. 21 Q. And if you thought that the phrase "brain 22 maturation" was vague, did it lead you to want to 23 investigate further what they were talking about? 24 MS. NOWLIN-SOHL: Object to form. 25 THE WITNESS: From this specific</p> <p style="text-align: right;">Page 212</p> |
| <p>1 MS. NOWLIN-SOHL: Object to form. 2 THE WITNESS: We might know some 3 neurocognitive outcomes, but we don't know the 4 full range of neurocognitive outcomes. 5 Q. (BY MR. RAMER) And for pubertal 6 suppression, do we know some neurocognitive 7 outcomes? 8 A. I would say we have some mental health 9 outcomes, and we have executive functioning. And 10 those are the ones that I'm aware of. 11 Q. So same paragraph, final sentence at the 12 bottom starting with "If." I'll read it and ask 13 if I read it correctly first. 14 "If pubertal sex hormones are essentially 15 to these brain maturation processes, this raises a 16 secondary question of whether there is a critical 17 time window for the processes to take place or 18 whether catch-up is possible when estrogen or 19 testosterone is introduced later." 20 Did I read that correctly? 21 A. Yes. 22 Q. Are you aware of any study that addresses 23 whether a negative impact on brain maturation due 24 to pubertal blockade can be corrected later if the 25 child is exposed to either endogenous or cross-sex</p> <p style="text-align: right;">Page 211</p> | <p>1 international report, no. 2 Q. (BY MR. RAMER) Did anything in this 3 report lead you to do additional investigation? 4 A. What do you mean by "investigation"? 5 Q. I mean, did you read something in this 6 report and say, "Oh, that's a valid concern. I 7 should look into that"? Or no? 8 MS. NOWLIN-SOHL: Object to form. 9 THE WITNESS: I don't recall this report 10 bringing up anything relevant to my practice that 11 was new or interesting or present any new or 12 interesting data to my practice. 13 I remember the most interesting thing 14 being the description of how care is delivered in 15 the U.K. and how they're changing that. But it 16 didn't -- I don't recall it presenting any new 17 research or concepts that I wasn't previously 18 familiar with. 19 MR. RAMER: Okay. I'd like to go to 20 Turban Exhibit 17. Let me know when you have that 21 in front of you. 22 MS. NOWLIN-SOHL: Okay. 23 (Deposition Exhibit No. 17 was marked.) 24 Q. (BY MR. RAMER) Dr. Turban, do you 25 recognize this document?</p> <p style="text-align: right;">Page 213</p> |

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| <p>1 A. Yes.</p> <p>2 Q. What is it?</p> <p>3 A. I believe this was a report by a U.K.</p> <p>4 government agency looking at the research related</p> <p>5 to pubertal suppression for adolescent gender</p> <p>6 dysphoria.</p> <p>7 Q. And do you understand this to be a</p> <p>8 systematic review?</p> <p>9 A. Yes.</p> <p>10 Q. And is this something that you've read</p> <p>11 before?</p> <p>12 A. Yes.</p> <p>13 Q. And did you read it in some detail or did</p> <p>14 you skim it?</p> <p>15 A. When I initially read it, I read it in</p> <p>16 detail.</p> <p>17 Q. And what did you think when you read it?</p> <p>18 A. It's been a while, but I remember that --</p> <p>19 to our point earlier that all a systematic review</p> <p>20 really means is that they define their search</p> <p>21 terms. But then subsequent decisions about which</p> <p>22 research you include or don't include can be very</p> <p>23 subjective. I recall them excluding studies that</p> <p>24 I thought were important to include.</p> <p>25 Q. And did this review reach conclusions</p> <p style="text-align: right;">Page 214</p> | <p>1 A. Yes.</p> <p>2 Q. And the fourth one down on this table,</p> <p>3 the de Vries study, do you recall, is that also a</p> <p>4 study you cite in your declaration?</p> <p>5 A. Yes.</p> <p>6 Q. And the next page, third from the bottom,</p> <p>7 the Turban article. And do you recall is this a</p> <p>8 study you cite in your declaration?</p> <p>9 A. Yes.</p> <p>10 Q. And did you know the review excluded</p> <p>11 these studies?</p> <p>12 A. Yes.</p> <p>13 Q. And do you disagree with the review's</p> <p>14 conclusion to exclude these studies?</p> <p>15 A. I call it a decision, not a conclusion,</p> <p>16 but yes.</p> <p>17 Q. And why?</p> <p>18 A. Because I think the studies give you</p> <p>19 valuable information. The Achille study, though</p> <p>20 it doesn't separate GnRH analogues out from the</p> <p>21 other interventions because it's underpowered when</p> <p>22 it does that, I do think it's valuable information</p> <p>23 to know when they look at the group that received</p> <p>24 gender-affirming medical interventions including</p> <p>25 blockers and hormones that their mental health</p> <p style="text-align: right;">Page 216</p> |
| <p>1 that you disagree with?</p> <p>2 A. It's been a while since I read it, so I'd</p> <p>3 have to ask you if there's a specific line you're</p> <p>4 referencing.</p> <p>5 Q. Well, when you -- the comment you just</p> <p>6 made about them excluding studies that you thought</p> <p>7 were important, so do you have reason to doubt</p> <p>8 that the analysis in this document is reliable?</p> <p>9 MS. NOWLIN-SOHL: Object to form.</p> <p>10 THE WITNESS: I recall them not including</p> <p>11 all the studies that they should have included.</p> <p>12 Q. (BY MR. RAMER) And do you know whether</p> <p>13 this systematic review assessed any of the studies</p> <p>14 that you rely on in your declaration?</p> <p>15 A. I presume it reviews some of them, but</p> <p>16 it's been a while since I've read it.</p> <p>17 Q. Okay. Let's go to page 74. And kind of</p> <p>18 middle of the page, you see appendix D entitled</p> <p>19 "Excluded Studies Table"?</p> <p>20 A. Yes.</p> <p>21 Q. And do you recall whether you cite the</p> <p>22 first study -- let me rephrase.</p> <p>23 Do you recall whether in your declaration</p> <p>24 you submitted in this case that you cite the first</p> <p>25 study listed here?</p> <p style="text-align: right;">Page 215</p> | <p>1 improved. I think that that's useful information.</p> <p>2 The de Vries study they excluded, I think</p> <p>3 may be okay since this report was just interested</p> <p>4 in pubertal suppression, but I do think that's an</p> <p>5 important paper to know about because it looks at</p> <p>6 pubertal suppression followed by gender-affirming</p> <p>7 hormones followed by gender-affirming surgery. So</p> <p>8 it gives you a lot of fresh informational, albeit</p> <p>9 not just about puberty blockers.</p> <p>10 And then our study where it says they</p> <p>11 excluded because it doesn't report separately from</p> <p>12 other interventions, I'd have to pull up our paper</p> <p>13 again but I'm pretty sure that's not true. I</p> <p>14 believe we adjusted for access to gender-affirming</p> <p>15 hormones.</p> <p>16 Q. You don't know as you sit here whether</p> <p>17 you adjusted for --</p> <p>18 A. I just don't want to say on the record</p> <p>19 without double-checking, but do you want to pull</p> <p>20 up the --</p> <p>21 Q. No, I think my question is actually,</p> <p>22 like, as you sit here, you don't know the answer</p> <p>23 to that?</p> <p>24 A. I'm pretty sure, but want to</p> <p>25 double-check.</p> <p style="text-align: right;">Page 217</p> |

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| <p>1 Q. Okay. That's sufficient. 2 Okay. I'd like to go to -- let's stick 3 with this document and go to page 99. And at the 4 top it says "Appendix G Grade Profiles." 5 Do you see that? 6 A. Yes. 7 Q. And the first study in Table 2 here is 8 de Vries 2011 study. 9 And you cite that in your declaration, 10 correct? 11 A. Yes. 12 Q. And in that table, there's a little 13 footnote 2. And then you go down to footnote 2 14 and it says "Downgraded one level -- the cohort 15 study by de Vries, et al. (2011) was assessed as 16 at high risk of bias (poor quality overall, lack 17 of binding, and no control group)." 18 Do you see that? 19 A. Yes. 20 Q. And do you disagree with that assessment? 21 A. No. 22 Q. And then I'd like to go to page 101. 23 Actually, I'm sorry, 102. The following page. 24 And do you see they refer to the Costa 25 2015 study in this table?</p> <p style="text-align: right;">Page 218</p> | <p>1 subjective and there are different ways you can 2 decide to up score or down score each thing. 3 I'd really have to sit down with them and 4 go through it in detail to see how they decided 5 for each of the columns. But it doesn't surprise 6 me that on the GRADE supporting system that 7 prioritizes randomized controlled trials that it 8 would have ended up in a low, very low category 9 according to that term of art of GRADE scoring. 10 Q. (BY MR. RAMER) If you don't use GRADE, 11 what tool are you using to assess the degree of 12 bias in this study? 13 MS. NOWLIN-SOHL: Object to form. 14 THE WITNESS: GRADE is not really just 15 about bias. I think one part of the GRADE 16 criteria is they look at risk of bias. But I 17 generally look at study by study to go into more 18 detail on different types of bias and how they 19 impact the results. 20 Q. (BY MR. RAMER) Do you use a particular 21 methodology to assess the degree of bias in a 22 study? 23 A. Depends on the type of bias that you're 24 looking at. It could be recall bias, selection 25 bias. They're all managed differently.</p> <p style="text-align: right;">Page 220</p> |
| <p>1 A. Yes. 2 Q. And you also cite the Costa 2015 study, 3 right? 4 A. Yes. 5 Q. And if you go to page 106, down at the 6 very bottom there's another little footnote 1. 7 And it says "Downgraded one level -- the cohort 8 study by Costa, et al. (2015) was assessed as at 9 high risk of bias (poor quality overall, lack of 10 binding, and no control group." 11 Do you see that? 12 A. Yes. 13 Q. And do you agree with that assessment? 14 A. I agree with the lack of binding. I 15 don't think it's fully accurate to say there 16 wasn't a control group. 17 Q. Do you agree it's at high risk of bias? 18 A. It depends on how they're defining that 19 term. 20 Q. What if they're defining it in accordance 21 with the GRADE methodology? 22 MS. NOWLIN-SOHL: Object to form. 23 THE WITNESS: The thing about GRADE 24 methodology is there are several categories to go 25 through each one, and then it's somewhat</p> <p style="text-align: right;">Page 219</p> | <p>1 The other thing about the GRADE criteria 2 is that they -- they grade each individual study, 3 but I find it's useful to look at the body of 4 research as a whole because certain studies are 5 going to have weaknesses that other studies 6 complement with their strengths, so it's important 7 to look at the full body of research as a whole 8 where these individual GRADE scores for different 9 individual studies are true because studies are 10 going to have strengths and limitations. But it's 11 useful within the body of literature as a whole. 12 Q. (BY MR. RAMER) And you mention there 13 were different tools to assess different types of 14 bias. 15 What tools do you use? 16 A. Is there a specific type of bias you're 17 interested in? 18 Q. Any of the examples you provided. 19 A. So recall bias, for instance, you would 20 look at the amount of time between when you're 21 asking the person the survey question and when 22 that happened. 23 You would look at the salience of the 24 event. People are more likely to have more 25 intense recall bias if it was a relatively mundane</p> <p style="text-align: right;">Page 221</p> |

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| <p>1 event from the distant past than they are if it 2 were a very notable event from the somewhat recent 3 past. 4 Q. I guess do you use a method to assess 5 bias? Or do you just read the study and reach a 6 conclusion based on your expertise? 7 MS. NOWLIN-SOHL: Object to form. 8 THE WITNESS: It depends on the type of 9 bias. So if it's recall bias, you're looking, for 10 instance, at the number of years between the 11 recall and the event, which is quantitative. 12 And then secondarily you're assessing how 13 salient that event is. 14 Q. (BY MR. RAMER) What about a bias for a 15 confounding variable? How do you assess that when 16 you're reading an individual study? 17 A. Let's say it's a logistic regression 18 model. You would look at whether or not they 19 collected that -- the data point for that 20 potential confounder and built it into their 21 statistical model. If they didn't, then there's a 22 risk of confounding. 23 Q. And so do you agree that the evidence 24 quality for the use of puberty blockers to treat 25 gender dysphoria is very low on the GRADE scale? Page 222</p> | <p>1 "subjective" talking about the GRADE methodology. 2 What were you referring to? 3 A. That when you go through the categories, 4 like, for instance, bias, indirectness, and 5 inconsistency, there's subjectivity in how you 6 apply those criteria on each of those and 7 discretionary decisions that are made based on the 8 general guidance that the GRADE system creates. 9 MR. RAMER: I'd like to turn to Turban 10 Exhibit 18, if you have that, Li. 11 MS. NOWLIN-SOHL: Yes. 12 (Deposition Exhibit No. 18 was marked.) 13 Q. (BY MR. RAMER) Okay. And, Dr. Turban, 14 do you recognize this document? 15 A. Yes. 16 Q. And what is it? 17 A. This is a report from a U.K. agency 18 looking at the research of gender-affirming 19 hormone treatments for adolescent gender 20 dysphoria. 21 Q. And do you understand this to be a 22 systematic review? 23 A. Yes. 24 Q. And is this by the same organization as 25 the one we were just previously looking at? Page 224</p> |
| <p>1 MS. NOWLIN-SOHL: Object to form. 2 THE WITNESS: Again, GRADE scaling is a 3 little difficult because you go through -- and 4 really you're supposed to have a committee where 5 you go through each individual one and it's 6 somewhat subjective because there are many 7 determinations for deciding how to score each 8 category, but I will say the way the GRADE scoring 9 system is set up, it does really prioritize things 10 like randomized controlled trials. 11 So I would expect any group that went 12 through the GRADE scoring would find that it would 13 be in the low, very low categories. 14 Q. (BY MR. RAMER) And you say GRADE scoring 15 was somewhat subjective. 16 Do you think it's more or less subjective 17 than you just reading individual studies? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: I don't understand the 20 question. 21 Q. (BY MR. RAMER) What don't you understand 22 about it? 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: Subjective in what way? 25 Q. (BY MR. RAMER) Well, you used the term Page 223</p> | <p>1 Correct? 2 A. Yes. 3 Q. And is this something you've read before? 4 A. Yes. 5 Q. And did you study it closely? 6 A. At the time. 7 Q. And what did you think when you read it? 8 A. What I recall, it reviewed studies that I 9 generally was already aware of, and I believe 10 similarly had excluded a handful of studies. 11 I think when I was reading it, it was -- 12 it had been published for a while, so I also 13 noticed that there understandably was not 14 inclusion of important studies that were published 15 after it came out. 16 Q. Okay. I'd like to go to page 70. And 17 toward the bottom there's a bold blue header that 18 says "Appendix D Excluded Studies Table." 19 Do you see that? Sorry. I missed you. 20 Did you see that? 21 A. Yes. 22 Q. And then I'd like to go to page 72. And 23 the second study listed there, the de Vries 2014 24 study. That's a study that you cite in your 25 declaration, correct? Page 225</p> |

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| <p>1 A. Correct.</p> <p>2 Q. And then I'd like to go to -- well, and</p> <p>3 you were aware that the publishers of this</p> <p>4 systematic review excluded that study from</p> <p>5 consideration before you cited it in your</p> <p>6 declaration, correct?</p> <p>7 A. It's years ago that I read this, but yes,</p> <p>8 I would have at some point been aware of that.</p> <p>9 Q. And let's go to page 77. And that's</p> <p>10 entitled "Appendix E, Evidence Tables."</p> <p>11 Do you see that?</p> <p>12 A. Yes.</p> <p>13 Q. And there they are discussing the Achille</p> <p>14 article that you cite, correct?</p> <p>15 A. I believe that's how you pronounce it.</p> <p>16 Q. But that's the article that you cite,</p> <p>17 correct?</p> <p>18 A. Yes.</p> <p>19 Q. And then go to page 79. And toward the</p> <p>20 bottom, that's the Allen study that you cite,</p> <p>21 correct?</p> <p>22 A. Correct.</p> <p>23 Q. And then 81. And that's the Kaltiala</p> <p>24 study that you cite, correct?</p> <p>25 A. Yes.</p> <p style="text-align: right;">Page 226</p> | <p>1 Q. Do you agree that it will take longer</p> <p>2 than 5.8 years for some of the effects associated</p> <p>3 with these hormonal interventions to become</p> <p>4 apparent?</p> <p>5 MS. NOWLIN-SOHL: Object to form.</p> <p>6 THE WITNESS: Hard to know. I guess I</p> <p>7 would point out that this isn't uncommon in</p> <p>8 medicine. Any medication that was approved by the</p> <p>9 FDA in the past few years we're not going to have,</p> <p>10 you know, years and years of follow-up data for.</p> <p>11 That's not really unusual in medicine.</p> <p>12 And it would be unusual to ban the</p> <p>13 treatment because we didn't have more than six</p> <p>14 years of treatment. It would make it so you had</p> <p>15 to ban every treatment every time it was approved</p> <p>16 essentially.</p> <p>17 But I can't tell you with 100 percent</p> <p>18 certainty about years past, the data we have.</p> <p>19 Q. (BY MR. RAMER) And going to the next</p> <p>20 paragraph below that, the first sentence, just</p> <p>21 read it, ask if I read it correctly.</p> <p>22 It says "Most studies included in this</p> <p>23 review did not report comorbidities (physical or</p> <p>24 mental health) and no study reported concomitant</p> <p>25 treatments in detail."</p> <p style="text-align: right;">Page 228</p> |
| <p>1 Q. And then two more. Page 97. I'm sorry,</p> <p>2 page 92, I apologize.</p> <p>3 And that is the Cooper study that you</p> <p>4 cite, correct?</p> <p>5 A. Yes.</p> <p>6 Q. And then page 97 and toward the bottom,</p> <p>7 that is the de Lara study that you cite, correct?</p> <p>8 A. Yes.</p> <p>9 Q. I'd like to go back to page 13 of this</p> <p>10 document. And just above the middle of the page</p> <p>11 there is a bold blue header that says</p> <p>12 "Discussion." And then the third paragraph after</p> <p>13 that starts with the words "The included studies."</p> <p>14 And I'd just like to read that, and I'll ask if I</p> <p>15 read it correctly.</p> <p>16 "The included studies have relatively</p> <p>17 short follow-up with an average duration of</p> <p>18 treatment with gender-affirming hormones between</p> <p>19 around one year and 5.8 years. Further studies</p> <p>20 with a longer follow-up are needed to determine</p> <p>21 the long-term effect of gender-affirming hormones</p> <p>22 for children and adolescents with gender</p> <p>23 dysphoria."</p> <p>24 Did I read that correctly?</p> <p>25 A. Yes.</p> <p style="text-align: right;">Page 227</p> | <p>1 Did I read that correctly?</p> <p>2 A. Yeah. I think that's true because this</p> <p>3 was published prior to some of those other studies</p> <p>4 that looked at psychotherapy as a potential</p> <p>5 confounder.</p> <p>6 Q. But for the record, I read that</p> <p>7 correctly?</p> <p>8 A. Yes.</p> <p>9 Q. Okay. And what do you -- well, let me</p> <p>10 read the next sentence, and then I'll -- my first</p> <p>11 question will be did I read it correctly.</p> <p>12 "Because of this, it is not clear whether</p> <p>13 any changes seen were due to gender-affirming</p> <p>14 hormones or other treatments the participants may</p> <p>15 have received."</p> <p>16 And did I read that correctly?</p> <p>17 A. Yes.</p> <p>18 Q. And is this paragraph describing a</p> <p>19 confounding variable like we discussed earlier?</p> <p>20 MS. NOWLIN-SOHL: Object to form.</p> <p>21 THE WITNESS: Yes.</p> <p>22 Q. (BY MR. RAMER) And the, quote, other</p> <p>23 treatments in that last sentence could include</p> <p>24 psychotherapy, correct?</p> <p>25 A. Theoretically, yes. I can't be sure what</p> <p style="text-align: right;">Page 229</p> |

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| <p>1 they meant, but...</p> <p>2 Q. Well, when you read this, what did you</p> <p>3 understand it to mean?</p> <p>4 A. That was my best guess, but they didn't</p> <p>5 say.</p> <p>6 Q. Could it also include psychiatric</p> <p>7 medication?</p> <p>8 A. Potentially.</p> <p>9 MR. RAMER: I'd like to now go to Turban</p> <p>10 Exhibit 19. And do you have that, Li?</p> <p>11 MS. NOWLIN-SOHL: We do.</p> <p>12 MR. RAMER: Great.</p> <p>13 (Deposition Exhibit No. 19 was marked.)</p> <p>14 Q. (BY MR. RAMER) And, Dr. Turban, have you</p> <p>15 seen this document before?</p> <p>16 A. I think yes. It's a review article that</p> <p>17 was published in, I think, a Swedish medical</p> <p>18 journal.</p> <p>19 Q. And have you read this?</p> <p>20 A. I did read it. It has, if I remember</p> <p>21 correctly, a lot of hyperlinks to very long</p> <p>22 appendices that I have not fully read in detail.</p> <p>23 Q. I'd like to go to page 2280, which is the</p> <p>24 second page of the article. And right column</p> <p>25 under Section 2.1, I'll read the first sentence.</p> <p style="text-align: right;">Page 230</p> | <p>1 insufficient?</p> <p>2 MS. NOWLIN-SOHL: Object to form.</p> <p>3 THE WITNESS: I would need a precise</p> <p>4 definition of what they mean by "insufficient."</p> <p>5 Q. (BY MR. RAMER) When you read this, did</p> <p>6 you try to figure out what they meant by</p> <p>7 "insufficient"?</p> <p>8 A. Probably at the time. I don't recall</p> <p>9 what their definition was.</p> <p>10 Q. And so you said the article included a</p> <p>11 lot of hyperlinks to very long appendices; is that</p> <p>12 right?</p> <p>13 A. Yes.</p> <p>14 Q. And did you ever try to analyze those?</p> <p>15 A. I started to, but didn't have time. But</p> <p>16 as I mentioned earlier, a lot of what happens with</p> <p>17 the systematic review is there are subjective</p> <p>18 choices made in how you define your search</p> <p>19 terminology, how you decide to exclude and</p> <p>20 include.</p> <p>21 So my intention was to go through and</p> <p>22 better understand their full methodology, but</p> <p>23 ultimately I did not have time.</p> <p>24 Q. Okay. I'd like to go to -- maybe we're</p> <p>25 still on 2280. And in the right column there is a</p> <p style="text-align: right;">Page 232</p> |
| <p>1 It says "This systematic review</p> <p>2 originated from a two-year commissioned work from</p> <p>3 the governmental body of the Swedish agency for</p> <p>4 health, technology, assessment, and assessment of</p> <p>5 social services (SBU)."</p> <p>6 Did I read that correctly?</p> <p>7 A. Yes.</p> <p>8 Q. And do you understand this article to be</p> <p>9 a systematic review commissioned by the Swedish</p> <p>10 government?</p> <p>11 A. I believe so, yes.</p> <p>12 Q. So same page in the very top in the fully</p> <p>13 gray box, there is a conclusion. And I'll read it</p> <p>14 and ask if I read it correctly.</p> <p>15 It says "Evidence to assess the effects</p> <p>16 of hormone treatment on the above fields in</p> <p>17 children with gender dysphoria is insufficient.</p> <p>18 To improve future research, we present the GENDHOR</p> <p>19 checklist, a checklist for studies in gender</p> <p>20 dysphoria."</p> <p>21 Did I read that correctly?</p> <p>22 A. Yes.</p> <p>23 Q. Do you disagree with the conclusion that</p> <p>24 evidence to assess the effects of hormone</p> <p>25 treatment on children with gender dysphoria is</p> <p style="text-align: right;">Page 231</p> | <p>1 box with key notes and then some bullets below it.</p> <p>2 And the last bullet says "GnRHa treatment</p> <p>3 in children with gender dysphoria should be</p> <p>4 considered experimental treatment of individual</p> <p>5 cases rather than standard procedure."</p> <p>6 Did I read that correctly?</p> <p>7 A. Yes.</p> <p>8 Q. And do you disagree with that conclusion?</p> <p>9 MS. NOWLIN-SOHL: Object to form.</p> <p>10 THE WITNESS: Again, the terminology they</p> <p>11 use doesn't have clear definitions, from my</p> <p>12 perspective, by calling it an experimental</p> <p>13 treatment.</p> <p>14 I think that we always in medicine are</p> <p>15 considering treatments on a case-by-case basis,</p> <p>16 and for the individual patient we're weighing</p> <p>17 risks, benefits, and unknowns, including for</p> <p>18 puberty blockers.</p> <p>19 So it's in line with my clinical practice</p> <p>20 and I think most people's clinical practices that</p> <p>21 treatment is individualized, and we take things</p> <p>22 into account for the individual patient.</p> <p>23 I'm not sure what they would mean by</p> <p>24 "standard procedure."</p> <p>25 Q. (BY MR. RAMER) I'd like to go to 2281 to</p> <p style="text-align: right;">Page 233</p> |

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| <p>1 the next page, right column, 3.1. And the final 2 sentence of that paragraph in 3.1 says "A list of 3 excluded studies is provided at the SBU web page," 4 and then includes a hyperlink. 5 Do you see that? 6 A. Yes. 7 Q. All right. 8 MR. RAMER: I'd like to now introduce 9 Turban Exhibit 20 if you have that, Li. 10 MS. NOWLIN-SOHL: Yes. 11 (Deposition Exhibit No. 20 was marked.) 12 Q. (BY MR. RAMER) And, Dr. Turban, I will 13 represent to you that this document is located at 14 the hyperlink that we just read. 15 And is this one of the long appendices 16 you were referring to? 17 A. It looks a lot nicer than the one I 18 remember. I wonder if they fixed some of the 19 formatting in translation. 20 Q. It could be. 21 A. But no, that's fine. It's not very long. 22 Q. And the -- let's see here. 23 Okay. Can you see in the light blue -- I 24 won't ask you to read Swedish -- but after the 25 backslash, it says "Appendix 2 studies excluded</p> <p style="text-align: right;">Page 234</p> | <p>1 Do we want to take a break here? 2 MS. NOWLIN-SOHL: Yeah. 3 THE VIDEOGRAPHER: Okay. So the time is 4 3:20 p.m. Pacific time, and we are off the record. 5 (Break taken from 3:20 p.m. to 3:27 p.m.) 6 THE VIDEOGRAPHER: All right. So we are 7 recording. The time is 3:27 p.m. Pacific time, 8 and we are back on the record. 9 MR. RAMER: Okay. Dr. Turban, I'd like 10 to introduce Turban Exhibit 21 if that has 11 arrived. 12 MS. NOWLIN-SOHL: It has not. 13 MR. RAMER: Then we'll hold that as 14 Turban Exhibit 21 just to keep the numbering 15 clear, and I'll introduce Turban Exhibit 22. 16 MS. NOWLIN-SOHL: Okay. We have that up. 17 MR. RAMER: Okay. Great. 18 (Deposition Exhibit No. 22 was marked.) 19 Q. (BY MR. RAMER) And, Dr. Turban, have you 20 seen this document before? 21 A. Yes. 22 Q. I'm sorry? 23 A. Yes. 24 Q. And did you read it? 25 A. Yes.</p> <p style="text-align: right;">Page 236</p> |
| <p>1 due to high risk of bias." 2 A. Yes. 3 Q. And do you cite -- let me rephrase. 4 The first study listed is the Achille 5 study you cite, correct? 6 A. Yes. 7 Q. And the second study listed is the Allen 8 study you cite, correct? 9 A. Yes. 10 Q. And the third study listed is one of the 11 de Vries studies that you cite, correct? 12 A. Yes. 13 Q. And at the bottom of this page is the de 14 Lara study that you cite, correct? 15 A. Yes. 16 Q. Dr. Turban, are you aware of any 17 systematic reviews that have been able to draw 18 conclusions about the effects of gender-affirming 19 hormone therapy on suicide? 20 A. Like death from suicide? 21 Q. Yes. 22 A. No. 23 MR. RAMER: I think this is a good 24 breaking point. I also think I've been going for 25 about an hour.</p> <p style="text-align: right;">Page 235</p> | <p>1 Q. And when was the last time you read it? 2 A. I read this one recently, a few days ago 3 when I was writing my statement. 4 Q. And I'd like to go to page 3. And 5 under -- there's a blue header that says "Caution 6 in the use of hormonal and surgical treatment." 7 And I'll just read the first sentence and ask if I 8 read it correctly. 9 It says "At group level (i.e., for the 10 group of adolescents with gender dysphoria as a 11 whole) the National Board of Health and Welfare 12 currently assesses that the risk of puberty 13 blockers and gender-affirming treatment are likely 14 to outweigh the expected benefits of these 15 treatments." 16 Did I read that correctly? 17 A. Yes. 18 Q. And a little further down on this page, 19 the second full paragraph -- I guess, sorry. Let 20 me ask first, do you agree that the risks of 21 puberty blockers and gender-affirming treatment 22 are likely to outweigh the expected benefits of 23 those treatments? 24 MS. NOWLIN-SOHL: Object to form. 25 THE WITNESS: They have a strange clause</p> <p style="text-align: right;">Page 237</p> |

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| <p>1 of "at a group level (i.e., for the group 2 adolescents with gender dysphoria)" as a whole. 3 They say risks likely outweigh the benefits. 4 This document later goes on to note that 5 you should consider these interventions on a 6 case-by-case basis for the individual patient, 7 which, in my view, is very similar to WPATH 8 guidelines and how we practice. So we conduct 9 these biopsychosocial evaluations to determine if, 10 for an individual person, the potential benefits 11 outweigh the potential risks. 12 So I would say that sentence, I agree. 13 Q. (BY MR. RAMER) You think that the policy 14 set forth by this document is consistent with the 15 WPATH guidelines? 16 MS. NOWLIN-SOHL: Object to the form; 17 mischaracterizes prior testimony. 18 THE WITNESS: I think in that it 19 recommends being very thoughtful about who 20 receives gender-affirming medical interventions 21 but still considering them. I think that's a 22 theme of both. 23 Q. (BY MR. RAMER) If Sweden's policy were 24 implemented in the United States, would treatment 25 change at all?</p> <p style="text-align: right;">Page 238</p> | <p>1 some other questions we can ask, but you think 2 that that first sentence is consistent with the 3 practice in the United States currently? 4 MS. NOWLIN-SOHL: Object to form. Object 5 to prior mischaracterization of testimony. 6 Q. (BY MR. RAMER) And if that sentence is 7 just not relevant, that's fine, but just following 8 up on your answer. 9 A. I think I answered the question that it's 10 similar between what's written here and what's 11 practiced in the U.S., that we don't, without a 12 thoughtful biopsychosocial evaluation, routinely 13 provide gender-affirming medical interventions 14 without carefully weighing the potential risks 15 against potential benefits for individuals. 16 Q. On the same page a little further down, 17 second paragraph, there's a sentence that begins 18 with "In revising its recommendations." I just 19 want to read it and first ask if I read it 20 correctly. 21 "In revising its recommendations, the 22 National Board of Health and Welfare has taken 23 account of the fact that the efficacy and safety, 24 benefits, and risks of treatments are not proven, 25 and that three factors have shifted the balance</p> <p style="text-align: right;">Page 240</p> |
| <p>1 MS. NOWLIN-SOHL: Object to form. 2 THE WITNESS: You'll have to give me a 3 minute to read it in detail again for any 4 potential -- 5 Q. (BY MR. RAMER) Sorry. To read what in 6 detail? That sentence? 7 A. This document of the guidelines. You 8 wanted me to tell you if the guidelines are 9 essentially identical to what's practiced in the 10 U.S. 11 Q. Well, the question I originally asked was 12 about the first sentence. Do you agree that the 13 risks of puberty blockers and gender-affirming 14 treatment are likely to outweigh the expected 15 benefits of these treatments? 16 And I thought your answer was, well, 17 they're talking about the group level. They have 18 this strange clause about the group level. And we 19 don't practice medicine any different here in the 20 United States because we go on an individualized 21 basis. 22 And so I guess you were extrapolating 23 from the first sentence to the practice of care 24 here, and that's why I asked the question. So I 25 frankly do not want to take -- you know, I have</p> <p style="text-align: right;">Page 239</p> | <p>1 between benefit and risk in a negative direction." 2 Did I read that correctly? 3 A. Yes. 4 Q. And the first bullet they list is -- 5 refers to "the uncertainty resulting from the lack 6 of clarity about the causes that the number of 7 people diagnosed with gender dysphoria has 8 continued to rise since the publication of the 9 guidelines in 2015, particularly in the 13 to 17 10 age group, and especially among people whose 11 registered sex at birth is female." 12 Do you see that? 13 A. Yes. 14 Q. And do you agree there's uncertainty 15 resulting from the lack of clarity about the cause 16 for the increase of gender dysphoria among 17 adolescents whose registered sex at birth is 18 female? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: I believe I wrote this in 21 my declaration, but most experts think that the 22 reason for the increase in referrals to gender 23 clinics is due to increased public knowledge that 24 these interventions exist. 25 I believe I cited a paper from the Dutch</p> <p style="text-align: right;">Page 241</p> |

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| <p>1 group that noted that the number of referrals that 2 they received increased, but the percentage of 3 individuals who presented to the clinic and 4 actually received gender-affirming medical 5 interventions was low, highlighting that despite 6 the increase of referrals, there's still a 7 stringent process and evaluation on an individual 8 basis, as I noted, for who actually receives 9 gender-affirming medical interventions. 10 The question of the sex ratio, I believe 11 I discussed also. When we look at large data sets 12 in the United States of community samples, it's 13 actually quite close to one to one among trans 14 youth, how many are sex assigned at birth, male 15 versus female. 16 So there's a lot of research on this 17 question. 18 Q. (BY MR. RAMER) And so you disagree that 19 there's a lack of clarity about that? 20 MS. NOWLIN-SOHL: Object to form. 21 THE WITNESS: I think there's more known 22 than is explained here. 23 Q. (BY MR. RAMER) In the second -- flipping 24 to the next page, the second bullet states "The 25 documented prevalence among young adults of</p> <p style="text-align: right;">Page 242</p> | <p>1 The Brick, et al. study, I'm not sure if 2 I referenced that one or not, that one found of 3 those who started pubertal suppression, a few of 4 them did not go on to gender-affirming hormones 5 for various reasons. Some of them still 6 identified as transgender; some did not. 7 There's also the Wiepjes study where 8 1.9 percent of adolescents who started pubertal 9 suppression did not go on to gender-affirming 10 hormones. 11 So again there is more data known than is 12 provided in this bullet point, and I think the 13 bullet point is confusing and that it contradicts 14 itself. I don't know if it's a translation issue. 15 Q. Well, with respect to the contradiction, 16 you agree there is a distinction between knowing 17 the number of individuals who would detransition 18 and knowing how common it would be for people to 19 later detransition, correct? 20 A. Would you repeat the question? 21 Q. Is there a distinction between a number 22 and a probability is basically the question? 23 A. The probability is a number. Sorry. I'm 24 not understanding. 25 Q. I guess you're saying the first sentence</p> <p style="text-align: right;">Page 244</p> |
| <p>1 medical detransition, which is the process by 2 which a person discontinues gender-affirming 3 medical treatment for any reason or seeks to 4 reverse the medical effects of completed 5 gender-affirming treatment, according to the SBU, 6 it is not possible to assess how common it is for 7 young people to later change their perception of 8 their gender identity or to discontinue a 9 gender-affirming treatment." 10 Did I read that correctly? 11 A. You read it correctly. 12 Q. Do you agree that it is not possible to 13 assess how common it is for young people to later 14 change their perception of their gender identity? 15 A. I think this bullet point is somewhat 16 contradictory because it first says that there is 17 a documented prevalence of detransition, 18 suggesting that we do know the number, and then it 19 goes on to say that it's not possible to know the 20 number. 21 There are some studies that have looked 22 at that question. The de Vries study followed 55 23 adolescents through pubertal suppression, 24 gender-affirming hormones into young adulthood. 25 None of their gender identities changed.</p> <p style="text-align: right;">Page 243</p> | <p>1 of the bullet point is contradictory because the 2 first sentence says "The documented prevalence 3 among young adults," so it's admitting it knows 4 that these people exist. 5 And then the second sentence says "It is 6 not possible to assess how common it is." 7 And I thought your answer was that's 8 contradictory. 9 And I guess my question is is it really 10 contradictory if you know that a certain number of 11 people experience something but you also don't 12 know how common it will be for others to have that 13 same experience? 14 A. The word "prevalence" means how common 15 something is, not just that it exists. 16 Q. And so you think "prevalence" does mean 17 how common something is? 18 A. In medicine, that's what "prevalence" 19 means. 20 Q. And with respect to -- with respect to 21 determining how common it is for young people to 22 later change their perception of their gender 23 identity, is it your testimony that we do have 24 good evidence of how common it would be? 25 MS. NOWLIN-SOHL: Object to form.</p> <p style="text-align: right;">Page 245</p> |

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| <p>1 THE WITNESS: We have the studies I just 2 described. 3 Q. (BY MR. RAMER) And you think those 4 constitute good evidence for determining how 5 common it is for young people to later change 6 their perception of their gender identity? 7 MS. NOWLIN-SOHL: Object to form. 8 THE WITNESS: As a scientist, I don't 9 like words like this that don't have precise 10 meaning, but it is evidence to that question. 11 Q. (BY MR. RAMER) Do you agree that some 12 individuals regret receiving gender-affirming 13 medical interventions? 14 A. Yes. 15 Q. Is it possible to predict beforehand 16 which individuals will come to regret those 17 interventions? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: The goal of the 20 biopsychosocial evaluation is to understand the 21 person's biological factors, psychological 22 factors, social environment as much as is 23 possible. And it's all designed to minimize that 24 risk, but it's not certain, as with most things in 25 medicine, to determine with 100 percent certainty.</p> <p style="text-align: right;">Page 246</p> | <p>1 conducting a biopsychosocial evaluation prior to 2 proceeding with treatment. 3 And the second is that treatment is 4 offered in a step-wise fashion from most 5 reversible to least reversible. So you would 6 start with pubertal suppression prior to 7 considering gender-affirming hormones, which are 8 less reversible. And then the last resort would 9 be surgery. 10 Q. Does the criteria of the Dutch protocol 11 require incongruence since childhood? 12 A. I think they've evolved in their practice 13 over time. Certainly initially they focused 14 specifically on prepubertal diagnoses of gender 15 dysphoria, or at least documented history of that, 16 but I've not checked in with them recently to know 17 if that's still a search criterion or not. 18 Q. I'll read the second sentence here and 19 ask if I read it correctly. 20 It says "The criteria include the 21 existence of the incongruence since childhood, the 22 stability of gender identity over time, clear 23 distress caused by the onset of puberty, and the 24 absence of factors that complicate the diagnostic 25 assessment."</p> <p style="text-align: right;">Page 248</p> |
| <p>1 Q. (BY MR. RAMER) And then staying on this 2 page, I'd like to go down. There is a section 3 entitled "Decisions on Treatment in an Individual 4 Case." 5 Do you see that? 6 A. Yes. 7 Q. And I'm going to read the first sentence 8 and ask if I read it correctly. 9 It says "To guide the decision on 10 puberty-suppressing treatment for an adolescent in 11 Tanner Stage 3 and for gender-affirming hormone 12 therapy, the National Board of Health and Welfare 13 recommends the criteria whose use has been 14 documented and monitored within the framework of 15 the Dutch protocol." 16 Did I read that correctly? 17 A. Yes. 18 Q. And can you describe the criteria that 19 has been used for the Dutch protocol? 20 A. The WPATH guidelines are modeled off of 21 the Dutch protocol. They were the first to 22 publish in the academic literature their approach 23 to these gender-affirming medical interventions 24 for adolescents with gender dysphoria. 25 I'd say the biggest themes are, one,</p> <p style="text-align: right;">Page 247</p> | <p>1 Did I read that correctly? 2 A. Yes. 3 Q. And so the Swedish government seems to 4 think the criteria for the Dutch protocol does 5 include the incongruence since childhood, correct? 6 MS. NOWLIN-SOHL: Object to form. 7 THE WITNESS: That's what that sentence 8 is implying. Again, I've not checked with the 9 Dutch to know if they still have that element in 10 place. 11 Q. (BY MR. RAMER) If -- is that 12 requirement -- are the current WPATH guidelines 13 consistent with that requirement? 14 A. They are certainly influenced by that 15 requirement, but they say if there's not a clear 16 history of gender incongruence during childhood, 17 then you should extend the biopsychosocial 18 assessment process. 19 Q. But a patient would be eligible for 20 treatment under the WPATH guidelines even if that 21 patient did not have gender incongruence during 22 childhood, correct? 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: They would need to go 25 through a longer diagnostic assessment process,</p> <p style="text-align: right;">Page 249</p> |

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| <p>1 but it wouldn't be considered an absolute 2 contraindication, if you will, but something that 3 would kind of raise a flag for the medical team to 4 proceed with more caution. 5 Q. (BY MR. RAMER) Did the Dutch protocol 6 assess individuals who had a nonbinary gender 7 identity? 8 MS. NOWLIN-SOHL: Object to form. 9 THE WITNESS: Historically most of their 10 patients, I believe, had expressed a binary 11 understanding of their gender identity. I would 12 be surprised if they haven't also treated patients 13 with nonbinary identities, but I can't say for 14 sure. 15 Q. (BY MR. RAMER) Well, I guess the studies 16 that you cite out of the Dutch clinic -- well, no, 17 let's do it this way. 18 Same page, paragraph below the one we 19 were just looking at, first sentence says "The 20 documented experience with the Dutch protocol 21 includes only adolescents with binary gender 22 identity. And among participating experts, there 23 is a lack of clinical experience with 24 puberty-suppressing and gender-affirming hormone 25 therapy with adolescents with nonbinary gender Page 250</p> | <p>1 MS. NOWLIN-SOHL: Object to form; 2 foundation. 3 THE WITNESS: I don't know what you mean 4 by "less available." 5 Q. (BY MR. RAMER) Do you treat patients 6 whose gender identity -- excuse me. 7 Do you treat patients whose gender 8 incongruence arose during adolescence as opposed 9 to during childhood? 10 A. All of my patients I can think of had 11 some degree of gender incongruence during 12 childhood, but it's not considered an absolute 13 contraindication. 14 Again, as the WPATH guidelines note, if 15 you had a patient, they would have to meet 16 criteria for gender dysphoria, so they would need 17 to have a gender identity different than their sex 18 assigned at birth for at least six months. And 19 then you would need to extend the diagnostic 20 process to better understand the situation. 21 Q. So your clinical population -- let me 22 rephrase. 23 Your practice would not change if there 24 was a requirement imposed that patients needed to 25 have a history of gender incongruence in Page 252</p> |
| <p>1 identity." 2 Did I read that correctly? 3 A. Yes. 4 Q. And so are they wrong where they state 5 the Dutch protocol includes only adolescents with 6 binary gender identity? 7 MS. NOWLIN-SOHL: Object to form and 8 foundation. 9 THE WITNESS: Again, in the past I think 10 the vast majority of their patients had binary 11 gender identities. I'm not sure if they still 12 have that requirement in the Dutch clinic. 13 Q. (BY MR. RAMER) Did the individuals in 14 the de Vries 2011 or de Vries 2014 studies have a 15 nonbinary gender identity? 16 A. I believe in the 2014 study they all had 17 binary gender identities. 18 To the 2011 study, I'd have to go back 19 and look at the details of the methodology. 20 Q. If there was a requirement in the United 21 States that an adolescent could not obtain 22 gender-affirming medical interventions unless the 23 adolescent had a history of gender incongruence 24 since childhood, would gender-affirming medical 25 interventions be less available? Page 251</p> | <p>1 childhood; is that right? 2 MS. NOWLIN-SOHL: Object to form; 3 mischaracterizes prior testimony. 4 THE WITNESS: Some of my current patients 5 that I can think of, they all had some amount of 6 gender incongruence during childhood. But I can't 7 speak as to what patients I would have in the 8 future and if all of them would. 9 I think the WPATH guidelines, in 10 acknowledging that there are some patients who 11 come to understand their gender identity later, in 12 that they explain that you need to extend the 13 diagnostic process, highlights that patients like 14 that do exist. 15 The Journal of Adolescent Health paper we 16 talked about recently also shows there's a sizable 17 portion of patients like that. 18 So I think it would be limiting care for 19 those such patients who might need treatment. 20 Q. (BY MR. RAMER) Are puberty blockers 21 available as a treatment for gender dysphoria in 22 the U.K.? 23 A. My understanding is yes. My reading of 24 the Cass Interim Report is that the plan was to 25 close their centralized clinic and open regional Page 253</p> |

1 clinics around the country. I don't know what
 2 their progress has been in doing that.
 3 Q. So you think that minors with gender
 4 dysphoria can receive puberty blockers at those
 5 regional clinics in the U.K.?
 6 A. My understanding is that that their plan,
 7 to set up regional clinics so that patients could
 8 access care, and that care could include pubertal
 9 suppression.
 10 Q. So you do not think that access to
 11 pubertal suppression in the U.K. is limited to
 12 research trials?
 13 MS. NOWLIN-SOHL: Object to form;
 14 mischaracterizes prior testimony.
 15 THE WITNESS: I believe what they said is
 16 that the regional centers should have ongoing data
 17 collection. So if you would call that the
 18 clinical trial, then sure.
 19 Q. (BY MR. RAMER) Ongoing data collection
 20 on the administration of puberty blockers to treat
 21 gender dysphoria?
 22 A. I believe it said that the regional
 23 clinic should have ongoing data collection, yes.
 24 Q. And so the regional clinics, your
 25 understanding is that they are permitted to

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1 provide puberty blockers to adolescents with
 2 gender dysphoria; is that correct?
 3 MS. NOWLIN-SOHL: Object to form. Object
 4 to the extent that it calls for a legal
 5 conclusion.
 6 THE WITNESS: I'm not certain if it's
 7 physically in that center, but the report makes it
 8 clear that pubertal suppression is still an option
 9 for individual patients, and that the general
 10 gender dysphoria care is being moved from that
 11 centralized clinic to regional clinics.
 12 MR. RAMER: I'd like to look at -- did
 13 the Turban Exhibit 21 come through, Li?
 14 MS. NOWLIN-SOHL: Yes.
 15 MR. RAMER: Okay. I'd like to pull up
 16 Turban Exhibit 21, which has the title "Effects of
 17 Gender-Affirming Therapies and People With Gender
 18 Dysphoria: Evaluation of the Best Available
 19 Evidence."
 20 (Deposition Exhibit No. 21 was marked.)
 21 Q. (BY MR. RAMER) And Dr. Turban, have you
 22 seen this document before?
 23 A. I have not.
 24 Q. And were you aware that the Florida
 25 Agency For Healthcare Administration imposed

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1 policies that restricted access to
 2 gender-affirming medical interventions?
 3 A. I read it in the news.
 4 Q. And did you ever try to research the
 5 evidentiary basis for that decision?
 6 MS. NOWLIN-SOHL: Object to form.
 7 THE WITNESS: I know they commissioned a
 8 report that was criticized by others, but I
 9 personally did not go through it.
 10 Q. (BY MR. RAMER) Okay. That's all I have
 11 on that one.
 12 And, Dr. Turban, do you consider yourself
 13 to be an expert?
 14 MS. NOWLIN-SOHL: Object to form.
 15 THE WITNESS: Are you still there?
 16 Q. (BY MR. RAMER) I didn't hear you. I'm
 17 sorry.
 18 My question was do you consider yourself
 19 to be an expert?
 20 MS. NOWLIN-SOHL: Same objection.
 21 THE WITNESS: Do you mean in something
 22 specific?
 23 Q. (BY MR. RAMER) In anything.
 24 A. I would say I'm an expert in the research
 25 regarding the mental health treatment of

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1 adolescents and children with gender dysphoria.
 2 Q. And are you an endocrinologist?
 3 A. No.
 4 Q. Are you a surgeon?
 5 A. No.
 6 Q. Are you a social worker?
 7 A. No.
 8 Q. Are you a urologist?
 9 A. No.
 10 Q. Are you a gynecologist?
 11 A. I'm not.
 12 Q. Are you a bioethicist?
 13 A. I've given bioethics grand rounds at Yale
 14 and spoken on ethics issues, but it's not my
 15 primary area of focus.
 16 Q. Are you a neurologist?
 17 A. No.
 18 Q. And could you just briefly describe what
 19 your current position is?
 20 A. I'm an assistant professor of child and
 21 adolescent psychiatry at the University of
 22 California San Francisco and affiliate faculty as
 23 the chief for health policy studies there.
 24 I direct our gender psychiatry program in
 25 the area of child and adolescent psychiatry.

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| <p>1 And I serve as an attending in the eating 2 disorder clinic and the adult LGBT psychiatry 3 program as well, in addition to my research work. 4 Q. And if that were not enough, are you also 5 going to be attending law school soon? 6 A. I'm enrolled in a master's of legal 7 studies program. 8 Q. And where is that? 9 A. UC Law San Francisco. There's an 10 affiliation with UCSF. 11 MR. RAMER: And, Li, did Turban 12 Exhibit 23 come through? 13 MS. NOWLIN-SOHL: It did. 14 (Deposition Exhibit No. 23 was marked.) 15 Q. (BY MR. RAMER) And Dr. Turban, do you 16 recognize this document? 17 A. Yes. 18 Q. And what is it? 19 A. This is, like, a popular press article I 20 wrote for a Psychology Today blog. 21 Q. And this was initially published in 22 January of 2022, correct? 23 A. I do not recall the date. 24 Q. On the first page below the title and the 25 subheader, do you see it says "Posted January 24, Page 258</p> | <p>1 Q. Sure. 2 A. I think that's reference to my 3 declaration also, that often with gender-affirming 4 interventions, we see improvements of mental 5 health but not a complete elimination of mental 6 health challenges because although these 7 treatments improve mental health, these people are 8 still experiencing minority stress and societal 9 stigmas that can drive anxiety, depression, et 10 cetera. 11 So if you want to have a study where 12 you're looking at whether or not the intervention 13 improves, you need to either look at whether or 14 not the person improved before and after or 15 whether those who received treatment do better 16 than those who don't. 17 We've come to expect that you can't use 18 the general population as the control group 19 because though the treatments may improve physical 20 gender dysphoria, we don't expect them to improve 21 bullying, discrimination, et cetera. 22 Q. So going to the next page for study 7, 23 the final sentence there says "However, because 24 subjects received psychotherapy, the authors note 25 that the study did not provide direct evidence Page 260</p> |
| <p>1 2022"? 2 A. Yes. 3 Q. And then there's a list of key points. 4 And then a little further down there's a note that 5 says "This post was updated on October 11, 2022. 6 In discussions of studies 5, 7, 8, and 10, the 7 final sentence was appended to include further 8 information about the study." 9 Do you see that? 10 A. Yes. 11 Q. And I'd like to go down and just look at 12 those. 13 So study No. 5, which I think is the 14 fourth page in the PDF, and that is the Kaltiala 15 study, correct? 16 A. Yes. 17 Q. And the last sentence says "However, the 18 authors note that gender reassignment is not 19 enough to improve functioning and relieve 20 psychiatric comorbidities among adolescents with 21 gender dysphoria," correct? 22 A. Yes. 23 Q. And then going to study 7, which is on 24 the next page -- 25 A. To clarify -- Page 259</p> | <p>1 that pubertal suppression improves mental health 2 in transgender youth." 3 Did I read that correctly? 4 A. Yes. And again, this is why I wouldn't 5 take any one study in isolation since they all 6 have strengths and weaknesses. This was not one 7 of the studies that adjusted for psychotherapy. I 8 think we mentioned earlier some of the ones that 9 did. 10 Q. And so next page, study 10, I believe 11 this is your own study. And the final sentence 12 says "Of note, this study did not identify 13 psychotherapy as a potentially confounding 14 variable." 15 Did I read that correctly? 16 A. Yes. 17 Q. Was this the one you were struggling to 18 remember earlier? 19 A. No. The question was whether or not it 20 adjusted for access to gender-affirming hormones. 21 Q. Which -- the question in the study or the 22 question I had earlier? 23 A. The question I could not recall for sure 24 is whether or not it adjusted for gender-affirming 25 hormones, not psychotherapy. Page 261</p> |

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| <p>1 Q. Okay. And then just going back to 2 study 8 on the previous page, the last sentence 3 there is "Over the course of the study, there was 4 a statistically significant decrease in depression 5 scores in one group, male to female transitioners 6 who underwent pubertal suppression only." 7 Did I read that correctly? 8 A. Yes. I generally wouldn't use the word 9 "transitioners." I think these editors -- some of 10 these edits were from -- not me but from 11 Psychology Today. 12 And the thing about this study is they 13 found that overall there was mental health 14 improvement, the full group. And then I think 15 when they went and made their subgroups that 16 sample size got smaller and smaller and smaller so 17 they became underpowered to detect most 18 statistically significant differences. 19 Q. When you say the editors were changing 20 things in the document, was there anything else 21 that you can think of that the editors changed 22 without your approval? 23 A. I think several things. The story here 24 was that there was someone at the Manhattan 25 Institute who's been very focused on this blog</p> <p style="text-align: right;">Page 262</p> | <p>1 So they couldn't say one way or another 2 for those specific subgroups. 3 So it doesn't mean that the treatment 4 worked. It doesn't mean that the treatment 5 doesn't work. It just means that their sample 6 size got very small and they weren't able to tell 7 you one way or another. 8 Q. (BY MR. RAMER) And going back to the 9 first page of this, the second paragraph, the 10 first sentence, you say -- well, maybe you, maybe 11 the editors. I guess I'll ask you that. 12 The sentence says "Since several U.S. 13 states are introducing legislation to outlaw 14 gender-affirming medical care this year (despite 15 opposition from just about every major medical 16 organization, including the American Medical 17 Association, the American Academy of Pediatrics, 18 and the American Psychiatric Association), I 19 thought this was a good time to review the 20 relevant research for you all." 21 Did I read that correctly? 22 A. Yes. 23 Q. Did you write that sentence? 24 A. I believe so. 25 Q. And why did the introduction of</p> <p style="text-align: right;">Page 264</p> |
| <p>1 post and I think sent a long series of emails to 2 Psychology Today wanting them to add information. 3 And as it's a blog post, they didn't feel 4 it was essential to devote a lot of time going 5 back and forth to them, so I left Psychology Today 6 to do whatever edits they needed to do. And when 7 I read them, they were generally reasonable. 8 Q. Okay. So for study 8 -- well, just to 9 clarify, the individual at the Manhattan 10 Institute, are you referring to Leor Sapir? 11 A. Yes. 12 Q. And for study 8, just to unpack what's 13 going on there, so there was -- am I correct in 14 reading this to conclude that there was no 15 statistically significant -- start again -- no 16 statistically significant decrease in depression 17 scores for any female to male transitioners in 18 that study; is that right? 19 MS. NOWLIN-SOHL: Object to form. 20 THE WITNESS: So again, it's this issue 21 that you shouldn't -- you can't interpret a lack 22 of statistically significant findings to mean that 23 there's not an effect, because when you start 24 looking at smaller and smaller subgroups and parse 25 out your data, you lose statistical power.</p> <p style="text-align: right;">Page 263</p> | <p>1 legislation lead you to think it was a good time 2 to review the relevant research for the readers of 3 this blog? 4 A. Because legislators in several states 5 were making false statements that there was not 6 evidence regarding the benefits of this care, and 7 that I thought it was important for constituents 8 to know when statements by lawmakers are untrue. 9 Q. Is it fair to say that the -- I'm going 10 to put it this way: In the cases where you have 11 testified as an expert, is it fair to say that the 12 laws at issue in those cases were enacted by 13 Republican lawmakers? 14 MS. NOWLIN-SOHL: Object to form; 15 foundation. 16 THE WITNESS: I believe that's true. 17 MR. RAMER: And to go back to -- I think 18 I finally have the correction, so I will send 19 that. 20 Q. (BY MR. RAMER) Okay. So I will 21 represent to you that what I am sending is the 22 correction to the Plos One article entitled 23 "Access to Gender-Affirming Hormones During 24 Adolescence and Mental Health Outcomes Among 25 Transgender Adults."</p> <p style="text-align: right;">Page 265</p> |

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| <p>1 And once you receive it, I'll just ask 2 that we kind of pick up where we left off with the 3 prior version, which is Table 2. 4 MS. NOWLIN-SOHL: So, John, are you 5 saying we should open up the prior exhibit as well 6 as the correction? 7 MR. RAMER: Oh, no. I was just trying to 8 explain that we'll use the correction, Turban 9 Exhibit 24. And just go to Table 2, which was the 10 table I was previously asking questions about, and 11 then -- 12 MS. NOWLIN-SOHL: Got it. Okay. We're 13 still waiting on it, but I'll let you know when we 14 have it. 15 MR. RAMER: Okay. 16 Okay. Are we still waiting? 17 MS. NOWLIN-SOHL: We are. 18 MR. RAMER: We actually probably have 19 about an hour left on the clock would be my guess. 20 Do you want to take a final break here? 21 Or if it's arrived, we can just continue. 22 MS. NOWLIN-SOHL: Yeah, let's do a 23 five-minute break. 24 MR. RAMER: Okay. 25 THE VIDEOGRAPHER: Okay. So the time is Page 266</p> | <p>1 correction -- we might need to open the original 2 paper to see what the cutoff was. 3 Q. Hold on. What did you say? It has a 4 what correction? 5 A. So this is what I was saying earlier that 6 we try not to run a lot of comparisons because 7 when you run a lot of comparisons, it increases 8 the probability of you detecting something that 9 looks significant when it's not. 10 This is one of those papers where we did 11 run a lot of analyses. So when you do that, you 12 do something called a Bonferroni correction where 13 it takes into account how many things you looked 14 at. 15 And the more statistical comparisons you 16 make, the stricter it makes your statistical 17 cutoff. So I need to look at what that number was 18 from the original paper. 19 Q. When you say "what that number was," are 20 you referring to the threshold you're using? 21 A. Correct. 22 Q. So the P-value for the data in this row 23 where it says "less than .0001," I mean, that's 24 going to be -- 25 A. So those would all clearly meet the Page 268</p> |
| <p>1 4:07 p.m. Pacific time, and we are off the record. 2 (Break taken from 4:07 p.m. to 4:13 p.m.) 3 THE VIDEOGRAPHER: All right. So we are 4 recording. The time is 4:13 p.m. Pacific, and we 5 are back on the record. 6 (Deposition Exhibit No. 24 was marked.) 7 Q. (BY MR. RAMER) Okay. And, Dr. Turban, 8 do you have -- well, I'll introduce Turban 9 Exhibit 24. 10 And does this appear to be the correction 11 you were referring to earlier today? 12 A. Yes. 13 Q. And I'd like to go down to page 4 and 14 Table 2, and I just want to understand. 15 The first row of this chart is basically 16 showing that exposure to GAH, or gender-affirming 17 hormones, is associated with lower odds of past 18 year suicidal ideation; is that right? 19 A. Yes. 20 Q. And the way to understand that is because 21 the adjusted odds ratio for those categories are 22 less than one, and you've hit your statistical 23 significance threshold of less than .0001; is that 24 right? 25 A. I believe this paper has a bottom Page 267</p> | <p>1 threshold, but if you wanted to go through more, I 2 would need to look up what the threshold was. 3 Q. Maybe we should do that. So that was -- 4 the original, pre-corrections, was Turban 5 Exhibit 11, I believe. 6 And you would typically report your 7 threshold of statistical significance down in the 8 statistical analyses, I would assume? 9 A. Yes. 10 Q. So that's down on page 4. 11 A. So it was .001. 12 Q. And where are you seeing that? 13 A. Page 5 at the top. 14 Q. Oh, okay. Gotcha. Okay. So the -- 15 okay. So the threshold you were using was .001. 16 Now going back to what is Turban 17 Exhibit 24, the correction, we can see that the 18 P-values on those returns is less than .0001, so 19 clearly below the threshold for statistical 20 significance, correct? 21 A. Yes. 22 Q. Okay. And just staying on this row, in 23 looking at the first group, so those who accessed 24 gender-affirming hormones at age 13 through 15, 25 you have an adjusted odds ratio of .4. Page 269</p> |

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| <p>1 Do you see that?</p> <p>2 A. Yes.</p> <p>3 Q. And in plain English, to the extent these</p> <p>4 things can be explained in plain English, does</p> <p>5 that basically mean that exposure to</p> <p>6 gender-affirming hormones at ages 13 to 15 is</p> <p>7 associated with a 60 percent decrease in reporting</p> <p>8 past year suicidal ideation?</p> <p>9 A. 60 percent lower odds.</p> <p>10 Q. Okay. So you're 60 percent less likely</p> <p>11 to report that. Is that --</p> <p>12 A. Odds ratios are a little less intuitive</p> <p>13 than that, but I would say the odds ratio was</p> <p>14 60 percent less.</p> <p>15 Q. Okay. If we go down to -- if we go down</p> <p>16 a row to "Past Year Suicidal Ideation With Plan,"</p> <p>17 the odds ratios on this one all kind of hover</p> <p>18 around one, and the P-values do not really come</p> <p>19 close to statistical significance.</p> <p>20 So basically we can't really draw any</p> <p>21 conclusions from that row; is that right?</p> <p>22 A. Correct, one way or another.</p> <p>23 Q. And then going down to the fourth row,</p> <p>24 past year's suicide attempt requiring inpatient</p> <p>25 hospitalization, and with respect to the middle</p> <p style="text-align: right;">Page 270</p> | <p>1 somebody had asked us to do that, and I think we</p> <p>2 did it. But I don't remember the results, to be</p> <p>3 honest.</p> <p>4 Q. And so you don't recall whether there</p> <p>5 were any differences in outcomes based on whether</p> <p>6 the individual received testosterone or estrogen;</p> <p>7 is that right?</p> <p>8 A. I remember it cutting a lot of the sample</p> <p>9 sizes in half, so we lost a lot of the statistical</p> <p>10 power. So it's a little bit harder to interpret</p> <p>11 the results, but I don't remember the specifics.</p> <p>12 Because as you can see, for every single statement</p> <p>13 here, we ran a ton of analyses.</p> <p>14 Q. And do you think there could be a</p> <p>15 difference in outcomes based on whether the</p> <p>16 individual received testosterone or estrogen?</p> <p>17 A. Potentially.</p> <p>18 MS. NOWLIN-SOHL: Object to form.</p> <p>19 THE WITNESS: Sorry. Potentially.</p> <p>20 Q. (BY MR. RAMER) And why?</p> <p>21 A. I mean, just theoretically, when you</p> <p>22 break groups up by different characteristics, it</p> <p>23 could be that certain groups respond to things</p> <p>24 differently than others, but hard to know.</p> <p>25 I would expect so, based on clinical</p> <p style="text-align: right;">Page 272</p> |
| <p>1 group, which accessed gender-affirming hormones at</p> <p>2 ages 16 or 17, there you have an adjusted odds</p> <p>3 ratio of 2.2, correct?</p> <p>4 A. The P-value is .01, so the -- you can't</p> <p>5 interpret it. It doesn't mean anything. It's not</p> <p>6 statistically significant, so it doesn't tell you</p> <p>7 anything one way or another.</p> <p>8 Q. And you would decline to use any sort of</p> <p>9 terminology like "trending towards statistical</p> <p>10 significance," correct?</p> <p>11 A. No. That's technically incorrect.</p> <p>12 Q. Wait. What? No, I'm asking if you would</p> <p>13 use that term. And I thought --</p> <p>14 A. I would not. That's not appropriate</p> <p>15 statistical terminology.</p> <p>16 Q. And for this paper generally, did you</p> <p>17 ever break out data by sex assigned at birth?</p> <p>18 A. So in the original paper, we did not.</p> <p>19 Again, because the more comparisons you make, the</p> <p>20 more you need to do that Bonferroni correction</p> <p>21 that makes your levels for statistical</p> <p>22 significance more and more stringent. And if you</p> <p>23 go too far with that, then essentially nothing</p> <p>24 works.</p> <p>25 I believe as part of the correction,</p> <p style="text-align: right;">Page 271</p> | <p>1 experience and the general phenomenology of gender</p> <p>2 dysphoria.</p> <p>3 Q. What are --</p> <p>4 A. It's a few different things. So clinical</p> <p>5 experience we generally see, both for assigned</p> <p>6 males and for assigned females, tend to improve.</p> <p>7 And then in terms of just the</p> <p>8 phenomenology of gender dysphoria, we know a lot</p> <p>9 of the distress is from one's physical body not</p> <p>10 aligning with the secondary sex characteristics of</p> <p>11 one's gender identity. So our hypothesis would be</p> <p>12 that both would help with that.</p> <p>13 That being said, testosterone is a</p> <p>14 stronger hormone than estrogen, so its physical</p> <p>15 effects become apparent more quickly than</p> <p>16 estrogen, and it has more physical effects than</p> <p>17 estrogen does.</p> <p>18 So it's possible that those assigned</p> <p>19 female at birth who were taking testosterone might</p> <p>20 have more robust or earlier improvement, but the</p> <p>21 hypothesis would be that both would improve but</p> <p>22 not necessarily at the same rate or to the same</p> <p>23 degree.</p> <p>24 MR. RAMER: And, Li, do you have Turban</p> <p>25 Exhibit 25?</p> <p style="text-align: right;">Page 273</p> |

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| <p>1 MS. NOWLIN-SOHL: I believe so. Yes. 2 (Deposition Exhibit No. 25 was marked.) 3 Q. (BY MR. RAMER) And, Dr. Turban, do you 4 have a -- an account on the website formerly known 5 as Twitter, now known as X? 6 A. Yes. 7 Q. And is your handle @jack_turban? 8 A. Yes. 9 Q. And do you have Exhibit 25 in front of 10 you? 11 A. Yes. 12 Q. And is this a Tweet that you sent? 13 A. Yes. 14 Q. And I'll just read it first and then ask 15 if I read it correctly. It says "I'm really sick 16 of the #GOP's creative ways of signaling bigotry. 17 They don't care about the flag. They just want to 18 signal that they: (1) hate #LGBTQ people, (2) 19 want them to shut up and hide, and (3) want to 20 (and feel entitled to) have power over them. It's 21 gross." 22 Did I read that correctly? 23 A. Yes. 24 Q. Do you think that Republicans hate LGBTQ 25 people?</p> <p style="text-align: right;">Page 274</p> | <p>1 take care of know that it's not a universal view 2 that people think that they should be forced to 3 hide or that any symbols that represent that they 4 should be proud of themselves should be removed 5 from public life. 6 Q. Do you think the legislators who enacted 7 the law at issue in this case hate LGBTQ people? 8 MS. NOWLIN-SOHL: Object to form; 9 foundation. 10 THE WITNESS: Admittedly, I didn't follow 11 the legislative debates about this specific law in 12 Idaho, so I don't even know who introduced it. 13 Q. (BY MR. RAMER) So you think that 14 somebody could support legislation like the law at 15 issue in this case without hating LGBTQ people? 16 MS. NOWLIN-SOHL: Object to form; 17 foundation, mischaracterizes prior testimony. 18 THE WITNESS: I don't think I can say 19 anything about the motivations of the people who 20 introduced this specific bill. I think it's 21 possible that they were provided with 22 misinformation about the care that maybe led them 23 to want to introduce it, but I've not spoken with 24 them about their motivations. 25 Q. (BY MR. RAMER) And so you think that the</p> <p style="text-align: right;">Page 276</p> |
| <p>1 A. So this Tweet -- 2 MS. NOWLIN-SOHL: Object to form. 3 THE WITNESS: This Tweet was specifically 4 in reference to several GOP members not wanting 5 the LGBT Pride flag to be hung at certain events. 6 And they were arguing that they felt that having 7 the flag -- the LGBTQ flag raised in certain 8 places was disrespectful to the American flag, 9 which in my mind, that specific view of wanting to 10 erase a symbol of LGBTQ people from public spaces 11 was a creative way of wanting to force LGBTQ 12 people to hide or not be visible in society or 13 telling them that they need to hide the symbols 14 that represented them. 15 So it's not a broad statement about all 16 members of that political party, but in a specific 17 instance where people were very actively trying to 18 eliminate any symbol of LGBT people from public 19 spaces, I did feel that that was a creative way of 20 trying to exercise power over that population, 21 which includes a lot of young patients I take care 22 of who are very vulnerable and are impacted by 23 those messages. 24 And I think it was important for that to 25 be voiced, particularly so these young patients I</p> <p style="text-align: right;">Page 275</p> | <p>1 legislators that you were referring to in this 2 Tweet about the flag -- and sorry. Where was 3 that, the flag episode that you were describing? 4 A. This was back in June. I don't recall 5 the specifics. 6 Q. It was back just a few months ago. You 7 don't recall, like, what state? Was it Congress? 8 A. There have been many instances like this 9 over the past several months. I wish this one 10 stood out more than others, but no, I don't 11 remember this specific instance in June. 12 MR. RAMER: And I'd like to go to Turban 13 Exhibit 26. 14 (Deposition Exhibit No. 26 was marked.) 15 Q. (BY MR. RAMER) And do you have that up? 16 A. Yes. 17 Q. And I'll just read this one again and ask 18 if I read it correctly. 19 "Republicans don't believe in freedom of 20 speech. They silenced an elected representative 21 because she disagreed with them on the House 22 floor. It's not a coincidence that she's 23 transgender. They are steadfast in silencing and 24 attacking trans Americans. American democracy is 25 dead."</p> <p style="text-align: right;">Page 277</p> |

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| <p>1 Did I read that correctly? 2 A. Yes, with a -- there's a statement below 3 it from the representative who was forced to stop 4 speaking on the House floor. 5 Q. Do you think that Republicans are 6 steadfast in attacking trans Americans? 7 MS. NOWLIN-SOHL: Object to form. 8 THE WITNESS: I think there's been a 9 clear rise in legislation that is not evidence 10 based and goes against the broad consensus in 11 medicine about how we can help these young people 12 I'm responsible for taking care of. And I have 13 been watching more and more legislation being 14 introduced that is harmful to them and that is 15 concerning to me. 16 Q. (BY MR. RAMER) Do you think supporters 17 of that legislation are attacking trans Americans? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: Again, I can't speak to 20 every individual who's introducing legislation, 21 but I can tell you it's legislation where the 22 evidence suggests that it's going to be harmful to 23 this population. 24 And it's very sad to me to watch that 25 non-evidence-based legislation be pushed forward</p> <p style="text-align: right;">Page 278</p> | <p>1 democracy is dead? 2 MS. NOWLIN-SOHL: Object to form. 3 THE WITNESS: I think it's very scary 4 that politicians would weaponize the government to 5 silence elected representatives from being able to 6 speak on legislation. 7 And as someone who's aware that often 8 physicians don't do a good job sharing evidence 9 broadly and that often the information that we 10 have and this research and peer-reviewed journals 11 doesn't always make its way into legislative 12 debates, it's scary to imagine that the few ways 13 in which that research and data is supposed to get 14 into the law-making process is in some instances 15 being prevented. 16 MR. RAMER: And I'd like to go to Turban 17 Exhibit 27. 18 (Deposition Exhibit No. 27 was marked.) 19 Q. (BY MR. RAMER) And do you have that up? 20 A. Yes. 21 Q. And I'll just read it first and then ask 22 if I read it correctly. 23 "Our country is dying and the GOP is 24 killing it. They are abusing power to attack 25 minorities, then demand that they stand silent</p> <p style="text-align: right;">Page 280</p> |
| <p>1 when all the evidence we have suggests that it's 2 going to be harmful to the young patients that I 3 take care of. 4 Q. (BY MR. RAMER) You said the previous 5 Tweet was not a categorical statement. 6 Is this Tweet where you say "Republicans 7 are steadfast in attracting" -- excuse me. 8 "Republicans are steadfast in attacking 9 trans Americans," is that a categorical statement? 10 MS. NOWLIN-SOHL: Object to form; 11 mischaracterizes prior testimony. 12 THE WITNESS: This, again, was in 13 response to a specific instance that is described 14 in the screenshot below the Tweet in which a bill 15 was being discussed that would impact trans youth. 16 And there was a representative who was 17 trying to share information about the research and 18 evidence about why that legislation would be 19 harmful to young people. 20 And these Republican lawmakers in 21 question voted to ban her from the House floor to 22 prevent her from making any more comments about 23 the evidence behind why this legislation was 24 potentially dangerous. 25 Q. (BY MR. RAMER) And do you think American</p> <p style="text-align: right;">Page 279</p> | <p>1 while attacked. We've seen this before in 2 history, and it's never ended well." 3 Did I read that part of the Tweet 4 correctly? 5 A. I'll have to read the screenshot below it 6 to know what the context was, but you read the 7 part above the screenshot correct. 8 Q. And do you think that the GOP is killing 9 our country? 10 MS. NOWLIN-SOHL: Object to form. 11 THE WITNESS: I'll need a second to read 12 the part you didn't read. 13 Q. (BY MR. RAMER) Okay. 14 A. Okay. This seems like the same -- a 15 reference to the same situation as the last Tweet, 16 which, again, I think was very concerning that 17 there was a member of this legislative body trying 18 to share research and data about -- I think in 19 this case it was a ban on gender-affirming medical 20 care for adolescents being dangerous. 21 And they used different techniques to 22 eventually silence that representative from being 23 able to share that information. 24 And I think the representatives who did 25 that and actively worked to try and remove</p> <p style="text-align: right;">Page 281</p> |

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| <p>1 evidence from debates about health policy that 2 impact young people are dangerous. 3 I think when public policy doesn't 4 consider research and evidence and isn't based on 5 science and data, that that's dangerous. 6 And as somebody who spends all of my time 7 working with young people who are impacted by this 8 legislation and it's my responsibility to protect 9 their mental health and make sure that they do 10 well, I think it's important to call out when laws 11 are being passed that aren't based on research and 12 evidence and are not in the best interest of young 13 people based on what we know about the science. 14 Q. And in the first sentence of the Tweet 15 you say, "Our country is dying, and the GOP is 16 killing it." 17 And my question is do you think that is 18 true? 19 MS. NOWLIN-SOHL: Object to form; asked 20 and answered. 21 THE WITNESS: I think I already answered 22 that question. 23 Q. (BY MR. RAMER) I don't think you did. 24 I'll just ask it again. 25 And you say, "Our country is dying, and</p> <p style="text-align: right;">Page 282</p> | <p>1 and answered. 2 THE WITNESS: I think I answered the 3 question. 4 Q. (BY MR. RAMER) Are you refusing to 5 answer the question yes or no of whether you think 6 that those certain GOP lawmakers who you just 7 referenced are killing our country? 8 MS. NOWLIN-SOHL: Object to form; 9 argumentative, asked and answered. 10 THE WITNESS: I don't think it's a 11 yes-or-no question, and I think I answered the 12 question. 13 MR. RAMER: All right. Let's go to 14 Turban Exhibit 28. 15 (Deposition Exhibit No. 28 was marked.) 16 Q. (BY MR. RAMER) Do you have that up? 17 A. Yes. 18 Q. I'll just read this and then ask if I 19 read it correctly. 20 "I should clarify. I don't hate all 21 conservatives," exclamation point. "Mostly just 22 the aggressive anti-trans Heritage folks," heart 23 emoji. "I should use more precise terminology for 24 my haters." 25 Did I read that correctly?</p> <p style="text-align: right;">Page 284</p> |
| <p>1 the GOP is killing it." 2 And my question is do you think that is 3 true? 4 MS. NOWLIN-SOHL: Object to form; asked 5 and answered. 6 THE WITNESS: Again, this was a reference 7 to a situation in which certain GOP lawmakers 8 eliminated evidence that was important to be 9 discussed and made sure that scientific evidence 10 didn't enter discussion about laws that would 11 impact the mental health of young people who I'm 12 responsible for taking care of. 13 And I think that is a sad sign for our 14 country that we're pushing forward legislation 15 that's not based in science and evidence, 16 particularly when the stakes are as high as the 17 mental health of young people. 18 Q. (BY MR. RAMER) And do you think those 19 certain GOP lawmakers are killing our country? 20 MS. NOWLIN-SOHL: Object to form; asked 21 and answered. 22 THE WITNESS: I think I answered the 23 question. 24 Q. (BY MR. RAMER) Yes or no. 25 MS. NOWLIN-SOHL: Object to form; asked</p> <p style="text-align: right;">Page 283</p> | <p>1 A. Yes. 2 Q. And what are anti-trans Heritage folks? 3 A. I don't recall the specific context of 4 this Tweet, but presumably it was someone similar 5 to this line of questioning accusing me of hating 6 all conservatives. 7 I have many conservative friends. I have 8 all throughout my education. I'm very close with 9 conservatives and people across the political 10 spectrum. 11 At the end of the day I work as a child 12 psychiatrist who takes care of a specific 13 population that I care deeply, which are the young 14 transgender youth. 15 There are individuals at the Heritage 16 Foundation who intermittently have passed 17 misinformation or said things about this 18 population or the research regarding them that's 19 not true, and it is very upsetting for me to see 20 people spread misinformation that's going to hurt 21 the young patients that I take care of. 22 So again, this is meant to clarify -- I 23 think the line of questioning that you're going 24 after is whether or not I have an issue with a 25 certain political party. And this Tweet is</p> <p style="text-align: right;">Page 285</p> |

1 highlighting that I don't at all, but I do very
 2 much have a problem with attacks on young patients
 3 and the research that's designed to improve their
 4 mental health and keep them safe.
 5 Q. Who are the individuals at the Heritage
 6 Foundation you were referencing?
 7 A. Honestly, I haven't seen reports from
 8 them for a while. This is from back in 2020. I
 9 think at the time they were issuing individual
 10 reports that were non-peer-reviewed scientific
 11 research to spread misinformation about various
 12 forms of gender care for young people.
 13 Q. And so you do hate those people?
 14 MS. NOWLIN-SOHL: Object to form;
 15 mischaracterizes prior testimony.
 16 THE WITNESS: I have a strong negative
 17 feeling towards people spreading misinformation
 18 that would result in public policies that would
 19 harm young people.
 20 Q. (BY MR. RAMER) Is there anyone else you
 21 can think of you would group into the Heritage
 22 Foundation bucket?
 23 MS. NOWLIN-SOHL: Object to form.
 24 THE WITNESS: I think it's a large group,
 25 but specifically I believe this was years ago, and

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1 it was in reference to somebody who had written a
 2 supposed research paper that they didn't submit to
 3 peer review, which is the standard process for
 4 making sure that scientific research is valid and
 5 the sort of thing that should influence public
 6 policy because it's been checked by experts to be
 7 valid.
 8 And this person attempted to circumvent
 9 that process to spread the misinformation that
 10 could have had the potential to promote public
 11 policy that could have been harmful.
 12 Q. (BY MR. RAMER) When you say "it's a
 13 large group," what do you mean by that?
 14 A. I mean there are many people that work at
 15 the Heritage Foundation, and I do not know all of
 16 them.
 17 Q. So is your hate only directed at the
 18 Heritage Foundation?
 19 MS. NOWLIN-SOHL: Object to form;
 20 mischaracterizes prior testimony.
 21 THE WITNESS: As I just said, my hate or
 22 anger was towards the specific action that I
 23 thought had the potential to harm young people and
 24 lead to public policies that were harmful.
 25 And I wouldn't be able to give you an

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1 opinion on everyone at the Heritage Foundation as
 2 I know very few of them.
 3 Q. (BY MR. RAMER) Would you put Leor Sapir
 4 into this bucket?
 5 MS. NOWLIN-SOHL: Object to the form.
 6 THE WITNESS: I wasn't aware that he
 7 worked at the Heritage Foundation.
 8 Q. (BY MR. RAMER) I'm not saying he does.
 9 I'm saying would you classify Leor Sapir as
 10 somebody who is spreading misinformation?
 11 A. I haven't really seen something from him
 12 recently.
 13 Is there some specific report that he
 14 issued that you want me to comment on?
 15 Q. No, I'm just asking in general.
 16 A. I can't think of something specific. I
 17 know I've seen him spread things in the past that
 18 I didn't think were accurate or true, but I can't
 19 think of anything recently.
 20 Q. And a few times today you've discussed
 21 the "minority stress." I don't know if you called
 22 it a theory or minority stress -- a principle of
 23 minority stress.
 24 Just as a general matter, can you explain
 25 that to me?

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1 A. So minority stress is a framework that
 2 was described by Ilan Meyer at UCLA initially used
 3 to described why we see mental health disparities
 4 among sexual minorities to include bisexual
 5 cisgender men.
 6 And it describes distal factors and
 7 proximal factors. Distal factors are factors from
 8 the outside world that impact one's mental health,
 9 so things like harassment based on your sexual
 10 orientation, discrimination, violence.
 11 Both described that over time, those
 12 external factors can drive internal factors,
 13 things like internalized homophobia, feeling that
 14 you need to conceal your identity like we
 15 discussed earlier, and anticipatory anxiety where
 16 people develop a constant fear that they're going
 17 to be victims of that past discrimination again in
 18 the future even if they're in a safe environment.
 19 And they may have trouble calibrating when they're
 20 safe and when they're not, which can drive
 21 anxiety.
 22 That model was later adopted for trans
 23 people in the gender minority stress model
 24 by Hendricks and Testa that has essentially
 25 analogous proximal and distal factors described.

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1 Q. Did external factors ever drive internal
 2 factors --
 3 MS. NOWLIN-SOHL: Object to form.
 4 MR. RAMER: Sorry. I'm just talking
 5 slowly.
 6 Q. (BY MR. RAMER) Can external factors ever
 7 drive internal factors to lead someone to identify
 8 as transgender?
 9 MS. NOWLIN-SOHL: Object to form.
 10 THE WITNESS: Are you asking if -- what
 11 kind of external factor? Like a sexual minority
 12 stress external factor?
 13 Q. (BY MR. RAMER) Well, I guess do you
 14 think that external factors for -- let me back up.
 15 Somebody who identifies as transgender
 16 and then at some point ceases identifying as
 17 transgender, the reason they can do that could be
 18 for a number of external factors such as
 19 discrimination, correct?
 20 MS. NOWLIN-SOHL: Object to form.
 21 THE WITNESS: I'm trying to understand
 22 the question.
 23 Q. (BY MR. RAMER) Well, were there
 24 individuals who responded to the U.S. Transgender
 25 Survey who said that they detransitioned at some

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1 point in their life?
 2 A. Yes.
 3 Q. And what would you say are the
 4 explanations for why they would detransition at
 5 some point in their life?
 6 A. So we published a paper on this that you
 7 might be referencing in LGBT Health, I believe, in
 8 2021. I don't have the numbers in front of me,
 9 but we found that a substantial proportion of
 10 trans adults, so people who currently are living
 11 their lives in their gender identity, had
 12 transitioned, at some point in the past
 13 detransitioned. So it was presumably temporary
 14 because they're now living as trans adults.
 15 I want to say it was maybe somewhere
 16 between 10 and 15 percent said that they had that
 17 experience in the past. And of those,
 18 82.5 percent of them said it was due to at least
 19 one external factor, so things like harassment and
 20 discrimination.
 21 Q. And so external factors could lead
 22 someone to identify as cisgender; is that right?
 23 A. That's not specifically what the study
 24 said. You have to be careful about the term
 25 "detransition" and how it's defined.

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1 So in this case, it was, I believe, go
 2 back to living as your sex assigned at birth at
 3 least for some time, so it didn't necessarily
 4 imply that their gender identity changed, but
 5 their gender expression changed or, quote, they
 6 went into the closet, to use that colloquialism.
 7 Q. Well, gender identity never changes,
 8 correct?
 9 MS. NOWLIN-SOHL: Object to form.
 10 THE WITNESS: So as we talked about
 11 earlier, that core, biologically determined gender
 12 identity is not the way in which one ascribes body
 13 language to it or sexualizes or understands it.
 14 Q. (BY MR. RAMER) And so the -- is living
 15 as your sex assigned at birth different from
 16 identifying as cisgender?
 17 A. Yes.
 18 Q. How so?
 19 A. One may still identify as transgender but
 20 be somewhere where it wouldn't be safe to tell
 21 people that or be open about it, so they may
 22 present to the world as cisgender due to fear that
 23 they would be subject to violence or harassment or
 24 other maltreatment if they were to be openly
 25 transgender.

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1 Q. And so what you were measuring -- or I
 2 guess is this the point that you're making that
 3 the word "detransition" is complex?
 4 A. It can represent a broad heterogeneous
 5 range of experiences.
 6 And when looking at the academic
 7 research, it's important to look at how it's
 8 defined.
 9 Sometimes people will conflate
 10 detransition with regret, or conflate detransition
 11 with the changing gender identity understanding.
 12 So it's important to look at how the individual
 13 study really defines it.
 14 Q. And what was the last one you said,
 15 change in gender identity understanding? Is that
 16 right?
 17 A. Yeah, the way in which they conceptualize
 18 their gender identity.
 19 Q. And could somebody -- could a transgender
 20 individual cease identifying as transgender for
 21 reasons other than regret?
 22 MS. NOWLIN-SOHL: Object to form.
 23 THE WITNESS: Can you explain how you
 24 would see regret as a reason for one's identity
 25 change?

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| <p>1 Q. (BY MR. RAMER) Well, I'm asking can't 2 somebody do it without having regret? 3 A. Can somebody stop a gender-affirming 4 medical intervention and not have regret? Is that 5 the question? 6 Q. Let's start there, yes. Can somebody 7 cease a gender-affirming medical intervention and 8 not have regret? 9 A. Yes. 10 Q. And why? 11 A. It can be for all sorts of reasons. I've 12 had patients who took testosterone, for instance, 13 and had sufficient physical effects from it that 14 they felt that they didn't need any more physical 15 changes, so they stopped the medication but didn't 16 regret it. 17 We wrote about one patient who took 18 estrogen for a period of time and had some body 19 fat redistribution and then stopped it because 20 they identified as nonbinary, but they noted that 21 they didn't regret the body fat redistribution and 22 felt that that experience was necessary for them 23 to understand themselves. 24 Someone might lose insurance coverage and 25 not be able to access their gender-affirming</p> <p style="text-align: right;">Page 294</p> | <p>1 gender-affirming medical intervention? 2 A. I've not had such a patient, but 3 potentially. 4 Q. So if individuals receive 5 gender-affirming medical interventions and then 6 subsequently identify with their sex assigned at 7 birth, they likely would regret the 8 gender-affirming medical interventions? 9 MS. NOWLIN-SOHL: Object to form; 10 mischaracterizes prior testimony. 11 THE WITNESS: I think that's a different 12 question. I've not had such a patient. They 13 could potentially. That's something that we 14 counsel patients as a possibility. 15 MR. RAMER: And I'd like to introduce 16 Turban Exhibit 29. 17 Do you have that? 18 THE WITNESS: Yes. 19 (Deposition Exhibit No. 29 was marked.) 20 Q. (BY MR. RAMER) And you've seen this 21 before, correct? 22 A. Yes. I've not read it in a while, but 23 I've seen it. 24 Q. I'd just like to ask you one kind of 25 narrow question on -- so I'd like to go to</p> <p style="text-align: right;">Page 296</p> |
| <p>1 medical interventions anymore. So in that case 2 they would stop them, but it doesn't mean they 3 regretted taking them. In fact, they might want 4 to keep taking them. 5 Q. When you say the patient felt they didn't 6 need it anymore, are you using colloquial terms to 7 say that the distress associated with gender 8 dysphoria had resolved? 9 A. That they had -- in that example, 10 testosterone -- achieved a level of physical 11 masculinization of their secondary sex 12 characteristics that their gender dysphoria 13 resolved, yes. 14 Q. And so we were discussing why somebody -- 15 or we were discussing how and why somebody could 16 cease gender-affirming medical interventions and 17 not have regret. 18 And my next question is could someone 19 receive a gender-affirming medical intervention 20 and later in life decide -- take the word "decide" 21 out of it. I'm going to restart. 22 Could someone receive a gender-affirming 23 medical intervention and later in life identify 24 with their sex assigned at birth and not have 25 regret for having received the prior</p> <p style="text-align: right;">Page 295</p> | <p>1 page 11, right column under "Discussion," and the 2 second full paragraph. 3 And in that paragraph, the second to last 4 sentence -- and I'll just read it and ask if I 5 read it correctly, and then that will be my first 6 question. 7 "To the best of our knowledge, all of the 8 letters written to the editor JAMA Psychiatry, 9 many by respected academics and clinicians who 10 outlined the serious problems in the study, have 11 been rejected (some of them were later submitted 12 as non-indexed comments in the online 13 publication)." 14 Did I read that correctly? 15 A. Yes. 16 Q. And were you aware of letters being 17 written to the editor of JAMA Psychiatry outlining 18 problems with your study? 19 A. No. 20 Q. Were you serving as a manuscript reviewer 21 for JAMA Psychiatry at the time? 22 A. I do ad hoc manuscript reviews for most 23 of the top journals, so I probably intermittently 24 reviewed papers for them. 25 Q. Do you know if you were reviewing one at</p> <p style="text-align: right;">Page 297</p> |

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| <p>1 the time that these letters to the editor were 2 being rejected? 3 A. Not that I recall, but I'm kind of 4 reviewing a steady stream of articles for 5 different journals. 6 Q. And how often is there turnover at the 7 position of editor of JAMA Psychiatry? 8 MS. NOWLIN-SOHL: Object to form; 9 foundation. 10 THE WITNESS: I do not know. 11 Q. (BY MR. RAMER) How do the letters to the 12 editor -- I know they're called letters to the 13 editor, but, like, is the editor actually reading 14 them? 15 Or, just based on your experience working 16 at these journals, what is the process once a 17 letter to the editor is submitted? 18 MS. NOWLIN-SOHL: Object to form. 19 THE WITNESS: I think it probably varies 20 journal by journal, but generally they would be 21 read by members of the editorial board who would 22 read them to decide if they have scientific merit. 23 And if they were deemed to have 24 scientific merit, they would be sent to the author 25 of the paper, and they would ask the author of the</p> <p style="text-align: right;">Page 298</p> | <p>1 THE WITNESS: Yes. 2 Q. (BY MR. RAMER) And do you recognize this 3 document? 4 A. Yes. 5 Q. And what is it? 6 A. This is a paper we published in the 7 Journal of LGBT Health in 2021. 8 Q. And this is the article that either you 9 or I, probably me, was kind of alluding to earlier 10 that we were kind of talking around, right? 11 A. One of them, yes. 12 Q. Okay. And this study used data from the 13 U.S. Transgender Survey, correct? 14 A. Yes. 15 Q. And on 274, which I think is page 2, down 16 in the left column above "Methods," the last 17 sentence you acknowledge that because the USTS 18 exclusively surveyed people who currently 19 identified as TGD, that your study is restricted 20 to the examination of detransition among people 21 who subsequently identified as TGD, right? 22 A. Yes. 23 Q. And then in the right column below 24 "Quantitative Responses and Analysis," I'm just 25 going to read the first sentence.</p> <p style="text-align: right;">Page 300</p> |
| <p>1 paper to respond to them, in which case the letter 2 to the editor gets published and then a response. 3 The vast majority of the time, they're 4 not sent for external peer review, but sometimes 5 they are. Again, I think that's a 6 journal-by-journal decision. 7 MR. RAMER: And maybe it would be good if 8 we just took a short break and I can clarify if 9 there's anything else I need to ask, but otherwise 10 I'm pretty close to being done. 11 MS. NOWLIN-SOHL: Yes, that's fine. 12 MR. RAMER: We'll go off the record. 13 THE VIDEOGRAPHER: Okay. So the time is 14 4:56 p.m. Pacific time, and we are off the record. 15 (Break taken from 4:56 p.m. to 5:04 p.m.) 16 THE VIDEOGRAPHER: All right. So we are 17 recording. The time is 5:04 p.m. Pacific time, 18 and we are back on the record. 19 Q. (BY MR. RAMER) And, Dr. Turban, I just 20 wanted to kind of put more detail on the 21 conversation we were trying to have earlier. 22 MR. RAMER: And so I'll introduce Turban 23 Exhibit 30. And just let me know when you have 24 that up. 25 (Deposition Exhibit No. 30 was marked.)</p> <p style="text-align: right;">Page 299</p> | <p>1 Actually, no. It's a very long sentence. 2 I'm just going to read the first part, which says 3 "Respondents who reported a history of 4 detransition were asked 'Why did you detransition? 5 In other words, why did you go back to living as 6 your sex assigned at birth?' Mark all that 7 apply." 8 Do you see that? 9 A. Yes. 10 Q. And so the question you used to define 11 detransition in this study was whether the 12 participants went back to living as their sex 13 assigned at birth, right? 14 A. So this is from data we did a secondary 15 analysis on on the U.S. Transgender Survey, so I 16 didn't design this survey question, but that's the 17 question that was used. 18 Q. Right, but -- so fair enough. You didn't 19 write the survey questions, but to use the survey 20 data for this paper, you used that question to 21 shape the definition of "detransition" that you 22 use in this paper, right? 23 A. Yeah. I admittedly don't love the 24 wording of the question, but it's the question 25 that was in the data set that we had available, so</p> <p style="text-align: right;">Page 301</p> |

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| <p>1 that's the one that was used. 2 Q. What would you change about it? 3 A. I just find the term "detransition" in 4 general to be somewhat vague and heterogenous. So 5 I prefer a more specific question like "Did you 6 regret the certain intervention? Did you stop 7 gender-affirming medical care? Did you go back to 8 presenting as your sex assigned at birth?" 9 This was kind of a broad question that 10 encapsulated a lot of experiences, but 11 conveniently -- or not conveniently because it was 12 a lot of work -- but there was a free response, so 13 we were able to go through and code the 800 free 14 responses, which helped us get a rich perspective 15 on what exactly people were describing as their, 16 quote, detransition experiences. 17 Q. And in this paragraph toward the bottom 18 the second to last sentence, it says in 19 quotations, "I realized that gender transition 20 was not for me" was collapsed into a 21 'fluctuations in identity/desire' category." 22 Did I read that correctly? 23 A. Sorry. I'm just reading what it was -- 24 this paragraph. 25 Yeah, I think there weren't many people,</p> <p style="text-align: right;">Page 302</p> | <p>1 study that identified 100 people. 2 This one, we're looking at trans people 3 who have at least temporarily detransitioned, and 4 it was over 2,000 people, and that was just of 5 this survey. 6 So, I mean, it's an imperfect way to look 7 at it, but it appears that there are a lot of 8 people who detransition due to these external 9 factors. 10 Q. Were you just -- sorry. 11 Were you just comparing the 100 people in 12 that study to the 2,000 people here to draw a 13 conclusion about the prevalence? 14 MS. NOWLIN-SOHL: Object to form. 15 THE WITNESS: I think you were asking, 16 like, of people who detransition -- are you asking 17 if I think most people are, like, detransitioning 18 in this way versus are detransitioning in the 19 Littman description? I'm not sure I understand 20 the question. 21 Q. (BY MR. RAMER) Sorry. Let me just 22 clarify. Is the Littman study -- I didn't 23 actually hear you all that well. 24 Is the Littman study the one that you're 25 referring to that identified the 100 people? Did</p> <p style="text-align: right;">Page 304</p> |
| <p>1 if I remember correctly, who chose that one, which 2 I think is why we collapsed them together. But 3 that's another one where I think the wording was 4 pretty unclear, unfortunately. 5 Q. That was going to be my next question. 6 So using the definition of -- well, let 7 me step back. 8 I think it's implied in what we've 9 already discussed, but just to clarify, this study 10 did not set out to tell us and does not tell us 11 anything about individuals who transitioned and 12 then permanently went back to living as their sex 13 assigned at birth, correct? 14 A. Correct. 15 Q. And using the definition of 16 "detransition" that you use in this study, of all 17 individuals who have detransitioned, do you think 18 the majority of them subsequently identify as 19 transgender? 20 A. It's hard to answer quantitatively, but 21 the research that has worked to identify people 22 who detransitioned -- probably the science would 23 say they stopped gender-affirming medical 24 interventions -- the numbers have been relatively 25 low. The lowest one that I've seen was that one</p> <p style="text-align: right;">Page 303</p> | <p>1 you say Littman? 2 A. Yes. 3 Q. Okay. I guess what I'm asking is of 4 people -- let me try and ask it this way: Of 5 people who detransition using the definition you 6 use in this study, do you think most of them go on 7 to retransition and identify as transgender? 8 MS. NOWLIN-SOHL: Object to the form. 9 THE WITNESS: I just want to be clear 10 that this study doesn't look at that question at 11 all. 12 Q. (BY MR. RAMER) No. I understand that. 13 And that's why I'm asking. 14 I'm asking does this study capture the 15 typical detransitioner or not? 16 MS. NOWLIN-SOHL: Object to the form; 17 calls for speculation. 18 THE WITNESS: I don't know that we have 19 research because it seems there aren't enough 20 detransitioners to have a rigorous study on what 21 the common detransition experience is. 22 The largest study I know is that Littman 23 study of 100 individuals that I think I put in my 24 declaration, but it would be helpful if we pulled 25 the paper up.</p> <p style="text-align: right;">Page 305</p> |

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| <p>1 But even within there, they had 2 heterogenous experiences where some had regret; 3 some did not. Some felt that they benefitted from 4 the transition despite the fact that they later 5 stopped gender-affirming medical interventions; 6 others did not. 7 That study is also complicated because it 8 recruited from various and specific social media 9 websites, so it's really hard to know how 10 representative that is. 11 I don't know how to answer that question 12 with the data. 13 Q. (BY MR. RAMER) When you say we don't 14 have enough detransitioners to properly study the 15 question, are you basing that off of the fact that 16 Littman only identified 100 people? Or is there 17 something else that is leading you to that 18 conclusion? 19 A. Just all the research we have is 20 suggesting that it's not a very common experience. 21 There's that paper. 22 There's the Wiepjes paper that generally 23 looks like -- they were more looking at regret, 24 where regret rates were low, at least for surgery. 25 When we look at the papers, how many</p> <p style="text-align: right;">Page 306</p> | <p>1 less common, I think this would become a less 2 common experience. So I don't know that I can 3 predict. 4 Q. Would external factors only ever drive 5 somebody to detransition? Or could they ever 6 drive somebody to transition in the first 7 instance? 8 MS. NOWLIN-SOHL: Object to form. 9 THE WITNESS: It would be pretty -- maybe 10 we're not having a shared definition of "external 11 factors." 12 It sounds like generally external factors 13 are anti-trans discrimination. 14 I'm having trouble understanding why 15 someone would choose to transition because of 16 stigma and harassment towards trans people if they 17 weren't trans. 18 Q. (BY MR. RAMER) Well, I guess -- 19 A. That would seem counter to their personal 20 interests. 21 Q. I guess my question is are external 22 factors always negative, like discrimination? 23 MS. NOWLIN-SOHL: Object to form. 24 THE WITNESS: That's why I'm asking if we 25 have a shared definition.</p> <p style="text-align: right;">Page 308</p> |
| <p>1 people take blockers and then don't go on to 2 gender-affirming hormones, it's in the low, few 3 percent. 4 But, again, all of this is kind of 5 muddled by what your definition of "detransition" 6 is. 7 Q. Do you expect that the -- let me put it 8 this way: In terms of raw numbers, do you expect 9 that the number of detransitioners, using the 10 definition you use in this study, will increase in 11 the next 15 years? 12 MS. NOWLIN-SOHL: Object to form; calls 13 for speculation. 14 THE WITNESS: The definition of going 15 back to presenting as their sex assigned at birth? 16 Q. (BY MR. RAMER) Go back to living as your 17 sex assigned at birth, yes. 18 A. I think it's really hard to predict. It 19 would depend on a lot of different factors. This 20 study specifically was on -- most of the people in 21 the study were doing that because of some sort of 22 anti-trans stigma they were encountering in their 23 communities. 24 So if that were to continue to rise, this 25 would be a more common experience. If that became</p> <p style="text-align: right;">Page 307</p> | <p>1 The way they're used in the minority 2 stress framework is they're referring to stigma 3 external factors. 4 Q. (BY MR. RAMER) And so in the minority 5 stress framework, external factors are always 6 negative stigmatic factors; is that fair? 7 A. Definition in the way it's used in that 8 framework. 9 They do have other -- I mean, there's 10 other elements of the framework, a buffering 11 effect against internal and external factors of 12 community connectedness at pride, but I think we 13 call those resilience factors. 14 Q. And what do you mean by "pride"? 15 A. Like having pride in one -- as opposed to 16 shame, like being proud of the trans community, 17 recognizing that trans people make important 18 contributions to society, being able to have trans 19 role models in the type of things that you want to 20 do. 21 So say you're a young trans person who 22 wants to be a physician and you don't have any 23 role models. You might think, oh, trans people 24 can't be doctors. So meeting a trans doctor or 25 seeing an example of someone in the media.</p> <p style="text-align: right;">Page 309</p> |

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| <p>1 Q. Could an external factor like that ever 2 shape an internal factor? 3 MS. NOWLIN-SOHL: Object to form. 4 THE WITNESS: Those aren't called 5 external factors in the model. Those are 6 resilience factors. 7 But are you trying to ask if, like, 8 somebody being in a community where there are 9 positive views of trans people would lead them to 10 transition to be trans? 11 Q. (BY MR. RAMER) Well, sure. What is the 12 answer to that? 13 A. Is that the question? 14 Q. Yes. 15 A. Sorry. The question is kind of are 16 there -- you just asked -- 17 Q. What did you just say? Sorry. What did 18 you just say? And that's the question. 19 A. Are there environments where there could 20 be a positive view of trans people that would lead 21 someone to come out as trans when they're not 22 trans? 23 Q. Yes, that question. 24 MS. NOWLIN-SOHL: Object to form. 25 THE WITNESS: I have not experienced any</p> <p style="text-align: right;">Page 310</p> | <p>1 have never seen, but something that would come up 2 in the evaluation process as a possibility. 3 Q. And in your answer why did you say "even 4 in California"? 5 A. There's often a perception that in the 6 Bay Area where I work that there's a lot of 7 acceptance of trans young people. It's something 8 that people will often mention to me when they go 9 to conferences or when I'm presenting such as at 10 different academic institutions. 11 But sadly I find that's often not the 12 case in this area that people think of being very 13 accepting towards young trans people. 14 Q. And why did you reference a liberal 15 school? 16 A. Because those schools people tend to 17 think of as having more acceptance towards young 18 trans people. 19 Q. And do you disagree with that perception? 20 A. Yes, I don't think it's universal. I 21 think I've seen schools where people think of them 22 as being very liberal, whatever that means, but 23 that the kids still experience a lot of bullying 24 and harassment and stigmas when they come out as 25 trans.</p> <p style="text-align: right;">Page 312</p> |
| <p>1 such environment. Even in California where I work 2 in the Bay, my patients routinely have harassment 3 and stigma. Other people don't realize that. 4 But at one local school that people think 5 of liberal, somebody burned a Pride flag outside 6 to express anti-trans stigma. 7 We published a paper in Pediatrics where 8 we looked at the rates of bullying victimization 9 against trans youth versus cisgender sexual 10 minority youth, and the rates were substantially 11 higher, so I don't think that's the social 12 environment that we live in. 13 When we do a biopsychosocial evaluation, 14 we always ask, if you were to start a 15 gender-affirming medical intervention, how would 16 your parents react? How would your peers react? 17 How would other people in your community react? 18 I'll say almost universally young people 19 are afraid that there are going to be negative 20 reactions. 21 If there were a circumstance where they 22 said, "Oh, everyone is going to give me a ton of 23 praise and presents and positive things," then 24 that would be a major flag for us to try and 25 figure out what was going on. That's something we</p> <p style="text-align: right;">Page 311</p> | <p>1 MR. RAMER: And I don't have any further 2 questions for now. I'll turn things over to your 3 counsel, but thank you very much, Doctor. 4 THE WITNESS: Thank you. 5 MS. NOWLIN-SOHL: I think I just have a 6 couple. 7 8 EXAMINATION 9 BY MS. NOWLIN-SOHL: 10 Q. So, Dr. Turban, do you remember earlier 11 when we were talking about Exhibit -- I believe it 12 was 14, which is the article in the Journal of 13 Adolescent Health titled the "Age of Realization 14 and Disclosure of Gender Identity Among 15 Transgender Adults"? 16 A. Yes. 17 MS. NOWLIN-SOHL: John, do you want a 18 minute to pull that up? 19 Q. (BY MS. NOWLIN-SOHL) And I believe you 20 and Mr. Ramer at one point were talking about 21 table one, the demographics. 22 Do you recall that conversation? 23 A. Yes. 24 Q. And on that table, there's two kind of 25 columns for different age categories, one for the</p> <p style="text-align: right;">Page 313</p> |

1 age less than 10, and one for age 11-plus; is that
 2 correct?
 3 A. Yes.
 4 Q. And I think you and Mr. Ramer were
 5 talking about the percentages in those columns
 6 as -- at one point it was mentioned that they
 7 didn't quite add up to 100 percent.
 8 Can you help clarify what the numbers in
 9 parentheses after each block number reflects?
 10 A. Yes. So I think the question was trying
 11 to get at how many participants in the overall
 12 study were in each of those age brackets at the
 13 top left, 18 to 24, 25 to 44, 45 to 64, and 65
 14 plus.
 15 And the question was how many of them are
 16 in each of those categories of percentage of the
 17 full population, and I was doing incorrect math.
 18 My apologies.
 19 So in order to calculate that, you would
 20 add the two numbers in each of the rows from both
 21 columns, and then divide that by the total number
 22 in the study. So the percentages I was giving
 23 earlier were incorrect.
 24 MS. NOWLIN-SOHL: No further questions.
 25 MR. RAMER: Can I just ask one follow-up

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1 on that?
 2
 3 FURTHER EXAMINATION
 4 BY MR. RAMER:
 5 Q. Which, looking at that same table,
 6 looking at the 18 to 24 group, do you agree --
 7 well, sorry. I may have gotten more confused.
 8 But so the 33.4 next to 18 to -- in the
 9 18 to 24 row, the 33.4 in parentheses, that means
 10 that the 18 to 24 group makes up 33.4 percent of
 11 the early realization group; is that right?
 12 A. Yes. I believe that's true.
 13 Q. And then when you shift over a column,
 14 the 18 to 24 group makes up 56.4 percent of the
 15 later realization group, correct?
 16 A. Yeah, that looks correct. Whatever 6,322
 17 divided by 11,218 is, which sounds roughly like
 18 56.4.
 19 11,218 is the total number of people in
 20 the late realization group.
 21 Q. Got it. Okay. I'm clear now.
 22 MR. RAMER: Thank you very much, Doctor.
 23 I appreciate it. I think we're all set.
 24 THE VIDEOGRAPHER: All right. That's it?
 25 MR. RAMER: Yeah.

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1 THE VIDEOGRAPHER: Okay. Then this
 2 concludes our video deposition with Dr. Jack
 3 Turban. It is October 16, 2023. The time is
 4 5:26 p.m. Pacific time, and we are off the record.
 5
 6 (Whereupon the deposition was concluded at 5:26 p.m.)
 7 *****
 8 (Signature requested.)
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1 REPORTER'S CERTIFICATE
 2 STATE OF IDAHO)
 3)
 4 COUNTY OF ADA)
 5
 6 I, Amy E. Simmons, Certified Shorthand Reporter and
 7 Notary Public in and for the State of Idaho, do hereby
 8 certify:
 9 That prior to being examined, the witness named in
 10 the foregoing deposition was by me duly sworn to testify
 11 to the truth, the whole truth, and nothing but the truth;
 12 That said deposition was taken down by me in
 13 shorthand at the time and place therein named and
 14 thereafter reduced to typewriting under my direction, and
 15 that the foregoing transcript contains a full, true, and
 16 verbatim record of said deposition.
 17 I further certify that I have no interest in the
 18 event of the action
 19 WITNES day of October,
 20 2023.
 21
 22 
 23 AMY E. SIMMONS
 24 ID CSR No. 685
 25 CA CSR No. 14453
 WA CSR No. 22012915
 OR CSR No. 22-009
 RDR, CRR, CRC,
 and Notary Public
 My commission expires: 6/13/28.

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1 Philip S. May
 2 philip.may@groombridgewu.com
 3 October 20, 2023
 4 RE: Poe, Et Al. v. Labrador, Et Al.
 5 10/16/2023, Jack Turban , M.D., MHS (#6058443)
 6 The above-referenced transcript is available for
 7 review.
 8 Within the applicable timeframe, the witness should
 9 read the testimony to verify its accuracy. If there are
 10 any changes, the witness should note those with the
 11 reason, on the attached Errata Sheet.
 12 The witness should sign the Acknowledgment of
 13 Deponent and Errata and return to the deposing attorney.
 14 Copies should be sent to all counsel, and to Veritext at
 15 Calendar-Idaho@veritext.com.
 16
 17 Return completed errata within 30 days from
 18 receipt of testimony.
 19 If the witness fails to do so within the time
 20 allotted, the transcript may be used as if signed.
 21
 22 Yours,
 23 Veritext Legal Solutions
 24
 25

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1 Poe, Et Al. v. Labrador, Et Al.
 2 Jack Turban , M.D., MHS (#6058443)
 3 ACKNOWLEDGEMENT OF DEPONENT
 4 I, Jack Turban , M.D., MHS, do hereby declare that I
 5 have read the foregoing transcript, I have made any
 6 corrections, additions, or changes I deemed necessary as
 7 noted above to be appended hereto, and that the same is
 8 a true, correct and complete transcript of the testimony
 9 given by me.
 10
 11 _____
 12 Jack Turban , M.D., MHS Date
 13 *If notary is required
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
 15 _____ DAY OF _____, 20____.
 16
 17 _____
 18 NOTARY PUBLIC
 19
 20
 21
 22
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[guess - health]

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[sentence - shut]

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[witness - yeah]

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[yeah - zoom]

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Idaho Rules of Civil
Procedure

Rule
30

(e) Review by the Witness; Changes.

(1) Unless waived by the deponent and the parties, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which (A) to review the transcript or recording; and (B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them. (2) Changes indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30 (f) (1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period. (3) Witness Failure to Sign. (A) In General, If the deposition is not signed by the witness within the 30-day period, the officer must sign it and state on the record the fact of the waiver of signature, or of the illness or absence

of the witness or the fact of the refusal to sign the deposition together with any reason given for not signing.

(B) Use of Unsigned Deposition. The deposition may be used as if it were signed, unless pursuant to Rule 32 (d)(4) the court determines that the reasons given for the refusal to sign require rejection of the deposition in whole or in part.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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1 Poe, Et Al. v. Labrador, Et Al.

2 Jack Turban , M.D., MHS (#6058443)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Jack Turban , M.D., MHS, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10

11

Jack L. Turban

11/01/2023

12

Jack Turban , M.D., MHS

Date

13

*If notary is required

14

SUBSCRIBED AND SWORN TO BEFORE ME THIS

15

_____ DAY OF _____, 20__.

16

17

18

19

NOTARY PUBLIC

20

21

22

23

24

25

Witness: Jack Turban, M.D., MHS (Job #6058443)

Date: October 16, 2023

Poe, et al. v. Labrador, et al., Case No. 23-cv-269-BLW (D. Idaho)**Deposition Errata Sheet**

| Page | Line(s) | Currently Reads | Should Read | Reason |
|------|---------|--------------------------------|---|---------------|
| 20 | 20 | clinical courtships | clinical clerkships | Error |
| 34 | 16 | medical cohort study | and a cohort study | Error |
| 34 | 19 | introduction | intervention | Error |
| 39 | 17 | great | grade | Error |
| 48 | 18 | risk and bias | risk of bias | Error |
| 54 | 10 | bases | databases | Error |
| 56 | 18 | went in to | one can | Error |
| 59 | 5 | you might be able to create | you might use GRADE | Error |
| 73 | 22 | clinic-basing assent | clinically significant | Error |
| 75 | 8 | describe | ascribe | Error |
| 76 | 18 | [indiscernible] | external factors | Error |
| 76 | 19 | told that your gender identity | told that your gender identity is wrong | Clarification |
| 77 | 7 | commute | community | Error |
| 77 | 7 | minoritize | stigmatize | Error |
| 77 | 14 | yourself | themselves | Error |
| 77 | 18 | seeking | speaking | Error |
| 80 | 10–11 | Or even | Are you | Error |
| 83 | 8 | in actual history | the natural history | Error |
| 91 | 12 | need them to | need to | Error |
| 91 | 19 | will be in part | will be important | Error |
| 96 | 24 | gender roles' behavior | gender roles and behavior | Error |
| 97 | 15 | intent to | intent and | Error |
| 99 | 19 | wouldn't necessarily | they wouldn't necessarily | Error |
| 104 | 11 | was | wasn't | Error |
| 104 | 18 | address | dress | Error |
| 104 | 24 | decision | the decision | Error |
| 108 | 25 | Another side | On the other side | Error |
| 109 | 15 | events | appointments | Error |
| 129 | 12 | recitation | statistic | Error |
| 129 | 13 | I was trying not to | I was trained not to | Error |
| 130 | 12 | But want to | But we wanted to | Error |
| 138 | 2 | key value | p-value | Error |

Witness: Jack L. Turban
Jack Turban, M.D., MHSDate: 11/01/2023

Witness: Jack Turban, M.D., MHS (Job #6058443)

Date: October 16, 2023

| Page | Line(s) | Currently Reads | Should Read | Reason |
|------|---------|--------------------------------|---|---------------|
| 151 | 7 | the | a | Error |
| 169 | 23 | kind of square | chi-square | Error |
| 171 | 21 | So it's drawing the | Drawing | Error |
| 172 | 5 | isn't | is | Error |
| 173 | 4 | Absolutely. | Absolutely -- | Clarification |
| 179 | 15 | in mental health | and mental health | Error |
| 181 | 6 | mental health, especially | mental health treatment, and | Error |
| 182 | 4 | adherence | appearance | Error |
| 182 | 7 | person | person's | Error |
| 182 | 17 | monitoring | modeling | Error |
| 189 | 13 | one statistical finding | a non-statistically significant finding | Error |
| 193 | 20 | path | impact | Error |
| 194 | 6 | child in adolescent psychiatry | child and adolescent psychiatrist | Error |
| 195 | 12 | really | nearly | Error |
| 195 | 21 | did | didn't | Error |
| 196 | 7-8 | Psycho Neurologic Chronology | Psychoneuro-endocrinology | Error |
| 197 | 7 | answer any | answer that | Error |
| 197 | 25 | but nothing | which it seems | Error |
| 198 | 9 | from more | to form | Error |
| 198 | 19 | in that | and that | Error |
| 201 | 21 | market surveillance | post-market surveillance | Error |
| 205 | 13 | a co-occurrence | an over-occurrence | Error |
| 208 | 2 | looked it | looked at | Error |
| 210 | 1 | their | executive | Error |
| 220 | 6 | supporting | scoring | Error |
| 220 | 8 | low, very low | low or very low | Error |
| 223 | 13 | low, very low | low or very low | Error |
| 248 | 17 | search | strict | Error |
| 253 | 4 | Some of my | Of my | Clarification |
| 254 | 6 | is that that | is that that's | Error |
| 267 | 25 | bottom | Bonferroni | Error |
| 289 | 11 | Both described | It describes | Error |
| 292 | 12-13 | one ascribes body language | one ascribes language | Error |
| 292 | 13 | sexualizes | conceptualizes | Error |

Witness: Jack L. Turban
Jack Turban, M.D., MHSDate: 11/01/2023

Witness: Jack Turban, M.D., MHS (Job #6058443)

Date: October 16, 2023

| Page | Line(s) | Currently Reads | Should Read | Reason |
|------|---------|-----------------|--------------------------|---------------|
| 303 | 25 | lowest | largest | Error |
| 309 | 7 | Definition | That's the definition | Error |
| 311 | 11 | higher | higher among trans youth | Clarification |

Witness: Jack L. Turban
Jack Turban, M.D., MHS

Date: 11/01/2023