

**IN THE UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION**

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DYLAN BRANDT, et al.,	:	
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Plaintiff,	:	
v.	:	Case No. 4:21-CV-00450-JM
LESLIE RUTLEDGE, et al.,	:	
	:	
Defendant.	:	
	:	
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**BRIEF IN SUPPORT OF MOTION TO EXCLUDE EXPERT TESTIMONY  
OF MARK REGNERUS**

Plaintiffs challenge a law banning gender-affirming medical procedures to treat adolescents with gender dysphoria. They argue that the challenged law prohibits treatments that, based on scientific research and decades of clinical experience, are widely recognized in the medical community as safe and effective. Plaintiffs also allege that by cutting off patients’ access to needed care, the challenged law would cause serious harms to the minor plaintiffs and transgender adolescents throughout Arkansas. *See, e.g.*, Mem. Supp. Pls.’ Mot. Prelim. Inj. 40–43, 57–61, ECF No. 12. To defend the law, the State asserts an interest in protecting minors from what it contends are unnecessary, harmful, and experimental treatments that, they claim, lack evidence of effectiveness. *See, e.g.*, Defs.’ Combined Br. Opp’n Pls.’ Mot. Prelim. Inj. 1–2, 34, ECF No. 44. At trial, the Court will be tasked

with resolving factual disputes regarding medical treatments for adolescents with gender dysphoria, which will largely turn on expert testimony.

One of the States’ proposed expert witnesses, Prof. Mark Regnerus, offers opinions on a host of medical issues concerning treatments for gender dysphoria—including the state of the research regarding the efficacy of medical treatments for the condition, the actual practices of medical providers in this field, and the ability of minors to consent to the medical interventions prohibited by the state under the Act. But Prof. Regnerus lacks the qualifications necessary to offer those opinions. He is trained exclusively in sociology. According to his profile at the University of Texas, he conducts research “in the areas of sexual behavior, family, marriage, and religion.”<sup>1</sup> By his own admission, Prof. Regnerus has no experience or academic training in medicine, mental healthcare, or the treatment of gender dysphoria. And he candidly acknowledges that transgender people have never been a focus of his research.

Prof. Regnerus also opines that the medical organizations, providers, and researchers that support, provide and research medical interventions for gender dysphoria are acting based on ideology rather than science. But these opinions rest

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<sup>1</sup> Univ. of Texas at Austin, Dep’t of Sociology, Mark Regnerus, <https://liberalarts.utexas.edu/sociology/faculty/mdr93> (last accessed June 20, 2022).

on the same medical opinions Prof. Regnerus lacks the qualifications to offer, in addition to anecdotes and unscientific commentary.

Federal Rule of Evidence 702 ensures that expert witnesses opine only on subjects within their field, and that their opinions are based on facts and reliable methodology. Prof. Regnerus has failed to clear that hurdle. His testimony should be excluded in its entirety.

### **LEGAL STANDARD**

Federal Rule of Evidence 702 places a special “gatekeeping role” on district courts. *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 597 (1993). To be admissible under Rule 702, expert testimony must satisfy three requirements: “First, evidence based on scientific, technical, or other specialized knowledge must be useful to the finder of fact in deciding the ultimate issue of fact”; “Second, the proposed witness must be qualified to assist the finder of fact”; “Third, the proposed evidence must be reliable or trustworthy in an evidentiary sense, so that, if the finder of fact accepts it as true, it provides the assistance the finder of fact requires.” *Lauzon v. Senco Prods., Inc.*, 270 F.3d 681, 686 (8th Cir. 2001) (citing *Daubert*, 509 U.S. at 591). “The proponent of the expert testimony must be able to prove its admissibility by a preponderance of the evidence.” *Id.* (citing *Daubert*, 509 U.S. at 592).

One of *Daubert*'s most important functions is ensuring that witnesses do not speak on matters that go "beyond the expert's expertise." *Am. Auto. Ins. Co. v. Omega Flex, Inc.*, 783 F.3d 720, 724 (8th Cir. 2015) (citing *Weisgram v. Marley Co.*, 169 F.3d 514, 520–521 (8th Cir. 1999)); *Khoury v. Philips Med. Sys.*, 614 F.3d 888, 893 (8th Cir. 2010). "The trial judge must determine whether the testimony has a reliable basis in the knowledge and experience of the *relevant discipline*." *Smith v. Rasmussen*, 249 F.3d 755, 758 (8th Cir. 2001) (emphasis added) (quoting *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 149 (1999)). Accordingly, courts must exclude testimony whenever the witness is "not well-versed in the particular discipline relevant to their testimony." *Id.* at 759.

Even when a witness is testifying within the bounds of their expertise, the court must separate "expert opinion evidence based on 'good grounds' from subjective speculation that masquerades as scientific knowledge." *Pressley v. Lakewood Eng'g and Mfg. Co.*, 553 F.3d 638, 643 (8th Cir. 2009) (quoting *Glastetter v. Novartis Pharm. Corp.*, 252 F.3d 986, 989 (8th Cir. 2001)). If the testimony consists only of "vague theorizing based on general principles," it should be excluded. *Pro Serv. Auto., L.L.C. v. Lenan Corp.*, 469 F.3d 1210, 1216 (8th Cir. 2006).

## ARGUMENT

### **I. PROF. REGNERUS IS NOT QUALIFIED TO OPINE ON MEDICAL ISSUES CONCERNING THE TREATMENT OF ADOLESCENTS WITH GENDER DYSPHORIA**

Under *Daubert*, experts may opine only on matters within their own field of expertise. *See Am. Auto. Ins. Co.*, 783 F.3d at 724; *Khoury*, 614 F.3d at 893. Prof. Regnerus’s report offers a range of opinions about medical issues concerning the treatment of adolescents with gender dysphoria that go well beyond his qualifications. Although he may believe that his training in the field of sociology qualifies him to opine on research from other disciplines, *Daubert* requires a meaningful connection between an expert’s knowledge and the opinions offered at trial. *See Smith*, 249 F.3d at 758. That connection is completely absent here.

#### **A. Prof. Regnerus Lacks Any Qualifications in Medical Care, Mental Health, Gender Dysphoria, or Transgender People.**

Prof. Regnerus’s expertise is exclusively in sociology. He has a Bachelor’s degree, Master’s degree, and PhD in Sociology. Since entering graduate school, he has worked only in sociology as a professor at UT Austin and Calvin College. He has published four books and dozens of peer-reviewed articles on sociological questions. He teaches only sociology courses, and routinely appears to discuss sociology at academic conferences. When asked to describe his “major areas of research,” Prof. Regnerus listed “relationship behavior, sexual decisionmaking, . . . sexuality and family formation, marriage, and . . . sociology of

religion,” all of which are sociological subjects. *Exhibit 4 – Deposition of Mark Daniel Regnerus*, Transcript 44:3–6 (“Dep. Tr.”).

By his own admission, Prof. Regnerus has no training or experience in medical care or mental health. *Id.* at 40:16–41:9. During his deposition, he acknowledged that he has never worked in a clinical setting and does not consult with healthcare providers as part of his work. *Id.* at 58:17–20. Prof. Regnerus has not written any peer-reviewed works concerning the effectiveness of medical or mental health treatments, nor does he teach courses on those subjects. *Id.* at 43:12, 52:22–53:1.

Prof. Regnerus’s professional experience related to gender dysphoria and transgender people is similarly lacking. His education did not include instruction on “transgender healthcare or [gender] dysphoria,” *id.* at 42:9, and he does not teach courses related to gender identity, *id.* at 54:25–55:2. He admitted that transgender people have never been the primary subjects of his work, *id.* at 49:23–50:3, and that he does not know how to diagnose or treat gender dysphoria, *id.* at 100:4–6, 101:23–102:1. His only peer-reviewed work focusing on transgender people in any way is about popular attitudes towards gender-affirming medical interventions. In other words, it is a paper analyzing the personal views of non-medical experts, the vast majority of whom are not transgender. *Id.* at 47:12–17. That work did not study the effectiveness of treatments for gender dysphoria, nor

did it engage with medical research in any way. *Exhibit 1* – Declaration of Mark Regnerus ¶ 56 (“Regnerus Report”) (discussing Mark Regnerus & Brad Vermurlen, *Attitudes in The U.S. Toward Hormonal and/or Surgical Interventions for Adolescents Experiencing Gender Dysphoria*, 51(4) Archives of Sexual Behavior 1891 (2022)).

Put simply, Prof. Regnerus lacks any training or experience that would qualify him to speak on healthcare generally or the treatment of gender dysphoria in particular. When asked if it “would be fair to say you don’t have academic training, professional experience, or peer-reviewed scholarship related to the efficacy of treatment for gender dysphoria,” Prof. Regnerus candidly replied: “True.” *Exhibit 4* – Dep. Tr. 73:23–74:3.

**B. Prof. Regnerus’s Opinions On Medical Issues Concerning The Treatment of Adolescents With Gender Dysphoria Must be Excluded.**

Despite Prof. Regnerus’s lack of qualifications concerning medical science, mental health, or the treatment of gender dysphoria, his report is filled with assertions about (1) the research on the efficacy of gender-affirming medical interventions, *Exhibit 1* – Regnerus Report ¶¶ 46-77, (2) the types of research that ought to be conducted about the efficacy of gender affirming medical treatment, *id.* ¶¶ 70–77, (3) the current practices of medical providers treating adolescent patients for gender dysphoria, *id.* ¶¶ 98–99, (4) the ability of minors to give informed consent

to medical care, *id.* ¶¶ 120–122, and (5) the connection between adolescent gender dysphoria and suicidality, *id.* ¶¶ 150–162. These claims are well outside Prof. Regnerus’s sociological training and experience, and therefore inadmissible under Rule 702. *See Khoury*, 614 F.3d at 893 (holding that expert witnesses cannot opine on topics for which they lack any “training, education, or experience”).

1. *Opinions about research on the effectiveness of gender-affirming medical care:* Prof. Regnerus offers a host of opinions about medical research standards. He devotes an entire section of his report to critiquing existing research that demonstrates the effectiveness of gender-affirming medical care. *Exhibit 1 – Regnerus Report* ¶¶ 45–69. Throughout these discussions, Prof. Regnerus repeatedly draws conclusions about individual medical studies measuring the effectiveness of hormonal or surgical treatments for gender dysphoria. *See, e.g., id.* ¶ 57 (stating his view that “a cursory reading of [a medical research study] tells a far less optimistic story than the author’s own confident interpretations of the post-surgical data.”). And he offers his own views on whether existing medical research shows that gender-affirming medical care benefits patients—going so far as to suggest that his own calculations regarding the efficacy of gender-affirming surgery should “ha[ve] ramifications for the treatment of adult and adolescent patients alike.” *Id.* ¶¶ 57–60.

As discussed above, Prof. Regnerus lacks any qualifications in medical care or medical research in general, or the treatment of gender dysphoria specifically. Indeed, during his deposition, he acknowledged that he does not know basic facts about medical care, including facts that would be relevant to his assessment of the state of the science on gender-affirming medical care. For example, despite claiming in his report and during his deposition that any off-label use of drugs is “experimental,” *Exhibit 1 – Regnerus Report* ¶ 70, Prof. Regnerus was unaware of the fact that off-label use of drugs is very common in medicine, as Defendants’ medical experts recognized, *Exhibit 4 – Dep. Tr. 276:18–20* (admitting that he did not know how common it was for drugs to be used for off-label purposes); *see Exhibit 6 – Levine Dep. Tr. 250:14–19; Exhibit 5 – Hruz Dep. Tr. 337:14–18*. He also explained that his opinions about how doctors should treat patients when data is uncertain were based only on his “observations of what goes on in the world” and his own “experience with healthcare,” rather than “any kind of comprehensive survey” or “scientific study.” *Exhibit 4 – Dep. Tr. 203:22–204:4*.

*2. Opinions about research that should be performed:* Prof. Regnerus asserts that medical researchers assessing treatments for gender dysphoria should be conducting randomized controlled trials to evaluate the efficacy of that care. *Exhibit 1 – Regnerus Report* ¶¶ 70–77. His report attacks the so-called “gender medicine industry” for disagreeing with him about the ethics of randomized

controlled trials in this context, and accuses medical providers of “complicity” and “near lawlessness” for treating patients without first conducting the trials he believes to be necessary. *Id.* ¶¶ 72–76. Despite these broad assertions, Prof. Regnerus stated during his deposition that “it’s tough to see [how such a trial would] work in reality,” *Exhibit 4* – Dep. Tr. 179:14–15, and acknowledged that he does not know how common it is in medicine for drugs to be used without randomized controlled trials demonstrating effectiveness, *id.* at 276:14–17. Again, he lacks qualifications to opine on medical research.

3. *Opinions about how care is currently provided to adolescents with gender dysphoria:* Dr. Regnerus claims that healthcare providers treating patients for gender dysphoria are failing to follow the guidance of professional organizations. Specifically, he opines that many clinics are failing to conduct psychological assessments before providing care to minors. *Exhibit 1* – Regnerus Report ¶¶ 98–99; *Exhibit 2* – Rebuttal Report ¶ 3. When asked to explain the basis for that opinion, Prof. Regnerus confirmed that it was “entirely based on . . . public commentary in newspapers and magazines.” *Exhibit 4* – Dep. Tr. 247:1–3. He testified that he did not know “how care is provided at any clinics in Arkansas,” *id.* at 244:23–245:1, and had never “observed care being provided in an American clinic,” *id.* at 240:19–21. When asked if he could “name any clinic that is not providing psychological assessments before providing care,” Prof. Regnerus replied, “No. But nor can I

name, you know, clinics who are.” *Id.* at 242:20–24. As discussed above, Prof. Regnerus lacks qualifications to opine on the treatment of gender dysphoria.

4. *Opinions about adolescents’ ability to consent to care:*

Prof. Regnerus repeatedly offers opinions on the psychological capacity and mental health of transgender adolescents. Much of his report discusses research on the ability of teenagers to provide informed consent to medical interventions. *See, e.g., Exhibit 1* – Regnerus Report ¶¶ 120–122; *see also Exhibit 4* – Dep. Tr. 254:3–9 (testifying that one of his “beefs with this practice” is the “fundamental ability to have informed consent as a 13-year-old about something that you have not experienced”). His report lays out his own assessment of that topic, claiming that adolescents have a “questionable ability to consent.” *Exhibit 1* – Regnerus Report ¶ 172. As with his other views on medical issues, Prof. Regnerus has no training or experience that would qualify him to offer these views. In addition, he testified that he has no “first-hand experience with the way clinics obtained informed consent” and does not know how clinics in Arkansas do so. *Exhibit 4* – Dep. Tr. 296:20–24. When asked to explain the “basis for [his] views on the informed consent process for minors,” Prof. Regnerus responded that his knowledge on the topic came “[f]rom people’s description of it, from you know, the [Plaintiffs’] expert witnesses.” *Id.* at 284:5–15.

5. *Opinions about the relationship between gender dysphoria and suicidality:* Prof. Regnerus questions whether gender dysphoria causes increased suicide and suicidality among transgender adolescents. *See, e.g., Exhibit 1 – Regnerus Report* ¶ 158 (“The evidence for actual suicide risk among gender dysphoria minors is simply unclear.”). Throughout his discussion of this topic, he offers opinions about the research on the psychological causes of suicide, and the additional research that he believes would be needed to demonstrate a link between gender dysphoria and suicide. *Id.* ¶ 160 (“In the absence of data analyses that can control for the effects of other confounding and contributing factors, it becomes very difficult to establish that gender dysphoria is a solitary or primary driver of suicidality.”). Once again, Prof. Regnerus lacks the training necessary to evaluate psychological research and has no experience with the diagnosis or treatment of mental health conditions.

Rule 702 requires that experts be “well-versed in the particular discipline relevant to their testimony.” *Smith*, 249 F.3d at 759. Here, Prof. Regnerus opines on various medical issues concerning the treatment of gender dysphoria, while lacking the qualifications necessary to make him “well-versed” on those subjects. Prof. Regnerus is not a doctor, does not work in the field of healthcare, has never worked in or observed medical clinics, and has never published research on the effectiveness of medical treatments of any kind, let alone treatments for gender

dysphoria. The complete disconnect between Prof. Regnerus’s qualifications and his opinions renders his testimony inadmissible under *Daubert* and Rule 702.

**C. General Training in Social Science Does Not Qualify an Expert to Speak on Scientific Research Outside Their Field.**

Prof. Regnerus believes that he is qualified to opine on medical research because of his knowledge regarding “basic methodological matters.” *Exhibit 1 – Regnerus Report* ¶ 3. According to Prof. Regnerus, his sociological training qualifies him to speak to the state of the academic literature in many other disciplines, including medical science, economics, or other social sciences. *Exhibit 4 – Dep. Tr. 121:13–16* (agreeing with the statement “you don’t need expertise or training in a particular scientific field to evaluate the quality of the science in that field”).

Rule 702, however, is not satisfied simply because an expert has knowledge in some general subject unrelated to the parties’ actual dispute. *See Khoury*, 614 F.3d at 893 (holding that even when an expert has “ability or expertise” in one field, his testimony must be excluded when he lacks “training, education, or experience” relevant to the issues in the case). Even when an expert is unquestionably qualified in certain subjects, his testimony must be excluded if those qualifications do not extend to the specific subject matter at issue. *See Am. Auto.*, 783 F.3d at 723 (affirming a district court that limited the testimony of an expert with a “thirty-year academic career, [who] had published hundreds of articles on

metallurgy and arc physics,” because he lacked specific qualifications related to “product design and warnings”); *Wheeling Pittsburgh Steel Corp. v. Beelman River Terminals, Inc.*, 254 F.3d 706, 715–716 (8th Cir. 2001) (reversing a district court that permitted an expert that was well-qualified in one area to testify on matters beyond his expertise).

The Eighth Circuit has confronted this very problem in a case involving medical treatments for gender dysphoria. In *Smith v. Rasmussen*, an adult Medicaid recipient sued the Iowa Department of Human Services when the agency denied insurance coverage for a surgical treatment for gender dysphoria. 249 F.3d 755 (8th Cir. 2001). To justify its decision, the agency put forward the testimony of “an experienced, board-certified general psychiatrist, who has treated several patients with sexual disorders,” to opine on “the effectiveness and necessity of sex reassignment surgery.” *Id.* at 758. In excluding the expert’s testimony on those topics, the district court cited the expert’s lack of “expertise in the *specialized discipline of gender identity disorder.*” *Id.* at 758–759 (emphasis added) (referring to a diagnosis that preceded gender dysphoria). The Eighth Circuit unanimously affirmed that ruling. If the expert in *Smith* was not close enough to the bullseye to offer an opinion on the efficacy of gender-affirming care, then Prof. Regnerus is not even on the board.

Prof. Regnerus has acknowledged that different academic fields use different research standards. He has previously testified about the different research standards applied in sociology and psychology. *Exhibit 8* – March 4, 2014 Trial Tr. 14:2–6, *Deboer v. Snyder*, No. 12-10285 (E.D. Mich. Mar. 4, 2014). He also stated during his deposition that medical researchers employ different standards than sociological researchers. *Exhibit 4* – Dep. Tr. 120:8–13.<sup>2</sup> Prof. Regnerus’s own statements illustrate why the Eighth Circuit has repeatedly held that advanced training in one discipline does not qualify an expert to speak on unrelated topics.

Prof. Regnerus’s asserted expertise in “basic methodological matters” is the only qualification he has offered to support his specific opinions on medical research and the effectiveness of treatments for gender dysphoria. *Exhibit 1* – Regnerus Report ¶ 3. Under the principles long applied in this Circuit, that is not enough.

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<sup>2</sup> In *DeBoer*, Prof. Regnerus opined that psychological research showing that children raised by same-sex parents fared no differently than children raised by opposite-sex parents was methodologically flawed, and that the views of major medical organizations recognizing that conclusion could not be trusted. *Exhibit 7* – March 3, 2014 Trial Tr. 29–32, *Deboer*, No. 12-10285. He admitted on cross-examination that the research standards used in his field of sociology are different than the standards used in psychological research. *Exhibit 8* – March 4, 2014 Trial Tr. 13:13–14:22, *Deboer*, No. 12-10285. The district court ultimately decided that his testimony was not credible. See *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 765–766 (E.D. Mich. 2014).

## II. PROF. REGNERUS'S OPINIONS ABOUT "IDEOLOGICAL CAPTURE" SHOULD ALSO BE EXCLUDED

Prof. Regnerus opines that the “clinical discussion of gender dysphoria has recently become unmoored from empirical assessments,” and has been “captured” by “advocates for what is sometimes called ‘gender ideology.’” *Exhibit 1* – Regnerus Report ¶ 78. Throughout his discussion of that topic, he claims that organizations, doctors, and researchers who support, provide, and research gender-affirming medical care are acting based on ideology rather than science. But Prof. Regnerus’s opinion about “ideological capture” rests on medical opinions he is not qualified to offer.

Prof. Regnerus concludes that ideology is at play only after determining, in his view, that the medical research shows that gender-affirming medical interventions are not effective, *Exhibit 1* – Regnerus Report ¶ 86; that minors cannot consent to such treatment, *id.* ¶ 127; and that treatment is provided on demand, without proper evaluation of patients, *id.* ¶ 98. Given his assessment of these medical issues related to the treatment of gender dysphoria, it is not surprising that he would look for other factors, besides science, that explain the widespread acceptance of medical interventions to treat gender dysphoria.

Indeed, Prof. Regnerus recognizes that his opinion about ideological capture is inextricably intertwined with his views about medical research:

That any purported ‘consensus’ on hormonal and surgical interventions at earlier ages should have developed so rapidly among American professional associations—and with so much projected confidence—in *the absence of obvious, consistent indicators of treatment efficacy*, and amid a surge in cases of gender dysphoria, is suspicious.

*Exhibit 1* – Regnerus Report ¶ 86 (emphasis added). As that passage demonstrates, Prof. Regnerus’s claim that “American professional organizations” are in the thralls of “ideological capture” is entirely dependent on his belief that those organizations have reached a conclusion about the state of medical science that differs from his own; because he thinks there is an “absence of obvious, consistent indicators of treatment efficacy,” everyone who doesn’t must be acting based on ideology rather than science.

As discussed in point I, *supra*, Prof. Regnerus is demonstrably unqualified to offer expert opinions on medical issues related to the treatment of gender dysphoria, including whether medical research shows that gender-affirming medical care is effective, how this care is provided, and whether adolescents are able to consent to the care. Because Prof. Regnerus is not qualified to offer expert opinions on the host of medical issues that underlie his views on “ideological capture,” he should not be permitted to testify about his conclusions that necessarily depend on these medical judgments. For this reason alone, Prof. Regnerus’s testimony related to ideological capture should be excluded.

Prof. Regnerus’s opinion that ideological capture is at work with respect to support for gender-affirming medical care also relies on a number of unsupported and unreliable factual claims that should be rejected. *See Pro. Serv. Auto. LLC*, 469 F.3d at 1216 (“In the absence of any record evidence that [the expert] used reliable principles and methods or applied them reliably to the facts of this case to form his opinion, his causation opinion does not satisfy the Rule 702 standards for admissibility.”); *Grp. Health Plan, Inc. v. Philip Morris USA, Inc.*, 344 F.3d 753, 760 (8th Cir. 2003) (rejecting expert testimony that “entail[ed] a great deal of speculation”).

First, Prof. Regnerus’s report includes a number of claims about doctors and researchers. He accuses doctors who provide gender-affirming medical care of rushing minors into care without appropriate psychological assessment and providing such care “on demand.” *See, e.g., Exhibit 1 – Regnerus Report* ¶¶ 96–99; *Exhibit 2 – Rebuttal Report* ¶¶ 3, 12, 13. And he accuses researchers of ignoring important research questions, such as transition regret or the demographics of youth identifying as transgender, for ideological reasons. *See, e.g., Exhibit 1 – Regnerus Report* ¶ 45 (claiming that researchers are not interested in understanding the purported shift in the number of youth identifying as transgender); *id.* ¶ 109 (asserting that “[t]ransgender activists and their allies in the professions have sought to minimize the experiences of people who regret their transition”).

Prof. Regnerus fails to back up these bold claims with any reliable evidence. Instead, on topic after topic, he makes extraordinary claims that rest entirely on anecdotes or unadorned speculation. His claims about the nationwide practices of gender-affirming care providers are based on nothing more than “commentary” and the alleged practices of two clinics. *Id.* ¶ 97–99; *Exhibit 4* – Dep. Tr. 243:20–22. When pressed to explain his views, Prof. Regnerus admitted that he had no firsthand knowledge of how clinics provide gender-affirming medical care or how common it is for clinics to provide treatment in the manner he describes. *Exhibit 4* – Dep Tr. 240:19–21, 43:7–10 (when asked at deposition the basis for his statement in his report that psychological assessments of patients are “hardly occurring,” he said “I should have said it is unclear in its frequency.”). And despite Prof. Regnerus’s claims that researchers are ignoring important topics like transition regret or the changing demographics of young identifying as transgender, *Exhibit 1* – Regnerus Report ¶¶ 45, 109, his own report cites recent scholarship by one of Plaintiffs’ experts on the subject of transition regret, *id.* ¶ 111 (citing Dr. Turban’s 2021 study on detransitioners), while ignoring the discussion of the increase in referrals to gender clinics and the sex ratios of those young patients contained in the most recent draft of WPATH’s standards of care, *see Exhibit 3* – Karasic Rebuttal Report ¶ 19.

Second, Prof. Regnerus claims that ideological bias is driving the work of major medical organizations that provide guidance on gender affirming medical care, like the Endocrine Society and WPATH. Yet his report is bereft of any analysis distinguishing the Endocrine Society or WPATH from the dozens of comparable organizations that exist throughout the medical community to develop best practices for treatment and advocate on behalf of their patients.

These opinions offered by Prof. Regnerus are “subjective speculation that masquerade[] as scientific knowledge.” *Glastetter*, 252 F.3d at 989. In addition to resting on medical opinions he is not qualified to offer, Prof. Regnerus’s views on “ideological capture” “entail[] a great deal of speculation [and] involve[] inferences that approach leaps of faith.” *Grp. Health Plan*, 344 F.3d at 760. “Where opinion evidence is connected to existing data only by the *ipse dixit* of the expert, a district court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.” *Pro Serv. Auto.*, 469 F.3d at 1215. That result is appropriate here, as Prof. Regnerus’s report is devoid of any analysis that would close the gap between his sweeping opinions and the limited facts he offers in support. This is an additional reason Prof. Regnerus’s testimony about ideological capture should be excluded.

## CONCLUSION

Prof. Regnerus’s testimony does not reflect the “scientific, technical, or other specialized knowledge” that would make it “useful to the finder of fact.” *Lauzon*, 270 F.3d at 686. His opinions concerning medical issues related to the treatment of adolescents with gender dysphoria are well outside his area of expertise, and his opinions concerning ideological capture rely on those opinions he is not qualified to offer, in addition to unsupported assertions. Because Prof. Regnerus is unqualified to offer the opinions in his report, and has failed to base opinions on “good grounds,” *Glastetter*, 252 F.3d at 988–89, his testimony should be excluded in its entirety.

Dated: June 22, 2022

/s/ Leslie Cooper

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# Exhibit 1

**IN THE UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION**

**DYLAN BRANDT, et al.,**

**PLAINTIFFS,**

**v.**

**No. 4:21-CV-00450-JM**

**LESLIE RUTLEDGE, et al.,**

**DEFENDANTS.**

**DECLARATION OF DR. MARK REGNERUS**

Pursuant to 28 U.S.C. 1746, I declare:

**I. CREDENTIALS & SUMMARY OF OPINIONS**

1. I am Professor of Sociology at the University of Texas at Austin. I received my Ph.D. from the University of North Carolina at Chapel Hill in 2000. I became an Assistant Professor of Sociology at UT-Austin in 2002, an Associate Professor in 2007, and a full Professor in 2018.

2. I have published numerous articles and four books on sexual relationship behavior and decision-making since 2003.<sup>1</sup> The books, peer-reviewed journal articles, and essays I have written include material on sexual orientation and, more recently, perspectives on transgender medicine. I am an experienced peer reviewer, having reviewed dozens of manuscripts in the past decade on these and related topics—including for top journals in both sociology and sex/sexuality studies (e.g., *Archives of Sexual Behavior*, *Journal of Homosexuality*, etc.). I have extensive survey administration experience as well, having fielded three nationally-representative surveys since 2011, and consulted on survey construction for several others, including the National Study

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<sup>1</sup> Regnerus, M. D. (2007). *Forbidden fruit: Sex & religion in the lives of American teenagers*. Oxford University Press.; Regnerus, M. & Uecker, J. (2011). *Premarital sex in America: How young Americans meet, mate, and think about marrying*. Oxford University Press.; Regnerus, M. (2017). *Cheap sex: The transformation of men, marriage, and monogamy* Oxford University Press.; Regnerus, M. (2020). *The future of Christian marriage*. Oxford University Press.

of Family Growth and the National Longitudinal Study of Adolescent to Adult Health (or Add Health). A more complete review of my professional experience, publications, and research is provided in my curriculum vitae, a copy of which is attached hereto as Exhibit A.

3. My experience in the area of transgender research primarily concerns basic methodological matters, involving design, measurement, statistical inference, interpretation of data, and reflections on the research and publication norms that have developed in this new domain in conjunction with media interest and professional and organizational pressures. This leans not only on my knowledge of the research in this domain, but also on the details of quantitative and qualitative research, subjects I have taught to sociology majors at least 20 times since my appointment on the faculty at the University of Texas at Austin.

4. I have been retained as an expert witness by the State of Arkansas in connection with this litigation. I have actual knowledge of the matters stated in this report. I base the following opinions on my own knowledge, research, experience, and publications, and the work of other academics and writers. The materials I have used to research and write this report are the standard sources used by other experts in my field. I am receiving \$250 per hour for my time spent preparing this report. My compensation is not dependent upon the outcome of this litigation or the substance of my opinions.

5. The focus of this report is on science: scientific evidence, researcher conduct, the culture of scientific organizations, the role of values in scientific inquiry, and a review of the declarations (original and supplemental) submitted by the plaintiffs' witnesses (Deanna Adkins, Armand H. Matheny Antommara, and Jack Turban) during the preliminary-injunction stage of this litigation. In particular, I focus on the unscientific process by which "affirmative" treatment of transgender-identifying adolescents has come to be the default position advocated by various

professionals and organizations. This is what the sociology of science concerns—an evaluation of how science operates. In this case, I probe how the nascent field of transgender research has, in the United States, come to make premature claims about “standards of care” and profess a level of “consensus” about affirmative care that is not only uncharacteristically rapid for such a new scientific subfield, it’s also untrue. The actual practice of many gender clinicians (and surgeons, etc.) continues to shift toward earlier and more invasive treatments, even while the “standards of care” counsel patience. Something is amiss.

6. A summary of the key points I discuss in this statement includes:
  - a. The science of the origins and course of gender identity remain in flux.
  - b. The demographics of transgender-identifying adolescents is shifting in ways that are not yet understood.
  - c. Adolescent gender transition treatments are not supported by randomized clinical trials—an absence that is difficult to account for.
  - d. There is a great deal of evidence that discussion of gender dysphoria and its treatment has been captured by the assumptions of activists promoting what is sometimes called “gender ideology.”
  - e. The evidence for suicide risk among gender dysphoric minors is ambiguous at best, and the evidence for claims that treatments for adolescent gender transition lead to sustained improvement in mental health is remarkably weak.
  - f. The practice of “affirmative” treatment for young people with gender dysphoria is characterized by dubious assumptions and questionable value

judgments that increasingly result in a consumer-driven medical culture out of step with science.

7. My intention is not to offer a comprehensive literature review of the entire field of research in transgender science—or even that which is focused on minors. That is a task unsuited to this document. Rather, one of the central purposes of my report is to describe how and why any supposition that there is a legitimate scientific consensus about treatment for adolescents is unmerited. The research I cite and discuss is compelling evidence favoring a proper interpretation of this field as “in development” rather than as “settled science.”

8. In the declaration of Dr. Deanna Adkins, dated June 11, 2021 (“Adkins”), she identifies affirmative care as treatment for gender dysphoria that is “aimed at eliminating the clinically significant distress a patient experiences by helping the patient live in alignment with their gender identity.”<sup>2</sup> The same treatment is referred to both in the medical literature and in this report using similar terms, including “gender transition,” “gender affirming care,” and “affirmative” treatment—an approach that (typically) recommends the hormonal and surgical procedures that Arkansas has prohibited doctors from performing on minors.

9. I make no claims here about the most prudent course of treatment for a particular patient, and I have no desire to stoke identity politics or foster moral panic. Instead, as a sociologist, my claims highlight the unscientific processes by which “gender affirming” treatments have come to appear not simply as the dominant approach but increasingly the only permitted approach. And even among its proponents there is growing pressure to skip the psychological evaluations first and move to offer treatments to minors at younger and younger ages. All of this has

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<sup>2</sup> Adkins, D. (2021) Declaration, U.S. District Court, Eastern District of Arkansas, Case No.: 4:21CV450-JM, p. 4.

happened amid a surge in cases of gender dysphoria and transgender identity that emerged suddenly, was unanticipated, and remains demonstrably undertheorized.<sup>3</sup> In other words, most scholars have been insufficiently curious about these recent developments and appear instead to be more interested in connecting research strategies and conclusions to fit affirmative care prescriptions. This is the “elephant in the room” that ought to give pause to practitioners and their professional societies. But, instead, many have pressed ahead without sufficient interest in understanding why the current realities have come to be. This is not how medical science works in nearly every other branch. Indeed, medical science is often accused of being too cautious and conservative, preferring—as it typically does—wide and consistent confirmation of stably discernible patient benefits that outweigh the risks involved.

10. Since pubertal blockers are already permitted and prescribed for the treatment of precocious puberty in one’s natal sex, the plaintiffs’ witnesses frame Arkansas’s law as discrimination regarding who can access such treatments. But the issues at stake are even more fundamental than a question of fairness. Those fundamental issues include: First, has affirmative care been—and is it now—demonstrably and consistently helpful to minors, in terms of enhanced long-term psychological and physical health? Second, ought minors be permitted to make such consequential, life-altering decisions?

11. Lurking in the background are other inexplicable patterns besides a rapid surge in gender dysphoria. Twenty years ago, far more natal males than females exhibited gender dys-

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<sup>3</sup> Bernadette Wren, who was a senior clinician at the UK Tavistock gender clinic until her retirement, described the situation this way: “There are morally complex, there are clinically complex, there are politically complex issues that we are grappling with and there aren’t any easy answers. One of the things about the gender field is you can’t plausibly develop a foundational theory of gender identity in which to ground the work.” See Gossling, G. (2020). Bernadette Wren: On change. *In mind*. <https://100years.tavistockandportman.nhs.uk/bernadette-wren-on-change>

phoria. Ten years ago, comparable numbers of natal males and females sought help for it. Today, the sex ratio has reversed: for every one natal male seeking help, approximately three natal females do. Why? And why aren't certain researchers more interested in understanding this than in shuttling patients (regardless of their natal sex) toward "affirmative" care?

12. The plaintiffs' witnesses repeatedly reference current treatment regimens, "consensus," "standards of care," etc. But at a basic level, the question is whether any putative consensus has been formed without undue pressure. The evidence suggests that it has not.

13. Meanwhile, there is no global or even Western "consensus" on transgender treatments for adolescents. There is, rather, a coalition of organizations in the United States, Canada, the Netherlands, the United Kingdom, and Australia that use multiple platforms—scientific, medical, legal, and media—to suggest there is a consensus and employ language intended to reinforce the claim of a professional consensus backing "affirmative" care.

14. In reality—that is, when you include numerous pediatricians, psychotherapists, some researchers and endocrinologists, together with national health care systems in several European countries—there is no wide, shared consensus about the prudence and intelligence of giving puberty blockers and cross-sex hormones to adolescents. Only professional organizations whose assertions are partial to transgender activists would suggest there is a consensus. Indeed, how could a scholarly consensus emerge so quickly in a domain where research barely existed two decades ago, where much of what has been written is less than 7 years old, and is experiencing a surge in cases? Even some of the most well-known pioneering researchers in the field

acknowledge this: “...in actual practice, no consensus exists whether to use these early medical interventions.”<sup>4</sup>

15. Moreover, the consensus that is purported to exist is tentative and fragile, divided over age standards and whether putting patients in the driver’s seat of their own care is a good idea.<sup>5</sup> Although supporters of “affirmative” treatment approaches tend to *formally* endorse the experimental “Dutch protocol,” the contemporary practice of American gender clinics is not consistent even with that approach. In the Dutch protocol, baseline health and high functioning are required for adolescent patients to proceed through treatment. Psychiatric co-morbidities and the absence of childhood gender dysphoria (i.e., adolescent-onset only) are grounds for exclusion from subsequent treatment.<sup>6</sup> American gender clinics, however, increasingly offer treatment on-demand and with a much lower threshold for medical intervention than the Dutch protocol prescribes. That protocol is more rigorous and exclusive than the majority of patients who make up published American transgender research samples—in other words, most of the American patients would not qualify for the (experimental) procedures even under the Dutch protocol. Hence, when Dr. Turban appeals to the results of studies employing the Dutch protocol—including numerous references to Dr. de Vries’s research—to support affirmative gender medical treatments, this is sleight of hand, since the momentum in pediatric gender medicine that Turban endorses now disregards central aspects of the Dutch protocol that de Vries has long followed.

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<sup>4</sup> Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early medical treatment of children and adolescents with gender dysphoria: An empirical ethical study. *The journal of adolescent health : Official publication of the Society for Adolescent Medicine*, 57(4), 367–373, p. 367. <https://doi.org/10.1016/j.jadohealth.2015.04.004>

<sup>5</sup> Edwards-Leeper, L., & Anderson, E. (2021). The mental health establishment is failing trans kids. *Washington Post*, November 24. <https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist>.

<sup>6</sup> For a description of the protocol, see: Delemarre-van de Waal, H. A., Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European journal of endocrinology*, 155(suppl 1):S131–S137.

16. In essence, Drs. Adkins, Antommaria, and Turban are endorsing “affirmative” gender treatment based on research conclusions from a literature whose criteria for inclusion has long been quite different—more selective and rigorous—than it is today. To say, as does Thomas Steensma of the Dutch Center of Expertise on Gender Dysphoria, that “more research is really necessary, and very much needed” is an understatement.<sup>7</sup> Moreover, Steensma identifies the experimental nature of it all: “Little research has been done so far on treatment with puberty blockers and hormones in young people. That is why it is also seen as experimental.” The nature of the research, given it is “still being evaluated for efficacy, safety, and acceptability,” qualifies it as experimental under the American Psychological Association’s definition of experimental treatment.”<sup>8</sup>

17. How do adolescents fare when they are *not* screened for psychiatric co-morbidities? Finnish researchers can answer this question.<sup>9</sup> “Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems...” Indeed, “[p]sychiatric comorbidities, particularly depression, anxiety disorders and autism spectrum disorders as well as suicidality and self-harming behaviors are common among adolescents seeking gender reassignment.” Can “affirmative” treatment help them? We would have to suspend our attention to *any* study conclusions that employ the experimental Dutch protocol in order to make this assessment.

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<sup>7</sup> Tetelepta, B. (2021, February 27). More research is urgently needed into transgender care for young people. Where does the large increase of children come from? *Voorzij*. <https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/>

<sup>8</sup> <https://dictionary.apa.org/experimental-treatment>

<sup>9</sup> Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisén, L., Schorkopf, M., Suomalainen, L. & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. *Nordic journal of psychiatry*, 74(3), 213-219. The quotes are from page 213. doi: 10.1080/08039488.2019.1667429. See also Kaltiala-Heino, R., Sumia, M., Työlajärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9(1), 1-9.

18. Fundamentally, the ground has shifted here. Moves to medically treat adolescent gender dysphoria are being endorsed based on conclusions from studies whose sample inclusion criteria were far stricter than is commonly the case in practice today. The American medical establishment is being bamboozled by a bait-and-switch tactic, in service to a politicized movement to open up transgender medicine to adolescent patients who previously would not have been eligible for it.

## II. DOCUMENTING GENDER IDENTITY AND EXPLAINING THE RECENT SURGE IN GENDER DYSPHORIA AND TRANSGENDER-IDENTIFYING ADOLESCENTS

19. Transgender self-identifications have surged in the United States, and throughout much of the West, in the past 10 years. What had once comprised around 0.3 percent of the total population as recently as 2011 doubled to 0.6 percent by 2016 (with adolescent transgender self-identification comprising 0.7 percent). Since then, the pace of increase has accelerated further, especially among youth. Population-based survey data from 10 states and nine urban school districts found that an average of 1.8 percent of high school students currently identify as transgender.<sup>10</sup> A study in *Pediatrics*, leaning on a 2016 statewide survey in Minnesota, revealed a figure of 2.7 percent.<sup>11</sup> A 2018 application of the CDC's Youth Risk Behavior Survey to just

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<sup>10</sup> The states are as follows: Colorado, Delaware, Hawaii, Maine, Maryland, Massachusetts, Michigan, Rhode Island, Vermont, and Wisconsin; the nine large urban school districts are: Boston, Broward County, Cleveland, Detroit, District of Columbia, Los Angeles, New York City, San Diego, and San Francisco; see Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students - 19 states and large urban school districts, 2017. *MMWR Morbidity and mortality weekly report*, 68(3), 67–71. <https://doi.org/10.15585/mmwr.mm6803a3>

<sup>11</sup> Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics*, 141(3) e20171683. <https://doi.org/10.1542/peds.2017-1683>

under 5,000 high schoolers in a Northeastern city school district yielded 9.2 percent who reported “incongruence between gender identity and sex assigned at birth.”<sup>12</sup> This is no uptick; this is an inexplicable explosion that demands attention.

20. Countries like the UK—with a national health system—are better poised to keep centralized statistics about adolescent gender clinic patients. In 2009-10, a total of 32 natal females and 40 natal males were referred to the country’s Gender Identity Development Service (or GIDS).<sup>13</sup> A mere five years later, those figures rose to 399 natal females and 250 natal males. At the most recent year of data reporting (2018-19), the numbers had climbed to 1,740 natal females and 624 natal males. Beginning in 2011-12, the share of natal females outnumbered those of natal males, but by 2018-19, the sex ratio of referrals had exploded to 2.8 females for every male. This includes 171 children under age 10, 52 of whom are ages 3-6. A similar sex ratio is reported in North American gender clinics.<sup>14</sup>

21. Between 2015 and 2019, there was also a 27% increase among American high school boys in the share that identified as nonheterosexuals (from 4.5 to 5.7 percent). The same estimate among girls was even larger: a 46% increase (from 12.2 to 17.8 percent).<sup>15</sup> But the pace of growth in adolescent transgender self-identifications far eclipses the climb in rates of nonheterosexual orientations.

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<sup>12</sup> Kidd, K. M., Sequeira, G. M., Douglas, C., Paglisotti, T., Inwards-Breland, D. J., Miller, E., & Coulter, R. W. S. (2021). Prevalence of gender-diverse youth in an urban school district. *Pediatrics*, 147(6): e2020049823

<sup>13</sup> Tavistock & Portman NHS Foundation Trust. (2019, 28 June). Referrals to the gender identity development service (GIDS) level-off in 2018-19. <https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/>

<sup>14</sup> Sorbara, J. C., Chiniara, L. N., Thompson, S., & Palmert, M. R. (2020). Mental health and timing of gender-affirming care. *Pediatrics*, 146(4) e20193600. <https://doi.org/10.1542/peds.2019-3600>

<sup>15</sup> Rapoport, E., Athanasian, C. E., & Adesman, A. (2021). Prevalence of nonheterosexual identity and same-sex sexual contact among high school students in the US From 2015 to 2019. *JAMA pediatrics*. doi:10.1001/jamapediatrics.2021.1109

22. Dr. Turban, in his supplemental declaration submitted during the preliminary injunction phase of this litigation, balks at any use of the term “social contagion” to describe the rapid surge in transgender identity. “In contrast,” he writes, “transgender identity has been shown to be primarily influenced by innate biological factors.” While I have no reason to contest the presence of biological factors in the etiology of transgender identity, it strains the imagination to suggest there is nothing “social” going on here, especially since we are talking about something that once affected less than 1 in 10,000 children, according to DSM-5 prevalence rates.<sup>16</sup>

23. Intersex cases, often used to call attention to transgender cases, are distinctive and occur in roughly one in every 5,000 births, an estimate consonant across three continents.<sup>17</sup> They are considered a type of disorder of sex development (DSD), and are not, as has sometimes been suggested, evidence of a “spectrum” of biological sex.

24. The plaintiffs’ preliminary-injunction filings in this litigation described gender identity as both “innate” and “immutable,” as well as “durable and cannot be altered through medical intervention,” citing Dr. Adkins’s declaration as its sole support. Although Adkins appears to have characterized gender identity using the term “innate” before,<sup>18</sup> the report she submitted during the preliminary-injunction stage makes no use of that term (nor of “immutable”), instead describing a person’s gender identity merely as “fixed.” It is fair to say the terminology,

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<sup>16</sup> Tavistock & Portman NHS Foundation Trust (2021, June 3). Reply to Freedom of Information request for Charing Cross and GIC waiting and intake figures made by Harry Burns. [https://www.whatdotheyknow.com/request/request\\_for\\_charing\\_cross\\_gic\\_wa?nocache=incoming-1805111#incoming-1805111](https://www.whatdotheyknow.com/request/request_for_charing_cross_gic_wa?nocache=incoming-1805111#incoming-1805111)

<sup>17</sup> Kim, K. S., & Kim, J. (2012). Disorders of sex development. *Korean journal of urology*, 53(1), 1-8. doi: 10.4111/kju.2012.53.1.1; Thyen, U., Lanz, K., Holterhus, P. M., & Hiort, O. (2006). Epidemiology and initial management of ambiguous genitalia at birth in Germany. *Hormone research in paediatrics*, 66(4), 195-203. <https://doi.org/10.1159/000094782>; Sax, L. (2002). How common is intersex? A response to Anne Fausto-Sterling. *Journal of sex research*, 39(3), 174-178. <https://doi.org/10.1080/00224490209552139>

<sup>18</sup> Adkins, D., (2016). Declaration, U.S. District Court, Middle District of North Carolina, Case 1:16-cv-00236-TDS-JEP [https://www.aclu.org/sites/default/files/field\\_document/AdkinsDecl.pdf](https://www.aclu.org/sites/default/files/field_document/AdkinsDecl.pdf).

together with the science of the origins and course of gender identity, remain in flux. Indeed, this fact is acknowledged. The *Standards of Care* (version 7) published by the World Professional Association for Transgender Health (WPATH), for example, recognizes that “[t]erminology in the area of health care for transsexual, transgender, and gender-nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing.”<sup>19</sup> The Endocrine Society’s guidelines likewise acknowledge that “[t]erminology and its use vary and continue to evolve.”<sup>20</sup>

25. Categorical claims about the immutability of sexual orientation have fared well in recent legal decisions, as University of Utah psychology professor Lisa Diamond observed.<sup>21</sup> To invoke “immutability” in the absence of a genuine consensus on the etiology of gender dysphoria—especially amid the sudden surge in cases and its sex ratio disparity reversal—suggests political calculation is at work. There is little to suggest that experts in this domain are operating without particular interests.

26. Neither adolescent-onset gender dysphoria nor the rise in nonbinary self-identities fit the narrative that gender identity is “immutable” or “durable.” Rather, it suggests profound fluidity. What is durable or immutable about a “nonbinary” gender self-identity? Dr. Adkins, on the other hand, maintains that a person’s gender identity “is fixed, is not subject to voluntary control, cannot be voluntarily changed, and is not undermined or altered by the existence of other sex-related characteristics that do not align with it,” an assertion that seems out of step with the

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<sup>19</sup> World Professional Association for Transgender Health. (2012). *Standards of care for the health of transsexual, transgender, and gender nonconforming people* [7th Version]. <https://www.wpath.org/publications/soc> The quote is from p. 95.

<sup>20</sup> Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Hassan Murad, M., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T’Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society clinical practice guideline. *The journal of clinical endocrinology & metabolism*, 102, 11, 3869–3903, p. 3874. <https://doi.org/10.1210/jc.2017-01658>

<sup>21</sup> Diamond, L. M. & Rosky, C. J. (2016). Scrutinizing “immutability”: Research on sexual orientation and its role in legal advocacy for the rights of sexual minorities rights? *Journal of Sex Research*, 53, 363-391.

American Academy of Pediatrics (AAP) policy statement on the care and support for transgender and gender diverse children and adolescents, which holds that the self-recognition of gender identity “develops over time” and yet “[f]or some people, gender identity can be fluid, shifting in different contexts.”<sup>22</sup> Meanwhile, Columbia University sociologist Tey Meadow reports in her article on the production of legal gender classifications: “Many courts look to medical definitions of sex.... yet there is no consensus about when gender change actually happens.”<sup>23</sup>

27. Accounting for the surge in adolescent transgender cases has been very challenging for two reasons. First, it was an unexpected development. Ten years ago, there was simply no clinical literature on females ages 11 to 21 suffering from gender dysphoria.<sup>24</sup> Second, early onset gender dysphoria has been documented for years, but primarily in natal boys—and those typically lacking in extensive comorbidity (that is, co-occurring psychological problems such as anxiety or depression).

28. The new surge in adolescent transgender cases cannot be simplistically attributed to “pent-up demand”—that is, by suggesting that gender dysphoria and transgender self-identification exhibited longstanding manifestations that simply went undiagnosed or were entirely stigmatized. If that were true, we should be witnessing a parallel and documentable rise in gender dysphoria among, say, middle-aged adults. But no such rise has been observed. As recently as 2020, a Pew research study noted that only 0.2 percent of Gen X respondents (i.e., 40-55-year-olds) identify as transgender.<sup>25</sup> Dr. Turban, in his supplemental declaration, implies that were it

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<sup>22</sup> Rafferty, J. & Committee on Psychosocial Aspects of Child and Family Health.(2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents, 142 *Pediatrics* 4 e20182162; doi: <https://doi.org/10.1542/peds.2018-2162>.

<sup>23</sup> Meadow, T. (2010). “A rose is a rose”: On producing legal gender classifications, *Gender & society* 24(6), 814–837, p. 824. <https://doi.org/10.1177/0891243210385918>

<sup>24</sup> Shrier, A. (2020). *Irreversible damage: The transgender craze seducing our daughters*. Regnery Publishing.

<sup>25</sup> Jones, J. M. (2021, February 24) LGBT identification rises to 5.6% in latest U.S. estimate. *Gallup*. <https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx>

not for longstanding stigma—now diminishing, he admits—a similar surge in transgender self-identification would have materialized among adults as well (page 34). This is unlikely.

29. Second, the surge makes for a very sensitive research environment, all the more so given the rapid clinical shift from a “watchful waiting” approach to adolescent gender dysphoria to an “affirmative care” approach in which a swifter move to puberty blockers and cross-sex hormones is suggested. Among “affirmative care” backers, there is a further division that has materialized—between those who would press for psychological evaluations and monitoring, and a more aggressively affirming model characterized by a “trust the patient” (and treat promptly), with few questions asked. This ongoing shift appears to constitute much of the political struggle being witnessed over adolescent gender dysphoria, and it makes research efforts in this domain difficult to monitor, since research conclusions based on data about one approach (watchful waiting) are being used to foster endorsements of altogether different approach (“standard” as well as aggressive affirmative care).

30. In an attempt to understand this surge, Brown University public health scientist Lisa Littman explored possible “cluster outbreaks” of what she identified as “rapid onset gender dysphoria” (ROGD) among adolescents, meaning that the dysphoria happens suddenly either during or after puberty among teenagers who displayed no indications of such tendency in their childhood.<sup>26</sup> (Others identify this as “adolescent-onset” gender dysphoria.<sup>27</sup>) The study, which inquired of parents of teens, noted that ROGD tended to occur within groups of friends: more

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<sup>26</sup> Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. *Plos one*, 13(8), e0202330. <https://doi.org/10.1371/journal.pone.0202330>

<sup>27</sup> de Vries, A. L. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents. *Pediatrics*, 146(4). doi: <https://doi.org/10.1542/peds.2020-010611>; Seveler, M., & Meyer-Bahlburg, H. F. (2019). Late-onset transgender identity development of adolescents in psychotherapy for mood and anxiety problems: Approach to assessment and treatment. *Archives of sexual behavior*, 48(7), 1993-2001. <https://doi.org/10.1007/s10508-018-1362-9>

than one-third of the friendship groups in the study witnessed half or more of the group identifying as transgender in a similar time frame. This, Littman noted, is about 70 times higher than the expected (0.7%) prevalence rate. Only 13 percent of parents noted no evidence at all of a “social influence.”

31. Parents of the adolescents in the study tended to describe “a process of immersion in social media, such as ‘binge-watching’ YouTube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric.”<sup>28</sup> Littman also observed that 22 percent of adolescents in her study “had been exposed to online advice about what to say to doctors to get hormones.” Moreover, “the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist.”<sup>29</sup> A recent study about the surge in adolescent demand for gender dysphoria treatment in the UK and four Nordic countries similarly noted a potential role of social and media influences.<sup>30</sup>

32. Studies like Littman’s are exploratory, however, and not designed to discern causation. Professor Littman did not draw hard conclusions from her survey, which was nonrepresentative and relied on an opt-in sampling strategy that is very common in the study of transgender patients. Rather, she documented the associations between what she describes as the phenomenon of ROGD and certain social and psychiatric conditions.

33. An outcry on social media emerged after the Littman study was published. The journal’s editors pledged to “seek further expert assessment on the study’s methodology and analyses.” That is, they re-reviewed the study, a very unusual move in the sciences. This post-

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<sup>28</sup> Littman (2018), p. 3.

<sup>29</sup> Littman (2018), p. 36.

<sup>30</sup> Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisé, L., Schorkopf, M., Suomalainen, L. & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK. *Nordic journal of psychiatry*, 74(1), 40-44. doi: 10.1080/08039488.2019.1667429

publication review resulted in no substantive changes to the study's results, suggesting the motivation was rooted in political rather than scientific concerns. This example highlights the challenging atmosphere for documenting, understanding, and attempting to explain what is going on.

34. WPATH mildly criticizes Littman's study in their draft version 8 of their Standards of Care—which became available for preview and comment in December 2021 after 10 years of Version 7. While WPATH claimed Littman's study “contained significant methodological challenges which must be considered as context for the findings,” it nevertheless admits much of what Littman revealed, noting that “social influence on gender is salient” and that “by clinical observation an increasing number of youth are coming to self-identify as gender diverse in later adolescence.”<sup>31</sup>

35. Dr. Turban's disregard for Professor Littman's inquiry about the social cues of adolescent-onset gender dysphoria is obvious: her work is dismissed because “the scientific current understanding...does not focus on ‘social contagion.’” Perhaps the problem is less with Littman than with purveyors of a “science” that is more interested in safeguarding particular answers than it is with asking questions.

36. On page 7 of his report, Dr. Turban favorably cites a study published in a 2015 issue of *Psychoendocrinology* that measured Child Behavior Checklist scores based on parental self-report. Thus, Dr. Turban, whose previous declaration (on page 32) criticizes Littman's reliance on a parental questionnaire, has no trouble with parental self-reports as a measurement technique so long as they support his position.

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<sup>31</sup> World Professional Association for Transgender Health. (2021). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [DRAFT 8th Version]. <https://www.wpath.org/publications/sochttps://www.wpath.org/media/cms/Documents/SOC%20v8/SOC8%20Chapters%20for%20Public%20Comment/Letter%20eBlast%20-%20SOC8%20Public%20Comment%20Period%20December%202021%20FINAL.pdf?t=1638464778>

37. Dr. Turban seems far less curious about understanding surging gender dysphoria and the sex-ratio reversal than one would expect a purported expert about transgender identity to be. This matters. Professor Littman’s exploratory research was lambasted because it introduced the possibility that transgender identity is—at an unknown rate—not innate but developmentally responsive to social cues for an unknown but significant number of cases. If Littman is right, it means greater attention to the diverse origins of gender dysphoria is in order, with likely ramifications for treatment options. But her research is disparaged because this is not in accord with claims of those advocating for aggressively “affirmative” treatment. This isn’t how science is supposed to work.

38. Dr. Turban’s own attempt (beginning on page 33) to explain the surge in gender dysphoria and self-identified transgender cases is odd and under-documented, suggesting that he too—like most researchers in this domain—gives this important matter little thought. He claims that the “increase in referrals” is due to several causes. Among these, Dr. Turban suggests that “parents in the past may have had limited literacy regarding gender diversity,” something that has been ameliorated today. In other words, he claims that in the past parents neither had the language nor the interest in aiding their children to live as their authentic selves, except perhaps in “extreme types” of gender dysphoria. But today, he claims, “owing to media attention and the internet, it is easier to access information...making the threshold lower to search for help” (page 34). Dr. Turban thus appeals to the effects of media attention and the internet while simultaneously maintaining that Professor Littman’s interest in understanding the role of “social” forces and “transgender-related content” on the internet “is a fringe view not supported by evidence” (page 32). This is an obvious double standard.

39. Finally, Dr. Turban attempts to explain why clinics are “seeing more birth-assigned females than males in recent years”—which is a rather mild way of describing what is not a mere uptick but a radical reversal and surge, as I previously described. Dr. Turban begins with the observation that “tomboys” were much more likely to be “accepted in society, whereas feminine boys are ridiculed.” Perhaps so. But then he speculates that this phenomenon “likely led to more transgender males being satisfied with pushing gender expression toward more male [*sic*] without seeking support from a gender clinic...” (page 35). In asserting this, Dr. Turban categorically and anachronistically redefines tomboys as transgender males who simply had no access to a gender clinic. Where are they today? Still hidden—having suppressed their true identity? This explanation beggars belief. Perhaps instead, yesterday’s tomboys are largely content to have avoided medical dependency, living without health implications or impairments from lifelong treatments that were, at the time, unavailable. Their gender non-conformity fostered their own resilience.

40. Dr. Turban claims that “sex ratios that favor birth-assigned females” among the population of transgender patients is not unprecedented. While I can appreciate the subsequent international citations and consideration of international data, the sample sizes are simply too small (24 total cases of “female-to-male transsexuals” who “came from different parts of Poland” over four years in the study Dr. Turban cites<sup>32</sup>) to suggest anything about the sex ratio of transgender Poles in the 1970s. The rate of the much larger number seeking “sexologic” treatment from which this small pool is drawn, however, revealed the standard male-dominated pattern.

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<sup>32</sup> Godlewski, J. (1988). Transsexualism and anatomic sex ratio reversal in Poland. *Archives of sexual behavior*, 17(6), 547-548.

41. It is also ironic for Dr. Turban to have criticized Littman’s use of an opt-in, recruited “anonymous online survey,” when he has published extensively—including citations in his previous declaration—from the 2015 United States Transgender Study. The USTS recruited networked, self-identified transgender or nonbinary participants by advertising their survey among “active transgender, LGBTQ, and allied organizations.”<sup>33</sup> Now, there’s nothing inherently wrong with collecting data using a nonrandom approach like this, and it is common in this domain.<sup>34</sup> The problem, in this case, is when the conclusions based on such data are delivered to the reader in a way that suggests they are consonant with everyone who has identified as transgender or experienced gender identity disorder or dysphoria. Hence, to impugn Littman’s strategy is to impugn Dr. Turban’s own extensive use of the same method of collecting data from “some anonymous people recruited from the Internet...” (page 32).<sup>35</sup>

42. That Dr. Turban should commend the Almazan and Keuroghlian study (on page 25 of his initial declaration) is another irony, since it too is based on the USTS. Talk of a “control group” in the Almazan and Keuroghlian study connotes an experimental design, a randomi-

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<sup>33</sup> James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

<sup>34</sup> Littman, L. (2020). The use of methodologies in Littman (2018) is consistent with the use of methodologies in other studies contributing to the field of gender dysphoria research: Response to Restar (2019). *Archives of sexual behavior*, 49(1), 67-77. <https://doi.org/10.1007/s10508-020-01631-z>

<sup>35</sup> See, for example: Turban, J. L., King, D., Li, J. J., & Keuroghlian, A. S. (2021). Timing of social transition for transgender and gender diverse youth, K-12 harassment, and adult mental health outcomes. *Journal of adolescent health*. <https://doi.org/10.1016/j.jadohealth.2021.06.001>; Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to “detransition” among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT health*, 8(4), 273-280. <https://doi.org/10.1089/lgbt.2020.0437>; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725. <https://doi.org/10.1542/peds.2019-1725>; Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, 77(1), 68-76. [doi:10.1001/jamapsychiatry.2019.2285](https://doi.org/10.1001/jamapsychiatry.2019.2285); Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological attempts to change a person’s gender identity from transgender to cisgender: Estimated prevalence across US States, 2015. *American journal of public health*, 109(10), 1452-1454. <https://doi.org/10.2105/AJPH.2019.305237>

zation process, and/or some sort of multi-wave analysis in order to establish an obvious time order to events. The USTS and, by extension, the Almazan and Keuroghlian study, offers none of these methodological strengths and characteristics.

43. Moreover, the USTS creates the impression that the data collection effort was a population-based random sample, like the US Census. It is not. Indeed, the USTS yields information about the transgender population that is decidedly different from that which can be learned from the 2014 CDC's Behavioral Risk Factor Surveillance System (BRFSS) data, which is the product of a probability sample from 19 states (and Guam).<sup>36</sup> When the two are compared, stark differences are revealed, further suggesting that the empirical "truth" about the transgender population is simply difficult to discern—a fact of life in this domain of research. For example:

- a. Unemployment: 15% in the USTS vs. 8% in the BRFSS
- b. Sexual orientation: 47% of male-to-female identify as LGB in the USTS vs. 15% in the BRFSS; 24% of female-to-male identify as LGB in the USTS vs. 10% in the BRFSS
- c. Currently married: 18% in the USTS vs. 50% in the BRFSS
- d. Child in the household under 18: 14% in the USTS vs. 32% in the BRFSS
- e. General health rated as fair or poor: 22% in the USTS vs. 26% in the BRFSS

44. There are two conclusions to draw from this comparison of the USTS and BRFSS samples. First, opt-in samples like the USTS are for understanding processes and possibilities, not populations (as in the BRFSS). Second, Littman's use of an opt-in sample was hardly inappropriate. She sought to understand a process (that of rapid-onset gender dysphoria, or as others

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<sup>36</sup> Meyer, I. H., Brown, T. N., Herman, J. L., Reisner, S. L., & Bockting, W. O. (2017). Demographic characteristics and health status of transgender adults in select US regions: Behavioral Risk Factor Surveillance System, 2014. *American journal of public health*, 107(4), 582-589. <https://doi.org/10.2105/AJPH.2016.303648>

call it, late-onset or adolescent-onset gender dysphoria), one that curiously few scholars seem interested in understanding.

45. The general surge—and particular reversal of the anticipated sex ratio—in cases of adolescent gender dysphoria (commonly with comorbid conditions) has not simply escaped scholars and clinicians. Many seem actively hesitant to explore the matter, and quick to criticize those researchers who do. In most other domains of medicine, there is a rush to understand new developments. Professional, political, and cultural interests appear to be at stake here, putting the long-term flourishing of patients at risk.

### **III. STUDY CONCLUSIONS OF TRANSGENDER TREATMENT EFFECTS ARE DEMONSTRABLY INADEQUATE.**

46. Despite ample scientific resources—adequate funding, the interest of professional organizations, and competent researchers—the science of gender identity (and transgender outcomes) is often characterized by modest evidence followed by overreaching conclusions. Any talk of “consensus” or of enduring “standards” are baseless assertions. It is more accurate to say the field is rapidly evolving.

47. It remains the fact that little is understood about the long-term physical effects of puberty blockers and cross-sex hormones, especially when they are administered during those years that are critical for biological and brain development.<sup>37</sup> This is in part a function of (1) how few minors experienced these treatments in the past—a small pool to study, and (2) the fact that the surge in such treatments remains less than a decade old. In other words, too few and too new.

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<sup>37</sup> Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism & psychology*, 24(2), 271–291, p. 287. <https://doi.org/10.1177/0959353514526223>; Heneghan, C., & Jefferson, T. (2019, February 25). *BMJ EBM spotlight*. Gender-affirming hormone in children and adolescents. <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>

48. Adolescence is also a crucial period of social development. Artificially holding a child in a pre-pubescent state for several years while his or her peers navigate the social milestones and minefields of adolescence is likely to have at least some “subtle negative psychosocial and self-confidence effects.”<sup>38</sup> Indeed, the American Academy of Pediatrics recognizes that “[d]elaying puberty beyond one’s peers can also be stressful and can lead to lower self-esteem and increased risk taking.”<sup>39</sup> And the Endocrine Society’s guidelines recognize “the sense of social isolation from having the timing of puberty be so out of sync with peers.”<sup>40</sup>

49. But what the research does not tell us is the isolated effect of puberty blockers (and similarly, of subsequent cross-sex hormones), since today gender dysphoria infrequently appears apart from other (possibly confounding) psychiatric conditions and the experience of traumas.<sup>41</sup>

50. Seven endocrinologists and psychologists recently discussed the clinical characteristics of 79 children presenting to a new gender clinic in Australia, noting a high number of conflicted family situations and documented trauma.<sup>42</sup> Only five percent of their sample was believed to exhibit “healthy” levels of functioning.

51. Despite this, many of the new clinic’s patients and their families openly pressed the clinicians to begin medical (hormonal, etc.) treatments, believing that method was the only solution and “that their distress would be completely alleviated if they pursued the pathway of

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<sup>38</sup> Levine, S. (2020) Declaration, U.S. Circuit Court, Dane County, Wisconsin, Case No.: 20-CV- 454, p.41.

<sup>39</sup> Rafferty, J. & Committee on Psychosocial Aspects of Child and Family Health.(2018), p. 5.

<sup>40</sup> Hembree et al. (2017), p. 3885.

<sup>41</sup> E.g. In Littman (2018), 62 percent of parents reported their child had been previously diagnosed with a psychiatric disorder, while 48 percent reported a traumatic or stressful event occurring prior to the onset of their child’s gender dysphoria, p. 13.

<sup>42</sup> Kozłowska, K., McClure, G., Chudleigh, C., Maguire, A. M., Gessler, D., Scher, S., & Ambler, G. R. (2021). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems*, 1(1), 70-95.  
<https://doi.org/10.1177/26344041211010777>

medical treatment.” This frustrated the seven scholar-clinicians: “Lost were our efforts to highlight the many different pathways in which gender variation could be expressed, to explain potential adverse effects of medical treatment, to explore issues pertaining to future fertility and child rearing, and to highlight the importance of ongoing psychotherapy.” The authors attributed this now-predictable pattern to information that patients received from (1) their peers, (2) previously encountered health workers, and (3) the internet. Many children, they noted, arrived with “strongly entrenched beliefs and with no interest in further exploring their medical, psychological, social, or familial situation.” The study’s authors also asserted that many of the patients “did not have the cognitive, psychological, or emotional capacity to understand the decisions they were making.”<sup>43</sup>

52. These forces complicate treatment of gender dysphoria. A market increasingly characterized by patient demand for puberty blockers and, later, cross-sex hormones does not make for an atmosphere conducive to addressing pertinent co-occurring diagnoses. But this is exactly what is now developing in the “affirmative care” approach—an emerging split between those clinicians who want to (continue to) include psychological evaluations, counseling, and observation prior to hormonal and surgical treatments, and those clinicians—including researchers like Dr. Johanna Olson-Kennedy—who wish to skip those first steps and instead endorse (earlier) procedures.

53. As psychotherapist Robert Withers observes, “failure to address relevant psychological issues can result in trans people making unnecessary, permanent changes to their bodies, without adequate scientific justification for doing so.”<sup>44</sup> Withers additionally notes that “[m]any

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<sup>43</sup> Kozłowska et al. (2021). All quotes are from p. 15.

<sup>44</sup> Withers, R. (2020) Transgender medicalization and the attempt to evade psychological distress. *Journal of analytical psychology*, 65: 865– 889, p. 865. <https://doi.org/10.1111/1468-5922.12641>

of today's young people have also made 'gender affirming' medical treatment their goal. Unfortunately, the evidence base supporting the efficacy of such treatment is extremely poor."<sup>45</sup>

54. In his previous declaration Dr. Turban offered the unsubstantiated claim that "[a]ll existing published data...points to the fact that gender-affirming medical interventions improve mental health for transgender adolescents." Such a categorical claim is simply untrue.

55. As an example of this erroneous categorical claim, Dr. Turban immediately highlights on the very same page an example of how "research has shown that sexual functioning (along with romantic development) improves" after gender-affirming medical interventions on adolescents.<sup>46</sup> But the study he cites reveals no such thing. "Improvement" cannot even be measured here, since the study was a cross-sectional one, not longitudinal. The study, rather, asked transgender youth a series of questions about sexual and romantic experiences and satisfaction (at a mean age of 14, no less). The results revealed that, in comparison to the general population, transgender youth displayed less sexual and romantic experience. It is an odd study to reference in support of his (ironic) claim about state's experts' purported mischaracterizations.

56. Large, longitudinal data collection efforts on the psychological health effects of transgender medicine remain rare but do exist. The Swedish Total Population Register, a massive longitudinal survey effort that collected information from over 9.7 million Swedes, is an example. A study based on this data appeared in 2020 in the *American Journal of Psychiatry*, and purported to constitute high-quality evidence in favor of medical transition for gender dysphoric patients.<sup>47</sup> Its authors tracked dysphoric respondents over time and assessed their subsequent use

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<sup>45</sup> Withers (2020), p. 869.

<sup>46</sup> Bungener, S. L., Steensma, T. D., Cohen-Kettenis, P. T., & De Vries, A. L. (2017). Sexual and romantic experiences of transgender youth before gender-affirmative treatment. *Pediatrics*, 139(3) e20162283. <https://doi.org/10.1542/peds.2016-2283>

<sup>47</sup> Bränström, R., & Pachankis, J. E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. *American journal of psychiatry*, 177(8), 727-734. <https://doi.org/10.1176/appi.ajp.2019.19010080>

of mental health treatment (for a mood or anxiety disorder), as well as other related measures (such as hospitalization after a suicide attempt). There was no evidence that initiating hormone treatment paid benefits in reduced subsequent use of mental health treatment, but the authors concluded that “gender-affirming” surgery is associated with reduced demand for subsequent mental health treatment in a sample of persons diagnosed with “gender incongruence.”

57. However, a cursory reading of the study itself tells a far less optimistic story than the authors’ own confident interpretations of the post-surgical data. From the available published data, I was able to calculate the “Number Needed to Treat,” or NNT, which is a measure of clinical impact. It helps relate the actual size of the effect of the treatment back to the realities of clinical practice to aid physicians in decisions about whether a particular treatment is “worth it.”<sup>48</sup> A high NNT accompanied by significant risk (in the treatment) is considered high-risk, low payoff. On the other hand, a high NNT accompanied by modest risk (such as prescribing a daily statin pill to reduce risk of a subsequent heart attack) is considered low risk, low payoff. In this study, the NNT appears to be a staggering 49, meaning the beneficial effect of transgender surgery (or more commonly, a series of surgeries) is so small that a clinic may have to perform 49 gender-affirming surgeries before they could expect to witness one additional post-surgical patient’s reduction in subsequent mental health assistance. If no other treatment was available, or if the treatment was non-invasive and the hazards were insignificant, clinics might consider surgery a low-risk but low-payoff approach. But even the most common surgeries here (e.g., bi-

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<sup>48</sup> Citrome, L. (2014). Quantifying clinical relevance. *Innovations in clinical neuroscience*, 11(5-6), 26–30.

lateral mastectomy) are considered major surgeries—and particular ones are exceptionally challenging, with elevated likelihood of suffering a complication.<sup>49</sup> Conducting surgery on 49 patients in order to secure one patient who modestly benefits in slightly less psychological services? It ought to give physicians considerable pause, but in an industry increasing characterized by demand-driven care of patients, it does not.

58. The journal received numerous letters pointing out that the study’s analysis was flawed and its conclusions unsupported by the data. Almost one year later, the *American Journal of Psychiatry* published seven letters of critique, an editorial note on the subsequent statistical review those critiques prompted, and the resulting correction that nullified the study’s claim of a post-surgical mental health benefit. The correction curbed what conclusions the authors had originally made—that “this study provides timely support for policies that ensure coverage of gender-affirming treatments.”<sup>50</sup> This example is indicative of a wider trend of “looking” for statistical significance, however weak, to support claims that are consonant with the wishes of transgender medical practitioners.

59. The correction the Bränström and Pachankis study merited is far more significant than the “correction” (or more accurately, clarification) of Professor Littman’s original study, of which Dr. Turban speaks (on page 31 of his supplemental declaration during the preliminary injunction phase). Simply because Littman’s is an opt-in sample is no cause for implying it is

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<sup>49</sup> A recent study revealed that while just over 10 percent of a group of 1,212 adult “transmasculine” patients elected to undergo genital reconstruction surgery, those 129 patients reported 281 complications—more than two per patient, on average—requiring 142 “revisions.” The three most common complications? Urethral fistulas or strictures, and worsened mental health. The only documentable benefit? A surge in their “genital self-image.” See Robinson, I. S., Blasdel, G., Cohen, O., Zhao, L. C., & Bluebond-Langner, R. (2021). Surgical outcomes following gender affirming penile reconstruction: Patient-reported outcomes from a multi-center, international survey of 129 transmasculine patients. *The journal of sexual medicine*, 18(4), 800-811. <https://doi.org/10.1016/j.jsxm.2021.01.183>

<sup>50</sup> Bränström, R. & Pachankis, J. E. (2020) Correction to Bränström and Pachankis. *American journal of psychiatry* 177(8): 734. <https://doi.org/10.1176/appi.ajp.2020.1778correction>

without value, or that—unlike the Bränström and Pachankis study—its conclusions are incommensurate with its data. Professor Littman’s study was simply demonstrative—to highlight a surge in adolescent (or late onset) gender dysphoria cases. Four years later, her results are no longer surprising.

60. While Dr. Turban is correct to note that the Bränström and Pachankis study concerns adults rather than minors, my discussion of it is intended to highlight the unsettledness of the science here, and to suggest that the line between activists and academics is a rather thin one, provoking contests over the meaning of a study’s results. Given that it is arguably the largest longitudinal dataset capable of tracking the long-term effects of hormones and surgery, its lack of positive findings (following the editor’s requested correction) has ramifications for the treatment of adult and adolescent patients alike.

61. There are some cracks forming in the coerced consensus about aggressively treating youthful gender dysphoria. In just the past two years, three countries’ national gender medicine councils have commissioned focused studies on the efficacy of the “affirmative” approach to treating minors. These in-depth reviews by Finland, Sweden, and the UK’s National Institute for Health and Care Excellence (NICE) in Britain have all concluded that claims of benefit for medical gender interventions in children are based on “low quality evidence.”<sup>51</sup>

62. Sweden’s review of the evidence base and ethics considerations found “knowledge gaps and uncertain knowledge” to be a “central theme.”<sup>52</sup> A summary of their review of the literature reported the following: “No studies explaining the increase of children and

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<sup>51</sup> Society for Evidence Based Gender Medicine. (2021, May 5). Sweden’s Karolinska ends all use of puberty blockers and cross-sex hormones for minors outside of clinical studies.

[https://segm.org/Sweden\\_ends\\_use\\_of\\_Dutch\\_protocol](https://segm.org/Sweden_ends_use_of_Dutch_protocol)

<sup>52</sup> Swedish National Council on Medical Ethics. (2019, April 26). Letter to the Ministry of Health and Social Affairs re: treatment of gender dysphoria among children and adolescents (unofficial translation), p.2. <https://smer.se/wp-content/uploads/2019/04/Skrivelse-konsdysfori-eng-%C3%B6vers%C3%A4ttning.pdf>

adolescents seeking [treatment] for gender dysphoria were identified. The literature on management and long-term effects in children and adolescents is sparse, particularly regarding gender affirming surgery. All identified studies are observational, and few are controlled or followed-up over time.”<sup>53</sup> They conclude by observing that “scientific activity in the field seems high,” meaning extensive, but that a “large part of the literature that was considered relevant” was only published after 2017.

63. The UK’s Royal College of General Practitioners issued a report in mid-2019 asserting that “[t]he significant lack of evidence for treatments and interventions which may be offered to people with dysphoria is a major issue facing this area of healthcare.”<sup>54</sup> After the report highlights characteristics of the “affirmative” approach, it notes “a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of such treatments for people with gender dysphoria, particularly children and young people, which prevents (general practitioners) from helping patients and their families in making an informed decision.”

64. The UK NICE pair of reports each concluded that invasive treatment of youth doesn’t result in a confident determination of demonstrable success. Those studies, one report notes, “that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias, or chance.” The studies “all lack appropriate controls.” Moreover, the claims of “clin-

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<sup>53</sup> Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019). Gender dysphoria in children and adolescents: An overview of the literature. *SBU*. Report No. 307: SBU 2019/427. <https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/report-307>

<sup>54</sup> Royal College of General Practitioners. (2019). The role of the GP in caring for gender-questioning and transgender patients, RCGP position statement. <https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2019/RCGP-position-statement-providing-care-for-gender-transgender-patients-june-2019.ashx?la=en>

ical effectiveness, safety, and cost-effectiveness” of such treatments clearly are not substantiated.<sup>55</sup> Hence, claims of benefit for medical gender interventions in children are based, the reports observe, on “low quality evidence.”<sup>56</sup> These assessments offer reasons to be far more cautious about treating underage persons in such a way that permanently alters bodies as a response to problems of the mind.

65. Beginning on page 41 of his previous supplemental declaration, Dr. Turban makes much of the fact that the reports from the U.K., Sweden, and Finland “were not peer-reviewed” on his way to suggesting that each report “omits key studies,” and/or were “poorly researched,” before asserting that he would not recommend relying on their conclusions. A similar claim characterizes his remarks about the Swedish report: “No studies explaining the increase of children and adolescents seeking [treatment] for gender dysphoria were identified.... All identified studies are observational, and few are controlled or followed-up over time.”<sup>57</sup> It is plausible that they omitted particular studies, including Dr. Turban’s own 2020 USTS-based *Pediatrics* study not as an oversight but intentionally, due to the NICE reports’ elevated quality standards.

66. A cavalier manner characterizes how Dr. Turban brushes off the conclusions of each of these European medical decision-making bodies, as if admitting any weakness undergirding the “consensus” of American professional societies is potentially fatal to the “aggressive

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<sup>55</sup> National Institute for Health and Care Excellence (NICE). (2021). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, p.13. <https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtransgender%26s%3dDate>; National Institute for Health and Care Excellence (NICE). (2021). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. <https://www.evidence.nhs.uk/document?id=2334889&returnUrl=search%3Fq%3Dgender%2Bdysphoria>

<sup>56</sup> Society for Evidence Based Gender Medicine. (2021, May 5). Sweden’s Karolinska ends all use of puberty blockers and cross-sex hormones for minors outside of clinical studies. [https://segm.org/Sweden\\_ends\\_use\\_of\\_Dutch\\_protocol](https://segm.org/Sweden_ends_use_of_Dutch_protocol)

<sup>57</sup> Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU). (2019). Gender dysphoria in children and adolescents: An overview of the literature. *SBU*. Report No. 307: SBU 2019/427. <https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/>

affirmative” treatment strategy he represents. Turban simply claims that these too are “outlier views” not supported by the list of professional organizations—which do not even agree among themselves on definitions, terms, and issues such as minors’ ability to consent. There’s no trust in science here—only in patron professional associations and their client scholars.

67. Referring to the UK, Swedish, and Finnish reports, Dr. Turban previously concluded that, together with the other (state’s) experts, I “have inflated the importance of these reports...” (page 45). I see nothing to substantiate this. Rather, my modest original intention is to highlight how, despite advocates’ rhetoric, there is both individual and organizational dissent to any purported “consensus” about “affirmative” gender treatment for minors.

68. One conclusion is increasingly obvious in this dispute. We have rapidly reached a stage in the study of transgender medicine where the phrase “peer review” no longer guarantees quality analyses, apt measures, appropriate samples, thoughtful interpretations, and measured conclusions.

69. In sum, the science of transgender medicine—including but not limited to adolescents—does not speak with a univocal voice about the long-term psychological and physical benefits of hormonal and surgical treatment of dysphoria. Much published research in this domain is very recent, relies on nonrepresentative, opt-in samples, “loaded” survey questions, and/or exhibits overreaching conclusions. To suggest the existence of any obvious “consensus” or “standards” from existing research would make little scientific sense.

#### **IV. THE ABSENCE OF RANDOMIZED CLINICAL TRIALS RESEARCH**

70. In his previous declaration dated June 11, 2021, plaintiffs’ witness Dr. Antomaria claims that, in Arkansas, “adolescents with gender dysphoria are not being subject to...ex-

perimentation.”<sup>58</sup> The FDA, however, has not approved hormonal therapies for treatment of gender dysphoria. Hence, it is undeniable that the protocol of treatments for transgender-identifying youth, including its hormonal regimens, remains at least technically experimental by definition.

71. It’s not as if hormonal treatments have never been put to a clinical trial. The hormones estradiol and testosterone certainly have. The same is true of GnRH agonists (i.e., puberty blockers), which have been evaluated for adult infertility, prostate cancer, ovarian protection during chemotherapy, and even for tests of male contraceptives.<sup>59</sup> But these drugs have not been tested in randomized clinical trials as treatments for adolescent gender transition procedures. Puberty blockers have been approved only for treatment of precocious puberty.

72. Dr. Antommara is right when he states that, “With respect to study design, randomized trials generally provide “high” quality evidence and observational studies, in comparison, “low.”<sup>60</sup> But the entire gender medicine industry merits criticism for complicity in failing to conduct such a rigorous clinical trial. Invasive, and even life-threatening, clinical trials are regularly conducted in the quest for lifesaving treatments among children with serious diseases or conditions.

73. Dr. Antommara maintains that to propose and carry out “randomized placebo-controlled trials (trials that compare pharmacological treatment to no pharmacological treatment) in gender dysphoria are currently unethical.” He appeals to the principle of clinical “ equipoise,” namely, the assumption (underlying the ethics of randomized control groups) that there is no

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<sup>58</sup> Antommara, A. H. M. (2021). Declaration, U.S. District Court, Eastern District of Arkansas, Case No.: 4:21CV450-JM, p. 11.

<sup>59</sup> Garner, C. (1994). Uses of GnRH agonists. *Journal of obstetric, gynecologic, & neonatal nursing*, 23(7), 563-570. <https://doi.org/10.1111/j.1552-6909.1994.tb01922.x>

<sup>60</sup> Antommara (2021), p. 7.

clear “better” intervention present.<sup>61</sup> That is, he maintains that there is no clinical equipoise in the case of treating gender dysphoria; a control group in such a randomized trial would, he believes, receive an inferior, less-effective treatment as compared with the “affirmative” approach.

74. But this claim is in no small part a function of the putative “consensus” mentioned above and discussed more fully below. That is, since “affirmative” treatments are sometimes the subject of patient demand and are now endorsed by certain American professional organizations, there is indeed an assumption that clinical equipoise is not present. But that is a situation based not on longitudinal medical and social science research but on media-fostered patient demand and premature professional organizational claims and pressure. In other words, any lack of equipoise is more a psychological or cultural than a scientific development.

75. Further, even if (as Dr. Antommara claims) equipoise were lacking for randomized *placebo-controlled* trials (i.e., trials that compared groups that did and did not receive hormones), that would be no obstacle to randomized trials *without* placebo groups to “compare different types, dosages and methods of administration of active treatments.”<sup>62</sup> But no such trials have been conducted.

76. This assertion is not, as Dr. Turban states, irrelevant.<sup>63</sup> It is yet another piece of evidence demonstrating the many ways in which randomized clinical trials research can be conducted here—but are not. Dr. Turban is correct that such a study “would not answer the question regarding the efficacy or effectiveness of the class of medications in general,” but the lack of

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<sup>61</sup> Antommara (2021), p. 8; Cook, C., & Sheets, C. (2011). Clinical equipoise and personal equipoise: two necessary ingredients for reducing bias in manual therapy trials. *Journal of Manual & Manipulative Therapy*, 19(1), 55-57. doi: 10.1179/106698111X12899036752014

<sup>62</sup>Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane database of systematic reviews*, p. 10. <https://doi.org/10.1002/14651858.CD013138.pub2>

<sup>63</sup> Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane database of systematic reviews*, p. 10. <https://doi.org/10.1002/14651858.CD013138.pub2>

even dosage studies with control groups highlights the near lawlessness that this field of medicine seems to operate with, and provides further evidence of the “ideological capture” that I have thoroughly documented herein.

77. In his own previous response on this topic, Dr. Antommara continued his appeal to clinical equipoise, adding a pitch for off-label drug use, which “may be well-supported by evidence” and “does not mean that the use is experimental, untested, or unsafe.”<sup>64</sup> In the abstract, that is true. But there’s a significant gap between “may be” and “is” in particular circumstances. Perhaps a clinical trial really is in order.

## **V. THE IDEOLOGICAL CAPTURE OF GENDER DYSPHORIA**

78. There is a great deal of evidence that the clinical discussion of gender dysphoria has recently become unmoored from empirical assessments and instead has been captured by the activist assumptions of those advocating for what is sometimes called “gender ideology.” Ideological capture operates not unlike “regulatory capture,” a more familiar phrase. The end is the same—the corruption of authority by the successful co-opting of political or professional organizations to serve the aims of a particular interest group. Ideological capture is characterized by incorrigible commitments to certain conclusions regardless of the data and can lead whole organizations to disregard outcomes that are not consistent with the ideologically-motivated sense of rightness.<sup>65</sup> Ideological capture is inimical to the dissent and open debate that is critical to healthy medical and social science.

79. Although the plaintiffs in this case have tried to dismiss observations concerning the ideological capture of gender dysphoria as mere “conspiracy theory,” it is quite real and a

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<sup>64</sup> Antommara, A. H. M. (2021), p. 4.

<sup>65</sup> Chuang, J. A. (2010). Rescuing trafficking from ideological capture: Prostitution reform and anti-trafficking law and policy. *University of Pennsylvania law review*, 158(6), 1655–1728.

thoroughly documented phenomenon. As I explain below, the ideological capture of gender dysphoria is evidenced by efforts to re-educate people in the use of identity language, by the entrepreneurial explosion of gender clinics across the nation, by pressure-based suppression of open debate (including among most affirmative clinicians and scholars), by inconsistent claims concerning adolescents’ ability to give informed consent, by the tacit endorsement of social media “peer education” about transgender life, and even by the Department of Justice’s recent inconsistent actions. It has contributed to suppressing any sense of “watchful waiting,” a once-standard harm-reduction move that is now accused of fostering suicidality, and has tagged psychological counseling as bordering on “reparative therapy.” It fosters the belief that invasive medical—that is, hormonal and surgical—treatments should be performed at earlier ages, as the draft version of WPATH’s 8<sup>th</sup> edition of their Standards of Care reveals.

**A. Re-education in the Parlance of Gender Ideology**

80. To classify something in the social world is to penetrate the imagination, to alter public frameworks of knowledge and discussion, and to shift the perception of everyday life. It is why French sociologist Pierre Bourdieu understood this elite-driven effort as the power of “legitimate naming.”<sup>66</sup> In the domains of gender and sexuality—fraught as they are with great moral valence—there is poignant and bitter struggle over words and terms, and the politics of using them or avoiding them. This suggests we are not witnessing a simple quest for better understanding of an emergent population. We are also seeing social and cultural change fostered through scholarship wed to political activism.

81. The complaint and reports submitted by the plaintiffs in the preliminary-injunction stage of this case reflect this ideological effort. For example, Adkins’ claim that

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<sup>66</sup> Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and society*, 14(6), 723-744.

“[e]veryone has a gender identity”<sup>67</sup> is freighted with dubious ideological assumptions, as the following considerations show. The Endocrine Society guidelines describe “[e]xamples of conditions with similar features” to gender dysphoria, including “body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate).”<sup>68</sup> Dr. Anne Lawrence, who identifies as transgender, has also noted the parallels between gender dysphoria and body integrity identity disorder (BIID).<sup>69</sup> A person with BIID is able-bodied but identifies as an amputee and reports feeling trapped in a fully functional body. Such persons “often assert [that] their motives for wanting to change their bodies reflect issues of identity.”<sup>70</sup>

82. Now, it is one thing to recognize that some people with BIID make such identity claims. But it is something else altogether to say that, because *some people with BIID* make that claim, therefore *everyone* has to be defined in terms of whether they identify as able-bodied, as an amputee, or as something in between. To make this further claim is to advocate a highly disputable ideology that says an able-bodied person’s identifying as an amputee is not a disorder at all, but simply one of multiple “functional identities” that an able-bodied person may happen to have. But it is another thing (and altogether inappropriate) to use the terms in which persons experiencing mental distress or a pathology understand themselves as the new prism through which *all persons* must be defined. Claiming that “everyone has a gender identity” is an effort to do precisely that: to define everyone who does *not* suffer gender incongruence in terms of the self-experience of those who do.

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<sup>67</sup> Adkins (2021), p. 3.

<sup>68</sup> Hembree et al. (2017), p. 3878.

<sup>69</sup> Lawrence, A. A. (2006). Clinical and theoretical parallels between desire for limb amputation and gender identity disorder. *Archives of sexual behavior*, 35, 263-78.

<sup>70</sup> Lawrence (2006), p. 263.

83. One of the reasons why advocates include (in their articles, briefs, reports, etc.) sections defining terms is because new words are a source of social change itself. They are not simply illuminating but indoctrinating. Certainly, the challenges of measurement and data collection can benefit from clarification of terms. But they can become vehicles of cultural change themselves by endorsing particular ways of speaking about matters of gender identity that are highly contested. Even official surveys, the root source of so much social science raw data, are not only not exempt from politicization and the fostering of “legitimate naming,” but are now a medium of the same.<sup>71</sup>

84. Plaintiffs’ complaint is also saturated with references to “well-established standards of care,” “best practices,” and lists a litany of terms and statements like these in a section entitled “Standards of Care...” where one might expect to see prescriptions rather than definitions. Such rhetoric fosters a sense that the plaintiffs are attempting to re-educate the reader rather than convince them of the merits of a position through sound argument and evidence. What was meant to map and understand the experience of gender dysphoria—particularly but not only in adolescents—has turned instead to name (new terms and protocols) and shame (the cautious or contrarian voice).

85. I concur with psychiatrist Dr. Stephen Levine, who has explained that “clinical work in the gender identity arena, which used to be based on symptoms and social, vocational, and educational dysfunction, is now based on sociopolitical concepts. Cultural forces have provided a new narrative about the vital importance of having strict consonance between one’s

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<sup>71</sup> The GenIUSS Group. (2014). Best practices for asking questions to identify transgender and other gender minority respondents on population-based surveys. J.L. Herman (Ed.). The Williams Institute.

sexed body and gender identity.”<sup>72</sup> This new narrative is not grounded in evidence-based science but in political activism.

## **B. The Rapidly Evolving “Consensus”**

86. In her report, Dr. Adkins writes, “All of the major medical professional groups in the United States . . . agree that [gender transitioning] is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.”<sup>73</sup> But, despite the fact that American professional associations have endorsed the (general) “affirmative” approach to treating dysphoric adolescents, there is no wide, international consensus about its superiority. Nor is there evidence that the consensus is stable;<sup>74</sup> rather, there is an uneven evolution among advocates toward affirming treatments “on demand,” with decreasing regard for the Dutch protocol’s commitment to (1) a slower pace, with more listening and observation, and (2) the refusal to pursue medical treatments in the absence of childhood gender dysphoria and in the presence of psychiatric co-morbidities. That any purported “consensus” on hormonal and surgical interventions at earlier ages should have developed so rapidly among American professional associations—and with so much projected confidence—in the absence of obvious, consistent indicators of treatment efficacy, and amid a surge in cases of gender dysphoria, is suspicious. It suggests, instead, a concerted effort to suppress alternative (or even decade-old) treatment approaches in favor of a demand-driven endorsement of hormonal and surgical treatments.

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<sup>72</sup> Levine, S. B. (2019). Informed consent for transgendered patients. *Journal of sex & marital therapy*, 45(3), 218-229, p. 219.

<sup>73</sup> Adkins, D. (2021), p. 6.

<sup>74</sup> Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015).

87. Closely connected to the idea of ideological capture is that of a “Castro consensus,” wherein a consensus “is viewed as a proxy for truth.”<sup>75</sup> Certainly, “when a consensus is fashioned via the independent and free deliberations of many, it is a strong indicator of truth.” But “not all consensuses are independent and freely formed.” Some are pieced together by “external pressure,” while “dependence among individuals can force consensus around an issue, regardless of the underlying truth of the affirmed position.” Indeed, simple bias can lead to a purported (and premature) consensus, given that decision-makers (and researchers) “are both human and political.”<sup>76</sup> This is an accurate description of what has occurred in the domain of medicine concerned with the treatment of gender dysphoria.

88. For instance, WPATH, formed in 1979, has evolved from its beginnings as a group of professionals seeking to understand and assist those with gender dysphoria to acting as a professional association that purports to offer “consensus” clinical guidelines while simultaneously acknowledging that “WPATH is committed to advocacy for . . . changes in public policies and legal reforms.”<sup>77</sup> WPATH’s treatment recommendations shape the recommendations of other professional organizations; the APA’s guidelines, for example, follow WPATH’s recommendations and label any approach other than “affirming” to gender dysphoric youth as “unethical.”<sup>78</sup>

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<sup>75</sup> Allen, J., Lay, C., & Montanez, G. (2020) A Castro consensus: Understanding the role of dependence in consensus formation, 1-9, p. 1. [https://www.researchgate.net/publication/344703449\\_A\\_Castro\\_Consensus\\_Understanding\\_the\\_Role\\_of\\_Dependence\\_in\\_Consensus\\_Formation](https://www.researchgate.net/publication/344703449_A_Castro_Consensus_Understanding_the_Role_of_Dependence_in_Consensus_Formation)

<sup>76</sup> Socol, Y., Shaki, Y. Y., & Yanovskiy, M. (2019). Interest, bias, and consensus in science and regulation, *Dose-response*, 17, 1-5. <https://doi.org/10.1177/1559325819853669>

<sup>77</sup> World Professional Association for Transgender Health (2012), p. 2; Levine, S. B. (2018). Ethical concerns about emerging treatment paradigms for gender dysphoria. *Journal of sex & marital therapy*, 44(1), 29-44; Vrouenraets et al. (2015).

<sup>78</sup> American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American psychologist*, 70(9), 832-864.

89. Despite WPATH’s purported “consensus” building, the organization continues to struggle with both the research and clinical communities, as well as their own penchant for establishing—not just recognizing—new ground to cover. Such appears to be the case in the December 2021 preview of their forthcoming Standards of Care version 8, where they devote an entire chapter to “eunuch-identified people,” most often natal males who exhibit a “strong urge to live without testicles.”<sup>79</sup> If a 17-year-old male presents as “eunuch-identified,” this is a valid transgender identity under WPATH guidance, and he should be eligible for “affirming” orchiectomy or more for castration to align his body with his mind. In a 2007 study of this unusual community, researchers noted that the typical time from development of interest to actual castration—physically or chemically—was 18 years.<sup>80</sup> The researchers identified four factors at work in the minds of such persons: sustained abuse during childhood, homosexuality, exposure to animal castration during youth, and religious condemnation of sexuality. The authors noted both BIID and GID among self-identified eunuchs.

90. My point about this group is only this. It is beyond ironic that Professor Littman is professionally scourged for observing an exploding number of post-pubertal adolescent dysphoria cases, while WPATH devotes more attention to eunuchs, who as recently as 2015 were considered to be so uncommon as to merit single-case discussion in professional journals.<sup>81</sup>

91. The WPATH “consensus” is not stable. It is clearly evolving in the direction of aggressive affirmation. In their preview of Standards of Care version 8, WPATH has lowered some of the recommended ages for treatment. No one can suggest anymore that surgery is not

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<sup>79</sup> Hermann, M., & Thorstenson, A. (2015). A rare case of male-to-eunuch gender dysphoria. *Sexual medicine*, 3(4), 331–333. <https://doi.org/10.1002/sm2.81>

<sup>80</sup> Johnson, T. W., Brett, M. A., Roberts, L. F., & Wassersug, R. J. (2007). Eunuchs in contemporary society: Characterizing men who are voluntarily castrated (Part I). *The journal of sexual medicine*, 4(4), 930–945, <https://doi.org/10.1111/j.1743-6109.2007.00521.x>.

<sup>81</sup> Hermann, M., & Thorstenson, A. (2015).

being authorized for minors, since WPATH commends age 15 (and above) as appropriate for “chest masculinization” treatment, age 16 for breast augmentation and facial surgeries (e.g., rhinoplasty, tracheal shave, and genioplasty), age 17 for hysterectomy, vaginoplasty, metoidioplasty (or bottom surgery for female-to-male patients), and orchidectomy (the removal of testicles), and 18—the end of status as a minor—for phalloplasty or the construction of a penis in female-to-male transgender patients.<sup>82</sup>

92. Hence, plaintiffs’ witness Turban is no longer able to claim, as he did in the *New York Times* in 2020, that “[u]nder current medical guidelines, genital surgeries for transgender patients are never offered before adulthood.” It may have been rhetorically useful, but the claim wasn’t even true when he wrote it. A 2017 interview-based study of 20 surgeons revealed that vaginoplasties are being performed on minors by surgeons in the United States.<sup>83</sup> While such may have contravened WPATH’s previous standards of care, it is no longer true of their forthcoming standards.

93. Full gender-affirming surgery in minors, however, now constitutes irreversible surgical sterilization, as even the most ambitious of affirmative clinicians admit.<sup>84</sup>

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<sup>82</sup> World Professional Association for Transgender Health. (2021).

<sup>83</sup> Milrod, C., & Karasic, D. H. (2017). Age is just a number: WPATH-affiliated surgeons’ experiences and attitudes toward vaginoplasty in transgender females under 18 years of age in the United States. *The journal of sexual medicine*, 14(4), 624-634.

<sup>84</sup> Olson-Kennedy, J. (2015). *The future of trans care in the new millennium*. Gender Infinity Annual Conference. <https://youtu.be/pO8v--tztSg>. What is critical here about the pairing of puberty blockers then cross-sex hormones is that if patients commence puberty blockers early enough, they will not go through puberty (of their natal sex); hence, their gametes do not have enough time to mature (for the purpose of being subsequently harvested for possible future artificial reproduction). See Hudson, J., Nahata, L., Dietz, E., & Quinn, G. P. (2018). Fertility counseling for transgender AYAs. *Clinical practice in pediatric psychology*, 6(1), 84-92. doi: 10.1037/cpp0000180

94. Dr. Turban claimed in his previous supplemental declaration, “Although gender affirming hormones can cause some irreversible changes, such as body fat redistribution and vocal changes, these effects are primarily cosmetic.”<sup>85</sup> Vocal changes may not be considered “cosmetic” by many, and fat redistribution is hardly a more significant irreversible change than infertility. For Dr. Turban, infertility seems largely irrelevant. He misrepresents a 2019 study, claiming that “fertility was similar between transgender men who had been on testosterone treatment and cisgender women.”<sup>86</sup> In reality, the study is about comparing the pregnancy success rate of assisted reproductive technology—an expensive, demanding process with modest success rates—between self-identified transgender males (natal females) and a parallel group of women.<sup>87</sup> Given that over 98 percent of live births in the United States do not employ assisted reproductive technology<sup>88</sup> and involve no “fertility preservation” of the sort that WPATH recommends to counseled patients, the reference to “similar” fertility is at best misleading.

95. In the short span of a decade, psychiatrists, psychologists, pediatricians, and their patients have been pressed both to think about and to treat child and adolescent dysphoria in one “correct” manner—via the aggressively affirmative approach. Even some early advocates for the Dutch protocol are now concerned about the on-demand, skip-the-counseling version that is

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<sup>85</sup> Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: Understanding transition and “de-transition” among transgender youth. *Journal of the American academy of child & adolescent psychiatry*, 57(7), 451–453. <https://doi.org/10.1016/j.jaac.2018.03.016>. The quote is from page 453.

<sup>86</sup> Turban, J. L. (2021), p. 12.

<sup>87</sup> Leung, A., Sakkas, D., Pang, S., Thornton, K. & Resetkova, N. (2019). Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine. *Fertility and sterility* 112(5), 858-865. The quote is from page 859.

“To be included in this study, the patient had to identify as a transgender man and have completed an ovarian stimulation cycle for oocyte cryopreservation, embryo cryopreservation, or intended uterine transfer. Most couples who desired to conceive did so through reciprocal IVF, whereby the transgender patient provided the oocytes and their cisgender partner carried the pregnancy. The few transgender men who opted to carry the pregnancy themselves underwent several failed intrauterine insemination cycles before proceeding to IVF.”

<sup>88</sup> Centers for Disease Control and Prevention. (2018). ART success rates. <https://www.cdc.gov/art/artdata/index.html>

emerging.<sup>89</sup> Psychotherapy has now become more difficult to come by, even disparaged as “conversion” therapies, as discussed below.<sup>90</sup>

### C. The Entrepreneurial Explosion of Gender Clinics

96. When this contrived consensus meets a free-market health care delivery system, it is no surprise that the result is an explosion in gender clinics. Less than 15 years ago, the United States featured a solitary pediatric gender clinic (Boston Children’s Hospital’s Gender Management Service, founded in 2007). But today there are over 300 clinics that provide some form of “gender affirmative” care to minors, ranging from full-service operations (i.e., hormone and surgical services) to private practice doctors that will perform surgeries on minors.

97. Planned Parenthood clinics, as noted in the organization’s recent annual report, are “the second largest provider of hormone therapy to those who identify as transgender/have gender dysphoria.”<sup>91</sup> Planned Parenthood’s director of health media was recently reported as confirming that the organization offers hormone therapy to transgender patients in 16 states. Mara Keisling, executive director of the National Center for Transgender Equality, remarked about Planned Parenthood that “It’s possible they’re the largest provider of trans health in the country.”<sup>92</sup> Formally, the organization purports to serve only those 18 and older; informally, some facilities report serving 16- and 17-year-olds with “parental consent.”<sup>93</sup>

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<sup>89</sup> Edwards-Leeper, L., & Anderson, E. (2021).

<sup>90</sup> For example, see Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA psychiatry*, 77(1), 68–76. doi:10.1001/jamapsychiatry.2019.2285.

<sup>91</sup> Planned Parenthood Federation of America. (2021). 2019-2020 annual report, p. 11. [https://www.plannedparenthood.org/uploads/filer\\_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf](https://www.plannedparenthood.org/uploads/filer_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf)

<sup>92</sup> Allen, S. (2017, January 10). The attack on Planned Parenthood hurts transgender people, too. *Daily beast*. <https://www.thedailybeast.com/the-attack-on-planned-parenthood-hurts-transgender-people-too>

<sup>93</sup> <https://www.plannedparenthood.org/planned-parenthood-massachusetts/campaigns/gender-affirming-hormone-therapy>

98. Planned Parenthood operates its gender services on an “informed consent” basis, with no need for a diagnosis or mental health exam.<sup>94</sup> In other words, access to treatment is offered if the patients indicate they understand and accept the possible side effects. “I had no gate-keeping at all,” one patient reported. “I had a prescription in my hand the same day I went in.” The “affirmative” approach hence leads in short order to patient-driven, on-demand services.<sup>95</sup> More natal females than males seek out Planned Parenthood’s gender services, which serve as a more stable source of income than abortions. One anonymous employee described them as “cash cows...kept on the hook for the foreseeable future.”<sup>96</sup>

99. It is clear that clinics make their own decisions about treatment, and are proving even more aggressive than professional organizations’ own recommendations. For example, New York’s Mount Sinai Center for Transgender Medicine and Surgery (CTMS) operates with a “patient-centered model,” and reported that 45 percent of 139 patients seeking vaginoplasty were deemed ready for surgery, well above the 15 percent who met WPATH’s criteria for surgery eligibility.<sup>97</sup> If patients seeking surgical treatments are apt to see their odds of getting it tripled, it is only reasonable to believe that providers with fewer restrictions will thrive.

100. In a mid-2020 contribution to the *Journal of Medical Ethics*, an Australian attorney and six co-authors make the ethical case for supporting the practice of “ongoing puberty suppression,” that is, to “permanently prevent the development of secondary sex characteristics, as a

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<sup>94</sup> Urquhart, E. (2016, January 29). Planned Parenthood is helping transgender patients access hormone therapy. *Slate*. <https://slate.com/human-interest/2016/01/how-planned-parenthood-helps-transgender-patients-get-hormone-therapy.html>

<sup>95</sup> Allen (2017).

<sup>96</sup> Shrier, A. (2021, February 8). Inside Planned Parenthood’s gender factory: An ex-reproductive health assistant speaks out. Substack: Abigail Shrier, <https://abigailshrier.substack.com/p/inside-planned-parenthoods-gender>

<sup>97</sup> Lichtenstein, M., Stein, L., Connolly, E., Goldstein, Z. G., Martinson, T., Tiersten, L., Shin, S. J., Pang, J. H., & Safer, J. D. (2020). The Mount Sinai patient-centered preoperative criteria meant to optimize outcomes are less of a barrier to care than WPATH SOC 7 criteria before transgender-specific surgery. *Transgender Health*, 5(3), 166-172.

way of affirming (one's) gender identity.”<sup>98</sup> There is reason to question the clinical stability of an approach that is so rapidly giving young people suffering from significant psychiatric distress the agency to accept experimental medical interventions with irreversible effects, especially in an ideologically-charged atmosphere where medical professionals hold out the treatments to be the child's only hope of leading a peaceful, happy life.

101. Reports like these highlight how—in a few short years—advocates have injected American sexual politics into the medical evaluation and treatment of gender dysphoria. In a study to be published in the *Archives of Sexual Behavior*, a co-author and I observed in a survey of over 5,000 adults that the central framework through which Americans (as well as supplier organizations like Planned Parenthood) perceive the treatment of adolescent transgender patients is that of bodily autonomy and choice. That is, American adults' attitudes about abortion are the strongest predictor of what they think about “affirmative” treatment for minors, even after controlling for religion, political affiliation, voting behavior, and a variety of other factors.<sup>99</sup> This makes sense. And we are hardly the first to note it. Years ago journalists observed that the same principles at work in understanding abortion attitudes—about access to and control over one's body—are applied to decision-making about transgender treatments, even invasive ones. By extension, then, it is unsurprising to see how the authority over treatment decisions, including among minors, appear to have shifted from physician to patient.<sup>100</sup>

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<sup>98</sup> Notini, L., Earp, B. D., Gillam, L., McDougall, R. J., Savulescu, J., Telfer, M., & Pang, K. C. (2020). Forever young? The ethics of ongoing puberty suppression for non-binary adults. *Journal of medical ethics*, 46(11), 743-752. <https://jme.bmj.com/content/46/11/743.abstract>

<sup>99</sup> Regnerus, M. & Vermurlen, B. (Final acceptance October 2021, forthcoming). Approval of hormonal and/or surgical interventions for adolescents experiencing gender dysphoria. *Archives of sexual behavior*.

<sup>100</sup> Urquhart, E. (2016, March 11). Gatekeepers vs. informed consent: Who decides when a trans person can medically transition? *Slate*. <https://slate.com/human-interest/2016/03/transgender-patients-and-informed-consent-who-decides-when-transition-treatment-is-appropriate.html>

#### **D. Pressure-based Suppression of Open Debate**

102. Physicians and researchers have been sanctioned for questioning “affirmative” gender treatment. Some have resigned, some have been demoted, and others fired. (Many have endured social media barrages.) A few examples may prove illuminating. Allan Josephson, chief of the University of Louisville’s Division of Child and Adolescent Psychiatry and Psychology for nearly 15 years, was demoted after public remarks he offered criticized aspects of affirmative treatment, saying the “notion that gender identity should trump chromosomes, hormones, internal reproductive organs, external genitalia, and secondary sex characteristics when classifying individuals is counter to medical science.”<sup>101</sup>

103. The *Archives of Sexual Behavior*’s editor Kenneth Zucker likewise endured professional and personal scrutiny for his work on the transgender experience. Zucker was head of a Toronto addiction and mental health clinic’s “Gender Identity Service” until he was fired in 2015 after an external review by two adolescent psychiatrists found his method insufficiently “affirmative” for transgender-identifying youth. His crime? Too much caution, patience in treatment, and displaying concern for parents and family dynamics. (Zucker won a legal settlement and an apology,<sup>102</sup> and he remains the editor-in-chief of *Archives*, the top sexology journal in the field.) Intimidation of this nature discourages wider interest in this field, narrowing the pool of researchers to those who don’t rock the boat or question the purported consensus. This is not how a healthy field of science works.

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<sup>101</sup> Watkins, M. (2019, March 29). Professor sues U of L, claims he was demoted over comments seen as anti-LGBTQ. *Courier journal*. <https://www.courier-journal.com/story/news/2019/03/29/anti-lgbt-comments-university-of-louisville-professor-sues-over-demotion/3300002002/>

<sup>102</sup> Rizza, A. (2018, October 7). CAMH to pay more than half a million settlement to head of gender identity clinic after releasing fallacious report. *National post*. <https://nationalpost.com/news/camh-reaches-settlement-with-former-head-of-gender-identity-clinic>

104. Angela Sämford, a child and adolescent psychiatrist at Sahlgrenska University Hospital in Gothenburg, Sweden, launched the Lundstrom Gender Clinic in 2016. Two years later, she resigned because of her own fears about the lack of evidence for hormonal and surgical treatments. Her decision-making process reveals what others have also noted: “There’s a lot of tension between some approaches of gender clinics and the trans community. Patients found it hard to accept that they needed to undergo a full mental health assessment before being referred for medical treatment. Parents would say that nobody ever discussed that other issues...might be implicated in the child’s dysphoria.”<sup>103</sup> Her patients displayed “many psychiatric symptoms,” she notes. Gender dysphoria was just “one part of a complex problem.” “Concentrating only on the gender dysphoria meant we might miss other things,” she held. “When I realized the complexity [of these cases]...and that health care professionals are still expected to okay gender-affirming treatment despite the lack of evidence that we currently have, it preyed on my conscience.” Sämford’s story contributed to Sweden’s recent decision to curb hormonal treatments for adolescents.

105. The controversy over a CBS *60 Minutes* segment about detransitioners, which aired on May 23, 2021, provides another sobering illustration of the ideological capture of much of this field of treatment. The popular news program sensed it would be illuminating to have a public discussion about patients who have undergone a gender transition but who wish to detransition back to their natal sex. Yet not only did activists seek to alter the *60 Minutes* episode (or prevent it from airing altogether), clinicians did too, including Dr. Johanna Olson-Kennedy, one of the more well-known researchers in the field, who posted on social media that “so many of us

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<sup>103</sup> McCall, B. & Nainggolan, L. (2021, April 23). Transition therapy for transgender teens drives divide. *WebMD*. <https://www.webmd.com/children/news/20210427/transition-therapy-for-transgender-teens-drives-divide>

worked hard to dissuade them from doing this segment.” Lesley Stahl, the segment’s correspondent and lead interviewer, reported that she could not remember another story “where comments and criticisms began surfacing from advocates before the piece aired.”<sup>104</sup> Other major media outlets are feeling comparable pressure to vet transgender news stories prior to release.<sup>105</sup>

106. The *60 Minutes* controversy also sheds light on the new fissure between “conventional” affirmative care and the even more aggressive form of patient-driven care that “affirms without question,” a position staked out Olson-Kennedy, who perceives little advantage to conducting pre-treatment mental health evaluations, and is known to offer cross-sex hormones to patients as young as 12 years old—a position that puts her at odds even with WPATH’s aggressive new Standards of Care.<sup>106</sup> The only thing “settled” about transgender medical science is the advocates’ use of that term. In truth, it is perpetually unsettled, and is now shifting toward putting the patient in the driver’s seat of their own treatment decisions.

107. A pair of “affirming” clinical psychologists who work with gender dysphoric adolescents, called the *60 Minutes* backlash “unconscionable” and “harmful to detransitioned young people” who are being “made to feel as if their lived experiences are not valid.” Moreover, they recognize that silencing detransitioners “will undoubtedly raise questions regarding the objectivity of our field...”<sup>107</sup> Indeed, as explained below, it has.

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<sup>104</sup> Zubrow, K. (2021, May 23). Inside the 60 Minutes report on transgender healthcare issues. *CBS News*. <https://www.cbsnews.com/news/60-minutes-transgender-health-care-issues-2021-05-23/>

<sup>105</sup> Manning, S. (2021, June 26). BBC Pride activists demand right to vet transgender news stories on Radio 4’s Today programme after host Justin Webb clashed with Pink News CEO over Stonewall’s stance on single-sex spaces. *Daily Mail*. <https://www.dailymail.co.uk/news/article-9728735/BBC-Pride-activists-demand-right-vet-transgender-news-stories-Radio-4s-Today-programme.html>

<sup>106</sup> Singal, J. (2018, July/August.) When children say they’re trans. *The Atlantic Monthly*. <https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/>

<sup>107</sup> Edwards-Leeper & Anderson (2021), paragraph 6.

108. The evidence demonstrates that desistance rates—that is, the share of adolescents who cease identifying as transgender and accept their natal sex—may have been around 90 percent for patients treated with a “watchful waiting” approach.<sup>108</sup> In a review of childhood gender dysphoria, prior studies demonstrated desistance rates ranging from 61% to 98%.<sup>109</sup> This method, however, is now contested in the United States, Canada, Australia, and the UK, and for dysphoric adolescents put on the “gender affirmation” schedule, the reverse has become true. Rather than pressing a pause button for time to think, 98 percent of the adolescents put on puberty blockers at the UK’s Tavistock clinic proceeded to cross-sex hormones,<sup>110</sup> thereby triggering irreversible effects.<sup>111</sup> In other words, the “watchful waiting” method consistently predicted desistance because it recognizes the transience of cross-gender identification in minors. But taking an aggressively “affirmative” approach almost guarantees transition.

109. Transgender activists and their allies in the professions have sought to minimize the experiences of people who regret their transition and silence the voices of those who have de-transitioned because of the challenges these present to the transgender identity narrative. Serious studies into this increasing phenomenon have been successfully squelched due to pressure from activists,<sup>112</sup> but the fact is that transition regret is real.<sup>113</sup> Recently, a wave of rapid adolescent

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<sup>108</sup> Singh, Bradley, and Zucker (2021) recently released a longitudinal study where the desistance rate was 88%. See: Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. *Frontiers in psychiatry*, 12, 1-18. <https://doi.org/10.3389/fpsy.2021.632784>

<sup>109</sup> Ristori, J., Steensma, T. D. (2016). Gender dysphoria in childhood, *International review of psychiatry*, 28(1), 13-20.

<sup>110</sup> Carmichael et al. (2021)

<sup>111</sup> de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The journal of sexual medicine*, 8(8), 2276-2283. <https://doi.org/10.1111/j.1743-6109.2010.01943.x>

<sup>112</sup> Hardy, R. (2017, October 13). How a psychotherapist who has backed transgender rights for years was plunged into a Kafkaesque nightmare after asking if young people changing sex might later regret it. *Daily mail*. <https://www.dailymail.co.uk/news/article-4979498/James-Caspian-attacked-transgender-children-comments.html>

<sup>113</sup> Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M. B., & Buncamper, M. (2016). Reversal surgery in regretful male-to-female transsexuals after sex reassignment surgery. *The journal of sexual medicine*, 13(6), 1000-

transitions numbering in the tens of thousands has been accompanied by a surge of young people who have come to see that their transition was not the answer to their problems after all. There are now so many detransitioners that suppression of their stories is becoming impossible. One recent study surveyed 237 detransitioners, both male and female, and noted that over half of the respondents had three mental health co-morbidities, a trait that once nixed their eligibility for aggressive treatments.<sup>114</sup> The majority of the sample, a full 70 percent, said a reason for detransitioning was due to realizing their “gender dysphoria was related to other issues.”

110. Additionally, 62 percent marked health concerns as a reason for detransitioning, 50 percent said they did not find transition beneficial for their dysphoria, and 45 percent found other ways of dealing with their dysphoria. None of these reasons comport with the trans-affirmative narrative claiming that detransition is primarily due to social pressure or discrimination.<sup>115</sup> “Lack of support from social surroundings (13%), financial concerns (12%) and discrimination (10%)” were the least compelling reasons for detransitioning.<sup>116</sup>

111. Dr. Turban’s recent study of USTS survey data (gathered from an online, opt-in convenience sample) reported far higher levels of “external” rather than “internal” reasons for detransitioning—meaning that motivation for detransitioning was thought to come from the respondent’s social environment rather than from internal motivation. This conclusion, however, is a direct result of how the survey question was posed to respondents. External reasons for detransitioning dominated the answer options, including seven “pressure” answers (e.g., pressure

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1007. <https://doi.org/10.1016/j.jsxm.2016.02.173>; Entwistle, K. (2021). Debate: Reality check—Detransitioners' testimonies require us to rethink gender dysphoria. *Child and adolescent mental health*, 26(1), 15-16. doi/epdf/10.1111/camh.12380

<sup>114</sup> Vandenbussche, E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of homosexuality*, 1-19. <https://doi.org/10.1080/00918369.2021.1919479>

<sup>115</sup> Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to “detransition” among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT health*, 8(4), 273-280. <https://doi.org/10.1089/lgbt.2020.0437>

<sup>116</sup> Vandenbussche (2021), p. 5.

from a parent, pressure from a spouse or partner, pressure from an employer, etc.). Only two vaguely-worded internal answer options were offered: “I realized that gender transition was not for me” and “It was just too hard for me.” (Write-in options were nevertheless allowed, but predictably revealed the lowest response frequency.)

112. In a 2021 study published in the *Archives of Sexual Behavior*, public health scientist Lisa Littman surveyed a convenience sample of 100 detransitioners in order to better understand this population.<sup>117</sup> Her survey of detransitioners offered a far wider array of possible reasons for doing so than the USTS did, and revealed what the USTS could not, by design—namely that internal reasons were far more apt to be selected than external ones. Sixty percent of them became “more comfortable identifying as their natal sex,” nearly half indicated concerns with “potential medical complications from transitioning,” and 38% had come to view their dysphoria as “caused by something specific, such as trauma, abuse, or a mental health condition,” each of which are—if the traditional pathway to treatment were followed—supposed to be probed prior to hormonal or medical treatments.<sup>118</sup>

113. In the USTS, and hence in Turban’s published study of detransitioning, no answer options were offered that would recognize that dysphoria and initial transitioning might have involved “difficulty accepting themselves as homosexual,” traumas (including but not limited to sexual trauma), mental health conditions, and peer effects. Littman’s survey did not include the first of these—but nevertheless revealed its importance: “Despite the absence of any questions about this topic in the survey, nearly a quarter (23.0%) of the participants expressed the internal-

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<sup>117</sup> Littman L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of sexual behavior*, 50(8), 3353–3369. <https://doi.org/10.1007/s10508-021-02163-w>

<sup>118</sup> *Ibid.*, p. 3353.

ized homophobia and difficulty accepting oneself as lesbian, gay, or bisexual narrative by spontaneously describing that these experiences were instrumental to their gender dysphoria, their desire to transition, and their detransition.”<sup>119</sup>

114. Additionally, 37% of detransitioners reported feeling pressure—mostly external—to have transitioned in the first place. It seldom came from family, however. Open-response answers included: “My gender therapist acted like it [transition] was a panacea for everything;” “[My] [d]octor pushed drugs and surgery at every visit;” “I was dating a trans woman and she framed our relationship in a way that was contingent on my being trans;” “A couple of later trans friends kept insisting that I needed to stop delaying things;” “[My] best friend told me repeatedly that it [transition] was best for me;” “The forums and communities and internet friends.”<sup>120</sup>

115. By contrast, only seven percent (collectively) reported in Littman’s study that a parent, spouse, or a family member had pressured them to detransition, far below the USTS’s report of 36%, 18%, and 26%, respectively.

116. Notably, only 24% of those surveyed by Littman had informed the doctor or gender clinic of their detransition, which means that any “official” numbers on detransitioners are apt to be a significant undercount.

117. Further, not even all who experience regret or difficulties attributable to their transition will actually seek to physically detransition. There are many reports of individuals having regret but seeking to make the best of the irreversible changes and situation they find themselves in.<sup>121</sup> Consider the pioneer patient of the experimental Dutch protocol, “B,” who was followed

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<sup>119</sup> Ibid., p. 3362.

<sup>120</sup> Ibid., p. 3360.

<sup>121</sup> E.g.: Jax, R. (2017). *Don’t get on the plane: Why a sex change will ruin your life*. CreateSpace Independent Publishing Platform.; Heyer, W. (2018). *Trans life survivors*. Bowker Identifier Services.; Teller Report. (2020, May 12). Aleksa Lundberg: “I am a gay feminine man with a female body.” <https://www.tellerreport.com/news/2020-05-12-aleksa-lundberg--%22i-am-a-gay-feminine-man-with-a-female-body%22.SyWGzCjDcU.html>

for 22 years until the age of 35. It was reported that “he indicated no regrets about his treatment.”<sup>122</sup> However, B “scored high on the measure for depression. Owing to ‘shame about his genital appearance and his feelings of inadequacy in sexual matters,’ he could not sustain a romantic relationship.”<sup>123</sup> One cannot help but wonder whether B could have enjoyed greater lifetime wellbeing if he had not been placed on the medicalized transgender trajectory at the tender age of 13.

118. The scholar/activist authors of a 2020 *JAMA Psychiatry* study, led by plaintiffs’ witness Dr. Turban, paint an entire class of cautious therapeutic approaches as intrinsically harmful—conversion attempts—using survey language stated as follows: “Did any professional (such as a psychologist, counselor, or religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?” Given the hundreds of questions and items the USTS posed to its respondents six years ago, the fact that it lumps any scenario that does not involve unqualified affirmation (including “watchful waiting”) into one imprecise, binary measure is psychometrically irresponsible.<sup>124</sup> In other words, it is foisting on people a one-size-fits-all definition. What one can learn from a poor-quality question posed to an opt-in

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<sup>122</sup> Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L.C., & Delemarre-van de Waal, H. A. (2011) Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of sexual behavior*, 40(4), 843–847, p. 843.

<sup>123</sup> Biggs (2019) p. 49; Cohen-Kettenis et al. (2011), p. 845.

<sup>124</sup> Turban et al. (2020). This study was thoroughly critiqued in: D’Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of sexual behavior*, 50(1), 7-16. The authors concluded: “Turban et al.’s (2020) singular endorsement of “affirmative” therapies, which their data failed to substantiate, contributes to the alarming trend to frame any non-“affirming” approaches as harmful. We are deeply concerned that this false dichotomy, reinforced by Turban et al.’s unproven claims of the harms of GICE, will have a chilling effect on the ethical psychotherapists’ willingness to take on complex GD patients, which will make it much harder for GD individuals to access quality mental health care. We maintain that availability of a broad range of non-coercive, ethical psychotherapies for individuals with GD is essential to meaningful informed consent, which requires consideration of the full range of treatment options, from highly invasive to non-invasive. Further, given the potential of agenda-free psychotherapy to ameliorate GD non-invasively among young people with GD, withholding this type of intervention, while promoting “affirmation” approaches that pave the way to medical transition, is ethically questionable. We believe that exploratory psychotherapy that is neither “affirmation” nor “conversion” should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures.” p. 13

sample of respondents motivated—even recruited—to participate is limited by definition. That such studies seem easily publishable today highlights the extent to which certain medical journals—officially sponsored by the same associations that have claimed a stake in the outcome here—have been “ideologically captured.” They seem uninterested in holding transgender research to standards comparable to other divisions of medicine.

119. As an aside, one notable development is the explosion in the number of academic journals focused on topics of sexuality and gender identity. There has been, on average, at least one new peer-reviewed journal in the domain of sexuality and gender launched every year for the past 30 years. The supply of journals is certainly in part a function of demand. But it is also invariably the case that where the competition for publication in peer-reviewed journals is tight (and therefore, there is a scarcity of supply), the pathway to publication is more challenging. Hence, the quality of what is published tends to be higher. The opposite happens when there is a large supply of journals: the barrier to publication is lower, and so typically is the quality. This is a problem that pervades the field.

120. If counseling can be construed as conversion attempts, this sends a clear message to psychiatrists and psychotherapists alike about their role in the doctor-patient relationship here—as a supplier of whatever the patient wishes to do. In a marketplace where professionals, just like any business, are subject to public reviews of their work, the label of “transphobic” is unwelcome and may have serious adverse professional consequences.

121. I concur with Dr. Stephen Levine, who has highlighted the quandary facing professionals attempting to provide “informed” counsel to patients about the biological, social, and

psychological risks posed by any treatment approach.<sup>125</sup> Such risks are real and ought to be discussed—this is what ethical informed consent does. But a serious, ranging conversation—the “informed” part of obtaining informed consent—could be perceived as an attempt to “convert” the person from pursuing gender affirmation treatments (e.g., hormones, surgery).

122. The idea that it is a “conversion” to become convinced that perhaps you may be able to live with the body you have strains simple logic as well as the advice of pioneering clinicians that less invasive outcomes were preferable to more aggressive ones.<sup>126</sup> In any case, there is no defined psychotherapeutic method for treating gender dysphoria that can be widely characterized and consistently identified as “conversion therapy” in order to be banned. Nor has there been a clinical trial evaluating specific psychotherapeutic methods of counseling gender dysphoria that could potentially demonstrate whether one or more such methods are indeed helpful or harmful.

123. On page 36 of his previous supplemental declaration, Dr. Turban contests—by misrepresenting—this claim. I did not state that there are no definitions. Rather, I assert that there is no wide and consistent agreement about what exactly constitutes “conversion therapy.” Only his reference to American Academy of Child and Adolescent Psychiatry (AACAP) offers a definition for conversion therapy. The subsequent citations each refer to conversion therapy but do not define it.

124. Following the AACAP’s policy on conversion therapy, Dr. Turban employs a “frame alignment”<sup>127</sup> move to suggest efforts at conversion therapy for same-sex attraction and

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<sup>125</sup> Levine (2019).

<sup>126</sup> Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(4), 472-481.

<sup>127</sup> Snow, D. A., Rochford Jr., E. B., Worden, S. K., & Benford, R. D. (1986). Frame alignment processes, micromobilization, and movement participation. *American sociological review*, 464-481.

gender expression are equivalent, since both—he claims—specifically “aim to promote heterosexuality” (page 36). That is, he links two different movements—the one to suppress gay conversion therapy and the one, noted above, on gender identity “conversion” efforts—in the hopes that overlapping interests, values, beliefs, and goals are complementary. But I am not talking about heterosexuality. I concur with another critic who has observed, “Studies of conversion therapy have been limited to *sexual orientation*, and, moreover, to the sexual orientation of *adults*, not to gender identity and not of children in any case.”<sup>128</sup> One British psychotherapist observes this challenge, noting that “[s]ome therapists, trans people, and their allies seem to regard any psychological description of GD as inherently pathologizing and equate it with gay conversion therapy.”<sup>129</sup>

125. Here again is evidence that a central framework for understanding the treatment of adolescent transgender patients is not that of mental and physical flourishing, but rather has become that of securing bodily autonomy and patient choice. The ideological capture of much of this field of treatment makes for a very difficult environment for psychological treatment of gender dysphoria in minors.

126. Many other examples of undue pressure could be given, both within and outside the professions. Amazon’s decision to withdraw from selling books that so much as suggest the idea that gender dysphoria is (or had been associated with) a mental disorder is one. Public fora for legitimate debate are actively being curbed.<sup>130</sup> Even *reviews* of books are being retracted and

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<sup>128</sup> Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of sex & marital therapy* 46(4): 307-313. The quote is from page 308.

<sup>129</sup> Withers (2020), p. 865.

<sup>130</sup> Trachtenberg, J. A. (2018, March 11). Amazon won’t sell books framing LGBTQ+ identities as mental illnesses. *Wall street journal*. <https://www.wsj.com/articles/amazon-wont-sell-books-framing-lgbtq-identities-as-mental-illnesses-11615511380>

withdrawn.<sup>131</sup> Certain conclusions are now penalized both professionally and in the wider social and economic marketplace. To suppose that such external social and political pressures do not affect basic social or medical research on transgender-related matters would be naïve.

#### **E. Inconsistent Claims about Adolescents’ Ability to Consent**

127. A central and persistent concern about hormonal (and subsequent surgical) courses of treatment for gender dysphoria in adolescents is their ability to genuinely consent to treatments that will almost invariably lead to de facto sterilization. Parental consent to sterilization used to be unlawful in many locales, creating ethical dilemmas that commonly required judicial review.<sup>132</sup>

128. These are complicated matters, no doubt. Bernadette Wren, who was a senior clinician at the Tavistock until her retirement in 2020, admits in her diary of reflections to doubts about her field at the UK’s gender clinic: “Can children and adolescents realistically consent to these treatments? If yes, how is their competence ensured? If no, is this decision within the scope of parental discretion? And if young people, with or without their parents, are deemed competent, where does the responsibility lie if there are subsequent feelings of regret?” If senior clinicians who have worked in this domain for decades have such fundamental questions, they are certainly worth considering.

129. The stakes are high. The bar to informed consent for experimental medical treatments (of any sort) has long been elevated for minors. It is decreasingly so in gender medicine. As gender therapist Diane Ehrensaft observes, “continuity of care in gender affirmation” from

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<sup>131</sup> Novella, S. & Gorski, D. (2021, June). Retraction notice for Hall, H. (2021, June 15.) Book review: *Irreversible damage: The transgender craze seducing our daughters*, by Abigail Shrier. *Science-based medicine*. <https://science-basedmedicine.org/irreversible-damage-the-transgender-craze-seducing-our-daughters/>

<sup>132</sup> For example, it remains illegal in Oregon to sterilize a person under age 15, regardless of parental permission. See also Boynton, M. (1994). Sterilization of minors. *Minn med.* 77(1):23-4. <https://pubmed.ncbi.nlm.nih.gov/8127303/>

puberty blockers to cross-sex hormones results in “discontinuity in potential capacity to ever create progeny with their own genetic material.”<sup>133</sup> In other words, affirmative care eventually means sterilization *as a minor*, under WPATH’s proposed new guidance.

130. Even researchers and clinicians trained on the experimental Dutch protocol are signaling new allegiances to the “affirm without question” paradigm, after claiming that the recent surge in cases merely reflects hidden demand previously unsurfaced.<sup>134</sup> As an example of this, Dutch child and adolescent psychiatrist Annelou de Vries and six co-authors registered their disappointment with the (original) *Bell v Tavistock* decision, asserting that “minors as young as 12 years of age frequently possess this ability”—that is, the competency to understand the consequences of a decision to begin puberty blockers.<sup>135</sup>

131. In asserting this, de Vries and her colleagues claim to concur with “all the major medical associations.” But even some medical associations offer reasons to doubt that adolescents are competent to consent. The APA recognizes that “adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would benefit and to which they feel entitled. This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering de-

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<sup>133</sup> Ehrensaft, D. (2021, April 7). Fertility issues for transgender and nonbinary youth. Training presentation sponsored by the UC San Francisco Child and Adolescent Gender Center. Discussion and video links available at: <https://4thwavenow.com/2021/04/13/tmi-genderqueer-11-year-olds-cant-handle-too-much-info-about-sterilizing-treatments-but-do-get-on-with-those-treatments/>

<sup>134</sup> Arnoldussen, M., Steensma, T.D., Popma, A. *et al.* (2020). Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals?. *European child & adolescent psychiatry*, 29, 803–811. <https://doi.org/10.1007/s00787-019-01394-6>.

<sup>135</sup> de Vries, A. L., Richards, C., Tishelman, A. C., Motmans, J., Hannema, S. E., Green, J., & Rosenthal, S. M. (2021). *Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents*, *International journal of transgender health*, p. 5. doi: 10.1080/26895269.2021.1904330

cisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery.”<sup>136</sup> For its part, the Endocrine Society guidelines recognize that “no objective tools to make such an assessment [i.e., of an adolescent’s competence in decision making] are currently available” and notes that some “believe that . . . abilities (such as good risk assessment) do not develop until well after 18 years.”<sup>137</sup>

132. The American Medical Association (AMA) presents a curious case about consent. In an April 26, 2021 letter to the National Governors Association (NGA), the AMA wrote to urge the NGA to “oppose state legislation that would prohibit the provision of medically necessary gender transition-related care to minor patients.”<sup>138</sup> But this statement is flatly inconsistent with the position the AMA has taken concerning adolescents’ abilities in other contexts. In its 2005 amicus brief to the U.S. Supreme Court in *Roper v. Simmons*, a case that concerned capital punishment for crimes committed by minors, the AMA asserted that “[a]dolescents’ behavioral immaturity mirrors the anatomical immaturity of their brains. To a degree never before understood, scientists can now demonstrate that adolescents are immature not only to the observer’s naked eye, but in the very fibers of their brains.”<sup>139</sup>

133. The AMA brief makes an additional pair of comparative claims about the adolescent brain: “First, adolescents rely for certain tasks, more than adults, on the amygdala, the area of the brain associated with primitive impulses of aggression, anger, and fear. Adults, on the

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<sup>136</sup> American Psychological Association (2015), p. 842.

<sup>137</sup> Hembree et al. (2017), p. 3884.

<sup>138</sup> Madara, J. L. (2021, April 26). Official AMA letter to legislators. <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children>

<sup>139</sup> American Medical Association et al. (2005). Brief of Amici Curiae in *Roper v. Simmons*, (U.S. Sup. Ct.), 543 U.S. 551 (No. 03-633), 2004 WL 1633549, p. 10. The AMA was joined in their claims by the American Psychiatric Association, American Society for Adolescent Psychiatry, American Academy of Child & Adolescent Psychiatry, American Academy of Psychiatry and the Law, National Association of Social Workers, Missouri chapter of the National Association of Social Workers, and the National Mental Health Association.

other hand, tend to process similar information through the frontal cortex, a cerebral area associated with impulse control and good judgment. Second, the regions of the brain associated with impulse control, risk assessment, and moral reasoning develop last, after late adolescence.”<sup>140</sup> This is widely recognized today in the conventional wisdom that (prefrontal) brain development does not stabilize in human beings until around age 25.

134. One of the attorneys who penned the brief in *Roper* on behalf of the AMA and other organizations later reinforced—by referring to the brief itself—that the “ability of adolescents to make cost-benefit calculations, as compared to adults, is deficient. Additionally, their susceptibility to peer pressure is greater because of this impaired judgment. Moreover, adolescents are more volatile than adults, experiencing more extreme emotions that are not as regulated as they are in adults.”<sup>141</sup>

135. When it comes to criminal activity, the AMA asserts that minors cannot be trusted to navigate peer pressure, weigh costs and benefits, make clear-minded judgments, and move ahead with life-altering decisions. But when it comes to transgender medicine and its life-altering consequences, the AMA asserts that minors are competent to make such decisions.

136. Is a child at the cusp of puberty competent to weigh the risks and consequences that transgender medicine entails? That was the question at stake in *Bell v Tavistock*. In 2020, Keira Bell petitioned the court to review the treatment given to minors and young people, saying she had been rushed to transition, was not given other therapeutic options, and lacked the capacity to understand the long-term implications of her decisions at the time. “I was an unhappy girl who needed help,” Bell stated. “Instead, I was treated like an experiment.”<sup>142</sup> In its December

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<sup>140</sup> American Medical Association et al., p. 11.

<sup>141</sup> Haider, A. (2006) *Roper v. Simmons*: The role of the science brief. *Ohio state journal of criminal law* 3: 369-377, p. 372.

<sup>142</sup> Bell, K. (2021, April 7). Keira Bell: My story. *Persuasion*. <https://www.persuasion.community/p/keira-bell-my-story>

2020 decision, the UK’s highest court ruled that children could not give genuine consent to hormonal treatments offered at the National Health Service’s gender clinic.

137. In its original verdict, the UK High Court also highlighted a “lack of clarity over the purpose of the treatment: in particular, whether it provides a “pause to think” in a “hormone neutral” state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later.”<sup>143</sup>

138. When the initial judgment in *Bell v Tavistock* was announced, plaintiff Keira Bell responded, “I am delighted at the judgment of the court today. It was a judgment that will protect vulnerable young people. I wish that it had been made for me before I embarked on the devastating experiment of puberty blockers. My life would be very different today. This time last year I joined this case with no hesitation, knowing what I knew about what had and has been going on at the gender identity clinic. My hope was that outside of the noise of the culture wars the court would shine a light on this harmful experiment on vulnerable children and young people. These drugs seriously harmed me in more ways than one and they have harmed many more particularly young girls and women.”<sup>144</sup>

139. What is certainly clear is that the use of puberty blockers in the present is linked to the potential outcomes of future drugs and surgeries, thus revealing a presumption of medical “path dependence” in these treatment protocols. That is why the court determined that puberty blockers and cross-sex hormones are essentially two parts of “one clinical pathway.”<sup>145</sup> Consequently, for minors to be competent to consent to blockers, they would have to adequately understand and consent to the effects of future cross-sex hormones as well.

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<sup>143</sup> Bell & A v. Tavistock & Portman NHS Foundation Trust. (2020), para. 134.

<sup>144</sup> Bell, K. (2020) Keira Bell case: Statements from BBC interview. Transcript available here: <https://our-duty.group/2020/12/02/keira-bell-case-statements/>

<sup>145</sup> Bell & A v. Tavistock & Portman NHS Foundation Trust. (2020), para. 136.

140. In the most recent ruling on the Tavistock’s subsequent appeal, the Court of Appeals’ opinion did not reflect any change in the evidentiary bases, nor did it draw any conclusions about harm or risk of harm to minors, but instead upheld a legal precedent favoring physicians’ discernment of adolescent competence to consent, on a case-by-case basis.<sup>146</sup> (The case is currently proceeding to the UK Supreme Court.)

141. The legal precedent, established in *Gillick v West Norfolk and Wisbech Area Health Authority*, presupposes that all clinicians are subject to professional regulation, with established review mechanisms. However, there is growing concern from within the transgender medical community that such established review mechanisms are increasingly disregarded. Wren recently reflected that the landscape for treating gender dysphoria in the UK had shifted. There is now “growing resistance from families toward...[a] slow-paced model of care. Young people and their parents, arriving at [Tavistock’s GIDS clinic] many months after referral, were becoming more assertive in their demands for validation of their new gender identity and for faster, earlier and simpler access to puberty suspension and cross-sex hormones.”<sup>147</sup> Social media sources add motivation, while external providers add competition. Caution and reflection, Wren observed, “were now pitted against online sources of anecdote, emotion and personal history. Private providers waited in the wings, willing to meet these requests with a minimal protocol.”<sup>148</sup>

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<sup>146</sup> <http://www.bailii.org/uk/cases/UKHL/1985/7.html> or <https://www.judiciary.uk/judgments/bell-and-another-v-the-tavistock-and-portman-nhs-foundation-trust-and-others/>

<sup>147</sup> Wren, B. (2021, Dec. 2). Epistemic injustice. *London review of books*, 43 (23), <https://www.lrb.co.uk/the-paper/v43/n23/bernadette-wren/diary>, paragraph 12.

<sup>148</sup> *Ibid.*

142. Hence, the September 2021 Court of Appeals deference to “Gillick competence,” the precedent established in the 1985 case by that name, formally affirms an approach that is increasingly informally ignored—including at the Tavistock clinic, according to Wren.

143. The same observations are being made in the United States. A pair of clinical psychologists—one of whom identifies as transgender—who work with gender dysphoric adolescents, recently asserted that “we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery.”<sup>149</sup> Formal standards, they claim, are being openly ignored in favor of believing the patient, no matter how young. This, the pair observes, is what gender-affirming medicine has become—skipping the psychological assessment and believing the patient is capable of making all decisions about their own body. They make reference to a popular physician and gender clinic director’s claim that gender-affirming medicine means that “‘you are best equipped to make decisions about your own body,’ full stop.”<sup>150</sup>

144. Sweden and Finland have, on the other hand, scaled back their protocols concerning adolescent transgender treatments after witnessing surging cases and the sex-ratio inversion—far more natal girls than boys seeking medical treatment for gender dysphoria. Finnish guidelines now hold that that identity exploration is a natural phase of adolescence and therefore medical interventions ought to be restricted until their “identity and personality development appear to be stable.” Brain development, they observe, continues until early adulthood—about age

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<sup>149</sup> Edwards-Leeper & Anderson (2021), paragraph 6.

<sup>150</sup> Ibid., paragraph 13.

25—which affects young people’s ability to assess the consequences of their decisions on their own future selves for rest of their lives.<sup>151</sup>

145. “Cross-sex identification in childhood, even in extreme cases, generally disappears during puberty,” the Finnish document maintains. Moreover, the new guidelines prioritize non-invasive psychotherapeutic interventions as the first course of action, due to “variations in gender identity in minors.”<sup>152</sup> Finally, Finnish guidelines similarly recommend further study, citing “a need for more information on the disadvantages of procedures and on people who regret them.”<sup>153</sup>

146. Sweden’s rollback—in the wake of a 1,500 percent increase in youth gender clinic referrals over a ten-year period—is even more pronounced. Hormonal treatments will no longer be offered to persons under age 18, although clinical trials research on 16-18-year-olds will be allowed. This followed a late 2019 Swedish health system publication and a similar evidence review published in October 2020 that revealed little evidence to suggest that puberty-blocking and hormonal treatments improve the mental health and psychosocial functioning of minors. The literature provides very little knowledge about their safety in the long term.<sup>154</sup>

#### **F. The Department of Justice’s Dramatic Flip-Flop on *Bostock***

147. Not to be overlooked in a discussion of matters bearing on the politically-charged nature of issues affecting persons who identify as transgender is the Department of Justice (DOJ) Civil Rights Division’s dramatic flip-flop on implementing the U.S. Supreme Court’s decision in

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<sup>151</sup> Council for Choices in Healthcare (COHERE). (2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation-summary. Healthcare Services Selection Council (Palko). Government, Finland. [https://palveluvalikoima.fi/documents/1237350/22895008/Summary\\_minors\\_en.pdf/aaf9a6e7-b970-9de9-165c-abadfae46f2e/Summary\\_minors\\_en.pdf](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abadfae46f2e/Summary_minors_en.pdf)

<sup>152</sup> Council for Choices in Healthcare (COHERE) (2020).

<sup>153</sup> Ibid.

<sup>154</sup> Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) (2019).

*Bostock v. Clayton County, Georgia*. That decision held that firing an individual because they are transgender violates Title VII of the Civil Rights Act.

148. On January 17, 2021, the DOJ’s Civil Rights Division issued a memorandum addressing *Bostock*’s implications for various provisions of law, for religious liberty, and for the DOJ’s own employment practices.<sup>155</sup> But a mere five days later—after the inauguration of a new presidential administration—the Civil Rights Division withdrew the memorandum.<sup>156</sup> The whip-lash-inducing speed with which the Civil Rights Division reversed itself after the new administration took over simply highlights the politically-charged nature of the matter.

149. I have reviewed the Civil Rights Division’s statement of interest filed in this lawsuit, which accentuates the point to an even greater degree. The Civil Rights Division’s January 17, 2021 memorandum articulated several reasons why the *Bostock* decision did not bear on the Equal Protection Clause. But on June 17, 2021, the Civil Rights Division filed a statement of interest in this lawsuit that repeatedly appeals to *Bostock* in support of the plaintiffs’ Equal Protection claim in this lawsuit. The DOJ Civil Rights Division’s direct contradiction of the precise legal position that it took only a few months prior renders undeniable the politically-charged nature of matters bearing on individuals who identify as transgender.

## **VI. ASSESSING THE RISK OF SUICIDE AS MOTIVATION FOR “AFFIRMATIVE” TREATMENT**

150. Parents’ fears about children’s suicide are understandable and ought never to be dismissed. However, such fears should not override scholarly evaluations of suicidality—which

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<sup>155</sup> Daukas, J. B. (2021, January 17). Department of Justice memorandum to the Civil Rights Division on the application of *Bostock v. Clayton County*. Although the DOJ removed the January 17 memorandum from the Internet, it is archived online here: <https://web.archive.org/web/20210120125231/https://www.justice.gov/crt/page/file/1356531/download>

<sup>156</sup> Friel, G. B. (2021, January 22). Department of Justice memorandum to the Civil Rights Division withdrawing the memorandum on the application of *Bostock v. Clayton County*. <https://www.justice.gov/crt/page/file/1373621/download>

the APA defines as risk of suicide indicated by ideation and intent—with suicide itself.<sup>157</sup> The association of the two (suicide and suicidality) varies notably in subpopulations.<sup>158</sup> Too often, however, suicidal “ideation” is equated with “attempted” suicide, and even seems to be treated as a proxy for suicide.

151. For example, Dr. Turban proposes suicidality as an important motivation for endorsing the “affirmative” approach to treating dysphoric adolescents.<sup>159</sup> But suicidal ideation and suicidal behavior are not as tightly associated as some surmise. For example, young adults are at least three times as likely to report past-year thoughts of suicide than are adults age 50 and older.<sup>160</sup> But the actual suicide rate among older Americans remains well above that among young adults, and far above children below age 15.<sup>161</sup> New data, collected during the COVID-19 era, complicates matters further, given that young adults ages 18-24 reported suicidal thoughts in the past month at rates 12 times higher than that of respondents age 65 and over, and six times that reported by those between 45 and 64 years old (25.5, 3.8, and 2.0 percent, respectively).<sup>162</sup>

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<sup>157</sup> <https://dictionary.apa.org/suicidality>

<sup>158</sup> Han, B., Compton, W. M., Gfroerer, J., & McKeon, R. (2015). Prevalence and correlates of past 12-month suicide attempt among adults with past-year suicidal ideation in the United States. *The journal of clinical psychiatry*, 76(3), 295–302. <https://doi.org/10.4088/JCP.14m09287>

<sup>159</sup> Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145, e20191725. <https://doi.org/10.1542/peds.2019-1725>. This touted study, however, proves insufficient for the claims it makes. Oxford University sociologist Michael Biggs argues that the study leans on “a low-quality survey which is known to have elicited unreliable answers on puberty blockers.” Biggs concludes that Turban’s study “provided no evidence to support the recommendation ‘for this treatment to be made available for transgender adolescents who want it.’” See Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from gender dysphoria. *Archives of Sexual Behavior*, 49, 2227-2229. <https://link.springer.com/content/pdf/10.1007/s10508-020-01743-6.pdf>

<sup>160</sup> Lipari, R. N., Hughes, A., & Williams, M. (2016, June 16). State estimates of past year serious thoughts of suicide among young adults: 2013 and 2014. *The CBHSQ report*, 1-7. Substance Abuse and Mental Health Services Administration (US). PMID: 27854411.

<sup>161</sup> Hedegaard, H., Curtin, S. C., Warner, M. (2021). Suicide mortality in the United States, 1999–2019. *NCHS data brief*, no. 398. Hyattsville, MD: National Center for Health Statistics. doi: <https://dx.doi.org/10.15620/cdc:101761>.

<sup>162</sup> Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E. & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30. *MMWR Morbidity & mortality weekly report*, 69(32), 1049–1057. doi: <http://dx.doi.org/10.15585/mmwr.mm6932a1>

Based on thoughts of suicide, then, it could be said that there is a crisis of suicidality among the young. But the crisis of actual suicide affects older Americans to a more significant degree.

152. One of the most recent evaluations of suicidal ideation using the CDC's 2019 Youth Risk Behavior Survey noted that 19 percent of Americans ages 14-18 report having seriously thought about suicide (i.e., had suicidal ideation) in 2019.<sup>163</sup> Nine percent reportedly attempted suicide. The CDC did not track such rates among youth identifying as transgender, but did note elevated rates among individuals identifying as lesbian, gay, or bisexual. Previous research has noted that between 25 to 30 percent of adolescents identifying as transgender report having attempted suicide during their lifetimes.<sup>164</sup>

153. Suicides and attempted suicides among the self-identified transgender population are indeed higher than those in the population at large. It is, however, difficult to determine this subpopulation's scope of suicide risk with accuracy. Moreover, suicide rates have increased strikingly in the general population over the past decade.<sup>165</sup>

154. Nevertheless, localized estimates of suicidal ideation and attempts among transgender-identifying adolescents vary notably. A 2017 chart review from a Cincinnati gender

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<sup>163</sup> Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E., Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students - Youth Risk Behavior Survey, United States, 2019. *MMWR Suppl.*, 69(Suppl. 1), 47-55. doi: 10.15585/mmwr.su6901a6. See also: Gender Identity Development Service. (2021). Evidence base: Psychosocial difficulties. <https://gids.nhs.uk/evidence-base>

<sup>164</sup> Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *Journal of adolescent health*, 57(4), 374-380; Grossman, A.H., Park, J.Y., & Russell, S.T. (2016). Transgender youth and suicidal behaviors: Applying the interpersonal psychological theory of suicide. *Journal of gay & lesbian mental health*, 20(4), 329-349.

<sup>165</sup> Whalen, J. (2018, May 15). Youth suicidal behavior is on the rise, especially among girls. *Wall street journal*. <https://www.wsj.com/articles/youth-suicidal-behavior-is-on-the-rise-especially-among-girls-1526443782>

clinic noted that among patients (ages 12-22) diagnosed with gender dysphoria, 30 percent reported at least one suicide attempt.<sup>166</sup> (Overall, 58 percent of the Cincinnati clinic patients exhibited at least one additional psychiatric diagnosis.) Two similar studies support these findings, with attempted suicide rates among transgender or dysphoric adolescents of between 26 and 31 percent.<sup>167</sup> Others note lower rates, including 14 percent in a Toronto clinic and 10 percent in an Australian clinic.<sup>168</sup>

155. The UK's Gender Identity Development Service (GIDS) observes that suicide remains "extremely rare" among dysphoric youth, even while noting their rates of self-harm are consonant with those among adolescents in the general population. An extensive, longitudinal "chart study" of all 8,263 adult, adolescent, and child referrals to an Amsterdam gender clinic between 1972 and 2017 documented that 41 natal men (0.8 percent) and 8 natal women (0.3 percent) died by suicide.<sup>169</sup> Among the former, suicide deaths had decreased over time, while it did not change in natal women. Only four suicide deaths were observed among patients referred to the clinic before the age of 18 (0.2 percent), which was a lower risk than among adult patients (0.7 percent).

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<sup>166</sup> Peterson, C. M., Matthews, A., Copps-Smith, E. and Conard, L. A. (2017). Suicidality, self-harm, and body dissatisfaction in transgender adolescents and emerging adults with gender dysphoria. *Suicide and life-threatening behavior*, 47, 475-482. <https://doi.org/10.1111/sltb.12289>

<sup>167</sup> Eisenberg, M. E., Gower, A. L., McMorris, B. J., Rider, G. N., Shea, G., & Coleman, E. (2017). Risk and protective factors in the lives of transgender/gender nonconforming adolescents. *Journal of adolescent health*, 61(4), 521-526. <https://doi.org/10.1016/j.jadohealth.2017.04.014>; Grossman, A. H. & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and life-threatening behavior*, 37(5), 527-537. <https://guilfordjournals.com/doi/abs/10.1521/suli.2007.37.5.527>

<sup>168</sup> Sorbara, J. C., Chiniara, L. N., Thompson, S., & Palmert, M. R. (2020). Mental health and timing of gender-affirming care. *Pediatrics*, 146(4). <https://doi.org/10.1542/peds.2019-3600>; Kozłowska et al. (2021).

<sup>169</sup> The median age at first visit, however, was 25. See Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam cohort of Gender Dysphoria study (1972–2017). *Acta psychiatrica Scandinavica*, 141(6), 486-491. <https://doi.org/10.1111/acps.13164>

156. The Tavistock report also revealed that after a year on puberty blockers, a significant increase was noted in responses to the statement “I deliberately try to hurt or kill myself.” This finding, however, was not replicated across the duration of the study.<sup>170</sup>

157. In 2020, the Swedish National Board of Health and Welfare reported that minors with gender dysphoria have a high incidence of “co-occurring psychiatric diagnoses, self-harm behaviors, and suicide attempts compared to the general population” and that suicide mortality rates are higher among people with gender dysphoria than in the general population. They also observe, however, complications in figuring out what is to blame: “At the same time, people with gender dysphoria who commit suicide have a very high rate of co-occurring serious psychiatric diagnoses, which in themselves sharply increase risks of suicide. Therefore, it is not possible to ascertain to what extent gender dysphoria alone contributes to suicide, since these psychiatric diagnoses often precede suicide.”<sup>171</sup>

158. Hence, the evidence for actual suicide risk among gender dysphoric minors is simply unclear, and not just because completed suicides are far more apt to be documented in terms of demographic characteristics rather than sexual and gender-related ones. Rather, as one psychiatrist aptly notes, “Suicide is rare and noisy,” that is, understanding particular causes is challenging. The white male suicide rate, for example, is the highest in the United States by a significant margin. But to suggest that race or sex plays a compelling motivation in suicidal decision-making does not make sense. Complicating matters here is the known, elevated frequency

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<sup>170</sup> Biggs (2019).

<sup>171</sup> Swedish National Board of Health and Welfare. (2020). The evolution of the diagnosis of gender dysphoria: Prevalence, co-occurring psychiatric diagnoses and mortality from suicide. *Socialstryelsen*, p. 11.

of “significant psychopathology” among dysphoric adolescents.<sup>172</sup> This makes direct, unmediated claims about the causes of suicidal ideation very difficult.

159. An earlier study of 55 transgender youth reported that “nearly half of the sample reported having seriously thought about taking their lives and one quarter reported suicide attempts.”<sup>173</sup> Among them, however, “a significantly greater proportion of those who had attempted suicide expressed weight-related body dissatisfaction than those who had not,” a finding observed in other studies as well.<sup>174</sup> They also tended to ruminate about how others evaluated their bodies.

160. Simply documenting elevated “suicidality” among self-identified transgender youth does not recommend a particular treatment approach.<sup>175</sup> As one psychoanalyst put it, “We treat suicide first of all by keeping people safe, and by helping them become more resilient.”<sup>176</sup> Understanding the relationship between gender dysphoria and suicidality is complex; that is, there is an association, but the dysphoria may or may not be a central cause. Research has noted recently that particular aspects of body dissatisfaction may constitute independent risk factors for suicidality among patients with gender dysphoria.<sup>177</sup> In other words, dissatisfaction with appearance—all the more in the age of Instagram and the selfie—may be a factor in the elevated risk of attempted suicide. In the absence of data analyses that can control for the effects of other confounding and contributing factors, it becomes very difficult to establish that gender dysphoria is

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<sup>172</sup> Kaltiala-Heino, R., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and adolescent psychiatry and mental health*, 9(1), 1-9. <https://doi.org/10.1186/s13034-015-0042-y>

<sup>173</sup> Grossman & D’Augelli (2007), p. 527.

<sup>174</sup> Day et al. (2019), p. 2; Grossman & D’Augelli (2007).

<sup>175</sup> Day, D. S., Saunders, J. J., & Matorin, A. (2019). Gender dysphoria and suicidal ideation: Clinical observations from a psychiatric emergency service. *Cureus*, 11(11), e6132. <https://doi.org/10.7759/cureus.6132>

<sup>176</sup> Shrier (2020), pp. 137-138.

<sup>177</sup> Peterson et al. (2017).

a solitary or primary driver of suicidality, all the more since the majority of gender dysphoric minors never attempt suicide.

161. The specter of suicide has nevertheless become a central narrative among supporters of the affirmative treatment approach. Some advocates compare puberty suppression to cancer treatments, claiming that these interventions are as “life-saving” for gender-dysphoric youth as oncology treatments are for those afflicted with cancer.<sup>178</sup> However, the science behind claims that such treatments lead to sustained improvement in mental health—improvement that cannot possibly occur in its absence—is remarkably weak.

162. Affirmative clinicians Dr. Edwards-Leeper and her transgender co-author Dr. Erica Anderson have criticized advocates’ weaponization of suicidality—a tool they believe to be wielded by the “affirm without question” wing of clinicians, whose argument can be summarized as follows: support the minor’s self-diagnosis and put them on the pathway to transition, lest they take their own life. Edwards-Leeper and Anderson have heard enough; the “specter” of suicide “should not be used to push forward unrelated medical treatment without professional care or attention for each patient.”<sup>179</sup>

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<sup>178</sup> In the Tavistock study, children were barred from beginning GnRha treatment if their baseline bone density was too low or agreed to stop treatment if it fell below a certain threshold. In the original Dutch protocol, several participants had to discontinue treatment due to medical complications from the hormone therapy. Did these children die from lack of medicine? Was the progression of their natural puberty and release of sex congruent hormones akin to the progression of metastatic cancer? Of course not. One hopes that these children were rightly encouraged in resilience, rather than surmise that they were doomed to commit suicide because they could not tolerate living in their body apart from transgender medical interventions.

<sup>179</sup> Edwards-Leeper & Anderson, E. (2021), paragraph 15.

## VII. THE ROLE OF VALUES IN THE PRODUCTION OF SCIENCE

163. Many scientists have long asserted the reality and importance of the fact/value distinction. That is, there are facts—real things—and then there are values, our opinions or attitudes. The study of transgender medicine undermines any strong confidence in this distinction because what a person values shapes what they discern as facts.

164. Misunderstanding the place of values in science is not just an intellectual problem. It can have practical consequences, especially where science has implications for public health and policy. A trio of philosophers aptly note: “If values play a role in science, then the public and public officials cannot take scientific results as given and scientific authorities as beyond challenge. Responsible public policy will require responsible use of science; responsible use of science will require explicit critical awareness of its value assumptions.”<sup>180</sup>

165. Although this report has focused on the scientific evidence, researcher behavior, and the culture of scientific organizations, it is nevertheless easy to observe how values saturate “affirmative” approaches to treating gender dysphoria. This is not a criticism per se. Values necessarily infuse the sciences, including the medical sciences as well. The Endocrine Society openly notes how particular values affect their counsel: “These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.”<sup>181</sup> In other words, the Endocrine Society is more concerned with helping young people achieve a certain subjective satisfaction

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<sup>180</sup> Kincaid, H., Dupré, J., & Wylie, A., (Eds.). (2007). *Value-free science? Ideals and illusions*. Oxford University Press, pp. 4-5.

<sup>181</sup> Hembree et al. (2017), p. 3881.

with their physical appearance than it is avoiding possible harms of experimental medications, the threat of sterilization, or addressing the long-term health and well-being of its young patients.

166. The Endocrine Society is not alone here. Even Dr. de Vries and her colleagues, cited earlier as one-time representatives of the (less reckless but still experimental) Dutch protocol, make a play for the same privileging of physical appearance in their criticism of the UK court's *Tavistock* decision: "Our deep concern is that the High Court overlooked . . . the lifelong benefits of having a physical appearance which is congruent with one's gender identity (e.g., no or less breast development and less feminine body shape in an affirmed male and no low voice, Adam's apple, or masculine facial features in an affirmed female)."<sup>182</sup>

167. Indeed, value-laden questions may outnumber purely clinical ones in this domain. Is the physician's role one of granting the requests of patients in order to fulfill what the latter believe or want to be true, or is the physician's role to treat the gender dysphoria with as little longstanding harm to the wellbeing of the body and mind as possible? Are we to master our feelings and emotions or be subject to them?

168. The very experience of social, hormonal, and surgical "transition" is a value leap—the introduction of a new meaning of "life cycle." The "body and its meanings" are now considered "contingent."<sup>183</sup> The concept of "gender identity" requires body dissociation de facto, subjugating material reality to the subjective feelings of youth susceptible to suggestion.

169. Dr. Adkins comments on pre-pubertal social transitioning behaviors, including "allowing children to wear clothing, to cut or grow their hair, to use names and pronouns, and to access restrooms and other sex-separated facilities and activities in line with their gender identity

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<sup>182</sup> de Vries et al. (2021), p. 4.

<sup>183</sup> Pyne, J. (2014). Gender independent kids: A paradigm shift in approaches to gender non-conforming children. *The Canadian journal of human sexuality*, 23(1), 1-8, p. 5. <https://doi.org/10.3138/cjhs.23.1.CO1>

instead of the sex assigned to them at birth.”<sup>184</sup> But her description is wrong because these behaviors are not in line with some immutable thing called a “gender identity.” Rather, they are in line with current, valued (and culture-specific) expressions of sex-typed behavior. If “gender identity,” a concept not invented until mere decades ago, was associated with each of these practices, from where (and why) did such norms arise? Instead of questioning the exclusive validity of two-dimensional, historically contingent gender stereotypes (e.g., the cartoonishly “feminine” Barbie doll or an excessively “masculine” counterpart), many have instead capitulated to (social) media-intensified values about dress, attire, look, and practice. Rather than impugn one’s own body, perhaps norms associated with this or that “gender identity” ought to be more flexible.

170. Bernadette Wren, the retired senior clinician from the Tavistock clinic, wrote in 2014 how trendy postmodern ideas about gender had impacted clinicians’ work with children and adolescents, namely, by adopting the idea of “all gender as fictional and artificial.” After discussing the possible conundrums that arise when directing minors toward irreversible physical changes in light of these conceptions, Wren concluded: “the meaning of trans is constantly shaped and re-shaped, [and] rests on no foundation of truth. The therapist is not burdened with needing to be right or certain, but to offer a reflexive and thoughtful space to help clients explore the architecture and borders of their gendered world view.”<sup>185</sup>

171. Wren recognizes the value-laden nature of gender medicine for minors: “We are concerned about overstepping what the current evidence can tell us about the safety of our interventions. And we are fully alive to the complexities of informed consent, especially with respect to irreversible bodily change and fertility—and to the possibility of young people having later

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<sup>184</sup> Adkins (2021), p. 7.

<sup>185</sup> Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism & Psychology*, 24(2), 271-291, p. 271 and p. 287, respectively.

misgivings around medical intervention. We see that these are not matters of narrow ‘clinical’ judgement, but relate to broader social acceptance of the challenges brought by new medical technologies, new ideologies of self-determination and new models of parental responsiveness and love.”<sup>186</sup> Unquestionably, values saturate this domain.

### VIII. CONCLUSION

172. The field of adolescent transgender medicine is saturated by conflict over competing values. High quality longitudinal research is rare. Randomized clinical trials research has not occurred. Bait-and-switch tactics are being employed—conclusions from studies based on patients without psychological comorbidities are being applied to patients displaying anxiety disorders, autism spectrum disorders, suicidality, and self-harming behaviors. Protocols are becoming more permissive (and aggressive in “affirmation”), motivated by a market-driven medical culture in which emphasis is placed on liking what one sees in a mirror, or, increasingly, how others respond to a selfie. Careful practitioners are put in a position to only guess at what may result based on research conducted under quite different conditions. To object, however, invites professional censure. Meanwhile, the basics of the explosion in gender dysphoria, especially among natal girls, remain understudied and undertheorized—perhaps now on purpose—even as minors’ questionable ability to consent is validated because minors (and their parents) are demanding the experimental treatments. This is not how healthy medical research operates.

173. A premature—and still evolving—“consensus” has been contrived among some professional organizations in this field of medicine. Activists and other interested parties have played a significant role in shaping medical policy, and researchers have taken steps to suppress public discussion and debate and to push medical practice in directions that outpace and even

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<sup>186</sup> Wren, B. (2020). Debate: You can't take politics out of the debate on gender-diverse children. *Child and adolescent mental health*, 25(1), 40-42, p. 41. <https://doi.org/10.1111/camh.12350>

contradict the available evidence. As I have documented, such practices are often openly observable. The pace and extent of ideological capture is staggering.


174. Bernadette Wren, the retired Tavistock senior clinician quoted earlier, helps articulate the dilemma here. “For some advocates,” a term that certainly includes the plaintiffs in this case, “[a] justice-based approach extends to the demand that all gender-diverse people, including the young, should have the unquestionable right to make fully autonomous treatment decisions – the full freedom, we might say, to make their own mistakes.”<sup>187</sup>

175. Based on the current state of the science, giving minors the power to make “fully autonomous treatment decisions” and “make their own mistakes” here is to abdicate responsibility and to abandon them to the risks of irreversible and long-term consequences. Medical treatment protocols for youth gender dysphoria are becoming more aggressive, at earlier ages, even as interest in discerning the long-term presence and stability of the dysphoria before treatment is diminishing.

176. Given the state of disarray in the science, the activist capture of medical organizations, and the market motivations shaping medical decision-making in a surging domain, there are compelling reasons to protect young people by ensuring that they reach adulthood before submitting to experimental, life-altering gender transition treatments.

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

**Executed on December 10, 2021.**



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Dr. Mark Regnerus

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<sup>187</sup> Wren, B. (2021), paragraph 20.

## MARK REGNERUS

(December 2021)

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### EDUCATION

Ph.D., Sociology, University of North Carolina at Chapel Hill, 2000.

M.A., Sociology, University of North Carolina at Chapel Hill, 1997.

B.A., Sociology, with high honors, Trinity Christian College, 1993.

### PROFESSIONAL APPOINTMENTS

2018–Present: Professor, Department of Sociology, The University of Texas at Austin.

2007–2018: Associate Professor, Department of Sociology, The University of Texas at Austin.

2002–2014: Faculty Research Associate, Population Research Center, The University of Texas at Austin.

2002–2007: Assistant Professor, Department of Sociology, The University of Texas at Austin.

2001–2002: Assistant Professor of Sociology, Department of Sociology and Social Work, and Director, Center for Social Research, Calvin College.

2000–2001: Postdoctoral Research Associate, Carolina Population Center.

### PUBLICATIONS

#### Books

Regnerus, Mark. 2020. *The Future of Christian Marriage*. New York, NY: Oxford University Press. (268 pages)

Reviewed or discussed in *Journal for the Scientific Study of Religion*, *Publishers Weekly*, *National Review*, *Choice*, *World*, *Public Discourse*, and *Christianity Today*.

Regnerus, Mark. 2017. *Cheap Sex: The Transformation of Men, Marriage, and Monogamy*. New York, NY: Oxford University Press. (262 pages)

Reviewed in *The Atlantic Monthly*, *Commentary*, *Washington Post*, *New York*, *Humanum*, *Men & Masculinities*, *Public Discourse*, *National Review*, *Claremont Review of Books*, *Nevada Appeal*, *Jet*, *Contemporary Sociology*, and *The Globe and Mail*.

Regnerus, Mark and Jeremy Uecker. 2011. *Premarital Sex in America: How Young Americans Meet, Mate, and Think about Marrying*. New York, NY: Oxford University Press. (295 pages)

Reviewed in *American Journal of Sociology*; *BYU Studies Quarterly*; *Commentary*; *Contemporary Sociology*; *Culture, Health & Sexuality*; *First Things*; *Horizons*; *INTAMS Review*; *Journal of Family Theory & Review*; *Journal of Popular Romance Studies*; *Journal of Youth and Adolescence*; *Mercatornet*; *Public Discourse*; *Sex Roles*; *The New Republic*; and *The New York Times*.

Regnerus, Mark D. 2007. *Forbidden Fruit: Sex and Religion in the Lives of American Teenagers*. New York: Oxford University Press. (304 pages)

Reviewed in *American Journal of Sociology*, *Contemporary Sociology*, *Journal of Youth and Adolescence*, *Journal of Sex Research*, and *The New Yorker*.

### **Peer-Reviewed Journal Articles (including Accepted and In Press)**

Regnerus, Mark and Brad Vermurlen. 2021. "Attitudes toward Hormonal and/or Surgical Interventions for Adolescents Experiencing Gender Dysphoria." Forthcoming, *Archives of Sexual Behavior*.

Regnerus, Mark. 2020. "Understanding How the Social Scientific Study of Same-Sex Parenting Works," *Annals of Social Science* 12 (3): 43-60. <https://doi.org/10.18290/rns20483-3>

Regnerus, Mark, Joseph Price, and David Gordon. 2017. "Masturbation and Partnered Sex: Substitutes or Complements?" *Archives of Sexual Behavior* 46: 2111-2121.

Regnerus, Mark. 2017. "Is Structural Stigma's Effect on the Mortality of Sexual Minorities Robust? A Failure to Replicate the Results of a Published Study." *Social Science & Medicine* 188: 157-165.

Regnerus, Mark, David Gordon, and Joseph Price. 2016. "Documenting Pornography Use in America: A Comparative Analysis of Methodological Approaches." *The Journal of Sex Research* 53(7): 873-881.

Price, Joseph, Rich Patterson, Mark Regnerus, and Jacob Walley. 2016. "How Much More XXX is Generation X Consuming? Evidence of Changing Attitudes and Behaviors Related to Pornography Since 1973." *The Journal of Sex Research* 53(1): 12-20.

Regnerus, Mark. 2012. "How Different are the Adult Children of Parents who have Same-Sex Relationships? Findings from the New Family Structures Study." *Social Science Research* 41: 752-770.

Woodberry, Robert D., Jerry Z. Park, Lyman A. Kellstedt, Mark D. Regnerus, and Brian Steensland. 2012. "The Measure of American Religious Traditions: Theoretical and Measurement Considerations." *Social Forces* 91(1): 65-73.

Uecker, Jeremy E. and Mark D. Regnerus. 2010. "Bare Market: Campus Sex Ratios, Romantic Relationships, and Sexual Behavior." *The Sociological Quarterly* 51: 408-435.

McFarland, Michael J., Jeremy E. Uecker, and Mark D. Regnerus. 2010. "The Role of Religion in Shaping Sexual Frequency and Satisfaction: Evidence from Married and Unmarried Older Adults." *The Journal of Sex Research* 47: 1-12.

Stokes, Charles E. and Mark D. Regnerus. 2009. "When Faith Divides Family: Religious Discord and Adolescent Reports of Parent-Child Relations." *Social Science Research* 38: 155-167.

- Hill, Terrence D., Amy M. Burdette, Mark Regnerus, and Ronald J. Angel. 2008. "Religious Involvement and Attitudes Toward Parenting Among Low-Income Urban Women." *Journal of Family Issues* 29(7): 882-900.
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- Uecker, Jeremy E., Mark D. Regnerus, and Margaret L. Vaaler. 2007. "Losing My Religion: The Social Sources of Religious Decline in Early Adulthood." *Social Forces* 85(4): 1-26.
- Regnerus, Mark D. and Jeremy E. Uecker. 2007. "Religious Influences on Sensitive Self-Reported Behaviors: The Product of Social Desirability, Deceit, or Embarrassment?" *Sociology of Religion* 68(2): 145-163.
- Regnerus, Mark D. and Viviana Salinas. 2007. "Religious Affiliation and AIDS-based Discrimination in Sub-Saharan Africa." *Review of Religious Research* 48(4): 385-401.
- Trinitapoli, Jenny and Mark D. Regnerus. 2006. "Religion and HIV Risk Behaviors among Married Men: Initial Results from a Study in Rural Sub-Saharan Africa" *Journal for the Scientific Study of Religion* 45: 505-528.
- Regnerus, Mark D. and Jeremy Uecker. 2006. "Finding Faith, Losing Faith: The Prevalence and Context of Religious Transformations during Adolescence." *Review of Religious Research* 47: 217-237.
- Regnerus, Mark D. and Amy Burdette. 2006. "Religious Change and Adolescent Family Dynamics." *The Sociological Quarterly* 47: 175-194.
- Regnerus, Mark D. and Laura B. Luchies. 2006. "The Parent-Child Relationship and Opportunities for Adolescents' First Sex." *Journal of Family Issues* 27: 159-183.
- Regnerus, Mark D. and Christian Smith. 2005. "Selection Effects in Studies of Religious Influence." *Review of Religious Research* 47: 23-50.
- Regnerus, Mark D. 2005. "Talking about Sex: Religion and Patterns of Parent-Child Communication about Sex and Contraception." *The Sociological Quarterly* 46: 81-107.
- Regnerus, Mark D., Christian Smith, and Brad Smith. 2004. "Social Context in the Development of Adolescent Religiosity." *Applied Developmental Science* 8: 27-38.
- Regnerus, Mark D. 2003. "Linked Lives, Faith, and Behavior: An Intergenerational Model of Religious Influence on Adolescent Delinquency." *Journal for the Scientific Study of Religion* 42: 189-203.
- Regnerus, Mark D. 2003. "Moral Communities and Adolescent Delinquency: Religious Contexts and Community Social Control." *Sociological Quarterly* 44: 523-554.
- Regnerus, Mark D. 2003. "Religion and Positive Adolescent Outcomes: A Review of Research and Theory." *Review of Religious Research* 44: 394-413.
- Regnerus, Mark D. and Glen H. Elder, Jr. 2003. "Religion and Vulnerability among Low-Risk

Adolescents.” *Social Science Research* 32: 633-658.

- Regnerus, Mark D. and Glen H. Elder, Jr. 2003. “Staying on Track in School: Religious Influences in High and Low-Risk Settings.” *Journal for the Scientific Study of Religion* 42: 633-649.
- Rostosky, Sharon S., Mark D. Regnerus, and Margaret L.C. Wright. 2003. “Coital Debut: The Role of Religiosity and Sex Attitudes in the Add Health Survey.” *Journal of Sex Research* 40: 358-367.
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- Regnerus, Mark D. 2002. “Friends’ Influence on Adolescent Theft and Minor Delinquency: A Developmental Test of Peer-Reported Effects.” *Social Science Research* 31: 681-705.
- Smith, Christian, Melinda Denton, Robert Faris, and Mark D. Regnerus. 2002. “Mapping American Adolescent Religious Participation.” *Journal for the Scientific Study of Religion* 41: 597-612.
- Ge, Xiaojia, Glen H. Elder, Jr., Mark D. Regnerus, and Christine Cox. 2001. “Pubertal Transitions, Overweight Self Perceptions, and Adolescent Psychosomatic Adjustment: Gender and Ethnic Differences.” *Social Psychology Quarterly* 64: 363-375.
- Regnerus, Mark. 2000. “Shaping Schooling Success: A Multi-level Study of Religious Socialization and Educational Outcomes in Urban Public Schools.” *Journal for the Scientific Study of Religion* 39: 363-370.
- Steensland, Brian, Jerry Park, Mark Regnerus, Lynn Robinson, Bradford Wilcox, and Robert Woodberry. 2000. “The Measure of American Religion: Toward Improving the State of the Art.” *Social Forces* 79: 291-318.
- Regnerus, Mark, David Sikkink, and Christian Smith. 1999. “Voting with the Christian Right: Contextual and Individual Patterns of Electoral Influence.” *Social Forces* 77 (4): 1375-1401.
- Regnerus, Mark and Christian Smith. 1998. “Selective Deprivatization among American Religious Traditions: The Reversal of the Great Reversal.” *Social Forces* 76: 1347-72.
- Regnerus, Mark, Christian Smith, and David Sikkink. 1998. “Who Gives to the Poor? The Role of Religious Tradition and Political Location on the Personal Generosity of Americans toward the Poor.” *Journal for the Scientific Study of Religion* 37: 481-493.

### **Peer-Reviewed Book Chapters**

- Regnerus, Mark D. 2010. “Religion and Adolescent Sexual Behavior.” In *Religion, Families, and Health: Population-Based Research in the United States* (Christopher G. Ellison and Robert A. Hummer, editors), pp 61-85. New Brunswick, NJ: Rutgers University Press.
- Regnerus, Mark D. 2005. “Adolescent Delinquency.” Pp. 259-276 in Helen Rose Ebaugh (ed.), *Handbook of Religion and Social Institutions*. New York: Kluwer/Plenum.
- Sikkink, David and Mark Regnerus. 1996. “For God and the Fatherland: Protestant Symbolic Worlds and the Rise of German National Socialism.” Pp. 133-147 in Christian Smith (ed.), *Disruptive Religion: The Force of Faith in Social Movement Activism*. New York: Routledge.

### **Non-Peer-Reviewed Journal Articles and Book Chapters**

- Regnerus, Mark D. 2020. "Measurement and Analytic Vulnerabilities in the Study of Structural Stigma." (Commentary). *Social Science & Medicine* 244: 112567.
- Regnerus, Mark D. 2019. "Sexual Media as Competition in the Heterosexual Relationship Market" (Commentary). *Archives of Sexual Behavior* 48: 2279-2281.
- Regnerus, Mark. 2019. "Comment on Barbara Risman's review of Cheap Sex: The Transformation of Men, Marriage, and Monogamy." *Contemporary Sociology* 48: 130-131.
- Regnerus, Mark D. 2018. "Reproducing Homes: Intergenerational Transmission of Marriage and Relationship Legacy." In *The Home: Multidisciplinary Reflections* (Antonio Argandoña, editor). Cheltenham, UK: Edward Elgar. 24 pp.
- Regnerus, Mark D. 2015. "The Family as First Building Block." In *The Thriving Society: On the Social Conditions of Human Flourishing* (James R. Stoner, Jr. and Harold James, editors), pp 49-66. Princeton, NJ: The Witherspoon Institute.
- Regnerus, Mark. 2012. "Contemporary Mating Market Dynamics, Sex-Ratio Imbalances, and Their Consequences." *Society* 49: 500-505.
- Regnerus, Mark. 2012. "Parental Same-Sex Relationships, Family Instability, and Subsequent Life Outcomes for Adult Children: Answering Critics of the New Family Structures Study with Additional Analyses." *Social Science Research* 41: 1367-1377.
- Regnerus, Mark D. 2010. "Sexual Behavior in Young Adulthood." The Changing Spirituality of Emerging Adults Project. 16 pp.
- Regnerus, Mark D. 2009. "Imitation Sex and the New Middle Class Morality" (chapter 6 of *Forbidden Fruit*), reprinted in *Speaking of Sexuality: Interdisciplinary Readings, 3<sup>rd</sup> Edition* (Nelwyn B. Moore, J. Kenneth Davidson, and Terri D. Fisher, editors). New York, NY: Oxford University Press.
- Regnerus, Mark D. and Jeremy E. Uecker. 2007. "How Corrosive Is College to Religious Faith and Practice?" Social Science Research Council. 6 pp.
- Reprinted as Regnerus, Mark D., and Jeremy E. Uecker. 2008. "College Students Value Religion." *Opposing Viewpoints in Context: America's Youth*. Jamuna Carroll, editor. Farmington Hills, MI: Greenhaven Press. [link.galegroup.com/apps/doc/EJ3010300238/OVIC?u=txshracd2598&xid=ea8e31f3](https://link.galegroup.com/apps/doc/EJ3010300238/OVIC?u=txshracd2598&xid=ea8e31f3). 7 pp.
- Regnerus, Mark D., Christian Smith, and Melissa Fritsch. "Religion in the Lives of American Adolescents: A Review of the Literature." A Research Report of the National Study of Youth and Religion, No. 3. Chapel Hill, NC: University of North Carolina, 2003.
- Regnerus, Mark D. "Living up to Expectations." Report, Center for Research on Religion and Urban Civil

Society, University of Pennsylvania, 2003.

Regnerus, Mark D. “Making the Grade: The Influence of Religion upon the Academic Performance of Youth in Disadvantaged Communities.” Report, Center for Research on Religion and Urban Civil Society, University of Pennsylvania, 2001.

Regnerus, Mark. “Challenges to Liberal Protestant Identity and Diversity Work: a Qualitative Study.” *Sociological Analysis* 1998, 1: 139-149.

### **Book Reviews**

Review of: *Nationalizing Sex: Fertility, Fear, and Power*, Richard Togman (New York: Oxford University Press, 2019). In *Review of Politics* 82: 500-502 (2020).

Review of: *Charitable Choices: Religion, Race, and Poverty in the Post-Welfare Era*, John P. Bartkowski and Helen A. Regis (New York: NYU Press). In *Social Forces* 82: 861-863 (2003).

Review of: *They Still Pick Me Up when I Fall: The Role of Youth Development and Community Life*, Diana Mendley Rauner (New York: Columbia University Press). In *Social Forces* 79: 1545-1547 (2001).

### **Select Essays and Op-Eds (all sole-authored)**

“Weak Data, Small Samples, and Politicized Conclusions on LGBT Discrimination.” *Public Discourse*, January 12, 2020.

“New Data Show ‘Gender-Affirming’ Surgery Doesn’t Really Improve Mental Health. So Why are the Study’s Authors Saying It Does?” *Public Discourse*, November 13, 2019.

“Does ‘Conversion Therapy’ Hurt People who Identify as Transgender? The New JAMA Psychiatry Study Cannot Tell Us.” *Public Discourse*, September 18, 2019.

“Queering Science.” *First Things*, December 2018.

“The Death of Eros.” *First Things*, October 2017.

“Can Same-Sex Marriage Really Reduce Teen Suicide?” *Public Discourse*, February 24, 2017. 4 pp.

“Hijacking Science: How the ‘No Differences’ Consensus about Same-Sex Households and Children Works.” *Public Discourse*, October 14, 2016. 5 pp.

“Making Differences Disappear: The Evolution of Science on Same-Sex Households.” *Public Discourse*, May 12, 2015. 4 pp.

“Minecraft over Marriage.” *First Things*, March 31, 2015. 5 pp.

“The Good-Enough Marriage.” *First Things*, December 4, 2014. 4 pp.

“The Pornographic Double-Bind.” *First Things*, November 11, 2014. 3 pp.

“Diversity as Slogan and Reality.” *First Things*, October 9, 2014. 3 pp.

“Resurrecting the Dead in America.” *First Things*, September 11, 2014. 4 pp.

“The Government’s in Your Bedroom, but This Time It’s Okay.” *National Review*, July 16, 2014. 3 pp.

“‘Right Side of History,’ or Primed to Say Yes?” *National Review*, August 20, 2013. 5 pp.

“Assessing the Australian Study.” *National Review*, June 6, 2013. 3 pp.

“Sex is Cheap: Why Young Men Have the Upper Hand in Bed, Even When They're Failing in Life.”  
*Slate*, February 25, 2011. (9<sup>th</sup>-most read *Slate* article of 2011.) 4 pp.

“Freedom to Marry Young.” *Washington Post*, April 26, 2009. 2 pp.

## **RESEARCH GRANTS**

Principal Investigator, “The Relationships in America Survey Project.” \$328,426 grant from the Austin Institute, January 2014-September 2014. (Approved, 100% under PI’s supervision)

Principal Investigator, “The New Family Structures Study.” \$640,000 grant from the Witherspoon Institute, May 2011-August 2013. (Approved, 100% under PI’s supervision)

Principal Investigator, “The New Family Structures Study (supplementary assistance).” \$90,000 grant from the Bradley Foundation, Nov 2011-Nov 2012. (Approved, 100% under PI’s supervision)

Principal Investigator, “The New Family Structures Study.” \$55,000 planning grant from the Witherspoon Institute, Oct 2010-June 2011. (Approved, 100% under PI’s supervision)

Principal Investigator, “The New Pentecostals and Political and Social Activism.” \$9,565 grant from the National Science Foundation (Dissertation Improvement Grant, for Nicolette Manglos), 2010-2011. (Approved but returned)

Co-Investigator, “Developing Health Behaviors in Middle Adolescence” (Lynn Rew, PI, The University of Texas at Austin School of Nursing). \$1,276,919 grant from the National Institute of Nursing Research, 2006-2011. (Approved, <5% under Regnerus’ supervision). R01-NR009856.

Principal Investigator, “Testing Differences: The Transfer and Transformation of HIV Testing from the West to Sub-Saharan Africa.” \$7,500 grant from the National Science Foundation (Dissertation Improvement Grant, for Nicole Angotti), 2008-2009. (Approved)

Co-Investigator, “Religious Organizations, Local Norms, and HIV in Africa” (Susan Watkins, PI, University of Pennsylvania). \$864,000 grant from the National Institute of Child Health and Human Development, June 2005-May 2008. (Regnerus is PI of \$279,000 sub-contract to The University of Texas at Austin). R01-HD050142-01.

Seed grant for “Sex and Emotional Health in Emerging Adulthood.” \$4,000 grant from the Population Research Center and \$2,000 grant from the College of Liberal Arts, The University of Texas at Austin, 2007.

## **SELECT INVITED PRESENTATIONS**

“The Future of Christian Marriage.”

- University of Mary, Bismarck, ND, April 2021
- Faulkner University, Montgomery, AL, March 2021

“The Transformation of Men, Marriage, and Monogamy.” Universidad Francisco de Vitoria, Madrid, November 2018.

Author meets critics panel on *Cheap Sex: The Transformation of Men, Marriage, and Monogamy*. Society for the Scientific Study of Religion, Las Vegas, NV, October 2018.

“The Transformation of Men, Marriage, and Monogamy.” Archdiocese of Denver, September 2018.

Author meets critics panel on *Virgin Nation: Sexual Purity and American Adolescence* (by Sara Moslener, Oxford University Press, 2016). American Academy of Religion, San Antonio, TX, November 2016.

“Intergenerational Transmission of Marriage and Relationship Legacy.” Home Renaissance Foundation, London, United Kingdom, November 2015.

“The Future of Marriage and Family in America.” University of St. Thomas, Houston, TX, March 2015.

“The New Family Structures Study and the Challenges of Social Science.” Brigham Young University, Provo, UT, October 2014.

“Sex in America: Sociological Trends in American Sexuality.” Ethics and Religious Liberty Commission, Nashville, TN, April 2014.

“Premarital Sex in America.” Department of Sociology, University of North Carolina at Chapel Hill, Chapel Hill, NC, January 2012.

Book discussion session on *Premarital Sex in America*. Society for the Study of Emerging Adulthood, Providence, RI, October 2011.

“The Future of Sex and Marriage in American Evangelicalism.” National Association of Evangelicals Advisory Board, Washington, D.C., October 2011.

Heyer Lecture. Austin Presbyterian Theological Seminary, Austin, TX, September 2011.

Thematic session on “The Cultural War and Red/Blue Divide: Re-examining the Debate Demographically and Behaviorally.” American Sociological Association, Las Vegas, NV, August 2011.

“Sexual Economics: The Forces Shaping How Young Americans Meet, Mate, and Marry.” Heritage Foundation, Washington, D.C., May 2011.

“Marital Realities, Current Mindsets, and Possible Futures.” Institute of Marriage and Family Canada, Ottawa, Canada, May 2011.

Panel on “Teen Pregnancy: What Is California Doing Right?” Zócalo Public Square, Los Angeles, CA, December 2010.

“Marriage and Parenthood in the Imagination of Young Adults.” Baby Makes Three: Social Scientific Research on Successfully Combining Marriage and Parenthood (seminar), Princeton, NJ, June 2010.

“Saving Marriage Before It Starts.” Q Conference, Lyric Opera, Chicago, IL, April 2010.

“The Price of Sex in Contemporary Heterosexual Relationships.” TEDxUT, The University of Texas at Austin, Austin, TX, April 2010.

“Love and Marriage in the Minds of Emerging Adults.” Child Trends and Heritage Foundation, Washington, D.C., October 2009.

“Forbidden Fruit? Sex and Religious Faith in the Lives of Young Americans.” Baylor University, Waco, TX, September 2007.

“Great Expectations: Culture, Emotion, and Disenchantment in the Sexual Worlds of Young Americans.” Bay Area Colloquium on Population, Berkeley, CA, September 2007.

## **CONFERENCE PRESENTATIONS**

“The Math Behind Declining Christian Marriage,” Society for the Scientific Study of Religion, Las Vegas, NV, October 2018.

“Consent and the Presumption of the Exchange Theory of Relationship Behavior.” Paper presented at the annual meeting of the American Political Science Association, Boston, MA, September 2018.

“Is There a Recession in Marriage among Western Christians?” Paper presented at the annual meeting of the Society for the Scientific Study of Religion, Atlanta, GA, October 2016.

“Gender and Heterosexual Sex.” Panel discussion at the annual meeting of the American Sociological Association, New York, NY, August 2013.

“The New Family Structures Study: Introduction and Initial Results.” Paper presented at the annual meeting of the Population Association of America, San Francisco, CA, May 2012.

“Religious Distinctions in Nonmarital Romantic Relationship Formation” (with Ellyn Arevalo). Paper presented at the annual meeting of the Society for the Scientific Study of Religion, Milwaukee, WI, October 2011.

“Premarital Sexual Initiation and Fertility among Pentecostal Adolescents in Brazil.” Paper presented at the annual meeting of the Population Association of America, Washington, D.C., April 2011.

“Red Sex, Blue Sex: Distinguishing Political Culture and Religious Culture in the Sexual Decisions of Young Americans.” Paper presented at the annual meeting of the Society for the Scientific Study of Religion, Denver, CO, October 2009.

“Bare Market: Campus Sex Ratios and Romantic Relationships” (with Jeremy Uecker). Paper presented at the annual meeting of the Population Association of America, Detroit, MI, May 2009.

“Religion and Sexual Initiation in Brazil” (with Ana Paula Verona). Paper presented at the annual meeting of the Population Association of America, Detroit, MI, April 2009.

## **ADVISING**

Ph.D. Committees in the Department of Sociology (Year Degree Awarded, \* Co-Chair/Co-Supervisor, \*\* Chair/Supervisor)

2016 Jennifer McMorris  
 2015 Stanley Kasun  
 2015 Nina Palmo  
 2012 Nicolette Manglos \*\*  
 2012 Catherine McNamee  
 2011 Charles Stokes  
 2010 Nicole Angotti \*\*  
 2010 Georgina Martínez Canizales  
 2010 Viviana Salinas  
 2010 Jeremy Uecker \*\*  
 2010 Ana Paula Verona  
 2008 Margaret Vaaler  
 2008 Sara Yeatman  
 2007 Amy Burdette \*  
 2007 Bryan Shepherd  
 2007 Jenny Trinitapoli \*\*  
 2007 Elisa Zhai

M.A. Committees in the Department of Sociology (Year Degree Awarded, \* Co-Chair/Co-Supervisor, \*\* Chair/Supervisor)

2013 Ellyn Arevalo \*  
 2012 Kristen Redford \*\*  
 2011 David McClendon \*\*  
 2010 Aida Ramos Wada  
 2008 Nicolette Manglos \*\*  
 2007 Andrea Henderson  
 2006 Jeremy Uecker \*\*

Undergraduate Thesis Supervision for Honors, Plan II, BDP (Year Degree Awarded, \* Reader, \*\* Supervisor)

2019 Clarisa Trevino \*\*  
 2014 Tiffany Fong \*  
 2011 Mary Lingwall \*\*  
 2008 Hong Nguyen \*\*

Ph.D. Committees at other universities (Year Degree Awarded)

2018 Yana Mikhaylova, Higher School of Economics, Moscow

## **DEPARTMENTAL AND UNIVERSITY SERVICE**

Member, Executive Committee, Department of Sociology, 2012-2014

Member, Graduate Admissions Committee, Department of Sociology, 2012-2014

Member, Promotion and Tenure Committee, Department of Sociology, 2012-2014

Member, Undergraduate Research Award Selection Committee, College of Liberal Arts, 2010-2012

Guest presenter, Peer Educator Sexual Health courses, University Health Services, 2008-2012

Presenter, Orange Jackets' Week of Women, Tejas Club, Spring 2011

Moderator, Thesis Symposium, Plan II Honors Program, 2011

Member, Graduate Steering Committee, Department of Sociology, 2010-2011

Member, Promotion and Tenure Committee, Department of Sociology, 2010-2011

Member, Executive Committee, Department of Sociology, 2009-2011

Presenter, TEDxUT, The University of Texas at Austin, Spring 2010

Member, Governing Board, Population Research Center, 2009-2010

Member, Graduate Admissions Committee, Department of Sociology, 2009-2010

Presenter, Sexual Health Panel, Tejas Club, Fall 2009

Member, Graduate Steering Committee, Department of Sociology, 2007-2009

Participant and presenter, Faculty Fellows Program, The University of Texas at Austin, 2007-2009

Chair, Religion Faculty Search Committee, Department of Sociology, Fall 2008

Member, Population Junior Faculty Search Committee, Department of Sociology, Fall 2007

Member, Speaker Colloquium Committee, Department of Sociology, Fall 2007

## **PROFESSIONAL SERVICE AND ORGANIZATIONAL MEMBERSHIP**

Co-organizer and session chair, *The Moynihan Report at 50: Reflections, Realities, and Prospects*.  
Princeton University, Princeton, NJ, October 30-31, 2015

Distinguished Article Award Committee member, American Sociological Association (Religion Section),  
2010-2011

- Committee chair, 2011

Editorial Board member, *Interdisciplinary Journal of Research on Religion*, 2005–2011

Editorial Board member, *Journal for the Scientific Study of Religion*, 2004–2011

Distinguished Article Award Committee member, Society for the Scientific Study of Religion, 2009-2010

- Committee chair, 2010

Nominating Committee member, Society for the Scientific Study of Religion, 2007-2009

Jack Shand Research Award Committee member, Society for the Scientific Study of Religion, 2005-2007

Council member, American Sociological Association (Religion Section), 2004-2007

Member of:

American Academy of Religion, 2017-2019

Population Association of America, 2004-2018

Society for the Scientific Study of Religion, 1996-present

Ad-hoc reviewer for:

*American Journal of Sociology, American Sociological Review, Archives of Sexual Behavior, Biodemography and Social Biology, Gender & Society, Interdisciplinary Journal of Research on Religion, International Journal of Environmental Research and Public Health, Journal for the Scientific Study of Religion, Journal of Adolescent Health, Journal of Behavioral Addictions, Journal of Family Issues, Journal of Health and Social Behavior, Journal of Homosexuality, Journal of Marriage and Family, Journal of Psychology and Christianity, Pediatrics, Perspectives on Psychological Science, Review of Religious Research, Social Forces, Social Problems, Social Psychology Quarterly, Social Science & Medicine, Social Science Quarterly, Social Science Research, Sociological Forum, Sociological Inquiry, The Sociological Quarterly, National Institutes of Health (2007), National Science Foundation (2010, one review), Templeton Foundation (2012, 2019)*

# Exhibit 2

**IN THE UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION**

**DYLAN BRANDT, et al.,**

**PLAINTIFFS,**

**v.**

**No. 4:21-CV-00450-JM**

**LESLIE RUTLEDGE, et al.,**

**DEFENDANTS.**

**REBUTTAL DECLARATION OF DR. MARK REGNERUS**

Pursuant to 28 U.S.C. 1746, I declare:

1. My credentials, research, and professional qualification are detailed in my declaration in this matter dated December 10, 2021. Here, as there, my opinions are based upon my knowledge and research in the matters discussed. The materials I have used to research and write this report are the standard sources used by other experts in my field. I have actual knowledge of the matters stated in this declaration. My opinions as detailed in this report are based upon my knowledge and direct professional experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that other experts in my field rely upon when forming opinions on the subject. This declaration does not exhaust my opinions.

2. I have reviewed the newly submitted declarations by Dr. Deanna Adkins (dated December 9, 2021), Dr. Armand Antommara (dated December 10, 2021), Dr. Jack Turban (dated December 10, 2021), as well as the declaration submitted by the plaintiffs' additional witness, Dr. Dan H. Karasic (dated December 10, 2021).

3. My primary discussion of the medicalization of adolescent gender dysphoria does not concern the pharmacological details of treatment plans. I am not a psychiatrist or pediatric

endocrinologist. Rather, my primary concerns are sociological. The main points of my rebuttal are as follows:

- The protocols for careful mental-health assessments and stringent criteria for eligibility repeatedly invoked by the plaintiffs' witnesses are, in practice, hardly occurring and are being diminished or removed entirely in favor of "informed consent" models in discussions of evolving professional standards of care.
- The plaintiffs' witnesses deny or downplay social and external factors, whereas these influences are undeniable in the recent surge of transgender identification.
- There are open debates, divisions, and concerns now being expressed within the field, even by some gender-affirmative clinicians within the United States, which are not even acknowledged by the plaintiffs' witnesses, much less the concerns and conclusions of vast national health system reviews of research and care that now are protecting youths from being subjected to these medical treatments.
- The medical protocols recommended in the United States for the treatment of adolescents with gender dysphoria are increasingly out of step with developments and changes in numerous countries with progressive policies and decades of research. Where these countries are limiting and/or prohibiting gender medicine for minors in order to protect vulnerable youth, advocates in the United States seek to do the opposite, as reflected by the ideological capture of the professional organizations cited by the plaintiffs' witnesses
- The plaintiffs' witnesses claim that hormonal treatments are largely reversible, and yet only a tiny fraction of patients opt out of subsequent treatment options. If that is true, we are indeed talking about very early decisions with (*de facto*) permanent consequences.

- Strong legal norms once protected minors from consenting to experimental and irreversible procedures. Children’s inability to consent to treatments that result in sterilization at ages as young as 10 and 11 is one of the primary reasons that laws such as the SAFE Act are needed.
- The threat of suicide is inflated and increasingly employed to justify these drastic interventions. Meanwhile, the risk of regret over irreversible changes and/or detransition is minimized or ignored.
- In the end, the laws of the state either function as they always have—to protect children and minors from preventable harms—or the state shirks its obligation to them.

## I. SOCIOLOGICAL ISSUES

4. My concerns are primarily sociological—that is, how social influences are demonstrably evident, but inexplicably ignored, in the rapid “evolution” of protocols, and the swift ideological capture of professional organizations, resulting in suppressed internal rifts now coming to light. Observable radical shifts (e.g., the surge in cases, sex-ratio reversal in cases, disappearing emphasis on psychotherapy in practice, diminishing barriers to medical treatment) are being ignored by many “professionals,” including the plaintiffs’ witnesses. None of them make reference to any of these troubling developments that are now openly haunting some of their professional peers.<sup>1</sup> They do not wish to debate it, but rather defend only one way forward. To borrow from Admiral Farragut’s famous command, it’s “Damn the surge. Full speed ahead.”

5. Social norms are a basic building block of society and a common notion in sociology. They are patterns of behavior and internalized values that are socially enforced.

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<sup>1</sup> Anderson, E. (2022). When it comes to trans youth, we’re in danger of losing our way. *San Francisco Examiner*, January 3, <https://www.sfoxaminer.com/opinion/are-we-seeing-a-phenomenon-of-trans-youth-social-contagion/>; Ghorayshi, A. (2022). Doctors debate whether trans teens need therapy before hormones. *The New York Times*, January 14, <https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html>.

Norms simplify life and enable persons to classify (and hence understand) each other's actions, a process that contributes to social order.<sup>2</sup> While Dr. Karasic insists on page 6 that “[g]ender identity...is not a product of external influence and not subject to voluntary change,” his description of the 2013 definition of “Gender Dysphoria in Children” as outlined in the Diagnostic and Statistical Manual Fifth Edition (DSM-5), highlights the profoundly social (and hence external) aspects of gender dysphoria. All but one of the seven criteria Dr. Karasic lists on page 6 concerns social norms: talk of “the other gender,” “simulating female attire,” “typical masculine clothing,” “typical feminine clothing,” “cross-gender roles,” “activities stereotypically used or engaged in by the other gender,” “playmates of the other gender,” “typically masculine toys,” and “typically feminine toys, games, and activities.”

6. It's not just the DSM-5. Dr. Karasic himself makes reference to “typically male or typically female” when discussing the definition of gender identity on page 5. To suggest something is “typical” means to accord it a mental image or “type” socially considered common to most cases of a given phenomenon. This is what early sociologist Max Weber identifies as an “ideal type,” or (socially) shared mental constructs that help us bring order to reality.<sup>3</sup> (The “ideal” language is no moral claim, but a reflection of wide agreement on key traits.) And yet Dr. Karasic, ignoring universal practice and usage, claims that “the terms biological sex and biological male or female...should be avoided” (page 5). His advice seeks to disable human societies from understanding and classifying each other—a process necessary for social stability.

7. My point is not to belabor what constitutes something that is masculine or feminine; rather, I am simply observing that these are all social judgments that vary within and

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<sup>2</sup> Norms. (2013). *Oxford Bibliographies Online*, Sociology. doi: 10.1093/obo/9780199756384-0091.

<sup>3</sup> Britannica, T. Editors of Encyclopaedia (2018, October 10). *ideal type*. *Encyclopedia Britannica*. <https://www.britannica.com/topic/ideal-type>.

across societies. And yet they are not arbitrary, but instead helpful to shaping and predicting the behavior of other people. To Judith Butler, author of the book (and phrase) *Gender Trouble* and key contributor to what its critics call “the theory of gender,” gender constitutes unconscious, culturally compelled “performance” and is thereby powerfully socially rooted, constructed, and hence malleable.<sup>4</sup> Her influence on contemporary gender matters, including the transgender movement, is extensive. To suggest, as Dr. Karasic does, that gender identity “is not a product of external influence” is to maintain—in the face of evidence to the contrary—that gender is *only* molded by biology, that is, dimorphic sex differences. In doing so, he denies and contradicts what even the draft version of WPATH’s SOC 8 acknowledges: “The phenomenon of social influence on gender is salient...as some who have changed their thoughts about their own gender identity have described how social influence was relevant in their experience of their gender during adolescence.”<sup>5</sup>

8. Some clinicians perceive a practical dilemma. That is, suppress puberty and treat those teens who identify as transgender with cross-sex hormones in order to avoid presumed distress of having gone through the endogenous (i.e., normal) puberty process of one’s natal sex, or consider the possibility that endogenous puberty may alter the experience of gender dysphoria and lead—over time—to the acceptance of one’s natal sex. The plaintiffs and their experts assume that a transgender identity is stable over time. (Hence, the vociferous pushback against observations of “rapid-onset” gender dysphoria.) But in a social milieu in which cases of “nonbinary” gender identity are similarly surging, it becomes increasingly difficult to defend the

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<sup>4</sup> Butler, J. *Gender Trouble*. New York: Routledge, 1990.

<sup>5</sup> World Professional Association for Transgender Health. (2021). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [DRAFT 8th Version: Adolescent Chapter].

idea of a stable gender identity—and with it a stable understanding of both (1) what is going on socially among a great many adolescents, and (2) what to do next.

9. In my December 2021 declaration, I claimed that ideological capture well explains the professional discussion of gender dysphoria in the United States. This ideological capture is a cousin to the regulatory capture that is occurring in the domain of gender medicine, since there are now strong material incentives to offer treatments that are loosely governed by professional statements and perceptions of legitimate authority (e.g., WPATH, Endocrine Society).<sup>6</sup> In other words, gender medicine is a new and lucrative line of medicine. Its origins are cultural, rooted in recent notions that men can become women and vice versa by way of social discourse and medical treatments. But the end is the same in both cases—the “capture” of authority by the successful co-opting of professional organizations to serve the aims of a particular interest group.

10. This process is accelerated by what could be described as *conceptual veiling*, that is, the construction of new (and extensive) narratives to both diffuse criticism and obtain professional organizations’ support for new treatment norms—norms that as little as 10 years ago would have stunned most pediatricians, not to mention the families they serve.<sup>7</sup> Personal stories, not unlike those told by the plaintiffs in this case, are powerful material. And yet they “veil” what is fundamentally going on here—that is, the failure of medical and legal institutions to protect those who are particularly exposed and vulnerable to manipulation and influence by social media content. The evidence suggests this is in no small part responsible for the surge in

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<sup>6</sup> Kwak, J. (2013). Cultural capture and the financial crisis in preventing regulatory capture. In Carpenter, & Moss (Eds.), Preventing regulatory capture: Special interest influence, and how to limit it, pp. 72–98. Cambridge: Cambridge University Press.

<sup>7</sup> Palea, V. (2021). “‘Unreliable accounts: How regulators fabricate conceptual narratives to diffuse criticism’ by Karthik Ramanna: A comment on ideological capture.” *Accounting, Economics, and Law*, November, 1-8, <https://doi.org/10.1515/acl-2021-0054>.

teen gender dysphoria. To lurch further in the direction of treatment on demand with mere consent and to enable minors' willful destruction of healthy body parts that are undergoing normal development and maturation is an unprecedented and stunning shift.

## II. PROTOCOLS ENDORSED—THEN IGNORED

11. Hence, there is a very real gender medicine *industry* today, on a scale that is unparalleled. It is experiencing explosive growth, and there are now somewhere around 300 gender clinics in the United States.<sup>8</sup> Social media influencers and activists urge clinicians to offer services that self-identified transgender persons ask for, regardless of age. In turn, gender medicine providers and scholars supporting them now engage in what is, in effect even if not in intention, a bait-and-switch maneuver: sell the public on wide access to hormonal and surgical treatments for dysphoric teens based on study results employing the Dutch protocol's very different patient characteristics and far more rigorous mental health safeguards.

12. In reality, the Dutch protocol is now all but ignored. Even WPATH's current guidelines—which have evolved considerably away from the Dutch protocol—are increasingly bypassed in favor of an “affirmative” approach whose primary criterion for moving forward to treatment is simple informed consent. That approach no longer scrutinizes dysphoric patients' psychological co-morbidities but instead believes that its treatments can alleviate them. By age 18, this approach is a given. For example, Planned Parenthood Great Plains, whose clinics cover the state of Arkansas, requires no evidence of previous gender-related psychotherapy or a

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<sup>8</sup> E.g. “In 2019, there were over 200 Planned Parenthood facilities in 31 states providing services for patients who identify as transgender.” Planned Parenthood. (2020). 2019-2020 Annual Report. Planned Parenthood Federation of America, [https://www.plannedparenthood.org/uploads/filer\\_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf](https://www.plannedparenthood.org/uploads/filer_public/67/30/67305ea1-8da2-4cee-9191-19228c1d6f70/210219-annual-report-2019-2020-web-final.pdf), page 11; Society for Evidence-based Gender Medicine. (2021). “Gender-affirming” hormones and surgeries for gender-dysphoric US youth, *Spotlight Blog*, May 28, [https://segm.org/ease\\_of\\_obtaining\\_hormones\\_surgeries\\_GD\\_US#:~:text=There%20are%20over%2060%20pediatric,currently%20estimated%20at%20over%20300](https://segm.org/ease_of_obtaining_hormones_surgeries_GD_US#:~:text=There%20are%20over%2060%20pediatric,currently%20estimated%20at%20over%20300).

documented history of gender dysphoria prior to supplying hormone prescriptions. Their website even reads, “You don’t need to participate in therapy or provide information from a mental health provider to receive hormone therapy.”<sup>9</sup>

13. Hence, there is a *de jure* protocol—the WPATH Standards of Care—which all of the plaintiff’s experts have taken pains to carefully state and reiterate. But the evidence suggests a quite different *de facto* reality has now emerged, one that is increasingly tailored to patient demands.

14. WPATH is, as Dr. Karasic points out on page 8, an organization whose suggested protocols are “endorsed and cited as authoritative” by a series of medical professional organizations.

15. Repeatedly, Dr. Karasic suggests WPATH SOC7’s ongoing authority:

- a. Page 9: “The WPATH SOC 7 and Endocrine Society Guidelines do not recommend genital surgery until a patient has reached adulthood.”
- b. Page 9: “The WPATH SOC 7 states that ‘[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken.’”
- c. Page 9: “The WPATH SOC 7 makes clear that ‘[h]ormonal or surgical interventions are appropriate for some adolescents, but not for others.’”
- d. Page 9: “After ongoing work with mental health professionals and when the adolescent has lived in accordance with their gender identity for a significant period of time, they may start treatment with hormones...if and when medically indicated.”

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<sup>9</sup> See: <https://www.plannedparenthood.org/planned-parenthood-great-plains/patient-resources/gender-affirming-care>.

- e. Page 10: “The WPATH SOC 7 and the Endocrine Society Guideline further provide that before any medical or surgical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met, and the appropriateness of such care for the patient.”
- f. Page 12: “[T]here is the additional safeguard of the assessment by a mental health professional, who, in addition to diagnosing gender dysphoria, also reviews the risks and benefits of treatment with the youth and parents.”
- g. Page 15: “Gender-affirming medical interventions in accordance with the WPATH SOC 7 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria.”

16. Dr. Adkins follows suit in her report, taking pains to reiterate the same claim: “The Endocrine Society and WPATH have published widely accepted guidelines for treating gender dysphoria...” (page 4). She also notes that “[b]efore any medical intervention is initiated, the Endocrine Society Guideline and the WPATH Standards of Care for the Treatment of Gender Dysphoria (“WPATH SOC”) provide that extensive mental health evaluations should be conducted” (page 7). On page 8, she further remarks that WPATH SOC 7 maintains that “[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken . . . . The duration of this exploration may vary considerably depending on the complexity of the situation.”<sup>10</sup>

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<sup>10</sup> World Professional Association for Transgender Health (WPATH). (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people [7th version] <https://www.wpath.org/publications/soc>. The quote is from p. 18.

17. The key word here, and in five other instances on the same page (8), is “should.” Mental health evaluations “should” be conducted, she notes. It does not mean they are required to, or that they will. Dr. Adkins goes on to present (on page 9) the Endocrine Society Guideline’s mental health qualifications for eligibility for pubertal suppression. Indeed, at least five pages of Dr. Adkins’s report consist of a simple restatement of official protocols—how such organizations believe minors *should* be evaluated and how treatments *should* be administered. The reader is left to presume that this is how treatment happens everywhere. But that is nowhere stated.

18. Even Dr. Turban notes (on page 7 of his report) that “gender-affirming genital surgeries are not recommended until adulthood” under the guidelines of both the Endocrine Society and the WPATH’s SOC 7. Does this mean he does not object to the SAFE Act’s prohibiting these surgeries on minors? On the contrary, Dr. Turban approvingly discusses (on page 7) a study about the benefits of “masculinizing chest surgery” for the relief of what he labels “chest dysphoria” among a small sample of natal female “transmasculine” adolescents.<sup>11</sup> The average age of these post-surgical patients was just under 18 years old, for whom the average time-since-surgery was 19 months. In other words, the mean age at “top” surgery was around 16½ years old. These were minors who were approved for such surgeries in spite of the Endocrine Society and WPATH guidance to the contrary.

19. What difference does it make for the plaintiffs’ witnesses to repeatedly cite the protocols of professional organizations if practitioners—including plaintiffs’ own witnesses—are clearly not interested in adhering to them? It matters a lot, actually. Regulatory capture—the formal co-opting of professional organizations’ recommended policy and practice about the

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<sup>11</sup> Mehringer, J.E., Harrison, J.B., Quain, K.M., et al. (2021). Experience of chest dysphoria and masculinizing chest surgery in transmasculine youth. *Pediatrics*, 147(3):e2020013300.

hormonal and surgical treatment of minors—is not simply driven by material incentives (e.g., new, permanently-dependent patients). It is also driven by “expert knowledge” to help generate the social context for such a radical change, that is, the medical treatment of minors’ gender dysphoria on demand, without counseling.<sup>12</sup> This historically unprecedented approach is, without a doubt, at stake in this case.

### III. THE RAPID UPTAKE OF AN UNOFFICIAL TREATMENT PROTOCOL

20. None of the plaintiffs’ witnesses admit that there is a debate among clinicians about whether psychological assessments—a core component of the Dutch protocol—are necessary before proceeding to treat someone with hormones and surgeries. The question is particularly poignant for adolescents. A *New York Times* feature article in January 2022 describes how clinicians are at odds with each other over whether adolescents should be allowed pubertal blockers and cross-gender hormones on demand rather than after a psychological evaluation and several years spent questioning their gender identity.<sup>13</sup> The *New York Times*’s illuminating probe reveals that a journalist is more comfortable with observing (and admitting) that teenagers may be more subject to “emotional distress” and “more vulnerable to peer influence” than the plaintiffs’ witnesses have been.<sup>14</sup>

21. Indeed, there is now open conflict among practitioners of transgender medicine over whether gender dysphoria even need be diagnosed before moving to desired medical treatment.<sup>15</sup> Alex Keuroghlian, a frequent co-author with Dr. Turban and a clinical psychiatrist

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<sup>12</sup> Palea, *op. cit.*

<sup>13</sup> Ghorayshi, A. (2022). “Doctors Debate Whether Trans Teens Need Therapy Before Hormones,” *New York Times*, January 13. <https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html>.

<sup>14</sup> *Ibid.*, paragraph 5.

<sup>15</sup> Anderson, *op. cit.*; Edwards-Leeper, L., Anderson, E. (2021). The mental health establishment is failing trans kids. *The Washington Post*, November 24, <https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/>.

and director of the Massachusetts General Hospital Psychiatry Gender Identity program, told the *Times* reporter that pre-treatment mental health assessment is unnecessary: “I’m really not a believer in requiring that for people,” he stated when asked. “Being trans isn’t a mental health problem,” he later asserted. “To make that a requirement for everybody is inherently unnecessary gatekeeping and also stigmatizing and pathologizing and a waste of resources,” Dr. Keuroghlian maintains.<sup>16</sup>

22. Minors now present themselves as transgender and ask that clinicians respect their self-identity and offer the medical treatments—pubertal blockers, cross-sex hormones, and subsequent surgical options—that they cannot access without the permission of these clinical “gatekeepers.” It is the professionals (i.e., the gatekeepers) who are being pressured by patients and activists to offer care to those who ask for it.

23. For many practitioners, acquiescence is the path of least resistance. For example, while Dr. Karasic quotes Dr. Kenneth Zucker approvingly (on page 12 of his report), Karasic sought to ban Zucker from presenting his own research at the 2017 USPATH conference. Karasic, who chaired the conference and oversaw the program which included a pair of talks by Zucker, nevertheless gave way to activist critics *during the conference*, apologized to them, and proceeded to cancel Zucker’s final scheduled talk.<sup>17</sup> Why? Because Zucker is consistently on record as supporting more rigorous conditions for subjecting minors to gender-transition procedures. Doctors, so the emerging protocol implies, should not be gatekeepers to medical treatment anymore. What are physicians for, then?

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<sup>16</sup> Ghorayshi, *op. cit.*, paragraph 33.

<sup>17</sup> Singal, J. (2016). How the fight over transgender kids got a leading sex researcher fired. *The Cut*, February 7, <https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html>.

24. Already in a 2018 article appearing in the *AMA Journal of Ethics*, a series of practitioners advocated for a shift away from WPATH's SOC7 and toward "an informed consent approach to care as more patient centered and respectful of the patient's sense of agency."<sup>18</sup> The motivation for this is grounded in a conviction about "a person's right of self-determination—and the belief that clinicians will work to facilitate patients' decisions about the course of their own lives and care." This is the aggressively affirmative treatment pathway. It is demand-driven, with fewer "speed bumps."

25. Published research using clinic data reflects this shift away from WPATH's current standards toward even easier and faster treatment enrollment (which also disregards the lopsided sex-ratios that follow).<sup>19</sup> In other words, there is increasing support for informed consent as the only threshold for initiating hormone therapy in teenagers.

26. Even WPATH's new (draft) 8<sup>th</sup> Standards of Care mark a significant shift in the direction of an informed consent approach to care as more focused on the patient's sense of agency. More to the point, SOC8 suggests minimum ages that are demonstrably "lower than those in the previous version, for each treatment: 14 for starting hormone therapy, 15 for chest masculinization and at least 17 for more invasive genital operations."<sup>20</sup> That is, cross-sex hormones no later than age 14 and surgeries beginning at age 15. Why do the plaintiffs' expert witnesses spend so much ink restating old standards when newer ones are imminent?

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<sup>18</sup> Cavanaugh, T., Hopwood, R., & Lambert, C. (2016). Informed consent in the medical care of transgender and gender-nonconforming patients. *AMA Journal of Ethics*, 18(11), 1147-1155.

<sup>19</sup> Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302–311, <https://doi.org/10.1037/cpp0000288>. On page 304, the authors note that their clinic does not require an in-house mental health evaluation prior to treatment: "To avoid unnecessary delays in medical care, our clinic does not require patients to be seen by one of our clinic's mental health professionals if they have an established GD diagnosis and referral from a community mental health professional."

<sup>20</sup> Ghorayshi, *op. cit.*, paragraph 30.

27. Perhaps anticipating that this shift in actual practice could jeopardize legal goodwill (in this case), the plaintiffs’ witnesses go to great lengths to declare that the old protocols are still in place. For example, Dr. Turban repeats the mantra that “[p]rotocols for the provision of such care” have been made clear in the Endocrine Society Guideline and in WPATH’s SOC 7 (page 3), and that the “WPATH SOC 7 highlight that an adolescent must be assessed by a mental health professional with specific qualifications prior to initiating any gender-affirming medical interventions” (page 4).

28. The plaintiff’s expert witnesses still like to cite evidence from studies employing the Dutch protocol—as Dr. Turban does multiple times on pages 4 and 5.<sup>21</sup> (Dr. Antommara does the same on pages 15 and 16 of his report.)<sup>22</sup> It is a bait-and-switch tactic. Such studies imposed rigorous requirements for study participation, but they are being employed in this case to defend newer and far looser protocols for hormonal treatments on a very different class of adolescents with demonstrable, co-occurring mental health problems.

29. Hence, Dr. Turban’s citation (on page 5) of the de Vries et al. 2014 *Pediatrics* study, which “found steady improvement in mental health over the course of the study” should be put into context: the participants did not have the type of significant baseline mental health

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<sup>21</sup> The following studies cited on pages 4 and 5 of Dr. Turban’s report each employ the Dutch protocol for treatment (and hence study enrollment) eligibility: de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276-2283; van der Miesen, A.I., Steensma, T.D., de Vries, A.L., et al. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, 66(6), 699-704; de Vries, A.L., McGuire, J.K., Steensma, T.D., et al. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704.

<sup>22</sup> The following studies cited on pages 15 and 16 of Dr. Antommara’s report each employ the Dutch protocol: de Vries et al. (2011) *op. cit.*; Delemarre-van de Waal H.A., Cohen-Kettenis P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(suppl 1): S131–S137; Schagen S.E., Cohen-Kettenis P.T., Delemarre-van de Waal H.A., Hannema S.E. (2016). Efficacy and safety of gonadotropin releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *Journal of Sexual Medicine*, 13(7):1125-32.

problems that are consistent with the current surge in dysphoric adolescents presenting at gender clinics around the United States. The *Pediatrics* study sample consisted instead of those “adolescents (who) belonged to a group of 196 consecutively referred adolescents between 2000 and 2008, of whom 140 *had been considered eligible* for medical intervention” (emphasis mine).<sup>23</sup> Eligibility in the Dutch protocol for medical treatment is not by demand, but only after careful psychological scrutiny of the sort that many clinicians and researchers are now actively seeking to drop or disregard.

30. As an extension of this, Dr. Turban discusses transition regret (on page 11) among the history of patients in the Amsterdam cohort, and asserts that the regret rate for those who had undergone “gender-affirming surgery” was 0.6% for transgender women and 0.3% for transgender men.<sup>24</sup> For a discussion of the medical treatment of minors, this observation is irrelevant, because the Amsterdam cohort adheres to the Dutch protocol, and the 0.6% and 0.3% observations refer to adult gonadectomy regret rates. That is, these are observations made of adults, not minors.

31. On p. 13, Dr. Karasic cites a 2021 meta-review<sup>25</sup> which found regret rates of 1%. However, the primary studies reviewed were “inherently flawed due to loss to follow up.” A more recent review out of the UK found that 20% of patients in the sample had stopped hormone treatment, with half of these citing “regret” or “detransition” as a reason.<sup>26</sup> One case note review

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<sup>23</sup> de Vries et al. (2014), *op. cit.*, p. 697.

<sup>24</sup> Wiepjes C.M., Nota, N.M., de Blok, C.J.M., et al. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15:582–590.

<sup>25</sup> Bustos, V.P., Bustos, S.S., Mascaro, A., Del Corral, G., Forte, A.J., Ciudad, P., Kim, E.A., Langstein, H.N. and Manrique, O.J., 2021. Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plastic and Reconstructive Surgery Global Open*, 9(3): e3477.

<sup>26</sup> Boyd, I., Hackett, T., & Bewley, S. (2022). Care of transgender patients: A general practice quality improvement approach. *Healthcare*, 10(1), 121. <https://doi.org/10.3390/healthcare10010121>.

found a detransition rate of 6.9% at one UK clinic.<sup>27</sup> Either regret rates have been underestimated in the past or they are increasing. In reality, both are true.

32. In the conclusion of Dr. Turban’s report, he claims that reports of transition and treatment regrets are unusual, given the “1.4 million transgender people in the United States alone” (page 13). Turban leans on a study employing the (more rigorous) Dutch protocol for support of his claims about modest surgical regret rates, and yet that study claims a transgender prevalence rate of 1 in every 3,600 persons above age 16.<sup>28</sup> Meanwhile, Turban’s 1.4 million estimate yields a ratio of 1 in every 235 Americans—reminding us again of the bait-and-switch tactic employed here. That is, draw upon conclusions based on a rigorous criterion of inclusion, but then apply its findings to a social setting—the contemporary United States—that now exhibits a baseline rate (of transgender self-identity) at least 15 times larger than that employed in the Dutch protocol-based study sample. And still neither Turban nor any of the other plaintiffs’ expert witnesses address whether there is anything different about the two populations.<sup>29</sup>

33. In 2020, Dutch clinician Annelou de Vries acknowledged that the “new developmental pathway” seen in youth presenting as trans at or past puberty without a history of childhood gender dysphoria and often with mental health diagnoses “raises the question whether the positive outcomes of early medical interventions also apply to adolescents who more recently present in overwhelming large numbers for transgender care.” Dr. de Vries expressed a need for

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<sup>27</sup> Hall, R.; Mitchell, L.; Sachdeva, J. Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJPsych Open* 2021, 7, e184.

<sup>28</sup> Wiepjes et al. (2018), *op. cit.* The rate quoted is equivalent to the article’s reference to 27.7 transgender persons per 100,000 people.

<sup>29</sup> Johns, M.M., Lowry, R., Andrzejewski, J., et al. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students — 19 states and large urban school districts, 2017. *MMWR Morbidity and Mortality Weekly Report*, 68:67–71, <http://dx.doi.org/10.15585/mmwr.mm6803a3>.

“caution” and mentioned concern for those later-presenting adolescents that “may detransition.”<sup>30</sup> Thomas Steensma warned that clinicians around the world were “blindly adopting” their research, stating that “we don’t know whether studies we have done in the past can still be applied to this time” due to the novel type of presentation.<sup>31</sup>

34. Such an acknowledgement is not lost on other nations’ decision-making. Indeed, Sweden’s Karolinska Institute—along with four of the country’s five other gender clinics—has recently moved away from the original Dutch protocol, allowing pediatric transitions only in strictly controlled trials going forward.

35. Similarly, Finland now recommends psychotherapy as the preferred initial treatment for youth presenting with gender dysphoria, even advising clinicians to wait until age 26 (after brain maturation has completed) before administering medical interventions. While still allowing pediatric transitions, Finland has now returned to a stricter adherence to the original Dutch protocol, requiring evidence of childhood onset gender dysphoria, no mental health co-morbidities, and “watchful waiting.”<sup>32</sup> Thus, Finland’s national recommendations now differ from what WPATH’s SOC7 had already endorsed, and are worlds apart from the proposed SOC8 guidelines and the Informed Consent Model.

36. Meanwhile, in contrast to the Dutch protocol, a statement by the American Academy of Pediatrics proposes that mental health comorbidities are caused by gender dysphoria rather than the other way around. “[I]f a mental health issue exists, it most often stems from

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<sup>30</sup>de Vries, A. L. C. (2020). Challenges in timing puberty suppression for gender-nonconforming adolescents, *Pediatrics*, 146(4), e2020010611. The quotes are from p. 1-2.

<sup>31</sup>Tetelepta, B. (2021). More research is urgently needed into transgender care for young people. Where does the large increase of children come from? *Voorzij*, February 27, <https://www.voorzij.nl/more-research-is-urgently-needed-into-transgender-care-for-young-people-where-does-the-large-increase-of-children-come-from/>.

<sup>32</sup> “Watchful waiting” was a key component of the original Dutch protocol. See page 61 of: Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent health, medicine and therapeutics*, 8, 57-67.

stigma and negative experiences rather than being intrinsic to the child,” wrote a small cadre of clinicians tasked with articulating policy for all pediatricians<sup>33</sup> In other words, the emerging scholarly mentality no longer wonders whether minors may come to the conclusion that they are transgender and need hormonal and (later) surgical treatments *because* they are unhappy. They have concluded instead that it is sufficient to take gender dysphoric teens at their word and deduce that they are unhappy *because* of social responses to being transgender. Hence, treatment will alleviate unhappiness by aligning their gender identity with their physical body. The closer the alignment—a socially- and culturally-attuned measure, of course—the better the expected outcome.

37. If there were not a concurrent explosion—and a reversal in the longstanding sex ratio—of cases of gender dysphoria and rates of self-identified transgender teenagers, this transition from a template of caution to one of haste might well have gone unnoticed.

#### IV. THE CENTRAL ROLE OF A NARRATIVE ABOUT SUICIDALITY

38. The specter of suicide is not simply a motivation undergirding the push toward “affirmative” medical treatment of minors at younger ages. It is the only thing that could possibly justify such drastic interventions. Hence, it is an absolutely essential component of the narrative. Dr. Adkins moves straight to the threat of suicide in her page 19 section on the harms of withholding or terminating transgender treatment among minors with gender dysphoria, and concludes her report (on page 21) by warning that “[w]e barely save some of these young people’s lives by getting them on treatment; to take them off mid-treatment where the treatment is working could be life-threatening.” This is a narrative widely employed by clinicians, who

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<sup>33</sup> Rafferty, J., et al. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, 142(4): e20182162. The quotes are from page 4.

pose the question, “Would you rather have a living son or a dead daughter?”<sup>34</sup> While none of the experts employ that particular claim in their reports, its use is widespread and an invention of the perception—as distinct from the reality—of a strong association between gender dysphoria and actual completed suicide (as distinct from suicidality or attempted suicide).

39. Throughout the entire seventh edition of WPATH’s Standards of Care document, published in 2011 and amounting to 120 pages, the terms “suicide,” “suicidal,” and “suicidality” appear only four times total—two of which are in the same sentence. The terms appears in no references (i.e., in the titles of journal articles) at all. In the eighth edition, a draft of which is now circulating, the terms appear 31 times in the text of the document, and in 45 references. (For perspective, Dr. Turban uses the terms 21 times in his report’s 13 total pages.) Why the skyrocketing interest? It is not because of any surge in actual suicides.

40. In a January 2022 article published in the *Archives of Sexual Behavior*, Oxford University sociologist Michael Biggs documents how reports of attempted suicide dramatically exceed the actual rate of completed suicides among adolescent transgender patients.<sup>35</sup> To be sure, Biggs notes that the suicide rate is in fact higher—5.5 times higher—than among that observed among adolescents ages 14 to 17 in the UK. And yet some perspective is in order: the actual number of adolescent suicides Biggs uncovers among patients at the UK’s GIDS—the world’s largest gender clinic—over a decade is four (or 0.03 percent of all patients), which the author notes “is orders of magnitude smaller than the proportion of transgender adolescents who report attempting suicide when surveyed.”<sup>36</sup>

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<sup>34</sup> Soh, D. (2020). *The end of gender: debunking the myths about sex and identity in our society*. New York: Simon & Schuster. The quote is from page 160.

<sup>35</sup> Biggs, M. (2022). Suicide by clinic-referred transgender adolescents in the United Kingdom. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-022-02287-7>. The quote is from page 4.

<sup>36</sup> Ibid., page 4.

41. The disparity between suicide “risk” and actual completions is so dramatic that Biggs concludes that “[i]t is irresponsible to exaggerate the prevalence of suicide,” adding that Bernadette Wren, a former senior clinician at the GIDS clinic, warned “when inaccurate data and alarmist opinion are conveyed very authoritatively to families we have to wonder what the impact would be on children’s understanding of the kind of person they are...and their likely fate.”<sup>37</sup>

42. Dr. Biggs notes that completed suicide rates were considerably higher at the Belgian pediatric clinic, despite better average patient psychological function there, as well as at the Amsterdam clinic, a finding he attributed to higher median age (25) at first visit there.<sup>38</sup> Suicide rates tend to peak in middle age, an observation that seems lost on participants in this debate. Instead, simple assumptions about the etiology of suicidality among self-identified transgender youth remain the preferred narrative of advocates.<sup>39</sup>

43. Biggs discusses the meaning of self-reporting suicide attempts, citing a pair of small-sample studies of non-heterosexual youth in which half of the studies’ respondents who had initially reported a suicide attempt eventually clarified that their attempts had gone no further than imagining or planning suicide. The remainder of actual attempted suicides, he notes, did not typically involve life-threatening situations. The reported attempts, one of the original

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<sup>37</sup> Wren, B. (2015). Making up people. Presented at the meeting of the European Professional Association for Transgender Health, Ghent, Belgium. A selection of this presentation was quoted in Biggs (2022), page 4.

<sup>38</sup> Biggs (2022), *op. cit.*

<sup>39</sup> E.g. Brown, M. (2017). Suicides peak in middle age. So why do we call it a young person’s tragedy? *The Guardian*, September 13, <https://www.theguardian.com/commentisfree/2017/sep/13/suicide-middle-aged-young-people-death>; Van Orden et al. (2010) Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, 117(2), 575-600.

studies noted, instead reflected efforts “to communicate the hardships of lives or to identify with a gay community.”<sup>40</sup>

44. Biggs notes that elevated prevalence of other conditions, like eating disorders, depression, and autism spectrum conditions—the latter of which occurs at a rate 15 times higher than that found among UK students as a whole—are each known to increase the probability of suicide.<sup>41</sup> Despite Biggs’s observation of a profoundly disproportionate rate of autism among GIDS patients, Dr. Turban questioned the connection in print, claiming that “current research has not established an over-representation of GD in those with ASD [Autism Spectrum Disorder] or the converse.”<sup>42</sup> Even if there is a link between autism and gender dysphoria, Dr. Turban maintains that it doesn’t matter: “they should be provided with access to gender-affirming medical care.”<sup>43</sup> Thus, it seems that medical treatments are the go-to prescription. Maslow’s “law of the instrument,” a form of cognitive bias, is evident here: if the only tool you work with is a hammer, it’s tempting to treat everything as if it were a nail.<sup>44</sup>

45. Suicide is being weaponized in service to a political end. This is unsurprising. Indeed, it is part of the “conceptual veiling” that aids the capture of professional organizations and, with them, policy shifts and legal protections in practice. Refusing to subject minors with gender dysphoria to puberty blockers, cross-sex hormones, or any of a host of surgical procedures will not kill them—as many seem to imply. It is not akin to withholding insulin from

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<sup>40</sup> Savin-Williams, R. C. (2001). Suicide attempts among sexual-minority youths: Population and measurement issues. *Journal of Consulting and Clinical Psychology*, 69, 983–991. <https://doi.org/10.1037/0022-006X.69.6.983>. This is quoted in Biggs (2022), *op. cit.*, page 1.

<sup>41</sup> Ibid.

<sup>42</sup> Turban, J. L., & van Schalkwyk, G. I. (2018). “Gender dysphoria” and autism spectrum disorder: Is the link real? *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(1), 8-9. The quote is from page 9.

<sup>43</sup> Turban, J. L., & van Schalkwyk, G. I. (2018). Drs. Turban and van Schalkwyk reply. *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(11), 887–889, <https://doi.org/10.1016/j.jaac.2018.07.881>. The quote is from page 889.

<sup>44</sup> Maslow, A. (1966). *The psychology of science: a reconnaissance*. New York: Harper & Row, page 15.

a Type-I diabetic, a move which will indeed lead to death. The two are not comparable processes.

46. Similarly, Dr. Antommara compares the possibility of adolescents' subsequent treatment-induced infertility with that prompted by cancer. "Parents of children with some types of malignancies may choose treatments that may damage their children's gonads and result in infertility," he writes on page 20 of his report. The same, he notes there and again on page 23, goes for decisions about DSDs (disorders of sex development). Gender dysphoria, however, is not a malignancy, the invasive medical treatment of which is absolutely necessary to preserve life. Nor is it a DSD. A dysphoria is, rather, a psychological state marked by distress, unease, and dissatisfaction. Cancer is not, at bottom, a psychological problem. An intersex condition is likewise physically demonstrable. Moreover, childhood cancers have been and remain extremely rare—affecting 1 in every 6,500 minors per year.<sup>45</sup> DSDs remain comparably rare.<sup>46</sup> The same can no longer be said of gender dysphoria.

## V. CONSENT

47. Dr. Antommara outlines the ethical principles about informed consent, assent, and adolescents' decision-making capacity, as asserted by the Endocrine Society (on page 21 of his report). Is there an age that is too young for informed consent? Small children have difficulty understanding quantity, quality, and time, as well as assigning "causal attributions," that is, understanding that occurrences have both proximal and distal causes. The same goes for reasoning, anticipating the future, the formation of identity, self-reflexivity (or the ability to

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<sup>45</sup> Ries, L.A.G., Eisner, M.P., Kosary, C.L., Hankey, B.F., Miller, B.A., Clegg, L., Edwards, B.K. (eds). (2002). SEER Cancer Statistics Review, 1973-1999. National Cancer Institute. Bethesda, MD, [http://seer.cancer.gov/csr/1973\\_1999/](http://seer.cancer.gov/csr/1973_1999/).

<sup>46</sup> Witchel, S. F. (2018). Disorders of sex development. *Best practice & research. Clinical obstetrics & gynaecology*, 48, 90–102. <https://doi.org/10.1016/j.bpobgyn.2017.11.005>.

assess our own judgments), moral awareness, judgment, and truth seeking.<sup>47</sup> The capacity for each of these develops over time and is quicker in some than in others. Each is related to informed consent here, since adolescents are being asked to decide what their future will look like at a very young age.

48. Furthermore, Dr. Antommaria notes that a discussion of “fertility and options for fertility preservation” is recommended by the Endocrine Society as part of “the informed consent process for puberty blockers and sex hormones” (page 21). To speak with a minor about future fertility before beginning puberty blockers is to talk with them about it by around age 11. The Endocrine Society, he continues, “also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes, until an adolescent is developmentally capable of providing informed consent.” How old is “developmentally capable”? How insignificant is “partly irreversible”? Even the ability to have a serious conversation about the future is decreasingly possible given the move away from physician gatekeeping and toward earlier cross-sex hormone treatment. (WPATH SOC8 recommends age 14.)

49. Dr. Adkins discusses (on page 12 of her report) the process of acquiring informed consent from her adolescent patients, noting that those age 12 and over (and a parent or guardian) sign “line by line,” but that “a visual presentation” is used “with patients who have limitations on their ability to absorb the information...” Perhaps this concerns minors’ grasp of complex medical language. On the other hand, perhaps it signals that Dr. Adkins endorses puberty blockers and cross-sex hormone treatments for minors who either cannot read well or who are too young to understand concepts explained on the printed page. Either way, if pictures

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<sup>47</sup> Smith, C. (2011). *What is a person? Rethinking humanity, social life, and the moral good from the person up*. Chicago: University of Chicago Press.

must replace text, Dr. Adkins’s criteria undermine confidence in the ability of minor patients to understand long-term treatment consequences and offer their informed consent.

50. Dr. Antommara writes at some length about principles of informed consent and assent (pages 11-12). The matter of adolescent “medical decision-making capacity” remains central to the concern articulated in the SAFE Act. Antommara cites Douglas Diekema’s 2004 discussion of parental refusals of medical treatment for their minor children.<sup>48</sup> Diekema nevertheless commences his study with the proposition that minors “are generally considered incompetent to provide legally binding decisions regarding their health care.”

51. Experimental medicine has historically reinforced the importance of consent and fostered greater protections of those considered most vulnerable—chief among them pregnant women and children. For example, the Institutional Review Board of the Children’s Hospital of Philadelphia maintains that “[c]hildren are neither legally nor developmentally capable of consenting to their own treatment or participation in research.”<sup>49</sup>

52. In discussing the purported absence of clinical equipoise, Dr. Antommara observes that one particular challenge to conducting a randomized trial is the difficulty of locating a sufficient number of participants willing to risk being randomized into the control wing of the study (page 9). He considers this “inadequate sample size” to constitute an ethical problem. But given that so many studies in this domain rely on modest sample sizes, is Dr. Antommara sure he wants to consider sample size an issue of ethics? If so, we could disregard perhaps over three-quarters of all published research in this domain. While we’re at it, I consider drawing conclusions from recruited opt-in samples (like Dr. Turban does in his publications

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<sup>48</sup> Diekema, D.S. (2004). Parental refusals of medical treatment: The harm principle as threshold for state intervention. *Theoretical Medicine*, 25(4):243-64.

<sup>49</sup> Children’s Hospital of Philadelphia Research Institute, Criteria for IRB approval. <https://irb.research.chop.edu/criteria-irb-approval>. Retrieved: Feb. 10, 2022.

drawing upon the United States Transgender Study, or USTS) dubious at best and borderline unethical—especially if used to draw conclusions or propose policy about an underlying population—despite its large sample size.

53. While Dr. Antommaria discusses at length the varying quality of medical research, the General Assembly’s findings that there is “a lack of ‘long-term longitudinal studies’ on puberty-blocking drugs and a lack of ‘randomized clinical trials’ of cross-sex hormone therapy” also remains accurate.

## VI. CONCLUSIONS

54. It is evident by now that there is a widening split between clinicians over how and when to introduce transgender medicine to minor patients. Protocols are shifting to favor younger timelines, and some clinicians are opting to overlook mental health comorbidities and gamble instead that treatments will alleviate them. Given the rapid shift to looser protocols aggressively promoted by many advocates today, what WPATH or the Endocrine Society does or does not currently recommend should be of little or no concern in this case, because the guidance will soon change, and the confederation of medical professional organizations seems very unlikely to contest loosened guidance.

55. In the end, this is not about asking a judge to mull over the merits of this or that study’s methods, measurements, or conclusions. Debates are hardly unusual in the academy, nor is any single study beyond criticism. Rather, what I have sought to establish—primarily in my December 2021 report and in this rebuttal—is that what is going on in transgender medicine for teenagers is less about tweaking protocols and more about the ideological capture of professional organizations in service to ideas that were unthinkable up until a few years ago. Those ideas are: (1) that minors could consent to their own sterilization by age 14 and surgical removal of normal tissue by age 15, encouraged by strangers on social media; (2) that with the aid of social

collusion the human person can will their own sex change into existence; and (3) that major medical professional associations have—in service to purported respect for human agency—cooperated with activists to put patients in charge of their own diagnosis and treatment prescriptions. To justify all this, the threat of patient suicide has taken center stage, in spite of modest evidence.

56. The result is rightfully viewed as scandalous outside of the transgender medicine context. Ordinary Americans maintain critical opinions of treating transgender teenagers with hormones or surgery.<sup>50</sup> This is an example of “*déformation professionnelle*,” or job “conditioning” in which training and socialization processes associated with a profession—in this case the emergence of “gender” medicine—have resulted in a distorted understanding of the human person as a unity of mind and body.<sup>51</sup> That this branch of medicine seems particularly prone to patient activists’ emotional involvement in the development and revision of protocols—as compared to, say, cardiology or oncology—offers evidence of (and further fuel for) this professional distortion. As articulated in my own research, this case—and the medical treatment of adolescent gender dysphoria as a whole—has everything to do with a questionable ideological prioritizing of bodily autonomy over bodily integrity.<sup>52</sup> But this choice of values is rarely articulated or reflected upon, to the detriment of young people placed in the medical pipeline of transgender medicine.

57. The SAFE Act concerns minors. It makes no claims on the decisions adults wish to make. The law has long recognized the difference, and sought to protect minors from making

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<sup>50</sup> Regnerus, M., Vermurlen, B. (2022). Attitudes in the U.S. toward hormonal and/or surgical interventions for adolescents experiencing gender dysphoria. *Archives of Sexual Behavior*, <https://doi.org/10.1007/s10508-021-02214-2>.

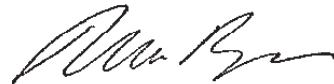
<sup>51</sup> The origin of the term is unclear, but is often attributed to the early Russian-American sociologist Pitirim Sorokin, who emigrated to the United States before becoming the inaugural professor of sociology at Harvard.

<sup>52</sup> Regnerus, Vermurlen (2022), *op. cit.*

premature judgments that come with strings attached, that is, unintended consequences, permanent changes, and altered life trajectories. Indeed, there is no shortage of things that the law prevents minors from doing, even if they wish to. The SAFE Act suggests there are grave misgivings about the ability of minors—especially but not only those who are very young, such as ages 11 and 12—to consent to the (rapidly evolving) medical interventions that constitute transgender medicine. Either the law will extend its protection to minors in these situations—telling them to wait—or it will leave them exposed to the subtly coercive claims of activists and their clinicians, whose rapid capture of professional organizations that once protected children is a stunning accomplishment. Hippocrates would be scandalized. Some priorities, he maintained, “may outweigh the surgeon’s knife and the chemist’s drug.”

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

**Executed on February 10, 2022.**



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Mark Regnerus, Ph.D.

# Exhibit 3

**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,	:	
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Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
	:	
v.	:	
	:	
LESLIE RUTLEDGE, et al.,	:	
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Defendants.	:	
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**EXPERT REBUTTAL REPORT OF DAN H. KARASIC, MD**

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. My background and credentials are set forth in my opening report dated December 10, 2021.

2. I reviewed the reports of Dr. Stephen Levine, Dr. Paul Hruz, Prof. Mark Regnerus, and Dr. Patrick Lappert. In this rebuttal report, I respond to some of the central points made in those reports. I do not address each and every assertion made in those reports that I believe are baseless, misleading, or mischaracterizations of the evidence, as there are many. Instead, my aim is to provide an explanation of the erroneous premises upon which their conclusions are based.

3. I reserve the right to supplement my opinions if necessary as the case proceeds.

**THE STATE’S EXPERT WITNESSES’ DESCRIPTION OF GENDER-AFFIRMING CARE FOR ADOLESCENTS WITH GENDER DYSPHORIA BEARS NO RESEMBLANCE TO THE PREVAILING TREATMENT PROTOCOLS**

4. The State’s experts offer a description of medical care for adolescents with gender dysphoria that bears no resemblance to the widely accepted protocols for treatment articulated in the WPATH Standards of Care 7 (“WPATH SOC”) and the Endocrine Society Guideline. Throughout their reports, the State’s experts claim that doctors who provide medical interventions to treat gender dysphoria “actively encourage” patients to be transgender, rush to provide medical interventions without psychiatric assessments of patients, disregard other mental health and family issues that could be causing the patient distress, oppose psychotherapy, and fail to inform patients and their families of the risks associated with treatment. (*See, e.g.*, Expert Report of Paul W. Hruz, M.D., PhD. (“Hruz”), ¶¶ 8, 62 (asserting that providers “actively encourage” patients to be transgender); Expert Report of Dr. Mark Regnerus (“Regnerus”), ¶ 95 (asserting that providers provide medication without psychological assessment); Expert Report of Stephen B. Levine, M.D. (“Levine”), ¶ 57 (asserting that providers assume psychological comorbidities need not be addressed); Levine, ¶ 64 (assuming mental health providers do not address family dynamics); Hruz, ¶ 60 (asserting providers do not inform patients of risks of treatments)).

5. Dr. Levine calls this the “affirmation therapy model” of care (Levine, ¶ 57), implying that it is an accepted mode of treatment, but the model he describes is not an accepted model and is completely at odds with the protocols provided in the WPATH SOC and the Endocrine Society Guideline:

- Under the WPATH SOC and Endocrine Society Guideline, affirming care for transgender youth does not mean steering them in any particular direction, but rather supporting them through their period of exploration of gender expression and

increasing self-awareness of their identity. (Coleman, et al., 2012, at 18; Ehrensaft, 2017). The WPATH SOC 7 makes clear that “[h]ormonal or surgical interventions are appropriate for some adolescents, but not for others.” (Coleman, et al., 2012, at 16).

- The protocols provide that before any medical or surgical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met and the appropriateness of such care for the patient. (Coleman, et al., 2012, at 18; Hembree, et al., 2017, at 3877).
- The protocols provide for the mental health assessment to evaluate other issues that may be causing the patient distress. (Coleman, et al., 2012, at 18 (“Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken.”); Hembree, et al., 2017, at 3876 (clinicians must be able to diagnose psychiatric conditions)).
- The protocols provide that clinicians should ensure that any psychiatric conditions are appropriately treated and that it is important that mental health care is available to patients before, during, and sometimes after transitioning. (Hembree, et al., 2017, at 3876, 3879.)
- The protocols provide for a rigorous informed consent process that includes informing the patient and their parents of side effects of treatment, including the potential loss of fertility. For hormone therapy, in addition to requiring the parents’ informed consent, the adolescent must have “sufficient mental capacity . . . to

estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent.” (Hembree, et al., 2017, at 3878.)

6. In sum, the State’s experts create a straw man by providing a false description of care under the prevailing protocols and then attack it. They either misunderstand the prevailing protocols or assume, without basis, that all or most gender clinics disregard them. In the case of Prof. Regnerus, it appears to be the latter. (*See* Regnerus, ¶ 5 (recognizing that the standards “counsel patience” but assuming doctors do not follow them)). And while Dr. Levine describes this “model” of care, he acknowledges “I do not know what proportion of practitioners are using” it. (Levine, ¶ 63). As a clinician who, unlike the State’s experts, actively works with a multitude of clinicians providing care to transgender youth and adults, I know firsthand that their characterization of treatment is wholly inconsistent with the prevailing practice.

7. If there are individual doctors who deviate from the accepted protocols and inappropriately provide care that is harmful to patients, medical licensing boards can address that without denying care to those who have been appropriately assessed and determined to need it. The State’s experts point to WPATH president-elect Dr. Marci Bowers “caution[ing] against too rapid transition of adolescents without adequate psychiatric care” (Levine, ¶ 14), and similar comments by Drs. Laura Edwards-Leeper and Erica Anderson. (*See* Regnerus, ¶ 95). These doctors’ comments were aimed at improving care, not banning it. After making the comments cited by the State’s experts, Dr. Bowers and Dr. Anderson were signatories to a letter from USPATH and WPATH supporting gender-affirming medical care for adolescents with gender dysphoria and opposing legislation like the Act 626.<sup>1</sup> And Dr. Edwards-Leeper and Dr. Anderson

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<sup>1</sup> United States Professional Association for Transgender Health and World Professional Association for Transgender Health. (2021). Joint Letter from USPATH and WPATH. *Available at* <https://www.wpath.org/media/cms/Documents/Public%20Policies/2021/Joint%20WPATH%20USPATH%20Letter>

similarly expressed their full support for gender-affirming care and “disgust” at legislative bans of such care.<sup>2</sup>

8. In painting their false picture of how treatment is provided to adolescents with gender dysphoria, the State’s experts use pejorative terms like “gender transition industry” to refer to health care providers who treat these patients. (*See, e.g.*, Levine, ¶ 85; Hruz, ¶ 84; Expert Report of Patrick W. Lappert, M.D. (“Lappert”), ¶ 9). Health professionals across disciplines providing medically necessary care for their gender dysphoric patients, as they do for their other patients, do not constitute an “industry.” This suggestion of improper motives on the part of these health-care providers is without basis.

9. It is clear from some of the State’s experts’ reports that their concern is not about the alleged lack of thorough mental health assessments or access to psychotherapy for patients; it is about opposition to transition-related medical care. (*See, e.g.*, Lappert, ¶ 49; Hruz, ¶ 61).

#### **THE STATE’S EXPERT WITNESSES OFFER NO ALTERNATIVE EFFECTIVE TREATMENT FOR ADOLESCENTS WITH GENDER DYSPHORIA**

10. The State’s expert witnesses disapprove of existing protocols for treating gender dysphoria in adolescents (and for some of the State’s experts, people of any age). (Lappert, ¶ 49; Hruz, ¶ 61. But the alternative treatments they propose lack any evidence of effectiveness.

11. Dr. Levine claims there is evidence that psychotherapy can sometimes enable a return to a gender identity that matches sex assigned at birth but offers nothing but anecdotes of “reinvestment” in one’s sex assigned at birth. (Levine, ¶ 56 (“I and other clinicians have witnessed reinvestment in the patient’s biological sex in some individual patients who are undergoing

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%20Dated%20Oct%2012%202021.pdf; *see also* World Professional Association for Transgender Health. WPATH Public Documents. *Available at* <https://www.wpath.org/policies>.

<sup>2</sup> Laura Edwards-Leeper and Erica Anderson, *the Mental Health Establishment is Failing Trans Kids*, Washington Post, Nov. 24, 2021, *available at* <https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/>.

psychotherapy.”)). Efforts were made in the past to assist patients to come to identify with their sex assigned at birth but those efforts have proven to be ineffective and harmful and, thus, treatment with the goal of changing a person’s gender identity are no longer considered ethical. (Coleman, et al., 2012, at 16; American Psychological Association, 2021).

12. Dr. Levine asserts that an alternative to gender-affirming medical care is “to teach coping and resilience skills to gender discordant children.” (Levine, ¶ 28). Therapy to promote coping and resilience is certainly appropriate and is an aspect of care for children and adolescents with gender dysphoria. But this type of therapy does not resolve the dysphoria and is not an alternative to medical interventions for adolescents who need them. My initial report discusses the harms that can result from the denial of medically indicated gender-affirming medical care. (Expert Report of Dan H. Karasic, M.D., ¶ 43).

13. Dr. Levine also suggests that as an alternative to medical interventions, health care providers can address gender dysphoria by helping patients understand that there are options beyond sex-stereotyped behaviors. (Levine, ¶¶ 28, 29). This represents a misunderstanding of gender dysphoria and its diagnosis and treatment. If a patient’s distress relates only to a sense of limitation on behaviors related to gender and they are not experiencing distress about their body, they would not meet the criteria for diagnosis and medical treatment of gender dysphoria.

14. Several of the State’s experts point to “watchful waiting” as an alternative treatment approach to the existing treatment paradigms outlined in the WPATH SOC and the Endocrine Society Guideline. While “watchful waiting” is an approach for prepubertal children followed by some clinicians, it is not an accepted approach used with adolescents. That is because, while there are studies finding that many prepubertal children diagnosed with Gender Identity Disorder (a precursor diagnosis to Gender Dysphoria in Children) identified with their sex assigned at birth at

a later follow up, there is no evidence that gender dysphoria that continues into adolescence is likely to desist. Some of the State’s experts appear to recognize that “watchful waiting” is a treatment modality for prepubertal children and not adolescents. (*See, e.g.,* Levine, ¶ 47 (“When a pre-adolescent child presents with gender dysphoria, a ‘watchful waiting’ approach seeks to allow for the fluid nature of gender identity in children to naturally evolve.”); Hruz, ¶ 64 (stating that “watchful waiting” is “currently the best scientifically supported intervention for young children reporting gender dysphoria.”)). Yet they still suggest that “watchful waiting” is an alternative to medical interventions such as hormone therapy for adolescents—*see, e.g.,* Hruz, ¶¶ 64-65; Regnerus, ¶ 29 (suggesting that “a ‘watchful waiting’ approach to adolescent gender dysphoria” is an accepted protocol)—even though there is no evidentiary support for applying “watchful waiting” to patients once they have started puberty.

15. The State’s experts rely significantly on the work of Kenneth Zucker in support of “watchful waiting.” (*See, e.g.,* Hruz, ¶ 64). But Zucker recognizes the need for medical interventions for gender dysphoria in adolescence and does not suggest that watchful waiting is appropriate for adolescents. (Zucker, et al., 2010). His clinic in Toronto provided puberty blockers and hormone therapy to adolescents with gender dysphoria. (Zucker, et al., 2010). Similarly, the Dutch researchers who coined the term watchful waiting for prepubertal children did the seminal research on medical interventions for those patients whose gender dysphoria persists until adolescence. (de Vries, 2011; Steensma, 2011; de Vries, 2014).

16. Dr. Hruz, presumably in an effort to support “watchful waiting” for adolescents, says there is no basis for the assertion made by Plaintiffs’ experts that patients who continue to have gender dysphoria after starting puberty typically persist in their transgender identity. (Hruz, ¶ 34E). But all of the research on this topic makes clear that desistance is a prepubertal

phenomenon. (*See, e.g.*, Steensma, 2011). The State's experts have offered no evidence that desistance among adolescence is likely.

17. There is no basis for the State's experts' suggestion that providing gender-affirming medical care will cause youth with gender dysphoria who would otherwise desist to, instead, persist. (*See, e.g.*, Levine, ¶ 79). This claim erroneously relies on the assertion that social transition in prepubertal children can cause their gender dysphoria to persist into adolescence. First, contrary to Dr. Levine's suggestion, the fact that there is a correlation between social transition prior to puberty and persistence does not establish that social transition *causes* persistence of gender dysphoria. As the Steensma study cited by the State's experts reported (*see* Steensma, 2013), the intensity of gender dysphoria prior to puberty predicted persistence, and children with more intense dysphoria were more likely to socially transition. Second, whatever conclusions can be drawn from these desistance studies about the impact of gender affirmation on the persistence rates in prepubertal children, as discussed above, this research does not apply to adolescents with gender dysphoria, for whom desistance is rare, and the treatments banned by Act 626 are not indicated until adolescence.

18. The suggestion that adolescents can just wait until they are 18 years old to get care ignores the harm of not providing the care. Allowing endogenous puberty to advance is not a neutral decision. For many adolescents, the development of secondary sex characteristics that do not match their gender identity can have a severe negative impact on their mental health and can exacerbate lifelong dysphoria because some of those characteristics are impossible to change later through surgeries.

**THE STATE’S EXPERTS DRAW INAPPROPRIATE CONCLUSIONS FROM THE  
NUMBERS AND SEX-RATIOS OF GENDER CLINIC REFERRALS**

19. The State’s experts devote many pages to the increase in the numbers of referrals to gender clinics, and changes in sex ratios of patients. (*See, e.g.*, Hruz, ¶ 51; Levine, ¶ 166). As an initial matter, in their caricature of doctors pushing medical transition, the State’s experts say the field is ignoring and avoiding exploration of these developments. (Levine, ¶ 25; Regnerus, ¶¶ 9, 49). That is not the case. Indeed, the draft WPATH SOC, 8<sup>th</sup> revision Adolescent chapter specifically discusses the increase in referrals to gender clinics and the sex ratios of these young patients. (*See* WPATH SOC Draft for Public Comment - Adolescent, Dec. 2021, at 1, 3-4). But the State’s experts draw unsupported conclusions about the rise in number of referrals and changes in sex ratios observed in some clinics. They claim this means adolescents are adopting a transgender identity due to “social contagion,” leading them to undergo irreversible medical treatments they later regret. This conclusion is baseless.

20. The rise in numbers of referrals is hardly surprising given the greater awareness on the part of youth and their parents of what gender dysphoria is and that care is available, as well as the significant increase in the number of clinics available to provide care. In addition, the stigma associated with being transgender, while still significant, has lessened in recent years. Coming out to parents and seeking care are options that did not exist for many youth until recently, so an increase in numbers of referrals to gender clinics is not surprising. While there is a documented increase in clinic referrals, the State’s experts’ exaggerate the increase by making inappropriate comparisons. For example, Dr. Hruz claims that “it has been reported that in 2018 2% (2 in 100) of high school students identified on surveys as ‘transgender’—this is 200 times greater response—a 20,000% increase—over reports during past decades which showed a rate of only .01 percent (one in 10,000 people).” (Hruz, ¶ 76). Prof. Regnerus also references gender dysphoria

“once affect[ing] less than 1 in 10,000 children, according to DSM-V prevalence rates”. (Regnerus, ¶ 22). The .01 percent figure in the DSM-5 is based on the small fraction of the population that received care in gender clinics in the Netherlands in 1990. (Bakker, et al., 1993).<sup>3</sup> The State’s experts compare the number of European gender clinic patients three decades ago to the number of people self-identifying as transgender now as evidence of an exploding number of transgender people, when in fact these numbers were measuring very different things. Put another way, the State’s experts are comparing apples to oranges.

21. An apples to apples comparison of self-identified transgender people over time shows a very different picture. Until the past decade, little data on the number of people identifying as transgender was available. From 2007 to 2009, a question asking whether the respondent identified as transgender was added to a large population-based health survey conducted in Massachusetts, and 0.5% of study participants identified as transgender. (Conron, et al., 2012). Since then, this question was added to large health surveys in other states, and analyses of surveys done in 2014 found that, nationally, 0.5-0.6% of adults identified as transgender, and 0.7% of youth ages 13 to 17 identified as transgender. (Crissman, et al., 2017; Flores, et al., 2016; Herman, et al., 2017). Prof. Regnerus cites Rider et al. (2018) as reporting that 2.7% of youth identified as transgender. (Regnerus, ¶19). However, in that study, the question asked was “Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?” The larger number does not demonstrate an increasing number of transgender youth as the survey question captured people who did not identify as transgender. Prof. Regnerus also cites a survey of public high school students disproportionately from large urban school districts, which had 1.8% of youth identifying as transgender. (Johns, et al., 2019). The higher number in this survey, done in 2017,

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<sup>3</sup> In 2015, the number in the Netherlands had changed to 1 in 3600. (Wiepjes, 2018).

more likely reflects the particular sample than a change over time, versus the lower numbers in Herman et al. (2017), as the time difference was small between the surveys.

22. While increases in numbers and changes in sex ratios of patients referred to some gender clinics have been reported, since the number of patients referred to gender clinics reflect only a small fraction of the people identifying as transgender, these changes may reflect changes in referral patterns to clinics rather than changes in the number of people identifying as transgender.

23. Sex ratios of patients vary from clinic to clinic and over time. When I was the psychiatrist for the Dimensions Clinic for transgender youth in San Francisco from 2003 to 2020, a consistent majority of my patients were assigned female at birth. Other clinics have had more assigned male at birth patients. The rise in numbers and percentage of patients assigned female at birth observed at some clinics in recent years is not surprising given the historical development of the study of gender dysphoria in youth. The first large American study of gender non-conforming youth was the Feminine Boy Study at UCLA. There was significant societal discomfort with and rejection of boys who departed from sex stereotypes—the director of the study referred to them as “sissy boys” in the book resulting from the study—and these boys often experienced bullying from peers. In this context, boys who were perceived to be effeminate were the population brought in to psychiatrists by their parents and were the population that was initially studied by researchers. (Green, 1987). Parents were not as concerned about gender non-conforming girls as they were more socially accepted. There was also less awareness among the general public of the existence of transgender males and that transitioning was an option for individuals assigned female at birth who were experiencing gender dysphoria. The increase in awareness in recent decades made it

possible for individuals who ultimately came to identify as transgender men to come out and seek care.

24. There is a social or cultural influence on gender in the sense that social and cultural developments make it more possible for youth struggling with gender dysphoria to access care. But there is no evidence that peer influence determines an individual's gender identity. The State's experts point to Lisa Littman's study discussing what she called "rapid onset gender dysphoria," where parents reported that their children who suddenly identified as transgender boys frequently reported consuming social media about transgender issues and having transgender friends. (*See e.g.*, Hruz ¶ 74). While there may be rapid onset parental awareness of a child's transgender status, as is often the case when lesbian and gay youth come out to their parents, that does not mean the gender dysphoria was sudden to the adolescent. In any case, this study does not provide evidence that peers and social media cause individuals to be transgender. As with other marginalized groups, such as lesbian and gay people, it is not unusual to seek out others like you. Nor is it unusual to seek out support and information online. Moreover, the diagnostic criteria for gender dysphoria are rigorous and if there were individuals claiming a transgender identity to fit into a peer group, they would not meet the criteria for a gender dysphoria diagnosis let alone be deemed to need medical interventions.

**SOME OF THE STATE'S EXPERT WITNESSES QUARREL WITH THE FIELD OF  
PSYCHIATRY AND THEIR OPINIONS REFLECT THEIR LACK OF EXPERIENCE  
IN THE FIELD**

25. Gender dysphoria is a psychiatric diagnosis. Some of the State's expert witnesses whose CV's indicate no experience in psychiatry or mental health more generally critique the diagnosis of gender dysphoria for being based on self-reports from patients. (*See, e.g.*, Hruz, ¶¶ 35B, 45 (objecting that gender dysphoria diagnosis is limited to self-report info from patients

without objective data like blood tests or x-rays); Lappert, ¶ 30 (“There is no objective diagnostic test for transgender.”)). But clinical interviews with patients are typically used to diagnose other DSM diagnoses and determine treatment. This widely used assessment tool is not unique to gender dysphoria.

26. Dr. Hruz candidly acknowledges that his objection is not limited to the gender dysphoria diagnosis and—quite extraordinarily—extends to the entire DSM and the mental health field in general, which he condemns as not being “science-based.” (Hruz, ¶¶ 35A, 48, 50).

27. Despite Dr. Hruz’s disapproval of the field of psychiatry, and despite his, Dr. Lappert’s, and Prof. Regnerus’s lack of expertise in the diagnosis or treatment of mental health conditions, all three of these expert witnesses did not hesitate to offer opinions about psychiatric care. For example, some of them compare surgery for gender dysphoria to amputating limbs of patients who have “Body Integrity Identity Disorder (BIID).” (*See, e.g.*, Hruz, ¶ 54). “BIID” is an extremely rare phenomenon, and is not a recognized disorder in the International Classification of Diseases (“ICD”) or the DSM. Gender dysphoria, in contrast, is a well-recognized condition with well-established treatments. Dr. Lappert, in opposing gender affirmation surgery, equates it to removing the functioning eyes of a brown-eyed patient who says they identify as blue-eyed and replacing them with blue glass eyes. (Lappert, ¶ 49). Of course, no such phenomenon exists. Comparing such an absurd hypothetical to the well-documented and studied gender dysphoria diagnosis disparages transgender people, and demonstrates Dr. Lappert’s lack of expertise and experience in transgender health.

**THE STATE’S EXPERT WITNESSES’ ATTEMPTS TO DISCREDIT THE WPATH  
STANDARDS OF CARE AND ALL OF THE PROFESSIONAL GROUPS THAT  
ACCEPT THEM ARE BASELESS**

28. The State’s expert witnesses characterize WPATH as an ideological, non-scientific, advocacy organization, open to transgender activists outside of the health field. (Hruz, ¶ 64; Levine, ¶¶ 66, 67). Many WPATH members are academics who publish in peer-reviewed journals. Many are academic leaders in endocrinology, internal medicine, plastic surgery, urology, psychiatry, psychology, and other disciplines of the health sciences. WPATH restricts its full membership to those with professional credentials and most members are licensed clinicians. The fact that WPATH engages in advocacy on behalf of its patient population for access to beneficial care is typical of medical associations. For example, the American Psychiatric Association advocates for a wide range of public policy changes to improve access to mental health care, *e.g.*, for migrants and for incarcerated people.<sup>4</sup>

29. Dr. Levine asserts “[i]n my experience most current members of WPATH have little ongoing experience with the mentally ill.” (Levine, ¶ 73). I do not know what he is basing this on since he has not been involved with WPATH in two decades. But it is simply not true. I have been involved with WPATH for many years and have 35 years of experience treating people with mental illnesses. And there are many others like me in WPATH. Mental health providers make up the largest percentage of WPATH’s membership. These mental health professionals are licensed and regulated by state licensing boards, and most provide care to both cisgender and transgender clients—including those with serious mental illness.

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<sup>4</sup> See American Psychiatric Association. (2019). Position Statement on the Care of Medically Vulnerable Migrants in the United States. *Available at* <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Care-of-Medically-Vulnerable-Migrants-in-the-US.pdf>; American Psychiatric Association. (2016). Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System. *Available at* <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Substance-Use-Disorders-in-the-Criminal-Justice-System.pdf>; *see generally* American Psychiatric Association Policy Finder, *available at* <https://www.psychiatry.org/home/policy-finder>.

30. Dr. Levine further claims that “[g]enerally speaking, therapists who encounter gender patients in inpatient psychiatric settings, those educated more thoroughly about the controversies in the field, and mental health professionals who are not members of WPATH do not support the ‘affirmation therapy’ model.” (Levine, ¶ 59). To the extent he is referring to his “model” of therapy that pushes people into adopting a transgender identity and rushes medical interventions and opposes psychotherapy, that would not be surprising and would also be opposed by members of WPATH as it is not a recognized treatment model. If he is referring to the accepted protocols for care, it is unclear what he bases this assertion on, but it is not consistent with my experience. Having been actively involved for three decades as a UCSF professor in the training of psychiatry residents, internal medicine residents and fellows, and medical students, as well as of mental health and medical professionals at conferences around the nation, by my observation, the mainstream views of health professionals on transgender care include widespread acceptance of the WPATH Standards of Care.

31. The State’s expert witnesses also argue that dissenting views are not tolerated in WPATH. (Levine, ¶ 68). Yet, as a number of them noted, Dr. Marci Bowers recently expressed some criticism about how some in the field are practicing, and she is the President-elect of WPATH. I have attended several WPATH conferences since 2001, and have been a member of the Scientific Committees that have reviewed abstract submissions for the conferences, and the diversity of views presented and discussed has always been notable. For example, as chair of the Scientific Committee for the 2017 WPATH conference, I helped organize a panel of therapists and trainees who had themselves detransitioned, and the presentations and discussion were well-received by attendees.

32. According to Dr. Hruz, it is not just WPATH, but also the American Medical Association, the American Academy of Pediatrics, and the Endocrine Society, that act based on political ideology rather than “evidence-based scientific methodologies.” (Hruz, ¶ 84). His unsupported claim that all of these major medical groups are sacrificing adolescents’ health to promote a particular ideology is staggering.

**GENDER-AFFIRMING MEDICAL CARE CAN HAVE LONG-TERM BENEFITS  
TO PATIENTS**

33. Dr. Levine faults Drs. Turban, Antommara, and Adkins, whose work focuses on pediatric populations, as lacking a “life course” perspective. (Levine, ¶¶ 11-14). I cannot speak for them, but I have treated people ranging from adolescents to the elderly. And many of my patients have remained with me for decades, *e.g.*, where a patient is on medications that need to be monitored, and their medical transition was a positive health care decision not just in the short term but for the course of their lives.

34. Dr. Levine’s assertion based on anecdotal evidence that regret and “detransition” are “not infrequent” (Levine, ¶¶ 141, *et seq.*) is inconsistent with the data. A study of everyone receiving gender-affirming surgery in Sweden over 50 years (1960 to 2010) found a regret rate of 2.2%, declining over the years. There were ten cases of regret from 1960 to 1980, and only five cases of regret total in the last 30 years that were reviewed, from 1981-2010. (Dhejne, et al., 2014). A meta-analysis of 27 studies which reported regret after gender-affirming surgery found that of 7928 people having gender-affirming surgery, the regret rate was 1%. (Bustos, et al., 2021). Dr. Levine’s assertion is also at odds with my clinical experience. I have had some patients who halted their transition due to challenging personal circumstances—*e.g.*, fear of losing family support—but they still had gender dysphoria. And some came back years later to resume their transition. But in 30 years, I have never seen a patient who had undergone hormone therapy and/or surgery

and later came to identify with their sex assigned at birth and, thus, regretted the treatment and wanted to undo its effects

35. The State’s expert witnesses point to elevated rates of mental health problems and substance use in the transgender community, suggesting that being transgender is the cause of these negative outcomes and, thus, something doctors should try to prevent. (*See e.g.*, Hruz ¶ 61; Levine ¶ 15j). As discussed above, being transgender is not something doctors can prevent. And these comments disregard the significant stigma transgender people continue to face, and stigma is a well-documented risk factor for mental health and substance use issues.

36. Apparently in support of the unattainable goal of trying to deter people from being transgender, Dr. Levine makes the wholly unsupported statement that transgender people are not attractive to either sex, are unable “to form lasting relationships and attract a desirable mate,” are not loved by others, and do not have friends because people will not be comfortable interacting with them. (Levine, ¶¶ 15j, 133, 135, 151). That may be his own view of transgender people, but it is not at all consistent with clinical experience, including my own. Many transgender people, when appropriately treated, lead fulfilling lives, forming romantic relationships and having families, and having close relationships with friends and extended family.

**THE STATE’S EXPERT WITNESSES MISREPRESENT THE AVAILABILITY OF TREATMENT FOR ADOLESCENTS WITH GENDER DYSPHORIA IN EUROPE**

37. Dr. Levine asserts that a number of countries have concluded that gender-affirming medical care for minors “must be halted.” (Levine, ¶ 94). But none of the countries he discussed—U.K., Finland, or Sweden—has banned care. One children’s hospital in Sweden, in response to the *Bell v. Tavistock* court decision in the U.K. (since overruled), made a decision to stop initiating gender-affirming medical interventions to minors outside of the context of research protocols, but to continue to provide care to existing patients. In none of these countries has a law banning

transition care to minors been enacted and in none of these countries is gender-affirming care for minors unavailable.

Executed on February 11, 2022



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Dan H. Karasic, MD

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# Exhibit 4

1 THE UNITED STATES DISTRICT COURT  
2 FOR THE EASTERN DISTRICT OF ARKANSAS  
3 CENTRAL DIVISION

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4 DYLAN BRANDT, by and through his mother,  
5 JOANNA BRANDT, et al.,  
6 Plaintiffs,

7 vs.

CASE NO.

4:21-CV-00450-JM

8 LESLIE RUTLEDGE, in her official  
9 capacity as the Arkansas  
10 Attorney General, et al.,  
11 Defendants.

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12 ORAL/VIDEOTAPED/VIDEO CONFERENCE  
13 DEPOSITION OF MARK DANIEL REGNARUS  
14 TAKEN ON BEHALF OF THE PLAINTIFFS  
15 LITTLE ROCK, ARKANSAS  
16 ON MAY 5, 2022  
17 9:01 a.m.

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24  
25 REPORTED BY: TRENA K. BLOYE, CSR



<p style="text-align: right;">Page 6</p> <p>1 VIDEO OPERATOR: Good morning. We are  2 going on the record at 9:01 a.m. on May 5th, 2022.  3 Please note that microphones are sensitive and may pick  4 up whispering and private conversations. Please mute  5 your phones at this time. Audio and video recording  6 will continue to take place unless all parties agree to  7 go off the record.  8 This is media unit 1 of the video  9 recorded deposition of Mark Regnarus taken by counsel  10 for Plaintiff in the matter of Dillon Brandt, et al.,  11 versus Leslie Rutledge, et al, filed in the United  12 States District Court, Eastern District of Arkansas,  13 Central Division, Case Number 4:21-cv-00450-JM.  14 The location of the deposition is  15 Arkansas Attorney General's Office, at 323 Center  16 Street, Suite 200 in Little Rock, Arkansas. My name is  17 Mark Tscheimer, the court reporter is Trena Bloye, both  18 representing Veritext. I am not related to any party in  19 this action nor am I financially interested in the  20 outcome. If there are any objections to proceeding,  21 please state them at the time of your appearance.  22 Counsel and all present, including  23 remotely, will now state their appearances and  24 affiliations for the record beginning with the noticing  25 attorney.</p>	<p style="text-align: right;">Page 8</p> <p>1 Q Okay. So this might sound familiar to you. I  2 just have a couple of ground rules off the top. I'll  3 try not to speak over you today, but I'd appreciate it  4 if you let me finish my question so the court reporter  5 can make an accurate record. Please answer every  6 question verbally. The reporter can't take down things  7 like a head nod or a hand gesture. If you need  8 clarification or if a question is ambiguous, just let me  9 know and I'll clarify.  10 I don't intend any of my questions to elicit  11 information protected by attorney-client privilege. If  12 you believe an answer to a question would disclose  13 privileged information, just say so. But for all other  14 questions, please do answer even if there is an  15 objection.  16 I know today is going to be long so I plan to  17 take breaks every hour, hour-and-a-half or so. But if  18 you need a break at any point, just let me know. I just  19 ask that you finish a question that is asked before the  20 break. Does that all sound all right?  21 A It does.  22 Q All right. Great. Are there any materials you  23 are consulting in connection with your testimony today?  24 A Consulting --  25 Q In person with you?</p>
<p style="text-align: right;">Page 7</p> <p>1 MR. RICHARDSON: This is Daniel James  2 Richardson for the plaintiff.  3 MS. ECHOLS: Beth Echols for the  4 plaintiff.  5 MR. STRANGIO: This is Chase Strangio for  6 the ACLU for the plaintiff.  7 MR. CANTRELL: Michael Cantrell, with the  8 Arkansas Attorney General's Office for the Defendants.  9 VIDEO OPERATOR: Madam Reporter, will you  10 please swear in the witness.  11 (The witness was sworn.)  12 VIDEO OPERATOR: Thank you. Please  13 proceed.  14 MARK DANIEL REGNARUS,  15 after having been first duly sworn, deposes and says in  16 reply to the questions propounded as follows, to wit:  17 EXAMINATION  18 BY MR. RICHARDSON:  19 Q Good morning, Dr. Regnarus. Thanks for being  20 here. For the record, can you please just state your  21 full name.  22 A Mark Daniel Regnarus.  23 Q Okay. Great. And you have been deposed  24 before; right?  25 A Once.</p>	<p style="text-align: right;">Page 9</p> <p>1 A -- materials? I'm not sure what you mean by  2 that.  3 Q Do you have any materials today that you will  4 be looking at?  5 A Oh, no.  6 Q Okay. Is there anything that would prevent you  7 from providing complete and accurate testimony today?  8 A I don't think so.  9 Q Have you taken any medicines or substances that  10 would impair your ability to testify?  11 A No.  12 Q All right. What did you do to prepare for your  13 testimony today?  14 A I went back through my witness reports,  15 rebuttals, mine, expert witness on the other side, took  16 notes on mine, summarized it in brief format and  17 reviewed it a few more times.  18 Q Okay. Thanks. Did you meet with counsel  19 before today?  20 A No. I mean, in person?  21 Q In any way to prepare for the testimony today.  22 A Just sort of he telling me what it's going to  23 be like. That's all.  24 Q Okay. How many times did you all talk?  25 A Twice about the deposition.</p>

<p style="text-align: right;">Page 10</p> <p>1 Q Okay. And were those brief conversations?</p> <p>2 A They were. One was just as I came in.</p> <p>3 Q Okay. Did you review any documents with</p> <p>4 counsel?</p> <p>5 A No.</p> <p>6 Q Okay. And have you spoken with anyone else</p> <p>7 other than counsel about your testimony here today?</p> <p>8 A I have a research assistant I asked questions</p> <p>9 of, go look for things and particular statistics and</p> <p>10 things like that.</p> <p>11 Q Okay. Are any of those things in addition to</p> <p>12 what's in your report? Was this research after you</p> <p>13 submitted your report?</p> <p>14 A I try to keep up to date what's going on in the</p> <p>15 field. So, you know, for the report, for today you mean</p> <p>16 or for --</p> <p>17 Q In terms of your preparation for testimony</p> <p>18 today, was this research assistant involved in helping</p> <p>19 you --</p> <p>20 A No, not for opinion.</p> <p>21 Q And anybody else beyond the research assistant</p> <p>22 that you talked to about your testimony today?</p> <p>23 A No.</p> <p>24 Q Are you being paid for your work in this case?</p> <p>25 A I am.</p>	<p style="text-align: right;">Page 12</p> <p>1 MR. RICHARDSON: Okay. And can we get</p> <p>2 Exhibit 2 as well, please?</p> <p>3 (Plaintiff's Exhibit 2 was marked for</p> <p>4 identification and made a part of the</p> <p>5 record.)</p> <p>6 Q And do you recognize that document?</p> <p>7 A I do.</p> <p>8 Q And is that your rebuttal report?</p> <p>9 A Yeah.</p> <p>10 Q Okay. Great. Do you stand by the statements</p> <p>11 in these two reports?</p> <p>12 A I do.</p> <p>13 Q Do these reports contain a complete statement</p> <p>14 of the opinions you intend to provide in this matter?</p> <p>15 A They do.</p> <p>16 Q Okay. Do these reports contain a complete</p> <p>17 statement of the opinions you intend to provide in this</p> <p>18 matter?</p> <p>19 A They do.</p> <p>20 Q Okay. Do these reports contain a complete</p> <p>21 statement of all of the bases and reasons underlying</p> <p>22 your opinions in this matter?</p> <p>23 A They do.</p> <p>24 Q Are there any documents or materials you relied</p> <p>25 on to form your opinions that are not cited in these</p>
<p style="text-align: right;">Page 11</p> <p>1 Q Did the State pay for your travel today?</p> <p>2 A I think they will. They said they will.</p> <p>3 Q Is anyone else compensating you for your work</p> <p>4 in this case?</p> <p>5 A No.</p> <p>6 Q And is your compensation from the State at all</p> <p>7 tied to the outcome of this litigation?</p> <p>8 A No.</p> <p>9 Q Okay. You prepared expert reports in</p> <p>10 connection with that matter; right?</p> <p>11 A I did.</p> <p>12 MR. RICHARDSON: Can you get Exhibit 1,</p> <p>13 please? Okay. Thank you.</p> <p>14 Now mark this Exhibit 1, please.</p> <p>15 (Brief off-the-record discussion.)</p> <p>16 (Plaintiff's Exhibit 1 was marked for</p> <p>17 identification and made a part of the</p> <p>18 record.)</p> <p>19 Q (By Mr. Richardson) All right. Do you</p> <p>20 recognize this document?</p> <p>21 A Yeah. I'm checking to see which -- which --</p> <p>22 what the date was. Got it.</p> <p>23 Q So is this your expert report that you</p> <p>24 submitted in this case?</p> <p>25 A In December, yes.</p>	<p style="text-align: right;">Page 13</p> <p>1 reports?</p> <p>2 A Could you restate that one?</p> <p>3 Q Are there any documents or materials you relied</p> <p>4 on to form your opinions that are not cited in these</p> <p>5 reports?</p> <p>6 A If I -- if there are, I don't recall them. You</p> <p>7 know, I do a thorough literature review on my way to</p> <p>8 writing this. Some of them I cite, some of them I</p> <p>9 don't.</p> <p>10 Q Okay. But nothing comes to mind?</p> <p>11 A No.</p> <p>12 Q Okay. The first document, this is the one</p> <p>13 marked Exhibit 1, that includes your CV; correct?</p> <p>14 A It does. Yeah, it does.</p> <p>15 Q Okay. And is that document accurate to your</p> <p>16 knowledge?</p> <p>17 A Let's see. This is from December. You know,</p> <p>18 it's a little bit updated, but not radically so.</p> <p>19 Q Okay. Any publications come to mind that you</p> <p>20 would add since December?</p> <p>21 A No, I don't think so. I think I had an essay</p> <p>22 or two since then, but nothing in the peer-reviewed</p> <p>23 topic or the book publications.</p> <p>24 Q Okay. Any essays that come to mind as -- as</p> <p>25 written since December?</p>

4 (Pages 10 - 13)

<p style="text-align: right;">Page 14</p> <p>1 A I had an essay in public discourse a couple of 2 months ago. That was about gender and the war in 3 Ukraine. 4 Q Okay. 5 A I think that's -- there might have been one 6 before that, but that's all that comes to mind. 7 Q Okay. So all that you recall is the essay 8 about the war in Ukraine and gender in Public Discourse? 9 A Yeah. Again -- 10 Q Okay. 11 A -- the thing is if it's not on the paper it 12 escapes my mind. 13 Q Okay. 14 A There could be something else, but nothing 15 significant that comes to mind. 16 Q Okay. So -- 17 A That's one I do recall that's probably the most 18 recent. 19 Q Okay. Thank you. So are there any relevant 20 qualifications not included on your CV? 21 A No. 22 Q Okay. And you also submitted declarations 23 opposing the preliminary injunction in this case; 24 correct? 25 A You mean the things back in July?</p>	<p style="text-align: right;">Page 16</p> <p>1 Q Okay. Could you look at Exhibit 4, please? 2 A Okay. 3 Q And do you recognize that document? 4 A I do. 5 Q And is that the Supplemental Declaration you 6 submitted opposing the preliminary injunction? 7 A It is. 8 Q Okay. And do you stand by the statements in 9 those two declarations? 10 A Yes. 11 Q Okay. Are you aware of any inaccuracies in the 12 reports or declarations you submitted in this matter? 13 A I'm not. 14 Q Is there anything in the reports or 15 declarations you would like to amend or correct? 16 A No, nothing comes to mind. 17 Q Have you changed any of your opinions since 18 completing your rebuttal report? 19 A No. 20 Q And have you conducted any additional analysis 21 relevant to this matter since completing your rebuttal 22 report? 23 A What do you mean by additional analysis? 24 Q Just any work, any research work that you have 25 done that would be relevant to your opinions in this</p>
<p style="text-align: right;">Page 15</p> <p>1 Q Yes. 2 MR. RICHARDSON: Can we get Exhibit 3, 3 please? 4 A Right. Okay. And a -- what was the rebuttal, 5 it was a supplementary document. Are we talking about 6 that? I think there are two in July. 7 Q Yes, there should have been two. We will mark 8 this one as Exhibit 3. 9 (Plaintiff's Exhibits 3 and 4 were 10 marked for identification and made a 11 part of the record.) 12 A Thank you. Does this contain both of those or 13 one of these? 14 Q That should be the first one you submitted and 15 then supplemental will be Exhibit 4. 16 A Okay. 17 Q Okay. So looking first at Exhibit 3, you 18 recognize that document? 19 A Exhibit 3? 20 Q Exhibit 3, yes. 21 A I go by the date. Looks like that's the 22 December one, yeah. 23 Q Okay. So that was the report you submitted 24 opposing the preliminary injunction in the case. 25 A Yeah.</p>	<p style="text-align: right;">Page 17</p> <p>1 case? 2 A Public, written, draft? 3 Q Anything that comes to mind, anything that 4 would form your opinions in the case? 5 A I mean, as I said earlier, I have continued 6 reading in this area and keeping up to date. But since, 7 February is the rebuttal, I mean, nothing that I could 8 sort of say, Oh, here, is a new piece of information or 9 a new set of analyses I have done. 10 Q So in terms of keeping up on the research, is 11 there anything you've seen that would inform your views 12 in this case that comes to mind that wouldn't be 13 included in those reports. 14 A Informs my views to shape it differently, you 15 mean? 16 Q To shape the opinions expressed in your 17 reports? 18 A Sure. I -- there are -- as you know, the 19 research in this is pretty dynamic, it's moving fairly 20 quickly, there is lots of new materials published. I 21 have tried my best to keep up with it. So, you know, as 22 recently as yesterday I read something that I hadn't 23 seen before. But it's not as if I stopped in February, 24 submitted it, and said, you know, I'm not adding 25 anything to my mental file until I talk to you folks.</p>

5 (Pages 14 - 17)

<p style="text-align: right;">Page 18</p> <p>1 Q Understood. I just want -- if I'm trying to 2 understand the basis for your expert opinions -- 3 A Right. 4 Q -- are there any reports that would post-date 5 the February -- 6 A That would change it significantly you mean? 7 Q Just inform in any way -- inform your view, 8 change it, reenforce it, whatever that may be? 9 A I don't quite see how that's different from 10 just keeping up with research. 11 Q Okay. So is there any research that comes to 12 mind then? 13 A You know, professor Biggs' stuff out of Oxford, 14 he keeps writing and I find that fairly interesting. 15 Q Anything else come to mind? 16 A I try to keep up to date with what Jack Turban 17 has written. Yeah, I try to keep up to date with it. 18 Q Okay. 19 A Now, if you want to go through each one of 20 those one by one that would be a challenge to me. But 21 different pieces come out, I ask my research assistant 22 to kind of keep her eye on what's new, so she sends me 23 things when they come out. 24 Q But all of the opinions expressed in your 25 report you stand by?</p>	<p style="text-align: right;">Page 20</p> <p>1 that? 2 A No. 3 Q Okay. Any other relevant academic training 4 beyond those degrees? 5 A No. 6 Q Okay. And what is your current position? 7 A Professor of Sociology at University of Texas 8 at Austin. 9 Q Okay. And how long have you been a UT Austin 10 professor? 11 A I think I'm finishing my 20th year. 12 Q And full professor right now; right? 13 A Um-hum. 14 Q And before that associate? 15 A Associate and assistant. 16 Q Okay. Are you also a senior fellow at the 17 Austin Institute for the Study of Family and Culture? 18 A I am. 19 Q Okay. What does the Austin Institute do? 20 A They -- they're kind of a -- they talk about 21 social science of family and marriage and things like 22 that, probably because that's what one of my strengths 23 is. But they have taken on the flavor of their 24 directors over time in their political theorist so they 25 can tack in the direction of content that is more</p>
<p style="text-align: right;">Page 19</p> <p>1 A I do. 2 Q Can you please describe your academic training? 3 A From what stage? 4 Q Let's say high school. 5 A High school? I got a high school degree from 6 it's called McBain Rural Agricultural High School in 7 McBain, Michigan 1989. Bachelor of Arts in Sociology 8 from Trinity Christian College in Palos Heights, 9 Illinois in 1993. I guess Master of Arts in Sociology I 10 think it was 1997, whatever the CV says. And PhD from 11 North Carolina Chapel Hill in 2000, same place. 12 Q So I've got the BA from Trinity Christian 13 College -- 14 A Yeah. 15 Q -- master's from UNC Chapel Hill, PhD from UNC 16 Chapel Hill. 17 A Correct. 18 Q All in sociology? 19 A Everything in sociology, yep. 20 Q Okay. Any other degrees beyond those? 21 A No. 22 Q Any other professional training of any kind? 23 A That would end in, like, a certificate or 24 something? 25 Q Yeah, a certificate program, something like</p>	<p style="text-align: right;">Page 21</p> <p>1 towards great books, literature, political thought, 2 things like that. 3 Q Okay. 4 A They tend to -- undergraduates and graduate 5 students at the University of Texas who are interested 6 in that -- yeah. So there is a variety of senior 7 fellows, some of us don't do much. 8 Q Okay. And -- 9 A I don't frankly do a whole lot for them either, 10 so. 11 Q And what sort of work does a senior fellow do? 12 A Just do what we do. I think they began that a 13 long time ago more for sort of to establish some early 14 credibility, but they don't -- I don't think they pay 15 senior fellows. So -- well, they don't pay me. 16 Q So what is, I mean, in the last year what kind 17 of work have you done with the Austin Institute? 18 A I attend their board meetings because I have a 19 vested interest in, like, what happens at the place. 20 Occasionally I will attend events that they host and I'm 21 friendly with the people who run the place. So I show 22 up and just say hi, drop in, see what's going on. 23 Q Okay. But it's not part of your research 24 agenda you work with the Austin Institute? 25 A Part of my research agenda. Like what do you</p>

<p style="text-align: right;">Page 22</p> <p>1 you mean by that?</p> <p>2 Q Like any of your research projects, do you work</p> <p>3 with the Austin Institute in any kind of capacity or</p> <p>4 network?</p> <p>5 A I have asked them for funding for surveys.</p> <p>6 They have funded or underwritten two or three surveys</p> <p>7 that I've done, so they are helpful in that sense.</p> <p>8 Q Okay. Anything else?</p> <p>9 A Anything else -- you said related to the</p> <p>10 research --</p> <p>11 Q Or your teaching, anything about your work.</p> <p>12 A Oh, not teaching. They have asked me to lead a</p> <p>13 four-week seminar, you know, once a week in the evenings</p> <p>14 on the last book I wrote. Public dissemination of</p> <p>15 research. I guess quotes don't go well on -- sorry.</p> <p>16 Public dissemination of research.</p> <p>17 Q So besides, like, board meetings and book talks</p> <p>18 and things like that, and the funding for certain</p> <p>19 research projects, nothing else with the Austin</p> <p>20 Institute comes to mind?</p> <p>21 A No.</p> <p>22 Q Okay. Does the Austin Institute have a view on</p> <p>23 gender identity?</p> <p>24 MR. CANTRELL: Object to form.</p> <p>25 A Do they have a view, like the organization has</p>	<p style="text-align: right;">Page 24</p> <p>1 the book?</p> <p>2 A I suspect it's fine. I just don't recall my</p> <p>3 thoughts of when I looked at it.</p> <p>4 Q Okay. Does the Austin Institute have a view on</p> <p>5 same sex marriage?</p> <p>6 A I would have to sort of say the same thing</p> <p>7 about that.</p> <p>8 Q Okay.</p> <p>9 A I mean, does the organization of which I am an</p> <p>10 unpaid senior fellow have a perspective. It would take</p> <p>11 on the character of its staff.</p> <p>12 Q And does the leadership of the Austin Institute</p> <p>13 have a view on same sex marriage?</p> <p>14 A Yes.</p> <p>15 Q And do you know that view?</p> <p>16 A Opposed.</p> <p>17 Q It's opposed?</p> <p>18 A Yeah.</p> <p>19 Q And do you share that view?</p> <p>20 A I do.</p> <p>21 Q And is the Austin Institute a religious</p> <p>22 organization in any way?</p> <p>23 A It is not.</p> <p>24 Q So no affiliation in any sense?</p> <p>25 A No.</p>
<p style="text-align: right;">Page 23</p> <p>1 a view?</p> <p>2 Q (By Mr. Richardson) Well, yeah, is there an</p> <p>3 organizational view?</p> <p>4 A Not that we've ever discussed it explicitly.</p> <p>5 The director and his wife have created some materials</p> <p>6 for -- they sell them online -- for kind of how to</p> <p>7 understand gender identity and sexuality, I think. And</p> <p>8 they used to run a few seminars for interested parties</p> <p>9 to go through that book.</p> <p>10 Q Okay. And can you just briefly summarize the</p> <p>11 views in that book?</p> <p>12 A I would have to give you the briefest of</p> <p>13 overviews because I'm -- honestly, I have glanced at the</p> <p>14 book, tried to make sure it, you know, didn't say</p> <p>15 anything empirically unverifiable. But I'm sure it's</p> <p>16 critical of modern gender etiology. But it has been a</p> <p>17 long time since I looked at that book and I have not</p> <p>18 attended their seminars for it, so -- so insofar as one</p> <p>19 would want to presume that the opinions of the director</p> <p>20 and his wife as reflected in that book are the opinions</p> <p>21 of the organization, you could probably feel free to do</p> <p>22 that.</p> <p>23 Q Do you agree with the content of the book?</p> <p>24 A I'd have to, you know, take a look at the book.</p> <p>25 Q Okay. So you have no view on the content of</p>	<p style="text-align: right;">Page 25</p> <p>1 Q Was this position included in your CV?</p> <p>2 A The position?</p> <p>3 Q Your position as a senior fellow at the Austin</p> <p>4 Institute?</p> <p>5 A Is it? It's in my signature file of most</p> <p>6 emails. I don't know if it's in here. I mean, it's not</p> <p>7 a professional appointment. It's -- so it is not in my</p> <p>8 CV, no, but it is available online, as you have probably</p> <p>9 already seen.</p> <p>10 Q Okay. And why is that position not included?</p> <p>11 A It's not a professional appointment. I mean,</p> <p>12 it's a --</p> <p>13 Q Okay.</p> <p>14 A These are sort of university-based</p> <p>15 appointments. I don't think it's ever occurred to me to</p> <p>16 put it in there.</p> <p>17 Q Okay. Are there other professional activities</p> <p>18 of any kind not included on your CV?</p> <p>19 A Professional activities?</p> <p>20 Q Things like being a senior fellow at an</p> <p>21 institute or receiving research funding from an</p> <p>22 organization.</p> <p>23 A I think I'm on Baylor University's -- I want to</p> <p>24 say it's Institute of Religion, Institute for Study of</p> <p>25 Religion, I think I'm a fellow there that's not on here.</p>

<p style="text-align: right;">Page 26</p> <p>1 It's these pro forma things that I don't include.</p> <p>2 Q I understand. I just to make sure I have the</p> <p>3 full range.</p> <p>4 A Let me think if there is something else. Give</p> <p>5 me a second. I will try to make my way around that</p> <p>6 space. You may know more than I do on this, so I'll</p> <p>7 agree if it's true.</p> <p>8 Q So nothing else comes to mind besides Baylor?</p> <p>9 A It doesn't, yeah. And that one sort of -- I</p> <p>10 think it's largely -- is it pro forma the term where</p> <p>11 it's -- they want it for their own publicity not because</p> <p>12 I do anything for them.</p> <p>13 Q Okay. So do you attend meetings of that group</p> <p>14 like kind of --</p> <p>15 A I have not attended a formal meeting. I have</p> <p>16 done an informal meeting where we are talking with one</p> <p>17 of the -- just to catch up with one of the staff.</p> <p>18 Q Gotcha. Okay. And do you, like, meet with</p> <p>19 Baylor students as part of that role at all --</p> <p>20 A No.</p> <p>21 Q -- or Baylor faculty?</p> <p>22 A Strictly a handful of faculty.</p> <p>23 Q Okay. And does that faculty group get together</p> <p>24 and meet under that umbrella?</p> <p>25 A I have no idea.</p>	<p style="text-align: right;">Page 28</p> <p>1 sociology of religion at UT that had come open, so I</p> <p>2 thought I should apply.</p> <p>3 Q All right. And did you also work at the</p> <p>4 Carolina Population Center?</p> <p>5 A As a post-doc research associate, yeah, for I</p> <p>6 guess that was a year. I was a pre-doc in it for a year</p> <p>7 and post-doc in it for a year.</p> <p>8 Q And what sort of work did you do for the</p> <p>9 center?</p> <p>10 A That is -- it's the kind of thing -- like the</p> <p>11 population center at UT where you have pre-doc,</p> <p>12 post-docs, and largely they are to pursue their own</p> <p>13 research interests, and often in conjunction with a</p> <p>14 advisor type person who you work under. So that's what</p> <p>15 I did.</p> <p>16 Q Okay.</p> <p>17 A Yeah.</p> <p>18 Q And in your current role as a professor at UT,</p> <p>19 what do you teach?</p> <p>20 A I teach -- the last few years I have taught</p> <p>21 two-two load, two spring, two in the fall. And those</p> <p>22 have included three sections of "Undergraduate Research</p> <p>23 Methods" and one, it's called a signature course. It's</p> <p>24 a unique course that the university, by state</p> <p>25 law asks -- State Legislature asked, sort of mandated</p>
<p style="text-align: right;">Page 27</p> <p>1 Q Okay. All right. Thanks. So after graduating</p> <p>2 Trinity Christian College did you work anywhere prior to</p> <p>3 UT?</p> <p>4 A Prior to UT? As in academic jobs or anything?</p> <p>5 Q Anything that comes to mind. Any professional</p> <p>6 work between graduating --</p> <p>7 A Before I -- after I got out of college?</p> <p>8 Q Let's stick to academic jobs.</p> <p>9 A Okay. Because I can go through what I did</p> <p>10 before I got into graduate school.</p> <p>11 Not academic, no. You said after Trinity? UT?</p> <p>12 Q Anything between, you know, finishing your</p> <p>13 education and starting at UT?</p> <p>14 A Calvin College, I was there for a year.</p> <p>15 Q Okay.</p> <p>16 A That's here.</p> <p>17 Q And why did you leave Calvin College?</p> <p>18 A Texas was a nice job, it was at a research</p> <p>19 university and it attracted me. Calvin job was near my</p> <p>20 family. It was to run a research center and help the</p> <p>21 faculty kind of become more research oriented. But no</p> <p>22 sooner did I get there than this Texas position opened</p> <p>23 and I felt like applying, not because I didn't like</p> <p>24 Calvin, but because at the time I was a sociologist of</p> <p>25 religion squarely, and that there were two jobs in</p>	<p style="text-align: right;">Page 29</p> <p>1 the university teach. So it's special topics courses</p> <p>2 that they are interested in so undergraduates get a --</p> <p>3 an experience of small-ish class at a large university</p> <p>4 taught by the professor, so I teach one of those. It's</p> <p>5 called Catholicism and Social Thought.</p> <p>6 Q Okay.</p> <p>7 A I teach that in the fall.</p> <p>8 Q Okay.</p> <p>9 A I taught it for the last five fall semesters.</p> <p>10 Q Okay. And it's kind of like a seminar, then.</p> <p>11 Is that roughly accurate?</p> <p>12 A Um-hum.</p> <p>13 Q Okay.</p> <p>14 A Correct.</p> <p>15 Q And do you supervise doctoral students?</p> <p>16 A Actively or ever?</p> <p>17 Q Let's say ever, since you joined UT.</p> <p>18 A I have.</p> <p>19 Q Okay.</p> <p>20 A That's listed, I think, in the CV, unless I</p> <p>21 gave you a short version of it. Let me see if it's</p> <p>22 there. Yeah, it's there. Next-to-last page.</p> <p>23 Q Gotcha.</p> <p>24 A I have none currently. Actually, I need to add</p> <p>25 somebody to the plan 2 supervision for honors.</p>

<p style="text-align: right;">Page 30</p> <p>1 Q Oh, down for the undergraduate?</p> <p>2 A Undergraduate thesis supervision for honors.</p> <p>3 Q Okay.</p> <p>4 A And I'll have one of those. I just haven't</p> <p>5 updated it.</p> <p>6 Q In terms of the PhD supervision and master's</p> <p>7 supervision, it looks like there hasn't been a master's</p> <p>8 candidate since 2013 and a PhD candidate since 2016. Is</p> <p>9 that correct?</p> <p>10 A It appears that way on here. I'm trying to</p> <p>11 recall if I haven't updated it or not. This is kind of</p> <p>12 part of the CV that I don't spend tons of time on. MA.</p> <p>13 Yeah, that may be accurate. Nobody comes to mind.</p> <p>14 Q Okay. And why have you not served on the</p> <p>15 committee in all that time?</p> <p>16 A I haven't been asked.</p> <p>17 Q So the students sort of -- how does that work?</p> <p>18 The students decide who they want to advise?</p> <p>19 A Yeah, yeah.</p> <p>20 Q Okay. And each committee has, what, like a</p> <p>21 chair and two other people?</p> <p>22 A The MA, I think it's a chair and maybe two</p> <p>23 readers, and the other one is usually a chair and three</p> <p>24 or four readers.</p> <p>25 Q Okay. So in that, you know, the last six years</p>	<p style="text-align: right;">Page 32</p> <p>1 you could say Catholicism and Socialism Thought is part</p> <p>2 of that, but it's not squarely sociology of religion.</p> <p>3 And then kind of the, I guess, the grandfather of it all</p> <p>4 changed positions.</p> <p>5 So for a while the sociology of religion sort</p> <p>6 of section, we offered a kind comprehensive exam in it</p> <p>7 for years. But, you know, the students kind of</p> <p>8 graduated, the last few are listed there I think. And</p> <p>9 then, you know, the first fellow left and the rest of</p> <p>10 us -- I mean, I drifted into other topics and one didn't</p> <p>11 get tenure and one still teaches a class in it, but --</p> <p>12 so they stopped offering -- the department stopped</p> <p>13 offering a comprehensive exam with our, you know,</p> <p>14 permission, because half of us weren't there anymore.</p> <p>15 Q Yeah.</p> <p>16 A So there aren't really students to supervise in</p> <p>17 religion.</p> <p>18 Q Okay. Thank you. And have you appeared as an</p> <p>19 expert in any other cases besides this one?</p> <p>20 A Expert in any other cases? I did, yes. What's</p> <p>21 the name of it? Something versus U.S. Department of</p> <p>22 Education. Hunter?</p> <p>23 Q Yeah.</p> <p>24 A And was joined by the CCCU, yes.</p> <p>25 Q Okay. So that's Hunter v Department of</p>
<p style="text-align: right;">Page 31</p> <p>1 or so, no students have asked?</p> <p>2 A That is correct.</p> <p>3 Q Why do you think that is?</p> <p>4 A Because they have decided they don't want me on</p> <p>5 their committee.</p> <p>6 Q I mean, it looks like you were on committees</p> <p>7 quite frequently before that. Is there --</p> <p>8 A Well, I was more squarely in the sociology of</p> <p>9 religion up until -- I still dabble in it, the last</p> <p>10 book. But these are mostly Sociology of Religion</p> <p>11 students.</p> <p>12 Q And does the university still have those</p> <p>13 students?</p> <p>14 A Have the students?</p> <p>15 Q Are there still students pursuing the same</p> <p>16 training that these students were --</p> <p>17 A No. And it's not because I changed, but</p> <p>18 because the primary professor who was squarely in</p> <p>19 sociology of religion and who chaired a majority of</p> <p>20 these -- these dissertations left the university in, it</p> <p>21 was probably '11 or '12 I think. I could be wrong.</p> <p>22 So there were one, two, three -- four of us in</p> <p>23 the Sociology of Religion. And one didn't get tenure,</p> <p>24 one kind of dabbles in it still and teaches a class on</p> <p>25 it. I haven't taught a class on it in a while. Well,</p>	<p style="text-align: right;">Page 33</p> <p>1 Education. Can you briefly describe the nature of your</p> <p>2 testimony in that case?</p> <p>3 A Briefly describe the nature of my testimony --</p> <p>4 Q Briefly just the views you offered in that case</p> <p>5 as an expert?</p> <p>6 A Do you want to talk about the case first or</p> <p>7 the --</p> <p>8 Q Sure. I mean, just a brief summary of the</p> <p>9 claim and then maybe what your --</p> <p>10 A Yeah. It would be helpful to walk backwards to</p> <p>11 the case itself. This is -- I think the organization is</p> <p>12 called REAP, R-E-A-P. It's an acronym. I can't</p> <p>13 remember what it stands for, probably religious</p> <p>14 something, that organizes a series of plaintiffs who are</p> <p>15 students, current or former, at Christian universities</p> <p>16 and colleges, most of which I think were in the</p> <p>17 coalition for Christian colleges and universities, but</p> <p>18 not all of them.</p> <p>19 And they filed suit against the U.S. Department</p> <p>20 of Education, I believe because it's seeking to end</p> <p>21 their Title IX -- their college's Title IX exemptions</p> <p>22 out of a sense of dissatisfaction with what they call</p> <p>23 discriminatory treatment about sexuality and gender</p> <p>24 identity in the college conduct codes.</p> <p>25 Q Gotcha.</p>

<p style="text-align: right;">Page 34</p> <p>1 A So I was approached to consider an expert  2 witness report on that topic.  3 Q Okay.  4 A So --  5 Q And you were an expert for the defendant in  6 that case?  7 A Yes.  8 Q Okay.  9 A I always have to stop for a second like  10 plaintiffs, defendants. Which one did what? Yes,  11 that's correct.  12 Q And were you also an expert in a case called  13 DeBoer against Snyder?  14 A Yes. Sorry. That's before that.  15 Q Can you just briefly described that, the nature  16 of that case?  17 A That was a -- essentially it was packaged as a  18 same-sex marriage case. I think it did involve an  19 adoption case at some level at first. State of  20 Michigan, federal district court in Detroit. I think  21 there were four or five of us as Defendants' witnesses  22 for the State of Michigan.  23 Q Okay. And anything besides the Hunter case and  24 DeBoer where you served as an expert?  25 A I don't think so. But if you know one it</p>	<p style="text-align: right;">Page 36</p> <p>1 Q Gotcha.  2 A To me, the names are largely irrelevant so I  3 lose track of what the names are. But the Obergafell  4 has kind of -- it's memorable, so I don't forget that  5 one very easily. Bostock. But there was two cases, the  6 Bostock one and the Harris.  7 Q Yeah, R.G &amp; G.R. versus Harris Funeral Homes?  8 A Yeah. That was the one I wrote for. I did not  9 write for the Bostock, but I guess they got packaged  10 together.  11 Q Okay. So it sounds like there was Masterpiece  12 Cakes versus Colorado Civil Rights Commission.  13 A Correct.  14 Q Obergafell against Hodges.  15 A Yes.  16 Q United States against Windsor.  17 A Yeah.  18 Q And then Bostock v. Clayton County consolidated  19 with --  20 A Yeah.  21 Q -- Harris Funeral Homes.  22 A And if there is another one -- I am blanking on  23 it. It might be. No, I don't think so. It was either  24 four or five.  25 Q Okay. But nothing else comes to mind besides</p>
<p style="text-align: right;">Page 35</p> <p>1 may --  2 Q No problem. And have you participated in any  3 other cases without serving as an expert, including as  4 an amicus?  5 A Yeah. I think they have all been supreme court  6 cases, but I could wrong about that. I think I've  7 written briefs in the Masterpiece case. I probably  8 wrote -- well, wrote or joined?  9 Q Wrote or joined.  10 A Yeah. Some of these I joined, some of these I  11 helped sort of format the main arguments. And I  12 probably -- I probably could recall which ones were  13 which, whether I wrote it or joined it. Is it Windsor  14 that first one? I think that was the first time I had  15 written an amicus brief. No. I think I joined that  16 one.  17 Then there was Obergafell and to the  18 Masterpiece. The one that's now known as -- as the  19 Georgia County? When I -- in my mind it's the Detroit  20 Funeral Home case.  21 Q Okay.  22 A I don't remember what the exact name of it is.  23 It got packaged and now it's known as --  24 Q Does Bostock sound right?  25 A Yes. Thank you.</p>	<p style="text-align: right;">Page 37</p> <p>1 these?  2 A It doesn't. Some sort of law search could  3 correct that if I'm mistaken.  4 Q Okay. So you mentioned that you have degrees  5 in sociology and nothing else; right?  6 A Correct.  7 Q That's all of your academic training?  8 A Um-hum.  9 Q Okay. Did your academic training include  10 training on how to provide medical care?  11 A No.  12 Q Any training at all in medicine?  13 A No.  14 Q Did it include training on how to test the  15 efficacy of medical interventions?  16 A The training did not, although I have learned  17 about that since.  18 Q Okay. But your formal training through the PhD  19 did not?  20 A Well, no. It depends on the -- repeat the  21 question before I answer that, would you?  22 Q Did your academic training include training on  23 how to test the efficacy of medical interventions?  24 A Yeah. I mean, it has helped me understand how  25 to do group differences, of course.</p>

<p style="text-align: right;">Page 38</p> <p>1 Q Okay.</p> <p>2 A Now, it depends on the kind of medical study</p> <p>3 we're talking about. So some of the plaintiff's expert</p> <p>4 witnesses conduct medical research using group</p> <p>5 differences analyses, those sort of statistics --</p> <p>6 Q Yeah.</p> <p>7 A -- that I did get training on. So it all</p> <p>8 depends on what you mean by medical studies.</p> <p>9 Q Okay.</p> <p>10 A Some people are -- they're statistical and</p> <p>11 methodological research training focuses on that, like</p> <p>12 epidemiology. Mine is more on sort of general</p> <p>13 statistical methods, but they overlap enough that I'm</p> <p>14 able to evaluate the research that -- that I talk about.</p> <p>15 Q Okay. So your training includes general social</p> <p>16 science methods training; right?</p> <p>17 A Statistical training.</p> <p>18 Q That sort of -- statistical training.</p> <p>19 A Methods in statistics.</p> <p>20 Q Yeah.</p> <p>21 A This is, like, how to collect data.</p> <p>22 Q Um-hum.</p> <p>23 A Which medical researchers do as well. So there</p> <p>24 is a lot of overlap there.</p> <p>25 Q Yeah.</p>	<p style="text-align: right;">Page 40</p> <p>1 Q Yeah.</p> <p>2 A You will use textbooks that are written by, um,</p> <p>3 epidemiologists, demographers, sort of pure</p> <p>4 statisticians, things like that. So I don't remember --</p> <p>5 I'm sure I've solved research problems in stats class,</p> <p>6 advanced quantitative methods that were about, you know,</p> <p>7 medical problems.</p> <p>8 Q But not focused on. It would be in the same</p> <p>9 way any subject matter could come up in a course like</p> <p>10 that.</p> <p>11 A Not focused in the way if you went to get a</p> <p>12 degree at a department of biostatistics, they are</p> <p>13 probably more focused on that.</p> <p>14 Q Okay.</p> <p>15 A Sure.</p> <p>16 Q And it wouldn't have included any training on</p> <p>17 how to diagnose or treat medical conditions?</p> <p>18 A That is correct.</p> <p>19 Q Okay. Did it include any training on how to</p> <p>20 diagnose or treat mental health conditions?</p> <p>21 A No.</p> <p>22 Q Okay. Did it include any training on medical</p> <p>23 care or psychological treatment for transgender people?</p> <p>24 A State it again, please.</p> <p>25 Q Did your training include any training on</p>
<p style="text-align: right;">Page 39</p> <p>1 A There is also statistical training, which is</p> <p>2 how to assess, you know, things like efficacy,</p> <p>3 statistical significance, affect sizes, things like</p> <p>4 that.</p> <p>5 Q Okay.</p> <p>6 A So there is overlap with that as well. It</p> <p>7 wasn't through a medical school or a medical degree that</p> <p>8 I got that. But they do certainly apply.</p> <p>9 Q Was there a medical focus to the training?</p> <p>10 Were the courses focused on how to --</p> <p>11 A I'll give you an example.</p> <p>12 Q Okay.</p> <p>13 A My best friend in graduate school, we both went</p> <p>14 to the same program at UNC. I entered the academic</p> <p>15 career. He entered using the same PhD, same degree,</p> <p>16 entered the sort of medical research field. He's going</p> <p>17 to be more well versed in, I think, it's mostly cardiac</p> <p>18 research than I am, but we lean on a comparable training</p> <p>19 for preparing us.</p> <p>20 Q Understood, yeah. But would any of the courses</p> <p>21 you took or the research you did in your academic</p> <p>22 training have been focused on the efficacy of medical</p> <p>23 interventions?</p> <p>24 A The training? Well, training is often generic.</p> <p>25 It depends on who writes the textbook.</p>	<p style="text-align: right;">Page 41</p> <p>1 medical care or psychological treatment for transgender</p> <p>2 people?</p> <p>3 A No. But my training ended in 2000.</p> <p>4 Q Yeah.</p> <p>5 A So fairly early for this topical of matter.</p> <p>6 Q So you feel that in 2000 there would not have</p> <p>7 been anything to study on -- related to transgender</p> <p>8 people?</p> <p>9 MR. CANTRELL: Object to form.</p> <p>10 A Not nothing, but sort of -- it was -- a lot of</p> <p>11 this research came after 2000, a lot of which we</p> <p>12 discussed. But that said, that research training would</p> <p>13 not have talked about diagnoses. They may have talked</p> <p>14 about criterion perhaps --</p> <p>15 Q (By Mr. Richardson) Okay.</p> <p>16 A -- if I had studied, you know, that. I had a</p> <p>17 professor who I didn't take a class with, but who had</p> <p>18 written -- wrote in gender identity so -- at the</p> <p>19 Carolina Population Center, but I didn't take a class</p> <p>20 from him.</p> <p>21 Q So there were courses, then, offered during</p> <p>22 your academic training about gender identity, you just</p> <p>23 didn't take them.</p> <p>24 A No. On gender in general.</p> <p>25 Q Gender in general. Okay.</p>

<p style="text-align: right;">Page 42</p> <p>1 A Yeah. I'm sure there are courses, or at least</p> <p>2 a course, I did not take it. It was not in my research</p> <p>3 interests at the time.</p> <p>4 Q Did you take any courses on gender?</p> <p>5 A I just told you I did not.</p> <p>6 Q Okay. And did your academic training involve</p> <p>7 education on transgender healthcare or transgender</p> <p>8 dysphoria?</p> <p>9 A My education, no.</p> <p>10 Q Okay. Have you published any academic books or</p> <p>11 peer review articles in your career?</p> <p>12 A Yes.</p> <p>13 Q How many would you say just roughly?</p> <p>14 A You want me to count?</p> <p>15 Q You don't need to count. Just a rough estimate</p> <p>16 is all right.</p> <p>17 A I have -- in my bio online I say 40'ish.</p> <p>18 Q Forty'ish? Okay.</p> <p>19 A But I'm sure it's probably not 40 exactly.</p> <p>20 Q Okay. And books, what, four or five?</p> <p>21 A Four.</p> <p>22 Q Okay. And did any of those works discuss the</p> <p>23 effectiveness of medical treatment?</p> <p>24 A No. Um, books did you say?</p> <p>25 Q The four books or the peer-reviewed articles.</p>	<p style="text-align: right;">Page 44</p> <p>1 Q Okay. Great. How would you describe your</p> <p>2 major areas of research?</p> <p>3 A Um, I tend to characterize my research as about</p> <p>4 relationship behavior, sexual decisionmaking, some about</p> <p>5 sexuality and family formation, marriage, and some of</p> <p>6 sociology of religion.</p> <p>7 Q So looking at your work on relationships, would</p> <p>8 it be fair to say that work is primarily focused on</p> <p>9 heterosexual relationships?</p> <p>10 A Primarily --</p> <p>11 Q Okay.</p> <p>12 A -- not exclusively.</p> <p>13 Q Okay. And have you ever conducted research</p> <p>14 related to transgender people?</p> <p>15 MR. CANTRELL: Object to form.</p> <p>16 A I have fielded a survey that asks a pair of</p> <p>17 questions about that, yeah.</p> <p>18 MR. RICHARDSON: Okay. Can I get Exhibit</p> <p>19 14, please, Beth? Thank you.</p> <p>20 (Plaintiff's Exhibit 14 was marked for</p> <p>21 identification and made a part of the</p> <p>22 record.)</p> <p>23 THE WITNESS: Your question was again?</p> <p>24 COURT REPORTER: Hold on, hold on.</p> <p>25 THE WITNESS: Sorry. Your question was</p>
<p style="text-align: right;">Page 43</p> <p>1 A Only public opinion about the effectiveness.</p> <p>2 Q Okay.</p> <p>3 A One article.</p> <p>4 Q Okay. So it gauged people's views towards</p> <p>5 care, but not an assessment whether or not care is</p> <p>6 effective?</p> <p>7 A Correct.</p> <p>8 Q Do any of those works discuss the effectiveness</p> <p>9 of psychological care?</p> <p>10 A The published works?</p> <p>11 Q The four books or the peer-reviewed articles.</p> <p>12 A Right. No. I have written essays towards this</p> <p>13 end --</p> <p>14 Q Okay.</p> <p>15 A But not peer reviewed essays.</p> <p>16 Q Gotcha. Do any of these works, the</p> <p>17 peer-reviewed articles or the academic books, assess the</p> <p>18 efficacy of medical interventions at all?</p> <p>19 A Not the peer-reviewed stuff.</p> <p>20 Q Okay. And do any of these works address</p> <p>21 treatment for gender dysphoria?</p> <p>22 A The peer reviewed stuff you mean?</p> <p>23 Q The peer reviewed or the books to the extent</p> <p>24 you --</p> <p>25 A No.</p>	<p style="text-align: right;">Page 45</p> <p>1 what?</p> <p>2 Q (By Mr. Richardson) Oh, the last question I</p> <p>3 asked was have you ever conducted research related to</p> <p>4 transgender people.</p> <p>5 A The data collection that -- issued in this</p> <p>6 article, yes.</p> <p>7 Q And can you just describe the research in that</p> <p>8 article, please?</p> <p>9 A The research or the conclusions or what?</p> <p>10 Q Maybe just a brief summary of the research and</p> <p>11 your conclusions?</p> <p>12 A The research question was evaluating what</p> <p>13 affected American adults' attitudes towards, as the</p> <p>14 title says, "Hormonal or Surgical Interventions For</p> <p>15 Adolescents Experiencing Gender Dysphoria."</p> <p>16 Q Gotcha. And you tested that through a survey?</p> <p>17 A I did.</p> <p>18 Q Okay. And was that the 2018 Post-Mid Term</p> <p>19 Election Study; is that right?</p> <p>20 A Correct.</p> <p>21 Q Okay. And were the people surveyed</p> <p>22 transgendered people?</p> <p>23 A They were -- it was a nationally representative</p> <p>24 sample of Americans. So in so far as there are</p> <p>25 transgender persons in America, and there are, they are</p>

<p style="text-align: right;">Page 46</p> <p>1 included in this. Let me see what -- we have a -- if  2 you see on Table 1.  3 Q Yes.  4 A Page -- well --  5 Q It's not paged.  6 A Well, no page. Table 1, far right column,  7 percent of N.  8 Q Um-hum.  9 A Go down to self IDs as transgender. It's the  10 fifth from the bottom.  11 Q Yeah.  12 A 1.7. So 1.7 percent of the population weighted  13 in that survey self-identified as transgender.  14 Q Okay. The survey, because it's nationally  15 representative, it's largely about cisgender people's  16 view towards gender-affirming care for transgender  17 adolescents.  18 A Could you repeat that?  19 Q So is the survey largely based on cisgender  20 people's approval or disapproval of gender-affirming  21 care for transgender people?  22 A Yeah, the study -- the survey itself --  23 Q Yeah.  24 A -- okay, asked all sorts of questions.  25 Q Yeah.</p>	<p style="text-align: right;">Page 48</p> <p>1 Q Okay. Did you interview or talk with any  2 transgender youth as part of that work?  3 A For this, no.  4 Q Okay. Did you interview or talk with any  5 healthcare providers who treat transgender youth as part  6 of this work?  7 A Not as part of this study, no.  8 Q Okay. So just stepping back, this is the one  9 study that came to mind on transgender people; right?  10 Nothing else?  11 A Peer reviewed.  12 Q Nothing peer reviewed or in an academic book.  13 A Correct.  14 Q So would it be fair to say that transgender  15 people and gender dysphoria are not the primary subjects  16 of your research?  17 A It's fair to say that I have had a more active  18 interest in this area in the past, I'd say, three  19 years --  20 Q Okay.  21 A -- four years. So I'm moving in that  22 direction.  23 Q Okay. But if I was to focus on the  24 peer-reviewed work and the academic books, would it be a  25 fair characterization that transgender people are not</p>
<p style="text-align: right;">Page 47</p> <p>1 A And like any researcher, we take what we're  2 interested in looking at and includes control variables,  3 et cetera. So what emerges was our interest in knowing  4 what the people, quote/unquote, thought about hormonal  5 and surgical interventions for adolescent transgender  6 minors.  7 Q Gotcha.  8 A So insofar as that's the question you asked, is  9 that right?  10 Q Yes, yes.  11 A Okay.  12 Q So it's fair to say that in your study, the  13 vast majority of people surveyed on the question you  14 care about were transgender people?  15 MR. CANTRELL: Object to form.  16 A They were not -- they are not transgender,  17 correct.  18 Q (By Mr. Richardson) Okay. And these were not  19 experts you were surveying. These were just regular  20 folks.  21 A Regular people.  22 Q Okay. Great. And did that paper at all  23 discuss the efficacy of the treatment for adolescents  24 that's being discussed?  25 A No, I don't believe so.</p>	<p style="text-align: right;">Page 49</p> <p>1 the primary focus of those works?  2 A I have a variety of research interests --  3 Q Yeah.  4 A -- and one of the things that's characterized  5 my entire career is that I have studied in an area for  6 several years, get interested in a different area --  7 Q Yeah.  8 A -- for several years --  9 Q Yeah.  10 A So you might say, oh, you have done a lot in  11 the relationship behavior, domain, heterosexual  12 relationship mostly, again, because I'm mostly geared  13 towards what the average American population expresses.  14 But that I started in -- 1994 I went to graduate  15 school --  16 Q Um-hum.  17 A -- mostly sociology of religion. I changed a  18 little bit of directions toward sexual relationship  19 behavior and decisionmaking in 2005'ish, and, you know,  20 in the last several years I've turned with a more  21 interest in these matters. So that is not yet reflected  22 in the academic peer-reviewed publication record.  23 Q Okay. So your -- your peer-reviewed  24 publication record confining to that, it would be fair  25 to say, does not yet reflect a primary interest in</p>

<p style="text-align: right;">Page 50</p> <p>1 transgender people?</p> <p>2 A It does not yet reflect my current interest in</p> <p>3 it, no.</p> <p>4 Q Understood. And earlier when I asked you your</p> <p>5 primary areas of research you said relationship</p> <p>6 behavior, sexual decisionmaking, sexuality, family</p> <p>7 formation, and the sociology of religion.</p> <p>8 A That has characterized my publication record.</p> <p>9 Q And none of those are about transgender people?</p> <p>10 MR. CANTRELL: Object to form.</p> <p>11 A I don't make explicit reference or forays of</p> <p>12 research into that in my published research until very</p> <p>13 recently.</p> <p>14 Q Okay. And when you say published research, if</p> <p>15 we're talking about peer-reviewed research --</p> <p>16 (Simultaneous crosstalk.)</p> <p>17 Q -- you mean just this one survey?</p> <p>18 A Correct.</p> <p>19 Q Okay. Thank you. Okay. So you mention you</p> <p>20 currently teach, it was in introductory sociology</p> <p>21 course. You teach that three sections a year, and then</p> <p>22 you have the seminar.</p> <p>23 A Not an introductory sociology.</p> <p>24 Q I'm sorry. What was that course?</p> <p>25 A Research Methods --</p>	<p style="text-align: right;">Page 52</p> <p>1 Q Okay. Some --</p> <p>2 (Simultaneous crosstalk.)</p> <p>3 A -- research.</p> <p>4 Q So students, they're learning about</p> <p>5 quantitative analysis methods. They are --</p> <p>6 A They are learning about quantitative in that</p> <p>7 class, they are learning about qualitative methods in</p> <p>8 that class.</p> <p>9 Q Gotcha.</p> <p>10 A Um-hum.</p> <p>11 Q Okay. And they'll be looking at different data</p> <p>12 sets to try things out or to do their own research? I'm</p> <p>13 just trying to figure out --</p> <p>14 A Right.</p> <p>15 Q -- what they do in this course.</p> <p>16 A Right.</p> <p>17 MR. CANTRELL: Object to the form.</p> <p>18 A It depends on how I run the class. But I'll</p> <p>19 ask them to analyze existing statistics and conduct</p> <p>20 their own interview data. So different methods teachers</p> <p>21 do a little bit differently.</p> <p>22 Q (By Mr. Richardson) Gotcha. So medical</p> <p>23 research would come into play there the same as any</p> <p>24 other kind of research, might as like an example they</p> <p>25 could look at for data?</p>
<p style="text-align: right;">Page 51</p> <p>1 Q Research Methods course.</p> <p>2 A -- for majors.</p> <p>3 Q Gotcha. Okay. And then you have the</p> <p>4 upper-level course, Catholicism and Social --</p> <p>5 A It's not an upper-level course.</p> <p>6 Q Sorry. I'm --</p> <p>7 A It's a freshman course.</p> <p>8 Q All right. Sorry. I'm not in academia so I</p> <p>9 apologize.</p> <p>10 A Not at all.</p> <p>11 Q So those are the courses you're currently</p> <p>12 teaching?</p> <p>13 A Currently.</p> <p>14 Q Okay.</p> <p>15 A Um-hum.</p> <p>16 Q Do any of those courses relate to medical care?</p> <p>17 A Research methods I use a variety of medical</p> <p>18 examples in it. Some social, some medical, some</p> <p>19 political, some religious examples. So we have a</p> <p>20 section about experimental research, which is not common</p> <p>21 in sociology, but some people do it. So I will use a</p> <p>22 medical example --</p> <p>23 Q Okay.</p> <p>24 A -- occasionally, but not a -- it's not a course</p> <p>25 that's focused on medical research --</p>	<p style="text-align: right;">Page 53</p> <p>1 A Right, but it's not something that I focus on.</p> <p>2 Q Okay.</p> <p>3 A Since they are sociology students they --</p> <p>4 Q Yeah.</p> <p>5 A -- they would like certain topics more than</p> <p>6 others. So mostly I stick to social research --</p> <p>7 Q Yeah.</p> <p>8 A -- examples.</p> <p>9 Q So sociology students generally don't study at</p> <p>10 medicine.</p> <p>11 A That is correct.</p> <p>12 Q And don't have an interest in looking at</p> <p>13 medical --</p> <p>14 A That is correct.</p> <p>15 Q -- data. So do any of those courses relate to</p> <p>16 psychology or mental healthcare?</p> <p>17 A More overlap in psychology.</p> <p>18 Q Okay. And for the same reason, because of the</p> <p>19 methods course?</p> <p>20 A I'm sorry.</p> <p>21 Q And is this because of the methods course or</p> <p>22 because of the seminar?</p> <p>23 A The methods course.</p> <p>24 Q It's the methods course.</p> <p>25 A Yeah.</p>

<p style="text-align: right;">Page 54</p> <p>1 Q Okay. And is that --</p> <p>2 A You know, it is a social science --</p> <p>3 Q Yeah.</p> <p>4 A -- and so there's a good deal of overlap</p> <p>5 between psychology and sociology and social psychology.</p> <p>6 So more of my examples would come from psychology than</p> <p>7 from pure medicine.</p> <p>8 Q Gotcha. And do these -- would the students be</p> <p>9 learning how to test the efficacy of a mental health</p> <p>10 treatment as part of this work?</p> <p>11 A No.</p> <p>12 Q Okay. Do any of those courses relate to gender</p> <p>13 dysphoria?</p> <p>14 A Again, as examples I might use one as a measure</p> <p>15 example or a -- a sort of a professional scenario --</p> <p>16 Q Um-hum.</p> <p>17 A -- especially when we're talking about</p> <p>18 measurement issues, because I think some of the things</p> <p>19 about -- for example stigma. There's a lot of</p> <p>20 disagreement about how to measure it, so I use that</p> <p>21 example with students in the class.</p> <p>22 Q Okay. But gender dysphoria is not -- not a</p> <p>23 primary focus of the work?</p> <p>24 A No.</p> <p>25 Q And do you teach any courses related to gender</p>	<p style="text-align: right;">Page 56</p> <p>1 Q Gotcha. And then in the -- in the seminar</p> <p>2 there is one day on gender identity?</p> <p>3 A About a day, yeah. No more than a day.</p> <p>4 Q Okay. And the emphasis there is about the</p> <p>5 views of the Catholic church on gender identity or --</p> <p>6 A Catholicism in general and understanding what</p> <p>7 the teachings of the church say on this and what</p> <p>8 Catholic thinkers of various sorts, how they understand</p> <p>9 that.</p> <p>10 Q Okay. And thinking back before your current</p> <p>11 2-2 course load, have you ever taught courses related to</p> <p>12 gender identity?</p> <p>13 A No.</p> <p>14 Q How about gender dysphoria?</p> <p>15 A A course on gender dysphoria?</p> <p>16 Q A course that had gender dysphoria as a primary</p> <p>17 subject to be covered in the course.</p> <p>18 A No.</p> <p>19 Q Okay. And have you ever practiced medicine in</p> <p>20 any way?</p> <p>21 A Only at home. Sorry. I mean --</p> <p>22 Q Have you ever provided mental healthcare?</p> <p>23 A We're talking about professional?</p> <p>24 Q Professional.</p> <p>25 A Not professional mental health. A listening</p>
<p style="text-align: right;">Page 55</p> <p>1 identity?</p> <p>2 A I don't.</p> <p>3 Q Okay. And thinking back to earlier courses you</p> <p>4 taught in your career --</p> <p>5 A I do briefly discuss it in my seminar class.</p> <p>6 Q How does that come up?</p> <p>7 A Uh, Catholicism and social thought, it's one of</p> <p>8 the domains. I think we cover it no more than one day.</p> <p>9 About how the Catholic church understands gender</p> <p>10 identity, yeah.</p> <p>11 Q Okay. So looking across the two courses you</p> <p>12 currently teach --</p> <p>13 A Um-hum.</p> <p>14 Q -- there is no primary focus on any of these</p> <p>15 issues in the methods course and then there is one day</p> <p>16 on gender identity in the seminar.</p> <p>17 A Say that first part again. Sorry.</p> <p>18 Q So for the methods course, there is no primary</p> <p>19 focus on medical interventions, psychological care, or</p> <p>20 gender dysphoria?</p> <p>21 MR. CANTRELL: Object to form.</p> <p>22 A Not a primary focus.</p> <p>23 Q (By Mr. Richardson) It comes up as an example?</p> <p>24 A References and, you know, measures, methods and</p> <p>25 that sort of thing.</p>	<p style="text-align: right;">Page 57</p> <p>1 ear --</p> <p>2 Q Yeah.</p> <p>3 A -- with regularity.</p> <p>4 Q Okay. And have you ever worked in a medical or</p> <p>5 mental health clinical setting of any kind?</p> <p>6 A No.</p> <p>7 Q Have you ever consulted with those working in a</p> <p>8 medical or mental health clinical setting as part of</p> <p>9 your professional work?</p> <p>10 MR. CANTRELL: Object to form.</p> <p>11 A Consulted as -- can you give me an example of</p> <p>12 that looks like?</p> <p>13 Q (By Mr. Richardson) Sure. Has doctor at a</p> <p>14 clinic ever reached out to you for consultation in how</p> <p>15 they provide their care?</p> <p>16 A Not in how they provide their care. I'm sure</p> <p>17 I've talked to doctors about some of the directions in</p> <p>18 which pediatric medicine is flowing, but not as sort of</p> <p>19 a here is how you should do your job kind of</p> <p>20 conversation.</p> <p>21 Q Okay. So those doctors aren't reaching out to</p> <p>22 you for guidance on how to provide care?</p> <p>23 A Illumination about trends.</p> <p>24 Q So they are reaching out to you to understand</p> <p>25 trends in medicine?</p>

15 (Pages 54 - 57)

<p style="text-align: right;">Page 58</p> <p>1 A More like trends popularly. Right?</p> <p>2 Q So help me understand. So a doctor has a</p> <p>3 patient and they would call you --</p> <p>4 A Usually it's not a particular patient.</p> <p>5 Q Okay.</p> <p>6 A They are just -- and these are typically social</p> <p>7 exchanges.</p> <p>8 Q Okay.</p> <p>9 A It's not like, Hey, I heard that you are good</p> <p>10 at X, Y, and Z. You know, they might seek me out in a</p> <p>11 conversation. Typically I already know these people.</p> <p>12 Q Okay.</p> <p>13 A We don't discuss particular patients that I</p> <p>14 have recalled. But some people know that I'm a</p> <p>15 sociologist who is active in this domain and research</p> <p>16 area and, you know, they want to chat.</p> <p>17 Q Okay. So these are -- these are social</p> <p>18 interactions. These aren't doctors formally reaching</p> <p>19 out --</p> <p>20 A Correct.</p> <p>21 Q -- for guidance? Okay. Have you ever been</p> <p>22 part of a group that established or revised medical</p> <p>23 standards?</p> <p>24 A Not medical standards. Survey, research.</p> <p>25 Q Okay. And what were those experiences?</p>	<p style="text-align: right;">Page 60</p> <p>1 A Not that I'm -- you know.</p> <p>2 Q Okay.</p> <p>3 A I don't think so.</p> <p>4 Q Okay. So we have walked through, you know,</p> <p>5 your academic training, your professional experience,</p> <p>6 teaching otherwise, and your peer-reviewed scholarship.</p> <p>7 A Yeah.</p> <p>8 Q Would it be fair to say that you have no</p> <p>9 academic training, professional experience or</p> <p>10 peer-reviewed scholarship related to the efficacy of</p> <p>11 medical care?</p> <p>12 MR. CANTRELL: Object to form.</p> <p>13 A Peer reviewed?</p> <p>14 Q (By Mr. Richardson) Yes.</p> <p>15 A I have things that I have put down in essay</p> <p>16 form --</p> <p>17 Q Yeah.</p> <p>18 A -- things that I have put down in these reports</p> <p>19 and, you know, sort of actively working on keeping up to</p> <p>20 date on this research form, not reflected in peer-</p> <p>21 reviewed publications.</p> <p>22 Q Okay. So we'll get to the work outside of the</p> <p>23 peer-reviewed context. So would it be fair to say,</p> <p>24 then, that you have academic training, professional</p> <p>25 experience or peer-reviewed scholarship related to the</p>
<p style="text-align: right;">Page 59</p> <p>1 A Oh, a long time ago I helped consult with the</p> <p>2 National Longitudinal Study of Adolescent Health, which</p> <p>3 is now the National Longitudinal Study of Adolescent and</p> <p>4 Adult Health I think.</p> <p>5 COURT REPORTER: Say that one more time.</p> <p>6 I'm sorry. The what?</p> <p>7 THE WITNESS: Sure, sure. I'm sorry.</p> <p>8 The National -- the title today is National Longitudinal</p> <p>9 Study of Adolescent and Adult Health.</p> <p>10 Way back at the beginning of their, I</p> <p>11 think it was their first of second wave of data</p> <p>12 collection. National Study of Family Growth, I have</p> <p>13 consulted on, uh, survey items of theirs. I have</p> <p>14 fielded three surveys of my own, four. But that's not</p> <p>15 really consulting.</p> <p>16 And your original question was --</p> <p>17 Q (By Mr. Richardson) Have you ever been part of</p> <p>18 a group that established or revised medical standards?</p> <p>19 A Medical standards. By medical standards you</p> <p>20 mean like treatment, protocols, things like this?</p> <p>21 Q That would certainly be included. Is there</p> <p>22 anything else that comes to mind on a broader</p> <p>23 definition?</p> <p>24 A I don't think so.</p> <p>25 Q Okay. So that's a no?</p>	<p style="text-align: right;">Page 61</p> <p>1 efficacy of medical care?</p> <p>2 MR. CANTRELL: Object to form.</p> <p>3 A Efficacy of medical care.</p> <p>4 Q (By Mr. Richardson) Yes.</p> <p>5 A Well, if you want to talk about -- you know, I</p> <p>6 don't know if you have this example, it's a publication,</p> <p>7 with you, the Hatzenbuehler article, 2016, 2017. I</p> <p>8 guess it's less about medical care and more about my</p> <p>9 assessment of the sort of methodological accuracy of</p> <p>10 their work. He's involved squarely in this domain,</p> <p>11 especially in the study of stigma.</p> <p>12 Q Sorry. When you say "this domain," what do you</p> <p>13 mean by that?</p> <p>14 A The domain of sexual and gender identity --</p> <p>15 Q Okay.</p> <p>16 A -- and health outcomes. Let me take a look at</p> <p>17 my CV. That's about health outcomes, not about</p> <p>18 prescriptions for things. Although, Hatzenbuehler --</p> <p>19 there is often prescriptive interpretations to these</p> <p>20 studies. And so when I -- you know, when I show that</p> <p>21 his 2014 article on structural stigma was not -- I</p> <p>22 couldn't replicate the essential finding, and then he</p> <p>23 admitted that it was, I believe, a coding error or</p> <p>24 something like that.</p> <p>25 Q Okay. And -- I'm sorry. Where is this on your</p>

<p style="text-align: right;">Page 62</p> <p>1 CV? I'm just trying to follow along here.</p> <p>2 A 2017.</p> <p>3 Q Okay.</p> <p>4 A "Structural Stigma's Effect on the Mortality of</p> <p>5 Sexual Minorities" --</p> <p>6 Q Gotcha.</p> <p>7 A -- "Robust. Failure to replicate the results</p> <p>8 of a published study."</p> <p>9 Q Gotcha.</p> <p>10 A So in that original study, if I'm not mistaken,</p> <p>11 and I -- if you have a copy I would appreciate being</p> <p>12 able to look at it. In his original study he'll often</p> <p>13 sort of makes real world or medical recommendations</p> <p>14 based on the findings of his study. So when one comes</p> <p>15 along and can't replicate his study he basically</p> <p>16 declares it invalid and then his study is retracted. I</p> <p>17 didn't make any sort of --</p> <p>18 Q Yeah.</p> <p>19 A -- medical claims about, you know, ignore</p> <p>20 whatever Hatzenbuehler says about structural stigma.</p> <p>21 I'm just saying this study isn't -- isn't correct.</p> <p>22 Q Okay.</p> <p>23 A So I didn't offer medical advice in it,</p> <p>24 although undermining somebody who has, it's tacit, a</p> <p>25 suggestion to, you know, think again before using this</p>	<p style="text-align: right;">Page 64</p> <p>1 So you can map, you know, when people who are</p> <p>2 participating in the general source survey passed way</p> <p>3 and you look at what they are like, et cetera. And so</p> <p>4 he had made the claim that stigma against sexual</p> <p>5 minorities led to premature deaths. Stigma among your</p> <p>6 neighbors, basically those who lived in the same county</p> <p>7 with you -- which is a generous definition of neighbors.</p> <p>8 Sometimes that's how research works -- led to the</p> <p>9 premature death of sexual minorities by 12 years.</p> <p>10 I read that. This was already in print or had</p> <p>11 been through a peer-reviewed process. One of the</p> <p>12 co-authors did the data merge. He's well familiar with</p> <p>13 public health, all of them, like distinguished positions</p> <p>14 in the academy. And I thought, how is it that you would</p> <p>15 have thought that stigma could knock off more years of</p> <p>16 somebody's life than smoking a pack a day for 20 years.</p> <p>17 So that made me suspicious.</p> <p>18 Q Okay.</p> <p>19 A And so I and my research assistant pursued a</p> <p>20 replication of the study. I presume it would be</p> <p>21 replicable. And then able to find, like, how did it do</p> <p>22 this? Let's look at some alternative arrangements. But</p> <p>23 we could not actually replicate the original study,</p> <p>24 especially on the key effect.</p> <p>25 Q Gotcha. And do you think somebody in the</p>
<p style="text-align: right;">Page 63</p> <p>1 article as a suggestion about medical treatment, but not</p> <p>2 direct advice from me.</p> <p>3 Q Okay. So you've -- so once again, your</p> <p>4 academic training, professional experience,</p> <p>5 peer-reviewed scholarship includes no research from you</p> <p>6 that would be used to assess the effectiveness of a</p> <p>7 medical treatment?</p> <p>8 MR. CANTRELL: Object to form.</p> <p>9 A Only indirectly if people had decided that</p> <p>10 whatever Hatzenbuehler's claim was in this paper was not</p> <p>11 valid.</p> <p>12 Q (By Mr. Richardson) Okay. And Hatzenbuehler,</p> <p>13 do you know his -- is he a -- he or she. Sorry.</p> <p>14 A Public health.</p> <p>15 Q Public health. Okay.</p> <p>16 A Same first name.</p> <p>17 Q So this study from 2017 is, you know,</p> <p>18 Hatzenbuehler had a study saying structural stigma</p> <p>19 caused some kind of harm; correct?</p> <p>20 A Oh, yeah. He said it lopped off an average of</p> <p>21 10 -- no -- 12 years of life from sexual minorities,</p> <p>22 sexual and transgender minorities, but I can't remember</p> <p>23 that for sure. In -- and this is a national study of</p> <p>24 the general social survey, population based, attached to</p> <p>25 the National Death Index.</p>	<p style="text-align: right;">Page 65</p> <p>1 medical profession would have used Hatzenbuehler's study</p> <p>2 to decide whether a particular treatment protocol was</p> <p>3 appropriate for a patient?</p> <p>4 MR. CANTRELL: Object to form.</p> <p>5 A I wouldn't know that. I just know that there</p> <p>6 is research in this domain that employs data and methods</p> <p>7 that are not as strong as they ought to be and make</p> <p>8 claims about it and seem to have reached into the</p> <p>9 clinical domain.</p> <p>10 Q (By Mr. Richardson) Okay.</p> <p>11 A But I cannot confirm those.</p> <p>12 Q So you don't know what kind of materials</p> <p>13 medical doctors consult to determine treatment</p> <p>14 protocols?</p> <p>15 A Okay. Switching gears here. Could you repeat</p> <p>16 that question?</p> <p>17 Q So when I asked you about Dr. Hatzenbuehler's</p> <p>18 report, if it was used by medical professionals to treat</p> <p>19 patients, you said you don't know.</p> <p>20 A I do not know, no.</p> <p>21 Q And so you don't know if your research</p> <p>22 rebutting his report would have been used by medical</p> <p>23 professionals to treat patients?</p> <p>24 A I don't know that.</p> <p>25 Q And that was the only article you mentioned</p>

<p style="text-align: right;">Page 66</p> <p>1 when I asked you for relevant writing about --</p> <p>2 A I will say one thing, if I may.</p> <p>3 Q Okay. Sure.</p> <p>4 A His articles were retracted, but it was only</p> <p>5 retracted after I finally wrote the journal publisher,</p> <p>6 because both of our articles remained in print at the</p> <p>7 same journal, Social Science and Medicine, and, uh, his</p> <p>8 was quite popular and continued picking up citations at</p> <p>9 a pretty good clip, and mine saying there's no evidence</p> <p>10 that this is -- there is active evidence that this is</p> <p>11 factually false and he admitted it already in print.</p> <p>12 And, you know, I wasn't racking up many citations at</p> <p>13 all, so I finally said, These two can't really be in</p> <p>14 print at the same time, and eventually the editors</p> <p>15 agreed and retracted his.</p> <p>16 But whether, you know, that changed anybody's</p> <p>17 mind in a clinical setting, I have no idea.</p> <p>18 Q Okay. So you don't know if your paper would</p> <p>19 have any utility to a medical provider determining</p> <p>20 whether or not to provide a certain treatment to a</p> <p>21 patient?</p> <p>22 MR. CANTRELL: Object to form.</p> <p>23 A I have no knowledge of that.</p> <p>24 Q (By Mr. Richardson) And that was the only --</p> <p>25 A I'm not sure how I could.</p>	<p style="text-align: right;">Page 68</p> <p>1 A I said I have no idea.</p> <p>2 Q You have no idea.</p> <p>3 A Yeah.</p> <p>4 Q So you don't know if a doctor would, you know,</p> <p>5 gain anything from reading either Exhibit 14 or your</p> <p>6 paper rebutting Dr. Hatzenbuehler?</p> <p>7 MR. CANTRELL: Object to form.</p> <p>8 A Since I don't keep active track of citations</p> <p>9 for this, I don't know. One can go into the citation</p> <p>10 index, see how it's been cited, both of these papers, by</p> <p>11 whom. So it's plausible and even possible that it has</p> <p>12 indirect applicability by peer-reviewed articles that</p> <p>13 have cited these studies.</p> <p>14 Q Okay.</p> <p>15 A But I have not paid attention to that.</p> <p>16 Q And that would be peer-reviewed literature in</p> <p>17 medical journals that you have in mind?</p> <p>18 A Yeah. I mean, it's searchable.</p> <p>19 Q Okay. And you don't keep track of --</p> <p>20 A So Social Science and Medicine is a crossover</p> <p>21 journal between --</p> <p>22 Q Yeah.</p> <p>23 A -- both science -- social science and medicine.</p> <p>24 Q And you don't know if it's being used for that</p> <p>25 purpose because you don't keep track of what's in</p>
<p style="text-align: right;">Page 67</p> <p>1 Q And that was the only paper you brought up when</p> <p>2 I asked for peer-reviewed scholarship related to the</p> <p>3 efficacy of medical care; correct?</p> <p>4 A About the sort of -- from a physician's</p> <p>5 perspective of this last one we talked about sort of</p> <p>6 popular assessment of medical permissibility, which I</p> <p>7 presume has something to do with perceived efficacy, but</p> <p>8 it's not about physicians, per se. It's about</p> <p>9 physicians conduct.</p> <p>10 Q Okay. So your survey, then, this Exhibit 14,</p> <p>11 is that what you're referring to?</p> <p>12 A Correct.</p> <p>13 Q Okay. Your survey, you're saying that, at some</p> <p>14 level, tells you something about the effectiveness of</p> <p>15 gender-affirming care?</p> <p>16 A No. It tells readers about what Americans</p> <p>17 think of who ought to be eligible for particular kinds</p> <p>18 of interventions.</p> <p>19 Q Okay. And you just said that a doctor would</p> <p>20 consider that kind of public opinion irrelevant</p> <p>21 when deciding on a treatment protocol?</p> <p>22 MR. CANTRELL: Object to form.</p> <p>23 A You're saying I said it?</p> <p>24 Q (By Mr. Richardson) Correct me if I am wrong.</p> <p>25 I thought --</p>	<p style="text-align: right;">Page 69</p> <p>1 medical journals?</p> <p>2 (Simultaneous crosstalk.)</p> <p>3 A -- my citation index.</p> <p>4 Q Okay. Do you keep track of what's published in</p> <p>5 medical journals?</p> <p>6 A Do I keep track of what's published in medical</p> <p>7 journals?</p> <p>8 MR. CANTRELL: Object to form.</p> <p>9 Q (By Mr. Richardson) Yeah.</p> <p>10 A As I indicated earlier, I asked my research</p> <p>11 assistant to kind of keep an eye on what's coming out</p> <p>12 and send me things that she finds interesting.</p> <p>13 Q Okay.</p> <p>14 A So I do keep track some, not for the purpose of</p> <p>15 seeing if my name appears in print, but seeing about</p> <p>16 what's going on.</p> <p>17 Q Okay. So not to belabor it, but --</p> <p>18 A All right.</p> <p>19 Q So when I ask you for relevant peer-reviewed</p> <p>20 scholarship regarding the efficacy of medical treatments</p> <p>21 you pointed me towards --</p> <p>22 A Say it like it's -- start slowly, please.</p> <p>23 Q Peer-reviewed scholarship related to the</p> <p>24 efficacy of medical treatments. You pointed me to</p> <p>25 Exhibit 14, which is the survey, and a paper you wrote,</p>

<p style="text-align: right;">Page 70</p> <p>1 I believe in 2016 or 2017, refuting Dr. Hatzenbuehler's  2 research on stigma; correct?  3 A Not refuting. Finding that it was not --  4 Q Sure.  5 A It's a mistake.  6 Q Yeah. The inability to replicate  7 Dr. Hatzenbuehler's study.  8 A Yeah. It was, you know -- correct.  9 Q Okay. So those are the two. Anything else?  10 MR. CANTRELL: Object to form.  11 A Publications. Influence? Peer reviews?  12 Q (By Mr. Richardson) Peer-reviewed scholarship  13 that would relate --  14 A Written by me.  15 Q Written by you.  16 A Okay. You're not counting my work on -- as a  17 peer reviewer of journal articles in these domains?  18 Q No, sir.  19 A Okay. Because that also happens.  20 Q So those are the two?  21 A I believe so.  22 Q Okay. And you -- is it correct that you told  23 me that you're not sure if either of those would be  24 relied on by a medical doctor deciding whether or not to  25 provide certain treatment?</p>	<p style="text-align: right;">Page 72</p> <p>1 right.  2 MR. CANTRELL: Okay. I'll continue to  3 object.  4 THE WITNESS: So could you repeat that?  5 Q (By Mr. Richardson) Would it be fair to say  6 you have no academic training, professional experience,  7 or peer-reviewed scholarship related to the efficacy of  8 psychological care?  9 MR. CANTRELL: Object to form.  10 A Efficacy of psychological care. We're talking  11 about psychiatry, psychotherapy?  12 Q (By Mr. Richardson) The kind of thing that  13 would be considered by a mental health provider in  14 deciding the appropriate course of treatment. Let's put  15 it that way.  16 A Which could be both psychiatry or psychology;  17 right? I mean, some of my work, I think tracks the  18 direction of social psychology. But whether  19 providers -- you know, I hear from counselors. Do you  20 consider counselors psychological care? I sort of  21 would.  22 Q Do you mean like school counselors or what do  23 you have in mind?  24 A Psychotherapists, people who are -- somebody is  25 on the couch talking to them about their issues.</p>
<p style="text-align: right;">Page 71</p> <p>1 MR. CANTRELL: Object to form.  2 A I would not know it if they did.  3 Q (By Mr. Richardson) So you don't know?  4 A That is correct.  5 Q Okay. And would it be accurate to say that you  6 don't have academic training, professional experience,  7 or peer-reviewed scholarship related to the efficacy of  8 psychological care?  9 MR. CANTRELL: Object to form.  10 A Efficacy of psychological care. So we're  11 moving from medical care to psychological care?  12 MR. CANTRELL: Dan, could we take those  13 one at time? You're listing a and/or I think --  14 MR. RICHARDSON: Well, yeah. If there is  15 anything in any category the answer would be yes, I have  16 something. So I think I just want to get a summary of  17 the three things we talked about. Because I asked those  18 questions within each topic. So if there is any  19 relevant experience within any three I think the answer  20 would be that statement is not accurate.  21 MR. CANTRELL: I just think it might be  22 helpful to ask one at a time.  23 MR. RICHARDSON: Well, I think we walked  24 through each category. So I just to -- I'm trying to  25 summarize sort of what we've heard so far if that's all</p>	<p style="text-align: right;">Page 73</p> <p>1 Q Sure. So have they told you they consult your  2 research, your peer-reviewed research?  3 A I'd say, the book Cheap Sex has been talked  4 about a lot, including by counselors. And whether they  5 take it up with their patients I don't know. But that  6 one has had a long track record, and especially with  7 regards to people, you know, counselors talking to  8 patients or -- about the things that they could learn  9 from that book.  10 Q Gotcha.  11 A So it's a little bit like the last example  12 where I won't know except as if they've reached out to  13 me. Some have done so and sort of thanked me for it,  14 you know, it's helped them in talking to people.  15 But -- so a little more demonstrable in terms  16 of the things I hear back from people than in the  17 medical community, which I wouldn't hear from. Make  18 sense?  19 Q Yeah, I think so.  20 A It's kind of wordy.  21 Q I'll just put a finer point on it if that's all  22 right to help make it a little more concrete.  23 Would it be fair to say that you don't have  24 academic training, professional experience, or  25 peer-reviewed scholarship related to the efficacy of</p>

<p style="text-align: right;">Page 74</p> <p>1 treatment for gender dysphoria?</p> <p>2 MR. CANTRELL: Object to form.</p> <p>3 A True.</p> <p>4 MR. RICHARDSON: Okay. I think if it's</p> <p>5 all right with you, now might be a good time for a</p> <p>6 break. Does that sound all right, Doctor?</p> <p>7 VIDEO OPERATOR: Okay. This will end</p> <p>8 media part 1 and we are off the record at 10:22 a.m.</p> <p>9 (A break was had.)</p> <p>10 VIDEO OPERATOR: We are back on the</p> <p>11 record at 10:35 a.m. This will begin media part 2.</p> <p>12 Please proceed.</p> <p>13 MR. CANTRELL: Let's go ahead and put on</p> <p>14 the record those who came in.</p> <p>15 MR. SULLIVAN: This is Gary Sullivan with</p> <p>16 the ACLU of Arkansas for the plaintiffs.</p> <p>17 MS. COOPER: Yes. This is Leslie Cooper</p> <p>18 of the ACLU for plaintiffs.</p> <p>19 MR. RODGERSON: This is Brandyn</p> <p>20 Richardson of Sullivan &amp; Cromwell, LLP, for the</p> <p>21 plaintiffs.</p> <p>22 MR. RICHARDSON: Is that everybody?</p> <p>23 Q (By Mr. Richardson) All right. Great. I'd</p> <p>24 like to pick up where we were just talking about, but</p> <p>25 focus solely on peer-reviewed scholarship that you have</p>	<p style="text-align: right;">Page 76</p> <p>1 Q Okay. But you don't recall any essential</p> <p>2 interactions of medical professionals where they ask for</p> <p>3 views on the direction of medicine in this area or</p> <p>4 gender identity broadly?</p> <p>5 A Just, you know, in passing sort of like --</p> <p>6 Q Okay.</p> <p>7 A -- as a friend of a friend kind of thing.</p> <p>8 Q Okay. What would you typically say in response</p> <p>9 to a question like that?</p> <p>10 A Some of the same things I've said in my report.</p> <p>11 You know, I think the research methodology we hear is</p> <p>12 often problematic, measurements, analytic procedures</p> <p>13 that are questionable, measures that are questionable,</p> <p>14 effects and effect sizes that are questionable.</p> <p>15 Um, yeah, it's fair to say that I'm -- I find</p> <p>16 the domain of research not what it ought to be and not</p> <p>17 what it tends to be in other domains of medicine so far</p> <p>18 as I can tell.</p> <p>19 Q Okay. You mentioned that you've written some</p> <p>20 non-peer-reviewed pieces relevant to transgender people;</p> <p>21 right?</p> <p>22 A Yes.</p> <p>23 Q Okay. I'm going to show you Exhibit 5.</p> <p>24 (Plaintiff's Exhibit 5 was marked for</p> <p>25 identification and made a part of the</p>
<p style="text-align: right;">Page 75</p> <p>1 authored.</p> <p>2 A Okay.</p> <p>3 Q Would it be fair to say that you have no</p> <p>4 peer-reviewed scholarship on the effectiveness of</p> <p>5 medical treatment?</p> <p>6 MR. CANTRELL: Object to form.</p> <p>7 A Not at present.</p> <p>8 Q (By Mr. Richardson) Okay. Thank you. And</p> <p>9 earlier in a response to a question I asked you</p> <p>10 mentioned that doctors sometimes will come to you to</p> <p>11 talk about the overall direction of research. Do you</p> <p>12 remember saying that?</p> <p>13 A Socially some may ask me about, you know,</p> <p>14 what's going on, like, culturally about what's going on</p> <p>15 with marriage.</p> <p>16 Q Do they ever come to you to talk to you about</p> <p>17 the research of gender identity or gender dysphoria?</p> <p>18 A Research in particular? I don't recall</p> <p>19 conversations towards that end. They may have occurred</p> <p>20 socially.</p> <p>21 Q But nothing comes to mind?</p> <p>22 A Not as, you know, they will leave a message on</p> <p>23 my phone saying I'm doctor so-and-so from Houston, I</p> <p>24 wanted to consult with you on the research. Not like</p> <p>25 that, no.</p>	<p style="text-align: right;">Page 77</p> <p>1 record.)</p> <p>2 A Thank you.</p> <p>3 Q Do you recognize that document?</p> <p>4 A I do.</p> <p>5 Q Is this an article you wrote in Public</p> <p>6 Discourse entitled "Arkansas and the Politics of</p> <p>7 Experimenting on Children."</p> <p>8 A Correct.</p> <p>9 Q Does this piece contain any independent</p> <p>10 research about the effectiveness of medical or</p> <p>11 psychological treatment?</p> <p>12 A I would have to go back and read it --</p> <p>13 Q Sure.</p> <p>14 A -- and give it a three, four-minute skim and</p> <p>15 then ask that question again?</p> <p>16 Q Will do.</p> <p>17 (The witness reviewed the document.)</p> <p>18 Q Apologize, professor. How is it coming?</p> <p>19 A I've got about two pages left. When I've</p> <p>20 written something I usually move on to the next thing.</p> <p>21 Q I understand.</p> <p>22 A So I appreciate the chance of going back to see</p> <p>23 what I said.</p> <p>24 (The witness reviewed the document.)</p> <p>25 Q Is this piece published in Public Discourse?</p>

20 (Pages 74 - 77)

<p style="text-align: right;">Page 78</p> <p>1 A Yes.</p> <p>2 Q Is Public Discourse a peer-reviewed journal?</p> <p>3 A It's reviewed by the editorial team.</p> <p>4 Q Yeah.</p> <p>5 A Which I am on for a particular domain.</p> <p>6 Q But you wouldn't --</p> <p>7 A So we don't send it out to other people unless</p> <p>8 it involves, at least in my domain, unless it involves</p> <p>9 some topic or form of methodology that, at least in my</p> <p>10 domain, that I don't understand. But I don't typically</p> <p>11 do that. The other editors might. It's not</p> <p>12 peer-reviewed in that we send it all to academics,</p> <p>13 because some of the people who submit stuff are not</p> <p>14 academics.</p> <p>15 Q Okay. So when I asked for peer-reviewed</p> <p>16 articles and if I look at your CV for peer-reviewed</p> <p>17 articles --</p> <p>18 A I don't put this in that --</p> <p>19 Q Public Discourse --</p> <p>20 A -- classification.</p> <p>21 Q Gotcha.</p> <p>22 A Right.</p> <p>23 Q Gotcha. And after having reviewed it does this</p> <p>24 piece contain any independent research by you about the</p> <p>25 effectiveness of mental or psychological treatment?</p>	<p style="text-align: right;">Page 80</p> <p>1 write, I think it was another Public Discourse piece</p> <p>2 about calculating the number needed to treat, which is</p> <p>3 an epidemiological statistic and found it rather high.</p> <p>4 It's basically a signal of, um -- a signal of small</p> <p>5 effect size. And given that that entity was about -- I</p> <p>6 think it was about surgeries, surgery is kind of a</p> <p>7 significant thing. So I thought small effect over ten</p> <p>8 years, I think it was, especially in the tenth year,</p> <p>9 ninth, tenth year is where you started to see the effect</p> <p>10 of surgery on improved medical -- improved use of</p> <p>11 psychotherapy services if I recall correctly.</p> <p>12 But I thought, well, an entity of 49 is -- is</p> <p>13 pretty high. You have to treat 49 people before you can</p> <p>14 expect to demonstrably help one out in this outcome.</p> <p>15 So --</p> <p>16 Q Okay. But --</p> <p>17 A It's not peer reviewed, no. I reported it in a</p> <p>18 previous issue of Public Discourse.</p> <p>19 Q Gotcha. And this NNT calculation doesn't</p> <p>20 appear in Exhibit 5?</p> <p>21 A No. A link to the one that it refers to does.</p> <p>22 MR. RICHARDSON: Gotcha. Okay.</p> <p>23 Can we get Exhibit 7, please, Beth?</p> <p>24 THE WITNESS: Is that that one?</p> <p>25 MR. RICHARDSON: Good guess.</p>
<p style="text-align: right;">Page 79</p> <p>1 MR. CANTRELL: Object to form.</p> <p>2 A Not so much independent -- actually what kind</p> <p>3 of research?</p> <p>4 Q Research about the effectiveness of</p> <p>5 psychological or medical treatment.</p> <p>6 MR. CANTRELL: Form.</p> <p>7 A So one of the references in here on whatever</p> <p>8 page -- it doesn't have a page -- a study released last</p> <p>9 month in the Journal of Sexual Medicine -- no, not that</p> <p>10 one. I'm sorry. A study appearing in the October 2019</p> <p>11 edition of the American Journal of Psychiatry declared</p> <p>12 that gender-affirming surgery was associated with</p> <p>13 reduced demand for subsequent mental health treatment, a</p> <p>14 sample of Swedish adults diagnosed with gender</p> <p>15 incongruence. Although that conclusion eventually</p> <p>16 succumbed to a correction, the authors' overreaching</p> <p>17 claims about the efficacy of surgical treatment on</p> <p>18 subsequent use of mental health services, the original</p> <p>19 version had already observed no effect of time since</p> <p>20 initiating hormone treatment on the likelihood of</p> <p>21 subsequently receiving mental health treatment.</p> <p>22 After the correction the authors admitted that</p> <p>23 surgeries did not yield the anticipated benefit in</p> <p>24 either.</p> <p>25 I did not participate in the correction. I did</p>	<p style="text-align: right;">Page 81</p> <p>1 (Plaintiff's Exhibit 7 was marked for</p> <p>2 identification and made a part of the</p> <p>3 record.)</p> <p>4 THE WITNESS: I'll need less time with</p> <p>5 this, but a couple of minutes still. Thank you.</p> <p>6 (The witness reviewed the document.)</p> <p>7 THE WITNESS: Okay.</p> <p>8 Q (By Mr. Richardson) So you recognize that</p> <p>9 document?</p> <p>10 A I do.</p> <p>11 Q And this is your article "New Data Show</p> <p>12 'Gender-Affirming' Surgery Doesn't Really Improve Mental</p> <p>13 Health So Why Are the Study's Authors Saying It Does?"</p> <p>14 A Correct.</p> <p>15 Q Okay. Great. And this has the number to treat</p> <p>16 calculation?</p> <p>17 A Correct.</p> <p>18 Q And just to clarify, this is also in Public</p> <p>19 Discourse; right?</p> <p>20 A Um-hum.</p> <p>21 Q And based on the prior definition, Public</p> <p>22 Discourse is not a peer-reviewed journal.</p> <p>23 A Correct.</p> <p>24 Q Have you ever published that number-needed-</p> <p>25 to-treat calculation in a peer-reviewed journal?</p>

<p style="text-align: right;">Page 82</p> <p>1 A I did not.</p> <p>2 Q Okay.</p> <p>3 A I thought about writing the editors of the</p> <p>4 original journal. I didn't, probably because I felt</p> <p>5 like I had already talked about it publically. And the</p> <p>6 correction that eventually was issued for that study</p> <p>7 came from a series of other -- in response to a series</p> <p>8 of other authors, clinicians, researchers who wrote the</p> <p>9 journal with similar complaints, but of a different</p> <p>10 nature.</p> <p>11 Q Okay. But you didn't write to the journal?</p> <p>12 A I did not.</p> <p>13 Q Okay. Gotcha. And is Public Discourse</p> <p>14 published by the Witherspoon Institute?</p> <p>15 A It is.</p> <p>16 Q Can you describe the Witherspoon Institute to</p> <p>17 me?</p> <p>18 MR. CANTRELL: Object to form.</p> <p>19 A They are not entirely unlike the Austin</p> <p>20 Institute. They are kind of a philosophical</p> <p>21 organization, non-profit that largely, I think, it began</p> <p>22 to serve the students of Princeton and have grown to</p> <p>23 have influence outside of Princeton. They teach summer</p> <p>24 courses on, like, natural law, stuff like that.</p> <p>25 Q (By snao) And you are currently affiliated with</p>	<p style="text-align: right;">Page 84</p> <p>1 Q And they don't include any independent research</p> <p>2 that was, at all, published in a peer-reviewed journal</p> <p>3 elsewhere; right?</p> <p>4 A Could you restate that?</p> <p>5 Q They don't include any independent research of</p> <p>6 clinical impact that you have published elsewhere in a</p> <p>7 peer-reviewed journal?</p> <p>8 A That I have published elsewhere? I think I</p> <p>9 make reference to the Hatzenbuehler piece in one of</p> <p>10 these or some other Public Discourse. So that has</p> <p>11 appeared in public research.</p> <p>12 Q Okay.</p> <p>13 A I think a more recent one talked about this</p> <p>14 study, also peer-reviewed. (Indicating)</p> <p>15 Q A more recent essay you mean?</p> <p>16 A I think so.</p> <p>17 Q Okay. Do you know the name of that essay?</p> <p>18 A Not offhand, no. I think I talked about it.</p> <p>19 MR. CANTRELL: Which study were you</p> <p>20 referring to?</p> <p>21 MR. RICHARDSON: It's Exhibit 14.</p> <p>22 MR. CANTRELL: Okay.</p> <p>23 THE WITNESS: I thought I did. It would</p> <p>24 have been since whatever, October 2021. You can look it</p> <p>25 up.</p>
<p style="text-align: right;">Page 83</p> <p>1 the Witherspoon Institute?</p> <p>2 A Oh, am I? I don't recall if I am or not. If</p> <p>3 it is it's sort of in the same non- -- some sort of</p> <p>4 fellow thing, if I am.</p> <p>5 Q But you are affiliated with Public Discourse?</p> <p>6 A Correct, yeah, which is produced out of their</p> <p>7 shop, yeah.</p> <p>8 Q And what is your role with Public Discourse?</p> <p>9 A Contributing editor.</p> <p>10 Q Okay. And do you have, like, a portfolio? Is</p> <p>11 that how it's set up?</p> <p>12 A I do.</p> <p>13 Q And what is that?</p> <p>14 A I'm in charge of stuff that comes in on</p> <p>15 sexuality and family. There is like one, two, three --</p> <p>16 five pillars. If somebody submits something in that</p> <p>17 domain I'll see it, other people will see it, and maybe</p> <p>18 three or four of us will read it, talk back to each</p> <p>19 other, vote on it independently and then -- I'm not the</p> <p>20 editor, so whether it shows up in print or not, I</p> <p>21 usually don't even know because I don't pay attention.</p> <p>22 Q Okay. So these are two of the</p> <p>23 non-peer-reviewed essays you have written on transgender</p> <p>24 people or gender dysphoria; correct?</p> <p>25 A Correct.</p>	<p style="text-align: right;">Page 85</p> <p>1 Q (By Mr. Richardson) Okay.</p> <p>2 A Okay. I thought I did, but --</p> <p>3 Q So in those two essays, Exhibit 5 and Exhibit</p> <p>4 7, the only measure of clinical impact or medical</p> <p>5 effectiveness was the number-needed-to-treat</p> <p>6 calculation; right?</p> <p>7 A That's original to me?</p> <p>8 Q Original to you, yes.</p> <p>9 A Original to me, perhaps. Most of what I do is</p> <p>10 evaluate the methods of what I'm reading.</p> <p>11 Q Okay. So the only independent research was the</p> <p>12 number-needed-to-treat calculation?</p> <p>13 A I believe so.</p> <p>14 Q And that has not appeared in any peer-reviewed</p> <p>15 publication?</p> <p>16 A That has not.</p> <p>17 Q Okay.</p> <p>18 A But it is, since I -- as I said in here, it's</p> <p>19 publically discernible. You don't need the data to do</p> <p>20 that. You just need the article to do that. Anybody</p> <p>21 with medical training could do it.</p> <p>22 Q Okay. Understood.</p> <p>23 A Medical statistical training.</p> <p>24 Q Okay.</p> <p>25 A Because I describe the formula in the footnote.</p>

<p style="text-align: right;">Page 86</p> <p>1 Q Gotcha. Okay. And are there other essays 2 related to transgender people or gender dysphoria beyond 3 these two? 4 A There may be. You would have to sort of scour 5 Public Discourse. I don't keep track. I write three or 6 four a year. There is probably some mention of it 7 somewhere. 8 Q Okay. Have you ever written a piece called 9 "Queering Science"? 10 A I did. 11 Q Did that appear in First Things? 12 A It did. It sounds like you know some of the 13 answers to these questions. 14 Q I did my homework a little bit. Is First 15 Things maintained by the Institute of Religion and 16 Public Life? 17 A I do, but I don't really know what their 18 organizational aim is, so -- 19 Q Do you know the mission of that organization? 20 A I don't. I just know that, you know, First 21 Things is a journal I deal with occasionally. I have 22 written occasional stuff in it. 23 Q Okay. Would you it surprise you to learn that 24 the mission is to oppose the, quote, ideology of 25 secularism?</p>	<p style="text-align: right;">Page 88</p> <p>1 support that, that objective? 2 MR. CANTRELL: Object to form. 3 A I confess I haven't really thought about that. 4 Q (By Mr. Richardson) Okay. I just want to 5 follow up on the piece "Queering Science." Do you 6 remember roughly what that was about? 7 A You know, I do, but, you know, if you have got 8 an example I'd sure love to see it. 9 Q I'm just curious. Did anything come to mind 10 about that piece, about what that -- what your argument 11 was in that piece? 12 A I think I probably. I think I probably should 13 take a look at it first before I make claims about it. 14 As I said earlier, one writes things and you move on and 15 I don't always remember what I've said. But I seldom 16 retract my own words. Do you have that copy of it? 17 Q Well, do you just recall anything about it at 18 all or -- 19 A I do recall -- 20 Q -- about the argument? 21 A -- little bits about it, yeah. 22 Q Okay. Do you mind sharing what you recall 23 about it? 24 A I think it's sort of a criticism of what I 25 called in this here, ideological capture of professional</p>
<p style="text-align: right;">Page 87</p> <p>1 A No. Because, you know first things -- do you 2 know what the reference to "first things" are? Like 3 first principles. So I'm not surprised that opposition 4 to secularism would be, kind of, one of their first 5 things, first principle. 6 Q And do you share that, that view? 7 A Opposition to secularism? I have to think what 8 that means. Generally I don't, when I submit something, 9 scour the parent organization's mission statement and 10 see if I agree with everything. Just it's an -- a 11 journal that I subscribe to, read occasionally, like 12 lots of things, you see an issue, eh, wait until the 13 next issue. But I published in there on occasion. 14 Q And so what do you understand "opposition to 15 secularism" to mean? 16 MR. CANTRELL: Object to form. 17 A What do I understand opposition to secularism 18 to mean? Probably that they seek to resist 19 understandings of the human person and social order and 20 maybe political order as -- a post -- things that would 21 neglect a perspective that entails sort of the divine 22 creation of persons and, you know, I suspect it's 23 another way of saying that it's Judeo-Christian in 24 intent. 25 Q (By Mr. Richardson) Okay. And do you broadly</p>	<p style="text-align: right;">Page 89</p> <p>1 organizations and the movement of research methods and 2 survey research design and question wording to kind of 3 press for a different understanding of the human person 4 than most methods and questions had heretofore. 5 Q And do you recall, as part of that essay 6 "Queering Science" you provided any independent 7 research? 8 A You know, I'm really going to have to insist on 9 seeing a copy of it. 10 Q So you don't recall anything? 11 A Just like with these, I would like -- can I see 12 a copy of it, and I can tell you. 13 Q Do you recall writing a piece called "Does 14 Conversion Therapy Hurt People Who Identify As 15 Transgender"? 16 A For Public Discourse? 17 Q That would be for Public Discourse, yeah. 18 A Yeah. 19 Q Okay. 20 A That was, I think, a criticism of probably one 21 of Jack Turban's articles, yeah. 22 Q Okay. And do you recall that including any 23 independent research done by you? 24 A I'm going to have to ask to see it, like the 25 last two.</p>

<p style="text-align: right;">Page 90</p> <p>1 Q So you don't recall, then, any independent 2 research as part of that article? 3 A That, I don't know. 4 Q So nothing -- does that mean you can't recall 5 anything or you don't know if you can recall anything? 6 A I would rather look at it first and then I 7 could give you an educated answer about it. 8 Q Okay. So I guess I'm just trying to think 9 across -- across the articles we have discussed with the 10 number-needed-to-treat calculation -- 11 A Um-hum. 12 Q -- did you ever submit that kind of research to 13 a peer-review journal and it was not published for 14 whatever reason or was it never submitted? 15 A No. NNT? I just calculated it and included it 16 in this. 17 Q Okay. 18 A Typically speaking, in hindsight, yeah, I 19 probably could have gone to the editor with it. But I 20 wrote that first and then I -- you know, well, now it's 21 already in print so it's sort of peer-reviewed stuff 22 usually it appears first there and then you write about 23 it. 24 Q Yeah. 25 A But I didn't take that order in that case.</p>	<p style="text-align: right;">Page 92</p> <p>1 folks, not experts? 2 A Right. 3 Q So to your knowledge you have never submitted 4 research on the effectiveness of care for gender 5 dysphoria to a peer-reviewed publication? 6 A Not at present. 7 Q Okay. When you say "at present," are you 8 currently working on research involving the 9 effectiveness of care for gender dysphoria? 10 A I don't think so, no, not at present. 11 Q Okay. 12 A Okay. Juggling a variety of topical matters 13 and I have not constructed any article on that for peer 14 review yet. 15 Q So nothing in the pipeline about the 16 effectiveness of gender-affirming care or other 17 treatments for gender disorder? 18 A Not in the pipeline, no. 19 Q Okay. Gotcha. And earlier you mentioned you 20 serve as a peer reviewer sometimes? 21 A Um-hum. 22 Q Can you discuss that role just broadly for me? 23 A General editors or associate editors, depends 24 on who is in charge of a particular submission, will ask 25 people in the field to review studies that come to them</p>
<p style="text-align: right;">Page 91</p> <p>1 What was your original question? 2 Q Have you ever submitted the research that was 3 reflected in those two essays to -- 4 A Oh, I see. 5 Q -- a peer journal? 6 A The 1NNT thing, um, you know, the calculation 7 1NNT would constitute nothing more than a letter to the 8 editor. 9 Q Okay. 10 A You know, it's not enough for a research paper, 11 per se. 12 Q Okay. So for any research you have done on the 13 effectiveness of care for people with gender dysphoria, 14 have you ever submitted any of that to a peer-review 15 publication? 16 A On care of gender dysphoria? 17 Q On the effectiveness of care. 18 A Not in -- you know, not if you're not counting 19 this article on popular opinion about care. 20 Q Okay. And that -- and that article, once 21 again, didn't discuss the efficacy of care. It just 22 surveyed attitudes towards care; right? 23 A Right. The kind of attitudes may have been 24 perceptions of efficacy; however, I do not know. 25 Q And that would be perceptions held by ordinary</p>	<p style="text-align: right;">Page 93</p> <p>1 that they consider good enough to go out for peer review 2 before the editors make a decision about it. 3 Q Gotcha. And you would provide your -- your 4 views on the quality of that work? Is that how it 5 typically goes? 6 A Right. 7 Q Okay. As a peer reviewer have you ever 8 reviewed a piece about gender dysphoria? 9 A I take a look at my CV. Somewhere in the back 10 I believe I listed -- I think I have, but I don't recall 11 which journal or what the article was exactly about. We 12 did ask for reviews frequently, some I accept, some I 13 don't, you know, pursue. 14 But I've -- I've been getting content in the 15 sexuality and gender domain, more sexuality than gender. 16 It would have been in the last three years and, again, 17 like lots of these pieces, especially a review, I will 18 read it, write my feedback, send it away, forget it, 19 list it in here if it's a new journal. 20 Q Got it. So you don't recall any specific 21 pieces involving gender dysphoria that you were a 22 reviewer for? 23 A No, but that doesn't mean I didn't do it 24 because it's very possible that I did do it. I mean, I 25 see Pediatrics is listed in here. I'm not sure why I</p>

<p style="text-align: right;">Page 94</p> <p>1 would get something from Pediatrics. But, again, I</p> <p>2 don't -- you know, I don't recall offhand.</p> <p>3 Q Gotcha. Do you recall reviewing any works</p> <p>4 about the efficacy of medical care of any kind?</p> <p>5 A I would say the exact same thing.</p> <p>6 Q So you don't recall anything specific?</p> <p>7 A If I was asked to do it, it would be not as,</p> <p>8 you know, an insider to the medical industry, but as a</p> <p>9 methodologist.</p> <p>10 Q Okay. But just to clarify, you don't recall</p> <p>11 reviewing any --</p> <p>12 A I don't recall.</p> <p>13 Q Okay. Gotcha. So do you recall any other</p> <p>14 essays regarding transgender people other than the ones</p> <p>15 we have discussed that come to mind?</p> <p>16 A No. But you have a good list.</p> <p>17 Q I'm just curious if anything that you recall</p> <p>18 coming to mind.</p> <p>19 A No.</p> <p>20 Q And just to clarify, I asked you about Exhibit</p> <p>21 5, which is the piece "Arkansas and the Politics of</p> <p>22 Experimenting on Children."</p> <p>23 A Okay.</p> <p>24 Q The piece "Queering Science" that was in First</p> <p>25 Things.</p>	<p style="text-align: right;">Page 96</p> <p>1 or gender dysphoria.</p> <p>2 A The PDs above them, New Data Show and Does</p> <p>3 Conversion Therapy Help; right?</p> <p>4 Q I meant the first chronologically. Sorry. The</p> <p>5 first in time would have been --</p> <p>6 A Oh. Perhaps, unless there is a Public</p> <p>7 Discourse piece that I didn't list on here, and it's</p> <p>8 possible because I don't list them all.</p> <p>9 Q Okay. So the first one that you recall or have</p> <p>10 listed was in 2018?</p> <p>11 A 2018? Uh, looks like it.</p> <p>12 Q And does that broadly track what you were</p> <p>13 saying earlier about your interest -- the timeline for</p> <p>14 your interest in gender dysphoria?</p> <p>15 MR. CANTRELL: Object to form.</p> <p>16 A What is it, 2022? No. In terms of gender</p> <p>17 essays? Because the Hatzenbuehler piece I read in I</p> <p>18 think it's 2014 publication. I read it in 2015. I</p> <p>19 wrote an article, submitted it, and it didn't appear in</p> <p>20 print until 2017. So probably 2015-ish. But one starts</p> <p>21 reading and it's long before one starts to write.</p> <p>22 Q (By Mr. Richardson) Okay. Is the Hatzenbuehler</p> <p>23 piece you're talking about, do you think that's related</p> <p>24 to gender dysphoria?</p> <p>25 A Not explicitly, no. But I started reading more</p>
<p style="text-align: right;">Page 95</p> <p>1 A Yeah. There may be others, yeah.</p> <p>2 Q And there was the piece "New Data Shows</p> <p>3 Gender-Affirming Surgery Doesn't Really Improve Mental</p> <p>4 Health." That's Exhibit 7.</p> <p>5 A Okay.</p> <p>6 Q And then I asked you about the piece "Does</p> <p>7 Conversion Therapy Hurt People Who Identify as</p> <p>8 Transgender."</p> <p>9 A So did we talk about "Weak Data, Small</p> <p>10 Samples"? Did you mention that one?</p> <p>11 Q Where would that be?</p> <p>12 A Public Discourse, January 2020.</p> <p>13 Q No. Does that involve gender dysphoria?</p> <p>14 A I don't know. But it's LGBT discrimination.</p> <p>15 Probably not gender dysphoria.</p> <p>16 Q Okay.</p> <p>17 A These are select essays. I don't list them</p> <p>18 all.</p> <p>19 Q Okay.</p> <p>20 A Write three or four a year.</p> <p>21 Q And this list on -- on your CV, this is page 6,</p> <p>22 it looks like the first of these was -- would be</p> <p>23 "Queering Science," which was in December of '18?</p> <p>24 A First of what?</p> <p>25 Q The articles that relate to transgender people</p>	<p style="text-align: right;">Page 97</p> <p>1 widely in the area --</p> <p>2 Q Okay.</p> <p>3 A -- around then.</p> <p>4 Q Okay. But the first written work that's</p> <p>5 explicitly related to gender dysphoria would be the</p> <p>6 piece "Queering Science" in 2018?</p> <p>7 MR. CANTRELL: Object to form.</p> <p>8 A Again, I -- my recall is failing me, but it's</p> <p>9 possible.</p> <p>10 Q (By Mr. Richardson) Okay. If I was looking at</p> <p>11 your CV --</p> <p>12 A Yeah, CV, correct.</p> <p>13 Q -- would that be an accurate starting point?</p> <p>14 A Yeah.</p> <p>15 Q Okay. Thank you. Okay. What is gender</p> <p>16 dysphoria?</p> <p>17 A So far as I understand it -- there may be</p> <p>18 different definitions of it -- it's psychological sense</p> <p>19 of a profound distinction between one's body and one's</p> <p>20 mind regarding gender or the sexed body.</p> <p>21 Q So, as you define it, gender dysphoria is the</p> <p>22 feeling of a distinction between --</p> <p>23 A Not just a distinction, but, you know, it's</p> <p>24 equated with negative feelings about that distinction.</p> <p>25 Q Okay. So how would you define transgender</p>

25 (Pages 94 - 97)

<p style="text-align: right;">Page 98</p> <p>1 people?</p> <p>2 A Again, open to a measurement of distinctions,</p> <p>3 which is the thing that I care about in this domain,</p> <p>4 probably like persons who self-identify as different</p> <p>5 than their natal sex. It may be opposite that, male to</p> <p>6 female, female to male. It may be something not quite</p> <p>7 opposite, like non-binary or something like that.</p> <p>8 And there is different kinds of gender</p> <p>9 identities, so the trans means, like, across identity,</p> <p>10 cross gender.</p> <p>11 Q Gotcha. Okay. What causes gender dysphoria?</p> <p>12 A Causes gender dysphoria? What is coterminous</p> <p>13 with it or what causes it? In my reading of gender</p> <p>14 dysphoria -- and it depends, I think, if it manifests</p> <p>15 itself in childhood or adolescence, I think there can be</p> <p>16 distinctions there. Sort of a -- what causes gender</p> <p>17 dysphoria?</p> <p>18 When I think about cause I think about, like,</p> <p>19 the conditions under which it's more likely to manifest</p> <p>20 itself, which is necessarily like a direct causation.</p> <p>21 In social science and measurement in general causation</p> <p>22 is sort of a specific thing and so we seldom use it in</p> <p>23 terms because we have to say it is this and nothing</p> <p>24 else.</p> <p>25 It seems to develop in some share of children</p>	<p style="text-align: right;">Page 100</p> <p>1 any particular patient is or is not. However, there has</p> <p>2 been a great surge in cases, so one does get a little</p> <p>3 skeptical when he sees a surge in cases.</p> <p>4 Q But you don't know how clinicians would</p> <p>5 diagnose gender dysphoria?</p> <p>6 A I don't.</p> <p>7 Q Okay. What is gender identity disorder?</p> <p>8 A Gender identity disorder is -- give me a</p> <p>9 moment. When we're talking about dysphorias and</p> <p>10 disorders it's overlapping but distinctive. So far as I</p> <p>11 know GID is not a common term that people use at</p> <p>12 present.</p> <p>13 A disorder is sort of when people have</p> <p>14 diagnosed that something is positively wrong about a</p> <p>15 situation as opposed to or as distinct from something is</p> <p>16 distinctive. Right? So, for example, I noticed in one</p> <p>17 of the reports somebody making reference to DSD,</p> <p>18 disorders of sexual development, also differences or</p> <p>19 disorders.</p> <p>20 I suspect that indicates a dispute among</p> <p>21 practitioners about whether something is inherently a</p> <p>22 problem, a problem for a particular person, or not a</p> <p>23 problem at all, just reflective of differences in</p> <p>24 populations. So GID would -- is more of an indicator of</p> <p>25 an inherent problem. So far as I know it's not used</p>
<p style="text-align: right;">Page 99</p> <p>1 for, you know, reasons that are not obvious to me. Now,</p> <p>2 I understand that it can emerge more frequently in kids</p> <p>3 who are experiencing emotional distress or household</p> <p>4 upheaval, but not necessarily so. It can develop more</p> <p>5 in children that are autistic, but not necessarily so.</p> <p>6 These are conditions under which it might --</p> <p>7 when you talk about causation, the threshold for saying</p> <p>8 something causes something is pretty rigid and typically</p> <p>9 discerned only in experimental research designs where</p> <p>10 you can sequester or account for other factors so that</p> <p>11 you can establish cause. But in this domain there's not</p> <p>12 a lot of that.</p> <p>13 Q Okay. So is it fair to say that you don't feel</p> <p>14 comfortable offering a causal explanation for gender</p> <p>15 dysphoria?</p> <p>16 A Well, I don't diagnose it. I'm not a</p> <p>17 clinician.</p> <p>18 Q Okay. So do you know how you would diagnose</p> <p>19 gender dysphoria?</p> <p>20 A Not as a clinician might, no.</p> <p>21 Q Okay.</p> <p>22 A So when I read materials about gender dysphoria</p> <p>23 I take for granted at some level that they, you know,</p> <p>24 are conducting the diagnoses in the trained manner in</p> <p>25 which they have done so. I don't typically dispute that</p>	<p style="text-align: right;">Page 101</p> <p>1 very often as a term, but was fairly recently.</p> <p>2 Q Okay. What is the appropriate way to treat</p> <p>3 adolescents diagnosed with gender dysphoria?</p> <p>4 MR. CANTRELL: Object to form.</p> <p>5 A You are asking a non-clinician this question.</p> <p>6 Appropriate ways to treat adolescents with gender</p> <p>7 dysphoria. I think if I was asked that I would say that</p> <p>8 is up for grabs to some extent. You have the Endocrine</p> <p>9 Society talks about it, guidelines. You have WPATH's</p> <p>10 standards of care.</p> <p>11 Q Sorry to stop you. Did you put "guidelines" in</p> <p>12 quotes just now?</p> <p>13 A Just as a distinction between guidelines and</p> <p>14 standards.</p> <p>15 Q Okay. And how do you see them as distinct?</p> <p>16 A They are two different words. The</p> <p>17 organizations had plenty of chance to coalesce around</p> <p>18 the term that they use. I do think they are similar, so</p> <p>19 far as I can tell, in what they mean by the term. They</p> <p>20 are not demands or orders. So when you say how</p> <p>21 should -- your original question was how to -- are</p> <p>22 adolescents -- adolescents be treated?</p> <p>23 Q What's the appropriate way to treat an</p> <p>24 adolescent with gender dysphoria?</p> <p>25 A Yeah. I don't make that kind of</p>

<p style="text-align: right;">Page 102</p> <p>1 recommendation. I think the value of my report is that  2 I highlight how there are distinctions in how these  3 organizations approach this. And there seems to be an  4 emergent dispute between clinicians and caregivers about  5 this very question.  6 So you can ask me for a solitary response I'd  7 say, Well, clinicians don't have a solitary response  8 about this.  9 Q Okay. But your answer yourself is that --  10 (Simultaneous crosstalk.)  11 Q Oh, sorry.  12 A I don't offer one.  13 Q Okay. So you don't know --  14 A I observe other people's suggestions and  15 disputes. I observe WPATH and Endocrine Society's  16 guidelines and standard of care, vice versa. And I  17 observe how those have changed over time and I can state  18 that it's a dynamic area.  19 Q So you have no view on how to treat adolescents  20 with gender dysphoria?  21 A I have not read about how to treat adolescents.  22 In terms of my personal views -- is that what you're  23 asking me, my personal view?  24 Q I mean, let's take your expert view first. Do  25 you have an expert view on --</p>	<p style="text-align: right;">Page 104</p> <p>1 significant treatments that put at risk future bodily  2 realities at early ages.  3 And I can tell that I'm not out of step with  4 some clinicians who are worried that those ages are  5 becoming earlier as well.  6 Q So I just want to make sure I have it in my  7 head the right way. I understand that you have an  8 expert view that other people's answer to the question  9 how to treat adolescents with gender dysphoria might be  10 wrong.  11 A Right.  12 Q I am asking your expert position. Am I  13 correct that your expert position is they should not  14 receive significant treatments?  15 MR. CANTRELL: Object to form.  16 A I think that treatments should be -- should not  17 sort of happen until they have experienced puberty. I  18 know that used to be the standard. Again, this is sort  19 of not me writing as an expert.  20 But that, you know, I think counseling is  21 something I would want to see more of. I think if this  22 was my own child I wouldn't want to rush them into  23 anything. I would say, Take your time.  24 Q (By Mr. Richardson) Okay. I'm just having  25 trouble following the expert piece and then the personal</p>
<p style="text-align: right;">Page 103</p> <p>1 A I have an expert understanding that there is  2 significant evolution in standards of care and  3 significant dispute within the community of caregivers  4 about what ought to happen and when.  5 Q But as an expert, you have no view about how to  6 treat gender dysphoria?  7 A I think kids should not be rushed into  8 significant treatments that will put at risk a future  9 that they have not yet experienced.  10 Q So your expert view is that adolescents with  11 gender dysphoria should not be given significant  12 treatments?  13 MR. CANTRELL: Object to form?  14 Q (By Mr. Richardson) Or is that --  15 A Well, if I had an expert opinion I would have  16 stated it. If I did you can draw my attention to it.  17 My approach as a sociologist is to highlight  18 what I call ideological capture, how these professional  19 organizations, WPATH, Endocrine Society, et cetera, have  20 you been kind of pressed by, for lack of a better term,  21 activist groups towards certain answers to the question  22 that you pose to me rather than other answers.  23 And when I look at it I'm not -- I'm not  24 convinced there is an outside analyst of their methods  25 and their conclusions that it's a good idea to begin</p>	<p style="text-align: right;">Page 105</p> <p>1 piece. Was the answer to the question for the expert  2 piece you don't have an expert opinion about the proper  3 course of treatment?  4 A Well, if I didn't -- if I didn't state it in  5 there then I didn't offer an expert opinion.  6 Q So you have no expert opinion on that point?  7 A Unless it's stated in there, and I don't recall  8 saying that.  9 Q Okay. And then you said on your personal views  10 you would oppose what you called significant treatments;  11 is that correct?  12 MR. CANTRELL: Object to form.  13 A Significant treatments that put at risk their  14 bodily integrity.  15 Q (By Mr. Richardson) Okay. I just want to pivot  16 here.  17 A Um-hum.  18 Q In your report you use the term "the sociology  19 of science."  20 A Yes.  21 Q Do you remember using that term?  22 A In the report? Yeah, I think I used it in the  23 "Queering Science" piece, too.  24 Q Okay. Can you describe what "the sociology of  25 science" means?</p>

<p style="text-align: right;">Page 106</p> <p>1 A So when you turn sort of your gaze at the --</p> <p>2 sociology is a science of a sort. Right? It's not like</p> <p>3 physics, but it uses the scientific method in a</p> <p>4 different way. And when you turn your attention at some</p> <p>5 domain in the social world, you know, there's lot of</p> <p>6 things one can learn sociologically. Sociology of race</p> <p>7 ethnicity, sociology of poverty, sociology of family.</p> <p>8 But one can also turn one's sociological attention to</p> <p>9 the norms, values, practices of, uh -- of science.</p> <p>10 Right? So that's what I mean by sociology of science.</p> <p>11 You turn your sort of analytical gaze and interests and</p> <p>12 methods to the conduct of science, of which sociology is</p> <p>13 a part. Right?</p> <p>14 Q Gotcha. And have you published works that you</p> <p>15 would say are in the area of the sociology of science?</p> <p>16 A So one of the things I do in this sociology of</p> <p>17 science domain is criticize the professional</p> <p>18 associations, ASA. I mean, the manner in which science,</p> <p>19 social science is conducted. And I'm sure I have</p> <p>20 critical references to it in the last two books.</p> <p>21 The 2020 Annals of Social Science piece on</p> <p>22 understanding how the social science of the study of</p> <p>23 same sex parenting works. That really is directly on</p> <p>24 sort of assessment of how the discipline operates.</p> <p>25 Q And just to follow up on that. That piece was</p>	<p style="text-align: right;">Page 108</p> <p>1 A If so many people -- if the claim was so</p> <p>2 overreaching and, yet, editors and peer reviewers passed</p> <p>3 on it. It's a -- it's a criticism of how the peer</p> <p>4 review process even works.</p> <p>5 Q Okay.</p> <p>6 A I think it's broken. There's a lot of people</p> <p>7 in my line of work, some of whom have criticized me</p> <p>8 extensively who think the peer review process is broken.</p> <p>9 Q Okay.</p> <p>10 A And there's a move afoot to even post your own</p> <p>11 work pre-peer review. So --</p> <p>12 Q Okay. And so you reference the 2020 piece</p> <p>13 about same sex parenting.</p> <p>14 A Um-hum.</p> <p>15 Q And then the 20, what is that, the 2017 piece</p> <p>16 about structural stigma?</p> <p>17 A Yeah. It's more apparent -- the 2020 piece is</p> <p>18 clearly more about the sociology of science.</p> <p>19 Q Okay. And do either of those pieces relate to</p> <p>20 medical science?</p> <p>21 A 2020 probably does. I'd have to take a look at</p> <p>22 the references I use, because I probably made reference</p> <p>23 to pieces that appear in Pediatrics and things like</p> <p>24 that. Because a fair number of publications in the</p> <p>25 domain that that article concerns are published in</p>
<p style="text-align: right;">Page 107</p> <p>1 about the discipline's research with respect to one</p> <p>2 empirical question; right?</p> <p>3 A Correct.</p> <p>4 Q The wellbeing of children raised by same sex</p> <p>5 parents?</p> <p>6 A Well, that domain? Right? Because in it is</p> <p>7 all sorts of intricate questions about what does it mean</p> <p>8 to be raised by, what is a household, what is the</p> <p>9 threshold for a household structural change. All sorts</p> <p>10 of things like this.</p> <p>11 Q Yeah.</p> <p>12 A So that piece is sort of critical of the social</p> <p>13 science conduct of this stuff.</p> <p>14 Q Gotcha. But -- but with respect to -- you</p> <p>15 know, it might include subquestions, but the broad</p> <p>16 question of the wellbeing of children being raised by</p> <p>17 same sex parents.</p> <p>18 A Yes.</p> <p>19 Q Okay.</p> <p>20 A So, for example, the "Structural Stigma" piece</p> <p>21 by Hatzenbuehler.</p> <p>22 Q Okay.</p> <p>23 A This is all critical of wide -- you know, I ask</p> <p>24 a question, why did this pass peer review?</p> <p>25 Q Yeah.</p>	<p style="text-align: right;">Page 109</p> <p>1 non-sociology journals, including, like, Clinical</p> <p>2 Psychology, Pediatrics, for example but I would have to</p> <p>3 take a look at the references.</p> <p>4 Q But you don't recall any specific references to</p> <p>5 medical science?</p> <p>6 A No, but I suspect they are in there.</p> <p>7 Q Okay.</p> <p>8 A That would require me to remember the</p> <p>9 references to my studies, let alone some of the details</p> <p>10 of what I have written.</p> <p>11 Q And do either of those two pieces involve the</p> <p>12 sociology of research with respect to transgender</p> <p>13 people?</p> <p>14 A Say that once more time, please.</p> <p>15 Q The sociology of research with respect to</p> <p>16 transgender people.</p> <p>17 A Respect to transgender people. No, I don't</p> <p>18 think so.</p> <p>19 Q Okay. Do you consider yourself an expert on</p> <p>20 the sociology of medicine?</p> <p>21 A What do you mean by "sociology of medicine"?</p> <p>22 Q So you have just described the sociology of</p> <p>23 science, which is applying broad sociological tools --</p> <p>24 A Right.</p> <p>25 Q -- to a field.</p>

<p style="text-align: right;">Page 110</p> <p>1 A Sociology of science is the domain of the 2 science. 3 Q Yes. 4 A In which are all these, you know, disciplines. 5 Sociology of sociology. My advisor wrote a book on the 6 sociology of sociology. I have not done that, per se. 7 But I write on the sociology of sort of particular 8 research questions -- 9 Q Gotcha. 10 A -- which can span from sociology to family to 11 medicine. 12 Q Gotcha. 13 A But sociology of medicine, per se, is not just 14 about, like, the efficacy of 3 milliliters of something 15 over five. It's about, sort of, how people fare. And 16 so go back to the same sex parenting stuff, you know, 17 how do children fair across this whole domain of 18 measures and outcomes. 19 Q Okay. 20 A So is that sociology of medicine? It's 21 probably the sociology of health, per se. 22 Q Okay. So you consider yourself an expert on 23 the sociology of health? 24 A Expert on sociology of health? I have done 25 work in it. I consider myself more of an expert on</p>	<p style="text-align: right;">Page 112</p> <p>1 treatment are? 2 A I do not. 3 MR. CANTRELL: Object to form. 4 Q (By Mr. Richardson) Do you know of other 5 examples besides Arkansas's ban on gender-affirming 6 care? 7 A Other examples comparable you mean? 8 Q Other examples of banning medical treatments 9 beyond Arkansas law for gender-affirming care? 10 MR. CANTRELL: Object to form. 11 A Again, I think in part Arizona is discussing 12 some law. I'm not sure what the status of that is. You 13 know, sometimes things will pass the house and senate. 14 I see the media discussing it, but I don't know what the 15 status of these things are, if they become law. 16 Q When you say "these things," you mean other 17 bans on gender-affirming care? 18 (Simultaneous crosstalk.) 19 A Correct. 20 Q Are you aware of any other bans on treatment 21 beyond gender-affirming care? 22 A Treatment beyond gender-affirming care. You 23 mean everything else in medicine beyond that? 24 Q Other medical treatments that might be 25 provided, yes.</p>
<p style="text-align: right;">Page 111</p> <p>1 sociology of research methodology. 2 Q Gotcha. 3 A The conduct of social science, sometimes 4 bleeding over into -- outside of social science and into 5 health sciences. 6 Q Gotcha. How common is it in the United States 7 to have laws banning medical treatments? 8 MR. CANTRELL: I'll object. Dr. Regnarus 9 is not an attorney. 10 MR. RICHARDSON: This is just the 11 existence of laws banning treatments, not a legal 12 question about those laws. 13 A I frankly don't know. One piece of our history 14 was tarnished by the Tuskegee syphilis study, which was, 15 you know, that should have had a law behind it. And the 16 Belmont report came out, in part, as a response to that 17 tragedy, which I may have mentioned the Belmont report 18 in my -- one of my reports. 19 A key part of the Belmont report is that the 20 threshold for participation in significant medical 21 research, the threshold for including children and 22 pregnant women is elevated, and that remains the case. 23 But about your exact question about laws, I -- 24 that is -- I'm no legal expert. 25 Q So you don't know how common laws banning</p>	<p style="text-align: right;">Page 113</p> <p>1 MR. CANTRELL: I'm going to object again 2 that Mr. -- Dr. Regnarus is not an attorney and can't 3 provide any legal conclusions. 4 MR. RICHARDSON: I mean, if I asked him 5 what's the speed limit, that's a law. I mean, that's 6 not a legal conclusion to know -- 7 THE WITNESS: It varies. 8 MR. RICHARDSON: -- that there are speed 9 limit states. 10 THE WITNESS: Some states don't actually 11 have speed limits for particular stretches of road. 12 MR. RICHARDSON: I understand. My only 13 point is the existence of a law is not a legal analysis. 14 THE WITNESS: That's a very common -- 15 MR. CANTRELL: I will just object to the 16 question. 17 MR. RICHARDSON: Understood. 18 THE WITNESS: There are some common laws 19 like the speed limit and then there are some that are 20 sort of narrowly tailored for particular situations. 21 MR. RICHARDSON: Understood. 22 THE WITNESS: That I would not know. 23 Q (By Mr. Richardson) Okay. So my question was 24 do you know of other examples of bans on medical 25 treatment beyond Arkansas's ban on gender-affirming</p>

<p style="text-align: right;">Page 114</p> <p>1 care?</p> <p>2 MR. CANTRELL: Object to form.</p> <p>3 A Again, the Arizona, I don't know what the</p> <p>4 status of that is, but it sounds like that was a ban on</p> <p>5 surgical treatment, perhaps. But I do not know the</p> <p>6 current status of that. I've read about it. That's it.</p> <p>7 There might be -- I mean, one reads in the</p> <p>8 newspaper that there are pieces of legislation about</p> <p>9 LGBTQ stuff that are circulating, but I don't usually</p> <p>10 know about specific ones.</p> <p>11 Q (By Mr. Richardson) Understood.</p> <p>12 A Though I have heard about the Arizona thing, I</p> <p>13 don't know what the status of it is.</p> <p>14 Q Okay. Is it the general practice that doctors</p> <p>15 and patients are free to make medical decisions without</p> <p>16 the state overriding those decisions?</p> <p>17 MR. CANTRELL: Object to form.</p> <p>18 A I think it depends a lot on sort of what that</p> <p>19 treatment is. But most of the time treatments are sort</p> <p>20 of considered within reason. I mean, so I don't think</p> <p>21 euthanasia, for example, is a treatment that is legal in</p> <p>22 most states. I could be wrong about particular</p> <p>23 states.</p> <p>24 So when we think about what is against the law,</p> <p>25 I don't think too much is made about the doctor-patient</p>	<p style="text-align: right;">Page 116</p> <p>1 this is not necessarily true within the field of</p> <p>2 psychology; is that right?" And then your response --</p> <p>3 A Right.</p> <p>4 Q -- was, quote, I know psychologists don't</p> <p>5 privilege those kinds of samples in a way that</p> <p>6 sociologists or certainly demographers do."</p> <p>7 Do you see that?</p> <p>8 A I do.</p> <p>9 MR. CANTRELL: I'm just going to object</p> <p>10 to jumping into the middle of a line of questioning</p> <p>11 without any context.</p> <p>12 MR. RICHARDSON: I started with the</p> <p>13 question on 13, Mike.</p> <p>14 MR. CANTRELL: Right, and I understand.</p> <p>15 But there has been quite a bit of testimony that appears</p> <p>16 before this point.</p> <p>17 Q (By Mr. Richardson) Okay. Do you understand</p> <p>18 the context of what that question was asking you?</p> <p>19 A This was in court. Yeah, I do.</p> <p>20 Q And then your response was, quote, I know</p> <p>21 psychologists don't privilege those kind of samples in</p> <p>22 the way that sociologists or certainly demographers do.</p> <p>23 Correct?</p> <p>24 A Correct.</p> <p>25 Q What did you mean by that statement?</p>
<p style="text-align: right;">Page 115</p> <p>1 agreement on treatments because there's wide</p> <p>2 acknowledgement that, you know, they are both seeking</p> <p>3 the same good of a person and have agreements about,</p> <p>4 like, what that entails.</p> <p>5 Q (By Mr. Richardson) Understood. Okay. Just</p> <p>6 shifting gears a little bit.</p> <p>7 A Okay.</p> <p>8 Q Do research methods vary among different</p> <p>9 scientific fields?</p> <p>10 A They do.</p> <p>11 MR. RICHARDSON: Okay. Can I get Exhibit</p> <p>12 9, please, Beth?</p> <p>13 (Plaintiff's Exhibit 9 was marked for</p> <p>14 identification and made a part of the</p> <p>15 record.)</p> <p>16 Q Okay. This is a part of your testimony in</p> <p>17 DeBoer against Snyder.</p> <p>18 A Okay.</p> <p>19 Q Do you see down at the bottom on page 13 there,</p> <p>20 you were asked the question, "In your view, the hallmark</p> <p>21 of a rigorous study is a large representative pool of</p> <p>22 participants drawn from a population-based random</p> <p>23 sample." And you responded that was correct.</p> <p>24 A Yeah.</p> <p>25 Q And then you were asked, "But you recognize</p>	<p style="text-align: right;">Page 117</p> <p>1 A That sociologist -- or I describe -- or you</p> <p>2 describe, I still agree with that statement.</p> <p>3 Psychologists will often take a convenience sample. So</p> <p>4 let me give you an example.</p> <p>5 University of Texas, I believe there's a class</p> <p>6 that all psychology majors have to sign up for, which</p> <p>7 the credit is given for their participation in a whole</p> <p>8 series of surveys conducted by their peers in psychology</p> <p>9 and perhaps the faculty.</p> <p>10 So psychologists often offer sort of</p> <p>11 convenience samples with the underlying presumption, I</p> <p>12 guess, that the population of people they are talking to</p> <p>13 is fundamentally similar to the population at large.</p> <p>14 Perhaps if they are talking about, like, psychological</p> <p>15 kinds of things, you know, big five measures, things</p> <p>16 like that. Any group of 50 to 100 people would be</p> <p>17 similar to what you would find in the wider population.</p> <p>18 I often, sort of, poke at that in my Research</p> <p>19 Methods class, I just did a week or two weeks ago,</p> <p>20 saying sociologists, we're not like that, you know, we</p> <p>21 want to know about things that are generalizable to a</p> <p>22 population at large. I'm not just talking about the</p> <p>23 population at large like this, but a population of a</p> <p>24 particular group. Right?</p> <p>25 So one of the things I've criticized, and so</p>

<p style="text-align: right;">Page 118</p> <p>1 has professor Biggs from Oxford, is Jack Turban's use of  2 the U.S. transgender study, survey, which is a little  3 bit like this in that it's a convenience survey of  4 people who agreed to answer questions. They were  5 solicited by membership in a variety of different  6 platforms.  7 And that's just -- is that reflective of the  8 entire group of transgender persons in the United  9 States? I believe one of these pieces I -- or perhaps  10 in the report, one of the reports I poked back at  11 Dr. Turban about this, as did professor Biggs just  12 recently in a response to a letter to the editor for  13 publication that Turban was author or co-author of  14 saying that, you know, we really thing the USTS is not  15 only problematic in its survey questions. Biggs pokes  16 at Turban in the analysis and interpretation of data,  17 but also for is this a representative sample of the  18 transgender population in America. These are not easy  19 things to get at, but sociologists do care about that.  20 Q So just to follow up --  21 A More than psychologists care about it I think.  22 Q So when you say that sociologists care more  23 about it than psychologists, is the bottom line that a  24 study can be useful to a psychologist that might not be  25 given a lot of weight by a sociologist?</p>	<p style="text-align: right;">Page 120</p> <p>1 A And my beefs, including Public Discourse and  2 things I've mentioned here, is more about the questions  3 they pose, sometimes the statistical methods they  4 employ, and sometimes about the interpretations,  5 statistical interpretations they give to their -- the  6 analyses and the conclusions they draw from those  7 analyses.  8 Q Understood. So we've got research standards  9 that may differ between fields like sociology and  10 psychology --  11 A Correct.  12 Q -- and medical research?  13 A Correct.  14 Q Is it common for researchers in one field to  15 critique the state of science in a different field?  16 A I don't think it's uncommon. I don't pay a  17 wide attention to sort of how economists talk about  18 sociologists. But I know they think that our methods  19 lack things in terms of especially longitudinal data.  20 For example, professor Turban's USTS is not  21 longitudinal.  22 Q Yeah.  23 A Okay. It's hard to collect, costs a lot of  24 money, et cetera. But, you know, I have done, published  25 work without longitudinal data. Sometimes I do use it</p>
<p style="text-align: right;">Page 119</p> <p>1 A That is true.  2 Q And do you think differences like that are  3 common across different scientific fields?  4 MR. CANTRELL: Object to form.  5 A Probably. I mean, if you think about health  6 practitioners, right, they will survey their existing  7 patients, right, not possible patients or patients who  8 have this condition that are not under their care.  9 Yeah, that comes back to sort of sampling  10 differences. At the same time, you know, call it  11 methodological purism, I think both the interpreters of  12 that research and eventually the public at large,  13 courtesy if journalists cover it or not, are apt to make  14 the leap, assumption that the sample, underlying sample  15 is reflective of the population at large. And  16 sociologists really care about being cautious about  17 that.  18 Q (By Mr. Richardson) I hear you and I understand  19 your opinion about the public at large. I guess my  20 question is you mentioned healthcare providers. And is  21 it just true that healthcare providers might place  22 weight on the kind of research that would not be  23 valuable to a sociologist?  24 A Certain samples.  25 Q Yeah. Okay.</p>	<p style="text-align: right;">Page 121</p> <p>1 wherever it's possible. One wants to. It's very  2 expensive.  3 But economists who often use nationally --  4 federal data, which is often longitudinal, they like to  5 poke at sociologists.  6 Q Gotcha.  7 A Perhaps there is a pecking order in the social  8 sciences that one can discern from this.  9 Q Yeah. So but in your view you don't need  10 expertise in a particular field or training in that  11 field to evaluate the quality of science in that field.  12 A State that once more, please.  13 Q Is it your view that you don't need expertise  14 or training in a particular scientific field to evaluate  15 the quality of the science in that field?  16 A Yeah, I think that's true. I don't need that.  17 You know, professor Biggs would agree with me if he was  18 sitting in this chair.  19 Q Okay. So --  20 A There is lots of people that can look at the  21 kinds of questions one can pose, the analysis one  22 conducts. And certainly like, you know, understanding  23 that effect size and how to describe that effect size  24 and then leap, as did the folks in this piece that I  25 highlight (Indicating), to sort of a clinical piece of</p>

<p style="text-align: right;">Page 122</p> <p>1 advice. Right?</p> <p>2 So they said that, Ah, this shows that surgery</p> <p>3 is effective using the sort of all Sweden data. And I</p> <p>4 point out in this that, you know, if three people, I</p> <p>5 think it was three or four people had reported something</p> <p>6 different out of the entire population of Sweden, you</p> <p>7 wouldn't see that result. Or if three or four people</p> <p>8 reported something different you might see a stronger</p> <p>9 result. It is very sensitive to sample size.</p> <p>10 And to make a clinical recommendations about</p> <p>11 such a significant thing as a sequence of surgeries</p> <p>12 based on effect size, which is so small as to be</p> <p>13 vulnerable to a handful of cases, I think that's</p> <p>14 methodologically wrong.</p> <p>15 Q Okay. So just to step back, do you think that</p> <p>16 any social scientist with your training could evaluate</p> <p>17 the quality of the evidence in any other scientific</p> <p>18 field?</p> <p>19 A That's a little bit of a stretch.</p> <p>20 Q In what way?</p> <p>21 A So any sociologist?</p> <p>22 Q With your training?</p> <p>23 A With my training. I typically don't weigh in</p> <p>24 on, like, economics as an example --</p> <p>25 Q Okay.</p>	<p style="text-align: right;">Page 124</p> <p>1 Q Yeah.</p> <p>2 A Then to -- to sort of back from there and</p> <p>3 think, Wow, 49 people you have to treat before you</p> <p>4 should expect one positive outcome in difference, and</p> <p>5 the treatment itself is a surgery or a series of</p> <p>6 surgeries, that doesn't seem to merit the author's</p> <p>7 conclusion that surgery helps people with whatever term</p> <p>8 they used, gender dysphoria or whatever the term they</p> <p>9 were working with. I think that was -- that's sort of</p> <p>10 uncalled for.</p> <p>11 But it's indicative of how I would say</p> <p>12 researchers with an interest in activism here are</p> <p>13 publishing things in journals that think that these are</p> <p>14 not outrageous claims to make, getting by peer review,</p> <p>15 et cetera, it's a signal of ideological capture of the</p> <p>16 professional organizations.</p> <p>17 Q Okay. So just to step back, could you evaluate</p> <p>18 the quality of evidence in chemistry?</p> <p>19 A No.</p> <p>20 Q Why not?</p> <p>21 A I'm not a chemist.</p> <p>22 Q And you're not a healthcare provider.</p> <p>23 A I am not a healthcare provider.</p> <p>24 Q What makes those two different?</p> <p>25 A We are dealing in research methods that are not</p>
<p style="text-align: right;">Page 123</p> <p>1 A -- because they -- they -- well, sexual</p> <p>2 economics is more than a theory than a field or domain.</p> <p>3 But if you're dealing with multiple repeated measures,</p> <p>4 and I won't -- I don't weigh in on those; right?</p> <p>5 But when I started looking in on these things I</p> <p>6 was struck by how the field was dominated by a handful</p> <p>7 of researchers using data. You know, my beef is not so</p> <p>8 much with the fact that it's not a representative</p> <p>9 population of the United States. Right? Sometimes they</p> <p>10 are using clinical data. The Swedish data is all</p> <p>11 Sweden, but, you know, they narrowed the focus on</p> <p>12 adults, I think, who had experienced transgender surgery</p> <p>13 or hormonal treatments.</p> <p>14 People with my training could weigh in on other</p> <p>15 areas and other disciplines. It would depend a lot on</p> <p>16 sort of what they understood about that discipline.</p> <p>17 Q Yeah.</p> <p>18 A But it's fair to say that some of the claims</p> <p>19 that I have made, one doesn't have to be even</p> <p>20 methodologically all that advanced to recognize it.</p> <p>21 Q So one doesn't need advanced training to make</p> <p>22 the observations you're making?</p> <p>23 A The NNT 49, I mean, that's just a calculation;</p> <p>24 right? It was available and doable from the information</p> <p>25 they provided in the study.</p>	<p style="text-align: right;">Page 125</p> <p>1 that different. Survey questions, you know, like the</p> <p>2 USTS, I mean, even professor Biggs and I concur with</p> <p>3 him, he -- Turban didn't even ask a question about</p> <p>4 gender dysphoria to this population of transgender</p> <p>5 persons in the United States, didn't ask a question.</p> <p>6 I could come up with a question on it. How --</p> <p>7 who, other people ask about this stuff. You put one on</p> <p>8 there.</p> <p>9 You know, so there's just -- chemistry is not a</p> <p>10 social science.</p> <p>11 Q But economics is?</p> <p>12 A Correct.</p> <p>13 Q And you said you would not feel --</p> <p>14 A And the time order methods that are a lot more</p> <p>15 advanced --</p> <p>16 Q So you would not feel --</p> <p>17 A -- that I deal with.</p> <p>18 Q So you would not feel comfortable offering an</p> <p>19 expert view on an economic question?</p> <p>20 MR. CANTRELL: Object to form.</p> <p>21 A Not particular kinds of economic questions, but</p> <p>22 about the economics of sex and how it markets in maybe</p> <p>23 markets operate, I think I can hang with that and have,</p> <p>24 and have published a book on it.</p> <p>25 Q (By Mr. Richardson) And the reason you wouldn't</p>

<p style="text-align: right;">Page 126</p> <p>1 comment beyond that is because, in your view, economics 2 is advanced?</p> <p>3 MR. CANTRELL: Object to form.</p> <p>4 A No. They ask and answer questions that I'm not 5 interested in. Some of the models and methods they use 6 are -- involve methods I don't -- I'm not trained in. 7 Whereas most of what I've seen in here are measures and 8 methods that I've been trained in.</p> <p>9 Q (By Mr. Richardson) And earlier we discussed 10 your training and you said you no training in the 11 effectiveness of medical care; correct?</p> <p>12 A No training in it. But so when someone like 13 Branstrom and Pachankis write an article in, is it 14 American Journal of Psychiatry, I can see their methods, 15 I can see the questions that they posed, and I can even 16 go sort of, Oh, do I like that question?</p> <p>17 If you recall, I say "The authors corrupted 18 otherwise excellent data and analyses with a skewed 19 interpretation." So I had no troubles with the Swedish 20 data. They are extremely extensive. I wish our country 21 had such extensive data collection, but, you know, 22 people don't like to be talked to here.</p> <p>23 Q Do chemists use data sets?</p> <p>24 A If they do it's not in the, sort of, quite the 25 same way or the same kind of variables that we use.</p>	<p style="text-align: right;">Page 128</p> <p>1 Harvard, wrote a book called States and Social 2 Revolutions, a lot about history in there, sociology of 3 history, social movements, revolutions.</p> <p>4 So we could do that and some of us do do that.</p> <p>5 My interest has not been in that. But, you know, it is 6 a closer leap than chemistry and certainly physics.</p> <p>7 MR. RICHARDSON: Understood. Okay. Is 8 now a good time for a break for you, Doctor?</p> <p>9 THE WITNESS: I can keep going. Do you 10 want to go until lunch? What time do you want to take 11 lunch?</p> <p>12 MR. RICHARDSON: You need to change --</p> <p>13 VIDEO OPERATOR: I can do it quick if we 14 want to keep going.</p> <p>15 MR. RICHARDSON: Okay. Well, let's do a 16 quick five then. Is that all right?</p> <p>17 THE WITNESS: A quick five.</p> <p>18 MR. RICHARDSON: And then we'll go to 19 lunch.</p> <p>20 THE WITNESS: Thanks.</p> <p>21 MR. RICHARDSON: Okay.</p> <p>22 VIDEO OPERATOR: This will end media part 23 2. We are off the record at 11:58 a.m. 24 (A break was had.) 25 VIDEO OPERATOR: We are back on the</p>
<p style="text-align: right;">Page 127</p> <p>1 Q So you don't think they use similar statistical 2 methods to measure the outcome of chemical phenomena?</p> <p>3 A Perhaps they do. I've never been interested in 4 chemical phenomena --</p> <p>5 Q Okay.</p> <p>6 A -- outside of household maintenance.</p> <p>7 Q But if they did you would feel comfortable in 8 commenting on their quality?</p> <p>9 A I would have to, you know -- the sociology of 10 health is -- is not a far leap from what I studied and 11 understood. Chemistry is a leap, so.</p> <p>12 Q So there's a leap between your field and 13 chemistry. Is there a leap between your field and 14 medical science?</p> <p>15 A A much closer step.</p> <p>16 Q A closer step. Okay. And there's a leap at 17 some level between your field and economics, as I 18 understand it, because you said --</p> <p>19 A Um-hum.</p> <p>20 Q Okay. All right. And so would you feel 21 comfortable commenting on the evidence in history?</p> <p>22 MR. CANTRELL: Object to form.</p> <p>23 A I don't think they use the same kinds of 24 research methods. Now, sometimes they might. Right? 25 For example, Theda Skocpol, professor of Sociology at</p>	<p style="text-align: right;">Page 129</p> <p>1 record at 12:11 p.m. This will begin media part 3. 2 Please proceed.</p> <p>3 MR. RICHARDSON: Thank you.</p> <p>4 Q (By Mr. Richardson) How did you hear about 5 this case?</p> <p>6 A That's a good question. Some news outlet 7 around early April.</p> <p>8 Q Okay. And how -- who first asked you to work 9 on the case as an expert?</p> <p>10 A He did. (Indicating)</p> <p>11 Q And that's Mike Cantrell?</p> <p>12 A Um-hum.</p> <p>13 Q Are you familiar with the state's other experts 14 in this case? Start with Dr. Steven Levine.</p> <p>15 A What do you mean familiar with?</p> <p>16 Q Have you ever met Dr. Steven Levine?</p> <p>17 A I have not.</p> <p>18 Q Okay. Have you ever met Dr. Patrick Lappert?</p> <p>19 A I don't believe so. The name doesn't sound 20 familiar. If I saw a picture, maybe.</p> <p>21 Q Have you met Dr. Paul Hruz?</p> <p>22 A Once, I believe.</p> <p>23 Q Okay. And where was that?</p> <p>24 A I think that was several years ago, don't ask 25 me when, at the Alliance Defending Freedom in</p>

<p style="text-align: right;">Page 130</p> <p>1 Scottsdale. I was at some meeting about research and  2 people doing research, different people doing different  3 research in areas that they were attended to.  4 Q Okay.  5 A I think he was there.  6 Q Okay. So are you familiar with the group  7 Alliance Defending Freedom?  8 A I have. They have -- they have represented me.  9 Q Okay. In what case did they represent you?  10 A Internal at University of Texas.  11 Q Oh, okay.  12 A Yeah.  13 Q And what do you know about the Alliance  14 Defending Freedom generally?  15 A First Amendment rights group.  16 Q Okay. Um --  17 A Started by evangelical pastor types. Now it  18 seems generally First Amendment rights for people.  19 Q And you said that you attended a meeting hosted  20 by the Alliance Defending Freedom in Arizona?  21 A I believe so.  22 Q And do you know rough when that was?  23 A That, I don't recall.  24 Q Does 2017 sound right?  25 A I don't know. It was probably before 2020, but</p>	<p style="text-align: right;">Page 132</p> <p>1 meeting?  2 A I think so, yeah.  3 Q And do you know if Dr. Lappert was at the  4 meeting?  5 A I don't know. Again, if I had a photo, maybe,  6 but it doesn't sound familiar.  7 Q Okay. And Dr. Levine?  8 A I don't believe so.  9 Q Was Paul McHugh at the meeting?  10 A No.  11 Q Have you met Paul McHugh before?  12 A I have.  13 Q How many times would you say?  14 A Maybe once.  15 Q Did you all have a discussion?  16 A No. I don't think Paul was -- no, Paul was not  17 at that meeting.  18 Q But you have met Paul McHugh before?  19 A Once.  20 Q And you didn't have any extensive discussion  21 with him?  22 A No.  23 Q Okay. Was Dr. Allan Josephson at the meeting?  24 A Is this the fellow from Louisville?  25 Q Yes.</p>
<p style="text-align: right;">Page 131</p> <p>1 after 2014, but I couldn't tell you when that was.  2 Q Okay. That's fine. How did you hear about the  3 meeting in Arizona?  4 A Somebody asked me if I wanted to come.  5 Q And who was that?  6 A That, I don't recall either.  7 Q Okay. And as you understood it, what was the  8 purpose of the meeting?  9 A I think they were sort of talking about cases  10 that were circulating and the research that was starting  11 to accumulate in -- I think generally in sexual and  12 gender identity topics.  13 Q Okay.  14 A It seemed generic.  15 Q Okay. So the meeting was to discuss research  16 on gender identity at it pertained to work the ADF was  17 doing?  18 A I don't know what motivated their side of it,  19 but, like, they just wanted to talk to some of us who  20 were operating in the research community in this domain.  21 Q Okay. So the purpose was mostly for you all to  22 inform them of your research?  23 A I believe so. I think we all took turns  24 talking about what we were working on.  25 Q Okay. So it sounds like Dr. Hruz was at this</p>	<p style="text-align: right;">Page 133</p> <p>1 A I think he was at the ADF meeting.  2 Q In Arizona.  3 A I think so. He's the one that kind of got in  4 trouble at his employer?  5 Q Did you talk to him at the ADF meeting?  6 A I'm sure I talked to him socially. I do not  7 remember what I said.  8 Q So you don't recall any conversations with him?  9 A No.  10 MR. CANTRELL: I'm going to just object.  11 I'm not sure what your questions are going toward, but  12 object on relevance and scope of discovery.  13 Q (By Mr. Richardson) Was Walt Heyer at the  14 meeting in 2017?  15 A I don't believe so.  16 Q Okay.  17 A And I don't recall what he looks like, so I  18 don't think I met him.  19 Q You haven't met him before that meeting?  20 A I don't believe I've met him period.  21 Q Okay. And had you met Allan Josephson before  22 that meeting?  23 A No.  24 Q Okay. And you mentioned that the meeting  25 was -- you were presenting to ADF on research you were</p>

<p style="text-align: right;">Page 134</p> <p>1 doing around gender identity. Was that your role at the 2 meeting?</p> <p>3 A Sexual and gender identity. I probably was 4 talking about, let's see, Cheap Sex was probably either 5 coming or recently out, depends on when the date was. 6 And I don't recall if -- when the date was in -- if I 7 was talking about the struggles stigma paper or not. I 8 don't recall the extent of what I talked about. Around 9 the table and share your story, what you're working on.</p> <p>10 Q Okay. Was there a discussion with the group 11 about gender identity and gender dysphoria?</p> <p>12 A I don't recall. It seems probable given that 13 Paul was there. But I don't recall that discussion.</p> <p>14 Q And by Paul, you mean Paul McHugh?</p> <p>15 A Paul Hruz.</p> <p>16 Q Oh, Paul -- I'm sorry. I got them mixed up. 17 Okay. And he would have led that discussion is your 18 point?</p> <p>19 A No. Just the fact that he's there, I suspect 20 we probably talked about this.</p> <p>21 Q Okay. At this meeting was there any discussion 22 about the need for scholarship concerning the effects of 23 gender-affirming care for transgender people?</p> <p>24 A I wouldn't have remembered if they had -- they 25 weren't funding anything, that's for sure. I mean,</p>	<p style="text-align: right;">Page 136</p> <p>1 Q Okay. And so you don't remember specifically 2 being asked to serve as an expert in cases involving --</p> <p>3 A I don't --</p> <p>4 Q -- gender?</p> <p>5 A -- but I may well have been asked.</p> <p>6 Q Okay. And you said this meeting took place 7 sometime between 2014 and 2022 -- or 2020 you said?</p> <p>8 A Yeah. It was pre COVID but I can't remember 9 exactly when.</p> <p>10 Q Okay. And just to clarify, when we spoke 11 earlier about the research on your CV involving 12 transgender people and gender dysphoria, we said the 13 earliest thing on the CV was 2018; is that correct?</p> <p>14 A On gender dysphoria? Are you talking about the 15 structural stigma piece?</p> <p>16 Q No. Earlier we were talking your CV and the 17 works listed on it. And we asked for the -- when the 18 first piece was chronologically that focused on --</p> <p>19 (Simultaneous crosstalk.)</p> <p>20 A -- piece?</p> <p>21 Q A piece of any kind that focused gender 22 dysphoria or transgender people. And I think we agreed 23 that the 2018 essay "Queering Science" was the first 24 one.</p> <p>25 A If you don't count 2017 "Structural Stigma"</p>
<p style="text-align: right;">Page 135</p> <p>1 that's not what they do.</p> <p>2 Q Were attendees asked to produce scholarship --</p> <p>3 A I highly doubt that.</p> <p>4 Q -- related to gender dysphoria?</p> <p>5 A No.</p> <p>6 Q Okay. So would it surprise you that others 7 have said that at that meeting there was a discussion 8 about the lack of experts willing to testify in cases 9 involving transgender issues?</p> <p>10 A I'm not surprised if that was said, yeah.</p> <p>11 Q And that at that meeting attendees were asked 12 if they would be willing to serve as experts?</p> <p>13 A Probably.</p> <p>14 Q And would you have been there for that?</p> <p>15 A For that discussion?</p> <p>16 Q For that discussion.</p> <p>17 A If it happened, yes, because I think I stayed 18 in the balance of the time.</p> <p>19 Q Okay. But you don't recall specifically 20 anybody talking about the lack of experts willing to 21 serve in cases involving transgender people?</p> <p>22 A No. It's possible that they did.</p> <p>23 Q Okay. And --</p> <p>24 A That seems, you know, in -- in form for what 25 ADF does.</p>	<p style="text-align: right;">Page 137</p> <p>1 which concerned LGBTQ.</p> <p>2 Q Yes. Primarily focused on transgender people 3 or gender dysphoria.</p> <p>4 A Okay. Yeah, perhaps.</p> <p>5 Q So that reflects our earlier discussion; right?</p> <p>6 A Um-hum, maybe.</p> <p>7 Q Okay. And once again, this meeting in Arizona 8 was sometime between 2014 and 2020?</p> <p>9 A Yes.</p> <p>10 Q And you -- your testimony is you don't recall 11 being asked to serve as an expert, but you may have 12 been.</p> <p>13 A That is correct.</p> <p>14 Q And you would have been there for the entire 15 discussion?</p> <p>16 A Yes.</p> <p>17 Q Okay. Are you familiar with a group called the 18 Witherspoon Institute? I think we talked about them 19 earlier.</p> <p>20 A Yeah, we already talked about that.</p> <p>21 Q And you said that you serve as a contributing 22 editor for Public Discourse.</p> <p>23 A Correct.</p> <p>24 Q Do you have any other involvement with the 25 Witherspoon Institute?</p>

<p style="text-align: right;">Page 138</p> <p>1 A Um, their board chair or their president is on  2 the board of Austin Institute. So I'm a senior fellow  3 at the institute, I interact with him with some  4 regularity.  5 Q And has the Witherspoon Institute ever funded  6 your research?  7 A They were -- they helped fund the 2012 -- 2011,  8 2012 New Family Structure Study. They helped raise  9 money for it.  10 Q Okay.  11 A I mean, they money was sent to the University  12 of Texas and then I used that to conduct a survey.  13 Q Okay. And do you recall your involvement with  14 the Witherspoon Institute being discussed by the  15 district court in DeBoer?  16 A Do I recall it? I'm quite confident it was.  17 MR. RICHARDSON: Okay. Can I get exhibit  18 18, please?  19 (Plaintiff's Exhibit 18 was marked for  20 identification and made a part of the  21 record.)  22 THE WITNESS: Thank you.  23 Q (By Mr. Richardson) Okay. And is --  24 A This is -- what exactly am I looking at here?  25 Q That is the district court's opinion in DeBoer.</p>	<p style="text-align: right;">Page 140</p> <p>1 Witherspoon Institute?  2 A I presume so.  3 Q And is the study the New Family Structure  4 study?  5 A Correct.  6 Q Okay. Um --  7 A But the part that is not true is "Regnarus  8 obliged." Regnarus was under no compulsion to deliver  9 anything. I was under self-generated compulsion to  10 collect the best possible random sample study I could on  11 this, a time when there was only one American study that  12 had a random sample, very few outcomes. And I want a  13 random sample, which is as most people I could find who  14 had a mother or father had been in a same-sex  15 relationship during some time during their growing up  16 years.  17 So that's what I was obliged to do and I told  18 the funder I was going to tell them what I saw in that  19 data, and that's what I did.  20 Q Understood. But the funder was the Witherspoon  21 Institute in that context?  22 A Correct.  23 Q Okay.  24 A I mean, just like the funder of research at UT  25 is the Buffet Foundation. They have vested interests in</p>
<p style="text-align: right;">Page 139</p> <p>1 A Okay.  2 Q Can you please turn to page 13 of that opinion?  3 Do you see that paragraph at the bottom?  4 A "The Court finds"?  5 Q "The Court finds," that's the one. Okay.  6 Let's just read together there. "The Court finds  7 Regnarus' testimony entirely unbelievable and not worthy  8 of serious consideration. The evidence adduced at trial  9 demonstrated that his 2012 'study' was hastily concocted  10 at the behest of a third-party funder."  11 A He puts in quotations, by the way, study --  12 Q Yes, study.  13 A -- as if he's presuming it's not actually valid  14 somehow.  15 Q Understood. And then on the next page, on page  16 14 --  17 A How would he have decided it was hastily  18 concocted. I mean, I have read this before. But, yes.  19 Okay. Sorry. If you want to continue.  20 Q Okay. And then on the next page, this is 14,  21 in that first paragraph the second sentence says, "The  22 funder clearly wanted a certain result and Regnarus  23 obliged."  24 A I see it.  25 Q Is the "funder" being referred to there the</p>	<p style="text-align: right;">Page 141</p> <p>1 keeping abortion legal in the United States and have  2 colleagues whose entire -- or a good chunk of their  3 research portfolio is funded by a private foundation.  4 Witherspoon is not really a private foundation. It's an  5 organization.  6 Q Okay. And we spoke about this earlier, but  7 Public Discourse is maintained by the Witherspoon  8 Institute.  9 A I think we have said that three times now, yes.  10 Q Okay. And when we talked about your research  11 on clinical impact it was limited to an essay published  12 in Public Discourse; correct?  13 A Clinical impact.  14 Q We talked about the number-needed-to-treat  15 calculation.  16 A Um-hum.  17 Q Okay. And we said that that was the only time  18 you've independently measured the impact of a medical  19 treatment.  20 A In print.  21 Q Yes. Okay. And so the only time you've  22 measured the impact of a clinical treatment was in  23 Public Discourse?  24 A In print, yeah.  25 Q And Public Discourse is maintained by the</p>

<p style="text-align: right;">Page 142</p> <p>1 Witherspoon Institute; correct?</p> <p>2 A Um-hum.</p> <p>3 Q Okay. And I want to turn back to -- I just</p> <p>4 want to make sure I understand --</p> <p>5 A I understand.</p> <p>6 Q -- the ADF meeting if that's all right. I</p> <p>7 know it's --</p> <p>8 A I have told you --</p> <p>9 Q I know it's been a few years.</p> <p>10 A -- about what I remember of it.</p> <p>11 Q Yeah.</p> <p>12 A But you can continue.</p> <p>13 Q Just to make sure I have this. Were you asked</p> <p>14 to testify in cases involving gender identity or</p> <p>15 transgender people?</p> <p>16 A I don't recall it. I may very well have.</p> <p>17 Q Okay. Thank you. And you also mentioned that</p> <p>18 your affiliation with ADF extends to your work at UT</p> <p>19 Austin; is that correct?</p> <p>20 A They represented me when the university put me</p> <p>21 under a scientific misconduct inquiry stimulated by the</p> <p>22 claims of a blogger from New York City who managed to</p> <p>23 convince the research integrity officer at UT to open up</p> <p>24 this inquiry, a fact that they said was really unusual</p> <p>25 and was dismissed predominantly thereafter.</p>	<p style="text-align: right;">Page 144</p> <p>1 other investigation related to your academic conduct?</p> <p>2 A So in 2014, I think it was 2014 my department</p> <p>3 chair had designated three of my colleagues to conduct</p> <p>4 an evaluation of -- for my every-six-year post-tenure</p> <p>5 review -- it happens every six years to all of us -- and</p> <p>6 they had turned in their review of my teaching research</p> <p>7 and departmental service that said I exceeded</p> <p>8 expectations.</p> <p>9 Department chair at the time was frustrated by</p> <p>10 that and wrote a letter of complaint to the dean saying</p> <p>11 she thinks I failed to meet expectations. So the dean</p> <p>12 has these competing evaluations and appointed an</p> <p>13 associate chair -- no -- associate dean who is a</p> <p>14 colleague of mine in sociology to write a report about</p> <p>15 the NSF study because he said this is what it seems to</p> <p>16 be about.</p> <p>17 So he wrote a report, 30-some-odd pages, I was</p> <p>18 not aware of it. The dean asked me for a meeting fall</p> <p>19 of 2015 -- '14, probably like in September. I remember</p> <p>20 I had kind of a -- fall off to work on other projects</p> <p>21 and I wanted to write this response to the associate</p> <p>22 dean's paper about my NFS.</p> <p>23 And so that was -- you know, the dean got my</p> <p>24 response, his response, seems to have thrown up his</p> <p>25 hands and said, Whatever, you know, we're going to hold</p>
<p style="text-align: right;">Page 143</p> <p>1 Q Okay. Can you describe the claim that was made</p> <p>2 against you?</p> <p>3 A There were eight different, sort of, complaints</p> <p>4 that this person made. I don't recall a single one of</p> <p>5 them, but I responded to every single one of them in the</p> <p>6 meeting that took place at UT, must have been probably</p> <p>7 September of 2012, and the committee then heard those</p> <p>8 answers, recommended to the Provost that the case be</p> <p>9 dismissed, it was accepted.</p> <p>10 Q Okay. So you don't remember the specific</p> <p>11 issues raised by the blogger; correct?</p> <p>12 A Not in particular.</p> <p>13 Q Do you remember the general objection raised by</p> <p>14 the blogger just in terms of the big picture nature of</p> <p>15 the concerns?</p> <p>16 A In his case he had been so hostile publically</p> <p>17 for so long, I don't recall which eight he settled on.</p> <p>18 Q Okay. Did it involve your work on --</p> <p>19 A It was NFS.</p> <p>20 Q It was the NFS?</p> <p>21 A Yeah.</p> <p>22 Q And you said that investigation concluded with</p> <p>23 the complaint being dismissed and dropped?</p> <p>24 A Yeah.</p> <p>25 Q Okay. Have you ever been the subject of any</p>	<p style="text-align: right;">Page 145</p> <p>1 these in tension and move forward. So they never even</p> <p>2 settled the case.</p> <p>3 Q Okay. So there was a 2015 -- or 2014 review</p> <p>4 you just described related to the NFS.</p> <p>5 A Right. It was not really like an ethical</p> <p>6 thing.</p> <p>7 Q Got it. So a just a departmental review of</p> <p>8 your work for --</p> <p>9 A It was a college-level review.</p> <p>10 Q College-level review. Okay. And that was just</p> <p>11 part of performance evaluation processes?</p> <p>12 A The department thing was a performance</p> <p>13 evaluation every six years.</p> <p>14 Q Yeah.</p> <p>15 A The dean decided to elevate it to, sort of,</p> <p>16 something larger and then just closed the case after</p> <p>17 that.</p> <p>18 Q Okay. Just so I got it, the elevating at</p> <p>19 larger was asking for that 30-page report you talked</p> <p>20 about?</p> <p>21 A Correct.</p> <p>22 Q Understood. Okay.</p> <p>23 A To which I was asked to respond --</p> <p>24 Q Okay. Gotcha.</p> <p>25 A -- which I did.</p>

<p style="text-align: right;">Page 146</p> <p>1 Q And then the blogger complaint, which also 2 involved the NFS, what was the timeline on that? 3 A September 2012 I think, give or take a month. 4 Q Okay. And anything else involving reviews of 5 your work by your department for performance evaluation 6 purposes? 7 A Yeah. There is my promotion case 2017. 8 Q And anything else involving investigations -- 9 A Investigations -- 10 Q -- of the sort like the blogger complaint about 11 academic conduct or the quality of your work or anything 12 like that? 13 A Not that I'm aware of. If you know something 14 you can enlighten me. 15 Q Are you familiar with a group called the Ruth 16 Institute? 17 A Yes. 18 Q Did you receive an award from that 19 organization? 20 A I do. I don't really recall what it was for -- 21 Q Okay. 22 A -- or what they said. 23 Q Are you aware that the Ruth Institute describes 24 itself as, quote, A global interface coalition equipping 25 Christians to defend the family and build a civilization</p>	<p style="text-align: right;">Page 148</p> <p>1 A I'm not aware of that. 2 Q Do you agree that people with homosexual 3 desires should overcome them? 4 A I have no opinion on that really. 5 Q Okay. 6 A Overcome them? You know, some people elect to 7 try to minimize this via, perhaps, behavior and 8 cognitive therapy. If they are unwanted feelings I am 9 not opposed to that. But I don't give advice to people 10 who are dealing with that issue. 11 Q Okay. What is a mixed orientation marriage? 12 A It's funny you say that because one of the 13 early critics of the NFS insisted that a bunch of these 14 cases were mixed orientation marriages. Which for the 15 scrutiny, I don't think it's true. 16 But I think that's when someone is married to 17 someone of a different sexual orientation. 18 Q Okay. And did you discuss mixed orientation 19 marriages in your expert report in Hunter? 20 A Briefly, yes. There is a study that had -- had 21 been published. I want to say this is the Yarhouse 22 study I think. 23 Q Sounds correct. 24 A About people manage in those settings. I 25 evaluated it. It's a small sample. I probably</p>
<p style="text-align: right;">Page 147</p> <p>1 of love, and that, quote, We uphold the ancient 2 Christian teachings about marriage, family, and human 3 sexuality? 4 A Not having studied it, but I'm not surprised 5 that's how they describe themselves. 6 Q Okay. Would that be -- 7 A It's a little bit like First Things; right? 8 Q Yeah. Would that be a mission you support? 9 A Could you read it again, please? 10 Q "We uphold the ancient Christian teachings 11 about marriage, family, and human sexuality." 12 A "Ancient Christian teachings." You know, I 13 don't really think about mission statements. I sort of 14 look at, like, Well, what is Ruth Institute talking 15 about? You know, I have a friend, I think, who does 16 some research for them. They have asked me to come 17 speak at a conference before, so I come speak. There 18 you have it. 19 Q Okay. 20 A I don't really evaluate the mission statements 21 of people who ask me to sort of talk to them. 22 Q Understood. Are you aware that the Ruth 23 Institute has participated in something called the 24 Courage Conference which offers ministry to people 25 dealing with same-sex attraction?</p>	<p style="text-align: right;">Page 149</p> <p>1 mentioned that it was non-representative. And I just 2 evaluated it's findings. 3 Q Okay. Do you think that the goal for people 4 with same sex attraction should be a mixed orientation 5 marriage? 6 A I have never honestly thought about the goals 7 of this. 8 Q Okay. 9 A I'm a realist. I take at face value what 10 people decide to do. So I don't often think about, 11 like, "Oh, you should have done something different. 12 You should have done this." 13 Q Gotcha. Can we turn to your rebuttal report. 14 This is Exhibit 2. It should be on page 26. 15 A Two, 26. 16 Q Yes, sir. Okay. Do you see there in paragraph 17 56, I'm just going to read starting at the third 18 sentence I suppose. "This is an example of 'déformation 19 professionnelle' or job conditioning in which training 20 and socialization processes associated with a 21 profession, in this case the emergence of 'gender 22 medicine,' have resulted in the distorted understanding 23 of the human person as a unity of mind and body." 24 A Um-hum. 25 Q What did you mean by "unity of mind and body"?</p>

<p style="text-align: right;">Page 150</p> <p>1 A If I can make this reference, then, to this 2 paper. 3 Q Is this Exhibit 14? 4 A Exhibit 14. There is a table in the back that 5 kind of describes distinctive world views about human 6 body and the relationship to selfhood. 7 Q Um-hum. 8 A And I describe using the language of James 9 Hunter, sociologist from -- well, he's still alive, 10 still works. But in Ridley (phonetic) -- a study of I 11 think it was about abortion politics back in the 80s or 12 90s about different kinds of world views that animate 13 people, and one of which is sort of this idea that 14 there's a unified -- unity between body and mind. And 15 one that's sort of a more dualistic, sort of, you are a 16 self that occupies a body; right? 17 Q And these are contrasted as the progressive and 18 orthodox views; correct? 19 A Right. It's not a -- the -- those are the 20 terms that Hunter used. I don't know if they are 21 quite -- 22 Q Okay. But so -- 23 A -- efficacious. But, yeah. 24 Q So when you say unity of mind and body in your 25 expert report --</p>	<p style="text-align: right;">Page 152</p> <p>1 professional deformation or conditioning in which 2 training and socialization processes associated with a 3 provision, right down to medical school, sort of push in 4 the -- the direction of understanding the human person 5 in a way that's arguably quite distinctive from the way 6 people used to treat in medicine or think about the 7 human person in medicine. 8 Q Yeah, understood. So but your point, if I'm 9 reading paragraph 56 correctly, your point is not that 10 they've, you know, picked one of two camps. The point 11 is that they picked the wrong camp, that the orthodox 12 world view is -- 13 A You know, I certainly think we are not a mind 14 and a self occupying a body. Right? 15 Q So your expert opinion aligns with the Orthodox 16 World View in Exhibit 14. 17 A More so than that. 18 Q Okay. 19 A I would have to go through each of these and 20 see them. 21 Q So I just want to -- earlier when we talked 22 about Exhibit 14 you said that was just a survey of 23 ordinary folks with non-expert positions; right? 24 A Uh, yeah. 25 Q Exhibit 14.</p>
<p style="text-align: right;">Page 151</p> <p>1 A Um-hum. 2 Q -- you are reflecting the view that you 3 attribute to the orthodox world view in this survey; 4 correct? 5 A The fact that it's sort of -- it's a mind/body 6 dualism. 7 Q Gotcha. 8 A Sort of a unity. 9 Q And -- and your expert view in the report is 10 that gender medicine distorts the unity of mind and 11 body. 12 A They seem to certainly find themselves on the 13 progressive side of this, the idea that this true self 14 is in the body and that the two may be divergent. 15 Q Okay. But on -- on page 26 of your rebuttal 16 report you offer as your expert opinion -- 17 A Um-hum. 18 Q -- that gender medicine distorts the unity of 19 mind and body? 20 A As I said about ideological capture. The 21 professional organizations seem intent on understanding 22 the human person as a dualism between mind and body, 23 and I don't know that that is historic to medicine. 24 Q Understood. 25 A So I would say it's an example of sort of</p>	<p style="text-align: right;">Page 153</p> <p>1 A Yeah. 2 Q That's the survey. 3 A Right. 4 Q Um, and in your discussion section in Exhibit 5 14 you use this progressive versus orthodox world view 6 to explain support or opposition to gender-affirming 7 care. 8 A I think -- I think we're trying to interpret 9 the data. So why do this many people say this on a 10 survey, why do this many people say that. And if you 11 can -- I will show you -- we didn't come to it with that 12 frame in mind -- 13 Q Yeah. 14 A -- but table 2 of that Exhibit 14. 15 Q Yeah. 16 A Column 4 and 5, it's all model 4 and then 17 voters only, model 5. 18 Q Yeah. 19 A If you go down to political identity and 20 behavior, the pro-choice coefficient in terms its P 21 value, which you don't see reflected here. But you get 22 a sense of it in the P value. 23 Q Yeah. 24 A Is that it was probably the single best 25 predictor of what people thought about this question.</p>

<p style="text-align: right;">Page 154</p> <p>1 Q Understood.</p> <p>2 A The outcome variable. So to me, like when we</p> <p>3 saw that, wow, this sort of comports with Hunter's</p> <p>4 thesis, which was sort of progressive and orthodox. But</p> <p>5 Hunter didn't talk about transgender stuff because that</p> <p>6 really wasn't on the radar when he wrote his original</p> <p>7 work on this.</p> <p>8 So my co-author and I sort of created this</p> <p>9 table of trying to understand, well, what is the</p> <p>10 orthodox and progressive understandings here and can</p> <p>11 they help us understand why people have answered the way</p> <p>12 they did, especially in light of the idea that how they</p> <p>13 characterize themselves as pro-choice or pro-life was</p> <p>14 tightly associated with the answer they gave to the</p> <p>15 question about adolescent treatment of gender dysphoria,</p> <p>16 which, you know, is somewhat striking to us.</p> <p>17 Q Yeah.</p> <p>18 A And so this was an interpretive lens through</p> <p>19 which we discussed this.</p> <p>20 Q And if I read the discussion section right --</p> <p>21 sorry, I'm not an expert, so if this is wrong just tell</p> <p>22 me. But the conclusion was that people with the</p> <p>23 progressive world view would, in the main, support</p> <p>24 gender-affirming care for adolescents. People with the</p> <p>25 orthodox world view would oppose it.</p>	<p style="text-align: right;">Page 156</p> <p>1 idea that the reason someone might oppose</p> <p>2 gender-affirming care for adolescents is because they</p> <p>3 have the orthodox world view, even they don't use that</p> <p>4 language for it?</p> <p>5 A Yeah, I think that's probably fair.</p> <p>6 Q Okay. And that was a survey of ordinary people</p> <p>7 and the reason they would oppose gender-affirming care;</p> <p>8 correct?</p> <p>9 A Right. But it's not -- they don't offer that</p> <p>10 explanation. They just answer questions on a survey.</p> <p>11 Q Understood.</p> <p>12 A And we analyze data and effect sizes, we try to</p> <p>13 understand where did this come from.</p> <p>14 Q I understand. But the world view that you</p> <p>15 claim in Exhibit 14 would lead somebody, an ordinary</p> <p>16 person to affirm -- oppose gender-affirming care is what</p> <p>17 you pointed me to when I asked for your expert opinion</p> <p>18 that gender medicine distorts the unity of mind and</p> <p>19 body. And I'm just trying to --</p> <p>20 A Can you just backtrack and say that again?</p> <p>21 Q Sure. We just talked about Exhibit 14 and it</p> <p>22 was discussed that one of the conclusions in Exhibit 14</p> <p>23 is that a person with the orthodox world view with no</p> <p>24 expert background would opposed gender-affirming care</p> <p>25 for adolescents based on that world view.</p>
<p style="text-align: right;">Page 155</p> <p>1 A Yeah.</p> <p>2 Q And does that help explain why? I mean, is</p> <p>3 your conclusion that that helps explain why they oppose</p> <p>4 it or support it?</p> <p>5 A Yeah. I mean, I talk a little bit about how</p> <p>6 people describe, well, how does this become a culture</p> <p>7 war issue?</p> <p>8 Q Yeah.</p> <p>9 A And this is one of the ways in which it has</p> <p>10 become a culture war issue, is because, quite frankly,</p> <p>11 unbeknownst to me when I did the survey, it's tightly</p> <p>12 associated with how people think about their attitudes</p> <p>13 about abortion. So I was somewhat surprised by that. I</p> <p>14 don't always go in thinking I know exactly -- especially</p> <p>15 in a regression model, like what's going to be</p> <p>16 associated with that.</p> <p>17 Q So --</p> <p>18 A Especially given the fact that after given the</p> <p>19 fact after control for a variety of things, these things</p> <p>20 are still expensive. The study was expensive --</p> <p>21 Q Explanatory.</p> <p>22 A -- was consistently significant and with a</p> <p>23 fairly strong effect.</p> <p>24 Q Understood. So the -- the part of the</p> <p>25 discussion section I'm curious about, though, is the</p>	<p style="text-align: right;">Page 157</p> <p>1 And when I asked you to explain the statement</p> <p>2 in paragraph 26 of your rebuttal -- paragraph 56.</p> <p>3 A Right.</p> <p>4 Q I'm sorry -- that is your expert view, that</p> <p>5 gender medicine distorts the view of mind and body --</p> <p>6 A Uh --</p> <p>7 Q -- and you pointed me to what that means to</p> <p>8 Exhibit 14.</p> <p>9 A When I'm writing this I'm saying -- so, as I</p> <p>10 said, I cite ordinary Americans have critical opinions</p> <p>11 and some are endorsing. But when you look at the</p> <p>12 profession as a whole, right, this is why I conclude the</p> <p>13 rebuttal with a little word about Hippocrates. Right?</p> <p>14 I think the unity of mind and body, once</p> <p>15 characterized medicine to the whole person, et cetera.</p> <p>16 I think it does not -- and certainly not in gender</p> <p>17 medicine today I think people definitely think one --</p> <p>18 that the mind and the body are quite distinctive things</p> <p>19 and it's their job to help bring the body into alignment</p> <p>20 with the mind.</p> <p>21 Q Yeah. But as I -- as I read paragraph 56 I</p> <p>22 don't see you to be saying, you know, transgender</p> <p>23 medicine has gone awry by picking one interpretation</p> <p>24 within the progressive or orthodox world view. I see</p> <p>25 you saying it's wrong because the orthodox world view is</p>

<p style="text-align: right;">Page 158</p> <p>1 correct.</p> <p>2 MR. CANTRELL: Object to form.</p> <p>3 Q (By Mr. Richardson) You say, "This is an</p> <p>4 example of job conditioning," and then you say, "It has</p> <p>5 resulted in a distorted understanding of the human</p> <p>6 person as a unity of mind and body."</p> <p>7 A Okay.</p> <p>8 Q And that's your expert view.</p> <p>9 A Yes.</p> <p>10 Q And when I asked you what that meant you</p> <p>11 pointed me to the reason an ordinary American might</p> <p>12 oppose gender-affirming care without any expertise?</p> <p>13 MR. CANTRELL: Object to form.</p> <p>14 A Except I -- you know, these ideas animate</p> <p>15 professionals, not just normal people. It's not as if</p> <p>16 health professionals don't have understandings that are</p> <p>17 incontinent with how regular people might think about</p> <p>18 something. I think they were probably more reflective</p> <p>19 on it. Right?</p> <p>20 So we apply the template of these two things to</p> <p>21 explain why regular people will have particular</p> <p>22 attitudes about it. Because they would not be able</p> <p>23 to -- if we asked a follow-up question, Why did you say</p> <p>24 yes or no to this particular question, you know, they</p> <p>25 wouldn't give you an articulation about this.</p>	<p style="text-align: right;">Page 160</p> <p>1 A Is it an ethical judgment?</p> <p>2 Q -- in any way?</p> <p>3 A No. If I -- all the stuff I have written about</p> <p>4 ideological colonization, um, articulates how particular</p> <p>5 activists, clinicians, researchers, et cetera, have</p> <p>6 helped move the American Academy of Pediatrics, the</p> <p>7 American Medical Association, et cetera, in directions</p> <p>8 that sort of foster this -- this notion.</p> <p>9 So, for example, I talk about in one of those</p> <p>10 reports how the American Medical Association can hold in</p> <p>11 tension its criticism regarding the Supreme Court case</p> <p>12 about capitol punishment for minors. Minors are not</p> <p>13 able -- not mature enough to reflect and the consequence</p> <p>14 of their actions until they are age 25. They don't have</p> <p>15 pre-frontal cortex business (sic.).</p> <p>16 And that's actually a piece of kind of</p> <p>17 conventional wisdom out there. Right? Like half of all</p> <p>18 marriages end in divorce. That's a piece of</p> <p>19 conventional wisdom. You know, your mind isn't</p> <p>20 completely developed until you're age 25. Piece of</p> <p>21 conventional wisdom. But behind that is a fair amount</p> <p>22 of social -- or social and medical science -- medical</p> <p>23 science.</p> <p>24 So I think that you see this happen where they</p> <p>25 can say, Ah, we can't hold youth responsible until they</p>
<p style="text-align: right;">Page 159</p> <p>1 I actually think medical professionals probably</p> <p>2 be more articulate about it and I would expect them to</p> <p>3 agree with most, if not all, of the body autonomy</p> <p>4 aspects, which I think is indicative of what I had</p> <p>5 talked about as ideological colonization.</p> <p>6 Q (By Mr. Richardson) So your expert opinion is</p> <p>7 that the medical profession long adhered to an orthodox</p> <p>8 world view.</p> <p>9 MR. CANTRELL: Object to form.</p> <p>10 A I don't know what that would necessarily look</p> <p>11 like in early, you know, medicine prior to 1950</p> <p>12 necessarily. But the idea that doctors think that, you</p> <p>13 know, one can be born into the wrong body I think is --</p> <p>14 I would state is relatively new.</p> <p>15 Q (By Mr. Richardson) Okay. And in paragraph</p> <p>16 56 or -- yes, you call that distorting the unity of mind</p> <p>17 and body. When you use the word "distort" there, is</p> <p>18 that a medical judgment? What do you mean by "distort"?</p> <p>19 A Is it a medical judgment? No. An</p> <p>20 understanding of the human person is a philosophic and</p> <p>21 perhaps anthropologic understanding. It's a term</p> <p>22 that -- just to repeat myself, that one can be born into</p> <p>23 the wrong body signals this dualism that I don't think</p> <p>24 characterized most medical professionals.</p> <p>25 Q Okay. Is that -- is it an ethical judgment --</p>	<p style="text-align: right;">Page 161</p> <p>1 are 25 for capitol crimes in quite the same way as we</p> <p>2 might have. And we also think youth are capable of</p> <p>3 making dramatic distinctions about their physical,</p> <p>4 biological, physiological future well before age 25,</p> <p>5 including, say, 13, 14, 15.</p> <p>6 Holding those two in tension would seem to</p> <p>7 signal that -- you know, the ideological capture of the</p> <p>8 American Medical Association, they once sort of</p> <p>9 protected and liked to see themselves still as</p> <p>10 protecting children and, yet, they are comfortable with</p> <p>11 recommendations that are -- can be rather destructive to</p> <p>12 the body.</p> <p>13 Q I see. So just to step back.</p> <p>14 A Yeah.</p> <p>15 Q If there were abundant clinical trials showing</p> <p>16 that gender-affirming medical care improved the mental</p> <p>17 health of adolescents with gender dysphoria, would you</p> <p>18 support providing that care?</p> <p>19 A We're talking about speculation. Like, it</p> <p>20 doesn't exist.</p> <p>21 Q If it did exist --</p> <p>22 A If it did --</p> <p>23 Q -- would you support providing that care?</p> <p>24 A -- exist? You know, I haven't given much</p> <p>25 thought to that because I would be really surprised if</p>

<p style="text-align: right;">Page 162</p> <p>1 the kind of clinical trial that people sought -- and  2 we're talking about trials, not only of one method  3 versus another method, but like intra-methods, like how  4 much dosage of this versus that, the age at which things  5 should be done. Right? So WPATH is about to issue  6 updated standards of care that bump the ages for its  7 recommendations down in age.  8 You know, it's not the result of clinical  9 trials that compared doing this at one age versus  10 another age.  11 Q I understand that. I guess my question is if  12 there were abundant clinical trials showing that  13 gender-affirming medical care improved mental health for  14 adolescents with gender dysphoria --  15 A Improve -- again, here I get into my  16 methodological cap. How did they measure mental  17 improvement?  18 Q I mean, assume it was a clinical trial that  19 satisfied your standards for such a trial.  20 A Which are probably pretty high.  21 Q Pretty high. Okay.  22 A But it's not outrageous. I mean, these are  23 clinical trials that they do for cardiac medicine.  24 Q I understand. I just want to come back to the  25 question if such a trial, if these trials were done</p>	<p style="text-align: right;">Page 164</p> <p>1 permitting adolescents to undergo surgery on a perfectly  2 healthy tissue has got to be awfully high, higher  3 barrier than we're currently seeing.  4 Q So given that you fall, in your words, on the  5 bodily integrity side, do you have reasons for opposing  6 gender-affirming care for adolescents apart from the  7 critiques of the literature reflected in your expert  8 reports?  9 A You know, I hate to disappoint you, but I come  10 to these things accepting what is the situation here.  11 And I don't often think about, Oh, let's envision a  12 world where none of these things happen. Right?  13 And so one of the reasons I have agreed to  14 write on this topic is reported somewhere in here is  15 that I thought it was rationale for the State of  16 Arkansas to say this is -- we've got to put a stop to  17 this because the situation is kind of -- the medical and  18 clinical situation seems to be in disarray. The  19 professional organizations are saying one thing. The  20 clinicians, even among the affirmatives, are openly  21 disputing now in print. You know, something is wrong.  22 Q I understand. But when I asked you for your  23 views on gender-affirming care for adolescents, you  24 pointed me to the idea that you're closer to the bodily  25 integrity side.</p>
<p style="text-align: right;">Page 163</p> <p>1 would you support providing care --  2 A Support what?  3 Q -- gender-affirming care under those  4 circumstances?  5 A Gender-affirming care is defined by cross-sex  6 hormones, surgery as a minor?  7 Q Let's just say puberty blockers and  8 gender-affirming hormones.  9 A At what age?  10 Q At any age supported by the clinical trial.  11 A Using the Dutch protocol --  12 MR. CANTRELL: Object to speculation.  13 A -- or not the Dutch protocol where --  14 Q (By Mr. Richardson) Okay. So I just to make  15 sure I -- so it sounds like you don't have an answer to  16 the question of if there were abundant clinical trials  17 what you would --  18 A I don't think about -- a whole lot about what's  19 not present. Right? Like if those things existed, you  20 know, would I be here? I don't know. I -- it's just  21 not a realistic situation.  22 Q So I'm trying --  23 A I do agree that, you know -- I do find myself  24 more into the bodily integrity side of this model than  25 the bodily autonomy. I think, you know, the barrier to</p>	<p style="text-align: right;">Page 165</p> <p>1 A Yes.  2 Q What does that add?  3 A What does that add?  4 Q Beyond the critiques of the literature  5 reflected in your report.  6 MR. CANTRELL: Object to form.  7 A What is my support of this add beyond the  8 critiques of the --  9 Q (By Mr. Richardson) You said that one reason  10 you oppose -- or that you think there might be a  11 rationale reason to ban care --  12 A Right.  13 Q -- is the state of the literature surrounding  14 that care.  15 A Right.  16 Q Are there other reasons?  17 A Maybe, perhaps.  18 Q Can you enlighten me on what those might be?  19 A No. If you want to look down here I can look  20 at this and say, you know, we're not born into a body.  21 Q And to clarify, you just gestured to the bodily  22 integrity --  23 A Right.  24 Q -- list of Exhibit 14?  25 A Yeah, the second one in that list.</p>

<p style="text-align: right;">Page 166</p> <p>1 Q Okay.</p> <p>2 A I don't think people are born into a body.</p> <p>3 They are born as a mind-body unity. Right? So anything</p> <p>4 that sort of wishes to radically separate mind from</p> <p>5 body, you know, uh, you know, I cannot speculate about</p> <p>6 some other conditions or something. But it seems like</p> <p>7 it signals a commitment to fundamental approach to the</p> <p>8 human person that I find unconvincing.</p> <p>9 Q Okay. So do you think it's realistic, given</p> <p>10 your comments earlier about the state of the literature,</p> <p>11 that it's realistic that there could be research</p> <p>12 demonstrating the effectiveness of gender-affirming</p> <p>13 care?</p> <p>14 A It could be realistic -- there's already claims</p> <p>15 of such. Right?</p> <p>16 Q Yeah. But when I asked you earlier what if</p> <p>17 randomized controlled trials supported gender-affirming</p> <p>18 care, you said you can't even imagine such a world.</p> <p>19 A It seems unlikely and it's -- your experts,</p> <p>20 when we talk the lack of clinical equipoise.</p> <p>21 Q So you cannot envision what research would look</p> <p>22 like supporting gender-affirming care for adolescents?</p> <p>23 A I don't see it happening and neither do your</p> <p>24 expert witnesses.</p> <p>25 Q But what would it look like if it did exist?</p>	<p style="text-align: right;">Page 168</p> <p>1 A Um-hum.</p> <p>2 Q And I'm just looking for what would adequate</p> <p>3 research look like in your expert opinion on this</p> <p>4 subject?</p> <p>5 A Adequate research should involve some measure</p> <p>6 of clinical trials of a sort. It seems very difficult</p> <p>7 right now, given that -- you know, I understand what</p> <p>8 Dr. Antommaria talks about while it's very difficult</p> <p>9 when you have one group that is given the treatment that</p> <p>10 so many kids seem to want, affirming treatment, compared</p> <p>11 to some other form of treatment, right, that they are</p> <p>12 not interested in as much, to track them long term.</p> <p>13 It's a difficult medical research situation.</p> <p>14 Q Understood.</p> <p>15 A So that doesn't even happen. But more of it --</p> <p>16 it never really did happen, which is somewhat puzzling</p> <p>17 to me.</p> <p>18 Q But you think it could happen? I think your</p> <p>19 report references that people should be doing randomized</p> <p>20 clinical trials on the subject.</p> <p>21 A Of -- you know, if you can't get it to where</p> <p>22 you have equipoise, like people don't care if they are</p> <p>23 in one or the other, I mean, which is rare. But take,</p> <p>24 for example, my father when he was diagnosed with</p> <p>25 melanoma, 1998. He was offered a clinical trial of the</p>
<p style="text-align: right;">Page 167</p> <p>1 A What would it look like if it did exist?</p> <p>2 MR. CANTRELL: Object to the form.</p> <p>3 A You know, I'd have to -- if it did exist and it</p> <p>4 used particular methods and samples and had effect sizes</p> <p>5 that were impressive, I would have to sort of wonder am</p> <p>6 I missing something. Right?</p> <p>7 Q (By Mr. Richardson) You said you wonder that</p> <p>8 about why --</p> <p>9 A Am I missing something? Because right now all</p> <p>10 I see when I talk about this literature is minor effect</p> <p>11 sizes, a lack of long-term studies.</p> <p>12 You know, for example, you know, it's been</p> <p>13 documented recently that women who undergo menopause</p> <p>14 early, lack in estrogen, et cetera, have greater risk</p> <p>15 for cognitive decline early in life. So we're talking</p> <p>16 about people in this menopause like before age 40. What</p> <p>17 it's like if you forced it on somebody at age, you know,</p> <p>18 17 or 18, whether as a minor or, you know, a young</p> <p>19 adult, like force it. We'd have to track people for a</p> <p>20 long time. Frankly, we ought to be tracking people for</p> <p>21 a long time on this stuff.</p> <p>22 So I don't know if that answers your question.</p> <p>23 Q Well, I suppose I'll reframe it. Your -- your</p> <p>24 expert report is about the purported inadequacy of</p> <p>25 research of effectiveness; right?</p>	<p style="text-align: right;">Page 169</p> <p>1 standard treatment, chemotherapy, versus immunotherapy</p> <p>2 they were testing. Right? But the conditions for it</p> <p>3 were different. You know, the second involved a lot</p> <p>4 more time in the hospital, but it was a prospective</p> <p>5 possible -- not so much cure, but it seemed better.</p> <p>6 He picked against it. He said, "I don't want</p> <p>7 to get involved with this," because he didn't want to be</p> <p>8 in the hospital for so long. Right?</p> <p>9 You have situations where equipoise is</p> <p>10 difficult, but that reached the stage where you could</p> <p>11 still do a clinical trial. Because some people were</p> <p>12 interested enough and said, Okay, I can go with the</p> <p>13 standard --</p> <p>14 Q I see. So trials --</p> <p>15 A You don't know that you're in that standard</p> <p>16 versus the experimental design, um --</p> <p>17 Q Yeah. So I -- so your saying that trials</p> <p>18 should be done in this area. Your expert report says</p> <p>19 that people be should be doing randomized clinical</p> <p>20 trials in this area?</p> <p>21 A We do this in most areas of medicine.</p> <p>22 Q Understood. But when I'm asking you to define</p> <p>23 what a successful trial would look like, you haven't</p> <p>24 given me a definition.</p> <p>25 A Distinctions in outcome, notable distinctions</p>

<p style="text-align: right;">Page 170</p> <p>1 in outcome. Right? So Pachankis and Branstrom  2 characterize their article, as I recall, almost as sort  3 of like this neat experiment -- it's not quite an  4 experiment -- but like those who have this and those who  5 didn't and you compare the distinctions.  6 We can get close with some kinds of data. But  7 in that case, you know, if the effect size had been  8 remarkable, dramatic, like, Wow, that's something.  9 Right? But like many things in this domain, like, they  10 are small --  11 Q I understand. I guess what I'm --  12 A -- given the magnitude of the medical  13 invasiveness of the treatments.  14 Q Okay. But it sounds like you're saying there  15 is at least theoretically possible a randomized clinical  16 trial --  17 A I would --  18 Q -- that would address --  19 A -- revisit my presumptions --  20 Q Okay.  21 A -- at that point.  22 Q And if such a trial were performed, would you  23 have any reason, apart from your concerns about the  24 state of the science, to oppose --  25 A The trial?</p>	<p style="text-align: right;">Page 172</p> <p>1 the bodily integrity list, therefore, I should say yes  2 to this. I did not anticipate it.  3 But, yeah, I mean, I don't deny that I think  4 these things are true and good.  5 Q Okay. So I'm just trying to understand. So  6 your report says that certain conclusions follow from  7 the weakness of the data in this area?  8 A That's my angle here. That's what I do.  9 Q I understand. I'm asking if the data changed  10 would your conclusion change?  11 A It is a possibility that I have not  12 entertained, and if the data changed then I entertain  13 that possibility.  14 Q Okay. So it's a possibility that you would  15 adjust your view on this question in response to new  16 evidence?  17 A As I said earlier, like, if my own children  18 were faced with this, and it is a challenging diagnosis,  19 et cetera, I think I would counsel them to be patient  20 and I would try to sort of help them understand that the  21 ramifications of these things, et cetera. But I don't  22 think much about what I would tell every other parent.  23 Q Okay. Would you counsel them to not pursue  24 gender-affirming care?  25 MR. CANTRELL: Object to form.</p>
<p style="text-align: right;">Page 171</p> <p>1 Q -- gender-affirming care?  2 A I'm sorry. I misjudged where you were going.  3 Q We just talked about the evidence that would be  4 adequate to address the concerns you raise in your  5 report. If that evidence existed, would you still  6 oppose gender-affirming care for adolescents?  7 A Since I didn't come to work on this project in  8 the absence of an answer to that question, I frankly  9 don't know how to approach it. The same question was  10 posed to me during the DeBoer v. Snyder.  11 I don't really think about non-real options  12 that haven't been done. Right? I mean, I have -- like  13 I said, I fit with this sort of bodily integrity aspects  14 of this, but I didn't sign on to write an expert witness  15 report because I only cared about these things. I  16 signed on because I had been observing the science of  17 this and kind the ideological colonization that had been  18 happening and I thought I -- you know, I objected to  19 sort of the conduct of medical scientists in this  20 domain.  21 Q Was the bodily integrity part of your world  22 view part of what led you to agree to participate in  23 this case?  24 A Perhaps. It's not things like I don't sit  25 around and think, Oh, given that I held commitments to</p>	<p style="text-align: right;">Page 173</p> <p>1 A I think I would say: Think very hard before  2 your children make decisions that you do or don't agree  3 with that make permanent changes to their body at a time  4 when they're physical and mental development is hardly  5 complete.  6 Q (By Mr. Richardson) Okay. Sorry to jump all  7 over here. I do want to follow up on one thing that you  8 said earlier before we break for lunch here.  9 You mentioned earlier that you were also  10 reviewed by UT for, I think you called it the promotion  11 case.  12 A Correct.  13 Q Can you just describe that --  14 A I don't know how we got off that subject a  15 while ago.  16 Q Yeah, yeah. Sorry.  17 A What about it?  18 Q Can you describe what you meant by the  19 promotion case?  20 A Promotion to full professor. There is two  21 promotions that you get in your academic career in the  22 United States. Assistant to associate with tenure.  23 Q Okay.  24 A And associate to full.  25 Q Okay. And that's what you were referring to</p>

<p style="text-align: right;">Page 174</p> <p>1 earlier?</p> <p>2 A The last of those.</p> <p>3 Q Was the second. And that resulted in you</p> <p>4 becoming a full professor at UT?</p> <p>5 A Correct.</p> <p>6 MR. RICHARDSON: Well, I think, if it's</p> <p>7 all right with you all, we can wrap for lunch and aim</p> <p>8 for --</p> <p>9 THE WITNESS: Two.</p> <p>10 VIDEO OPERATOR: -- 45 or something.</p> <p>11 THE WITNESS: 2:50.</p> <p>12 (Simultaneous crosstalk.)</p> <p>13 VIDEO OPERATOR: Okay. This will</p> <p>14 conclude media part 3 and we are off the record at 1:08</p> <p>15 p.m.</p> <p>16 (A break was had.)</p> <p>17 VIDEO OPERATOR: We are back on the</p> <p>18 record at 2:02 p.m. This begins media part 4. Please</p> <p>19 proceed.</p> <p>20 Q (By Mr. Richardson) All right. Welcome back.</p> <p>21 I just want to follow up and some things we were talking</p> <p>22 about before lunch. In terms of this idea of the state</p> <p>23 of science that exists right now, is it your view that</p> <p>24 randomized controlled trials to test the effectiveness</p> <p>25 of gender-affirming care for adolescents with gender</p>	<p style="text-align: right;">Page 176</p> <p>1 remarkably weak on the prospect that gender-affirming</p> <p>2 care improves mental health.</p> <p>3 A All right. Give me a page and --</p> <p>4 Q And this will be page 70, paragraph 161.</p> <p>5 A Of --</p> <p>6 Q Exhibit 1.</p> <p>7 A Seventy? Page 70 you say?</p> <p>8 Q Yeah.</p> <p>9 A Speculative suicide; right?</p> <p>10 Q Yeah. And you say, "The science behind claims</p> <p>11 that such treatments," referring to puberty suppression,</p> <p>12 "lead to sustained improvements in mental health is</p> <p>13 remarkably weak."</p> <p>14 A Yeah. Well, that -- between the dashes is</p> <p>15 rather important. "Improvement that cannot possibly</p> <p>16 occur in its absence" --</p> <p>17 Q Okay.</p> <p>18 A Meaning like, this is sort of where you're</p> <p>19 looking for causation because what has been offered to</p> <p>20 one group is comparable, except in one domain, the</p> <p>21 treatment to what is offered to another group, groups</p> <p>22 that are similar to each other --</p> <p>23 Q Understood. But you think.</p> <p>24 A -- preferably randomly assigned.</p> <p>25 Q Understood. So but you think that a trial</p>
<p style="text-align: right;">Page 175</p> <p>1 dysphoria are feasible?</p> <p>2 A Types of them are feasible.</p> <p>3 Q Okay.</p> <p>4 A Especially if we're talking about dosage</p> <p>5 trials. Certainly, those things are minimally feasible.</p> <p>6 Q All right.</p> <p>7 A But even if you want to think about how do you</p> <p>8 counsel nine-year-olds, ten, eleven -- now, different</p> <p>9 forms of counseling, different forms of sort of psych</p> <p>10 evaluations that are more extensive than others. I</p> <p>11 mean, there is just lots of ways in which one can do a</p> <p>12 comparison between types of treatment. I think it's</p> <p>13 Swedes or Fins, that in their complaint some things that</p> <p>14 are going on, said we're only going to do -- going to</p> <p>15 deliver treatment while under, I think they said</p> <p>16 research trials or clinical trials. I'm not sure what</p> <p>17 they are working on exactly. But these things are</p> <p>18 feasible, yeah.</p> <p>19 Q Yeah, I understand. So your report critiques</p> <p>20 the lack of trials related to both hormone blockers and</p> <p>21 gender-affirming hormones?</p> <p>22 A Could you point that out to me in terms of</p> <p>23 page?</p> <p>24 Q Oh, sure. Well, I think at one point you</p> <p>25 call -- let me find it here. You call the evidence</p>	<p style="text-align: right;">Page 177</p> <p>1 could be performed that would address the concern you</p> <p>2 raise here where you say "the data is remarkably weak"?</p> <p>3 A Let me read the rest of the section to myself.</p> <p>4 So I talk about, like, improvement that can't</p> <p>5 possibly occurred in its absence, not only am I talking</p> <p>6 about the lack of clinical trials, but also -- but also</p> <p>7 the leaps in mental health, what's already out there are</p> <p>8 sort of notable, not just sort of tiny effect sizes,</p> <p>9 things like that.</p> <p>10 Q Yeah, I understand.</p> <p>11 A We're talking about a major kind of treatment.</p> <p>12 One wants to see, kind of heroic affects. Right? With</p> <p>13 cancer, it's like I don't know what happened to the</p> <p>14 clinical trial that my father decided not to go in, but</p> <p>15 were they dramatically different?</p> <p>16 You know, sometimes they will say, Hey, if it's</p> <p>17 just one month difference of life it's not worth the</p> <p>18 additional hazards and rigors of the treatment. But</p> <p>19 like in here you want to start -- you want to see a</p> <p>20 dramatic improvement --</p> <p>21 Q I understand.</p> <p>22 A -- over the long run.</p> <p>23 Q Yeah. So I'll back up a little bit. Is it</p> <p>24 feasible to do randomized controlled trials that test</p> <p>25 the effectiveness of hormone blockers and</p>

<p style="text-align: right;">Page 178</p> <p>1 gender-affirming hormones?</p> <p>2 A I think it's feasible. I think Dr. Antommaria</p> <p>3 disagrees with me. It depends when you are doing these</p> <p>4 things --</p> <p>5 Q So you think it's feasible in general?</p> <p>6 A It's feasible at least in theory. But I</p> <p>7 recognize the domain in which we're operating, there's</p> <p>8 such a demand for affirmative types of treatment that it</p> <p>9 makes it more difficult to get the condition of</p> <p>10 equipoise where, you know, people are okay with the</p> <p>11 treatment to which they have been assigned or they</p> <p>12 understand, like, you know, this the hazard of being in</p> <p>13 one group versus another group, which is the example I</p> <p>14 used when you opened the questioning is that minimally</p> <p>15 we can do clinical trials on dosing. And I think one</p> <p>16 actually has been done on dosing. I forget for what.</p> <p>17 But even sort of counseling of, say, nine-year-olds or</p> <p>18 something like that. Like do it differently, do it</p> <p>19 twice as long.</p> <p>20 Q Okay.</p> <p>21 A I mean, it's just an example of how these</p> <p>22 things can occur.</p> <p>23 Q Okay. But do you think there could be clinical</p> <p>24 trials beyond just dosing recommendations and content of</p> <p>25 counseling?</p>	<p style="text-align: right;">Page 180</p> <p>1 A Adults, children, adolescents, you know, that</p> <p>2 sort of thing.</p> <p>3 Q If multiple studies existed, let's say, on</p> <p>4 hormone therapy, would that change your view about using</p> <p>5 hormone therapy to treat gender dysphoria in</p> <p>6 adolescents?</p> <p>7 MR. CANTRELL: Calls for speculation.</p> <p>8 A It does -- I mean, we're not in that situation,</p> <p>9 so I don't think much about what is possible in the near</p> <p>10 future.</p> <p>11 Q (By Mr. Richardson) Okay.</p> <p>12 A While I strongly encourage the -- you know,</p> <p>13 again, if it's the Swedes or the Fins, but, you know,</p> <p>14 they criticize the research in this area because it's --</p> <p>15 it lacks such studies. I think the Swedes have only, if</p> <p>16 I'm not mistaken, have endorsed treatments using the --</p> <p>17 the original or modified Dutch protocol in a, kind of a</p> <p>18 clinical comparison format.</p> <p>19 Q Okay. Just changing gears here. Do you know</p> <p>20 what HB 1570 is?</p> <p>21 A I'm familiar with it.</p> <p>22 Q If I use terms like "healthcare ban" or</p> <p>23 "Arkansas law," it's referring to the same --</p> <p>24 A Those I'm okay with.</p> <p>25 Q But you know I'm referring to the same thing,</p>
<p style="text-align: right;">Page 179</p> <p>1 A Beyond -- be specific, please.</p> <p>2 Q So are there randomized control trials that</p> <p>3 could show that receiving gender-affirming care versus</p> <p>4 not receiving gender-affirming improves health?</p> <p>5 A So when you say not receiving -- I'm presuming</p> <p>6 that one can get everything except one particular thing</p> <p>7 to look at the exact --</p> <p>8 Q Sure. Let's call it hormone blockers.</p> <p>9 A Okay. Fine. So is that the only difference</p> <p>10 between groups?</p> <p>11 Q Is it possible to design a study like that?</p> <p>12 A Possible to design a study like it, yes. Is</p> <p>13 it -- you know, I recognize and I think I even agreed</p> <p>14 with Dr. Antommaria that it's tough to see it work in</p> <p>15 reality.</p> <p>16 Q Okay.</p> <p>17 A And I do care about what is real and what is</p> <p>18 possible.</p> <p>19 Q Sure. So given that it's at least possible to</p> <p>20 design such a study, if such a study existed would your</p> <p>21 views on gender-affirming care for adolescents change?</p> <p>22 A If a study existed. I would be pleased if a</p> <p>23 study existed. But, really, a domain like this deserves</p> <p>24 multiple studies.</p> <p>25 Q Okay. If multiple studies existed --</p>	<p style="text-align: right;">Page 181</p> <p>1 Arkansas law, state of fact.</p> <p>2 A Got it.</p> <p>3 Q Okay. Have you read HB 1570?</p> <p>4 A I have.</p> <p>5 Q Okay. What do you understand HB 1570 to do?</p> <p>6 A To restrict --</p> <p>7 MR. CANTRELL: I'm going to object that</p> <p>8 Dr. Regnarus is not an attorney and can't offer --</p> <p>9 MR. RICHARDSON: Okay. That's noted.</p> <p>10 Thanks.</p> <p>11 A To curb the conduct of treatment of gender</p> <p>12 dysphoria to minors from treatments using hormones and</p> <p>13 surgical methods.</p> <p>14 Q (By Mr. Richardson) And when you say "curb," do</p> <p>15 you understand that it prohibits --</p> <p>16 A Correct.</p> <p>17 Q -- those treatments? Okay.</p> <p>18 Is it your view that the government should</p> <p>19 prohibit doctors from providing gender-affirming medical</p> <p>20 care to minors regardless of the circumstances?</p> <p>21 A Could you, sort of, break that down slowly?</p> <p>22 Q Is it your view the government should --</p> <p>23 A "The government," meaning the State of</p> <p>24 Arkansas?</p> <p>25 Q The State of Arkansas.</p>

<p style="text-align: right;">Page 182</p> <p>1 A Okay.</p> <p>2 Q Should prohibit doctors from providing</p> <p>3 gender-affirming medical care to minors regardless of</p> <p>4 the circumstances?</p> <p>5 MR. CANTRELL: Object to form.</p> <p>6 A "Regardless of the circumstances," what do you</p> <p>7 mean by that?</p> <p>8 Q (By Mr. Richardson) Are there any circumstances</p> <p>9 under which you think that should not be the case?</p> <p>10 A You know, I hate to punt on this, but, you</p> <p>11 know, I look at the situation, I think the situation is</p> <p>12 problematic in terms of, like I said, the ideological</p> <p>13 capture, et cetera, and the internal disputes that are</p> <p>14 going on, the modest science. And, frankly, I think the</p> <p>15 state is merited in saying, "We're going to call a halt</p> <p>16 to this because the situation is untenable."</p> <p>17 Q So is that a yes?</p> <p>18 A Yeah.</p> <p>19 Q Okay. Your report, this is page 4, paragraph 9</p> <p>20 of Exhibit 1.</p> <p>21 A Page 4, paragraph 9. This is December; right?</p> <p>22 Q Yes. Exhibit 1, yeah. Okay. Do you see</p> <p>23 whether you say you make no claims about the most</p> <p>24 prudent course of treatment for a particular patient?</p> <p>25 A Correct.</p>	<p style="text-align: right;">Page 184</p> <p>1 dysphoria?</p> <p>2 Q Yes.</p> <p>3 A Improved psychological health? I mean, there</p> <p>4 are different domains, some of which are better studied</p> <p>5 than others.</p> <p>6 Q Let's take the first one.</p> <p>7 A Dysphoric. The admission of gender dysphoria.</p> <p>8 It's plausible, sure.</p> <p>9 Q Okay. Let's talk about could hormone therapy</p> <p>10 ever help a patients' overall psychological health?</p> <p>11 A Are you talking about minors or adults?</p> <p>12 Q Let's do adults first.</p> <p>13 A Okay. What about it?</p> <p>14 Q Could gender-affirming hormone therapy ever</p> <p>15 help the psychological condition of an adult patient?</p> <p>16 A Um, probably, yeah.</p> <p>17 Q Okay. And could gender-affirming hormone</p> <p>18 therapy ever help an adolescent with gender dysphoria?</p> <p>19 A It's possible. I think -- I usually</p> <p>20 distinguish in these cases by one's minority status,</p> <p>21 whether you have reached the age of majority and better</p> <p>22 poised to make decisions for yourself. I think we have</p> <p>23 to be, you know, just like the Belmont report and all</p> <p>24 the institutional review boards that I had to go</p> <p>25 through, they seek to protect minors and other protected</p>
<p style="text-align: right;">Page 183</p> <p>1 Q Is that statement still accurate?</p> <p>2 A Yeah.</p> <p>3 Q Does that mean that you recognize that for some</p> <p>4 patients gender-affirming medical care may be</p> <p>5 appropriate?</p> <p>6 MR. CANTRELL: Object to form.</p> <p>7 A It just means that, you know, these are</p> <p>8 individual cases, one -- I might sort of certainly</p> <p>9 empathize. But I look at sort of what's gone on in the</p> <p>10 medical community itself on this, and it would seem to</p> <p>11 be that, you know, it's time for an experiment of sorts.</p> <p>12 Q (By Mr. Richardson) Well, I guess my question</p> <p>13 is: Could gender-affirming medical care ever help any</p> <p>14 single patient?</p> <p>15 A Affirming care?</p> <p>16 Q Could hormone therapy ever help any single</p> <p>17 patient?</p> <p>18 A It sounds like it does in terms of reduction of</p> <p>19 dysphoria.</p> <p>20 Q Okay. So you think that hormone therapy could</p> <p>21 help particular patients?</p> <p>22 A Help meaning like -- you would have to specify</p> <p>23 the outcome.</p> <p>24 Q Improve the mental health of a patient.</p> <p>25 A Mental health as defined by diminished gender</p>	<p style="text-align: right;">Page 185</p> <p>1 classes of persons from invasiveness in research.</p> <p>2 Q Okay. But you do think there are individuals</p> <p>3 who may benefit, as adolescents, from hormone therapy?</p> <p>4 A I suspect.</p> <p>5 Q Do you think that cutting off care for a</p> <p>6 patient receiving hormone therapy would benefit their</p> <p>7 wellbeing?</p> <p>8 MR. CANTRELL: Object to form.</p> <p>9 A I have no idea except I understand that they</p> <p>10 would rather not be cut off in care. I understand that</p> <p>11 concern.</p> <p>12 Q (By Mr. Richardson) And when you say you</p> <p>13 understand that concern, is it because you think they</p> <p>14 might be benefitting from that care?</p> <p>15 A It means that I think they want that care and,</p> <p>16 uh, it would be unavailable.</p> <p>17 Q Okay. Could some adolescents who are currently</p> <p>18 receiving gender-affirming medical care be harmed if</p> <p>19 they were required to stop treatment?</p> <p>20 A Could. It's a conceptual, you know. Possible.</p> <p>21 All things are possible.</p> <p>22 Q Do you think it's likely?</p> <p>23 A I do not know.</p> <p>24 Q Okay. Do you support HB 1570?</p> <p>25 A Yes.</p>

<p style="text-align: right;">Page 186</p> <p>1 Q Okay. And you support the law even though you</p> <p>2 believe it's possible that some adolescents currently</p> <p>3 benefit from gender-affirming care?</p> <p>4 MR. CANTRELL: Object to form.</p> <p>5 A Yes.</p> <p>6 Q (By Mr. Richardson) And you support the law</p> <p>7 even though you're unsure whether some patients may</p> <p>8 suffer if they stop receiving care?</p> <p>9 MR. CANTRELL: Object to form.</p> <p>10 A True.</p> <p>11 Q (By Mr. Richardson) Okay. So if the parents,</p> <p>12 adolescent patient, and doctor --</p> <p>13 A This is largely -- sorry to belabor this.</p> <p>14 Because my dissatisfaction when I read all this is the</p> <p>15 you know, we haven't addressed it, but like the surge in</p> <p>16 this cases remains largely unexplained. Some of the</p> <p>17 plaintiffs' expert witnesses have sought to explain it</p> <p>18 in ways that I think are modest.</p> <p>19 But, you know, care of minors kind of went</p> <p>20 along quietly for quite some time and then came this</p> <p>21 surge about five or six years ago, maybe a little bit</p> <p>22 more, in which case it largely remained unaccounted for.</p> <p>23 And the fact that scholars are uninterested in</p> <p>24 explaining that surge, again, fuels this conviction that</p> <p>25 ideological capture has occurred in professional</p>	<p style="text-align: right;">Page 188</p> <p>1 A All things are possible.</p> <p>2 Q Okay. Are there other medical treatments that</p> <p>3 you believe patients and doctors should be prohibited</p> <p>4 from accessing?</p> <p>5 A Other medical treatments --</p> <p>6 Q Other medical treatments beyond</p> <p>7 gender-affirming care.</p> <p>8 MR. CANTRELL: Object to the form.</p> <p>9 A I don't think about counter-factuals or</p> <p>10 non-factuals.</p> <p>11 Q (By Mr. Richardson) So you can't think of any</p> <p>12 other treatments that you would support banning for</p> <p>13 adolescents?</p> <p>14 MR. CANTRELL: Object to form.</p> <p>15 A You know, I -- you know, you could perhaps</p> <p>16 rattle off some, but I don't actually think about this.</p> <p>17 Q (By Mr. Richardson) Okay. What should the</p> <p>18 standards be to determine when it's appropriate for the</p> <p>19 government to ban care?</p> <p>20 MR. CANTRELL: Again, I'm going to object</p> <p>21 that Dr. Regnarus is not an attorney and can't offer --</p> <p>22 MR. RICHARDSON: I appreciate that. I'm</p> <p>23 just asking about what he thinks is appropriate.</p> <p>24 A What standards are appropriate for --</p> <p>25 Q (By Mr. Richardson) What standards should</p>
<p style="text-align: right;">Page 187</p> <p>1 societies --</p> <p>2 Q Understood. I guess I just want to come back</p> <p>3 to the question here, which you acknowledge that there</p> <p>4 are some adolescents could benefit from receiving</p> <p>5 gender-affirming care like hormone therapy.</p> <p>6 A Could, sure.</p> <p>7 Q Okay. And you accept that there are some</p> <p>8 adolescents who would be harmed by no longer receiving</p> <p>9 gender-affirming care like hormone therapy?</p> <p>10 A Perhaps.</p> <p>11 Q Okay. And you, nonetheless, support --</p> <p>12 A Depends on how we define "harm." If we define</p> <p>13 harm as disappointed, it's not so much harm.</p> <p>14 Q Well, let's define harm as a reduction (sic.)</p> <p>15 in gender dysphoria.</p> <p>16 A A reduction of --</p> <p>17 Q The alleviation of clinical distress --</p> <p>18 (Simultaneous crosstalk.)</p> <p>19 Q -- caused by --</p> <p>20 A -- things like this --</p> <p>21 (Simultaneous crosstalk.)</p> <p>22 Q -- gender --</p> <p>23 A -- then we're talking about some degrees of</p> <p>24 subjective judgment. But, yeah, it's possible.</p> <p>25 Q Okay.</p>	<p style="text-align: right;">Page 189</p> <p>1 determine when it's appropriate for the government to</p> <p>2 ban care?</p> <p>3 A Who would set those standards?</p> <p>4 Q I'm asking your -- your view.</p> <p>5 A Where would the standards come from? Standards</p> <p>6 to which governments are held.</p> <p>7 Q When do you think it would be appropriate to</p> <p>8 ban care?</p> <p>9 A What kind of care again?</p> <p>10 Q Any health care.</p> <p>11 A I am -- I don't know what we mean by -- like,</p> <p>12 standards that would be set by governments themselves,</p> <p>13 courts?</p> <p>14 Q So you think it's appropriate and correct for</p> <p>15 the state to ban gender-affirming care for adolescents;</p> <p>16 right?</p> <p>17 MR. CANTRELL: Object to the form.</p> <p>18 A I don't disagree with HB 1570, yeah.</p> <p>19 Q (By Mr. Richardson) Okay.</p> <p>20 A Yeah.</p> <p>21 Q And that implies that there are conditions</p> <p>22 under which you think that sort of ban on care is</p> <p>23 appropriate.</p> <p>24 A I suppose, yeah.</p> <p>25 Q And I'm asking you what those conditions are.</p>

<p style="text-align: right;">Page 190</p> <p>1 A What those conditions are. It would certainly  2 satisfy me more if we had good long-term evidence from  3 clinical trials, like I've talked about, in that you  4 wouldn't have sort of a rapid surge in patient demand,  5 but organizations are entering into and filling the  6 gap --  7 Q So let's focus on the first thing you said, the  8 lack of randomized clinical trials. Would you support a  9 system that banned care whenever there were not  10 randomized clinical trials to support that care?  11 A It depends on sort of the significance of what  12 we're talking about. I mean, you can do randomized  13 clinical trials on something small. But this is -- this  14 is kind of a big deal. This is about life-altering  15 circumstances and a minor's biography and history.  16 Q Understood. So --  17 A Standards have to be pretty high.  18 Q So I guess -- so is that a no, that you would  19 not support banning care based solely on the absence of  20 randomized clinical trials for that care?  21 A Please repeat that again slowly.  22 Q Would you support banning care solely on the  23 basis of a lack of randomized clinical trials supporting  24 that care?  25 A No.</p>	<p style="text-align: right;">Page 192</p> <p>1 the doctor-patient (and family) relationship."  2 Do you see that?  3 A Yep.  4 Q And then you say, "While the legislature's  5 primary narrative revolved around longstanding  6 objections to medical experimentation on minors." And  7 then you say, "Both notions have merit to them."  8 A Okay.  9 Q What did you mean when you said that Governor  10 Hutchinson's veto had merit to it?  11 A So just for context, I wrote this probably  12 after the, you know, what is this -- April 11th. So the  13 legislation had recently passed. I was -- my  14 information about it came from reading journalistic  15 accounts of this, so I'm trusting that the journalists  16 had it right.  17 So basically I'm saying Hutchinson --  18 (Reading) -- was legislative overreach to obstruct the  19 doctor-patient (and family) relationship, which,  20 typically speaking, matters quite a bit. Right?  21 So that's his primary motivation so far as I  22 could discern it. And the legislature's primary  23 narrative -- well, I think there were several  24 narratives -- revolved around their objection to medical  25 experimentation on minors.</p>
<p style="text-align: right;">Page 191</p> <p>1 Q Okay.  2 A It would have to be -- you know, that's not  3 just the method, it's the measures --  4 Q Understood.  5 A -- it's the length of time. You know, to see  6 the group of scholars in this domain improve their  7 analytic capacities, improve their ability to not  8 overreach in their conclusions. I mean, like I --  9 Q Understood.  10 (Simultaneous crosstalk.)  11 A -- said, like it should be better. They should  12 do better.  13 Q Okay. So just to come back to the question.  14 The lack of randomized clinical trials alone is not a  15 basis to ban medical treatment?  16 A Correct, yeah.  17 MR. CANTRELL: Object to form.  18 Q (By Mr. Richardson) Can you turn to Exhibit 5?  19 This is your article "Arkansas and the Politics of  20 Experimenting on Children."  21 A Okay.  22 Q I ask you to look at the second page, please,  23 middle paragraph there. Do you see about six lines down  24 there's a sentence, "Hutchinson's veto was predicated on  25 the idea that it was legislative overreach to obstruct</p>	<p style="text-align: right;">Page 193</p> <p>1 Q Okay.  2 A But there were other objections to it as far as  3 I could tell.  4 Q When you say that Governor Hutchinson's concern  5 about overreach into the doctor-patient (and family)  6 relationship, you say that has merit generally?  7 A Generally, sure.  8 Q Okay. What do you mean by that?  9 A That's something that should be understood as  10 worthy of respect.  11 Q Okay. So that --  12 A Not worthy of absolute respect, but, like, that  13 counts basically, in parentheses.  14 Q Okay. And that should be like the default  15 position for medical care?  16 A No. It's something that shouldn't be ignored;  17 right?  18 Q Okay.  19 A What parents and a kid and the doctor think  20 about for each other is like, that's worthy of  21 consideration.  22 Q Okay. And does that ordinarily council in  23 favor of letting the doctor and parent and adolescent  24 make the choice?  25 MR. CANTRELL: Object to form.</p>

<p style="text-align: right;">Page 194</p> <p>1 A I suspect it has to do with what they are 2 talking about. Right? Historically, yes, because we're 3 not usually talking about very dramatic things that are 4 life altering. 5 Q (By Mr. Richardson) Okay. 6 A Although it can, right? I mean, cancer 7 treatments. For example, I have family friends whose, I 8 don't know, seven or eight-year-old daughter was 9 diagnosed with leukemia and the mother -- certainly 10 mother, if not the father wrestled with do they want to 11 put their child through this rigorous chemotherapy 12 schedule. And, you know, the doctor typically, like 13 doctors mostly sort of want to improve people's lives, 14 they think this is the pathway to doing so. It was the 15 standard protocol. 16 And but she wrestled with it. And I have no 17 idea what the doctor-patient-family interactions were 18 about that, but one can recognize that they ought to be 19 respected. 20 Q Understood. So given the two concerns that you 21 say both have merit here -- 22 A Um-hum. 23 Q -- do you think there's some way to balance 24 those two concerns with respect to gender-affirming 25 care?</p>	<p style="text-align: right;">Page 196</p> <p>1 Q Yeah. 2 A That could have been different. It could have 3 been harsher, it could have been no penalty. Lots of 4 things could have been different about the legislation. 5 I think the Arizona does not ban hormones, but only 6 surgery I think. I mean -- 7 Q Would that system -- would you support that 8 sort of law? 9 A I don't even know if that's the law. 10 Q Well, let's say it was, a law that banned 11 surgery but not hormone therapy. 12 A Again, I don't think about counterfactuals. I 13 deal with what's in front of me. 14 Q Well, I understand. But your report suggests 15 that, and what you said today, suggests -- 16 A Right. 17 Q -- that a ban on hormone therapy -- 18 A Yeah. 19 Q -- is appropriate, and a ban on surgery is 20 appropriate. 21 A Sure, yeah. I mean, surgery is -- 22 Q I understand. 23 A -- more -- 24 Q So I'm asking -- 25 A -- obviously dramatic.</p>
<p style="text-align: right;">Page 195</p> <p>1 A Perhaps, you know. 2 Q Okay. What would that look like? 3 A I have no idea. 4 Q But you think that the two concerns could be 5 balanced? 6 A The two could be balanced. 7 MR. CANTRELL: Object to the form. 8 A I think like if -- and I've said this in the 9 reports. Like if you see, I'd say, better behavior on 10 the part of researchers, clinicians, you know, you'd 11 have a situation where I think you wouldn't have people 12 who are members of professional organizations wondering 13 why, you know, they're AAP hierarchy is telling them to 14 alter how we treat minors and gender dysphoria. 15 I'm losing my train of thought. What was your 16 original question? 17 Q (By Mr. Richardson) The question was could 18 Arkansas have done something differently besides banning 19 care to balance the two concerns you mentioned? 20 A I'm sure they could have. Again, you know, I 21 don't consult on political matters. 22 Q But you're offering -- 23 A Those things could have been different. I 24 think they have some sort of penalty to the care 25 providers if I'm not mistaken.</p>	<p style="text-align: right;">Page 197</p> <p>1 Q So I'm asking, you just suggested an 2 alternative from Arizona which would ban some care but 3 not others. Is that something you would support? 4 A Alternatives are possible. 5 Q Yes. 6 A Would I support it? I haven't thought much 7 about it. Just I recognize when I read, I'm like, Okay, 8 they decided to do this a little bit differently than 9 Arkansas. 10 Q Okay. But you think there are options apart 11 from Arkansas law short of a total ban that would 12 address the legislature's concern that you talk about 13 here in your article? 14 A I suspect if the Arkansas legislature had seen 15 a pathway to, you know, greater -- better science on it 16 they might have never pursued it in the first place. I 17 don't know. Why did this come up now in 2021 rather 18 than in 2020, 2019, 2018. 19 I mean, again I think it's part of this sort of 20 inexplicable tidal wave of cases. Where did this come 21 from? Why aren't the researchers studying this? This 22 is the criticism you get from some of the overseas 23 countries on this. 24 Q Gotcha. Can you turn to the last paragraph of 25 that article?</p>

<p style="text-align: right;">Page 198</p> <p>1 VIDEO OPERATOR: Mr. Richardson, I'm 2 hearing noise from your pen. 3 MR. RICHARDSON: Oh, sorry. You want me 4 to put this down? 5 VIDEO OPERATOR: Yeah. 6 MR. RICHARDSON: Gotcha. 7 THE WITNESS: Last paragraph? 8 Q (By Mr. Richardson) Last paragraph. It's the 9 final sentence there. Do you see where it says, "But 10 what nobody has at their disposal are the results of 11 kind of rigorous trials that Americans have long 12 benefitted from in every other branch of medical 13 research except this one." Do you see that? 14 A Yeah. 15 Q What did you mean by "rigorous clinical 16 trials"? 17 A I'm not sure I remember my state of mind 18 exactly when I wrote this, but it's the kind of stuff 19 that I've just been describing to you. It's diversity 20 of measures, diversity of longevity of the study itself, 21 diversity of treatment. There's lots of things that 22 could be done here and it's just sort of stunning that 23 they are not, and there seems to be no interest in doing 24 so -- 25 Q Okay.</p>	<p style="text-align: right;">Page 200</p> <p>1 branch has always done clinical trials. It's just like 2 you look at cancer trials, cardiac drug trials. Like 3 they're all trials; right? 4 Q Okay. 5 A National Institute of Health is full of 6 clinical trials that people can enroll in if they fit 7 the criteria. 8 Q Yeah. So when you say "in every other branch 9 of medical research except this one," did you attempt to 10 exhaustively look at medical branches? 11 A I did not attempt to exhaustively look at them. 12 Q So was saying "every branch except this one" an 13 overstatement, inaccurate? 14 A It's neither of those. It's potentially an 15 overstatement. 16 Q Potentially an overstatement. Okay. 17 Is it rare for medical treatments to be 18 unsupported by clinical trials? 19 A Is it rare for clinical treatments to be 20 unsupported by trials? Can you give me an example? I'm 21 just trying to get my head around -- 22 Q I'm just asking your view. You talked about 23 the state of medical research overall. So I'm just 24 curious, overall is it rare for medical treatments to be 25 unsupported by clinical trials?</p>
<p style="text-align: right;">Page 199</p> <p>1 A -- which is particularly troubling. 2 Q So is it your view that there are clinical 3 trials like you referred to there supporting all 4 treatments that doctors use in this country? 5 A Say that again. I'm trying to get my head 6 around this. 7 Q Is it your view that there are clinical trials 8 supporting all treatments that doctors use in the 9 country? 10 MR. CANTRELL: Object to form. 11 A All treatments for -- 12 Q (By Mr. Richardson) For anything at all. 13 A -- gender dysphoria? 14 Q No. For anything at all. 15 A Forgive me. Say it again now that I've got the 16 frame in mind. 17 Q Yeah. Is it your view that there are clinical 18 trials supporting all treatments that doctors use in 19 this country? 20 MR. CANTRELL: Object to form. 21 A No, I suspect not. 22 Q (By Mr. Richardson) Okay. But you say right 23 here that, "Americans have long benefitted from in every 24 other branch of medical research except for this one." 25 A Oh, it doesn't mean like every other medical</p>	<p style="text-align: right;">Page 201</p> <p>1 A There's degrees of support. I mean, I think 2 Dr. Antommaria highlighted that. What I'm suggesting is 3 I think that's rare to have such invasive treatments 4 that have not been subject to some for of clinical 5 trial. 6 Q Okay. But do you have any idea how often 7 medical treatment are administered to patients without 8 the support of a clinical trial? 9 A I don't. 10 Q Okay. Is it possible that -- 11 A There are a ton of clinical trials going on at 12 any given time. 13 Q Understood. 14 (Simultaneous crosstalk.) 15 A -- looked at them. 16 Q But you don't know how likely it is for 17 treatments to be supported by those types of trials? 18 A Of all possible conditions, that would be an 19 overreach. 20 Q Okay. Is it possible that it's quite common? 21 MR. CANTRELL: Object to form. 22 A I suppose all things are possible. 23 Q (By Mr. Richardson) So you don't know? 24 A Um, no, I don't. 25 Q So you don't know how often or how likely it is</p>

<p style="text-align: right;">Page 202</p> <p>1 for treatment?</p> <p>2 A You know, I have -- you know, I have kept track</p> <p>3 of NIH stuff for family health reasons, et cetera. I</p> <p>4 realize that there are tons of clinical trials going on</p> <p>5 in significant things and insignificant things, and have</p> <p>6 for decades.</p> <p>7 Q I understand there are a lot of clinical</p> <p>8 trials. What I'm asking is how likely is it for care to</p> <p>9 be provided without the support of a clinical trial?</p> <p>10 A That would be speculation on my part.</p> <p>11 Q So you don't know?</p> <p>12 A I'm not going to guess.</p> <p>13 Q Okay. Is it typical in medicine for there to</p> <p>14 be a consensus that only one type of treatment is the</p> <p>15 appropriate course of treatment?</p> <p>16 A I think it is uncommon, but, uh, I think</p> <p>17 there's a lot of markers and things like this which</p> <p>18 track people into this is what we needed to do for you.</p> <p>19 This is -- you know, treatment is kind of framed as</p> <p>20 being individualized or personalized, which I think is</p> <p>21 probably a stretch. But insofar as we understand</p> <p>22 medicine better, genetics, different people there is</p> <p>23 going to be more than one answer to a lot of these kind</p> <p>24 of questions.</p> <p>25 Q Okay. So I asked if there was -- if it's</p>	<p style="text-align: right;">Page 204</p> <p>1 A No.</p> <p>2 Q Is it based on any kind of scientific study of</p> <p>3 medical care?</p> <p>4 A It's observation of what goes on in the world.</p> <p>5 Q In just your personal observation?</p> <p>6 A How I understand it, um-hum.</p> <p>7 Q So is it typical for doctors to disagree about</p> <p>8 the appropriate course of treatment?</p> <p>9 A I think internal disputes are common. In this</p> <p>10 case, internal disputes have become so poignant that</p> <p>11 they have spilled over into the popular press, which I</p> <p>12 think is much less common than disputes among cardiac</p> <p>13 care physicians.</p> <p>14 Q Understood. So when you say it's common for</p> <p>15 those disagreements to emerge, what is that view based</p> <p>16 on?</p> <p>17 A Because as a scientist I know that scientists</p> <p>18 are always kind of disputing each other on sometimes</p> <p>19 large, but oftentimes smaller matters.</p> <p>20 Q So that's, once again, not based on any</p> <p>21 scientific research --</p> <p>22 A Just my participation in the scientific</p> <p>23 community and listening and watches other conversations</p> <p>24 that are going on in the scientific community.</p> <p>25 Q Okay. But nothing you've -- you have not</p>
<p style="text-align: right;">Page 203</p> <p>1 typical for there to be consensus that only one type of</p> <p>2 treatment is appropriate, and you said you think it's</p> <p>3 uncommon; is that right?</p> <p>4 A Say that once more.</p> <p>5 Q I asked is it typical in medicine for there to</p> <p>6 be a consensus that only one type of treatment is the</p> <p>7 appropriate course of treatment, and you said you think</p> <p>8 it's uncommon.</p> <p>9 A It's probably not common that, like, everybody</p> <p>10 would agree that this is the one right way to do things.</p> <p>11 Q Okay. And what is that based on, your</p> <p>12 assessment of how likely that is?</p> <p>13 A I would say based on experience with</p> <p>14 healthcare, you know, doctors will try different things.</p> <p>15 Q So just your personal experience with</p> <p>16 healthcare?</p> <p>17 A Also observations. I know that, you know, for</p> <p>18 different conditions, heart cardiac conditions they try</p> <p>19 different things. And also for, like, different kinds</p> <p>20 of cancers occurring in the same place, they treat it</p> <p>21 accordingly, not necessarily with --</p> <p>22 Q This isn't based on any kind of comprehensive</p> <p>23 survey --</p> <p>24 A No, it's not.</p> <p>25 Q -- of medical care?</p>	<p style="text-align: right;">Page 205</p> <p>1 written about --</p> <p>2 A No.</p> <p>3 Q -- how likely --</p> <p>4 A I think --</p> <p>5 Q -- consensus is for medical professionals. You</p> <p>6 have not read studies about how likely consensus is for</p> <p>7 medical professionals. Is that accurate?</p> <p>8 A Correct.</p> <p>9 Q Okay. Do you think care should be prohibited</p> <p>10 if there isn't a consensus about the appropriate course</p> <p>11 of treatment?</p> <p>12 A Should care be prohibited if there is not a</p> <p>13 consensus?</p> <p>14 Q Yes.</p> <p>15 A Uh, no.</p> <p>16 MR. CANTRELL: Object to form.</p> <p>17 Q (By Mr. Richardson) Okay. So a lack of</p> <p>18 consensus alone would not be a reason to ban a certain</p> <p>19 medical treatment?</p> <p>20 A Correct.</p> <p>21 Q Okay. What normally happens in medicine when</p> <p>22 there's a lack of consensus among medical providers?</p> <p>23 A What happens?</p> <p>24 Q Yeah. What do medical providers usually do</p> <p>25 when there's a lack of consensus?</p>

<p style="text-align: right;">Page 206</p> <p>1 A Healthcare providers?</p> <p>2 Q Doctors, people who treat patients?</p> <p>3 A I think it's fodder for more study.</p> <p>4 Q Okay. Do they typically stop providing care</p> <p>5 when there's a lack of consensus?</p> <p>6 A It depends on probably what the sort of -- what</p> <p>7 the situation is. I mean, I would struggle to come up</p> <p>8 with an example. But, like, sometimes, you know, entire</p> <p>9 lines of -- so back in Thalidomide. Right? We figured</p> <p>10 out it this was causing birth defects. The whole thing</p> <p>11 was shelved, the whole thing, immediately. Right?</p> <p>12 Q Okay.</p> <p>13 A So sometimes that does occur. But oftentimes,</p> <p>14 you know, debates resolve over time.</p> <p>15 Q And how common would it be to stop providing</p> <p>16 care when there is a lack of consensus in the medical</p> <p>17 community?</p> <p>18 A I would be speculating about how often that</p> <p>19 happens.</p> <p>20 Q So you don't know?</p> <p>21 A I don't know.</p> <p>22 Q Okay. And the example you just raised, I'm</p> <p>23 going to pronounce it wrong. I'm sorry.</p> <p>24 Falidomide (phonetic)?</p> <p>25 A Thalidomide.</p>	<p style="text-align: right;">Page 208</p> <p>1 Q Okay. I'd like you to turn to, I guess, the</p> <p>2 last two paragraphs at the very end.</p> <p>3 A The whole thing?</p> <p>4 Q The last two paragraphs, yep. Do you see that</p> <p>5 second sentence?</p> <p>6 A Which paragraph?</p> <p>7 Q It starts "Rarely have researchers been so</p> <p>8 explicit." See that paragraph down at the bottom of the</p> <p>9 second-to-last page?</p> <p>10 A Okay, yeah.</p> <p>11 Q Okay. There's a sentence there that says, "If</p> <p>12 this study is really the first study to show adverse</p> <p>13 mental health outcomes related to conversion therapy,</p> <p>14 how can it be sufficient, even if it were high quality,</p> <p>15 to justify government bans."</p> <p>16 A Um-hum.</p> <p>17 Q Can you explain that statement?</p> <p>18 A Get a little more context here.</p> <p>19 Q Okay.</p> <p>20 A I want to read up a couple of paragraphs.</p> <p>21 Okay.</p> <p>22 Q Okay. Can you explain that statement, please?</p> <p>23 A If the study is really the first study, which</p> <p>24 was what Jack Turban had described it as, to show</p> <p>25 adverse mental health outcomes related to conversation</p>
<p style="text-align: right;">Page 207</p> <p>1 Q Thalidomide? Is that -- Thalidomide? Is that</p> <p>2 it?</p> <p>3 A Am I now the older person in the room.</p> <p>4 Thalidomide was for, uh, a treatment I believe it was</p> <p>5 for morning sickness in the 60s -- 50s, 60s, but turned</p> <p>6 out to be a source of profound birth defects.</p> <p>7 Q Okay. And is that the kind of thing that</p> <p>8 you've -- you know about that experience because you</p> <p>9 have researched that topic or is that just general</p> <p>10 knowledge?</p> <p>11 A Read history, yeah.</p> <p>12 MR. RICHARDSON: Okay. Just general</p> <p>13 knowledge. Okay.</p> <p>14 Can we get Exhibit 8, please?</p> <p>15 (Plaintiff's Exhibit 8 was marked for</p> <p>16 identification and made a part of the</p> <p>17 record.)</p> <p>18 Q (By Mr. Richardson) Do you recognize that</p> <p>19 document?</p> <p>20 A Did I not include it in our previous</p> <p>21 conversation? I can't recall.</p> <p>22 Q I think it came up, yes. So is this the</p> <p>23 article you wrote, let me see, "Does Conversion Therapy</p> <p>24 Hurt People Who Identify As Transgender"?</p> <p>25 A Yes.</p>	<p style="text-align: right;">Page 209</p> <p>1 therapy, how could it be sufficient, even it were high</p> <p>2 quality, to justify government bans.</p> <p>3 You know, one should have more than one study</p> <p>4 on something. And in this case I think his methodology</p> <p>5 is weak.</p> <p>6 Q Okay. And is there --</p> <p>7 A His measurement is weak. So I -- to me it's</p> <p>8 like I look at it like, well, if that's the first study,</p> <p>9 like -- you need more than one weak study to call for</p> <p>10 something to be banned.</p> <p>11 Q Okay. And why is that?</p> <p>12 A Because it's weak.</p> <p>13 Q Is it because there would be uncertainty about</p> <p>14 it?</p> <p>15 A One should be uncertain about something that is</p> <p>16 measured in the manner in which Turban measures about</p> <p>17 it.</p> <p>18 Q Okay. So is it fair to say that your view is</p> <p>19 that care should not be banned when data on the harms of</p> <p>20 that care are uncertain?</p> <p>21 MR. CANTRELL: Object to form.</p> <p>22 A Uncertain as in -- I mean, again, back to</p> <p>23 Dr. Biggs, he uprated (phonetic) Dr. Turban. And I</p> <p>24 believe in this journal for -- I think it was for this</p> <p>25 study -- but for the use of the USTS and the manner in</p>

<p style="text-align: right;">Page 210</p> <p>1 which he asks questions.</p> <p>2 Q (By Mr. Richardson) No. I understand your</p> <p>3 critiques of Dr. Turban and the USTS. I guess what I'm</p> <p>4 asking is you say that because there has only been one</p> <p>5 study showing that conversion therapy is harmful that</p> <p>6 would be an insufficient basis to ban care; is that</p> <p>7 correct? To ban conversion therapy.</p> <p>8 A Typically, yeah. I mean, you want to sort of</p> <p>9 see -- so like in health research perhaps, but also like</p> <p>10 in lots of fields. When I first got into the sociology</p> <p>11 of religion there was this dispute about whether --</p> <p>12 sorry. Take a drink of water -- whether free market in</p> <p>13 religion contributed to, sort of, higher religious</p> <p>14 involvement in a country or not.</p> <p>15 Like there were competing studies on this</p> <p>16 stuff. Right? So only after some time and some</p> <p>17 consistency across studies would you sort of start to</p> <p>18 claim this is actually -- we're starting to see the</p> <p>19 answer to this question.</p> <p>20 Q Okay. So your point is there were competing</p> <p>21 studies. It meant there --</p> <p>22 A There are, but --</p> <p>23 Q They wasn't certainty about it.</p> <p>24 A -- they would be using different measures, et</p> <p>25 cetera, in people.</p>	<p style="text-align: right;">Page 212</p> <p>1 A I'd have to -- since the USTS is about adults,</p> <p>2 but they are retrospectively answering questions. I</p> <p>3 haven't read this in a while so I'd have to -- I think</p> <p>4 it was not about adults. I'm sorry. Not about minors</p> <p>5 alone. They might have included minors.</p> <p>6 Yeah, because if they talk about unemployment</p> <p>7 rates, they wouldn't be talking about unemployment rates</p> <p>8 on minors. So this includes adults and might have been</p> <p>9 limited to adults.</p> <p>10 Q Okay. So just coming back to the point here,</p> <p>11 you said because there was only one study showing that</p> <p>12 conversion therapy was harmful it should not be banned</p> <p>13 and you thought that study was weak.</p> <p>14 A Yes.</p> <p>15 Q Okay. Do you think that there -- are there</p> <p>16 studies showing that gender-affirming care harms minors?</p> <p>17 A Yeah. I mean, Biggs' reanalysis of USTS data</p> <p>18 shows that the -- I mean, this was a comment to -- in a</p> <p>19 journal -- or letter to the editor or commentary --</p> <p>20 showed that, you know, if Turban had controlled for the</p> <p>21 provision of -- I think this was about suicidality --</p> <p>22 had controlled for the provision of estrogen to natal</p> <p>23 male to female patients he would have noted that -- that</p> <p>24 it was actually aggravating to suicide. But he didn't</p> <p>25 control for the provision of estrogen, he only sort of</p>
<p style="text-align: right;">Page 211</p> <p>1 Q Yeah.</p> <p>2 A Weighted to their measure and not --</p> <p>3 Q Understood. So when they are competing studies</p> <p>4 and uncertainty like that --</p> <p>5 A Sure.</p> <p>6 Q -- is it your point here that under those</p> <p>7 conditions a ban would not be appropriate?</p> <p>8 A I guess it depends on the situation. You know,</p> <p>9 when we're talking about -- and this, I don't think it</p> <p>10 was about minors if I'm not mistaken. Does it? Oh,</p> <p>11 this was about adults if I'm not mistaken, or adults and</p> <p>12 minors.</p> <p>13 I go back to what I've said before, when you're</p> <p>14 dealing with minors the bar has got to be higher.</p> <p>15 Q For providing care or for withholding care?</p> <p>16 A For clear understanding of what's going on,</p> <p>17 for -- depends on the kind of care we're talking about.</p> <p>18 Right? If WPATH standard of care endorses the move for</p> <p>19 surgical treatments down to age 17, which I think the</p> <p>20 age standard of care recommends, that's kind of a big</p> <p>21 deal. I can't believe the spirit of Belmont report</p> <p>22 would endorse a move down into adolescence.</p> <p>23 Q So is it your view that Dr. Turban's research</p> <p>24 that you're talking about in this paper was not about</p> <p>25 minors?</p>	<p style="text-align: right;">Page 213</p> <p>1 highlighted, if I'm not mistaken, if I recall,</p> <p>2 testosterone is generally positive on mental health.</p> <p>3 But estrogen was aggravating to the mental health of</p> <p>4 natal male to female patients.</p> <p>5 Q Okay. So if we focus on --</p> <p>6 A For comparing -- another thing he didn't do was</p> <p>7 compare adults who didn't want hormone therapy. Because</p> <p>8 a bunch of people in USTS didn't want it. You bring</p> <p>9 those people back into the study and you see that they</p> <p>10 turned out relatively okay as well.</p> <p>11 Q So I guess my question is -- let's focus on</p> <p>12 hormone therapy. Do you think there are studies showing</p> <p>13 that gender-affirming hormone therapy is harmful to</p> <p>14 adolescents?</p> <p>15 A I think there's a variety of studies that show</p> <p>16 either a weak positive or a, you know, an effect that is</p> <p>17 so modest that it doesn't merit invasiveness of the</p> <p>18 treatment.</p> <p>19 Q Okay. But your point here in this article is</p> <p>20 that when there's only one study showing that a certain</p> <p>21 treatment protocol, here conversion therapy, is harmful,</p> <p>22 it shouldn't be banned.</p> <p>23 A Right.</p> <p>24 Q And just to be clear, the conversion therapy</p> <p>25 ban at issue here was for minors.</p>

<p style="text-align: right;">Page 214</p> <p>1 A Right. But he's talking to adults.</p> <p>2 Q Yes. But implication is for a ban on --</p> <p>3 A Reflecting back on their experience while they</p> <p>4 are growing up. Which, of course is, you know, in</p> <p>5 hindsight, like do you remember your experience growing</p> <p>6 up on this stuff. Some will, some won't --</p> <p>7 Q I understand your concerns about the USTS --</p> <p>8 A -- longitudinal --</p> <p>9 Q -- and the study.</p> <p>10 A Okay.</p> <p>11 Q What I'm asking about is this was a -- you were</p> <p>12 talking when you say justified government bans, that</p> <p>13 means bans on medical care for minors --</p> <p>14 A Right. Based on one --</p> <p>15 Q -- in that case of conversion therapy.</p> <p>16 A One study alone? No.</p> <p>17 Q Okay. I'm asking, was there a study that shows</p> <p>18 that gender-affirming hormone therapy is harmful to</p> <p>19 adolescents?</p> <p>20 A In terms of -- yeah, I'm not clear on that.</p> <p>21 Q So you don't know if there is a study that</p> <p>22 shows that gender-affirming hormone therapy harms</p> <p>23 adolescents?</p> <p>24 A If you give me time with this I can probably</p> <p>25 pull one out.</p>	<p style="text-align: right;">Page 216</p> <p>1 gender-affirming care in the absence of studies showing</p> <p>2 that they cause harm, but it's not appropriate to ban</p> <p>3 conversion therapy unless there would be multiple</p> <p>4 studies showing some harm? Do you see the question?</p> <p>5 A Plenty -- yeah. Plenty of what I talk about in</p> <p>6 my reports is a matter of informed consent. And I think</p> <p>7 informed consent is very challenging among youth,</p> <p>8 especially when it concerns their future and their</p> <p>9 future reproductive capacity and things like this,</p> <p>10 that -- there is a reason I wrote about informed consent</p> <p>11 because it matters a great deal.</p> <p>12 Q But the ban on conversion therapy would apply</p> <p>13 to minors and they would have to consent to care;</p> <p>14 correct?</p> <p>15 A A ban on conversion therapy is usually about</p> <p>16 talk therapy so far as I can tell. Part of my problem</p> <p>17 with the ban on conversion therapy is that, you know,</p> <p>18 linguistically it doesn't make sense because it is about</p> <p>19 the possibility of helping children become more</p> <p>20 comfortable with living in their, you know, with their</p> <p>21 current state.</p> <p>22 Q But do you think that an adolescent could</p> <p>23 consent to conversion therapy or gender identity change</p> <p>24 efforts?</p> <p>25 A I find Turban's definition of what constitutes</p>
<p style="text-align: right;">Page 215</p> <p>1 Q But nothing comes to mind?</p> <p>2 A Not off the top of my head.</p> <p>3 Q Okay.</p> <p>4 A I see a lot of studies that are talking about</p> <p>5 modest effects or are conducted with measures that are</p> <p>6 poor or, as in the case with the Swedish study,</p> <p>7 member -- large sample but dragged out over a long</p> <p>8 period of time, which is typically good, but only see</p> <p>9 the effect in, like, the tenth year --</p> <p>10 Q I understand. But so your statement here was</p> <p>11 that when there is only one study showing that a certain</p> <p>12 type of care is harmful --</p> <p>13 A Yes.</p> <p>14 Q -- that does not justify bans on that care for</p> <p>15 minors.</p> <p>16 A I understand.</p> <p>17 Q And you cannot identify for me any study</p> <p>18 showing that gender-affirming hormone therapy is harmful</p> <p>19 to adolescents?</p> <p>20 A Hormone therapy? I could if I had time to work</p> <p>21 through my documents.</p> <p>22 Q Okay. But nothing comes to mind?</p> <p>23 A Not offhand.</p> <p>24 Q Okay. So I'm trying to understand how you see</p> <p>25 these two issues. Why is it appropriate to ban</p>	<p style="text-align: right;">Page 217</p> <p>1 a gender identity change effort, I find it problematic</p> <p>2 in many ways as a measure. And if you want to go</p> <p>3 through it --</p> <p>4 Q We don't -- how would you define conversion</p> <p>5 therapy?</p> <p>6 A It sort of rifts off of conversion therapy for</p> <p>7 sexual orientation. Like conversion therapy for</p> <p>8 transgenders is about sort of, you know, the idea that</p> <p>9 gender identity they use or self-identify as can't</p> <p>10 change and that, uh, the notion that they couldn't be</p> <p>11 comfortable without sort of radically altering their</p> <p>12 bodies via hormones or surgery. Whereas, in some ways,</p> <p>13 like sexual orientation change efforts are trying to get</p> <p>14 people to feel things that they don't feel.</p> <p>15 Q I understand. So I guess --</p> <p>16 A This is sort of like gender identity change,</p> <p>17 like, well, are you trying to convert them from just</p> <p>18 being more comfortable with their body?</p> <p>19 Q But you accept that whatever it is, it is</p> <p>20 healthcare?</p> <p>21 MR. CANTRELL: Object to form.</p> <p>22 A Part of psychological care.</p> <p>23 Q (By Mr. Richardson) Okay. And could a minor</p> <p>24 give informed consent to that psychological care?</p> <p>25 A So if somebody experiences gender dysphoria, I</p>

<p style="text-align: right;">Page 218</p> <p>1 mean, typically speaking, even WPATH and Endocrine  2 Society, like, they have an idea what should be provided  3 to children; right?  4 Q This is like a straightforward question so I'm  5 sorry for not being clear about it. Could a minor  6 content --  7 A Consent to --  8 Q -- to psychological care involved in conversion  9 therapy?  10 A Well, if they can't consent to anything, which  11 like we're talking talk therapy, I mean --  12 Q I'm asking your view. Can a minor consent  13 to --  14 A To talk therapy?  15 Q -- to psychological care?  16 A I suspect, yeah.  17 Q Okay. So I come back to the question, your  18 view seems to be that it is not appropriate to ban  19 conversion therapy based on one study showing that it's  20 harmful, but that it is okay to ban gender-affirming  21 care and you can't think of any study showing that it's  22 harmful. And I'm just asking what explains that  23 difference and you said informed consent.  24 MR. CANTRELL: Object to form.  25 A I think of bans, okay, I think about having a</p>	<p style="text-align: right;">Page 220</p> <p>1 conversion therapy for minors because there weren't  2 multiple studies showing that care was harmful.  3 A One would want multiple studies for anything.  4 Q To ban care for minors; right? That's what  5 we're talking about --  6 A When we're take talking about this kind of care  7 for minors, it is not of the sort of hormonal or  8 physical --  9 Q Understood.  10 A -- nature that --  11 Q But you just said you want multiple studies.  12 And when I asked you do you know any studies showing  13 that gender-affirming hormone therapy harms minors, you  14 did not identify one.  15 A Right.  16 Q So I'm just trying to get you to explain --  17 A And I -- well, I'm explaining it.  18 Q Okay.  19 A The manner in which these studies are performed  20 is not consistent with the manner in which they are  21 being described, so I call it a bait and switch --  22 Q I understand.  23 A -- report. Right?  24 Q So is it fair to say you were --  25 A Most of this studies that sort of highlight the</p>
<p style="text-align: right;">Page 219</p> <p>1 preponderance of evidence, not just one study.  2 Q (By Mr. Richardson) Okay. And you think you  3 have a preponderance of evidence showing that  4 gender-affirming hormone therapy --  5 A I think a preponderance of evidence that the  6 manner in which most of this research is conducted is  7 subpar, substandard methodologically and --  8 Q I understand your critiques of the field. I  9 guess my point is in this piece you say until we have --  10 A Just because something is published in a  11 peer-reviewed journal --  12 Q I understand that.  13 A -- doesn't mean it's good.  14 Q I'm saying your words here --  15 (Simultaneous crosstalk.)  16 A That entire industry --  17 COURT REPORTER: Hey, one at a time,  18 please.  19 A -- has kind of highjacked the peer review  20 process.  21 Q (By Mr. Richardson) I am familiar with your  22 critiques --  23 A Okay.  24 Q -- on that point. I'm just asking about your  25 statement that it would not be appropriate to ban</p>	<p style="text-align: right;">Page 221</p> <p>1 positive effects were conducted under the Dutch protocol  2 where kids did not have --  3 Q I understand.  4 A -- psychological problems, and yet they are  5 turned around and the results are shown as evidence that  6 kids who do have significant psychological coterminous  7 problems should be given treatments.  8 Q Okay. So I'll just ask you two separate  9 questions.  10 A There is a problem with the scientific industry  11 here.  12 Q I understand. Maybe it will be easier if I  13 just ask it two separate questions. You think that  14 gender-affirming hormone therapy, a ban on that care is  15 appropriate for minors even though you cannot recall a  16 study showing that it is harmful to minors?  17 MR. CANTRELL: Object to form.  18 A The studies -- I mean, you're acting as if the  19 studies publication industry --  20 Q I'm just trying --  21 (Simultaneous crosstalk.)  22 A -- of their --  23 Q I'm not talking about --  24 A -- merits.  25 Q I'm just asking you to summarize what we've</p>

<p style="text-align: right;">Page 222</p> <p>1 already talked about. You think that a ban on  2 gender-affirming hormone therapy for minors is  3 appropriate even though you cannot recall a study  4 showing that that care harms --  5 A Because I can't recall --  6 Q -- adolescents.  7 MR. CANTRELL: Object to form.  8 A -- a study whose measures, methods, analyses,  9 interpretation and magnitude of gauging risk --  10 Q (By Mr. Richardson) Understood.  11 A -- meets any standard of statistical and  12 epidemiologically decency --  13 Q Understood.  14 A -- in terms of the way these things are  15 conducted. This goes back to the idea that these  16 organizations have been highjacked.  17 Q I understand. But is the answer -- so that's  18 yes?  19 A Yes.  20 Q Okay. And then the other question, you think  21 that a ban on conversion therapy for minors would be  22 inappropriate without multiple studies showing that it's  23 harmful?  24 MR. CANTRELL: Object to form.  25 A Again, it's the -- it's not about -- you know,</p>	<p style="text-align: right;">Page 224</p> <p>1 show adverse mental health outcomes related to  2 conversion therapy how can it be sufficient to justify  3 government bans?  4 A I'm talking back to Jack in this -- this  5 article.  6 Q Understood. But your point is it's not  7 appropriate to ban conversion therapy on the basis of  8 only one study because there would be uncertainty about  9 it?  10 MR. CANTRELL: Object to form.  11 A Um, certainly his study.  12 Q (By Mr. Richardson) Okay.  13 A Right?  14 Q Okay. And I just want to come back briefly to  15 your critiques of the studies on gender-affirming  16 hormone therapy. You're critique about reliance on the  17 Dutch protocol, that is a reason for doubting that those  18 studies show that care is effective.  19 Do those studies show that care is harmful?  20 A Um, which studies?  21 Q The ones you just referred to.  22 A When I'm referring to studies, I'm referring to  23 sort of the class of studies that were conducted using  24 the Dutch protocol when the sample was comprised of  25 patients who did not display psychological problems.</p>
<p style="text-align: right;">Page 223</p> <p>1 he's calling for a ban. I'm calling for clarity about  2 what is the meaning of conversion therapy because I  3 don't buy the --  4 Q Understood.  5 A -- the basic thesis that it is conversion  6 therapy.  7 Q I'll try again. So --  8 A So he's talking about a ban.  9 Q Understood.  10 A I'm saying I don't even agree with you about,  11 like, what it is you are speaking about. Okay?  12 Q Yes.  13 A Because bans would have to be sort of, uh --  14 Q So you're saying in the absence of greater  15 clarity --  16 A Clarity and scientific rigor --  17 Q -- and certainty about, you do not think that a  18 ban on conversion therapy would be appropriate?  19 MR. CANTRELL: Object to form.  20 A There's not agreement on what constitutes  21 conversion therapy.  22 Q (By Mr. Richardson) I'm just trying to look at  23 this statement right here.  24 A Yeah.  25 Q So if this study is really the first study to</p>	<p style="text-align: right;">Page 225</p> <p>1 Q Okay. Let's just follow up on the Dutch  2 protocol. Okay?  3 A Okay.  4 Q The Dutch protocol, you use that in your  5 report; right?  6 A I do.  7 Q And you mean by that a protocol where there's  8 more psychological --  9 A The scrutiny --  10 Q -- screening --  11 A -- for screening was notably higher.  12 Q Okay.  13 A Yeah.  14 Q So there is more psychological screening  15 involved; right?  16 A Right.  17 Q And is there also a requirement of childhood  18 gender incongruence of some kind. Is that the idea?  19 A Yeah, it is.  20 Q Okay.  21 A That is correct, such that, you know -- go  22 ahead.  23 Q And your view is that there were studies  24 showing that care under those conditions could be  25 effective?</p>

<p style="text-align: right;">Page 226</p> <p>1 A They seem to be more effective than -- I mean,  2 those just aren't the reality for how --  3 Q Understood. I'm just trying to --  4 A -- we are evaluating applicability for such  5 care today.  6 Q Okay. So let's just put that to the side, the  7 Dutch protocol itself.  8 A We can't put it to the side.  9 Q I'm just asking for the Dutch protocol itself,  10 where there is studies showing that protocol could be  11 effective for people with gender dysphoria.  12 A I would have to go back and examine them.  13 Q Okay.  14 A There's been a lot of writing on this domain  15 lately.  16 Q Okay. Do you think that if doctors in the  17 United States are following the Dutch protocol, as you  18 understand it --  19 A They are not.  20 Q -- they should be banned from providing  21 gender-affirming care to minors?  22 A They're not --  23 Q If they were.  24 A -- so far as I can tell. You know, if you can  25 broker an agreement that that would be possible I</p>	<p style="text-align: right;">Page 228</p> <p>1 groups who would say we don't need any psychological  2 evaluation, let anybody who, sort of, self-identifies as  3 opposite gender or something else is free to pursue  4 this, which some clinicians and some researchers  5 endorse, signaling a major dispute.  6 Q Okay. So do you think if providers were  7 required to follow the Dutch protocol, that would  8 address your concerns?  9 A Again, it's not about my concerns. It's about,  10 like, the reality has occurred.  11 Q I understand.  12 A I don't deal with things that are not real.  13 Q Let me rephrase. You've raised a number of  14 methodological objections to the research involving the  15 treatment of gender-affirming gender dysphoria in your  16 report.  17 A Right.  18 Q Would care, according to the Dutch protocol, be  19 subject to those same methodological objections?  20 A My typical objections are to -- I mean, I  21 certainly deal with true Dutch protocol and, sort of a  22 much less critical fashion than I do through other forms  23 of research and research -- not even research, but  24 claims that conclusions from Dutch protocol are  25 applicable to all minors.</p>
<p style="text-align: right;">Page 227</p> <p>1 suspect we wouldn't even be here and I suspect that this  2 matter wouldn't have risen to the attention of the  3 Arkansas Legislature. But it's not the reality.  4 Q I understand. So I'm saying -- you just said  5 that we wouldn't be here if clinics were following the  6 Dutch protocol.  7 A Because I think people who would be authorized  8 for treatment, that number would be a lot smaller. It  9 would not even sort of -- I mean, it didn't really come  10 to the attention of the public or the legislative eye  11 for years. Why are we talking about this now? Because  12 of the surge in cases, the flipped-sex ratio of these  13 cases.  14 Q I understand what you're saying. So do you  15 think that if clinics were following the Dutch protocol,  16 care should be banned under those circumstances?  17 MR. CANTRELL: Object to form.  18 A I'm not going to speculate about that. I could  19 speculate that it probably -- yeah, we probably wouldn't  20 be here if there is scrutiny and their standards were a  21 lot higher.  22 Q (By Mr. Richardson) So you think the Dutch  23 protocol has high standards?  24 A Much higher than, sort of, the generalized  25 affirmative care, which is, of course, is divided into</p>	<p style="text-align: right;">Page 229</p> <p>1 Q Okay. So let's say if the legislature passed a  2 law that said that care had to be provided consistently  3 with the Dutch protocol as you understand it. All  4 right?  5 A Again, they wouldn't -- we wouldn't even get to  6 that point --  7 Q But say we just --  8 A -- because they wouldn't have done it.  9 Q Meet me at the hypothetical, please. Okay?  10 MR. CANTRELL: Objection to speculation.  11 A I don't deal in hypotheticals. I deal in, sort  12 of, real situations.  13 Q (By Mr. Richardson) So you talk about the Dutch  14 protocol at length in your report.  15 A Some, yeah.  16 Q And I'm asking you, do you think care along the  17 lines of the Dutch protocol would benefit patients?  18 MR. CANTRELL: Object to the form.  19 A Then I would say, you know, perhaps for adults,  20 minors, you know, it's very sensitive stuff, but it had  21 passed for a long time. These were kind of the  22 standards and now they are not. Even though WPATH and  23 Dr. Adkins writes at great length endorsing WPATH  24 standards of care, at least No. 7, and as if these were  25 the standards that people are following.</p>

<p style="text-align: right;">Page 230</p> <p>1 And as I signaled in my report, I don't think  2 those are the things -- pathways people are following.  3 We see internal disputes, you know, indicator of some  4 problem.  5 Q (By Mr. Richardson) So I just want to --  6 A It may be the standards of care turn out to be  7 not rules --  8 Q I understand.  9 A -- not even norms.  10 Q I'm just trying to understand --  11 A They are suggestions that don't have teeth.  12 And so I think the legislature must have started  13 figuring this out and said, "These aren't norms, these  14 aren't standards. Let's give them some rules."  15 Q I understand.  16 A But that's purely speculation about their  17 mentality and I have no idea how they thought about  18 this.  19 Q I understand. But you are an expert in this  20 case and your expert report focuses on the state of the  21 research supporting gender-affirming medical care;  22 correct?  23 A It also highlights --  24 Q Understood.  25 A -- the things going on in the industry and the</p>	<p style="text-align: right;">Page 232</p> <p>1 about it.  2 Q Understood. So I'm just asking, if care was  3 provided according to the Dutch protocol would you  4 support that system?  5 MR. CANTRELL: Object to speculation.  6 A I think I first need to see how many cases  7 this -- it characterizes.  8 Q (By Mr. Richardson) So if there were a lot of  9 people who needed care, you would oppose care under the  10 Dutch protocol?  11 A No. It's just like how many people -- what  12 share of the persons who are receiving care now in the  13 affirmative kind of regimen are clinically depressed,  14 anxious, things that would rule them out of the Dutch  15 protocol. I don't think we know that.  16 Q That's why I'm asking the question. If care  17 was provided according to the Dutch protocol would you  18 support that system?  19 MR. CANTRELL: Object to speculation.  20 A I'm going to have to punt on that because even  21 about adults, right, and I respect adults' freedoms  22 and -- to do as they please. But we're talking about  23 minors. To see WPATH walking back in time instead of  24 forward --  25 Q (By Mr. Richardson) So you're not gonna answer</p>
<p style="text-align: right;">Page 231</p> <p>1 weighing of the morality of --  2 Q I understand.  3 A -- of 13-year-olds going on cross-gender  4 hormones.  5 Q Understood. But I think that it's entirely  6 appropriate as an expert in this case that you answer a  7 hypothetical question about the issues in your report.  8 And I'm asking you, if care could only be  9 provided according to the Dutch protocol as you  10 understand it, would that be an appropriate system?  11 MR. CANTRELL: Same objection.  12 A Perhaps, because I would never have -- my  13 attention wouldn't have been called to it by sort of  14 watching the research develop and I would have probably  15 ignored it. So I don't weigh in on this because I think  16 I need to tell WPATH how to do its job. I weighed in on  17 this because, even starting essays, because it seems  18 kind of outrageous that we're talking about a wing of  19 American medicine, especially American medicine that  20 has -- almost seems lawless.  21 Q (By Mr. Richardson) I understand. So you said  22 that you might not have ever become involved in the  23 issue if care was provided according to the Dutch  24 protocol.  25 A Become involved as in start reading and writing</p>	<p style="text-align: right;">Page 233</p> <p>1 the question of whether or not you think care according  2 to the Dutch protocol, as you understand it, to be --  3 A I have not given it that much thought because  4 it is not the reality.  5 Q Okay. So you're not going to answer the  6 question?  7 MR. CANTRELL: Objection.  8 A I have answered the question.  9 MR. CANTRELL: I believe the witness has  10 answered the question.  11 Q (By Mr. Richardson) Okay. I think you said at  12 one point you referenced the morality of 13-year-old  13 girls going on --  14 A Yeah.  15 Q -- hormones.  16 A Right.  17 Q What do you mean by the morality?  18 A Morality is sort of the weighing of the good  19 and the bad, right and wrong, wise and unwise, prudent,  20 imprudent.  21 Q And you think --  22 A We are all moral believing animals --  23 Q And you think it's immoral --  24 (Simultaneous crosstalk.)  25 A -- advisor --</p>

<p style="text-align: right;">Page 234</p> <p>1 Q -- for a --</p> <p>2 A When you talk about immoral, these are moral</p> <p>3 judgments. Right? Do I go so far as to say immoral?</p> <p>4 But they are judgments about what is right and wrong in</p> <p>5 a situation, so I say the morality. The -- the</p> <p>6 weightiness of the judgment, like is it a good or bad</p> <p>7 idea. Right? So I don't juxtapose with morality. I</p> <p>8 juxtapose morality like it is -- when you're talking</p> <p>9 about medicine, you're talking about morality. What's</p> <p>10 good here.</p> <p>11 Q Okay.</p> <p>12 A What's good to do.</p> <p>13 Q And does your sense of morality inform your</p> <p>14 view of hormone therapy?</p> <p>15 A My sense of morality? Most of what I've talked</p> <p>16 about here is about dealing with reality, not morality.</p> <p>17 Q I understand. But you just referenced the</p> <p>18 morality of a 13-year-old --</p> <p>19 A Yeah.</p> <p>20 Q -- girl going on --</p> <p>21 A Right.</p> <p>22 Q And I'm just trying to understand how does</p> <p>23 that --</p> <p>24 A Juxtaposed with immorality.</p> <p>25 Q Understood.</p>	<p style="text-align: right;">Page 236</p> <p>1 good to -- you know, to encourage, this is -- this is</p> <p>2 something we don't want to do.</p> <p>3 So, for example, somewhere in one of these</p> <p>4 reports I talk about how Endocrine Society has -- they</p> <p>5 have labeled certain outcomes as valuable to them, good</p> <p>6 ideas; right? And other outcomes as less important to</p> <p>7 them.</p> <p>8 Q Yeah, I have seen that part of your report.</p> <p>9 A The long-term flourishing of patients; right?</p> <p>10 Q Yeah.</p> <p>11 A Which calls to mind, you know, this research</p> <p>12 about, that I just mentioned earlier, you know, what if</p> <p>13 you go through menopause at age 17 --</p> <p>14 Q I understand. I don't mean to cut you off. I</p> <p>15 just want to come back to the question --</p> <p>16 A Sure.</p> <p>17 Q -- that I asked.</p> <p>18 A All right. This is about values.</p> <p>19 Q Yes.</p> <p>20 A Value is good.</p> <p>21 Q Understood. You said that you think providing</p> <p>22 gender-affirming hormone therapy to a 13-year-old would</p> <p>23 be, I think, quote, a little young.</p> <p>24 A Um-hum.</p> <p>25 Q And I asked if that was based on your moral</p>
<p style="text-align: right;">Page 235</p> <p>1 A It is -- understand, like, what is good for a</p> <p>2 13-year-old kid to do versus this may not be so good.</p> <p>3 Q Okay. What is -- what is your view on that, on</p> <p>4 gender-affirming care?</p> <p>5 A For a 13-year-old? I think it's a little</p> <p>6 young.</p> <p>7 Q For hormone therapy?</p> <p>8 A What kind of hormone therapy are we talking</p> <p>9 about? I mean, by that time you -- I guess, 13, 14, you</p> <p>10 start to see cross-sex hormones. I mean, I think that's</p> <p>11 a little early.</p> <p>12 Q And that's based on a moral judgment?</p> <p>13 A I think it's based on -- well, it's always</p> <p>14 going to be based on a moral judgment. I mean, there's</p> <p>15 no such thing as a pure scientific judgment. Because we</p> <p>16 think, Ah, if this works, it is good to do. Anything</p> <p>17 you're dealing with a good and bad idea, you're dealing</p> <p>18 with morality.</p> <p>19 Q Okay. So your view that starting</p> <p>20 gender-affirming hormone therapy --</p> <p>21 A Just be clear on this. It's like I have</p> <p>22 written extensively about values in science.</p> <p>23 Q Understood.</p> <p>24 A Right? This is where values and science come</p> <p>25 into play because there is always a sense of this is</p>	<p style="text-align: right;">Page 237</p> <p>1 judgment. And I just want a yes or no on that.</p> <p>2 A Insofar -- well, you're not going to get a yes</p> <p>3 or no. Insofar as it involves the informed consent of</p> <p>4 minors who haven't experienced puberty perhaps, I think</p> <p>5 it's, you know, it would be wrong to press them forward</p> <p>6 into something that they have not experienced.</p> <p>7 Even -- I forget what her name is. There's a</p> <p>8 live discussion going on among affirmative care about</p> <p>9 what do we do about minors who have not gone through,</p> <p>10 sort of, puberty and, in this case, the sexual</p> <p>11 experiences that people can have at some point after</p> <p>12 puberty that people who have gone through blockers, the</p> <p>13 cross-sex hormones may not experience sexual sensations.</p> <p>14 And they were debating, is this a good idea or maybe</p> <p>15 we're doing this too early. Right? So this is --</p> <p>16 Q Understood.</p> <p>17 (Simultaneous crosstalk.)</p> <p>18 A -- for us to observe it. Like, ah, they're</p> <p>19 having significant debates, which is a good thing, about</p> <p>20 the appropriateness, which means a moral judgment, of</p> <p>21 treatments for teenagers.</p> <p>22 Q Okay. So let me just put a finer point on it.</p> <p>23 A Sure.</p> <p>24 Q If there is a 13-year-old girl who is receiving</p> <p>25 gender-affirming hormone therapy and it is significantly</p>

60 (Pages 234 - 237)

<p style="text-align: right;">Page 238</p> <p>1 reducing her distress and improving her mental health,  2 do you think that the hormone therapy is --  3 A Which hormone? The blocker or is this on cross  4 sex or what?  5 Q This is gender-affirming hormone therapy.  6 A Okay. Sorry.  7 Q So it's significantly reducing her distress,  8 improving her mental health. Would you still have a  9 moral objection to care?  10 A I mean, is she on her way to surgery? Is it,  11 you know, is she, like, to stay in that position  12 permanently? I mean, this is how old again? Thirteen?  13 Q Thirteen, taking your hypo.  14 A Thirteen? It's awfully young.  15 Q So you would have the same thought that it's,  16 as a moral matter, too young.  17 A I think people should experience their natal  18 puberty.  19 Q Okay. So you have the same moral objection to  20 care in that circumstance that you shared previously?  21 A Yes.  22 Q Okay. And so I'm trying to understand your  23 view on you talk about values and science, morality. Is  24 it your view that the medical appropriateness of  25 gender-affirming care is a moral question?</p>	<p style="text-align: right;">Page 240</p> <p>1 academically seems to suggest that, you know, it's not  2 strict Dutch protocol.  3 It's sort of -- affirmative care and the Dutch  4 protocol are kind of separate things technically  5 speaking.  6 Q And I'm trying to understand. You said that's  7 based on your read of popular work or --  8 A So I have made reference to repeatedly sort of  9 the open kind of debate that we read, LA Times,  10 Washington Post, Atlanta Monthly. You know, this  11 playing out in sort of the court of -- not so much  12 public opinion -- but, you know, in long and short form  13 journalism.  14 So one can see, sort of, what's going on. And  15 these are all players in the -- either the research  16 community or the former leaders in WPATH. It signals  17 that there is a, you know, a significant dispute going  18 on.  19 Q Okay. So have you ever observed care being  20 provided in an American clinic?  21 A No.  22 Q Have you ever spoke with doctors who provide  23 care or gender-affirming care in a clinic?  24 A I spoke with pediatricians, but I'm not sure if  25 they are providing care themselves. I know they have</p>
<p style="text-align: right;">Page 239</p> <p>1 A The medical appropriateness of gender-affirming  2 care is a moral question? Yes.  3 Q It is?  4 A Yeah.  5 Q Okay. Is it also a scientific question?  6 A Yeah.  7 Q And are those two separate points?  8 A They can be.  9 Q Okay. We've talked a bit about your view on  10 the practices of American clinics a little bit. I just  11 want to look at -- this is your rebuttal report in  12 Exhibit 2. Okay. And this is on page 2.  13 A The bullet points there.  14 Q I think it is. Let me just make sure. Okay.  15 It's that first bullet there where you say "Careful  16 mental health assessments and stringent criteria for  17 eligibility invoked by the plaintiff's witnesses are, in  18 practice, hardly occurring." Do you see that?  19 A Right.  20 Q Okay. What is your basis for thinking that  21 that's hardly occurring in American clinics?  22 A Hardly occurring? In part, the open disputes  23 of gender-affirming care. And, you know, since this  24 signals the Dutch protocol in the background, my read of  25 the literature and both, sort of, popularly and</p>	<p style="text-align: right;">Page 241</p> <p>1 spoken of, you know, patient -- transgender patients  2 or -- uh, that they have seen, but I have not observed.  3 Q Okay. And have you ever interviewed a patient  4 who received gender-affirming care?  5 A No.  6 Q Okay. Have you ever reviewed medical records  7 of those receiving gender-affirming care to see if  8 they conform to the Dutch protocol.  9 A I don't think I would be privy to medical  10 records.  11 Q Okay. Have you done any kind of systemic  12 review of what clinics are doing?  13 A What familiarity is with the research in this  14 domain. How clinics are conducted themselves, I do not  15 know.  16 Q Okay. But your view is American clinics are  17 departing from the Dutch protocol?  18 A That is my impression. Not all of them  19 necessarily.  20 Q Okay.  21 A I suspect, again, as we've indicated, there is  22 diversity of thought in this.  23 Q Okay.  24 A Some it looks like, you know, they have kind of  25 tightened it, the criteria of eligibility. Others seem,</p>

<p style="text-align: right;">Page 242</p> <p>1 as I've highlighted in some of these reports, rebuttals,  2 open to sort of no psychological evaluation whatever,  3 just taking the patient's word for it.  4 Q Okay. And what clinics are not providing  5 psychological evaluations?  6 A Um, I don't know if I cited them in here.  7 But -- so I think I quoted Alex Keuroghlian. I'm  8 butchering his last name. Forgive me. But he's based  9 in Boston, I want to say Mass General, maybe Harvard  10 Family Clinic or Family Institute. He talks -- I don't  11 know if he practices this way, but he disparages the  12 criterion of psychological health prior to the  13 administration of treatment claiming that, you know, why  14 are we treating this as, you know, problematic on its  15 face.  16 Q But just to clarify, you don't know if he  17 practices according to that?  18 A I do not know if he practices according to  19 that.  20 Q Okay. So can you name any clinic that is not  21 providing psychological assessments before providing  22 care?  23 A No. But nor can I name, you know, clinics who  24 are.  25 Q So you can't name any clinics that provide</p>	<p style="text-align: right;">Page 244</p> <p>1 Q Okay.  2 A I mean, there's a -- one article I did cite,  3 whose clinic did not have the criteria of -- and it  4 was -- it was a sample from the clinic and they did not  5 use -- did not use a sample whose with the psychological  6 evaluation criteria.  7 Q Okay. Do you know how care is provided in  8 Arkansas?  9 A I suspect it is provided in a variety of  10 different ways because --  11 Q Okay.  12 A -- when you think about clinic criterion there  13 is no rules about it. You have the standards of care,  14 which Dr. Adkins claims is, you know, the norm. I have  15 no idea why -- I haven't seen evidence that it's the  16 norm.  17 Q Yeah.  18 A Perhaps I haven't seen evidence that it's  19 not --  20 Q Yeah.  21 A -- except that one can infer this from its open  22 disputes.  23 Q But just to clarify, then, so you don't -- you  24 don't know how care is provided at any clinic in  25 Arkansas.</p>
<p style="text-align: right;">Page 243</p> <p>1 gender-affirming care?  2 A I don't study internal clinic behavior, and a  3 lot of times I suspect it's not even public. Right?  4 Q Okay. So I want to understand, then, on your  5 report where you say that there in practice a certain  6 kind of treatment is hardly occurring.  7 A Okay. Hardly, you know, that is a vague term  8 and perhaps I should have said it is unclear in its  9 frequency. Because I see lots of commentary about how  10 this is -- this is not happening.  11 You hear about Planned Parenthood which serves,  12 technically, only adults. Some commentary on whether  13 they are actually treating adolescents or not, and they  14 don't have this eligibility criteria.  15 So one gets the impression, okay, and it is an  16 impression, that, you know, unless we have long lines at  17 gender clinics, and I think we have lines, but not long  18 lines like they do in national healthcare services,  19 there's a surge in cases. And, uh, so...  20 Q So your view about the practice of this sort of  21 care is entirely informed by just commentary.  22 A Correct.  23 Q Not observations of the care.  24 A Well, the literature that I attend to typically  25 does not talk about -- it's not sort of clinic care.</p>	<p style="text-align: right;">Page 245</p> <p>1 A I don't.  2 Q Okay. And if you were to learn that gender  3 clinics in Arkansas provide care with thorough  4 psychological evaluations, would that change your  5 opinion in the case?  6 MR. CANTRELL: Object to speculation.  7 A I don't know. But I have seen enough -- I've  8 read enough of, sort of, WPATH's and Endocrine Society's  9 standards that these are strictly voluntary. It's a  10 dynamic time. I would want to see evidence that those  11 standards of care are being followed.  12 Q (By Mr. Richardson) Understood. But when I  13 asked for a clinic that wasn't following those standards  14 you mentioned only -- I think only Planned Parenthood is  15 the only specific clinic you have mentioned; right? Or  16 the provider of clinics that you mentioned.  17 A Right.  18 Q And they only provide care to adults; right?  19 A Right, uh, formally. Informally I think that's  20 open to question.  21 Q Okay. So what are your views about the care  22 offered at Planned Parenthood based on?  23 A It sounds like it does not involve the  24 documentation of psychological services.  25 Q And what's the basis for that belief?</p>

<p style="text-align: right;">Page 246</p> <p>1 A Their website, Planned Parenthood of Great 2 Plains. 3 Q Okay. Their website says that they -- 4 A I believe that is correct. 5 Q Okay. And they say they provide care to minors 6 on the website? 7 A No. The minors reference was to an article, I 8 forget exactly where that appeared, claiming that, you 9 know, kids from high school come over and can get a 10 prescription filled. It sounded sort of surreptitious, 11 but I do know that plan parent hood does not have that 12 as a policy. 13 Q So the policy is -- 14 A It may be a practice, but not a policy. At the 15 same time, like, one of my beefs that I've talked about 16 in here is, like, there are no rules here, there are 17 just suggestions. 18 Q Okay. But you think the field is characterized 19 by what you call open debate. 20 A Yes. 21 Q And you think the field is characterized by 22 clinics who vary in their practice. 23 A Yes. 24 Q And if I ask you the basis for why you think 25 some clinics are not providing mental health</p>	<p style="text-align: right;">Page 248</p> <p>1 is pro forma. Are they doing pro forma psychological 2 care or not? I mean, what is psychological care? 3 Because Dr. Turban's conversion therapy sounds an awful 4 lot like psychological care at times. Like just sort of 5 how do you -- do pediatricians feel free to say, "I 6 don't think you should do this?" 7 Q Understood. Yeah. 8 A You know. 9 Q But if you were to find out that a clinic was 10 conforming to those sorts of -- was asking those sorts 11 of questions you just raised and was providing 12 psychological evaluations, that might change your view? 13 A Change my view of -- 14 Q Of whether or not -- 15 A -- the ban? 16 Q -- gender-affirming care should be banned. 17 A Um, you know, at the risk of being repetitive, 18 there is more than just psych evals here. There is the 19 wisdom of minors who have not experienced puberty. 20 Q So let's come back to that. Earlier you 21 said -- 22 A Consent of -- that sort of thing. 23 Q So earlier you said in this hypothetical about 24 a 13-year-old girl in significant distress whose 25 healthcare was improving because of gender-affirming</p>
<p style="text-align: right;">Page 247</p> <p>1 evaluations, that's entirely based on just public 2 commentary in newspapers and magazines, things like 3 that? 4 A Right. It's not from, like, regular people. 5 It's from people who used to run WPATH. And, uh, 6 this -- for better or worse the sort of medical and 7 psychological treatment is playing out in -- more widely 8 than it might in this domain than it might in other 9 domains of medicine. 10 Q Okay. And so when I asked you if -- if you 11 were to find out that the clinics in Arkansas were 12 providing psychological assessments, would that change 13 your view? I think you said you don't know; is that 14 correct? 15 MR. CANTRELL: Object to speculation. 16 A I don't know. 17 Q (By Mr. Richardson) Okay. So there is a chance 18 that you would have a different view? 19 A I would say this is impressive. Do they rule 20 out cases who are, you know, don't fit the Dutch 21 protocol? The provision of care, but does that affect, 22 you know, what happens next? 23 I mean, I get the -- from the wider debate 24 that's happening in some of these long -- from 25 journalistic pieces I get the impression that some of it</p>	<p style="text-align: right;">Page 249</p> <p>1 hormone therapy. 2 A Right. 3 Q You said that you would still object on moral 4 grounds because she hadn't experienced puberty yet; 5 right? 6 A I'd object -- I mean, every objection is on 7 moral grounds in general. I mean, whatever -- it's -- 8 Q Understood. So what if it was -- 9 A It's saying like it's a moral judgment to say 10 this is okay, this is not okay. So -- 11 Q Understood. 12 A -- clinicians, doctors do this all the time, to 13 give or not give, to withhold or to -- it's a moral 14 judgment. 15 Q Understand. One more hypo, then. 16 A All right. 17 Q Let's keep it the same but the person is now 15 18 years old and has gone through a few years of puberty. 19 Does that change your view at all? 20 A A few years of puberty. Right? Just to punt 21 back to this open conversation that was being had by 22 clinicians, you know, they are starting to wonder 23 whether they should stall longer because, you know, the 24 person doesn't know -- and it's a little interesting to 25 listen to. Like they don't know -- they don't know what</p>

<p style="text-align: right;">Page 250</p> <p>1 it's like to live as a post-pubertal -- people on  2 (sic.) post-pubertal minor and experience, sort of,  3 relationships and sexuality and et cetera. And so I  4 think there's this conversation that's going on. I  5 watch it and I'm glad that conversation is happening.  6 Q So just to follow --  7 A So she is rather young, you know.  8 Q So that argument about not experiencing life in  9 that way, that would apply to any adolescent  10 receiving --  11 A Well, I did --  12 Q -- care; right?  13 A I didn't write this about, you know, minors in  14 general.  15 Q Understood.  16 A Yeah.  17 Q So the point is not about not yet experiencing  18 puberty.  19 A It's not about sort of just being 13 or 15,  20 experiencing puberty or informed consent. It is a kind  21 of a package.  22 Q Okay. And just to conclude, those are all  23 moral judgments you've said.  24 MR. CANTRELL: Object to form.  25 A Everything in this domain from a doctor's</p>	<p style="text-align: right;">Page 252</p> <p>1 Q But all the objections you stated about a minor  2 receiving hormone therapy --  3 A Not all objections.  4 Q Many of the objections you raised.  5 A Some of the objections.  6 Q Um, that would apply to --  7 A It would apply to some --  8 Q -- a person --  9 A -- you know, that. But, like, you have to  10 weigh in that sort of the benefit you gain from clinical  11 trials, which, you know, I'm not confident in the least  12 will happen because nobody is really calling for them.  13 But I will grant your position.  14 Q I appreciate it.  15 A Then you have to weigh sort of the -- the  16 ability to consent to such a thing. Um, yeah, there is  17 a lot at play. And it's -- I think about, like, well,  18 would these be good trials, are the measures good, all  19 sorts of things.  20 Again, it would be kind of this conceptual -- I  21 think the situation is better than moving forward as is  22 with no trials claims about treatment based off of  23 cross-sectional data of opt-in internet samples. I  24 mean, it's just looking from the outside of medicine as  25 a social scientist, it looks like a problem.</p>
<p style="text-align: right;">Page 251</p> <p>1 prescription is a moral judgment that this is good to  2 do. Should I do this? I'm going to do this?  3 Q (By Mr. Richardson) Okay.  4 A Morality is something we exude all the time,  5 every day.  6 MR. RICHARDSON: Okay. Need a break?  7 VIDEO OPERATOR: All right. This will  8 end media part 4 and we're going off the record at 3:30  9 p.m.  10 (A break was had.)  11 VIDEO OPERATOR: We are back on the  12 record at 3:47 p.m. This will begin media part 5.  13 Please proceed.  14 Q (By Mr. Richardson) Thank you. So earlier we  15 talked about the possibility of clinical trials to test  16 the efficacy of gender-affirming care. I'm just  17 curious, would you support clinical trials to support  18 the efficacy of care even though it would require  19 providing that care to minors?  20 A That's a good question. It seems like  21 something that would make sense if you were actually  22 trying something out. So I haven't given it a lot of  23 thought, but it certainly -- it is preferential to the  24 current state of things. But, again, I haven't given it  25 a lot of thought.</p>	<p style="text-align: right;">Page 253</p> <p>1 Q Understood. So but -- so you support doing  2 clinical trials in this space where possible?  3 A A clinical trials research is preferential --  4 Q Okay.  5 A -- to what we've had before.  6 Q Understood.  7 A Again, though, you know, I grant Dr. Antommaria  8 his point that it's going to be hard to pull off.  9 Q Understood. But those trials would involve  10 providing gender-affirming hormone therapy to  11 adolescents.  12 A You know, if practitioners, researchers,  13 ethicists, legislators could come together on something  14 like that I probably would be -- it beats not knowing.  15 Q Okay. So in that case care provided in the  16 context of a clinical trial would be appropriate in your  17 judgment?  18 MR. CANTRELL: Object to form.  19 A I'm not sure I would, you know, go so far as to  20 claim that, because it doesn't answer the question of  21 should an adolescent make such decisions, even with  22 their parents' endorsement, about treatments that would  23 cut them off from natal puberty and the revelations that  24 that may have.  25 You know, if we're talking about surgery at 17</p>

<p style="text-align: right;">Page 254</p> <p>1 or something like that, you know, I can see ways in  2 which one could come to sort of an easier conclusion on  3 some of these things. But my beefs with this practice  4 go beyond the lack of clinical trials and beyond the  5 method of good measures and evaluation to the  6 fundamental ability to have informed consent as a  7 13-year-old about something that you have not  8 experienced, that is, you know, the outcome of natal  9 puberty.  10 Q (By Mr. Richardson) Okay. So just to clarify,  11 so you would -- you would still have objections to care  12 provided to adolescent -- let's call it hormone  13 therapy --  14 A Okay.  15 Q -- in the context of a clinical trial?  16 A Do I have objections? I think I would have  17 misgivings, short of objections. Again, I go back to  18 that, I don't make these decisions, I don't get to make  19 those decisions.  20 Q But you just said you're --  21 A I can see a scenario in which, you know, all of  22 this could have been avoided had the -- the gender  23 medical community decided to pursue treatments in a more  24 clinical evaluative manner, and that didn't happen. And  25 your asking me like, "Oh, can we go back now and do it,"</p>	<p style="text-align: right;">Page 256</p> <p>1 practices that some other countries have taken in this  2 area --  3 A Um-hum.  4 Q -- and research in those countries.  5 A Um-hum.  6 Q I think Sweden, Finland, the UK. Are there  7 any --  8 A Their references too, yeah.  9 Q Are there any practices in those countries that  10 you think would be a good way forward for  11 gender-affirming care?  12 A Let's see. I'm thinking -- the Fins have  13 nixed -- if I'm not mistaken, looking at this  14 recently -- have nixed surgery until at least age 18. I  15 can't recall about the hormone treatments.  16 I think the Swedes have said hormone treatments  17 can proceed as long as they are in this kind of  18 clinical -- I'm not sure if it's actually clinical  19 trial, but I think they use clinical research language  20 around it.  21 To me I look at that as, well, they are being  22 more prudent and cautious. And I compare that to the  23 United States, I guess Canada too, but I'm more familiar  24 with the United States as being imprudent and  25 uncautious. So I look at that as, like, well, that's an</p>
<p style="text-align: right;">Page 255</p> <p>1 I have no confidence that will happen.  2 Q Okay. So --  3 A Are you asking me for a wedge into what would I  4 be okay with, when I don't really deal with what would I  5 be okay with. I deal with what is happening around  6 here, what's even possible. I don't see any space or  7 any openness to clinical trials.  8 Q Understood. Let's back up a little bit. Okay.  9 So you said that -- just a second ago that I think you  10 said your beef with this area of research extends beyond  11 the lack of clinical trials and beyond the research  12 methodological issues --  13 A Yeah, and then I talked about --  14 Q -- to the informed consent question.  15 A Yeah, right.  16 Q So those objections would be true even for care  17 provided as part of a clinical trial; correct?  18 A Yeah.  19 Q So your view --  20 A Are my objections based on that so absolute  21 that I would not permit, I mean, a world in which I was  22 in charge, which I'm not? I don't know. Maybe. I  23 fundamentally don't think about such things, about what  24 would satisfy me.  25 Q Okay. So you've talked a bit about the</p>	<p style="text-align: right;">Page 257</p> <p>1 improvement. But I say, like, that's something that I  2 would wholeheartedly endorse, I don't know, because it  3 doesn't get past some of these other issues I have with  4 the treatment of minors.  5 Q Okay. So the issues of the treatment of  6 minors, once again, that is your view on informed  7 consent for minors and also your view on the morality of  8 care for people who have not yet experienced post-  9 pubertal life; is that --  10 A Yeah.  11 Q -- basically right?  12 A You add the term "morality" because I said the  13 term "morality." But the wisdom and prudence is also  14 the same definition of it.  15 Q Okay.  16 A Whether it's a good idea or not to have not  17 experienced your natal puberty before making up these  18 decisions. Now, I recognize that plenty of the  19 clinicians and researchers totally dispute that, and  20 that the Dutch protocol itself has sort of kind of been  21 weakened or lightened in part because of demand from  22 clinicians and from patients. I don't think it's going  23 in the other direction.  24 Q Okay. And just to come back to the framework  25 you gave for your objections here, you said the</p>

<p style="text-align: right;">Page 258</p> <p>1 objection about the lack of clinical trials.</p> <p>2 A Um-hum.</p> <p>3 Q There's the objection about research and</p> <p>4 methodological concerns. And these are separate</p> <p>5 objections about the wisdom of care for people who have</p> <p>6 not experienced puberty and informed consent.</p> <p>7 A Right, right, yeah.</p> <p>8 Q And those are different objections in your</p> <p>9 mind?</p> <p>10 A Right.</p> <p>11 Q I just want to ask also, do you have religious</p> <p>12 objections to gender-affirming care?</p> <p>13 A Religious objections to gender-affirming care?</p> <p>14 Insofar as, you know, in the back of this interpretive</p> <p>15 frame I already agreed that I'm kind of in the bodily</p> <p>16 integrity camp.</p> <p>17 Q And just to clarify, that's Exhibit 14?</p> <p>18 A Is it? Are you asking me?</p> <p>19 Q I'm sorry.</p> <p>20 A Okay. Fine. Are those religious? I don't</p> <p>21 know that those are religious. I'm Catholic. I know</p> <p>22 the Pope isn't a big fan of gender ideology, but, uh --</p> <p>23 Q Do you share that view?</p> <p>24 A It depends on what he means by gender ideology.</p> <p>25 The church hasn't made extensive statement on the</p>	<p style="text-align: right;">Page 260</p> <p>1 in the description.</p> <p>2 But, you know, I don't think people can</p> <p>3 actually change their sex insofar as we understand sex,</p> <p>4 sexual dimorphism of the human organism.</p> <p>5 Q When you say pass for the opposite sex --</p> <p>6 A Like be understood to be somebody of the</p> <p>7 opposite sex.</p> <p>8 Q Okay. And you see that as related to</p> <p>9 transgender people in the sense that you think they are</p> <p>10 attempting to pass --</p> <p>11 A Some transgender persons are attempting to pass</p> <p>12 as the opposite sex, yeah. I mean, Dr. Karasic -- is</p> <p>13 that how you say his name? I wrote in I think the</p> <p>14 rebuttal where he describes this sort of -- the</p> <p>15 normative goals of treatment, which are often to sort of</p> <p>16 feel, appear, understand one's self as a member of the</p> <p>17 opposite sex. So we're talking about, like, the desire</p> <p>18 to do so; right?</p> <p>19 Q Okay. Do you think that anybody who presents</p> <p>20 as the opposite sex is transgender or who wants to</p> <p>21 present as the opposite sex is transgender?</p> <p>22 A Not necessarily, no.</p> <p>23 Q So what is the distinction there?</p> <p>24 A The distinction? I mean, my understanding is</p> <p>25 that there are lots of goals that people have when they</p>
<p style="text-align: right;">Page 259</p> <p>1 matter. These are -- these aren't necessarily</p> <p>2 religious, but they do characterize largely how I</p> <p>3 understand this to be. Um, you know, I don't know that,</p> <p>4 like, my Bishop in Austin, I don't know what his</p> <p>5 thinking is on this, but he wouldn't be out of step, I</p> <p>6 think, with the church. So how much does that influence</p> <p>7 me, I have no idea. I couldn't pick apart these things.</p> <p>8 Q Okay.</p> <p>9 A But it's safe to say my church isn't --</p> <p>10 wouldn't make it easy for me mentally, theologically, to</p> <p>11 sort of endorse these things. But all the things I've</p> <p>12 told you really stand independently so far of that.</p> <p>13 Q Okay. Just to come back, you said the church</p> <p>14 has opposition to gender ideology. What does that term</p> <p>15 mean?</p> <p>16 A That's how they frame -- you know, I'm not a</p> <p>17 good person to ask about that.</p> <p>18 Q Okay.</p> <p>19 A I do think, you know, they would not be fans</p> <p>20 of, or even believers in the idea that one can change</p> <p>21 one's sex.</p> <p>22 Q And is that a view you share?</p> <p>23 A I mean, I think one can pass extremely</p> <p>24 effectively as a member of the opposite sex. Do you</p> <p>25 pass as non-binary? That's a different kind of passing</p>	<p style="text-align: right;">Page 261</p> <p>1 pursue this or self-identify as such, some to appear as</p> <p>2 both male and female, neither male, nor female, as a</p> <p>3 member of the opposite sex -- you know, there's a lot of</p> <p>4 goals that people have when they pursue this and some of</p> <p>5 it is idiosyncratic. At the same time I think there's</p> <p>6 some share, a non-insignificant share that seeks to</p> <p>7 appear as somebody as the opposite sex.</p> <p>8 Q Okay. And coming back to this idea of gender</p> <p>9 ideology. I know you said that's not --</p> <p>10 A It's not a term I have used a whole lot I don't</p> <p>11 think.</p> <p>12 Q Okay.</p> <p>13 A I may have used it a few times. But it's sort</p> <p>14 of like the package of -- insofar as I understand what</p> <p>15 the Pope is referring to, like both sort of</p> <p>16 understanding one is ontologically able to change one's</p> <p>17 sex and -- so.</p> <p>18 Q Well, the reason I ask is because it's in your</p> <p>19 Declaration for the preliminary injunction. I think</p> <p>20 this is Exhibit 3. I think it should be paragraph 6D.</p> <p>21 At the beginning you kind of list -- you have a list</p> <p>22 there on page 3.</p> <p>23 A 6D, "There is a great deal of evidence that</p> <p>24 discussion of gender dysphoria has been captured by the</p> <p>25 assumptions of activists promoting what is sometimes</p>

<p style="text-align: right;">Page 262</p> <p>1 called 'gender ideology.'"</p> <p>2 Q So what did you understand the term to mean in</p> <p>3 the report?</p> <p>4 A When I said that? Gender ideology, when I am</p> <p>5 referring to it here, is sort of an understanding that</p> <p>6 one can change one's sex, that it is fine and good to</p> <p>7 pursue that if one wants, or, you know, to pursue one's</p> <p>8 personal goals in regarding with hormones and surgery</p> <p>9 and medicine, et cetera, et cetera.</p> <p>10 It's, I think, a short phrase for what some</p> <p>11 call the -- both the provision of the teaching about --</p> <p>12 and it bridges into sort of academic teaching around</p> <p>13 gender performativity (sic.), things like Judith Butler.</p> <p>14 I think the term kind of encompasses this sort of world</p> <p>15 view, physical, psychological, social about sort of the</p> <p>16 malleability of gender or sex.</p> <p>17 Q Okay. And that -- and that is the same meaning</p> <p>18 that you say is part of the Catholic church's teaching</p> <p>19 on gender ideology? Is there a different meaning?</p> <p>20 A I'm trying to think. That is kind of the</p> <p>21 phrase that they use, but some other people have used it</p> <p>22 as well, to characterize -- I think it's the phrase they</p> <p>23 use -- the sort of package of this stuff. Right?</p> <p>24 And in some places, you know, there is still</p> <p>25 gender ideology, but, you know, you don't have minors</p>	<p style="text-align: right;">Page 264</p> <p>1 Q Am I summarizing that right?</p> <p>2 A Fine.</p> <p>3 Q I'm trying to make sure I'm accurate with what</p> <p>4 you were saying.</p> <p>5 Okay. Is your view that transgender identity,</p> <p>6 then, is not something that is inherently part of a</p> <p>7 person's identity?</p> <p>8 MR. CANTRELL: Object to form.</p> <p>9 A Oh, I think as -- you know, adolescents and</p> <p>10 adults it clearly is, you know, part of how they</p> <p>11 characterize themselves and a very meaningful part. And</p> <p>12 is it true that they are ontologically not their natal</p> <p>13 sex? You know, I'm not sure I would agree with that,</p> <p>14 but I understand that they understand themselves this</p> <p>15 way or may understand themselves this way.</p> <p>16 Q (By Mr. Richardson) Gotcha. Earlier you talked</p> <p>17 about -- I think you called it a surge in cases of</p> <p>18 adolescent --</p> <p>19 A Um-hum.</p> <p>20 Q -- gender dysphoria. Is there evidence of an</p> <p>21 increase in adolescents receiving gender-affirming</p> <p>22 treatment in the United States?</p> <p>23 A I base that on sort of like the growth in</p> <p>24 clinics, basically.</p> <p>25 Q Okay.</p>
<p style="text-align: right;">Page 263</p> <p>1 wrestling with medical and surgical decisions. And they</p> <p>2 will still, sort of, encompassed in the gender ideology</p> <p>3 would be this notion that people can become something</p> <p>4 that they were not ontologically born as.</p> <p>5 Q So your view is that --</p> <p>6 A It's kind of a package deal of social,</p> <p>7 intellectual, academic, psychological, medical,</p> <p>8 understandings around this stuff.</p> <p>9 Q Just to clarify. Transgender identity is not</p> <p>10 something that, in your words, you were ontologically</p> <p>11 born as?</p> <p>12 MR. CANTRELL: Object to form.</p> <p>13 A Say it once more, please.</p> <p>14 Q (By Mr. Richardson) Well, I'm trying to</p> <p>15 under -- you just said that this stuff --</p> <p>16 A Transgender identity --</p> <p>17 Q -- includes --</p> <p>18 A -- is not something you would be ontologically</p> <p>19 born as.</p> <p>20 Q You said that gender identity -- or gender</p> <p>21 ideology captures the idea that you can change, I think</p> <p>22 your language was --</p> <p>23 A Change one's sex.</p> <p>24 Q -- what you were ontologically born as.</p> <p>25 A Yeah, made sex.</p>	<p style="text-align: right;">Page 265</p> <p>1 A Like in the UK there is kind of one standard</p> <p>2 clinic with a long wait list. So you kind of map the</p> <p>3 surge there. Here, I don't think we keep great clinic</p> <p>4 data. Well, at least, I don't think it's public. But</p> <p>5 there is a far greater number of clinics in the United</p> <p>6 States than there is in other places, probably because</p> <p>7 we don't have a national health service.</p> <p>8 Q Okay. So you think there are explanations,</p> <p>9 then, beyond a number of people seeking care that would</p> <p>10 explain why we have more clinics. You just said because</p> <p>11 we don't have a national health service.</p> <p>12 MR. CANTRELL: Object to form.</p> <p>13 A Okay. Repeat that first part.</p> <p>14 Q (By Mr. Richardson) You just said that one of</p> <p>15 the reason we might have more clinics is because we</p> <p>16 don't have a national health service; right?</p> <p>17 A So, yeah. So we have sort of a free market on</p> <p>18 medicine.</p> <p>19 Q Okay.</p> <p>20 A So it's no surprise that if there is clinics</p> <p>21 growing in number, they are meeting demand, because you</p> <p>22 don't start a clinic when there is no demand.</p> <p>23 Q Okay. So have you done anything to track the</p> <p>24 number of people seeking care at these clinics?</p> <p>25 A Seeking care? I track the number -- I haven't.</p>

<p style="text-align: right;">Page 266</p> <p>1 Other people have tracked the number of people who are  2 claiming on surveys to be transgender, et cetera. But  3 exact clinic numbers, I don't know. I'm talking about  4 surge in the cases of self-identified transgender.  5 Q Okay. Couldn't it be possible that the number  6 of people reporting to a single clinic could increase?  7 A Sure.  8 Q Like I believe that happened in the UK you  9 reported talking about something to that effect?  10 A Yeah.  11 Q Okay. So wouldn't it be possible that the  12 number of clinics isn't necessarily related to the  13 number of people seeking care?  14 A Oh, I disagree. I mean, you don't start a  15 clinic if you don't have a base of demand for it.  16 Clinics are growing in number because demand is growing  17 in number. That's just classic supply and demand.  18 Q Okay. So your support for the proposition that  19 there is an increase in the number of adolescents  20 receiving care in the United States is entirely based on  21 the number of clinics?  22 A That and sort of the surging numbers of  23 self-identified transgender individuals.  24 Q Okay. And that's survey data in the United  25 States?</p>	<p style="text-align: right;">Page 268</p> <p>1 government decides whether it's good to supply or not in  2 general. But in medical care, I'm unfamiliar with it.  3 Q Okay. Are you aware of a growth in the  4 incidence of other medical conditions for which people  5 needed care?  6 A I think we are seeing growth in sort of  7 psychological care, not necessarily medical  8 psychological care, but certainly, you know, growth in  9 psychotherapy provision and growth in anxiety among  10 youth.  11 Q Okay. So just taking anxiety --  12 A Depression, things like that. I mean, those  13 have surged over the last several years as well, and I  14 believe I mentioned that.  15 Q To your knowledge has any state responded by  16 banning care for anxiety and depression?  17 A No.  18 Q Okay. Are you aware of -- in the growth of the  19 number of people seeking treatment for autism spectrum  20 disorder?  21 A Seeking treatment? I have heard that is  22 growing in diagnosis.  23 Q Okay. And do people who are diagnosed with  24 that condition receive care associated with that  25 condition?</p>
<p style="text-align: right;">Page 267</p> <p>1 A Yes. High schools, CDC's behavioral  2 surveillance surveys. We haven't seen those numbers  3 turned down by any stretch, only grow.  4 Q Okay. Is it your view that an increase in  5 incidents of a certain condition typically lead to that  6 condition being banned?  7 MR. CANTRELL: Object to form.  8 A That's a question I have not thought about.  9 Q (By Mr. Richardson) Well, is it common, as  10 more people need care of a certain kind, to then ban  11 that care?  12 MR. CANTRELL: Object to form.  13 A Need care of a certain kind?  14 Q (By Mr. Richardson) Seek care.  15 A Seek care of that kind.  16 Q Yes.  17 A The question is -- say it again, please.  18 Q Do you believe that generally when there is an  19 increase in the incidents of people seeking medical care  20 that we ban that care?  21 MR. CANTRELL: Object to form.  22 A I really don't have anything to calibrate that  23 or gauge that against.  24 Q (By Mr. Richardson) Are you aware of other --  25 A People demand certain things that then the</p>	<p style="text-align: right;">Page 269</p> <p>1 A I presume so. Though I presume that the care  2 does not involve invasive hormones and surgery prior to  3 turning 18.  4 Q Okay. And are you aware of any state that has  5 banned care for that condition?  6 A Probably not, given that the acceptable  7 treatment of that is not as radical as Arkansas is  8 perceiving this one to be.  9 Q Understood. So in general, then, an increase  10 in the incidence of a condition is not a reason alone to  11 ban the treatment for that condition?  12 MR. CANTRELL: Object to form.  13 A No. Agreed. For my situation it is a reason  14 to inquire as to what's happening, what's going on, why  15 is this occurring, and get a better understanding of it.  16 Which frankly, I'm struck, again, that researchers seem  17 insufficiently curious about it. Some of them are  18 talking about it now. Some of them realize it needs to  19 be talked about.  20 But I think I cited Dr. -- I think she's a  21 doctor -- Wren of the UK kids clinic formerly, sort of  22 reflecting on, sort of, this surge in cases, swap in the  23 sex ratio and , you know, wanting to know more about it  24 and saying, We owe it to our patients to understand this  25 better.</p>

<p style="text-align: right;">Page 270</p> <p>1 Q (By Mr. Richardson) I see. So why in this 2 context, then, does the increase of the number of 3 adolescents seeking care in your view provide a basis 4 for banning that care?</p> <p>5 MR. CANTRELL: Object to form.</p> <p>6 A In this case the number of -- the increase in 7 cases that is -- has gone, like, undertheorized by 8 clinicians and scholars who seem very hesitant to talk 9 about it, to me that is yet another signal of an 10 industry that is not monitoring itself well and, 11 therefore, one wants some reform to come to this.</p> <p>12 Q (By Mr. Richardson) So I suppose earlier you 13 had raised anxiety and depression among youth as another 14 condition that has grown in prevalence in recent years.</p> <p>15 A Yeah, yeah.</p> <p>16 Q Have you examined the state of science around 17 those treatments?</p> <p>18 A I've -- not in a systematic way.</p> <p>19 Q Okay.</p> <p>20 A However, I recognize that there's a science 21 about giving black box antidepressants. Nobody under 22 age 18 -- I could be wrong about that. But certain 23 black box, that's what the term is, lest it can become 24 suicidal, have the reverse affect.</p> <p>25 Q I'm sorry. What does black box mean? I'm not</p>	<p style="text-align: right;">Page 272</p> <p>1 treatments I think that we are not pursuing, you know. 2 We're not listening to our children very well, we're not 3 spending more time with our children. We're basically 4 saying a pill is an answer for the more difficult work 5 of being with one's child and maybe separating them from 6 risk factors and ways in which depression and anxiety 7 occur, and so we see a pill as potentially a panacea for 8 it.</p> <p>9 Q Okay.</p> <p>10 A I think pills have a place, but I think so do 11 those other things that people generally just don't do, 12 but clinicians sort of say, you know, I can't prescribe 13 mom and dad listen to this kid and have dinner with them 14 every night, knock off their, you know, cellphone at 15 6:00 p.m. These things might be helpful. They probably 16 would be helpful to widespread experience of depression 17 and anxiety, but we're not doing that. We're sort of, 18 kind of, prescription oriented. But that's --</p> <p>19 Q I gotcha.</p> <p>20 A It's the American way, frankly.</p> <p>21 Q I guess my question is, so you have said there 22 is an increased demand for anxiety treatment among 23 youth?</p> <p>24 A There's -- for help, yeah.</p> <p>25 Q Yeah. And you said some of the treatments that</p>
<p style="text-align: right;">Page 271</p> <p>1 familiar with that term.</p> <p>2 A You know, if I'm not mistaken, I could be 3 wrong, this should not be given to people under age 18, 4 it ought to be accompanied by careful oversight, careful 5 oversight instead of just, you know, "Here is a 6 prescription, go."</p> <p>7 Q So they would get assessments before they 8 receive care?</p> <p>9 A They should get assessments before care, once 10 they are on care, while they are on care -- you know, 11 frequent assessments --</p> <p>12 Q Okay.</p> <p>13 A -- because of the risk of the medication not 14 working as designed.</p> <p>15 Q Okay.</p> <p>16 A Right.</p> <p>17 Q So in that --</p> <p>18 A For particular kinds of people especially at 19 younger ages.</p> <p>20 Q Okay. So in that context we have a treatment 21 where the need for it is growing, more people are 22 seeking it, it has these risks --</p> <p>23 A No. One second. Sorry.</p> <p>24 Q Yes.</p> <p>25 A It's a treatment. Like there are other</p>	<p style="text-align: right;">Page 273</p> <p>1 are given in that context require, you know, 2 psychological evaluations beforehand and then ongoing 3 monitoring because they have health risks.</p> <p>4 A Certainly -- well, because the medicine itself 5 can not act as intended.</p> <p>6 Q Yes. So they -- they involve a risk and they 7 require monitoring to assess that risk.</p> <p>8 A (Nods head.)</p> <p>9 Q Okay. So given that those conditions are 10 present, increased demand, need for psychological 11 assessment beforehand and risks, do you support banning 12 that treatment for anxiety?</p> <p>13 A I don't.</p> <p>14 MR. CANTRELL: Object to form.</p> <p>15 A But I think it certainly should be one thing in 16 the arsenal of treating anxiety, not necessarily the 17 primary. At the --</p> <p>18 Q (By Mr. Richardson) Okay. So what explains --</p> <p>19 A -- same time -- at the same time it is, you 20 know, it's a pill that's -- it's a selective serotonin 21 reuptake inhibitor. It should work as designed in that 22 way and sort of not radically reorient the human body.</p> <p>23 Q But you said it might lead to suicide; right?</p> <p>24 A It can, right.</p> <p>25 Q That's the risk that you're assessing for?</p>

<p style="text-align: right;">Page 274</p> <p>1 A Right. They need to monitor that closely.</p> <p>2 Q And you don't support banning that care for</p> <p>3 minors with anxiety?</p> <p>4 A When they say block box, I think that means</p> <p>5 that minors can't have it. I could be wrong about that,</p> <p>6 that it can only be given to 18 and up, but that they</p> <p>7 are very careful about how 18-year-olds and 19-year-olds</p> <p>8 deal with it. Again, not my area of study here.</p> <p>9 But I would rather such black box SSRIs not be</p> <p>10 given to 18, 19, 20-year-olds. They can be given</p> <p>11 effectively, but how do you know it's not going to have</p> <p>12 the reverse effect? That's alarming; right? We would</p> <p>13 like to steer kids away from this.</p> <p>14 Q Okay.</p> <p>15 A And I think it involves more than just a pill.</p> <p>16 Q So I'm just trying to understand. So you do</p> <p>17 support a ban to minors receiving that sort of care?</p> <p>18 MR. CANTRELL: Object to form.</p> <p>19 A I haven't thought about it. Again, like I'm</p> <p>20 never in a position to -- for any idea I have of mine to</p> <p>21 become reality. Haven't given it much thought.</p> <p>22 Q (By Mr. Richardson) Okay. But so we have --</p> <p>23 A Very wary, though, I will say that.</p> <p>24 Q But you have said that you do support a ban on</p> <p>25 gender-affirming care for minors.</p>	<p style="text-align: right;">Page 276</p> <p>1 paragraph 70 you talk about --</p> <p>2 A At the bottom of 30?</p> <p>3 Q Bottom of 30, yes, but it's actually the</p> <p>4 sentence on the next page. It says, The FDA has not</p> <p>5 approved hormonal therapies for the treatment of gender</p> <p>6 dysphoria. Hence, it is undeniable that the protocol of</p> <p>7 treatments remains technically experimental.</p> <p>8 A Yeah. Okay.</p> <p>9 Q Okay.</p> <p>10 A FDA approval comes when it's -- typically</p> <p>11 when the trials and all this stuff has -- right now it's</p> <p>12 sort of off label if I'm not mistaken. That is my</p> <p>13 understanding, that the FDA has not approved of --</p> <p>14 Q Okay. Well, how common is it, once a drug has</p> <p>15 been approved for one use, for there to be randomized</p> <p>16 controlled trials for alternative uses of that drug?</p> <p>17 A I don't actually know that.</p> <p>18 Q How common is it in medicine for drugs to be</p> <p>19 used for off-label purposes?</p> <p>20 A I don't know, but I know that it does occur.</p> <p>21 Q Okay. Do you think it's rare?</p> <p>22 A Probably not rare. But in this case it's, you</p> <p>23 know, it's profound in its -- in its outcomes. So I</p> <p>24 don't know if we -- you know, during the COVID era</p> <p>25 people were talking about repurposing different</p>
<p style="text-align: right;">Page 275</p> <p>1 MR. CANTRELL: Object to form.</p> <p>2 A By, you know, becoming an expert witness, yeah.</p> <p>3 Q (By Mr. Richardson) And part of the reason for</p> <p>4 that in your report is the increase in the number of</p> <p>5 people seeking that care?</p> <p>6 MR. CANTRELL: Object to form.</p> <p>7 A No. I mean, I have mentioned that as sort of</p> <p>8 an unexplained thing. Just the mere fact that it has</p> <p>9 increased is not enough. But it's the fact that it has</p> <p>10 not been talked about enough. It seems like it's a</p> <p>11 source of demand for gender clinics. Our insufficient</p> <p>12 curiosity -- I shouldn't say "our" -- is problematic</p> <p>13 here.</p> <p>14 Q (By Mr. Richardson) Okay. Just --</p> <p>15 A I want to know why this is happening.</p> <p>16 Q Understood. But I think you just said this. I</p> <p>17 just want to clarify. So an increase in the number of</p> <p>18 people seeking care is alone not enough to support a ban</p> <p>19 on care?</p> <p>20 A Correct.</p> <p>21 Q Okay. Can we turn to your report again? This</p> <p>22 is Exhibit 1. I think that's the Declaration, the</p> <p>23 preliminary injunction.</p> <p>24 A Exhibit 1.</p> <p>25 Q Exhibit 1, yeah. And this is page 31. So on</p>	<p style="text-align: right;">Page 277</p> <p>1 antivirals for fighting COVID. Some of them found they</p> <p>2 may be helpful, some not at all. This would be sort of</p> <p>3 off-label usage in a domain that's comparable.</p> <p>4 Q Okay. So in your view are all off-label uses</p> <p>5 of medicine experimental?</p> <p>6 A I think by FDA definitions they are. I could</p> <p>7 be wrong about that. But I think that's -- the</p> <p>8 definition of an off-label is not that for which it was</p> <p>9 designed.</p> <p>10 Q Okay. And do you think people within the field</p> <p>11 of medicine would agree with that statement?</p> <p>12 A I don't know. I'm not sure.</p> <p>13 Q Okay. Do you think all off-label uses in</p> <p>14 medicine should be banned?</p> <p>15 A No. Some of them are fairly tame.</p> <p>16 Q Okay. So the fact that gender-affirming care</p> <p>17 involves an off-label use of medication is not alone</p> <p>18 enough to ban care?</p> <p>19 A Its off-label usage is far more significant</p> <p>20 than some more tame off-label uses of -- of particular</p> <p>21 drugs, like these antivirals, while they either</p> <p>22 worked -- they worked or they didn't work. They -- you</p> <p>23 know, they are not sort of harmful, per se. Right?</p> <p>24 It's one thing if we're talking about ineffectual,</p> <p>25 versus effectual, but rather significant in its outcome.</p>

70 (Pages 274 - 277)

<p style="text-align: right;">Page 278</p> <p>1 Q Okay. So once again, what is your basis for 2 saying that gender-affirming care is harmful? 3 A What is my basis for saying gender-affirming 4 care is harmful? Back to what we talked about before. 5 Altering the bodies of minors who have a limited sense 6 of the, sort of, what they might want in the future 7 presumes their ability to give genuinely informed 8 consent and disables them from having experienced the 9 sort of natal puberty that their body was aiming for in 10 service of the pursuit of the moderation of gender 11 dysphoria. So different than the off-label use of 12 Tamiflu to see if it kills COVID. 13 Q Okay. And when you say those things happened 14 in service of eliminating gender dysphoria, what 15 evidence do you have that that's harmful? 16 MR. CANTRELL: Object to form. 17 A Harmful as in sort of, you know, is it damaging 18 to their psychological health? I'm starting to lose 19 track of where we are in this conversation. 20 Q (By Mr. Richardson) So you said that what made 21 gender-affirming care's off-label usage different was 22 that it was harmful. 23 A Well, significant in, like, preventing the 24 minor from experiencing natal puberty, potentially and 25 certainly actively if we move to cross-sex hormones and</p>	<p style="text-align: right;">Page 280</p> <p>1 prior to growth of the penis that they are -- you know, 2 it stunts the ability to create a vaginoplasty in the 3 future. And Dr. Karasic has said that himself in an 4 article that he wrote about interviews with surgeons. 5 So it seems like, you know, one can't have 6 everything that one wishes in this domain. I can see 7 the affirmative communities are wrestling with what to 8 do about this. So -- 9 Q All right. 10 A I'm losing track of your original question. 11 Q I'm just asking if some changes from endogenous 12 puberty are irreversible, and it sounds like your answer 13 is yes. 14 A Right. And at the same time, like, you know, 15 if you don't go through some aspects of puberty I think 16 even the subsequent changes and surgeries sought by 17 transgender minors and adults become more difficult if 18 one doesn't experience natal puberty. 19 Q Gotcha. And you said that one of the surgeries 20 you were discussing was vaginoplasty. 21 A I believe that was the case about -- with 22 regard to the article that Dr. Karasic coauthored. 23 Q And would you say that -- 24 A I would have to refer to it in particular to 25 make more commentary about it.</p>
<p style="text-align: right;">Page 279</p> <p>1 into surgical procedures for, you know, severing their 2 reproductive capacity and their natal sex and locking 3 them into a future that they had to choose when they 4 were 13, 14, or 15 rather than wait to experience it. 5 Q Okay. 6 A I think right now there is finally some debate 7 whether that's a good idea or not from within the 8 affirmative medicine community. 9 Q Okay. Do you think the changes that happen 10 from endogenous puberty are irreversible? 11 A Happen from endogenous puberty are 12 irreversible? What do you mean? 13 Q Would -- 14 A Example. 15 Q Would denying somebody gender-affirming care 16 also lock them into a certain future? 17 A It would give them the experience of their 18 natal body's construction and experience of that prior 19 to making the decision about what they want to do in the 20 future. 21 Q And would some of those things be irreversible? 22 A Uh, yeah, probably so. At the same time we 23 also know that sort of in terms of the surgical 24 procedures that are -- might be sought, that if you stop 25 puberty and reverse it, for example, on a natal male</p>	<p style="text-align: right;">Page 281</p> <p>1 Q Understood. And would you say that you are an 2 expert on the surgical options for vaginoplasty? 3 A I am not. 4 Q Okay. 5 A I'm basically telling you what an interviewee 6 of Dr. Karasic's said -- 7 Q Understood. 8 A -- in Dr. Karasic's article about it -- 9 Q Okay. 10 A -- saying it's kind of unfortunate that the 11 position that this failure to go through natal puberty 12 puts us in. We don't have much to work with is what he 13 said. 14 Q Okay. But you're not an expert on that 15 subject. 16 A I am not. 17 Q Okay. I just want to come back a question I 18 asked earlier. I want to make sure I have it straight. 19 You said the fact that a label -- or use of a 20 drug is off label is not itself a reason to ban care; 21 correct? 22 A That is off label? You know, not in terms of a 23 categorical ban I suspect. But, you know, I would 24 have -- you know, if you want my opinion on it, which, 25 of course, opinions -- again, I don't deal with my</p>

<p style="text-align: right;">Page 282</p> <p>1 opinion very often. I don't think about opinion. I 2 deal with reality. 3 I'd have to sort of look at a whole bunch of 4 examples. 5 Q Okay. But so you said that you think it could 6 be quite common that there are off-label uses of drugs 7 for different medical treatments; right? 8 A It could be. 9 Q Okay. 10 A I don't know that it is. 11 Q And you wouldn't, based on that fact alone, 12 support banning those treatments? 13 MR. CANTRELL: Object to form. 14 A Just a mere off -- you know -- no, although -- 15 Q (By Mr. Richardson) Okay. 16 A -- you know, lots of times you will see, for 17 example, was it -- the treatment for COVID that people 18 believed worked and the latest studies didn't confirm 19 it. So doctors started banning the procedure, the CDC 20 recommended against it. I'm forgetting the name of it. 21 So bans happen within clinics. Doctors won't 22 prescribe particular things if they are not convinced 23 that they work as designed or work as off label. But 24 that's a little bit different. 25 Q But you would not support a legal ban on all</p>	<p style="text-align: right;">Page 284</p> <p>1 understands what you're saying if you have to show them 2 pictures. 3 So I think informed consent practices vary 4 widely in their thoroughness. 5 Q Okay. And where -- what is your basis for your 6 views on the informed consent process for minors? 7 A What do you mean what is my basis -- 8 Q Where does your knowledge of that subject come 9 from? 10 A Of the -- the -- the knowledge of the subject 11 about informed consent? 12 Q Yeah. 13 A From people's descriptions of it, from, you 14 know, these, the opposition -- opposition, you know, 15 expert witnesses. You know, I know from experience 16 writing protocols for university institutional review 17 boards to approve surveys and things like that, you 18 know, they have sections on dealing with minors and 19 informed consent and what -- not even minors. I mean, 20 everybody has to have informed consent. Sometimes it 21 can be verbal. Sometimes it can be -- must be written. 22 Sometimes it needs to be translated into a language the 23 participants and the research can understand. 24 All sorts of things are -- so some of it is 25 personal experience, some of it -- I teach Research</p>
<p style="text-align: right;">Page 283</p> <p>1 off-label uses of drugs? 2 A No, I don't think that makes sense. 3 Q Okay. Do you think that doctors who prescribe 4 drugs off label are behaving unethically? 5 A It would depend on -- it's not a categorical 6 evaluation I would make. 7 Q So you wouldn't say yes as a general matter? 8 A To all off-label usages of things? 9 Q Yeah. 10 A No. 11 Q Okay. You have mentioned a couple of times the 12 ability of minors to consent to care. 13 A I have. 14 Q Are you familiar with the informed consent 15 process for minors? 16 A As described by Dr. Adkins perhaps? 17 Q In any capacity. 18 A Well, I think the forms for it can vary widely. 19 In fact, critics of it have described that some places 20 and sometimes it's quite pro forma. Very quick, read 21 it, sign every page. Other people seem to sort of dwell 22 upon it. In her case I think she tries to, sort of, 23 even offer visual cues if you can't understand the 24 written cues, which I could say that's noble, but it 25 also sounds like, I'm not sure this person truly</p>	<p style="text-align: right;">Page 285</p> <p>1 Methods. We always have a week on research ethics. And 2 informed consent is always the linchpin of one of those 3 discussions. 4 Q Okay. And have you ever done research that 5 involved in seeking informed consent from minors? 6 A From minors? I have been involved not as a 7 principal investigator, but as a co-investigator. 8 Q Okay. And were you involved in, you know, 9 crafting the -- sounds like there's kind of survey 10 questions that go with this or a way you seek informed 11 consent for minors? 12 A With informed consent for minors you often have 13 to get, you know, it -- read it out to them and their 14 parents have to sign, things like that. So I'm familiar 15 with it. I haven't done it as a principal investigator. 16 I've participated in it as a collaborator, 17 co-investigator in the past. 18 Q Okay. And did that involve seeking informed 19 consent yourself? Like were you the one reading this 20 out to a minor? 21 A Yeah, I think I did. It's been a long time, 22 but I think I did, yeah. 23 Q Okay. And do you know what the Applebaum 24 criteria is? 25 A I don't.</p>

<p style="text-align: right;">Page 286</p> <p>1 Q Okay. Just as a general matter, do you think 2 that parents should generally have the right to make 3 medical decisions for their children in consultation 4 with the child's doctor? 5 MR. CANTRELL: Object to form. 6 A I'd say in general, although I think I wrote in 7 one of my reports it is unusual for parents to be given 8 permission to consent on behalf of their minor child to 9 procedures that would render the child infertile. 10 Q (By Mr. Richardson) So do you think the 11 government should tell parents which medical procedures 12 they can provide to their children? 13 MR. CANTRELL: Object to form. 14 A Say that again, please. 15 Q (By Mr. Richardson) Do you think the 16 government should tell parents which medical procedures 17 they can provide to their children? 18 A I think we've been over this before. It 19 depends on the procedure and sort of the severity and 20 the significance of it and the permanence of it and the 21 ramifications of it. And in this case those things are 22 all rather significant and serious. 23 Q Okay. 24 A And insofar as they, you know, render somebody 25 permanently infertile prior to age of majority -- you</p>	<p style="text-align: right;">Page 288</p> <p>1 treatment. 2 It sounds like that reflects a lot of what you 3 have said today about informed consent; right? 4 A Um-hum. 5 Q So do you think a central issue in this case is 6 a minor's ability to consent? 7 A In part. I mean, it's certainly like, in 8 addition to these other things, but it's also sort of 9 like is it prudent to permit procedures that would lead 10 to the permanent sterilization of minors, whether with 11 their consent or not. 12 Q Okay. And are you aware that HB 1570 bans 13 treatment even when the parents consent as well? 14 A I believe I do, yeah. 15 Q Okay. 16 A Probably -- this is where I sort of write this, 17 you know, parental consent of sterilization used to be 18 unlawful in many locales creating ethical dilemmas that 19 commonly required judicial review, and I cite this -- 20 Q Understood. 21 A -- reference. 22 MR. RICHARDSON: Okay. Do you mind if we 23 take five and then we'll -- 24 THE WITNESS: Sure. 25 MR. RICHARDSON: I just want to use the</p>
<p style="text-align: right;">Page 287</p> <p>1 know, I'm aware of doctors who will not give a vasectomy 2 to a young adult male who is of age seeking one. 3 So, I mean, that's informed consent, but some 4 doctors won't do it. 5 Q And that's left to the doctor to make that 6 decision in that context? 7 A This is if the -- in this case it was the 8 patient pursuing it from a doctor who refused to give 9 it. 10 Q You think the doctors usually can make 11 judgments like that about when informed consent would be 12 appropriate on their own? 13 MR. CANTRELL: Object to form. 14 A I -- whether they can, I think they -- they do 15 make those judgments and I suspect it's not too 16 difficult to find a doctor who is willing to do so. But 17 some won't. 18 Q (By Mr. Richardson) Okay. We can turn to your 19 report. This is page 56. 20 A Which -- it's No. 1? 21 Q Number 1, yeah. Thanks. And this is paragraph 22 127, just that first sentence. Quote, A central and 23 persistent concern about hormonal and subsequent 24 surgical courses of treatment for gender dysphoria in 25 adolescents is their ability to genuinely consent to</p>	<p style="text-align: right;">Page 289</p> <p>1 restroom real quick. 2 VIDEO OPERATOR: All right. This will 3 end media part 5. We are off the record at 4:38 p.m. 4 (A break was had.) 5 VIDEO OPERATOR: We are back on the 6 record at 4:49 p.m. This will begin media part 6. 7 Please proceed. 8 Q (By Mr. Richardson) All right. Dr. Regnarus, 9 you expressed the view that one reason that 10 gender-affirming care for adolescents might be improper 11 is that people should be able to go through natal 12 puberty and have relationships and gender transition 13 might interfere with that. 14 A I didn't say relationships, but sort of 15 understand the experience of it. And, you know, this is 16 not necessarily just me talking. This is some 17 affirmative clinicians talking now about the wisdom and 18 prudence of that, so. 19 Q Understood. But would those concerns stop when 20 somebody turns 18? 21 A Which concerns? 22 Q Your concerns about somebody going through 23 natal puberty and being able to live post-pubertal life 24 in the way you've described. 25 A Right. I know you're asking a significant</p>

<p style="text-align: right;">Page 290</p> <p>1 question but I'm still failing to understand. What's 2 the -- 3 Q Maybe I can just rephrase. So earlier we 4 talked about the reasons that you might oppose care for 5 somebody, you know, age 13, age 15. 6 A Um-hum. 7 Q And you talked about that person hadn't gone 8 through natal puberty and they deserve to sort of live 9 past that point in that state I suppose. 10 A Yeah. 11 Q Is that roughly accurate? 12 A Roughly, sure. 13 Q Okay. And would those concerns stop when they 14 turn 18? 15 A Not necessarily. I mean, 18 is sort of this 16 legal age of majority, but it is a social construction 17 really. 18 Q Yeah. 19 A As a sociologist I totally can acknowledge 20 that. 21 Q Okay. So if the bases for your opposition to 22 care might extend beyond 18 would you support banning 23 care beyond 18 for some people? 24 A Banning? I mean, again, I don't think about 25 this. In the United States we understand the age of</p>	<p style="text-align: right;">Page 292</p> <p>1 immoral for somebody between 18 and 25 -- 2 A I don't know. 3 Q -- to receive gender-affirming care? 4 A I haven't -- I haven't given that thought. You 5 know, just back to what I said, you know, we allow all 6 sorts of behaviors at the age of maturity or close to it 7 or shortly thereafter. Smoking, drinking, marriage, I 8 mean, that we don't for 13-year-olds or -- you know, 9 like marriage. I think most states you have to be 18 or 10 17 with permission or things like that. 11 We have to have some sort of benchmark of when 12 we do this. Some things it's 18, drinking it's 21, 13 driving a rental car without great fees is 25. 14 Q Okay. And which benchmark do you think would 15 make sense in this context? 16 A I don't have an opinion on that. 17 Q Okay. So earlier -- 18 (Simultaneous crosstalk.) 19 Q I'm sorry. Go ahead. 20 A No. 21 Q Well, earlier I had asked you if a doctor who 22 prescribes a drug for an off-label use is necessarily 23 behaving unethically and I believe you said no. 24 A Wait. I think this -- you know, again, I'm not 25 going to speculate wildly on the nature of the drug or</p>
<p style="text-align: right;">Page 291</p> <p>1 majority, whether you set it at 18 or not, is when 2 adults make decisions for themselves. Even if their 3 frontal cortex or prefrontal cortex isn't developed well 4 until 25, we seem to sort of set this as the age at 5 which people can make decisions by themselves and it 6 extends to, like, is it HIPAA or FERPA, I forget which 7 one it is, like you have to be -- once you're 18 your 8 medical decisions cannot necessarily be discussed with 9 your parents. I'm forgetting which one that is. But we 10 have decided these things, like, legally at age 18. 11 So, you know, I recognize the age of sort of 12 majority is a social construction. It kind of is what 13 it is. At some point people make their own decisions. 14 Whether I think they ought to or not is completely 15 irrelevant at that point it seems like. 16 Q Okay. But it sounds like the research suggests 17 that, in your view, the prefrontal cortex isn't 18 developed until 25. 19 A Not in my view. If you study Roper v Simmons 20 there is an extensive discussion of maturation of the 21 human person and the brain and why this is kind of 22 important for their, not just their consent, sort of to 23 be responsible for one's actions, you know. 24 Q So putting the law to the side and kind of the 25 legal line we've drawn at 18, do you think it would be</p>	<p style="text-align: right;">Page 293</p> <p>1 the treatment, I mean, or what are we -- I mean, off 2 label can be a quack using it to sort of try to cure 3 cancer with vitamin C pills, but that -- you know, 4 vitamin C is not a -- not an off label. Anyways, but 5 you see my point. 6 Q I take the point, yeah. So do you think that 7 doctors who are providing gender-affirming medical care 8 to adolescents are behaving unethically? 9 A Do I believe doctors providing gender care to 10 adolescents, um, are acting unethically? Within the 11 standards of care that seem to govern them, they aren't. 12 The -- nevertheless, I think that is problematic and 13 unideal conduct. 14 Q Is it unethical conduct? 15 A Unethical? When you say ethical, you're 16 talking about what, immoral? What is the definition 17 of -- 18 Q Let's try immoral. Would it be immoral 19 conduct? 20 A Ethical or moral, they are all kind of, you 21 know, talking about the good, right, reference to the 22 good. I think that it's suboptimal to treat adolescents 23 with hormones or surgery. 24 Q As a matter of fact or value? 25 MR. CANTRELL: Object to form.</p>

<p style="text-align: right;">Page 294</p> <p>1 A The fact/value distinction is radically</p> <p>2 overestimated.</p> <p>3 Q (By Mr. Richardson) Okay. So --</p> <p>4 A We get -- we don't get to pick facts that are</p> <p>5 separate from values. Right? Values saturate our</p> <p>6 facts. For example, when I ask a survey question about</p> <p>7 what sex are you, you know, I can give them two options,</p> <p>8 I can give them more than two options. But the question</p> <p>9 wording, it's like, What sex are you, do you consider</p> <p>10 yourself, is -- implies a valuing of how people</p> <p>11 understand themselves as sexed.</p> <p>12 If I asked a question in a survey, What sex</p> <p>13 were you assigned at birth, both of those signal -- are</p> <p>14 value saturated. They might look to be facts, which is</p> <p>15 establishing people's sex, what they say about it, but</p> <p>16 in our facts are embedded values.</p> <p>17 Q Understood. So let me rephrase it a little</p> <p>18 bit --</p> <p>19 VIDEO OPERATOR: I'm sorry. Before you</p> <p>20 do that I need to take a quick media break. Just one</p> <p>21 second.</p> <p>22 MR. RICHARDSON: Oh, sure. No problem.</p> <p>23 VIDEO OPERATOR: We are going to go off</p> <p>24 the record at 4:57 p.m.</p> <p>25 (A pause was had.)</p>	<p style="text-align: right;">Page 296</p> <p>1 Q Do you know how --</p> <p>2 A It's not -- go ahead.</p> <p>3 Q Do you know how gender-affirming clinics in</p> <p>4 Arkansas obtain informed consent?</p> <p>5 A I don't.</p> <p>6 Q Okay.</p> <p>7 A And I wouldn't presume there is a standard to</p> <p>8 it either.</p> <p>9 Q And why is that?</p> <p>10 A Because I -- so far as I can tell there are</p> <p>11 only recommendations out there, not standards. I mean,</p> <p>12 even WPATH standards of care are, at the bottom,</p> <p>13 suggestions. They can be the violated without impunity.</p> <p>14 Q Okay. So if I asked how many clinics in the</p> <p>15 United States are using a thorough informed consent</p> <p>16 process --</p> <p>17 A I don't think any of us know this.</p> <p>18 Q But you don't have a guess.</p> <p>19 A I don't, no.</p> <p>20 Q And you don't have any first-hand experience</p> <p>21 with the way these clinics obtain informed consent?</p> <p>22 A I don't, but to presume that there is a</p> <p>23 uniformity would make it -- you know, would be likely to</p> <p>24 be wrong.</p> <p>25 Q And you haven't surveyed clinics --</p>
<p style="text-align: right;">Page 295</p> <p>1 VIDEO OPERATOR: We're back on the record</p> <p>2 at 4:57 p.m. Please proceed.</p> <p>3 Q (By Mr. Richardson) So I asked if doctors that</p> <p>4 are providing gender-affirming medical care to</p> <p>5 adolescents are acting unethically.</p> <p>6 A Um-hum.</p> <p>7 Q And you said that they are not acting to the</p> <p>8 good. Is that -- is that --</p> <p>9 A Oh, well, you know, I first described, you</p> <p>10 know, within their code of ethics and with regard to the</p> <p>11 Endocrine Society and the WPATH's standards of care, you</p> <p>12 know, they're not doing anything that's unethical.</p> <p>13 Q Okay.</p> <p>14 A But I think treating adolescents with hormones</p> <p>15 or surgery is decidedly suboptimal.</p> <p>16 Q Okay. And that view that it is suboptimal has</p> <p>17 a moral component to it?</p> <p>18 A All treatment decisions have a moral component</p> <p>19 to it.</p> <p>20 Q Including that judgment that it's suboptimal.</p> <p>21 A Yes.</p> <p>22 Q Okay. You raised some concern about the</p> <p>23 informed consent process actually happening at clinics</p> <p>24 regarding gender-affirming care; is that right?</p> <p>25 A Yes.</p>	<p style="text-align: right;">Page 297</p> <p>1 A I have not.</p> <p>2 Q -- as a part of any methodological inquiry?</p> <p>3 A I have not. And I'm not aware of any research</p> <p>4 on the surveying of clinics about how they understand</p> <p>5 consent. I probably would have come across it in</p> <p>6 writing my report.</p> <p>7 Q And do you have any basis to doubt clinicians</p> <p>8 who say that they do a thorough informed consent</p> <p>9 process?</p> <p>10 A Doubt? I mean, just sort of, it would be nice</p> <p>11 to know more about what that looks like.</p> <p>12 Q But you don't -- do you have any reason to</p> <p>13 think that anybody who said they are providing thorough</p> <p>14 informed consent is lying?</p> <p>15 A Not out of hand, no.</p> <p>16 Q So as far as you know most of them may be</p> <p>17 providing thorough informed consent?</p> <p>18 A They may.</p> <p>19 Q Just don't know?</p> <p>20 A I don't, and I don't think anybody knows.</p> <p>21 Q Okay. I'd like to turn to --</p> <p>22 A You know, like WPATH, they issue suggestions,</p> <p>23 standards of care. But like, what is going on in the</p> <p>24 clinics, I think there are lots of different clinics</p> <p>25 under lots of different auspices and authority. You</p>

75 (Pages 294 - 297)

<p style="text-align: right;">Page 298</p> <p>1 know, I suspect nobody knows.</p> <p>2 Q Is it unusual for medical associations to</p> <p>3 promulgate standards of care that don't have an</p> <p>4 enforcement mechanism?</p> <p>5 A Is it unusual? One would think they have an</p> <p>6 enforcement mechanism, but I see no evidence of one.</p> <p>7 Q Do most medical standards of care outside of</p> <p>8 the context of gender dysphoria have enforcement</p> <p>9 mechanisms?</p> <p>10 A I don't know.</p> <p>11 Q Can we turn to your report, page 68, paragraph</p> <p>12 158?</p> <p>13 A Same exhibit I'm on?</p> <p>14 Q It should be Exhibit 1, yeah.</p> <p>15 A Okay. Say again. 68?</p> <p>16 Q Sixty-eight.</p> <p>17 A Okay.</p> <p>18 Q And starting at 158 you have a discussion of</p> <p>19 suicide among gender dysphoric minors.</p> <p>20 A Um-hum.</p> <p>21 Q Do you think suicidal ideation as a condition</p> <p>22 that is important to address?</p> <p>23 A It is a condition important to understand for</p> <p>24 sure.</p> <p>25 Q Okay.</p>	<p style="text-align: right;">Page 300</p> <p>1 and other forms of sudden which are prompted by</p> <p>2 different kinds of things than, kind of, the -- in our</p> <p>3 mind, the idea that, oh, someone is so depressed or</p> <p>4 discouraged that at the end of a long sequence of</p> <p>5 anxiety and depression they take their own life. And</p> <p>6 there are very different social generations of suicide.</p> <p>7 And in the literature on this stuff, I don't</p> <p>8 see much in the way of nuance around it. I think</p> <p>9 professor Biggs from Oxford notes this and in his study</p> <p>10 of suicide in the UK GIDS Clinic notes that, in reality,</p> <p>11 it's rather uncommon.</p> <p>12 Q Okay. So putting completed and attempted</p> <p>13 suicide to the side and just focusing in on people with</p> <p>14 suicidal ideation that never becomes an attempted or</p> <p>15 completed suicide. Do you think that's the sort of</p> <p>16 thing that it would be good to limit or prevent?</p> <p>17 A One -- it's pretty hard to prevent suicidal</p> <p>18 ideation because it's a thought; right?</p> <p>19 Q You don't think people can be treated to reduce</p> <p>20 the frequency of suicidal ideation?</p> <p>21 A Well, I mean, we would have to -- some people</p> <p>22 never really envision suicide despite their</p> <p>23 difficulties. Some people think about it, you know,</p> <p>24 after they perform poorly on a test; right?</p> <p>25 Ideation seems here to be kind of this catchall</p>
<p style="text-align: right;">Page 299</p> <p>1 A As I think I have made known in the report or</p> <p>2 somewhere, in the report or rebuttal, I think ideation</p> <p>3 has kind of become this general term that captures risk</p> <p>4 of attempt, and attempt, sort of, obviously may end in</p> <p>5 completion or not completion of suicide.</p> <p>6 Ideation is kind of a, so as far as I can tell,</p> <p>7 it's become a catchall for anything ranging from the</p> <p>8 most severe outcome to, you know, thinking about it;</p> <p>9 right? And lots of adolescents, and frankly lots of</p> <p>10 Americans, think about suicide at one point or another</p> <p>11 and often more than once.</p> <p>12 So I think ideation should be taken seriously,</p> <p>13 but it is well short of an attempt or, God forbid, a</p> <p>14 completion.</p> <p>15 Q So do you think it's important to treat people</p> <p>16 with suicidal ideation, even if that would not have lead</p> <p>17 to a complete --</p> <p>18 A What does it mean to treat with suicidal</p> <p>19 ideation? I think most people get so discouraged,</p> <p>20 upset, whatever, you know, they think about suicide.</p> <p>21 And, frankly, suicide comes in a lot of different forms,</p> <p>22 not in terms of method, but in terms of what's prompting</p> <p>23 it. Right?</p> <p>24 I'm a sociologist, I've read Émile Durkheim. I</p> <p>25 know something about suicide. It's egoistic, anomic,</p>	<p style="text-align: right;">Page 301</p> <p>1 from the most severe to the least severe. And I really</p> <p>2 think the least severe kinds of experiences with being</p> <p>3 discouraged about performing badly on an exam, these are</p> <p>4 not realistic likelihood of moving forward towards an</p> <p>5 attempt.</p> <p>6 Q Sure. And I'm saying even if there is nothing</p> <p>7 to suggest there would be an attempted or completed</p> <p>8 suicide in the research, is the mere fact of someone</p> <p>9 having suicidal ideation the sort of thing that --</p> <p>10 A I think if it's a repeated thing then perhaps.</p> <p>11 But to prevent minors in this example from ever thinking</p> <p>12 about, like, Oh, I would be better off dead, that's</p> <p>13 pretty difficult to do because a lot of people give</p> <p>14 fleeting thought to this in their -- in their lives and</p> <p>15 certainly as adolescents.</p> <p>16 Q But do you think there is some people for whom</p> <p>17 it is persistent?</p> <p>18 A I suspect it is.</p> <p>19 Q And do you think they can be treated?</p> <p>20 A In so far as you're trying to prevent a</p> <p>21 thought, like, "Oh, I wish I was dead," right, versus</p> <p>22 the kind of context which gave rise to this, is it</p> <p>23 anxiety that gives rise to suicidal ideation? Is it</p> <p>24 depression that gives rise to suicidal ideation? You</p> <p>25 can attempt to one way or another, which I talked about</p>

<p style="text-align: right;">Page 302</p> <p>1 earlier. I'm not sure we're treating that smartly these 2 days. 3 That's different, though, from the kinds of 4 suicidal ideation that are infrequent, you know, 5 fleeting, that sort of thing. I feel like -- not feel 6 like. 7 My read on this literature is that there's a 8 preference for evaluating suicidality or suicide 9 ideation as kind of a latent term, as a catchall of a 10 serious risk if this person is in eminent probability of 11 having an attempt as suicide. 12 And I don't see together -- professor Biggs, I 13 don't see a lot of evidence of the eminent risk of this 14 stuff. 15 Q Okay. Once again -- 16 A I agree with -- 17 Q -- just putting -- 18 A I agree with you that, yeah, repeated ideation 19 is not good and we should help minors and adults who are 20 doing this. 21 Q Okay. If even if it doesn't lead to a 22 completed or attempted suicide, it's a harm in itself 23 that should be -- 24 A Yeah. It's a good thing to treat, right -- 25 Q Okay.</p>	<p style="text-align: right;">Page 304</p> <p>1 concept. 2 A I don't think I wrote about that at great 3 length, but I have mentioned it. 4 Q Okay. But do you think it's one of 5 the things -- 6 A Hard to track. 7 Q -- one of the things that's being ignored by 8 the field? 9 A Probably, yeah. 10 Q Are you aware if there is any research being 11 funded on that topic? 12 A So I know that Lisa Lemon did a study of 100 13 detransitioners. I don't know if she had external 14 funding for it or not. She might have. 15 Q Okay. And do people have their work published 16 on that topic? 17 A At least she does. Not too many people do. 18 Q Okay. 19 A Detransitioners are somewhat of a mystery, I 20 think, but one that the entire industry should seek to 21 understand better, not necessarily perceive as a threat. 22 So, you know, I think Biggs, professor Biggs was 23 criticizing Dr. Turban about the USTS who people who 24 aren't -- who are detransitioners I think if they were 25 eliminated from the study itself or, if I'm not</p>
<p style="text-align: right;">Page 303</p> <p>1 A -- by one mechanism or another. 2 Q Okay. 3 A However, I mean, as I pointed out in this, I 4 think the term has been weaponized, certainly not 5 weaponized for adults who are far at greater risk for 6 attempts and actual completed suicides, despite the fact 7 that their ideation patterns for sudden are much lower 8 than teenagers. 9 Q Okay. But do you believe that suicidal 10 ideation is higher for adolescents with gender dysphoria 11 than other adolescents? 12 A I suspect so, yeah. I mean, it seems to 13 have -- I think we saw that in the GIDS study, yeah. So 14 I think they do ideate about this more. 15 Q Okay. And to your point earlier, treating them 16 for that would be beneficial? 17 A Correct. 18 Q Okay. 19 A In some fashion. Right? Yeah. 20 Q Okay. And you express some belief, I think 21 this is early in your report, that the practitioners and 22 researchers involved in gender dysphoria are ignoring 23 certain trends. 24 A Yes. 25 Q I think one of this is desistance as a -- as a</p>	<p style="text-align: right;">Page 305</p> <p>1 mistaken, were not included in the sort of threshold for 2 completing the survey. I can't remember it. But he 3 seemed uninterested in people who had been and then were 4 not. 5 Q Okay. But it would seem like if a field was 6 ignoring a certain topic there wouldn't be research 7 received on that topic and there wouldn't be papers 8 published on that topic; right? 9 A No. I think there isn't much published on this 10 topic, so I'm grateful for what exists. I think it's a 11 healthy sign in a scientific subfield that people are 12 taking up somewhat neglected topics like that. 13 Q Okay. So what is your basis for saying that 14 it's been neglected? 15 A Um, in my read of the literature there's just 16 not a whole lot out there about it. It's not a 17 complaint that it doesn't exist. It's a complaint that 18 it's overlooked. We have kind of radically different 19 estimates of it, you know. 20 Depending on when the detransition occurred, 21 you know, I think something I saw lately was -- was it 22 the GIDS study, it's closer to between 6 and 20 percent 23 than, you know, I think I read the four or -- 2 to 4 24 percent in one of the studies that I reported. It was 25 kind of not well documented what the, sort of,</p>

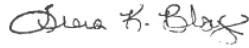
<p style="text-align: right;">Page 306</p> <p>1 desistance rate is.</p> <p>2 Plus, you know, when you stop going to a</p> <p>3 clinic, why did you stop going? And do they track you,</p> <p>4 keep track of what's going on. It's a little like,</p> <p>5 what's the term, in survey research where sort of</p> <p>6 longitudinal survey you're tracking people and then</p> <p>7 you're lost to it. Right? You fail to answer the</p> <p>8 fourth wave and they can't contact you and they don't --</p> <p>9 you don't know what happened to that person.</p> <p>10 In this case, did they detransition, did they,</p> <p>11 you know -- are they just not interested in the</p> <p>12 treatment anymore? So kind of keeping really good</p> <p>13 records here is helpful. And I'm sure some</p> <p>14 practitioners think that -- agree with that.</p> <p>15 Q Okay. So do you keep up on research that's</p> <p>16 coming out about desistance? I mean, this view that</p> <p>17 it's being ignored, do you keep tabs on what's out there</p> <p>18 and --</p> <p>19 A I do.</p> <p>20 Q -- what's -- what's in the pipeline?</p> <p>21 A Yeah.</p> <p>22 Q Have you seen anything recently about</p> <p>23 desistance?</p> <p>24 A It rings a bell, but, you know, if you've got</p> <p>25 one I can tell you whether I've seen it or not.</p>	<p style="text-align: right;">Page 308</p> <p>1 Q Is that research being published?</p> <p>2 A I haven't seen a lot on it.</p> <p>3 Q Okay.</p> <p>4 A And I usually see sort of the bigger studies</p> <p>5 that come out.</p> <p>6 Q Okay.</p> <p>7 A Now, it may be that one has recently come out</p> <p>8 that I wasn't aware of or -- so --</p> <p>9 Q Okay. I guess if I was just asking this</p> <p>10 question generally about is a scientific discipline</p> <p>11 ignoring a certain topic and that that would call into</p> <p>12 question the conclusions of organizations in that space,</p> <p>13 how would I -- how would I know?</p> <p>14 A Right. So give you an example from my report.</p> <p>15 Right? The kind of kerfuffle about 60 Minutes talking</p> <p>16 to detransitioners and kind of the dialogue between some</p> <p>17 of the, sort of, better known affirmative clinician</p> <p>18 researchers to -- not to talk to the media about this.</p> <p>19 And I forget her name, but 60 Minutes host said, I've</p> <p>20 never seen a program try to be killed before it aired,</p> <p>21 you know, rather than criticize after it aired.</p> <p>22 Q But people who work in gender-affirming care</p> <p>23 are researching detransitioners; right?</p> <p>24 A Some, yeah.</p> <p>25 Q All right.</p>
<p style="text-align: right;">Page 307</p> <p>1 Q Okay. You raise a similar concern about social</p> <p>2 contagion as a concept to, right, that the field is sort</p> <p>3 of not paying attention. I guess I have the same</p> <p>4 question. Is there --</p> <p>5 A I think some are paying attention to it.</p> <p>6 Q Okay.</p> <p>7 A I've seen WPATH start talking about it. But,</p> <p>8 you know, sometimes in the expert witness reports from</p> <p>9 the plaintiff's side I can see where they don't want to</p> <p>10 talk about it because we've brought it up and it's, you</p> <p>11 know, dismissed or, kind of in a rebuttal form, poked</p> <p>12 at.</p> <p>13 The idea of a social side to now it might be</p> <p>14 called adolescent onset gender dysphoria. I mean,</p> <p>15 Littman called it rapid onset meaning that it occurred</p> <p>16 fairly quickly during adolescence. Now people very</p> <p>17 critical of her at the beginning, nothing really</p> <p>18 fundamentally changed about her study, and now we hear</p> <p>19 talk about adolescent onset gender dysphoria from other</p> <p>20 sources, so that's a positive in the literature.</p> <p>21 Q So is there research ongoing about that topic?</p> <p>22 It sounds like there is.</p> <p>23 A It does sound like there is.</p> <p>24 Q Okay.</p> <p>25 A I'm glad to see it.</p>	<p style="text-align: right;">Page 309</p> <p>1 A I don't think it's a popular line of research,</p> <p>2 but it does exist.</p> <p>3 Q Okay. So if I was looking to understand</p> <p>4 something like this all I would have is, you know,</p> <p>5 anecdotes like a 60 Minutes. I wouldn't have a systemic</p> <p>6 way to evaluate the question?</p> <p>7 A So like Littman, she pulls in 100, I forget</p> <p>8 where she found them, but there are examples of pooling</p> <p>9 together people who say they are detransitioning or have</p> <p>10 detransitioned and kind of exploring the reasons why.</p> <p>11 And I think she does a fairly good job of the span of</p> <p>12 possible reasons for it.</p> <p>13 Q Okay. But if I wanted to understand, for</p> <p>14 instance, like is the field of sociology ignoring the</p> <p>15 connection between drug use and family dissolution?</p> <p>16 A They are not.</p> <p>17 Q They are not, but take me at the hypo there.</p> <p>18 A It would be, you know --</p> <p>19 Q Wouldn't it matter whether or not people are</p> <p>20 pursuing research agendas on that topic and whether or</p> <p>21 not that research is being funded and published,</p> <p>22 wouldn't that be how I would answer that question?</p> <p>23 A Those are two things, right, the funding to</p> <p>24 publish and the thing before it is --</p> <p>25 Q Research agenda's from scholars.</p>

<p style="text-align: right;">Page 310</p> <p>1 A Right. I mean, some things cost money to do.  2 But like -- in Littman, I don't know if he's funded for  3 that. But it doesn't look an expensive thing to do to  4 talk to a hundred detransitioners perhaps once. I can't  5 remember if she talked to them twice. But, you know,  6 it's helpful, I suppose, when funding is earmarked  7 towards it. Now, funding isn't usually earmarked that  8 narrowly in a discipline.  9 And these decisions are made from somewhere.  10 Right? You know, what constitutes funding in this area.  11 Plus, if you're talking about federal funding then  12 you're talking about navigating the peer review process  13 for grants.  14 And back to my claim about ideological capture.  15 And this is not just true of this domain, but the  16 federal granting agencies, you know, one could say these  17 are -- you know, the claims have been made that these  18 are peers that are endorsing each other's research.  19 It's this cycle where everybody sort of takes their turn  20 on it to keep people funded.  21 Whereas, kind of more sort of perhaps cutting  22 edge or -- I don't know a better word for it -- research  23 that didn't necessarily fit with the paradigm can find  24 themselves pushed out of the peer review process at the  25 federal system because, you know, people don't like it.</p>	<p style="text-align: right;">Page 312</p> <p>1 exhibited research on the social contagion idea. I  2 don't know that she terms it that. But she was widely  3 pilloried and that kind of, I think, surprised her.  4 And, you know, Brown sort of stopped things and  5 scrutinized it more closely and then decided, Well,  6 nothing untoward has happened here so -- but I think  7 PLOS, Public Library of Science, PLOS One, the journal  8 that was published and issued some sort of, you know --  9 that Dr. Turban makes reference to in a disparaging  10 fashion, like she had to go through this process that  11 Plos One indicated a sort of note of caution, which  12 frankly, was ridiculous to have a re-review and a note  13 of caution when nothing fundamentally changed about  14 analyses or her conclusion, maybe a little bit about the  15 language.  16 Q Okay. Just a couple of final things here. I  17 know we're kind of getting near the end.  18 You said that -- I think you referenced a Biggs  19 study on detransition; is that right?  20 A The 100-case thing? Is that big? That's not  21 really big in sociology.  22 Q But, you said the Biggs study?  23 A Biggs --  24 Q Yeah. My mistake.  25 A -- from Oxford. Detransition. Biggs. Did I</p>
<p style="text-align: right;">Page 311</p> <p>1 Q But that can suggest --  2 A Even though it could be a very viable area of  3 study.  4 Q But that suggests that -- you would answer a  5 question like that by looking to what is being funded,  6 published, researched; right? I mean, that would be the  7 way you would do it methodologically, and then you'd get  8 into issues about, you know --  9 A Right.  10 Q -- you could draw conclusions about funding  11 sources and all of that.  12 A True. And also sort of who is interested in  13 it. Are they talking? Is there conference proceedings  14 that deal with the topic? There's lots of ways that you  15 can kind of see what's going on in your field.  16 Q Okay. But -- but once again, on the subjects  17 of desistance research and social contagion research,  18 which I believe you call it --  19 A Those are distinctive, though.  20 Q Distinctive things, yeah.  21 A Right.  22 Q But you said for both that there is research  23 ongoing, there is papers being published.  24 A There are people who are curious about it.  25 There seems to be research ongoing. I mean, Littman has</p>	<p style="text-align: right;">Page 313</p> <p>1 mention that?  2 Q I think it might be in the report. Let me just  3 check real fast.  4 A Yes, I have. It rings a bell, but not very  5 loudly.  6 Q Okay. I may circle back there if you don't  7 mind.  8 A Sure.  9 Q Take up your time. Are you familiar with a  10 group called Society For Evidence-Based Gender Medicine?  11 A A little bit, not a lot.  12 Q Are you involved in that organization?  13 A No.  14 Q Okay. How did you hear about them.  15 A I met somebody at a conference somewhere who  16 told me that they're involved with it. But -- no, no,  17 no. I think my research assistant had mentioned it, and  18 then I met somebody who -- that was the second reference  19 to it. But SEGM I think they're called.  20 Q SEGM, yeah.  21 A I don't look at their website much. You know,  22 my research assistant mentions things occasionally. But  23 I don't -- I don't talk to them. I don't know who runs  24 the place, all that stuff.  25 Q Do you think that their views are influenced by</p>

<p style="text-align: right;">Page 314</p> <p>1 ideology?</p> <p>2 A I really can't tell you what their views are</p> <p>3 except they're a little more cautious than, say, WPATH.</p> <p>4 I don't know exactly how much more cautious.</p> <p>5 Q Okay. Can you go back to Exhibit 5 here? This</p> <p>6 is your essay, "Arkansas and the Politics of</p> <p>7 Experimenting on Children."</p> <p>8 A Oh, did I mention SEGM in that? It's possible.</p> <p>9 Q Okay. This will be the bottom of --</p> <p>10 A Keep in mind that was a year ago. SEGM had</p> <p>11 probably issued something. They are usually quick out</p> <p>12 of the gate.</p> <p>13 Q Yeah.</p> <p>14 A I don't read it, but, like, they say things</p> <p>15 fairly quickly, I know that.</p> <p>16 Q Gotcha. So this will be the bottom of page 4.</p> <p>17 A Got it. For instance --</p> <p>18 Q It says, "Not all medical societies ignore such</p> <p>19 cautions, but the mainstream ones are captured,</p> <p>20 one-sided, and so silencing of all but affirmative care</p> <p>21 voices that alternative professional groups are forced</p> <p>22 to form."</p> <p>23 A Right. Force is kind of a -- not actually</p> <p>24 forced. They feel like they have no choice but to form</p> <p>25 a voice to be heard.</p>	<p style="text-align: right;">Page 316</p> <p>1 Q Yeah. So have you analyzed SEGM in the same</p> <p>2 way that you have analyzed those organizations?</p> <p>3 A No. I mean, I know they serve -- they're</p> <p>4 antagonistic to the same things I see, but I haven't</p> <p>5 trained my lens on it. My sense is that they are not</p> <p>6 popular perhaps in sort of terms of -- I don't know if</p> <p>7 there is membership to the thing or what. But, you</p> <p>8 know, they seem sort of like a smaller group, though I</p> <p>9 could be wrong.</p> <p>10 Q Okay. So there is no -- you haven't looked at</p> <p>11 them the same way you have looked at the other</p> <p>12 organizations to determine if there is any kind of</p> <p>13 ideological bias involved?</p> <p>14 A Well, if you want to talk about bias, everybody</p> <p>15 is biased.</p> <p>16 Q The same way you have, you know, inquired as to</p> <p>17 the other organizations, you have not done that for</p> <p>18 SEGM?</p> <p>19 A Right. Because I suspect I would find that we</p> <p>20 are probably more on the same page, so -- or at least</p> <p>21 similar.</p> <p>22 Q Okay. And so would being on the same page you</p> <p>23 mean they are not ideologically motivated?</p> <p>24 A No. I think on the same page as they are not</p> <p>25 crazy about hormonal and surgical treatment for minors.</p>
<p style="text-align: right;">Page 315</p> <p>1 Q Understood. So when you say "mainstream ones,"</p> <p>2 is that a reference to the AAP, WPATH, and the Endocrine</p> <p>3 Society?</p> <p>4 A Correct.</p> <p>5 Q Okay. And is it your view that WPATH, the</p> <p>6 Endocrine Society, and the AAP are influenced by</p> <p>7 ideology?</p> <p>8 A Well, I mean, they have been captured</p> <p>9 ideologically, which means a small -- smaller set of,</p> <p>10 sort of, activists have managed to convince the American</p> <p>11 Academy of Pediatrics to endorse affirmative medicine</p> <p>12 and all that it entails --</p> <p>13 Q I see.</p> <p>14 A -- which is distinctive from sort of -- well,</p> <p>15 what -- if we were to take a poll of pediatricians in</p> <p>16 the United States, and I have no reason to think that</p> <p>17 the AAP can't pull their membership or do a -- conduct a</p> <p>18 study of their membership, you know, interviewing 500</p> <p>19 pediatricians out of 60,000 or some odd --</p> <p>20 Q Sure.</p> <p>21 A -- to kind of get their sense of this, I think</p> <p>22 that's -- would be a helpful thing to do and they have</p> <p>23 the resources to do it.</p> <p>24 Q So have you --</p> <p>25 A Basically, they didn't do that.</p>	<p style="text-align: right;">Page 317</p> <p>1 Q Okay. Do you have any experience with</p> <p>2 adolescents diagnosed with gender dysphoria who were</p> <p>3 unable to access gender-affirming care?</p> <p>4 A That's a tight set of criteria.</p> <p>5 Q Yeah.</p> <p>6 A Say it again, please.</p> <p>7 Q Do you have any experience with adolescents</p> <p>8 diagnosed --</p> <p>9 A People under 18.</p> <p>10 Q Diagnosed with gender dysphoria.</p> <p>11 A Now, I'm typically not privy to that, but I</p> <p>12 have -- okay. That also --</p> <p>13 Q Who were unable to access gender-affirming</p> <p>14 care?</p> <p>15 A Who are interested in accessing it and unable</p> <p>16 to access it?</p> <p>17 Q Yes.</p> <p>18 A I mean, I have some knowledge of kids who were</p> <p>19 assessed as gender dysphoric and in-patient care whose</p> <p>20 parents decided that was wildly different from their</p> <p>21 experience of that child at home and pulled her out of</p> <p>22 the care facility. I mean, I'm not sure if that's quite</p> <p>23 close to what you were talking about.</p> <p>24 Q This is a social interaction, this is somebody</p> <p>25 who --</p>

<p style="text-align: right;">Page 318</p> <p>1 A Correct.</p> <p>2 Q Okay. Like family friends and this is their</p> <p>3 kid or something?</p> <p>4 A (Nods head.)</p> <p>5 Q Okay. So you have never spoken with an</p> <p>6 adolescent who was seeking gender-affirming care for</p> <p>7 gender dysphoria and was not able to obtain it?</p> <p>8 A Correct.</p> <p>9 Q Okay. Do you have any basis to dispute</p> <p>10 clinicians who treat adolescent patients with gender</p> <p>11 dysphoria and see the benefits of that care for their</p> <p>12 patients?</p> <p>13 MR. CANTRELL: Object to form.</p> <p>14 A All right. Say that again slowly, please.</p> <p>15 Q (By Mr. Richardson) Do you have any basis to</p> <p>16 dispute clinicians who treat adolescent patients with</p> <p>17 gender dysphoria and see the benefits of care for those</p> <p>18 patients?</p> <p>19 MR. CANTRELL: Object to form.</p> <p>20 A So Dr. Adkins talks a lot about this. And one</p> <p>21 of the ways I criticize her -- I think I criticized her</p> <p>22 in print -- is constantly referring to sort of her</p> <p>23 assessment of her patients, right. You know, since I</p> <p>24 don't have patients and I don't interact with patients,</p> <p>25 I assess the literature on this.</p>	<p style="text-align: right;">Page 320</p> <p>1 A That would be rather invasive I would say.</p> <p>2 Q Did you discuss Medicare for gender dysphoria</p> <p>3 at all?</p> <p>4 A No.</p> <p>5 Q Okay. Have you ever read or heard anything</p> <p>6 about the plaintiff families in this case?</p> <p>7 A The who?</p> <p>8 Q Plaintiff families, the Brandts, the Jennens.</p> <p>9 A Um, I think I did a cursory read back last,</p> <p>10 whenever that was, June, early July.</p> <p>11 Q Okay.</p> <p>12 A But not -- not a detailed read.</p> <p>13 Q Did you see that they talked about uprooting</p> <p>14 the families and moving out of the state?</p> <p>15 A I do recall that.</p> <p>16 Q Okay. Did you have any reaction to that?</p> <p>17 A Well, I feel for people. Right? It's -- but,</p> <p>18 you know, the empathetic part seems that that's a</p> <p>19 frustrating thing to do and, yet, it's not enough to</p> <p>20 make me think the treatments are a good idea.</p> <p>21 Q Okay. Do you recognize that their teen-age</p> <p>22 children may be harmed if they are forced to stop</p> <p>23 receiving care?</p> <p>24 MR. CANTRELL: Object to form.</p> <p>25 A Harmed in what fashion? This is where I get a</p>
<p style="text-align: right;">Page 319</p> <p>1 So when Adkins says things like this we come to</p> <p>2 a bit of a loggerhead where she'll say, Ah, I know what</p> <p>3 my patients need and want and benefit from. You know,</p> <p>4 I'm kind of not in a position to be privy to those kinds</p> <p>5 of conversations, but privy to the wider literature.</p> <p>6 Q (By Mr. Richardson) Do you not think that</p> <p>7 clinical experience should inform medical care?</p> <p>8 A Oh, you know, I think that's part of it.</p> <p>9 Q Okay.</p> <p>10 A Sure.</p> <p>11 Q So you have no basis to think that Dr. Adkins</p> <p>12 is lying about the benefits?</p> <p>13 A I don't think she's lying about what she sees</p> <p>14 and perceives. That doesn't solve my disputes with her</p> <p>15 about all the other things that we've talked about.</p> <p>16 Q Okay. So have you ever talked to any</p> <p>17 adolescent with gender dysphoria?</p> <p>18 A Would you qualify transgender adolescents as</p> <p>19 fitting that? I mean, they would have to give me their</p> <p>20 diagnosis. You know, I have talked to transgender</p> <p>21 minors.</p> <p>22 Q Okay. Did you discuss --</p> <p>23 A We did not discuss their diagnoses of dysphoria</p> <p>24 or not.</p> <p>25 Q Okay.</p>	<p style="text-align: right;">Page 321</p> <p>1 little frustrated with harm as its generic term meant to</p> <p>2 signal significant risk of things.</p> <p>3 Q (By Mr. Richardson) Harm by the clinical</p> <p>4 distress that accompanies gender dysphoria.</p> <p>5 A You know, frustrated, sad, upset, yeah,</p> <p>6 discouraged. I get that that can occur.</p> <p>7 Q Okay. And you said that you've talked to some</p> <p>8 transgender adolescents before; right?</p> <p>9 A Yes.</p> <p>10 Q How many would you say you?</p> <p>11 A Not a lot. Sometimes I -- one has subjective</p> <p>12 assessment of it. But students mostly, in fact, mostly</p> <p>13 over 18. Sorry.</p> <p>14 Q So any adolescents?</p> <p>15 A Yes, but not many.</p> <p>16 Q Okay. And the context for those conversations,</p> <p>17 was it --</p> <p>18 A Social.</p> <p>19 Q Okay. This wasn't a research setting of any</p> <p>20 kind or --</p> <p>21 A No.</p> <p>22 Q Okay. Do you recall appearing on a program</p> <p>23 called the Dr. J Show with a host Jennifer Roback Morse?</p> <p>24 A A show? Vaguely, yeah. This is Zoom era</p> <p>25 perhaps.</p>

<p style="text-align: right;">Page 322</p> <p>1 Q That sounds right. And the host was Jennifer 2 Roback Morse? 3 A Yes. 4 Q Okay. Do you recall the host saying "The truth 5 will always be at war with transgender people"? 6 A I don't recall her saying that. I will say 7 that there are moments when you're talking with Jennifer 8 Roback Morse that you don't quite know what she is going 9 to say. 10 Q Okay. 11 A It's not my style of operating in this domain. 12 Q Okay. 13 A But, you know, I take responsibility for what I 14 say, not for what other people say. 15 Q Okay. Do you agree with her statement that 16 "The truth is always at war with transgender people"? 17 A You know, I'd have to break that down piece by 18 piece. It seems like a kind of -- a characterization 19 that, you know, is unnecessarily inflammatory with the 20 kind of wartime imagery. I don't think about things 21 being at war with persons. I try to keep things about 22 ideas, right, this is a good idea, this is a bad idea, 23 rather than sort of being at war with persons. 24 Which is why in all of my research, you know, I 25 try hard not to disparage persons. I have to criticize</p>	<p style="text-align: right;">Page 324</p> <p>1 empirically more solid research in this domain. When 2 we're doing things with samples we're getting estimates 3 of the real thing. 4 Any time you're dealing with samples and not 5 entire censuses of populations you are estimating 6 things, which means there is a margin of error, standard 7 of errors, deviations. You don't get to know the entire 8 truth. You estimate how close it is to the truth. 9 Which, of course, is more difficult to do when you don't 10 have random samples, but that's a different story. 11 Warring. I don't know how to evaluate that 12 statement of Jennifer's. I'm not sure what she's 13 meaning. 14 Q Okay. 15 A I don't think of myself as warring with 16 transgender people. 17 Q Okay. So we're getting near the end so I have 18 to ask you one of your favorite questions, which is an 19 if-you-were-in-charge question. 20 If you were in charge would you impose a ban on 21 care for all adolescents seeking gender-affirming 22 medical treatment or would you prefer a system that 23 allows for care in the cases where there is demonstrated 24 need and care is regulated by a state medical board? 25 MR. CANTRELL: Object to form.</p>
<p style="text-align: right;">Page 323</p> <p>1 in rebuttal. Right? Sometimes I have no choice but to 2 go after people because this is -- but I typically try 3 to treat them with dignity, respect, you know, I don't 4 think certain kinds of lingo is helpful. 5 Q Okay. So just focusing on ideas, then, do you 6 think the truth is at war with gender ideology? 7 A The truth. What do you mean by the truth? 8 Empirical truth? 9 Q In the way she meant it, yeah. 10 A I'm not sure exactly how she meant it. I would 11 have to have the context for that discussion. I'm sure 12 when she said that I'm like, "Jennifer why do you say 13 such things?" But that's her -- her style. 14 Q So that's a -- the truth, I mean, it sounds 15 like you said -- you just used the descriptor. 16 A Empirical? 17 Q Yeah. So the empirical truth is at war with 18 gender ideology? 19 A I'm not sure that's what she was saying, 20 though. 21 Q Okay. Let's just take it separately then. Do 22 you -- do you think that the empirical truth is at war 23 with gender ideology? 24 A I'm not sure what that means frankly, the 25 empirical truth. I'm questing, searching for, like,</p>	<p style="text-align: right;">Page 325</p> <p>1 A What is demonstrated need? This is kind of 2 where you go to this sort of medically necessary 3 language, which is, of course, somewhat subjective to 4 the physician. Right? You know, somebody deems 5 something as medically necessary and somebody else would 6 not necessarily. 7 So if you would, read that to me once more. 8 Q (By Mr. Richardson) So I will make it a little 9 simpler. If you were in charge would you impose a 10 ban -- 11 A Charge of what? 12 Q -- on all gender-affirming care for adolescents 13 or prefer a system -- 14 A So by gender-affirming care we mean the 15 psychological aspects of this as well or not? 16 Q We mean the procedures banned by HB 1570. 17 A So it's for puberty blockers, cross-sex 18 hormones, surgeries of different types. Right? I don't 19 think they are appropriate for minors. 20 Q Okay. So that would be the optimal system in 21 your view over any kind of individualized assessments? 22 A Well, I think people should have individualized 23 assessments. But certain things should be permissible. 24 Certain things should be preferred to other things. 25 But to sort of sever one from, sort of,</p>

<p style="text-align: right;">Page 326</p> <p>1 experience of puberty I think is imprudent. One does  2 not know what one will feel, think, find when that  3 occurs. And so I think that conversation is even  4 starting to break back into the affirmative care group.  5 I don't expect the conflict with them to diminish any  6 time soon. I think it's a very live thing. I watch,  7 so.  8 Q Would you say the conflict like that is a sign  9 of a healthy --  10 A Well, I do think --  11 Q -- profession?  12 A Open conflict and respect is better than, sort  13 of, what we have seen in the past.  14 Q And you think that the current field of  15 transgender healthcare is characterized by open  16 conflict?  17 MR. CANTRELL: Object to form.  18 A I think we are starting to see signs of more  19 open conflict. I think in the past it looks like it  20 was, you know, suppressed, probably still is suppressed  21 at some level. But how it will end I have no idea.  22 Q (By Mr. Richardson) Okay.  23 A I mean, we're talking about an industry that is  24 guided by suggestions rather than hard rules.  25 Q And do you think that's unusual in medical</p>	<p style="text-align: right;">Page 328</p> <p>1 CERTIFICATE  2  3  4 I, Trena K. Bloye, Certified Shorthand Reporter  5 within and for the State of Oklahoma, certify that MARK  6 DANIEL REGNARUS was by me first duly sworn to testify  7 the truth, the whole truth, and nothing but the truth,  8 in the case aforesaid; that the witness chooses to read  9 and sign the deposition; that the above and foregoing  10 videotaped deposition was taken by me in shorthand and  11 thereafter transcribed; that the same was taken on May  12 5, 2022, at 9:01 a.m., at the Arkansas Attorney  13 General's Office, 323 Center Street, Suite 200, Little  14 Rock, Arkansas, that I am not an attorney for, nor a  15 relative of any of said parties or otherwise interested  16 in the event of said action.  17 IN WITNESS WHEREOF, I have hereunto set my hand  18 and official seal this 14th day of May, 2022.  19  20  21  22  23    24  25 Trena K. Bloye, CSR  State of Oklahoma CSR No. 1522</p>
<p style="text-align: right;">Page 327</p> <p>1 science?  2 A When you're dealing with minors I suspect there  3 is a lot more things that involve laws and rules than  4 when you're dealing with adults.  5 MR. RICHARDSON: Okay. That's it for me.  6 MR. CANTRELL: I have no questions. But  7 we will review and sign.  8 VIDEO OPERATOR: Okay. This concludes  9 today's testimony given by Mark Regnarus. The total  10 number of media used was six and will be retained by  11 Veritext. We are off the record at 5:39 p.m.  12 (Deposition concluded.)  13  14  15  16  17  18  19  20  21  22  23  24  25</p>	<p style="text-align: right;">Page 329</p> <p>1 MICHAEL A. CANTRELL  2 michael.cantrell@arkansasag.gov  3 May 17, 2022  4 RE: BRANDT, et al. vs. RUTLEDGE, et al.  5 5/5/2022, Mark D. Regnarus (#5163547)  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 erratas-cs@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</p>

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 2 5/5/2022 - Mark D. Regnarus (#5163547)  
 3 E R R A T A S H E E T  
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 24 Mark D. Regnarus Date  
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1 BRANDT, et al. vs. RUTLEDGE, et al.  
 2 5/5/2022 - Mark D. Regnarus (#5163547)  
 3 ACKNOWLEDGEMENT OF DEPONENT  
 4 I, Mark D. Regnarus, 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 Mark D. Regnarus Date  
 13 \*If notary is required  
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS  
 15 \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.  
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 19 NOTARY PUBLIC  
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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, 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.

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# Exhibit 5

1 THE UNITED STATES DISTRICT COURT  
2 EASTERN DISTRICT OF ARKANSAS  
3 CENTRAL DIVISION  
4

5 -----x  
6 DYLAN BRANDT, by and through his  
7 Mother, JOANNA BRANDT, et al.,  
8 Plaintiffs

9 V. CASE NO. 4:21-CV-00450-JM  
10 LESLIE RUTLEDGE, et al.,  
11 Defendants.

12 -----x

13  
14  
15 REMOTE/ORAL/WEB VIDEOCONFERENCE

16 VIDEOTAPED DEPOSITION OF

17 PAUL W. HRUZ, M.D., Ph.D.

18 May 25, 2022

19 9:00 a.m. CT  
20  
21  
22  
23

24 Reported by:

25 Maureen Ratto, RPR, CCR

<p style="text-align: right;">Page 2</p> <p>1                   * * *</p> <p>2</p> <p>3           Videotape deposition of Paul W.</p> <p>4   Hruz, M.D., Ph.D., held virtually via</p> <p>5   Zoom Teleconference, hosted from</p> <p>6   Veritext Legal Solutions, pursuant to</p> <p>7   notice, before Maureen Ratto, Certified</p> <p>8   Court Reporter, License No. XI01165,</p> <p>9   Registered Professional Reporter,</p> <p>10   License No. 817125, and Notary Public.</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 4</p> <p>1   A P P E A R A N C E S, continued:</p> <p>2</p> <p>3   Co-counsel for Plaintiffs:</p> <p>4       GILL RAGON OWEN, PA</p> <p>5       425 West Capitol Avenue</p> <p>6       Little Rock, Arkansas 72201</p> <p>7       BY: BETH ECHOLS, ESQ.</p> <p>8           echols@gill-law.com</p> <p>9</p> <p>10   Counsel for the Defendants:</p> <p>11       SENIOR ASSISTANT ATTORNEY</p> <p>12       GENERAL, PUBLIC PROTECTION DIVISION</p> <p>13       OFFICE OF ARKANSAS ATTORNEY GENERAL</p> <p>14       323 Center Street</p> <p>15       Little Rock, Arkansas 72201</p> <p>16       BY: AMANDA LAND, ESQ.</p> <p>17           aland@arkansasag.gov</p> <p>18       MICHAEL CANTRELL, ESQ.</p> <p>19           michael.cantrell@arkansasag.gov</p> <p>20</p> <p>21   ALSO PRESENT:</p> <p>22   MICHAEL TSCHIEMER, Legal Video</p> <p>23   Specialist</p> <p>24</p> <p>25</p>
<p style="text-align: right;">Page 3</p> <p>1   A P P E A R A N C E S:</p> <p>2</p> <p>3   Counsel for the Plaintiffs:</p> <p>4       SULLIVAN &amp; CROMWELL, LLP</p> <p>5       125 Broad Street</p> <p>6       New York, New York 10004</p> <p>7       BY: BRANDYN RODGERSON, ESQ.</p> <p>8           rodgersonb@sullcrom.com</p> <p>9       SOPHIA M. MATTHEWS, ESQ.</p> <p>10          matthewss@sullcrom.com</p> <p>11</p> <p>12   AMERICAN CIVIL LIBERTIES UNION</p> <p>13   125 Broad Street</p> <p>14   New York, New York 10004</p> <p>15   BY: CHASE STRANGIO, ESQ.</p> <p>16          cstrangio@aclu.org</p> <p>17   LESLIE COOPER, ESQ.</p> <p>18          lcooper@aclu.org</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 5</p> <p>1           VIDEOGRAPHER: Good morning,</p> <p>2   we are going on the record at 9:00</p> <p>3   a.m. Central Time on May 25th,</p> <p>4   2022.</p> <p>5           Please note that microphones</p> <p>6   are sensitive and may pick up</p> <p>7   whispering and private</p> <p>8   conversations. Please mute your</p> <p>9   phones at this time.</p> <p>10          Audio and video recording will</p> <p>11   continue to take place unless all</p> <p>12   parties agree to go off the record.</p> <p>13          This is Media Unit 1 of the</p> <p>14   video-recorded deposition of</p> <p>15   Dr. Paul Hruz taken by counsel for</p> <p>16   Plaintiff in the matter of Dylan</p> <p>17   Brandt, et al versus Leslie</p> <p>18   Rutledge, et al filed in the United</p> <p>19   States District Court, Eastern</p> <p>20   District of Arkansas, Central</p> <p>21   Division 4:21-cv-00450-JM.</p> <p>22          The location of the deposition</p> <p>23   is the Arkansas Attorney General's</p> <p>24   Office at 323 Center Street, Suite</p> <p>25   200, in Little Rock, Arkansas. This</p>

<p style="text-align: right;">Page 6</p> <p>1 deposition is also being conducted</p> <p>2 remotely using virtual technology.</p> <p>3 My name is Mike Tschiemer</p> <p>4 representing Veritext and I'm the</p> <p>5 videographer. The court reporter is</p> <p>6 Maureen Ratto, from the firm of</p> <p>7 Veritext.</p> <p>8 I am not related to any party</p> <p>9 in this action, nor am I</p> <p>10 financially interested in the</p> <p>11 outcome.</p> <p>12 If there are any objections to</p> <p>13 the proceeding, please state them</p> <p>14 at the time of your appearance.</p> <p>15 Counsel and all present, including</p> <p>16 remotely, will now state their</p> <p>17 appearances and affiliations for</p> <p>18 the record, beginning with the</p> <p>19 noticing attorney.</p> <p>20 MR. STRANGIO: Good morning.</p> <p>21 This is Chase Strangio from the</p> <p>22 ACLU for the Plaintiffs.</p> <p>23 MS. COOPER: And also in the</p> <p>24 room, Leslie Cooper, with the ACLU</p> <p>25 for Plaintiffs.</p>	<p style="text-align: right;">Page 8</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 first duly sworn according to law by</p> <p>3 the Officer, testifies as follows:</p> <p>4 DIRECT EXAMINATION MR. STRANGIO:</p> <p>5 VIDEOGRAPHER: Thank you.</p> <p>6 Please proceed.</p> <p>7 Q. Good morning, Dr. Hruz. How</p> <p>8 are you this good morning?</p> <p>9 A. Good morning. Doing well.</p> <p>10 Q. Thank you for being here.</p> <p>11 My name is Chase Strangio.</p> <p>12 I'm with the ACLU representing the</p> <p>13 Plaintiffs and I'll be asking you some</p> <p>14 questions today.</p> <p>15 Can you just start by stating</p> <p>16 your name for the record, please?</p> <p>17 A. Paul Hruz.</p> <p>18 Q. And you've had your deposition</p> <p>19 taken before, right?</p> <p>20 A. Correct.</p> <p>21 Q. So you generally know how this</p> <p>22 process goes?</p> <p>23 A. That is correct.</p> <p>24 Q. I'm just going to run through</p> <p>25 some basic ground rules that you're</p>
<p style="text-align: right;">Page 7</p> <p>1 MR. ROGERSON: Also in the</p> <p>2 room Brandyn Rogerson with Sullivan</p> <p>3 &amp; Cromwell for the Plaintiffs.</p> <p>4 MS. MATTHEWS: Sophia</p> <p>5 Matthews, Sullivan &amp; Cromwell also</p> <p>6 for Plaintiffs, and we're joined by</p> <p>7 two of our summer associates.</p> <p>8 MS. ECHOLS: Also in the room,</p> <p>9 Beth Echols with Gill Ragon Owens</p> <p>10 for the Plaintiffs, and I'm</p> <p>11 accompanied by our summer</p> <p>12 associate, Jordan Jones.</p> <p>13 MS. LAND: Amanda Land, on</p> <p>14 behalf of the Defendants, with the</p> <p>15 Office of the Attorney General.</p> <p>16 VIDEOGRAPHER: Thank you.</p> <p>17 Doctor, will you raise your right</p> <p>18 hand to be sworn in.</p> <p>19 MR. CANTRELL: This Michael</p> <p>20 Cantrell, also appearing remotely</p> <p>21 for the Defendants. I'm with the</p> <p>22 Arkansas Attorney General's Office.</p> <p>23 VIDEOGRAPHER: Anybody else?</p> <p>24 * * *</p> <p>25 PAUL W. HRUZ, M.D., Ph.D., having been</p>	<p style="text-align: right;">Page 9</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 probably familiar with, just to make sure</p> <p>3 we're on the same page. Is that okay?</p> <p>4 A. Very good.</p> <p>5 Q. So when answering my questions</p> <p>6 I ask that you respond verbally out loud</p> <p>7 so that the court reporter can hear you</p> <p>8 and document your response. Is that okay?</p> <p>9 A. Yes.</p> <p>10 Q. And to help the court</p> <p>11 reporter, please wait for me to finish</p> <p>12 asking a question before you answer and</p> <p>13 I'll try to do the same.</p> <p>14 A. Very good.</p> <p>15 Q. And if you do not understand</p> <p>16 my question, please let me know and I can</p> <p>17 try to rephrase. Does that work for you?</p> <p>18 A. Yes.</p> <p>19 Q. But if you answer my question</p> <p>20 I'll assume you understood it. Okay?</p> <p>21 A. Understood.</p> <p>22 Q. Are you feeling okay today?</p> <p>23 A. Yes.</p> <p>24 Q. Okay. And are you on any</p> <p>25 medication that would impair your ability</p>

<p style="text-align: right;">Page 10</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to answer truthfully and accurately my  3 questions?  4 A. No.  5 Q. And is there any reason that  6 you don't feel able to give complete and  7 truthful testimony today?  8 A. I'm fine. Thank you.  9 Q. And today is likely going to  10 be a long day and so we will need to take  11 breaks.  12 If there comes a time when you  13 feel you need to take a break, please let  14 me know, we will find a good breaking  15 point. I would just ask that you answer  16 any pending questions before we break. Is  17 that okay?  18 A. Understood.  19 Q. I think that's all for the  20 basics, if that sounds good to you.  21 A. It's good with me.  22 Q. Okay. So can you tell me again  23 your full name?  24 A. Paul William Hruz.  25 Q. And you have been retained by</p>	<p style="text-align: right;">Page 12</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. It was receiving quite a bit  3 of attention in the media.  4 Q. And did you ever speak with a  5 member of the Arkansas legislature about  6 House Bill 1570?  7 A. I spoke with a number of  8 individuals. I don't believe that anybody  9 was directly a sponsor of the bill.  10 Q. But they were members of the  11 Arkansas legislature?  12 A. Not that I recall.  13 Q. So you spoke with individuals  14 but not members of the Arkansas  15 legislature?  16 A. Again, recollecting all that  17 has been going on, I've had numerous  18 conversations with numerous individuals  19 over an extended period of time. So for  20 me to recall specifically what  21 conversations happened in what context,  22 whether they were related to this  23 legislation or other legislation that is  24 being put forth throughout the country is  25 challenging for me and those details.</p>
<p style="text-align: right;">Page 11</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the Defendants as an expert in this case;  3 is that right?  4 A. That is correct.  5 Q. How did you come to be  6 retained as an expert in this case?  7 A. I was contacted by one of  8 their counsel, I think it was Vincent  9 Wagner, about a year ago asking if I  10 would be willing to serve in this case.  11 Q. And you're aware that this  12 case concerns an Arkansas law called the  13 Safe Act?  14 A. Correct.  15 Q. And when this law was pending  16 as House Bill 1570 did you take a public  17 position on the bill?  18 A. No.  19 Q. Did you testify in support of  20 the bill?  21 A. No.  22 Q. Were you aware of the bill  23 when it was pending?  24 A. Yes.  25 Q. How were you aware of it?</p>	<p style="text-align: right;">Page 13</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And is there anyone who you  3 recall specifically speaking with about  4 HB 1570?  5 A. I'm not aware of any details,  6 so no.  7 Q. So you don't recall any  8 specific individuals?  9 A. That's correct.  10 Q. Do you recall speaking with  11 anyone from the Family Research Council  12 about HB 1570?  13 A. Again, I've had so many  14 conversations over the last couple of  15 years that it's hard for me to remember  16 specific details.  17 Q. Do you remember if you spoke  18 to anyone within the State of Arkansas  19 about HB 1570?  20 A. Again, I had numerous  21 conversations with numerous individuals.  22 I did not really keep track of who was  23 who.  24 Many of the questions in the  25 conversations had to do with people</p>

<p style="text-align: right;">Page 14</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 asking me for my opinion about the nature  3 of human sexuality; how we define it; how  4 we understand that around that time and  5 that was most of the conversation that I  6 was engaged in.  7 Q. And were you involved in  8 drafting HB 1570?  9 A. No, but I do recall, either it  10 was this bill or some of the similar  11 bills, where some individuals had  12 contacted me asking me for my  13 professional opinion as far as whether  14 there was accuracy in the language that  15 was being used to define and recognize  16 what sex is.  17 Q. What did you say about the  18 accuracy in the language of this or  19 similar bills concerning sex and  20 sexuality?  21 MS. LAND: Object to form.  22 A. I have spoken in many  23 different venues in answer to that  24 question and whatever conversation I had  25 is consistent with those opinions that</p>	<p style="text-align: right;">Page 16</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Complaint as well.  3 Q. And when you say the  4 declarations, do you mean both the  5 declarations you filed at the preliminary  6 injunction stage and the two reports that  7 you filed during discovery?  8 A. Correct.  9 Q. And did you meet with counsel?  10 A. I spoke on the telephone.  11 Q. And how many times?  12 A. Two conversations leading  13 directly to this deposition.  14 Q. And how long, approximately,  15 were those conversations?  16 A. They were each about 90  17 minutes.  18 Q. And did you speak with anyone  19 other than your counsel about your  20 testimony?  21 A. Only to inform those that  22 needed to know that I would be absent  23 today to be able to take the deposition.  24 Q. But no one about the substance  25 of your testimony?</p>
<p style="text-align: right;">Page 15</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 I've expressed about the nature of sex as  3 a biological variable related  4 intrinsically to the process of human  5 reproduction and the precision of  6 understanding conversations that go on  7 related to disorders of sexual  8 development and similar types of  9 questions.  10 So, again, specifically for  11 this bill I don't have recollection of  12 the conversations but everything that I  13 have opined on that topic is consistent  14 and has been throughout the time I've  15 been involved in this conversation.  16 Q. And what did you do to prepare  17 for your testimony today?  18 A. I reviewed first the  19 declarations that I prepared, since it  20 has been a considerable amount of time  21 since I first drafted and submitted them;  22 I was able to review the declarations  23 that were provided to me from both the  24 plaintiff and the defense witnesses; I  25 reviewed the Complaint; the original</p>	<p style="text-align: right;">Page 17</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. That is correct.  3 Q. And did you review any  4 documents, other than those that you've  5 mentioned, the declarations and the  6 Complaint?  7 A. I am continually reviewing the  8 literature. I probably read half dozen or  9 a dozen research papers in the last week  10 or two related to this subject and that  11 is something that I do on an ongoing  12 basis.  13 Q. Okay. I want to see if we can  14 just start by seeing how well we can use  15 this Exhibit Share system and see if we  16 can get a few exhibits admitted. So if  17 you can turn to the Exhibit Share, we're  18 going to be using that for a moment here.  19 So you prepared two reports in  20 connection with this matter; is that  21 correct?  22 A. That's my recollection, yes.  23 MS. LAND: Chase, give me one  24 second. I'm going to migrate over  25 to the laptop with the exhibits to</p>

<p style="text-align: right;">Page 18</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 make sure I can pull it up.  3 MR. STRANGIO: Understood.  4 We'll go slowly. So I'm just going  5 to -- because it may take us a  6 minute on our end too.  7 (Exhibit Hruz 1, Expert Report  8 of Paul Hruz, dated December 10,  9 2021, was received and marked on  10 this date for identification.)  11 Q. So for the first exhibit here  12 marked as Exhibit 1, are you able to see  13 and click on that document?  14 MR. STRANGIO: I'll wait for  15 you too, Amanda, to make sure we're  16 ready. We're just marking these for  17 now.  18 A. I'm not seeing anything come  19 up.  20 Q. It has been uploaded. You just  21 have to refresh the page.  22 MS. LAND: It would help if I  23 were in the right folder.  24 A. This is Exhibit 1 titled  25 Expert Report of Paul Hruz.</p>	<p style="text-align: right;">Page 20</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Hruz, you do have it in front of you;  3 that's correct, right?  4 A. I have it on my computer  5 screen here, yes.  6 Q. And do you recognize this  7 document?  8 A. Well, I'm only seeing the  9 first page and I do recognize that as the  10 report I submitted, yes.  11 Q. Are you able to scroll through  12 the document?  13 A. I certainly can do that.  14 Q. To verify, is this a true and  15 accurate copy of the report that you  16 filed in this case?  17 A. I certainly won't have the  18 opportunity to read through the entire  19 report but I'm scrolling through it  20 currently and it does look to be the  21 document that I submitted. So I'll go  22 through the whole thing if you wish me to  23 do so.  24 Q. No. I just want to make sure  25 that this looks like an accurate copy of</p>
<p style="text-align: right;">Page 19</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And do you recognize --  3 Amanda, are you all set?  4 MS. LAND: It's not pulling up  5 my folder for me.  6 MR. STRANGIO: You refreshed  7 it?  8 MS. LAND: Yes. Hold on. Let  9 me.  10 Q. Are you okay just proceeding  11 to mark the exhibits. We're not going to  12 be going through them at this point.  13 MS. LAND: To mark them? What  14 do you mean?  15 MR. STRANGIO: I'm just going  16 to have them just to make sure  17 they're opened and marked for the  18 record and that Dr. Hruz verifies  19 that he recognizes them.  20 MS. LAND: Do you have them  21 physically? I'll just look at them  22 physically.  23 MR. STRANGIO: Perfect. Beth,  24 why don't up hand Amanda Exhibit 1.  25 Q. So coming back to you, Dr.</p>	<p style="text-align: right;">Page 21</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the December 10, 2021 report you filed  3 and if you go to page, 98 you will see  4 your date and signature.  5 A. Okay. Without having a chance  6 to read through the entire document, it  7 does look like the document I submitted.  8 Q. And is there any reason to  9 doubt that it is the true and accurate  10 document?  11 A. Not at all.  12 Q. Okay. Great. Thank you. Can  13 you open now what is marked as Exhibit 2?  14 (Exhibit Hruz 2, Expert  15 Rebuttal Report dated February  16 10th, 2022, was received and marked  17 on this date for identification.)  18 A. Here we go. Very good.  19 Q. And do you recognize this  20 document?  21 A. Again, from what I can see,  22 it, scrolling through, appears to be the  23 document that I submitted, correct.  24 Q. And this would be your  25 February 10th, 2022 rebuttal report; is</p>

<p style="text-align: right;">Page 22</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that correct?  3 A. February 10th, correct.  4 Q. And do these reports contain a  5 complete statement of the opinions you  6 intend to provide in this matter?  7 A. Well, as I stated in my  8 declaration, itself, that I'm continually  9 gathering information and that my  10 opinions may be amended based upon new  11 information that becomes available and  12 the necessity to address statements that  13 are made by the Plaintiff experts. But  14 it is a complete and accurate declaration  15 of my opinions related to this matter at  16 the time that I filed it.  17 Q. And since February 10th, 2022,  18 which was the date that you filed the  19 rebuttal report, have there been any  20 studies or reports that have been  21 published that you believe support your  22 opinions in this case?  23 A. Yes, indeed. There have been  24 multitude of developments in this rapidly  25 changing field, including declarations by</p>	<p style="text-align: right;">Page 24</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 studies. Do you recall which studies you  3 are referring to?  4 A. Again, I read dozens of  5 studies every week. There's a number of  6 them that would be helpful if we have the  7 opportunity and time to be able to  8 discuss them, but I don't have a list in  9 front of me and I don't have an ability  10 to specifically cite authors and journals  11 and dates of those journal articles.  12 Q. Understood. Have any of your  13 opinions changed since you filed your  14 most recent report on February 10, 2022?  15 A. I would say that my opinions  16 have not changed. In fact, much of what  17 I've read have reinforced the opinions  18 that I have and actually provided even a  19 stronger argument for the questions and  20 concerns that are raised.  21 Q. Okay. Thank you. And did you  22 write all four reports and declarations  23 that you submitted in this case?  24 A. This is definitely my work  25 product. The declaration, itself, has</p>
<p style="text-align: right;">Page 23</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 several European countries calling into  3 question the safety and efficacy of this  4 treatment approach, there have been a  5 number of studies that have been  6 published, many of them with the same  7 weaknesses and limitations of the types  8 of research studies that I cite in my  9 declaration here. And this is an active  10 area of conversation and I've certainly  11 tried my best to keep up-to-date on the  12 conversation primarily related to the  13 scientific questions.  14 Q. And can you list for me the  15 declarations by European countries that  16 you are referring to?  17 A. Certainly I can speak to  18 statements made by Sweden, Finland, the  19 U.K. and France most recently.  20 Again, the timing of those  21 developments in relation to the timing of  22 the filing, I believe several of them,  23 these developments have happened since  24 that was filed.  25 Q. And you mentioned a number of</p>	<p style="text-align: right;">Page 25</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 been expanded and added to and developed  3 from prior cases that I have served as an  4 expert witness but this is my work  5 product, yes.  6 Q. And did anyone help you?  7 A. I had some organizational help  8 in making sure it was presented in a way  9 that was appropriate for the court and  10 formatting changes and proofing by the  11 defense counsel staff.  12 Q. And when you say proofing,  13 what do you mean by that?  14 A. Checking for errors in grammar  15 and spelling and ambiguity, redundancy,  16 to the best -- to make it the best  17 product we possibly can to serve this  18 court.  19 Q. And what kind of ambiguities  20 did defense counsel address with you?  21 MS. LAND: Objection to the  22 extent that would elicit any  23 responses that would reveal  24 attorney-client privilege or work  25 product.</p>

7 (Pages 22 - 25)

<p style="text-align: right;">Page 26</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 Q. Only answer to the extent, you</p> <p>3 know, it's about the type of back and</p> <p>4 forth, not the substance, in particular.</p> <p>5 A. Again, you know, the details</p> <p>6 I'm not able to recall at this time.</p> <p>7 Again, this was filed many many months</p> <p>8 ago and I've done much since that time.</p> <p>9 But, again, it was intended to make sure</p> <p>10 that it was as clear as possible and that</p> <p>11 I did not have any -- for example, I have</p> <p>12 a number of references that I cite from</p> <p>13 the peer-reviewed literature to make sure</p> <p>14 it is cited correctly. Again, there's</p> <p>15 quite a bit of information that's</p> <p>16 presented in this rather extensive</p> <p>17 document.</p> <p>18 Q. Understood. Are you aware of</p> <p>19 any inaccuracies in any of the reports</p> <p>20 that you submitted in this case?</p> <p>21 MS. LAND: Object to form.</p> <p>22 A. As far as -- I stand by --</p> <p>23 again, I've read over recently the</p> <p>24 declarations and I do not see any</p> <p>25 corrections at this time.</p>	<p style="text-align: right;">Page 28</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 A. As my role as a</p> <p>3 physician-scientist and expert in this</p> <p>4 field, feeling the need to be able to be</p> <p>5 aware of the developments that are</p> <p>6 occurring in this field and being as</p> <p>7 objective as possible and weighing the</p> <p>8 merits of the statements that are being</p> <p>9 made.</p> <p>10 Q. And was any of that analysis</p> <p>11 done in writing?</p> <p>12 A. The reason I'm hesitating is</p> <p>13 I'm trying to think of the timing of when</p> <p>14 I've published. Not -- not in a</p> <p>15 manuscript that was peer-reviewed since</p> <p>16 the time I filed the declaration.</p> <p>17 Q. Any that were not</p> <p>18 peer-reviewed?</p> <p>19 A. Some writings are currently</p> <p>20 being prepared.</p> <p>21 Q. And are you -- prepared for</p> <p>22 what?</p> <p>23 A. Prepared for publication. So</p> <p>24 as an ongoing effort to bring the science</p> <p>25 to the forefront and remain current that</p>
<p style="text-align: right;">Page 27</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 Q. And is there anything in your</p> <p>3 reports that you wish to amend at this</p> <p>4 time?</p> <p>5 A. No.</p> <p>6 Q. And just to confirm, none of</p> <p>7 your opinions have changed since</p> <p>8 completing your rebuttal report?</p> <p>9 A. As I stated earlier, I have --</p> <p>10 my opinions have been reinforced by the</p> <p>11 knowledge and studies that have come</p> <p>12 forward since I filed this declaration.</p> <p>13 Q. And have you conducted any --</p> <p>14 excuse me -- have you conducted any</p> <p>15 additional analysis relevant to this</p> <p>16 matter since completing your rebuttal</p> <p>17 report?</p> <p>18 A. If by additional analysis you</p> <p>19 mean critical review of the papers that</p> <p>20 have been published, looking for</p> <p>21 methodologic flaws, limitation,</p> <p>22 weaknesses, erroneous conclusions, the</p> <p>23 answer is yes.</p> <p>24 Q. In what context did you</p> <p>25 conduct that additional analysis?</p>	<p style="text-align: right;">Page 29</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 there is a need to update many of the --</p> <p>3 for example, the reviews that I</p> <p>4 previously published on this matter to</p> <p>5 include the latest data.</p> <p>6 Q. So just to summarize, you are</p> <p>7 currently in the process of preparing</p> <p>8 publications to present to journals; is</p> <p>9 that correct?</p> <p>10 A. I'm currently involved in</p> <p>11 systematically reviewing the literature</p> <p>12 to be able to be up-to-date on the</p> <p>13 literature that's available, adding to</p> <p>14 what I've already published for what</p> <p>15 pertains to this question.</p> <p>16 Q. And do you have -- sorry.</p> <p>17 Excuse me.</p> <p>18 Where do you intend to submit</p> <p>19 those current writings?</p> <p>20 A. It is to be determined. One of</p> <p>21 the challenges that one experiences in</p> <p>22 attempts to publish in this field is to</p> <p>23 be able to have comprehensive, accurate</p> <p>24 and unbiased review and certainly seeking</p> <p>25 to have the best journal to be able to</p>

<p style="text-align: right;">Page 30</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 present this and that has not been  3 determined yet.  4 Q. Okay. So shifting gears just a  5 bit, can you tell me what your current  6 job is?  7 A. I'm an Associate Professor of  8 Pediatric Endocrinology at Washington  9 University with a secondary appointment  10 as Associate Professor of Cellular  11 Biology and Physiology.  12 Q. And how long have you held  13 that position?  14 A. Associate or member of the  15 faculty I've been a member of the faculty  16 at Washington University since 2000,  17 after completing my Endocrinology  18 Fellowship from 1997 to 2000, and I have  19 been Associate Professor since 2011.  20 Q. Just to confirm, you are an  21 endocrinologist; is that correct?  22 A. A pediatric endocrinologist  23 and physician-scientist, correct.  24 Q. And what conditions do you  25 treat patients for?</p>	<p style="text-align: right;">Page 32</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 understand ways to elicit underlying  3 factors that may impact one's care, such  4 as depression, anxiety and other mental  5 health issues. But I am licensed in  6 pediatric endocrinology and Board  7 Certified in pediatric endocrinology and  8 general pediatrics.  9 Q. So just to confirm, you're not  10 a psychiatrist?  11 A. I'm not a licensed -- I'm not  12 a Board Certified psychiatrist, correct.  13 Q. Or a psychologist?  14 A. That is correct.  15 Q. And you don't -- excuse me. Do  16 you have any professional experience  17 providing mental healthcare?  18 MS. LAND: Object to form.  19 A. As I've just stated, the  20 psychological care that I provide is in  21 the context of my practice of pediatric  22 endocrinology and certainly it is a  23 relevant topic for me because many of the  24 treatments that we have could be  25 significantly impacted by comorbidity, in</p>
<p style="text-align: right;">Page 31</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I treat patients for diseases,  3 hormonal diseases from birth, all the way  4 into probably the early 20s. About half  5 of my patient population has diabetes  6 mellitus, but covers the whole gamut of  7 pediatric endocrinology, including  8 thyroid disease, pituitary dysfunction,  9 disorders of sexual development, bone  10 abnormalities, and the entire spectrum of  11 pediatric endocrinology.  12 Q. And you mention you treat  13 patients up to their early 20s. About  14 what age do you generally see patients  15 until?  16 A. Generally speaking, and there  17 have been exceptions, I will follow them  18 through college, if they so desire.  19 Q. And you are not a  20 psychiatrist, correct?  21 A. I am not a licensed  22 psychologist. My involvement in  23 psychological assessment relates to my  24 practice of pediatric endocrinology as  25 any physician would be required to</p>	<p style="text-align: right;">Page 33</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 particular depression and anxiety and  3 other mood disorders that may impair a  4 patient's ability to comply with the  5 treatment recommendations that we make.  6 So that is the extent of my involvement  7 in psychological care.  8 Q. And you don't have a degree  9 related to mental health; is that  10 correct?  11 A. I have a degree in medicine  12 and post-medical school training in  13 general pediatrics and fellowship  14 training in pediatric endocrinology, in  15 addition to my Ph.D. in biochemistry.  16 Q. And do you have any specific  17 training related to mental health  18 treatment?  19 A. All medical students receive  20 training related to mental health issues  21 as part of their normal medical school  22 curriculum, all throughout residency and  23 fellowship training. It is also  24 something that is covered to be able to  25 address these issues in the context of</p>

<p style="text-align: right;">Page 34</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the specialty which one works in.  3 Q. And beyond what is provided to  4 all medical students within the context  5 of their various specialties, do you have  6 any other specific training related to  7 mental health?  8 A. If you're -- if -- are you  9 asking whether I've had certification or  10 formal fellowship training or residency  11 training in psychiatry or psychology?  12 Q. Yes. Any of those.  13 A. No.  14 Q. And you mention that you've  15 been deposed before, right?  16 A. Yes, I have.  17 Q. How many times?  18 A. I listed the cases in my  19 declaration there and not all of the  20 cases was I deposed in, but most of the  21 ones related to this topic of gender  22 dysphoria. I've undergone depositions, I  23 can't count the exact number.  24 Q. So if I could just run  25 through. So you were deposed in the</p>	<p style="text-align: right;">Page 36</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 trying to find in my declaration where  3 that paragraph is located.  4 Q. The Whittaker case?  5 A. The Whittaker case, correct.  6 Q. So we have those four cases.  7 Are there any others?  8 A. I'm trying to remember. I'm  9 sure you'll tell me.  10 Q. Well, if you don't recall,  11 that's fine. I'm just trying to get a  12 sense of which ones you recall.  13 A. Very good.  14 Q. And what about the Tavistock  15 case in the United Kingdom, were you  16 deposed in that case?  17 A. I was not.  18 Q. And how did you come to be  19 involved in that case?  20 A. One of the attorneys from the  21 U.K. contacted me, asking me if they  22 could use some of the published  23 literature that I have contributed to  24 this question to assist them in that  25 litigation.</p>
<p style="text-align: right;">Page 35</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Adams case; is that correct?  3 A. That is correct.  4 Q. And in the Bruce case?  5 A. Sorry. Which case?  6 Q. The Bruce case.  7 A. Is that the South Dakota case?  8 Q. That is the South Dakota case,  9 yes.  10 A. I'm more familiar if you tell  11 me the location than the --  12 Q. Understood.  13 So Bruce case in South Dakota,  14 Adams case in Florida, the Kadel case in  15 North Carolina?  16 A. Are you talking the -- the  17 more recent one here? I'm trying to  18 think of the name. I have, yes.  19 Q. The healthcare one.  20 A. Yes. Correct.  21 Q. Other than those three cases,  22 were you deposed in any other cases that  23 you recall?  24 A. Yes. There was a bathroom case  25 in Kenosha that I served in as well. I'm</p>	<p style="text-align: right;">Page 37</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. Are there other cases in which  3 you were involved as an expert witness  4 but where you were not deposed?  5 A. Yes. For example, the  6 Vancouver case was a similar circumstance  7 where they asked for permission to use  8 the published literature that I had put  9 forward for their case.  10 I'm trying to recall if there  11 were any others. Those are the two that  12 come to mind.  13 Q. What about in the current  14 Alabama case challenging Alabama's recent  15 law restricting care for adolescents with  16 gender dysphoria, are you involved as an  17 expert in that case?  18 MS. LAND: Object to form.  19 A. So I have not submitted, or I  20 have not been deposed in that case. I did  21 file a declaration in that case for the  22 question of summary judgment.  23 Q. Are there any other cases you  24 are currently working on where reports  25 have not yet been submitted?</p>

<p style="text-align: right;">Page 38</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Yes.  3 Q. And what cases are those?  4 A. There is a case in Arizona and  5 one very recently in Washington State.  6 Q. And what is the case in  7 Arizona?  8 A. Snyder is one of the litigants  9 in that case.  10 Q. What does it concern?  11 A. It is a similar to the North  12 Carolina question.  13 Q. Regarding health insurance  14 coverage?  15 A. Right.  16 Q. And what about the Washington  17 State case?  18 A. It is also a question about  19 insurance coverage.  20 Q. Any other matters?  21 A. No.  22 Q. Have you ever reached out to  23 someone and offered to serve as an expert  24 witness in a case?  25 A. No.</p>	<p style="text-align: right;">Page 40</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 of my practice relates to that.  3 Q. Have you ever treated a  4 patient with gender dysphoria with  5 puberty suppression for their gender  6 dysphoria?  7 A. As clearly stated in my  8 declaration, the basis by which I have  9 not participated in gender-affirming care  10 is based upon my conclusion that there is  11 not sufficient evidence to warrant the  12 consideration of risks and benefits  13 providing that care. And to be  14 consistent with my professional judgment,  15 I have not engaged in any -- not just  16 related to gender dysphoria -- any care  17 which I have deemed not to be justified.  18 Q. So you have never treated a  19 patient with gender-affirming care; is  20 that correct?  21 MS. LAND: Object to form.  22 A. As I just stated, I have  23 treated patients with gender dysphoria.  24 I have not engaged in gender-affirming  25 medical care for the purpose of gender</p>
<p style="text-align: right;">Page 39</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. Have you ever treated a  3 patient with gender dysphoria?  4 A. Yes.  5 Q. And in what capacity?  6 A. In my role as a pediatric  7 endocrinologist.  8 Q. And what treatment did you  9 provide to them?  10 A. There's been quite a few,  11 actually. I treated a patient with  12 dyslipidemia, one with diabetes mellitus,  13 actually several with diabetes mellitus,  14 one with thyroid abnormalities and  15 probably many more as well.  16 Q. So for the patients that  17 you've treated who have gender dysphoria,  18 have you ever treated their gender  19 dysphoria or were you treating them for  20 other conditions?  21 MS. LAND: Object to form.  22 A. Well, I'm trying to understand  23 your question. So I'm a pediatric  24 endocrinologist. I treat diseases  25 related to the endocrine system and all</p>	<p style="text-align: right;">Page 41</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 affirmation, based upon my understanding  3 of the relative risks and purported  4 benefits of this treatment approach.  5 Q. When you say you have treated  6 patients with gender dysphoria, what  7 treatment did you provide them?  8 MS. LAND: Object to form.  9 A. I've actually already answered  10 that. I provided care for underlying  11 issues.  12 For example, many of the  13 patients at my institution are  14 hospitalized because of -- of, you know,  15 psychiatric issues and if they have  16 underlying conditions like diabetes, that  17 certainly needs to be cared for and I  18 provided that care for these individuals.  19 Q. And so have you ever provided  20 any treatments to patients aimed at  21 treating their gender dysphoria?  22 MS. LAND: Objection to form.  23 A. As I've already stated, the  24 basis by which I do not participate in  25 gender-affirming care for the purposes of</p>

<p style="text-align: right;">Page 42</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 gender affirmation is based upon my  3 conclusions that there is not sufficient  4 evidence on the safety and efficacy of  5 this treatment.  6 Q. Do you believe that there are  7 other medical interventions, other than  8 gender-affirming care, that one could  9 provide to treat a patient with gender  10 dysphoria aimed at their gender  11 dysphoria?  12 A. I certainly do believe that  13 there are, yes.  14 Q. And what are those?  15 A. Again, many of these  16 individuals have comorbidities, including  17 depression, anxiety, eating disorders,  18 substance abuse. All of these require  19 and can benefit from psychological  20 intervention and certainly would advocate  21 that they receive that care.  22 Q. So it's your position the way  23 -- excuse me.  24 So it's your position that the  25 way to treat the gender dysphoria would</p>	<p style="text-align: right;">Page 44</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. So are you asking me if I've  3 referred somebody for care that I've  4 already deemed as not justified by the  5 available scientific evidence?  6 Q. I asked about whether you  7 referred them for a diagnosis, which I  8 believe you mentioned was done by  9 psychological or psychiatric  10 professionals.  11 So my question was whether, in  12 the course of your treatment of a  13 patient, say, with diabetes you ever  14 referred them for a potential evaluation  15 for a diagnosis of gender dysphoria?  16 MS. LAND: Object to form.  17 A. I don't recall a specific  18 example where I've referred somebody for  19 psychological assessment related to  20 gender dysphoria. However, I have  21 encountered patients in my primary care  22 clinic -- I'm trying to remember if I  23 ever -- where we've had conversations  24 about referring them onto a psychologist.  25 Whether it's directly related to gender</p>
<p style="text-align: right;">Page 43</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 be to treat underlying comorbidities; is  3 that correct?  4 MS. LAND: Object to form.  5 A. That is a mischaracterization  6 of my opinion. I state that these  7 psychological care is helpful and  8 necessary for these individuals. As I  9 state very clearly in my declaration, and  10 it's consistently stated, there is much  11 uncertainty about what the most  12 efficacious approach is and there is  13 certainly a need for proper scientific  14 study to be done to address that  15 question.  16 Q. And have you ever diagnosed  17 anyone as having gender dysphoria?  18 A. I have never been called upon  19 to diagnose a gender dysphoria and  20 generally those of my colleagues that do  21 participate in that care rely heavily  22 upon the psychological and psychiatric  23 assessments to make that diagnosis.  24 Q. Have you ever referred anyone  25 for a diagnosis of gender dysphoria?</p>	<p style="text-align: right;">Page 45</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dysphoria or the underlying issues  3 related to depression and anxiety that  4 were impacting their successful care of  5 their diabetes mellitus or other  6 endocrine conditions, I have done that.  7 Q. And do you, yourself, provide  8 any of the care that you consider  9 appropriate for gender dysphoria to  10 patients with gender dysphoria?  11 MS. LAND: Object to form.  12 A. Can you be more specific about  13 what you're asking as far as care?  14 I have already declared in my  15 declaration the role of an  16 endocrinologist in treating endocrine  17 diseases and that's where I focus my  18 practice.  19 Q. Do you believe that there is a  20 role for an endocrinologist in treating  21 gender dysphoria?  22 A. I believe that there are many  23 scientific questions that remain  24 unanswered about whether or not, and I  25 think that there certainly is a role that</p>

<p style="text-align: right;">Page 46</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 a pediatric endocrinologist or  3 endocrinologists, in general, to care for  4 the medical needs of a patient that has  5 been deliberately medicalized in needing  6 hormone treatments. For example, a  7 patient who has undergone gonadectomy is  8 depended upon a hormone administration  9 for regular health, and that is an area  10 where an endocrinologist would be need to  11 be involved.  12 Q. Have you ever been present for  13 a discussion between a provider and a  14 patient about treatment options for  15 gender dysphoria?  16 A. In the context I -- usually I  17 practice in at the Children's Hospital  18 where I'm practicing individually, yes, I  19 would say that in the context of  20 disorders of sexual development, which  21 I've been involved with throughout my  22 career, there have certainly been  23 questions related to gender issues in --  24 in those affected patients.  25 There is actually a</p>	<p style="text-align: right;">Page 48</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 ambiguity about how one is going to be  3 able to live their lives with -- in a  4 sexual manner most effectively and most  5 fulfilling, and that is a topic of  6 conversations that I've been involved  7 with.  8 Q. And have you been -- have you  9 personally prescribed treatment for  10 individuals with disorders of sexual  11 development aimed at bringing their body  12 into alignment with their gender  13 identity?  14 MS. LAND: Object to form.  15 A. I would broaden the question.  16 To adequately answer your  17 question, it has to be considered in the  18 greater context of how care is delivered  19 to individuals that have VSDs and focus  20 of the care is to; one, understand the  21 basis for which the disorder of sexual  22 development occurred, their functional  23 ability related to that, including  24 fertility and engagement in sexual acts  25 as they mature throughout life.</p>
<p style="text-align: right;">Page 47</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 multidisciplinary clinic at my  3 institution which I regularly participate  4 in discussions on these patients with  5 disorders of sexual development and that  6 does include questions about gender  7 identity and how to best care for these  8 individuals.  9 Q. And so for patients with  10 disorders of sexual -- excuse me -- for  11 patients with disorders of sexual  12 development who are also experiencing, as  13 you characterize, gender issues, have you  14 been present for discussions around  15 gender-affirming treatment options?  16 MS. LAND: Objection to form.  17 A. So to adequately answer your  18 question it would be necessary to provide  19 the context of care that's provided for  20 patients with disorders of sexual  21 development in our multidisciplinary  22 model, which does include attention to  23 issues of gender identity.  24 There are decisions that need  25 to be made when there is genital</p>	<p style="text-align: right;">Page 49</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 And so it is a much broader  3 question than focusing specifically on  4 gender identity. It includes all aspects  5 of their human sexuality and all geared  6 at allowing them, in these rare  7 situations where people are born with  8 this ambiguity, to have the best outcome.  9 Q. In these rare situations, as  10 you describe them, of individuals with  11 disorders of sexual development, is their  12 gender identity part of the consideration  13 that -- excuse me. Let me back up.  14 In patients with disorders of  15 sexual development, is treatment -- does  16 treatment take into account an  17 individual's gender identity?  18 A. As part of comprehensive care  19 it is necessary to consider aspects of  20 biological function, psychological  21 function, which includes gender identity.  22 Q. You're currently affiliated  23 with the Department of Pediatrics at the  24 Washington University School of Medicine  25 in St. Louis; is that right?</p>

<p style="text-align: right;">Page 50</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. That is correct.  3 Q. And St. Louis Children's  4 Hospital is the pediatric teaching  5 hospital for that School of Medicine; is  6 that correct?  7 A. That is correct.  8 Q. And do you work at the St.  9 Louis Children's Hospital?  10 A. I have my clinic in the  11 Children's Hospital and I attend on the  12 wards, in patient wards at St. Louis  13 Children's Hospital, yes.  14 Q. And is there a transgender  15 clinic at the St. Louis Children's  16 Hospital called the Washington University  17 Transgender Center?  18 A. Yes.  19 Q. And what is your connection to  20 the Transgender Center?  21 A. This relates directly to how I  22 became involved in the entire  23 conversation that has led for me to be.  24 Here this morning with you.  25 While I was Chief of the Division of</p>	<p style="text-align: right;">Page 52</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the exact dates. It was -- I don't want  3 to guess, but it was several years after  4 that.  5 Q. So more than five years ago  6 from today, you would say?  7 A. It started more than five  8 years ago, yes.  9 Q. And the Transgender Center  10 treats adolescent patients with gender  11 dysphoria; is that correct?  12 A. Correct.  13 Q. And as part of that treatment  14 they prescribe pubertal suppression to  15 treat gender dysphoria at the clinic?  16 A. That is my understanding  17 there, they do prescribe GnRH agonists.  18 Q. And what about cross-sex  19 hormones to treat gender dysphoria for  20 adolescents at the clinic?  21 A. Do you mean the administration  22 of testosterone to biological females and  23 estrogen to biological males? The answer  24 is yes.  25 Q. So the hospital where you work</p>
<p style="text-align: right;">Page 51</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Endocrinology and Metabolism at  3 Washington University in 2012 I had a  4 colleague of mine that approached me  5 asking to start a gender clinic. That  6 necessitated that I investigate the  7 proposal that was being made, put  8 forward, the basis for establishing that  9 clinic. And in that capacity spend a  10 considerable amount of effort beginning  11 my investigation of the available medical  12 literature and have continued to -- I've  13 continued to assist many of our fellows  14 in their fellowship training.  15 I served for many years as the  16 Fellowship Program Director and I am no  17 the Associate Fellowship Program Director  18 and oversee the research activities that  19 our fellows do, with several of them  20 actually engaging in topics related to  21 gender dysphoria.  22 Q. And you said that these  23 discussions started in 2012. When was the  24 clinic founded?  25 A. I would have to look back at</p>	<p style="text-align: right;">Page 53</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 currently provides the treatments that  3 you oppose in this lawsuit; is that  4 correct?  5 A. They provide the care that is  6 covered by the topic of this legislation,  7 correct.  8 MS. LAND: Object to form on  9 that previous question.  10 Q. And are you aware that a law  11 similar to HB 1570 has been introduced in  12 the State of Missouri?  13 A. I am aware, yes.  14 Q. And if Missouri were to pass a  15 law like Arkansas what would happen to  16 the current patients at -- the  17 transgender patients at your hospital?  18 MS. LAND: Objection to form  19 and vague and calls for  20 speculation.  21 A. It's a hypothetical question.  22 I can certainly share what I would  23 perceive as the best path forward if that  24 were to occur and that would be something  25 that I have been sharing with my</p>

<p style="text-align: right;">Page 54</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 colleagues over the last decade.  3 That there is a certainly a  4 need to engage in the proper scientific  5 investigation into the most effective  6 treatments that minimize risk and  7 maximize benefit. And much of that care  8 to be transitioned, like it has been in  9 European countries such as Sweden,  10 relegated to investigational use under  11 the auspices of IRB approval and  12 supervision to make sure that the best  13 standards of care are delivered under  14 that experimental setting.  15 Q. So if a law like that were to  16 pass in Missouri the best course would be  17 to transfer those patients into clinical  18 research settings; is that correct?  19 MS. LAND: Object to form.  20 A. That is a very -- that is an  21 overstatement of my opinion on that.  22 There are many aspects of the  23 care of these individuals that would need  24 to be considered on an individual basis  25 to continue their psychological care to</p>	<p style="text-align: right;">Page 56</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 excuse me. Let me back up.  3 So going back to Missouri and  4 the Transgender Center, is it your  5 position that all of the patients that  6 are currently under the hospital's care  7 would benefit from having their current  8 treatment cut off?  9 MS. LAND: Object to form.  10 A. I would not characterize that  11 in the way that you phrased it.  12 Q. How would you characterize it?  13 MS. LAND: Object to form.  14 A. Can you please rephrase your  15 question for me?  16 Q. Is it your position -- so if  17 Missouri passed a law like Arkansas and  18 all the patients under the care of the  19 Transgender Center at St. Louis  20 Children's Hospital could no longer  21 receive their treatment, is it your  22 position that they would benefit from  23 having that treatment terminated?  24 MS. LAND: Object to form.  25 A. Again, I don't accept the</p>
<p style="text-align: right;">Page 55</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 address their comorbidities such as  3 depression, anxiety, eating disorders and  4 all of the other comorbidities that are  5 experienced by this patient population.  6 That would certainly continue. It's my  7 understanding that -- that the  8 legislation that is being proposed would  9 allow for that to occur.  10 Q. Are you aware that the  11 legislation in Arkansas would not allow  12 for the continuation of any treatments  13 even for purposes of clinical research?  14 MS. LAND: Object to form.  15 A. You're asking me a legal  16 question and I'm testifying as a  17 physician-scientist and medical expert.  18 So any questions that are related to  19 implications from the legal aspect, I  20 will defer to those that have the  21 competence to be able to say so.  22 Q. Would you support -- would you  23 support the law to the extent it would  24 prohibit the continuation of medical  25 research into this area insofar as --</p>	<p style="text-align: right;">Page 57</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 premise of that question. That -- again,  3 as I stated very clearly in my  4 declaration -- that my concern with the  5 care that is being delivered, it has not  6 been demonstrated that there is  7 sufficient benefit versus risk of the  8 affirmation approach and that would stand  9 whether or not legislation was passed in  10 the State of Missouri. Those concerns  11 would remain.  12 I think the most prudent  13 approach would be able to answer those  14 existing questions about what is the most  15 appropriate care to alleviate suffering  16 in this vulnerable population and I would  17 certainly support efforts to arrive at  18 those very important answers.  19 Q. But what type of efforts would  20 you support to arrive at those answers?  21 A. I think that there are  22 numerous hypotheses that have been put  23 forward both as to the etiology, the  24 natural history and the effects of  25 various treatment approaches, all</p>

15 (Pages 54 - 57)

<p style="text-align: right;">Page 58</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 directed toward alleviating suffering in  3 these patients.  4 I think that all of the  5 hypotheses that have been put forward  6 need to be considered and to the extent  7 that they're followed with the safeguards  8 that are present under institutional  9 review boards and all of the controls  10 that are done in the conduct of human  11 research, that there are many questions  12 that could be asked in a rigorous manner  13 elevating the science to the state where  14 we would be able to have answers to the  15 questions about causal relationships  16 between intervention and outcome and a  17 greater knowledge of the relative risks  18 and the purported or real benefits of  19 that intervention.  20 Q. So help me understand. So you  21 would support, for example, a rigorous  22 assessment under the oversight of a  23 institutional review board of, say, for  24 example, treating natal female with  25 testosterone to alleviate gender</p>	<p style="text-align: right;">Page 60</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 made, so you do believe that the state of  3 the science could benefit from, say,  4 randomized controlled trials in the  5 future under the support and supervision  6 of an institutionalized review board  7 wherein one population received the  8 gender-affirming medical treatments and  9 another population did not; is that your  10 position?  11 MS. LAND: Object to form.  12 A. So if you wish for me to  13 provide the proper context for my opinion  14 on the conduct of research in this field,  15 I think it's very important to recognize  16 the fundamental basics of how research is  17 normally performed, and much of the  18 discussion is lacking in that  19 understanding. That science, as it's  20 normally conducted, usually begins with a  21 hypothesis, and there can often be  22 multiple hypotheses approached. One  23 should not dismiss outright any  24 hypothesis that is being put forward.  25 One weighs the relative merits of a</p>
<p style="text-align: right;">Page 59</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dysphoria?  3 A. I think that to date the way  4 that studies have been conducted have not  5 allowed us to reach a valid conclusions  6 and any effort to be able to answer that  7 question, in comparison to alternative  8 approaches, would be -- as we would in  9 any other area of medicine, be certainly  10 valid and necessary to investigate.  11 Due to the state of where  12 things are at that, for example, thinking  13 about a randomized controlled trial, it  14 may necessitate individuals that are  15 given the hormonal treatments that are  16 for gender affirmation in comparison to  17 alternative approaches being able to do  18 this in a randomized controlled manner  19 where we can look at outcomes and really  20 have those answers that we don't have  21 yet.  22 Q. Just to clarify, not speaking  23 about what has been done, but speaking  24 about what you would support in the  25 future, and that last point that you</p>	<p style="text-align: right;">Page 61</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 hypothesis, which is always based upon a  3 basic scientific premise, and one then  4 designs a trial to be able to answer the  5 question as to whether the hypothesis is  6 valid or invalid.  7 In fact, the way science is  8 normally conducted is in a state of  9 inherent skepticism one needs to look at  10 the evidence available to disapprove the  11 null hypothesis.  12 So if one puts forward a  13 hypothesis that gender-affirming hormonal  14 care, specifically cross-sex hormones,  15 testosterone to a biological female or  16 estrogen to a biological male, is going  17 to have a defined outcome that is  18 measurable and in a way that can be  19 objectively assessed, one needs to find  20 evidence. You begin with the presumption  21 that there is no difference in the  22 treatment versus the control arm and seek  23 to find evidence to disprove that  24 hypothesis.  25 That's the way science is</p>

<p style="text-align: right;">Page 62</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 always conducted. It's not the way that  3 it's being conducted in this field right  4 now and there are many many deficiencies  5 that I have outlined in my declaration  6 and the basis for those objections to the  7 way the science is being conducted. And  8 that, again, very lengthy answer, and I  9 apologize for the lengthy answer, is only  10 the surface of the necessary  11 considerations that need to be made in  12 performing the proper research in this  13 field.  14 Q. If I understand your position  15 is that there are questions that still  16 need answering with respect to treatment  17 of gender dysphoria; is that correct?  18 A. That is absolutely correct.  19 MS. LAND: Object to form.  20 Q. And that in order to answer  21 those questions we need to conduct more  22 research; is that correct?  23 A. I've said that repeatedly  24 throughout the time that I've been  25 involved in this conversation, that the</p>	<p style="text-align: right;">Page 64</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Object to form.  3 A. So, again, we would need to be  4 specific about what you're asking. I'm  5 not entirely sure. That's a rather broad  6 statement. But I think in any area of  7 scientific investigation there are many  8 hypotheses that can be put forward and  9 many treatment approaches that can be  10 proposed, not all of them have the same  11 merit, as in my time in reviewing NIH  12 studies, over my career serving on NIH  13 study sections, one of the tasks that we  14 have is to be able to assess the merits  15 of proposed research, not all research --  16 proposed research studies get funded for  17 a variety of reasons. Many times they're  18 based upon a flawed premise an  19 incorrectly proposed hypothesis or  20 inadequate study methodology to address  21 the question at hand.  22 Q. I think -- I think -- I think  23 I understand. I don't mean to cut you  24 off, but it seems like we're launching  25 into a sort of an area that is not</p>
<p style="text-align: right;">Page 63</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 current literature has major methodologic  3 flaws, weaknesses and limitations and  4 that as a physician-scientist who has  5 worked in the area of conducting research  6 investigations throughout my entire  7 career, we need to elevate the science to  8 the way it is conducted in other fields.  9 Q. And in order to conduct that  10 research there needs to be a way to  11 provide different forms of treatment to  12 the patient population and compare them;  13 is that correct?  14 A. I would -- I would narrow that  15 down a little bit, that there needs to be  16 an unbiased consideration of valid  17 hypotheses that are based on plausible  18 scientific premises and then the design  19 of scientific trials that can address the  20 validity of those hypotheses that are  21 generated.  22 Q. And among those hypotheses,  23 that would include providing treatment  24 and observing outcomes as compared to  25 other outcomes; is that correct?</p>	<p style="text-align: right;">Page 65</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 responsive to the question. So I'm going  3 to move us on, if that's okay with you.  4 Can you describe your  5 educational background for me, beginning  6 with college?  7 A. I received my undergraduate  8 from Marquette University in the field of  9 chemistry as a major. I then, following  10 college, did my M.D. and Ph.D. training  11 at the Medical College of Wisconsin,  12 where I did my Ph.D. research in the area  13 of biochemistry studying inborn air of  14 metabolism, doing structure and function  15 studies about an enzyme involved in  16 ketogenesis that included my general  17 medical education.  18 Following the completion of  19 the medical scientist training program at  20 the Medical College of Wisconsin, after I  21 received my Ph.D. and M.D. degrees. I  22 went to the University of Washington in  23 Seattle where I trained in general  24 pediatrics.  25 At that time I made the</p>

<p style="text-align: right;">Page 66</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 decision to pursue subspecialty training  3 in pediatric endocrinology, and that is  4 when I arrived at Washington University  5 in St. Louis in 1997, where I completed  6 that fellowship training and chose to  7 remain at Washington University following  8 completion of that training to the  9 present date.  10 Q. And do you have any education  11 or training related specifically to  12 gender dysphoria?  13 MS. LAND: Object to form.  14 A. I would say that physicians  15 never complete their education by the  16 time they graduate from the fellowship  17 training. If they stop their education  18 at that point in time they're not going  19 to be very good physicians. There is  20 ongoing maintenance of certification that  21 is required, there is ongoing learning  22 that needs to be required -- that is  23 required.  24 The training that I have in  25 understanding issues related to gender</p>	<p style="text-align: right;">Page 68</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 types of research, bench research,  3 literature research, and a limited number  4 of clinical studies and certainly have  5 gained through those experiences an  6 expertise in being able to critically  7 evaluate the conduct of research studies  8 and the critical evaluation of research  9 papers.  10 Q. And have you submitted any  11 proposals for funding for research  12 related to gender dysphoria?  13 A. I have had several  14 conversations with my colleagues at  15 Washington University about how clinical  16 trials can and should be conducted. To  17 date there has -- these studies have not  18 been adopted or submitted.  19 We did put together proposals  20 related to the area of disorders of  21 sexual development as part of that  22 multidisciplinary team. We were -- at one  23 time our center was part of a large  24 network of other institutions providing  25 similar care.</p>
<p style="text-align: right;">Page 67</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dysphoria occurred after I finished my  3 fellowship training while I was on  4 faculty, again, as I was Chief of the  5 Division of Pediatric Endocrinology at  6 Washington University and that education  7 has included the extensive review of the  8 literature that I've brought to this  9 declaration that I've provided for this  10 case.  11 Q. And have you conducted any  12 research related to gender dysphoria  13 personally?  14 A. Yes.  15 Q. And what is that research?  16 A. It's reflected in the  17 publications that I have of critically  18 analyzing the relevant scientific  19 literature, doing reviews of the papers,  20 and that is a type of research that is  21 highly valued in the academic community,  22 and many people have that as the primary  23 focus of their scholarly activity  24 throughout their careers.  25 In my case I've done many</p>	<p style="text-align: right;">Page 69</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 In my role as Fellowship  3 Associate, Fellowship Program Director  4 I've helped to guide the research that's  5 being conducted by several of our  6 fellows, but to date I have not received  7 NIH funding for that purpose.  8 Q. And when you mentioned you  9 guided research of your -- of any  10 research of fellows related to gender  11 dysphoria?  12 A. Yes. Two of our fellows  13 currently are involved in research  14 projects that are related to the area of  15 gender dysphoria.  16 Q. And those are -- is that  17 research that is being funded by the NIH?  18 A. I believe there's been -- I'm  19 not sure where there's been proposals.  20 They've been funded by institutional  21 funds and I think there's been -- one of  22 our fellows has submitted research grants  23 to get that funded. They're in the early  24 stages of their research careers but I  25 don't believe they're -- I'm certain</p>

<p style="text-align: right;">Page 70</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 there is not a NIH R01 level research  3 grant that's granted in this area.  4 Q. And what is -- first, what is  5 your role in guiding that research with  6 the fellows?  7 A. One of my tasks as a  8 fellowship -- Associate Fellowship  9 Director is to be able to make sure that  10 the research that is being conducted has  11 -- that the fellows are trained on the  12 way that research is conducted, that has  13 sufficient scientific rigor, that they're  14 able to focus their question, develop  15 their hypotheses, develop their research  16 methodology. This is usually done in the  17 context of a primary mentor, which I am  18 not for either of those fellows, and a  19 Scholastic Oversight Committee that  20 provides guidance.  21 So I provide lectures and  22 training and review, for example, as the  23 fellows are getting ready to submit a  24 grant, a research presentation at a  25 national meeting or to submit a</p>	<p style="text-align: right;">Page 72</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And what age -- what ages does  3 that research cover?  4 A. It's covering the adolescent  5 group of patients that are receiving  6 these hormones. It is a randomized trial  7 of various forms of estrogen to compare  8 side-effects that occur in receiving that  9 intervention.  10 Q. And you are supervising the  11 fellow in that clinical trial?  12 A. I am serving my role as  13 Associate Fellowship Director. I am not  14 the primary mentor. There are a number of  15 other individuals on the Scholastic  16 Oversight Committee.  17 I do sit in on the meetings  18 where they propose their research. I was  19 actually involved as they were selecting  20 their mentors and putting together their  21 Scholastic Oversight Committee. I have  22 listened to and provided feedback when  23 they prepared for presentation at  24 national meetings and will be reviewing  25 the manuscript that comes out of this</p>
<p style="text-align: right;">Page 71</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 manuscript to be able to help them to  3 elevate the quality of their research to  4 meet the basic standards that we expect  5 in all of their areas of medicine.  6 Q. And just going back a minute,  7 you discussed -- you were discussing  8 clinical trials to treat gender  9 dysphoria.  10 If I understood correctly, you  11 and your colleagues at Washington  12 University have been exploring potential  13 clinical trials to treat gender  14 dysphoria; is that right?  15 A. I would say that they're  16 actually conducting a very limited  17 clinical trial, one of my fellows is  18 conducting a clinical trial at the  19 current time.  20 Q. And what is that -- what is  21 the subject of that clinical trial?  22 A. It is assessing various forms  23 of estrogen and risks associated with  24 giving estrogen to biological males that  25 have gender dysphoria.</p>	<p style="text-align: right;">Page 73</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 research as they complete their  3 fellowship training, which is a  4 requirement of all fellowship training  5 that they engage and have a work product  6 related to their scholarly activity. That  7 is my role.  8 Q. Understood. Can you open up  9 Exhibit 1 for me again, which is your  10 reports, initial report in this case and  11 scroll to the back because I believe  12 that's where your CV is, at page 99?  13 A. I'm having connectivity  14 issues.  15 Q. We can also hand over a  16 hardcopy if that would be useful.  17 MS. LAND: It disconnected  18 from the internet.  19 MR. STRANGIO: Oh, good. We're  20 still seeing you. At least we  21 haven't failed that.  22 Do you, Amanda, want to look  23 on with the hardcopy that you had?  24 We're just going to look at the CV  25 which is at the back of --</p>

<p style="text-align: right;">Page 74</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: I was talking about  3 Dr. Hruz has disconnected from the  4 laptop that he has.  5 THE WITNESS: I have it now.  6 Q. So this is your CV dated  7 7/7/21, which is attached. Do you see  8 that, starting around page 99?  9 A. I'm scrolling down. I haven't  10 quite gotten there yet. Okay. I am here.  11 Q. Okay. And then -- so do you  12 have an updated CV since the one you  13 submitted here?  14 A. I probably -- I didn't bring  15 it with me.  16 Q. Well, could you provide that  17 to us?  18 A. I certainly can. I don't think  19 it's -- yes, I can do that for you.  20 Q. So I just want to ask you  21 about a few things in your CV related to  22 articles concerning gender dysphoria  23 and/or transgender people.  24 Sort of looking at the various  25 types of publications here, are these, to</p>	<p style="text-align: right;">Page 76</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. Have you published -- so among  3 these articles, have any of the writings  4 that you've done on the treatment of  5 gender dysphoria or transgender people  6 been published in peer-reviewed journals?  7 A. Yes.  8 Q. Which ones are those?  9 A. The Linacre is a peer-reviewed  10 journal. The other papers have been --  11 undergone extensive editorial review.  12 But I will state that this question came  13 up previously in other depositions that  14 I've had related to The Linacre and since  15 the time that I've been previously  16 deposed, I, myself, have served as a peer  17 reviewer for other papers in the Linacre,  18 it's a very -- it's the longest standing  19 ethics journal in the United States, very  20 well respected and it does undergo, I can  21 guarantee from my experience in being a  22 peer reviewer, that a paper submitted to  23 that do undergo peer review.  24 Q. Is that a scientific journal?  25 A. It is an ethics journal.</p>
<p style="text-align: right;">Page 75</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 your knowledge, all of your publications  3 related to the treatment of gender  4 dysphoria or transgender people?  5 A. Let me get to that part here.  6 So there are a couple of articles in the  7 NCBC Quarterly, a Linacre article, there  8 is a book chapter, and there is a paper  9 that was published in the New Atlantis.  10 I think those are the primary  11 publications that I have currently  12 related to gender dysphoria.  13 Q. Any that have been published  14 since this version of your CV, any post  15 July 2021?  16 A. Nothing that is currently  17 available, no.  18 Q. And anything that you're  19 currently working on related to treatment  20 of gender dysphoria or transgender  21 issues?  22 A. No, other than what I  23 mentioned before about the manuscripts  24 that we're working on right now that have  25 not been submitted.</p>	<p style="text-align: right;">Page 77</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And is it a Catholic ethics  3 journal?  4 MS. LAND: Object to form.  5 A. It is an ethics journal for  6 which the publisher has affiliation to  7 the Catholic Medical Association.  8 Q. Okay. I think we're going to  9 have to refresh, open up Exhibit 5.  10 A. Exhibit 5? I don't see an  11 Exhibit 5.  12 Q. Sorry. Exhibit 3. Sorry.  13 Excuse me.  14 (Exhibit Hruz 3, Abstract re:  15 The Use of Cross-Sex Steroids in  16 the Treatment of Gender Dysphoria  17 by Paul W. Hruz was received and  18 marked on this date for  19 identification.)  20 A. I only see two exhibits.  21 Q. We're working on it on our  22 end. This time it's definitively our  23 fault. So Exhibit 3 should be there now.  24 A. Okay. I do see it now and  25 opening this up.</p>

<p style="text-align: right;">Page 78</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. So we'll mark this Exhibit 3.  3 And do you recognize this document?  4 A. I'm looking at the first page  5 and I do recognize this, yes.  6 Q. And scrolling through this  7 document, does this appear to be a copy  8 of your article, The Use of Cross-Sex  9 Steroids in the Treatment of Gender  10 Dysphoria?  11 A. That is correct.  12 Q. And this was published in the  13 National Catholic Bioethics Quarterly in  14 2017, correct?  15 A. Correct.  16 Q. And we'll come back to the  17 articles. I'm just going to try to mark  18 some exhibits right now based on  19 publications in your CV.  20 So now you can go back and if  21 you can look for Exhibit 4?  22 (Exhibit Hruz 4, article from  23 New Atlantis entitled Growing  24 Pains, was received and marked on  25 this date for identification.)</p>	<p style="text-align: right;">Page 80</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 That was my first meeting with  3 my two coauthors. I was introduced to  4 them. We had a number of conversations  5 initially about how we would address,  6 first identifying what the relevant  7 questions were, how we would address a  8 discussion of those questions in relation  9 to what we do and do not know about  10 pubertal blockade, and through a very  11 extensive back-and-forth process we --  12 this is the product of that conversation.  13 Q. Did you first meet your  14 coauthors, Lawrence Mayer and Paul  15 McHugh, in the context of writings this  16 piece, is that what you just stated?  17 A. That is my recollection.  18 Again, it was many years ago, but I don't  19 recall that I had ever been introduced to  20 them prior to that time.  21 Q. And based on our prior  22 conversations, the New Atlantis is not a  23 peer-reviewed scientific journal; is that  24 correct?  25 A. It is rigorously editorially</p>
<p style="text-align: right;">Page 79</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Okay. It just came up.  3 Q. Okay. Great. Do you recognize  4 this document?  5 A. This appears to be the article  6 in the New Atlantis, Growing Pains.  7 Q. And this is an article that  8 you published in the New Atlantis in 2017  9 with Lawrence Mayer and Paul McHugh; is  10 that correct?  11 A. That is correct. That's what  12 it looks like right here, yes.  13 Q. And how did you come to  14 publish this article?  15 A. I was -- let's see. That was  16 way back. I'm trying to remember how we  17 actually came about that. I was asked  18 if I would participate, because of my  19 role as a pediatric endocrinologist, to  20 contribute my expertise in the question  21 of pubertal blockade.  22 I was contacted -- I'm trying  23 to remember the actual person that  24 contacted me asking -- if I was willing  25 to participate in that.</p>	<p style="text-align: right;">Page 81</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 reviewed. I, again, for all of the --  3 these types of publications, other than  4 The Linacre, where I served, myself, as a  5 peer reviewer, I'm not privy to the exact  6 extent of that review process. It was --  7 I know it was very extensively  8 editorially reviewed because we had to  9 address many comments that were made for  10 clarification throughout the drafting of  11 this document.  12 Q. But I'm using the "peer  13 review" as sort of the term of art in the  14 scientific context. So it was not a  15 peer-reviewed scientific journal; is that  16 correct?  17 A. Well, again, how you define  18 peers, those that have the expertise to  19 be able to assess the information that is  20 being presented, I would assume that the  21 editors of this journal did provide an  22 opportunity to be able to check the  23 accuracy of the statements that were made  24 on this paper, checking the references  25 that were made in there as to whether</p>

<p style="text-align: right;">Page 82</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 they were accurate and relevant. So in  3 that respect peer-reviewed. But, again,  4 as I stated, I have not reviewed for the  5 New Atlantis. I don't know the editorial  6 and review process. To the best of my  7 knowledge, it is a different review  8 process than for many of the other papers  9 that I have written.  10 Q. Do you distinguish between --  11 generally between peer-reviewed and  12 non-peer-reviewed publications in your CV  13 or other aspects of your professional --  14 A. Yeah. In general, I  15 distinguish in my CV those that I was  16 invited to be able to be able to submit a  17 publication, to one where it was a fruit  18 of my own research. And I have broken  19 that out into invited reviews versus  20 other papers and that is reflected in my  21 CV.  22 Q. Okay. Thank you. Sorry. One  23 second. To your knowledge, is the --  24 sorry. Excuse me.  25 Is the New Atlantis recognized</p>	<p style="text-align: right;">Page 84</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Experimental Approaches to Alleviating  3 Gender Dysphoria in Children?  4 A. It appears to be so, yes.  5 Q. And it was published in the  6 National Catholic Bioethics Quarterly; is  7 that correct?  8 A. That is correct.  9 Q. We are going to come back to  10 these documents. I just wanted to get  11 them marked as exhibits.  12 How are you doing, Dr. Hruz?  13 Do you want to keep going?  14 A. I would prefer to keep going.  15 Q. Okay. Let's keep going.  16 Have you given any  17 presentations about gender dysphoria,  18 transgender or related people at any  19 scientific or medical conferences?  20 A. Yes.  21 Q. Can you tell me about those?  22 A. I have delivered -- I don't  23 know the exact number. I've delivered  24 grand rounds presentations to a number of  25 major universities; I presented at the</p>
<p style="text-align: right;">Page 83</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 as a peer-reviewed journal in the medical  3 field?  4 MS. LAND: Object to form.  5 A. I'm not sure how one assesses  6 that. I don't know of my colleagues in  7 my department of pediatrics at Washington  8 University, I'm not aware of any of my  9 colleagues that have published in this  10 journal.  11 Q. Okay. Can you go back to  12 Exhibit Share, I think it's marked as  13 Exhibit 5.  14 (Exhibit Hruz 5, article from  15 NCBC entitled Experimental  16 Approaches to Alleviating Gender  17 Dysphoria in Children by Paul W.  18 Hruz, MD was received and marked on  19 this date for identification.)  20 A. Okay. I do see it now.  21 Q. So this -- do you recognize  22 this document?  23 A. From what I can see, yes.  24 Q. And is this an article that  25 you published in 2019 entitled</p>	<p style="text-align: right;">Page 85</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 National Catholic Medical Association  3 meeting; I've given presentations to --  4 I'm just trying to think through all of  5 the different presentations I've given  6 over the years, quite a few.  7 Q. And for the grand rounds  8 presentations, what were the topics?  9 A. Generally, the -- so related  10 to gender dysphoria or in general?  11 Q. Related to gender dysphoria.  12 A. Yeah. All of the  13 presentations I've made have been  14 primarily focused on the scientific  15 evidence related to questions in this  16 field of medical intervention, related to  17 many of the topics that are covered  18 within my declaration.  19 So it's essentially the same  20 type of information that I've included  21 addressing the methodologic weaknesses,  22 flaws, concerns, questions about  23 etiology, epidemiology, intervention  24 approaches, what's known about responses  25 to those interventions and proposing what</p>

<p style="text-align: right;">Page 86</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 needs to be put forward to elevate this  3 field to the same degree of rigor that we  4 have seen in other areas of medicine.  5 VIDEOGRAPHER: This is the  6 videographer. Sometime within the  7 next ten minutes we'll need to take  8 a media break.  9 MR. STRANGIO: Let's go ahead  10 and take a five minute break now. I  11 think this would be a good time.  12 Thank you.  13 VIDEOGRAPHER: This will end  14 media part 1 and we're off the  15 record at 10:20 a.m.  16 (Recess is taken.)  17 VIDEOGRAPHER: We are back on  18 the record at 10:31 a.m. This will  19 begin media part 2. Please proceed.  20 Q. Going back, I just have one or  21 two followup questions about the various  22 papers we were discussing.  23 Have you submitted papers to  24 journals that have not been accepted?  25 A. Unfortunately, yes.</p>	<p style="text-align: right;">Page 88</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. All of the papers that I have  3 written on this topic that have been  4 completed are reflected in my CV.  5 Q. So none have been rejected  6 from a journal?  7 A. They've all been published as  8 reflected in my CV.  9 Q. They may have been published  10 elsewhere but were they previously  11 submitted to a journal in which they were  12 rejected?  13 A. I have not had a paper that's  14 been outright rejected. I've certainly  15 had requests to review and revise the  16 manuscripts that I've submitted as part  17 of the normal review process.  18 Q. And as to those papers, were  19 they ultimately published elsewhere from  20 where you initially submitted them?  21 A. No.  22 Q. Okay. Do you believe there are  23 some people that have a gender identity  24 that differs from their natal sex?  25 MS. LAND: Object to form.</p>
<p style="text-align: right;">Page 87</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And papers on gender  3 dysphoria?  4 A. No.  5 Q. Papers on transgender  6 individuals?  7 A. No.  8 Q. And papers on any of the  9 issues related to the care that is the  10 subject matter of this case?  11 MS. LAND: Object to form.  12 A. All of the manuscripts that I  13 have completed are reflected in my CV,  14 excluding the ones that are currently in  15 preparation.  16 Q. Okay. Do you believe that --  17 sorry. Going back, that wasn't the  18 question.  19 I asked whether you've  20 submitted any papers to journals related  21 to gender dysphoria, transgender people,  22 gender identity that have not been  23 accepted?  24 MS. LAND: Object to form,  25 asked and answered.</p>	<p style="text-align: right;">Page 89</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Well, there is many elements  3 of the way that you phrased that question  4 that I wouldn't accept.  5 If you were asking me -- well,  6 maybe I should have you rephrase the  7 question so I can understand it properly.  8 Q. Do you believe that there are  9 people who have a gender identity -- I'll  10 take that back.  11 How would you describe someone  12 with gender dysphoria?  13 A. Thank you. I would say that I  14 do not deny that there are individuals  15 that experience a gender identity that is  16 discordant with their biological sex.  17 Q. And that there are adolescents  18 who would fit this description?  19 A. There are certainly  20 adolescents that have a gender identity  21 and experiences gender identity that  22 differs from their biological sex.  23 Q. And for the population of  24 individuals that experience this  25 discordance between their gender and</p>

<p style="text-align: right;">Page 90</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 their biological sex, that that  3 discordance can cause severe distress?  4 MS. LAND: Object to form.  5 A. So I would say that there is  6 an association with gender dysphoria and  7 distress. There are many factors that  8 lead to that distress.  9 Q. Is the discordance between  10 one's gender identity and biological sex  11 one of the factors in your opinion that  12 leads to the distress?  13 MS. LAND: Object to form and  14 vague.  15 A. So what we know about people  16 that experience gender dysphoria is that  17 it is a -- well, we don't fully know the  18 etiology. We know that there are many  19 contributing factors. And as I've often  20 said, and I believe I said in my  21 declaration, the actual nature and degree  22 of those contributing factors are going  23 to likely differ between individuals that  24 have that experience.  25 Q. But I asked you the question;</p>	<p style="text-align: right;">Page 92</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dozen over a period of several decades,  3 all show consistent findings that the  4 vast majority of those individuals will,  5 if no intervention is engaged upon, have  6 a spontaneous realignment of their gender  7 identity with their biological sex. That  8 is what the literature shows.  9 Q. But some will not?  10 MS. LAND: Object to form.  11 A. So the numbers range anywhere  12 from just above 50% up to 98%. Most  13 estimates are about 85 to 87%. Since  14 that number is not 100, that means there  15 is a percentage that will have  16 persistence.  17 There is no biological test,  18 there is no reliable indicator to  19 determine which of those individuals will  20 have that experience of persistence or  21 desistance or whether there are factors  22 that influence that outcome.  23 Q. And is there any evidence  24 showing that this desistance to  25 biological sex is likely for individuals</p>
<p style="text-align: right;">Page 91</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 is the discordance between gender  3 identity and biological sex one factor  4 leading to distress?  5 MS. LAND: Object to form,  6 asked and answered.  7 A. Again, when you're looking at  8 a complex trait that has multifactorial  9 etiologies, there are many contributing  10 factors.  11 There is -- I would say  12 definitively there is an association  13 between having a sex-discordant gender  14 identity and those that experience  15 distress and that is by definition in the  16 DSM-V, what we mean by gender dysphoria.  17 Q. And so is it your view that a  18 significant percentage of prepubertal  19 children who have a discordance between  20 gender and biological sex come to  21 identify with their birth sex by  22 adolescents?  23 A. I can refer and as I have  24 actually in my declaration, that the  25 studies that we have in hand, about a</p>	<p style="text-align: right;">Page 93</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 who continue to experience gender  3 dysphoria after the onset of puberty?  4 MS. LAND: Object to form.  5 A. There are many claims that are  6 made on either little or no scientific  7 data, that that is the case. And when  8 I've investigated the bases for those  9 assertions I've come up empty with  10 research studies that actually validate  11 that assertion.  12 It is known that in the  13 current context of affirming gender  14 identity, that the vast majority of these  15 individuals will have that experience of  16 persistence. As I believe in either in  17 my declaration or one of my rebuttals  18 went at length to trace back the claims  19 that were made by the plaintiff experts  20 making that claim and, in fact, found  21 that the references -- made reference to  22 other references that made reference to  23 papers that, themselves --  24 Q. Doctor, I understand your  25 dispute of the underlying data but I'm</p>

<p style="text-align: right;">Page 94</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 asking you -- I would like you to stay  3 focused on the questions that I'm asking.  4 So you -- so you said that  5 there is -- that there is evidence of  6 persistence once an individual reaches  7 adolescents. Is that a fair summary of  8 what you said?  9 MS. LAND: Objection to form.  10 A. If one takes as evidence of  11 persistence those that receive  12 gender-affirming interventions, including  13 puberty blockers, that proceed on to get  14 cross-sex hormones, the current evidence  15 suggests in the published papers that the  16 vast majority of those that are affirmed  17 in their gender identity will go on to  18 those interventions.  19 The question of whether that  20 is sustained throughout one's lifetime,  21 the percentage of individuals that  22 generally have a later desistance is  23 quite unknown.  24 I'm happy to discuss many of  25 the limitations and challenges in the</p>	<p style="text-align: right;">Page 96</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 based upon scientific evidence. These are  3 assertions that are being made repeatedly  4 in the absence of that information that  5 there are individuals -- so as a  6 developmental process I think there is  7 clear evidence that that stage of puberty  8 is important as far as the response that  9 an individual has with the bodily changes  10 of sexual maturation from the prepubertal  11 reproductive incompetent state to that of  12 being productively mature and competent,  13 and in that experience there are many  14 changes that occur. It occurs in the  15 setting not only of the biological  16 changes that occur but also in the  17 psychosocial dimension with what we refer  18 to as adolescence. And there are  19 multiple factors that affect one's  20 experience at that time of life.  21 And, again, in my  22 investigation of the claims that are made  23 that those that have persistence into  24 puberty will not desist is not supported  25 by the available evidence. There is an</p>
<p style="text-align: right;">Page 95</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 existing literature to arrive at an  3 adequate understanding of what that  4 frequency is.  5 Q. And is there any evidence of  6 spontaneous desistance by individuals who  7 continue to experience gender dysphoria  8 after the onset of puberty?  9 MS. LAND: Objection to form  10 and vague.  11 A. So if you are asking the  12 question of how many people undergo  13 gender-affirmation interventions --  14 Q. That's not what I'm asking.  15 Just as a general matter, is  16 there any evidence of spontaneous  17 desistance by individuals who continue to  18 experience gender dysphoria after the  19 onset of puberty; just is there any  20 evidence?  21 MS. LAND: Objection to form.  22 A. So in my investigation of the  23 claims of persistence or desistance  24 differing in those that -- as a dividing  25 line prepubertally and pubertally is not</p>	<p style="text-align: right;">Page 97</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 absence of credible data to support that  3 assertion.  4 Q. But going back to the  5 question; is there any evidence that  6 spontaneous desistance by untreated  7 individuals who continue to experience  8 gender dysphoria after the onset of  9 puberty?  10 MS. LAND: Object to form.  11 A. You're asking in a way that I  12 would acknowledge the literature in this  13 area has major limitations and cannot be  14 definitively answered. But there are  15 certainly reports of individuals, in  16 fact, there are reports of individuals --  17 well, you said spontaneous and it's  18 really hard to make that assertion. So  19 one -- when one enters into an  20 intervention, they're no longer  21 spontaneous. So the question is really  22 a; how to refute a negative. So that  23 those that have desistance aren't going  24 to seek intervention and they're not  25 going to report to the medical</p>

25 (Pages 94 - 97)

<p style="text-align: right;">Page 98</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 establishment, so there is no way to  3 assess that number if they don't come to  4 attention.  5 Q. Can I ask you to go back to  6 Exhibit 4, please, what's previously  7 marked as Exhibit 4, Growing Pains.  8 A. Again, I'm locked out here. I  9 don't know why it's locking me out.  10 Which exhibit is it --  11 Q. Exhibit 4, this is your  12 Growing Pains article, and if you could  13 turn to the second page, second  14 paragraph.  15 A. "Of particular concern"?  16 Q. The paragraph beginning "Of  17 particular concern", about midway down.  18 So there you wrote, "Most  19 children with gender identity problems  20 come to accept the gender associated with  21 their sex and stop identifying as the  22 opposite sex. There is some evidence,  23 however, that gender dysphoria and  24 cross-gender identification become more  25 persistent if they last into</p>	<p style="text-align: right;">Page 100</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And do you still believe what  3 you wrote there? Sorry. Excuse me.  4 Is that still your view, that  5 there is some evidence that gender  6 dysphoria and cross-identification become  7 more persistent if they last into  8 adolescence?  9 A. So with the caveats of the  10 limitations and methodologic weaknesses  11 of the papers that have been published in  12 that area, again, as I write these papers  13 I think as a physician-scientist it's  14 important to be very objective, to be  15 able to acknowledge the published  16 literature. But in this type of format  17 it is merely pointing that there are  18 published papers making that claim, in  19 the context of that statement did not  20 allow a full elucidation of the  21 deficiencies or problems related to that.  22 Q. But as a general matter, there  23 is some evidence that  24 cross-identification and gender dysphoria  25 become more persistent if they the last</p>
<p style="text-align: right;">Page 99</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 adolescence." Did I read that correctly?  3 A. You read that correctly. I'll  4 go back to reference 7, which is the  5 basis for that statement. And I'm trying  6 to -- I'll need to go to that reference  7 to be able to refresh my memory, as I  8 wrote that -- while I'm doing that I'm  9 happy to --  10 Q. So one question was what  11 evidence are you referring to there?  12 A. That's why I'm going to the  13 references, so you anticipated that  14 precisely.  15 Okay. So reference 7 talks  16 about a paper from Child -- in Clinical  17 Child Psychology and Psychiatry,  18 published in 2000 and the Steensma paper  19 that was also published in Clinical Child  20 Psychology and Psychiatry in 2011.  21 Q. Were you thinking of any other  22 evidence at that time?  23 A. I don't recall at that time.  24 But certainly those are papers that I  25 used as evidence for that statement.</p>	<p style="text-align: right;">Page 101</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 into adolescence?  3 MS. LAND: Object to form.  4 A. So without, you know,  5 specifically analyzing the quality of  6 that evidence and the strength of that  7 evidence to say there is evidence,  8 whether it's of poor quality or  9 questionable quality, that is correct.  10 Q. Okay. And can you go back to  11 Exhibit 1, which is your report? I'm  12 going to ask you to turn to page 47,  13 paragraph 34E?  14 A. Is there a way for me to jump  15 to the specific pages or do I have to  16 scroll down?  17 Q. I believe you have to scroll  18 down. I do not have the  19 technological knowledge to advise  20 otherwise.  21 A. Okay. You said page 47?  22 Q. Sorry. It's actually page 46.  23 A. Okay. I'm on page 46 now. You  24 are talking 34E?  25 Q. Okay. Sorry.</p>

<p style="text-align: right;">Page 102</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. So you mentioned -- you  3 directed me to 34E and, in fact, the  4 statement that I just made and the  5 response to that prior question about  6 examining the evidence that is presented  7 by the plaintiff experts is very well  8 contained within that paragraph, where I  9 trace back what they reference and then  10 the references that are present within  11 that book chapter and then the article,  12 itself, that was referenced in the  13 referenced chapter. So that will point  14 you directly to the -- my previous  15 comments.  16 Q. Okay. Thank you. I'm actually  17 going to move on. Sorry I had you open  18 the wrong exhibit.  19 If you go back and open  20 Exhibit 5, which is Experimental Approach  21 to Alleviating Gender Dysphoria in  22 Children.  23 A. Okay.  24 Q. And I'm in the abstract here.  25 I'm on page 1. So this was published in</p>	<p style="text-align: right;">Page 104</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 current literature is of low quality and  3 inadequate to address the safety and  4 efficacy of the affirmation model and  5 because of that there is a need for  6 ongoing higher quality scientific  7 studies.  8 Q. And how would -- excuse me.  9 Let me take that back.  10 How would a study be conducted  11 in light of -- in Arkansas, for example,  12 in light of the current ban on treatment  13 there?  14 MS. LAND: Object to form and  15 vague.  16 A. How long do you want me to go  17 on in that? To my knowledge, I'm not  18 aware of any research that is being done  19 in this state, although, there may be  20 that I'm not aware of.  21 So you are asking me how, when  22 I question the low quality of evidence  23 and make that conclusion, similar to what  24 is made in other areas, including several  25 European countries, that the bar that is</p>
<p style="text-align: right;">Page 103</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the National Catholic Bioethics Center;  3 is that correct?  4 A. The NCBC Quarterly, correct.  5 Q. And is that a medical journal?  6 A. It is an ethics journal.  7 Q. So it's not a medical journal.  8 A. It's an ethics journal.  9 MS. LAND: Object to form.  10 Q. And in the abstract here you  11 write, "There is an urgent need for  12 high-quality research to establish the  13 overall risks and benefits of the current  14 treatment paradigm." That's about midway  15 through the abstract. Is that -- did I  16 read that correctly?  17 A. You did.  18 Q. And do you agree with that?  19 A. As reflected in my  20 declaration, yes.  21 Q. So you believe that more  22 research is generally needed in this  23 field?  24 MS. LAND: Object to form.  25 A. I definitely believe that the</p>	<p style="text-align: right;">Page 105</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 normally established for the engagement  3 of new medical practice that needs to be  4 achieved, are you asking me what type of  5 studies would need to be done to elevate  6 this from the category of lower, very low  7 quality evidence to something that  8 approaches a higher standard? Is that  9 what you're asking?  10 Q. No. That's not what I'm  11 asking.  12 Let's say all states in the  13 United States had laws like Arkansas'  14 laws, so this care could never be  15 provided, would it be possible to conduct  16 any research into the efficacy of the  17 treatment?  18 MS. LAND: Object to form.  19 A. As I stated earlier in this  20 deposition, I am testifying as a  21 physician-scientist and medical expert on  22 the scientific literature in this field.  23 Questions related to legal  24 issues, as far as legislation, which my  25 understanding is that many of the</p>

<p style="text-align: right;">Page 106</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 languages in the various proposals that  3 are being put forward throughout the  4 country vary, I would not be able to  5 answer that. I would defer to the legal  6 counsel to be able to make that.  7 However, there are many things  8 in medicine where when new therapies are  9 being proposed and we engage in the  10 proper method of scientific research that  11 can be done under the auspices of an  12 institutional review board with all of  13 the safeguards in place to protect the  14 study subjects.  15 Q. So you've mentioned Sweden a  16 few times. So in Sweden are you aware  17 that patients with gender dysphoria are  18 able to receive treatment with hormone  19 therapy in a clinical trial setting, for  20 example?  21 MS. LAND: Object to form.  22 A. So my understanding of the  23 policy statements made in Sweden, which  24 were first adopted by the Karolinska  25 Institute and later adopted by the entire</p>	<p style="text-align: right;">Page 108</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that the current paradigm is based on low  3 quality scientific evidence, in many  4 cases no scientific evidence, and have  5 chosen to put a pause on the practice of  6 that outside of the experimental setting.  7 So, again, it is a move in the  8 right direction to acknowledge what I've  9 been saying for many years, that have  10 been noted by other leaders in the field,  11 that we need to get answers.  12 The question of what is the  13 most efficacious approach, either  14 alternatives that increase the efficacy  15 and reduce the risk, is something that  16 absolutely needs to be considered.  17 Q. Would you support a law that  18 prohibited clinical research trials into  19 the efficacy of hormone therapy to treat  20 gender dysphoria in adolescents?  21 MS. LAND: Object to form.  22 A. Your question actually  23 addresses really the rationale as to  24 why -- my understanding as to why this  25 legislation was put forward. It is a</p>
<p style="text-align: right;">Page 107</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 country, prioritizes psychology  3 assessment and necessitates that if this  4 care is going to be provided to minors  5 that it needs to be done in the setting  6 of an experimental trial.  7 Q. And do you support that  8 approach?  9 A. As adequately and extensively  10 discussed in my declaration, I said  11 repeatedly that there is a need for  12 higher quality evidence. The only way  13 that you're going to gain higher quality  14 evidence is to conduct clinical research  15 to address those relevant questions.  16 How those studies are done is  17 a topic of much discussion but that it  18 needs to be done is absolutely clear.  19 Q. So is your answer yes, that  20 you support the approach that is being  21 taken in Sweden, that the care is being  22 provided in clinical research trials?  23 MS. LAND: Object to form,  24 asked and answered.  25 A. I agree with their recognition</p>	<p style="text-align: right;">Page 109</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 reflection of a failure of the medical  3 institution to do the normal controls and  4 process of evaluating new treatments.  5 Ideally, and as it is in other areas of  6 medicine, there would not be a need for  7 legislation because the type of research  8 would be done, as it is done in other  9 areas where the safeguards are in place,  10 where things are rigorously tested, where  11 people proceed with the utmost of caution  12 in the absence of information.  13 So the ideal scenario would be  14 for this field of medical intervention to  15 return to the basic principles that are  16 present in all of medicine, which we  17 claim to be valued for evidence-based,  18 recognizing how those studies are done.  19 Q. So my question was, would you  20 favor a law that banned clinical trials  21 into the efficacy of hormone therapy to  22 treat gender dysphoria in adolescents?  23 MS. LAND: Object to form,  24 asked and answered.  25 A. Are you asking me whether in</p>

<p style="text-align: right;">Page 110</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 light of the fact that we have inadequate  3 scientific evidence, that I would  4 advocate for not gaining scientific  5 evidence? The answer to --  6 Q. That wasn't my question.  7 A. I think it would be an  8 egregious failure to not put forward  9 alternative hypotheses and design  10 clinical trials.  11 The whole practice of medicine  12 is designed to alleviate suffering in our  13 patients, to correct disease processes  14 that are present when we encounter them.  15 And to say that we're not going to  16 investigate ways to do our job I think  17 would be a failure of us as physician-  18 scientists and clinicians.  19 Q. So you would not favor a law  20 that banned clinical research trials into  21 the efficacy of treatment in this area?  22 MS. LAND: Object to form,  23 asked and answered.  24 A. I'm struggling to understand  25 why you're still asking that question</p>	<p style="text-align: right;">Page 112</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 fields, and that is the way that it  3 should be done. So, you know, to opine  4 that we shouldn't do research studies,  5 when we need the research studies, is --  6 is -- it's an interesting question that  7 you've asked. I thought I answered it  8 directly.  9 Q. What is the problem saying  10 whether you support or oppose a law that  11 bans research studies?  12 MS. LAND: Object to form of  13 that question.  14 A. As I said previously, I'm a  15 physician-scientist and a pediatric  16 endocrinologist, I'm not a lawyer, I'm  17 not a politician and I'm opining in this  18 case related to questions of scientific  19 evidence and defer to those that are  20 politicians and lawyers to be able to  21 really interpret the basis.  22 I would say that it's a  23 failure of the medical establishment to  24 do its job as the basis for which these  25 type of legislative efforts are put</p>
<p style="text-align: right;">Page 111</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 when I've already answered the fact that  3 there is an urgent need to gain greater  4 information. It's -- maybe I'm not  5 understanding your question in the way  6 that I've answered previously, that  7 there is inadequate information and there  8 is a need for more information.  9 So if you are asking me that  10 in light of the fact we need more  11 information, and I would support not  12 getting that information, that is what  13 the question sounds like. Maybe I'm not  14 understanding the question correctly.  15 Q. I don't believe you answered  16 my question directly which is simply;  17 would you be opposed to a law that  18 prohibited the ability to get this  19 information that you desire through  20 clinical trials?  21 MS. LAND: Object to form,  22 asked and answered.  23 A. I will say again the way this  24 should be proposed is in the conduct of  25 medical research, as we do in other</p>	<p style="text-align: right;">Page 113</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 forward and that it would be best for our  3 profession if we engaged upon research in  4 the way that it should be done and then  5 there would be no need to have any  6 legislation related to that.  7 Q. Okay. So you support the  8 ability of the medical profession to do  9 more research in this area?  10 MS. LAND: Object to form.  11 A. I have stated very clearly in  12 my declaration that we need to do more  13 research of high quality in the way that  14 science needs to be conducted.  15 Q. And I'm asking you here today;  16 it is your view that more research is  17 needed into the treatment for gender  18 dysphoria in adolescence?  19 MS. LAND: Object to form,  20 asked and answered.  21 A. There is a need for  22 understanding better the etiology, the  23 natural history, the effects of various  24 treatment approaches, both short-term and  25 long-term of overall health and the</p>

<p style="text-align: right;">Page 114</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 relative risks of the interventions that  3 are being put forward.  4 Q. Okay. I'm going to ask you --  5 one second.  6 One thing in your report you  7 mention a few times that treatment of  8 gender dysphoria is different from other  9 conditions because you cannot objectively  10 verify the diagnose or symptoms; is that  11 an accurate description of your position?  12 A. As stated very clearly in my  13 declaration, it differs from other  14 conditions in that it relies entirely  15 upon the patient's expressed experience.  16 There is no validated biological tool or  17 test that can be done to assess the  18 veracity of that claim, to objectively  19 know what is being said.  20 So I think in that area it  21 is -- and the uniqueness, actually,  22 doesn't exist with the fact of a patient  23 report, but the fact that it has been  24 effectively politicized and put forward  25 that this is a reliable form of</p>	<p style="text-align: right;">Page 116</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 what is contained within my declaration  3 about my concerns about the assumptions  4 that are made from the DSM, and how those  5 statements are made, there are many that  6 assume erroneously that this is put  7 together as a scientifically validated  8 process.  9 As I stated very clearly in my  10 declaration, that is not the way that  11 document is proposed. It's actually --  12 the DSM is more of a dictionary of  13 various conditions and it's often -- and  14 we see that very clearly in relation to  15 gender dysphoria how the evolution of  16 even the terminology that we use to  17 express this condition is -- there was --  18 to my knowledge, there was absolutely  19 zero scientific evidence that was put  20 forward to support the transition from  21 "gender identity" to "disorder" to  22 "gender dysphoria", and to the new  23 designation that they're proposing of  24 "gender incongruence".  25 These was voted upon by the</p>
<p style="text-align: right;">Page 115</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 evaluation, which is contrary to what we  3 can know.  4 Q. Do any of your patients, any  5 of your current patients, have mental  6 health diagnoses?  7 A. Yes. Unfortunately, quite a  8 few of them do.  9 Q. And are any of your patients  10 also seeing psychologists or  11 psychiatrists?  12 A. Yes, they are.  13 Q. And do you consider psychiatry  14 to be a legitimate field in medicine?  15 MS. LAND: Object to form.  16 A. I think psychology and  17 psychiatry provide very valuable, when  18 done properly, provide very valuable  19 assistance to our patients. I don't deny  20 that at all. I actually have referred my  21 patients many times to psychologists.  22 Q. And do you consider the DSM to  23 be a non-scientific publication?  24 MS. LAND: Object to form.  25 A. So if your question relates to</p>	<p style="text-align: right;">Page 117</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 members that put together these manuals.  3 And that is -- it's not that there is not  4 utility in having that, the DSM, but it  5 is certainly not of the rigor that other  6 areas -- it can't be considered science.  7 Q. And that's a critique as to  8 the DSM as a whole?  9 A. Well, I think the purpose of  10 the DSM, in general, relates to that  11 cataloguing of conditions. It doesn't say  12 that there are not references that can be  13 used to demonstrate the existence of the  14 experiences that people have. But in the  15 end, there are -- it's a voting process  16 that is actually used to be able to  17 determine what is put in that manual and  18 how those decisions are made. And we can  19 see that very clearly in the revisions  20 that have been made over time, especially  21 and most uniquely in those changes that  22 have been made without new scientific  23 data, mostly reflecting cultural changes  24 and ideological agendas.  25 Q. And does your critique apply</p>

<p style="text-align: right;">Page 118</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 generally to the DSM as a whole? That's  3 my question.  4 MS. LAND: Object to form,  5 asked and answered.  6 A. I would say that the manual,  7 again, for its purpose, in general, has  8 that for its purpose and we need to  9 understand that for the DSM. There are  10 many different --  11 Q. Not just related to gender  12 dysphoria, you're speaking about the DSM  13 as a whole?  14 A. I would say that there are  15 levels of evidence that is available for  16 the different components of the DSM.  17 But, in general, the decisionmaking  18 process of how to categorize and portray  19 this as evidence in the revisions that  20 have been made, I would say that that  21 applies generally to the DSM.  22 Q. And is it your opinion that  23 reliance on patients' self-report for  24 diagnosis is unique to gender dysphoria?  25 MS. LAND: Object to form.</p>	<p style="text-align: right;">Page 120</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. But separate and apart from  3 the response, is it your opinion that  4 reliance on patient's self-report for  5 diagnosis is unique to gender dysphoria?  6 MS. LAND: Objection to form,  7 vague.  8 A. Again, there are so many --  9 because of -- why don't you restate your  10 question just so I focus that.  11 Q. How about I be more specific.  12 Is anxiety based on self-report?  13 A. There are objective measures  14 of anxiety that can be monitored, as far  15 as physiologic responses, including heart  16 rate and blood pressure and physical  17 findings that can be used to corroborate  18 that experience of anxiety.  19 Q. So anxiety is not based on  20 self-report at all?  21 MS. LAND: Object to form,  22 asked and answered.  23 A. I did not say that. I said  24 there are objective physiologic  25 correlates that help in correlating with</p>
<p style="text-align: right;">Page 119</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I would say that our response  3 to the patient's self-report is unique to  4 the condition. And I've used in the past,  5 and others do as well, of analogous  6 conditions where we don't accept the  7 patient's perception as being verified  8 fact.  9 The perfect example of that is  10 in the example of anorexia nervosa, a  11 patient that is objectively  12 undernourished, that comes in with the  13 perception that they are overweight, the  14 clinician does not accept that  15 self-report as being true and will not  16 propose interventions that allow that  17 patient to lose weight.  18 That's one example that is  19 often used. I think it's -- any time you  20 use examples you have to recognize the  21 limitations. But that is a unique aspect  22 that we don't critically question the  23 assertion that is being made in relation  24 to the objective verifiable facts that  25 are present to the evaluator.</p>	<p style="text-align: right;">Page 121</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that reported experience.  3 Q. What about, are there -- what  4 about migraines?  5 A. Again, there are physiologic  6 responses that can be very much verified.  7 There are -- and this is used very  8 frequently in research studies as well,  9 which include pain responses, blood  10 pressure, heart rate, blood flow changes.  11 There are physiologic correlates to that  12 experience, yes.  13 Q. Can I have you turn to  14 paragraph -- going back to Exhibit 1  15 here, this is your report, I think I will  16 get you to the right place this time,  17 paragraph 46.  18 A. Paragraph 46?  19 Q. We're moving to page 58,  20 midway through. And here the sentence  21 begins, "This is a source of potentially  22 profound unreliability." Do you see that?  23 A. Is it midway down the page.  24 Q. Midway down 58?  25 A. Am I allowed to read the</p>

<p style="text-align: right;">Page 122</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 preceding sentence so I can get the  3 context?  4 Q. Absolutely.  5 A. Okay.  6 Q. So just to read to you the  7 sentence that I'm focused on here. You  8 write that, "There's profound  9 unreliability in patient care as the  10 relevant science documents that  11 physicians are poor 'lie detectors' often  12 no more reliable in discerning false  13 reports than flipping a coin and  14 sometimes much worse." Did I read that  15 correctly?  16 A. You read that correctly.  17 Q. And what is your basis for  18 believing that there is a problem of  19 false reports when it comes to gender  20 dysphoria?  21 MS. LAND: Objection to form.  22 A. So if you back up and read the  23 entire context of that paragraph, I begin  24 by talking about that this is -- again,  25 this is unique in that there is no</p>	<p style="text-align: right;">Page 124</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 falsehood in the statements is not borne  3 by the reality of what's present.  4 Q. And do you have any reason to  5 believe that patients are lying about  6 their gender dysphoria?  7 MS. LAND: Objection to form.  8 A. So perhaps, you know, the  9 question is, you know, whether what they  10 are claiming is true? Is that what you're  11 saying or that they're intentionally try  12 to deceive their physician?  13 Q. Let's take them each in turn.  14 Is there any reason to believe that  15 patients are intentionally trying to  16 deceive their physician?  17 MS. LAND: Object to form.  18 A. I'm aware of examples where  19 it's been circulated on social media  20 platforms the exact language that an  21 individual should speak to their provider  22 to be able to have access to  23 gender-affirming care, which is often  24 recited verbatim, and would lead one to  25 at least ask a hypothesis as to whether</p>
<p style="text-align: right;">Page 123</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 objective biological correlates to  3 confirm or refute the assertion that is  4 made by that patient. And then I go onto  5 and, actually, I include in my  6 declaration to support this assertion as  7 far as the reliability as far as being  8 able to detect veracity or falsehood in  9 statements that are being made and the  10 unique aspect of this actually to focus  11 upon is many of the people that are  12 providing this care have the inherent  13 belief that they are very good at being  14 able to determine the veracity of the  15 statements made by their patients. And  16 actually the evidence that is present in  17 the published literature refute that and  18 I didn't -- I provided some example of  19 that in the literature to illustrate that  20 point.  21 There is actually much more  22 extensive literature that actually proves  23 that, that one's confidence in being able  24 to be correct in one's ability to find  25 out whether there is veracity or</p>	<p style="text-align: right;">Page 125</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that was being done to obtain a  3 particular end or whether it was actually  4 a reflection of the actual experience  5 that individual had.  6 So is that a -- you know, I  7 mean, these are social media reports with  8 the limitations. But there are examples  9 that have been demonstrated by others  10 that would lead to at least a hypothesis  11 that not all patients are providing  12 objective data to for practitioner.  13 They come to their provider  14 with an intended goal of having access to  15 this form of intervention, and they will  16 like to do whatever they can to have that  17 result and attempt to facilitate that by  18 making these types of statements.  19 Q. So it's your view there is a  20 problem with adolescents intentionally  21 misleading their providers in order to  22 obtain treatment for gender dysphoria; is  23 that right?  24 MS. LAND: Objection to form.  25 A. I would not state in a</p>

<p style="text-align: right;">Page 126</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 categorical manner that it applies to all  3 patients that present to their providers.  4 But I will assert, as I did in my  5 declaration, that the provider that is  6 encountering the patients in their office  7 has no basis objectively to know whether  8 that patient is sincere and -- or not,  9 whether that is an accurate  10 representation of their internal feelings  11 or not.  12 Q. And do you have any reason to  13 believe that the Plaintiffs in this case  14 are intentionally misleading their  15 providers about their gender dysphoria?  16 MS. LAND: Objection to form.  17 A. I have no basis. I am not --  18 again, I am serving as an expert in this  19 case to present my expertise as a  20 physician-scientist in the literature.  21 I've not been directly  22 involved in the care of these patients, I  23 have not seen their medical records and  24 I'm not in a position to be able to make  25 that determination.</p>	<p style="text-align: right;">Page 128</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 health professionals to subjectively make  3 life-changing decisions in gender  4 dysphoria cases, such mental health  5 professionals often unreliably  6 overestimate their ability to offer such  7 'crystal ball' assessments and  8 predictions. Few of these professionals  9 seem aware of the research showing the  10 grave limitations on the experience,  11 judgment and methodologies of mental  12 health professionals." Did I read that  13 right?  14 A. You did indeed read that  15 correctly.  16 Q. What is a poorly qualified  17 social worker or other mental health  18 professional?  19 A. So somebody that -- well,  20 let's put it this way, the amount of  21 training that is provided for many of the  22 social workers that engage in essentially  23 checking the boxes for the DSM diagnosis  24 of gender dysphoria, their experience is  25 limited to reading the DSM and applying</p>
<p style="text-align: right;">Page 127</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. Given your concerns about the  3 lack of objective -- a lack of objective  4 criteria to verify gender dysphoria and  5 your concerns about potentially  6 misleading providers, are there any  7 circumstances in which you believe that  8 treatment for gender dysphoria in  9 adolescents could be effectively studied?  10 MS. LAND: Objection to form.  11 A. That is a very broad question  12 and I don't know if you have an hour for  13 me to go through to adequately answer  14 that question or if you want to focus the  15 question.  16 Q. Yeah. I don't have an hour for  17 you to go through, so I'll just move on.  18 Okay. If I could have you turn  19 to paragraph 50 on page 61, and this is  20 the bottom of page 61.  21 A. I have that at hand.  22 Q. So I'm going to read here.  23 You write, "As the gender transition  24 industry routinely permits poorly  25 qualified social workers or other mental</p>	<p style="text-align: right;">Page 129</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that criteria. Many of them have not even  3 a fraction of the knowledge of the  4 existing scientific literature, much of  5 which I provided in my declaration. They  6 accept it at face value as fact without  7 ever critically evaluating the merits of  8 the approach. And I know this from  9 conversations that I've had with many  10 that are providing that service. When I  11 directly challenge them, if they know the  12 research that I have mentioned in my  13 declaration, they are entirely unaware of  14 that.  15 Q. And you said many are doing  16 this. How many?  17 A. I have not systematically  18 surveyed nor am I aware of the absolute  19 number. What I have become aware of from  20 the reports of people that I have spoken  21 to, as I've done my due diligence in  22 trying to understand all the aspects of  23 this condition, I have repeatedly  24 encountered the exact scenario that I  25 mentioned previously, as far as people</p>

<p style="text-align: right;">Page 130</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 being unaware beyond the actual check  3 boxes for the DSM diagnosis. So that has  4 been my experience.  5 Q. And who have you spoken to?  6 A. I've spoken to dozens of  7 people over the last ten years.  8 Q. So dozens of people over the  9 last ten years. And that is the only  10 basis for your assertion that there are  11 poorly trained mental health  12 professionals providing these  13 evaluations?  14 MS. LAND: Object to form.  15 A. So if you're asking a  16 question, has there been a scientific  17 study that has directly assessed the  18 percentage of individuals that have  19 adequate qualifications that are aware of  20 the scientific literature in the field,  21 the limitations of the research that's  22 being done versus those that are merely  23 reading the DSM-V and providing a letter  24 for patients, I'm not aware of that  25 literature.</p>	<p style="text-align: right;">Page 132</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 base in making that, and actually to  3 challenge them when they make statements  4 that are not supported by scientific  5 evidence. And I've uniformly, when I've  6 had those conversations, are struck by  7 the lack of knowledge beyond, for  8 example, the WPATH statements to know the  9 basis for which those statements are  10 being made.  11 It is something that is highly  12 concerning to me, and that I continue to  13 engage in the dialogue to be able to  14 bring this to light.  15 Q. Do you remember the name of  16 anyone that you challenged in this  17 regard?  18 MS. LAND: Object to form.  19 A. I would have to -- I mean,  20 it's happened over so many times and so  21 many conversations. I believe my ability  22 to pick out isolated circumstances with  23 the context of when -- which those  24 conversations occurred and the details of  25 those conversations, I think would lead</p>
<p style="text-align: right;">Page 131</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And what was the context of  3 the discussions that you had with mental  4 health professionals about these  5 evaluations?  6 A. They have come under multiple  7 different settings for multiple different  8 purposes.  9 As I have stated previously,  10 my task, when this was first put forward  11 by a member of my faculty in 2012, was to  12 be able to understand the approach that  13 was being proposed, to be able to gather  14 information relevant to making an  15 assessment about whether this was a  16 prudent course of action and this did  17 include talking to as many individuals as  18 possible.  19 It's something that I've  20 continued to do over the last decade and  21 very much welcome conversations with  22 people that are advocating for this form  23 of medical intervention, to be able to  24 listen very carefully to their  25 experience, to assess other knowledge</p>	<p style="text-align: right;">Page 133</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to error, and I prefer to stay objective  3 to provide the best service to this  4 court.  5 Q. And so you can't remember the  6 name of anyone that you had one of these  7 conversations with?  8 MS. LAND: Objection to form.  9 A. I can certainly remember many  10 individuals I've spoken to, but the  11 circumstances by which I've spoken to  12 them for, the questions that were being  13 asked, the context of the questions  14 differed markedly and that certainly  15 influences one's ability to assess that  16 conversation.  17 In the context of this  18 deposition I think it would be misleading  19 to be able to draw attention to any one  20 of those conversations without having the  21 ability to engage in the full context of  22 that conversation.  23 Q. So you're unwilling today to  24 recall even a single name of someone you  25 had what you describe as these highly</p>

<p style="text-align: right;">Page 134</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 concerning conversations with?  3 MS. LAND: Objection to form,  4 asked and answered.  5 A. I would say I'm not unwilling,  6 I'm incapable of doing that in a way that  7 would serve this court.  8 Q. Who would be appropriately  9 qualified to evaluate someone for gender  10 dysphoria?  11 MS. LAND: Object to form.  12 A. So, again, those that are  13 typically charged with caring for  14 individuals that have the difficulties  15 that are experienced in the setting of  16 sex, gender identity discordance would be  17 the psychological profession. But there  18 are many different levels of expertise in  19 these areas.  20 The ones that would be most  21 reliable would be the ones that have --  22 there are members of the relevant  23 scientific community that have the  24 ability to objectively, in a  25 non-ideological, non-biased manner look</p>	<p style="text-align: right;">Page 136</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Objection to form.  3 A. That is not correct. I did not  4 say that. I said that people that have  5 the relevant -- they are members of the  6 relevant scientific community that have  7 expertise to be able to critically  8 evaluate the literature, recognize the  9 strengths and limitations.  10 So that is a general statement  11 of the qualifications of the relevant  12 scientific community. And I would draw  13 -- just looking at my own experience in  14 reviewing clinical trials and research  15 papers, I think that would be the  16 standard that I would expect of anybody  17 that would want to opine in that area.  18 Q. And among those currently  19 assessing adolescents with gender  20 dysphoria, what percentage would you say  21 currently meet that standard, based on  22 your best estimate?  23 A. Again, I don't have an  24 objective research study to know, but I  25 would say that it is a minority of</p>
<p style="text-align: right;">Page 135</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 at the evidence that's available that  3 have been involved in critically  4 assessing the literature and there are  5 individuals that have those  6 qualifications.  7 Q. Can you think of any  8 individuals that have those  9 qualifications?  10 A. You know, there's certainly --  11 I have to go through my database of  12 hundreds of papers that I reviewed and  13 many of them are authors of those papers  14 that acknowledge the limitations in the  15 literature that give me the evidence that  16 they are critically asking these  17 questions. And so I would have to go  18 back to my records to be able to pull out  19 individual names.  20 Q. So individuals who would be  21 qualified would be those who have  22 published in the area and who recognize  23 the limitations of the existing research;  24 is that correct?  25 A. No.</p>	<p style="text-align: right;">Page 137</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 patients. And I would say that the ones  3 that I am most aware of are the ones that  4 are being cared for are not within the  5 United States.  6 Q. For those that are receiving  7 proper assessment and evaluation, do you  8 support the provision of treatment for  9 those individuals -- sorry. Excuse me.  10 Let me rephrase.  11 For individuals who are  12 receiving proper assessment, as you just  13 described it in or outside the United  14 States, do you support a provision of  15 treatment for those patients?  16 MS. LAND: Objection, form.  17 A. So you'd have to specify what  18 you mean by "treatment".  19 Q. So for a patient who has  20 received proper assessment and been  21 recommended for treatment with, say,  22 pubertal suppression for gender  23 dysphoria, after proper assessment would  24 you support the provision of treatment?  25 MS. LAND: Objection to form.</p>

<p style="text-align: right;">Page 138</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I think this goes back to what  3 I've already answered previously about  4 the state of knowledge and about the  5 relative risks and benefits of the  6 treatment paradigm.  7 There are many other aspects  8 of which would be considered treatment  9 that would not fall under the category of  10 the interventions that I have concluded  11 are not supported by the available  12 scientific evidence.  13 Q. So it's not just the  14 assessment process that you're concerned  15 about; is that correct?  16 MS. LAND: Object to form.  17 A. As I said previously, there  18 are questions about etiology, diagnosis,  19 risks, benefits, long-term outcomes and  20 the availability of alternative  21 approaches, all that I have concerns  22 about.  23 Q. So taking just the assessment  24 alone, that is -- if that were done  25 properly, as you've described it, you</p>	<p style="text-align: right;">Page 140</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I stated that I don't have the  3 literature, the study has not been  4 conducted to be able to assess that, but  5 I think it is a substantial portion.  6 And, you know, to put a number on that,  7 I'm not aware of any research studies  8 that allow one to make a definitive  9 assessment on that. I do know that there  10 are, based on percent-wise of the number  11 of people that have expressed their  12 concerns, that it's a significant number.  13 Q. So you don't -- so you don't  14 know the percentage?  15 MS. LAND: Object to form.  16 A. Percentage of what?  17 Q. You don't know the percentage  18 of patients who are not receiving an  19 adequate assessment based on your  20 assessment of what is happening?  21 MS. LAND: Object to form.  22 A. Let me broaden this, okay,  23 because I think it's important. And it's  24 not -- you know, the concern I have is in  25 the whole assessment process, itself.</p>
<p style="text-align: right;">Page 139</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 would still have concerns; is that  3 correct?  4 MS. LAND: Object to form,  5 asked and answered.  6 A. In the context of the ability  7 -- so this is why it's critically  8 important to be able to do properly  9 controlled studies. So that if you take  10 a patient population that is  11 heterogeneous, as far as underlying  12 precipitating factors, etiologies, and  13 even ability to -- since there is not an  14 ability to accurately identify the  15 veracity of the claims that are being  16 made, it is essential then in that  17 setting to be able to conduct the  18 research in a randomized manner to be  19 able to make valid conclusions.  20 Q. So previously you said, going  21 back a few questions, you said a minority  22 of patients are receiving proper  23 assessments in the United States; is that  24 correct?  25 MS. LAND: Objection to form.</p>	<p style="text-align: right;">Page 141</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 So if one followed the DSM in  3 checking the boxes for the criteria but  4 failed to assess underlying psychological  5 comorbidity, oftentimes which predated  6 any evidence of onset of gender  7 dysphoria, and to critically evaluate  8 whether that might be contributory to the  9 experience that that individual  10 experienced, you know, that is an  11 important component of what would be  12 necessary for valid assessment. And the  13 way that the standards have been put  14 forward are to essentially check the  15 boxes for the diagnostic criteria to be  16 able to give them the label of gender  17 dysphoria, and that is inadequate for an  18 assessment.  19 When you use the phrase  20 "proper assessment", there are many  21 dimensions to what is necessary for a  22 proper assessment beyond the DSM check  23 box diagnosis.  24 Q. Do you have any specific  25 knowledge about how clinicians in</p>

<p style="text-align: right;">Page 142</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Arkansas are treating patients with  3 gender dysphoria?  4 MS. LAND: Objection to form.  5 A. Are you asking if I've ever  6 practiced medicine in Arkansas? I have  7 not.  8 Q. Do you have any specific  9 knowledge about how clinicians in  10 Arkansas are treating patients with  11 gender dysphoria?  12 MS. LAND: Objection to form.  13 A. So are you asking me; have I  14 read the consent forms of all of the  15 practitioners in Arkansas? Have I -- I'm  16 familiar with what is made in the  17 Complaint, as far as the assertions that  18 are being made about following the WPATH  19 guidelines, but that's the extent.  20 I've not practiced medicine in  21 Arkansas and I can only rely upon the  22 evidence that's been presented to me to  23 this point in time.  24 Q. So you have no knowledge  25 beyond the Complaint about how the</p>	<p style="text-align: right;">Page 144</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I have knowledge what is  3 stated in the Complaint and the  4 practitioners that have made public  5 disclosures.  6 My knowledge is that they  7 claim to follow the WPATH guidelines,  8 which there is much that can be said  9 about that guideline, and how it is being  10 implemented, and all of the difficulties  11 that are presented by those  12 recommendations.  13 Q. And which practitioners in  14 Arkansas are you referring to?  15 A. I believe that there's one in  16 the Complaint that was listed. I'd have  17 to go back to the actual Complaint. But  18 I'm talking specifically about the  19 assertions that are being made.  20 I've heard repeatedly in the  21 case here about statements about  22 referring to these medical group  23 guidelines as being followed. And if  24 they are being followed, in the absence  25 of exploring alternative hypotheses, I</p>
<p style="text-align: right;">Page 143</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 treatment for -- how adolescent patients  3 with gender dysphoria are treated in  4 Arkansas?  5 MS. LAND: Objection to form.  6 A. Again, you used the word  7 "treatment", which is a comprehensive  8 statement that includes a lot of  9 different dimensions. So I would  10 appreciate you be more specific about  11 what you mean by "treatment".  12 Q. Have you ever sat in on an  13 evaluation of a patient for gender  14 dysphoria in the State of Arkansas?  15 MS. LAND: Objection to form.  16 A. I do not practice in Arkansas  17 and I have not been present in a gender  18 clinic in the State of Arkansas.  19 Q. Okay. So you have no personal  20 knowledge about what the evaluation  21 process -- you have no personal knowledge  22 about the evaluation process for patients  23 with gender dysphoria in the State of  24 Arkansas?  25 MS. LAND: Objection to form.</p>	<p style="text-align: right;">Page 145</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 would not consider that to be adequate  3 assessment.  4 Q. Okay. Still on Exhibit 1, can  5 we turn to paragraph 60 on page 70?  6 A. Six-zero?  7 Q. Six-zero, yes. And here you're  8 describing here some of the fundamental  9 purposes of the practice of medicine. And  10 towards the end you write, "The gender  11 transition industry violates this  12 essential principle by using experimental  13 treatments on vulnerable populations  14 without properly informing them of the  15 actual risks and limitations of the  16 treatments." Did I read that correctly?  17 A. That is the sentence as it is  18 written, yes.  19 Q. And do you still agree with  20 that sentence?  21 A. I do.  22 Q. And what is your basis for  23 saying that patients are not properly  24 informed of the actual risks and  25 limitations of the treatments?</p>

<p style="text-align: right;">Page 146</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. It is based upon the --  3 everything that's contained within my  4 declaration, as -- because of the  5 deficiencies of the evidence that's  6 presented, it is not -- it's a question  7 that is not answered. So it is not  8 available to be able to know the actual  9 risks and limitations of the treatment  10 when they've not been investigated in a  11 rigorous manner, as I've stated  12 repeatedly.  13 Q. Your view is; based on the  14 current state of the science, it would be  15 impossible for someone to be properly  16 informed of the risks and limitations of  17 the treatment?  18 MS. LAND: Object to form.  19 A. I am not aware of anyone that  20 presents this in the proper context as an  21 experimental approach with unproven  22 efficacy and major risks, which is what  23 the scientific evidence currently shows.  24 Q. If someone were presented with  25 the -- if someone were presented with the</p>	<p style="text-align: right;">Page 148</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Object to form.  3 A. If you are asking questions  4 about consent, this is a broad question  5 that requires a discussion of multiple  6 elements related to the ability of both  7 parents and children to consent to these  8 procedures and it would be important to  9 be able to be more specific in addressing  10 each of those components to be able to  11 arrive at a proper understanding of the  12 important factors and why I believe that  13 these individuals have not been properly  14 consented.  15 Q. I'm not asking why you believe  16 it. I'm asking do you believe that they  17 have not been properly consented?  18 MS. LAND: Object to form.  19 A. Again, we need to discuss the  20 individual criteria for informed consent  21 to be able to answer that question. It's  22 a broad question that you've asked.  23 In the field of ethics it's  24 critically important that one consider  25 all of the contributing factors.</p>
<p style="text-align: right;">Page 147</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 information as being an experimental  3 treatment and consented to that, and  4 their parent consented to that treatment,  5 would that change your view on this  6 question of properly informed?  7 MS. LAND: Objection to form.  8 A. So are you asking if a parent  9 came and would be willing to be enrolled  10 in a randomized controlled trial under  11 the IRB auspices, I would certainly agree  12 with that.  13 Q. And do you have any basis to  14 believe that the Plaintiffs in this case  15 were not properly informed of the risks  16 and limitations of treatment?  17 MS. LAND: Objection to form.  18 A. I'm not aware of any of the  19 Plaintiffs that were enrolled in clinical  20 trials relative to this form of  21 intervention.  22 Q. So the only way to be informed  23 of the risks of treatment would be to be  24 enrolled in a criminal -- in a clinical  25 trial; is that your view?</p>	<p style="text-align: right;">Page 149</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. So here you said in your  3 report that people have not been properly  4 informed of the actual risks and  5 limitations of the treatment; that's your  6 position, right?  7 A. That is correct.  8 Q. And how could they be properly  9 informed?  10 A. Again, if you want to have a  11 discussion I would be very happy to go  12 through in great detail about all of the  13 necessary elements that would be required  14 for them to be able to adequately  15 consent. And I would actually argue that  16 because of the children, themselves, that  17 are affected by this, because of the  18 underlying factors, the state of their  19 psychological development, they,  20 themselves, are not able to give consent.  21 That was actually a topic that was  22 directly addressed in the Keira Bell case  23 in the U.K. And it's not just myself  24 raising concerns about that ability, that  25 the children, themselves, are usually</p>

<p style="text-align: right;">Page 150</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 left to give assent and the parents,  3 themselves, are often sought to give the  4 consent and they often, themselves,  5 present with inadequate information.  6 They certainly aren't -- so if they -- I  7 don't know of any parent -- I actually  8 know of specific examples of parents that  9 were not given the experimental nature of  10 the approach and they were essentially  11 told that if they did not affirm their  12 child that they would commit suicide and,  13 really, the basis for them to challenge  14 that is very difficult for a parent to be  15 able to do that.  16 I have not yet encountered one  17 of the people that is putting forward  18 this treatment approach to address that  19 question, and I'm not going to answer a  20 hypothetical about whether there is  21 anybody out there in the world that does  22 this. I don't have knowledge of that.  23 But I would say that I stand by my  24 statement that because of the limitations  25 of the knowledge we have, they are not</p>	<p style="text-align: right;">Page 152</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to give informed consent to treat gender  3 dysphoria with hormone therapy in  4 adolescents?  5 MS. LAND: Object to form.  6 A. I think it is certainly  7 possible for an individual or a parent to  8 consent enrolling their child in an  9 experimental protocol, informing them  10 that it is an experimental approach with  11 an uncertain outcome, that would be  12 possible.  13 Q. And so your knowledge of  14 practice is based on your conversations  15 with the dozens of people in the field  16 but you can't name any of them right now?  17 MS. LAND: Objection to form,  18 asked and answered.  19 A. The basis for me not giving  20 individual names is because it would be  21 misleading without the proper context of  22 the conversations that were made to be  23 able to use that as a basis for that  24 opinion.  25 I've already stated repeatedly</p>
<p style="text-align: right;">Page 151</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 being informed of the lack of evidence  3 and the significant risk before being  4 asked to engage in this intervention.  5 Q. Is it possible to provide  6 information sufficient to enable a family  7 to give informed consent to hormone  8 therapy to treat gender dysphoria in  9 adolescents?  10 MS. LAND: Object to form.  11 A. Again, that's a very broad and  12 hypothetical question, and because of the  13 nature of the ethics I think it would be  14 erroneous to make that. There are many  15 factors that potentially could be present  16 in a theoretical manner, but to be able  17 to opine on that in a hypothetical  18 situation is fraught with much difficulty  19 and possible for misinterpretation.  20 Q. I mean -- sorry. I think it's  21 appropriate to ask you as an expert what  22 you think is possible in a hypothetical  23 context.  24 So is it possible to provide  25 information sufficient to enable a family</p>	<p style="text-align: right;">Page 153</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 here as far as the basis for my concern,  3 and that's very adequately stated in my  4 declaration as well.  5 Q. Can you turn to, still on  6 Exhibit 1, paragraph 71, page 81, and  7 this is related to something you just  8 mentioned. This is toward the bottom of  9 paragraph 71, beginning with, "In  10 addition". Do you see that sentence?  11 A. I'm not there yet. Give me a  12 minute. Yes. "So in addition", I'm  13 there.  14 Q. You say, "In addition, parents  15 are often manipulated and coerced by  16 misinformed political activists or  17 providers who threaten them with dire  18 warnings that the only two operations are  19 treatment or suicide." Did I read that  20 correctly?  21 A. You did.  22 Q. What is the basis for that  23 statement?  24 A. I've seen many things that are  25 published on -- by people that are</p>

<p style="text-align: right;">Page 154</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 advocating for this affirmation approach  3 that use that exact same language and  4 I've heard this repeatedly. And it's  5 actually -- you can find this very  6 readily on social media, on blog posts  7 and even within papers, themselves. And,  8 again, I do provide a reference in my  9 declaration with some evidence. There is  10 certainly more that I can use to cite  11 that. There are many people that are  12 using the -- the concern over suicide  13 risk to justify.  14 There's very clear examples,  15 for example, where people have made  16 almost verbatim statements; would you  17 rather have a live child of a particular  18 sex or gender identity or a dead one of  19 the other?  20 Those are coercive and  21 manipulative. They don't adequately  22 reflect the fact that suicide rates  23 remain markedly elevated with the data  24 that we have available after affirmative  25 therapy. Again, with the limitations of</p>	<p style="text-align: right;">Page 156</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 problem of suicidality in this patient  3 population.  4 It has not been demonstrated  5 that it is definitively the cause of that  6 suicidality. And to make statements that  7 if one does not provide this care that  8 your child will commit suicide fits  9 within that category.  10 Q. And when you say that they're  11 "often manipulated and coerced", what  12 does "often" mean?  13 A. There is a plethora of  14 examples that one can find with even a  15 casual survey of what can be available  16 publicly. It doesn't take much effort to  17 find that.  18 Q. Do you believe that more than  19 50% of the time providers are  20 manipulating and coercing their patients  21 into receiving this treatment?  22 MS. LAND: Object to form.  23 A. You are asking a question  24 about actual magnitude within the absence  25 of any scientific data to make that</p>
<p style="text-align: right;">Page 155</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the literature that is present, they  3 don't reflect the fact of the basis for  4 why that exists. And that is what I'm  5 referring to in that statement I made in  6 my declaration.  7 Q. So you have political  8 activists or providers. Do you believe  9 that political activists and providers  10 are acting in comparable manners here?  11 MS. LAND: Object to form.  12 A. Well, many of the people that  13 are the ones administering this care are  14 not only medical providers. They are,  15 themselves, political activists, one in  16 the same people. And I think that many  17 people adopt the language that has been  18 put forward by the political activists in  19 presenting this to their patients.  20 Q. And what do you mean by  21 "manipulated and coerced" in this  22 context?  23 A. I think it's erroneous to make  24 the claim that the affirmative approach  25 has been demonstrated to solve the</p>	<p style="text-align: right;">Page 157</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 assertion and I have no basis to be able  3 to put a firm number on it, but it is a  4 very common observation.  5 Q. So there is no scientific data  6 to put a firm number on your assertion  7 that it's happening often?  8 MS. LAND: Objection to form.  9 A. I am not aware of an objective  10 scientific tool that's been generated to  11 adequately, in a population-based manner,  12 survey all those that are providing this  13 care to determine the precise methods  14 that they use in recommending this form  15 of intervention.  16 Q. Do you have any basis to  17 believe that the parent Plaintiffs in  18 this case were manipulated or coerced  19 into consenting to treatment for their  20 children?  21 MS. LAND: Object to form.  22 A. Again, I've stated my  23 knowledge of the Plaintiffs in this case  24 and the limitations of that knowledge  25 and, therefore, would not be able to</p>

<p style="text-align: right;">Page 158</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 comment specifically on their experience.  3 MR. STRANGIO: Amanda, I just  4 want to check in on timing of  5 lunch. Obviously, we're an hour  6 ahead. If we go another 20 minutes  7 or so, would that be doable on your  8 end and take a quick lunch after  9 that?  10 MS. LAND: That's good with  11 me.  12 MR. STRANGIO: Okay.  13 Q. Dr. Hruz, is that okay with  14 you?  15 A. I'm very fine with that.  16 VIDEOGRAPHER: This is the  17 videographer within the next 15  18 minutes or so we'll need to take a  19 media break.  20 MR. STRANGIO: So why don't we  21 -- you know what, can we just break  22 for lunch now, if we have to do 15  23 minutes. And then come back in  24 let's say 30 minutes, is that  25 enough time?</p>	<p style="text-align: right;">Page 160</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 report.  3 A. Well, essentially that is --  4 again, each of these approaches begin  5 with various scientific premises and have  6 contrasting goals of the treatment  7 approach.  8 The expectant management has  9 -- you know, the premise there is that  10 the vast majority of prepubertal children  11 will have a spontaneous realignment of  12 their gender identity with their sex with  13 time, and it's to provide ongoing support  14 for perhaps underlying comorbidities, but  15 not to intervene in any way to influence  16 that natural history outcome.  17 Q. Is that what you call the  18 watchful waiting treatment modality in  19 your report?  20 A. Correct. Expectant means  21 basically watching or waiting.  22 Q. So going through the three  23 general approaches it's; one, conversion  24 or reparative approach; two, watchful  25 waiting or expectant management approach;</p>
<p style="text-align: right;">Page 159</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Yes.  3 VIDEOGRAPHER: Okay. It's  4 11:47 and this will end media part  5 2 and we're off the record.  6 (Lunch recess is taken.)  7 VIDEOGRAPHER: We are back on  8 the record at 12:20 p.m. This will  9 begin media part 3. We can proceed.  10 Q. I'm still at what we've marked  11 as Exhibit 1. If I could ask you to turn  12 to page 72, paragraph 62. I'm not going  13 to be reading here, but just trying to  14 understand.  15 So in your report you  16 described three approaches for treating  17 gender dysphoria in children and  18 adolescents; is that right?  19 A. Yes. There are three  20 approaches that I mentioned as far as the  21 expectant management, the reparative  22 approach and the gender-affirming  23 approach, correct.  24 Q. What is the expected  25 management? I don't see that in your</p>	<p style="text-align: right;">Page 161</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 and three, the gender-affirming approach.  3 Do I have that right, the three that you  4 describe?  5 A. That is correct.  6 Q. Okay. So I just want to sort  7 of address each in turn.  8 So for the first, the  9 conversion or therapy approach, is that  10 where a clinician encourages a patient to  11 identify with their natal sex?  12 A. Again, the term "natal sex"  13 has got lots of connotations. I would  14 like to talk about sex or biological sex.  15 But, indeed, yes, that is an approach  16 where there is a desire to have one have  17 that experience of realignment with their  18 gender identity with their sex.  19 The premise there is if that  20 is successful, that one will not then be  21 medicalized, have all of the inherent  22 risks long-term that go along with the  23 affirmative approach, and that is deemed  24 a desirable outcome in mitigating those  25 potential risks.</p>

<p style="text-align: right;">Page 162</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 Q. And how in this approach would</p> <p>3 they encourage them to identify with</p> <p>4 their biological sex?</p> <p>5 A. There is a wide variety of</p> <p>6 ways that that has been done. Probably</p> <p>7 the pioneer in that approach is that by</p> <p>8 Ken Zucker, and he has extensive</p> <p>9 literature. It really is a wide variety</p> <p>10 of approaches that people have advocated</p> <p>11 for. And so -- but I think where it's</p> <p>12 distinguished from the expectant or</p> <p>13 watchful waiting approach or the</p> <p>14 affirmative approach is that it states as</p> <p>15 a premise that there is a desired goal to</p> <p>16 allow that child to have that experience</p> <p>17 of realignment.</p> <p>18 Q. And you would put Ken Zucker</p> <p>19 in the conversion or reparative category?</p> <p>20 MS. LAND: Object to form.</p> <p>21 A. If you read through his</p> <p>22 approach, he -- it was probably a</p> <p>23 combination of an expectant approach and</p> <p>24 a reparative approach. And he's not the</p> <p>25 only one that have put a focus on trying</p>	<p style="text-align: right;">Page 164</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 A. I would say that to have the</p> <p>3 experience of realignment, not to force</p> <p>4 them but allow them to experience that on</p> <p>5 their own.</p> <p>6 Q. And having the experience of</p> <p>7 realignment as a goal is unique to the</p> <p>8 conversion approach?</p> <p>9 MS. LAND: Object to form.</p> <p>10 A. First, I think that the term</p> <p>11 "conversion" has been influenced by much</p> <p>12 ideology and I prefer to use the term</p> <p>13 "reparative therapy".</p> <p>14 "Conversion" is in the</p> <p>15 declaration so it's very clear to the</p> <p>16 court what we're speaking of. But I</p> <p>17 think there are many erroneous</p> <p>18 assumptions when one thinks about, you</p> <p>19 know, that particular -- the means that</p> <p>20 are used to achieve that end. But as a</p> <p>21 whole, it is an approach that seeks to</p> <p>22 allow that individual to experience that</p> <p>23 realignment of gender identity with sex.</p> <p>24 Q. And to what age does -- to</p> <p>25 what age patients does this approach</p>
<p style="text-align: right;">Page 163</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 to identify underlying precipitating</p> <p>3 factors that may have led an individual</p> <p>4 to experience a sex-discordant gender</p> <p>5 identity, prior traumas, relationships</p> <p>6 with their peers or their parents. And</p> <p>7 to be able to explore those, to be able</p> <p>8 to address those underlying issues in the</p> <p>9 process of addressing those underlying</p> <p>10 issues that predate any sex-discordant</p> <p>11 gender identity to allow that individual</p> <p>12 then to have that reintegration process.</p> <p>13 So I wouldn't characterize</p> <p>14 he's the only one, and there are many</p> <p>15 different approaches that fit within that</p> <p>16 category, but it's based upon the</p> <p>17 scientific premise that is present, as</p> <p>18 far as what has led to the gender</p> <p>19 dysphoria and the desired outcome.</p> <p>20 Q. And just to clarify, the</p> <p>21 desired outcome within the conversion or</p> <p>22 reparative approach is for the patient to</p> <p>23 realign their gender identity with their</p> <p>24 biological sex; is that correct?</p> <p>25 MS. LAND: Object to form.</p>	<p style="text-align: right;">Page 165</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.</p> <p>2 apply?</p> <p>3 A. I don't know that there's</p> <p>4 necessarily -- again, when we think about</p> <p>5 these as broad categories, there are many</p> <p>6 ways of which this has been applied.</p> <p>7 As a pediatric endocrinologist</p> <p>8 talking specifically relevant to this</p> <p>9 litigation, we're talking about children,</p> <p>10 and I think that that would cover the</p> <p>11 entire timeframe that the pediatric</p> <p>12 practitioner would be engaged in this.</p> <p>13 Q. Might this approach apply to a</p> <p>14 17-year-old?</p> <p>15 A. It certainly could. It could</p> <p>16 apply at any age if it has not -- again,</p> <p>17 when you think about the changing</p> <p>18 demographics of this condition, there are</p> <p>19 patients that present prepubertally,</p> <p>20 there are patients that present during</p> <p>21 the adolescent years, and there are</p> <p>22 patients that present later. And there</p> <p>23 are people that will choose or at least</p> <p>24 advocate for each of these approaches,</p> <p>25 with the exception perhaps of the</p>

<p style="text-align: right;">Page 166</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 affirmative -- well, it does include the  3 affirmative approach in prepubertal  4 children as well because of the social  5 affirmation component of that.  6 So I think it applies to the  7 population in general and as it's being  8 thought of, as far as different treatment  9 modalities, can apply across the  10 spectrum.  11 Q. And that's including to  12 adults?  13 A. As far as -- well, we're not  14 talking about that here in this  15 litigation here. And my speaking on this  16 is focused on the question of -- of the  17 pediatric experience, but there are  18 individuals that seek that type of  19 intervention in adults.  20 Q. And the second is what you  21 refer to here I think as neutral or  22 watchful waiting and what you refer to  23 today as expected management. And this  24 approach is where clinicians wait and see  25 how the patient identifies as they grow;</p>	<p style="text-align: right;">Page 168</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Okay. The goal of the watch  3 and wait approach is to accompany the  4 person -- essentially if you think about  5 this in terms of medical interventions,  6 that if you have an outcome in which 85%  7 of individuals will spontaneously have  8 their realignment of their gender  9 identity with their sex and not be  10 subjected to the risks and questionable  11 benefits of the affirmation approach,  12 that any intervention that one would  13 propose it would need to establish  14 non-inferiority, meaning that that  15 outcome it has to be at least as good as  16 that observation of outcomes.  17 So it really tries to maximize  18 the benefit, while minimizing risk. And,  19 again, there are many areas of medicine  20 where one does not have an outcome that  21 is 100% effective and we seek to  22 alleviate suffering in the most patients  23 that we can, while minimizing risk in any  24 intervention that we do. And I think that  25 that's the basis for that approach,</p>
<p style="text-align: right;">Page 167</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 is that correct?  3 A. That is correct.  4 Q. And what treatment, if any,  5 happens while the waiting process is in  6 process?  7 A. That's a very good question,  8 and it involves addressing all of the  9 associated comorbidities. So if there is  10 underlying depression or anxiety or  11 substance abuse or eating disorders, that  12 those can be addressed in the ways that  13 we normally address, you know, those  14 conditions.  15 The difference is that not  16 knowing is, again, as I said previously,  17 that there is no way reliably for many  18 biological test or predictive value that  19 will allow us to know which of those  20 individuals will have desistance or this  21 experience of spontaneous realignment of  22 their gender identity with their sex.  23 Q. And what is the goal of this  24 modality?  25 MS. LAND: Object to form.</p>	<p style="text-align: right;">Page 169</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 knowing that if there is that experience  3 of spontaneous realignment that any  4 intervention that might affect that in a  5 way of leaning to persistence would be  6 considered inferior because of the risks  7 with that.  8 Q. And so if a patient -- under  9 this approach if a patient continues to  10 experience significant distress related  11 to the incongruence between their gender  12 identity and biological sex into  13 adolescence, what happens?  14 A. So if you're specifically  15 referring to the model of Ken Zucker or  16 others, they would argue that if this  17 experience of persistence occurs that  18 once they reach a stage of their life,  19 and in the past historically it had been  20 once they reached an age of majority,  21 that they would be allowed to be able to  22 move forward with those interventions. In  23 that, again, you're trying to maximize  24 benefit, minimize risk. And at that  25 point in time the dynamics of risk and</p>

<p style="text-align: right;">Page 170</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 benefit are different, they infer the  3 individual at a younger age. That is the  4 argument that is made.  5 Q. And you're aware that at Ken  6 Zucker's clinic in Toronto, once patients  7 reached adolescence under this watchful  8 waiting proposal if their distress  9 continued they would be treated with  10 pubertal suppression and hormone therapy?  11 A. As I mentioned before, that  12 that -- that is the approach that  13 Dr. Zucker has put forward. And, again,  14 in the time that this was being done in  15 Canada in the clinic that he was  16 operating, you know, there was a very  17 different patient demographic than we're  18 experiencing right now. And so there are  19 factors that need to be considered about  20 the relative risk and benefit  21 historically from what we're encountering  22 currently. And I think that  23 epidemiology, precipitating factors, you  24 know, all of those are necessary.  25 But your statement about what</p>	<p style="text-align: right;">Page 172</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 with puberty blockers or hormone therapy  3 if the gender dysphoria persisted into  4 adolescence; is that right?  5 MS. LAND: Objection to form.  6 A. So by definition, if one  7 engages in puberty blockers and cross-sex  8 hormones we're moving away from the  9 expectant approach, we're actually  10 providing an intervention.  11 It is often argued that  12 pubertal blockade is a neutral  13 intervention. I have many reasons that  14 I've stated in my declaration and in the  15 New Atlantis paper why I have concluded  16 that that is an erroneous assertion. But  17 nevertheless, that you're starting to  18 provide interventions that have  19 consequences and then you shift the  20 dynamics of that natural history  21 observation, and I think that there is  22 evidence to suggest very strongly that by  23 providing pubertal blockade you are no  24 longer in a neutral category, that you're  25 having consequences on that rate of</p>
<p style="text-align: right;">Page 171</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Dr. Zucker had advocated is accurate, as  3 far as if there was persistence, would  4 then recommend, still with concern about  5 the relative risk involved, that his  6 conclusion was that there may be  7 circumstances where that would be --  8 again, risk/benefit-wise to be pursued.  9 Q. And as the broader medical  10 community understands it, is watchful  11 waiting generally an approach applied to  12 prepubertal children?  13 MS. LAND: Objection to form,  14 vague.  15 A. So the expectant approach, as  16 I said, takes various forms. All of these  17 interventions are engaged upon at all  18 stages of life, prepubertally, during  19 adolescence and puberty and into  20 adulthood. So there are examples one  21 could find of each of these approaches,  22 in a variety of populations.  23 Q. And just beyond Zucker, more  24 generally, under this watchful waiting  25 approach, providers might move forward</p>	<p style="text-align: right;">Page 173</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 desistance.  3 Q. So at any point that a medical  4 intervention is provided, then the  5 watchful waiting approach is no longer  6 the modality; is that your -- is that  7 your understanding?  8 A. That is not correct. I've  9 already said previously that  10 psychological care for underlying  11 comorbidities can be provided under the  12 expectant approach.  13 There is no desire to change  14 whatever trajectory will occur but there  15 is a desire to alleviate suffering,  16 providing that psychological support, for  17 example, if they have depression or  18 eating disorders or anxiety.  19 So those are medical  20 interventions that still can be  21 performed. It's not to say that we don't  22 provide any care for these individuals.  23 It merely says that we're not making any  24 concerted effort to change the outcome  25 for those patients. We're allowing them</p>

<p style="text-align: right;">Page 174</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to experience whatever outcome would  3 occur for a variety of factors.  4 Q. Under the watchful waiting  5 approach, how long do you wait before  6 providing pharmacological interventions?  7 MS. LAND: Objection to form.  8 A. That's a broad question. There  9 are many different approaches that use  10 different time points. So I think many  11 will, because of the erroneous  12 assumptions about the quoted statistic  13 about persistence when one has continued  14 dysphoria during the adolescent years,  15 that they will advocate at that point to  16 move from the expectant approach to the  17 affirmative approach.  18 As I've already stated, there  19 are problems with that assertion and  20 difficulties in saying that that is -- at  21 that point shifts the dynamics as far as  22 relative risk and benefit.  23 Q. So I'm going -- turning your  24 attention to the same Exhibit 1,  25 paragraph 62, page 72, this is an</p>	<p style="text-align: right;">Page 176</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Dutch Protocol.  3 Q. But here you're summarizing it  4 as actively encouraging children to  5 embrace transgender identity with social  6 transitioning. But under the Dutch  7 Protocol my understanding was that social  8 transitioning was not encouraged; isn't  9 that right?  10 A. Exactly. And I think that's a  11 wonderful point. I think when you look at  12 how this has evolved since that original  13 Dutch study and the way it's being used  14 to justify this approach, you correctly  15 have identified that there has been a  16 movement away from that point of initial  17 caution and actually at a very early age  18 to affirm individuals requires the social  19 affirmation phase. And that's much of  20 what's been the subject of other areas of  21 litigation related to gender dysphoria,  22 about whether that involves the  23 participation of parents, teachers,  24 coaches, and other members of one's  25 social community in engaging in that, and</p>
<p style="text-align: right;">Page 175</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 explanation of the affirmative approach.  3 It's at the bottom of the page, the  4 third, it's affirming -- here -- it's the  5 last sentence before the bottom of page  6 72.  7 You write, "The third  8 affirming approach is to actively  9 encourage children to embrace transgender  10 identity with social transitioning,  11 followed by hormone therapy leading to  12 surgical interventions and lifelong  13 sterilization." Did I read that  14 correctly?  15 A. You have correctly read that  16 statement in my declaration.  17 Q. And where did this definition  18 come from?  19 A. Well, it's a summary of the  20 approach that is being used. And so it is  21 a way to summarize the various treatment  22 approaches. And many people would refer  23 to the first Dutch study, the de Vries  24 paper, for this approach in children. So  25 it's why it's often referred to as the</p>	<p style="text-align: right;">Page 177</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 including name change, preferred pronoun  3 usage and bathroom access. And that all  4 fits under the affirming approach, based  5 upon a different premise than we see in  6 the other two approaches.  7 It is based upon the premise  8 -- again, you see this stated many  9 different ways as far as this condition  10 being innate and immutable -- that there  11 is a biological basis that, again, has  12 not been proven by science, and that this  13 is the prudent approach to be able to  14 actively encourage social transition.  15 Q. So just to be clear, this is  16 your definition, it's not the one that  17 came from the Dutch Protocol or anywhere  18 else of what the so-called affirming  19 approach is?  20 A. It is not my definition. It is  21 the practice that is being put forward by  22 the WPATH and other advocacy groups very  23 vocally and, in fact, leading to  24 discouragement of anything that is  25 contrary to that social affirmation.</p>

<p style="text-align: right;">Page 178</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 So it's not something that I  3 generated on my own. It's a summary of  4 the approach to intervention that is  5 being widely applied within the United  6 States under the auspices of the WPATH  7 and other advocacy groups.  8 Q. And what does it mean to  9 actively encourage a child to embrace  10 transgender identity?  11 A. It means exactly that, it  12 means to encourage them to "come out"  13 within their social networks or at  14 schools, it's to encourage and support  15 them, making affirmative statements about  16 gender identity and in many cases  17 encouraging that. And that is being done  18 at very early ages. There are clear  19 examples that are well documented within  20 the not peer-reviewed literature but in  21 the internet and stories of these types  22 of efforts by advocacy groups to  23 encourage this affirmation.  24 Q. And if a child who was, let's  25 say, seven, biological male, told the</p>	<p style="text-align: right;">Page 180</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Objection to form.  3 A. Having a therapist tell them  4 that they will love their child no matter  5 what is a statement that has nothing to  6 do with a desired outcome of a  7 transgendered identity. It is something  8 that all parents would not necessarily  9 need to be told that. But what would be  10 actively encouraging them is to tell the  11 parents that it is necessary that they  12 use the preferred pronouns, allow them to  13 cross-dress, allow them to use bathroom  14 access, allow them to adopt the social  15 role of their desired or their gender  16 identity, that would be the affirmative  17 approach.  18 Q. And what is your basis for  19 believing that clinicians are telling  20 parents that it is necessary to engage in  21 say, for example, using a preferred  22 pronoun?  23 A. I don't have to rely on my  24 opinion. It's very readily available if  25 anyone does a very casual search of what</p>
<p style="text-align: right;">Page 179</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 child's family that they felt like a girl  3 and the therapist encouraged the family  4 to tell the child they would love them no  5 matter what, is that actively encouraging  6 a transgender identity?  7 MS. LAND: Objection to form.  8 A. I would say any parent would  9 say that they love their child no matter  10 what, that there's a non sequitur in that  11 question.  12 Q. So is that a no, that's not  13 actively encouraging a transgender  14 identity?  15 MS. LAND: Objection to form,  16 asked and answered.  17 A. Please state the question so I  18 can adequately answer it.  19 Q. So if a seven-year-old  20 biological male told their family that  21 they felt like a girl, and the therapist  22 encouraged the family to tell the child  23 that they would love them no matter what,  24 is that actively encouraging a  25 transgender identity?</p>	<p style="text-align: right;">Page 181</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 has been written about by advocacy groups  3 and that is exactly what they say. It is  4 not my opinion, it is verifiable by a  5 wealth of information that can be found  6 on various advocacy sites.  7 Q. And when you say that it's  8 readily available on the internet that  9 advocacy groups are actively encouraging  10 kids to embrace a transgender identity,  11 what are you referring to?  12 A. If you like I can provide you  13 with dozens of examples of that. I would  14 refer you to many of the publications of  15 books that have been presented to  16 children in that area, the directives  17 that are being given and they are, again,  18 available online as far as for people  19 that access these websites to address  20 this question when it arises. And,  21 again, it doesn't take much effort to be  22 able to find that information.  23 Q. Do you think providing a child  24 with -- excuse me.  25 Do you think providing a</p>

<p style="text-align: right;">Page 182</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 seven-year-old with a book that includes  3 a transgender character is actively  4 encouraging a transgender identity?  5 MS. LAND: Objection to form.  6 A. I think you mischaracterize  7 the publications that are available,  8 because if you look carefully at those  9 examples, they do much more than just  10 presenting the child that experiences a  11 transgender identity. They have many  12 aspects that are presented in there of  13 the affirmation approach that I'm  14 discussing, that we're discussing  15 currently.  16 Q. And how do those -- how do  17 those children's books do that?  18 A. I've seen them present either,  19 you know, fictionalized stories of  20 children that are struggling with gender  21 identity issues, where they present the  22 child in a fictionalized account of their  23 response to engaging with various  24 parents, caregivers and peers. There is  25 many different types of examples of that</p>	<p style="text-align: right;">Page 184</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 description of children struggling with  3 gender identity issues where they present  4 the child with various accounts with  5 parents, caregivers and peers. Is that an  6 example of a story where the desired goal  7 is a transgender identity?  8 A. It depends. Again, we're  9 talking in generalities and it might be  10 better to actually provide you with  11 specific examples of that so we can  12 actually look at the literature. I don't  13 have that in front of me, but it's  14 certainly easy to find and we can  15 certainly go through those publications  16 and address specifically in that  17 individual publication whether or not  18 that occurs.  19 I think the general message  20 that is being put forward is that this is  21 a desired outcome, that it is the only  22 approach in many cases or the best  23 approach to address this sex-discordant  24 gender identity.  25 Q. Can you think of any</p>
<p style="text-align: right;">Page 183</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that can be readily found.  3 Q. And is that actively  4 encouraging a transgender identity?  5 MS. LAND: Objection to form,  6 asked and answered.  7 A. As I said, again, we're  8 talking about an approach of social  9 affirmation. And if one is portraying  10 this as a desired goal, again, the  11 scientific premise or the intent of the  12 intervention is to lead to that outcome,  13 that would constitute the affirmation  14 approach.  15 Q. And is a desired goal the same  16 as something that is not to be -- that is  17 not to be shamed?  18 MS. LAND: Objection to form,  19 vague.  20 A. Let me understand the  21 question. So --  22 Q. Let me rephrase. You had said  23 your example of a children's book that  24 was actively encouraging a transgender  25 identity included, as you explained, a</p>	<p style="text-align: right;">Page 185</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 children's book that fit this --  3 A. I would say the book -- I  4 would say the book I Am Jazz is probably  5 the most recognized book in that  6 category.  7 Q. You would say that I Am Jazz  8 actively encourages transgender identity?  9 A. I would say --  10 MS. LAND: Objection to form.  11 A. I would say that of the three  12 approaches that we're discussing, it  13 falls closest to the affirmation approach  14 as compared to the watchful waiting or  15 the reparative approaches.  16 Q. Do you think a children's book  17 that shows a transgender child being  18 affirmed in their gender identity  19 necessarily falls to -- I take that back.  20 Okay. You mentioned Ken Zucker  21 a few times. Which approach does he fall  22 into?  23 A. I would say he has a hybrid  24 approach that falls into the watchful  25 waiting. He's actually, over his career,</p>

<p style="text-align: right;">Page 186</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 actually -- I think as a -- as a -- as a  3 very respected individual in this field  4 has considered all of the options. I  5 think some of his earlier work could be  6 easily construed to be in the reparative  7 model. I think he makes scientific  8 premises that there may be underlying  9 psychological distress and issues that  10 need to be addressed that could assist an  11 individual to experience that alignment  12 of their gender identity with their sex,  13 and then -- and I think he still holds  14 that there are circumstances in which  15 that is still true. Yet one has  16 proceeded far enough along that pathway  17 which they're not able to basically pull  18 themselves back, even with addressing the  19 underlying comorbidities, where in his  20 experience the likelihood that that  21 ongoing approach would have success has  22 changed and then would shift over into a  23 more of an affirmation approach.  24 And I think, again, as a  25 respected member of the relevant</p>	<p style="text-align: right;">Page 188</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 influence the calculus that one uses in  3 assessing the, you know, how one would  4 approach this.  5 The other factor that I have  6 to stress, as I've already said in my  7 declaration and I believe several times  8 today already, is that the demographics  9 of what we're seeing right now is  10 drastically different than the time that  11 Dr. Zucker was performing his research.  12 And it's becoming even, you know, the  13 categories that would fit into his  14 affirmative paradigm as a last resort  15 and, in fact, he often says it as that,  16 is very different.  17 And as far as risk and  18 benefit, what's not known is this  19 explosion of adolescent biological  20 females now presenting with gender  21 dysphoria without having any prepubertal  22 experience of that is vastly different  23 than the population of prepubertal males  24 that he encountered in his clinic in  25 Canada when he was performing that</p>
<p style="text-align: right;">Page 187</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 scientific community, I think he  3 acknowledges the limitations in each of  4 those approaches. He will acknowledge  5 much better than many of the other people  6 that are currently engaged in this  7 discussion about the unknowns and I think  8 appropriately phrases the question as a  9 risk/benefit type of analysis.  10 Q. And do you disagree with the  11 approach -- well, do you disagree with  12 what you just described as Zucker's  13 approach? Do you disagree with the  14 advisability of that?  15 A. As I said before, at the state  16 of knowledge that we have right now, on  17 the knowledge about etiology, about  18 natural history, about risks and benefits  19 of the current paradigm, one cannot  20 provide a definitive conclusion about  21 which approach is going to be the most  22 effective in the most number of patients.  23 If it were possible to  24 segregate patients out among these  25 different categories, it would certainly</p>	<p style="text-align: right;">Page 189</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 research.  3 Q. So if you -- if you had -- so  4 if a patient who begins a cross-sex  5 identification at, let's say, age 2 and  6 is persistent until they're 15-years-old,  7 at which point they come to clinic for  8 assessment, what does watchful waiting  9 look like for that patient?  10 A. Well, I can restate what I  11 stated previously because that paradigm  12 still applies in that specific example,  13 that the scientific premise there is that  14 there is no goal to influence in the  15 watchful waiting approach whether that  16 person has persistence or desistance.  17 It is geared toward assisting  18 that individual in providing support if  19 they do experience underlying  20 comorbidities in providing that care to  21 that individual, and then allowing them  22 -- again, this whole question that we  23 discussed earlier about -- about consent,  24 you know, to be able to have the data in  25 hand, which we don't have currently,</p>

<p style="text-align: right;">Page 190</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 about what the long-term outcome is going  3 to be for that individual, I think you  4 know, that there's disagreement among the  5 relevant scientific community as to the  6 particular point in one's life where one  7 is able to make that decision, where the  8 risk/benefit ratio is changed. Many have  9 strongly --  10 Q. I'm sorry -- I'm sorry to  11 interrupt. I think -- I think that you  12 got a little far afield from the question  13 because what I was -- what I meant to ask  14 here is for the watchful waiting  15 approach.  16 So it doesn't make a  17 difference at what age the person first  18 presents with a gender discordant  19 identity; is that your view?  20 MS. LAND: Object to form.  21 A. So the approach, itself,  22 doesn't change but the consideration of  23 which of the three potential approaches  24 has, you know, weighing out relative  25 risks and benefits, does change with the</p>	<p style="text-align: right;">Page 192</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. So the question is; which do I  3 support?  4 I am a physician-scientist  5 that believes that our goal in pursuing  6 any medical intervention, and  7 particularly in that area of gender  8 dysphoria, is to do the best we can to  9 alleviate suffering without inducing  10 harms, so having the best risk/benefit  11 ratio. And as I said repeatedly, it's  12 put forward that the affirmative approach  13 has been established, it's the preferred  14 approach and, in fact, many would argue  15 is the only approach. And I would argue  16 very strongly that the scientific  17 evidence does not allow one to make that  18 conclusion and that there is a need to  19 conduct adequate scientific investigation  20 to pursue alternative approaches that  21 would. Some of them would fit under the  22 category of the expectant or the  23 reparative models.  24 Q. And so just, what is your view  25 on the treatment approach that minimizes</p>
<p style="text-align: right;">Page 191</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 age of the patient.  3 So the paradigm with the  4 scientific premise and the goal and the  5 overall approach can happen at any age.  6 However, it is -- it does differ in the  7 age that the child presents. And once  8 they reach adulthood many would argue  9 that, you know, to continue with a  10 watchful approach, if there is a desire  11 for that individual to switch over to the  12 affirmative approach, based upon relative  13 risks and benefits and, you know, and  14 ability to obtain as best as possible the  15 consent, that is a different proposition  16 than doing it to an adolescent with an  17 immature brain that is going through all  18 of the traumas of adolescence or a  19 prepubertal child that actually hasn't  20 had the biological changes of sexual  21 maturity.  22 Q. And which of the three  23 treatment modalities that you described,  24 which treatment approach do you support?  25 MS. LAND: Object to form.</p>	<p style="text-align: right;">Page 193</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 suffering the most, based on the current  3 state of the science?  4 MS. LAND: Objection, vague.  5 A. So your question is quite  6 broad. The alleviating suffering, there  7 are many ways to look at that.  8 Many focus on the immediate  9 effect of alleviation of stress and  10 dysphoria, but others will weigh more  11 heavily long-term effects. There are many  12 things that we propose in medicine that  13 may have a short-term benefit in  14 alleviating distress that ultimately have  15 long-term consequences that do not have  16 sustained effects or in fact have more  17 significant adverse effects over time.  18 So I would look at this  19 question broadly, looking at the best  20 outcome for this individual, lifelong, to  21 -- if there is an approach that is  22 sustained, long-term, that does not carry  23 medical risk, it's preferable to a  24 short-term solution that carries  25 significant risk that is not sustained</p>

<p style="text-align: right;">Page 194</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 over time.  3 Q. Going back to this question,  4 if you -- if you had a patient who began  5 cross-sex identification, let's say there  6 is a patient who began -- who is a  7 biological male and begins to identify as  8 female at 2, age 2, and continues that  9 identification until they are  10 14-years-old and they come to a clinic  11 for assessment; what is your, your, Dr.  12 Hruz's view on what watchful waiting  13 would look like for this particular  14 individual?  15 MS. LAND: Objection to form.  16 A. So your question, in the  17 specific example of a two-year-old child  18 presenting with sex-discordant gender  19 identity with persistence to the age of  20 15, I think in that situation, as I've  21 described more generally for the watch  22 and wait approach, it does necessitate  23 exploration of the social dynamics of  24 that child, underlying conflicts within  25 the family, within peer groups,</p>	<p style="text-align: right;">Page 196</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 reparative approach that has the  3 scientific premise that sex and gender  4 identity are an integrated whole, and  5 that many of the precipitating factors  6 are identifiable and addressable. And  7 the watchful waiting approach takes an  8 agnostic approach saying; we don't know  9 and, therefore, we're going to take a  10 cautious approach and try to achieve the  11 least invasive outcome that one can  12 possibly have.  13 So if one looks at each of  14 those different premises in the model,  15 one can apply that in an individual  16 patient. And the way that one approaches  17 that will actually then allow one to  18 segregate it into these broad categories.  19 And I should say that there  20 are circumstances where, you know, this  21 segregation into three different  22 treatment approaches doesn't truly  23 reflect the complexity of the situation,  24 the heterogeneity that we see within  25 individuals, understanding, to the best</p>
<p style="text-align: right;">Page 195</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 investigation as to whether there are  3 other conditions like autism, which is  4 highly associated with sex/gender  5 identity discordance, to be able to  6 explore those factors and to address  7 those factors and then to be able to use  8 that information to provide the best care  9 to that individual.  10 Q. So it's a type of assessment  11 that would be needed? It's not a duration  12 of time in watchful waiting, as you just  13 described it?  14 A. I'm not sure I fully follow  15 the question. But I think that if you  16 divide out those different approaches for  17 the underlying scientific premise and,  18 you know, to elaborate, the affirmative  19 approach has the premise that  20 sex-discordant gender identity is a part  21 of normal human variation, that is innate  22 and immutable. You see many variations  23 of that, many will argue contrary to  24 that, and still try to use the  25 affirmative model. There is the</p>	<p style="text-align: right;">Page 197</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 best we can, about potential etiologic  3 factors that led to this sex/gender  4 identity discordance certainly can  5 influence how to approach this one  6 individual patient.  7 Q. And do you agree with the  8 premise of reparative therapy -- excuse  9 me.  10 Do you agree with the premise  11 of the reparative therapy approach that  12 sex and gender identity are an integrated  13 whole?  14 A. I have always stated this as a  15 -- as a hypothesis, as an alternative  16 hypothesis to what is being put forward  17 by the affirmation approach. And, again,  18 not all scientific premises are created  19 equally, but it is a starting point for  20 understanding this question of  21 sex-discordant gender identity.  22 Q. And is it your view that  23 sex-discordant -- sex/gender identity  24 discordance is not a part of human  25 identity?</p>

<p style="text-align: right;">Page 198</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Objection to form.  3 A. There are many statements that  4 are made by -- from an ideologic basis  5 that are contrary to science. And when  6 one looks at, as a physician-scientist  7 and as a pediatric endocrinologist, it is  8 -- you know, looking at sex as being  9 inherently binary is really -- had not  10 been controversial until the ideology had  11 been introduced. And that to say there  12 is variations of sex, as I've said in  13 many of the forums that I've spoken,  14 there are two and only two gonads that  15 participate in the process of  16 reproduction, there is not variability in  17 a continuum of that. The relationship  18 between sex and gender are distinct but  19 they're not entirely severable.  20 If we think about what we  21 mean, again, using the terms gender and  22 gender identity, has adopted many  23 different definitions over time, as  24 opposed to the objective scientific  25 biological understanding of the word sex.</p>	<p style="text-align: right;">Page 200</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that it's often presented with, as you  3 understand it?  4 A. The desired outcome of  5 presenting the publication to the child?  6 Q. Correct.  7 A. Again, as I said, I would have  8 to know more about the hypothetical  9 situation to be able to know what that  10 intent was.  11 Q. Well, you just said it's often  12 presented with a desired outcome, so I'm  13 just curious what you meant by that.  14 A. If that's the only information  15 that's presented to a child and then  16 there is a conversation with the parents  17 subsequent to that telling them that they  18 need to adopt preferred pronouns,  19 bathroom use and dress, that could be  20 constituted as an endorsement of the  21 affirmative approach.  22 Q. Do you think the book I Am  23 Jazz should be banned?  24 MS. LAND: Objection to form  25 and relevance.</p>
<p style="text-align: right;">Page 199</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 So in order to adequately  3 address that question one needs to be  4 using the terms in the same way and that  5 is not always the case.  6 Q. Do you think if the mental  7 health provider gives a family a copy of  8 the book I Am Jazz, that that is actively  9 encouraging a transgender identity?  10 MS. LAND: Objection to form,  11 asked and answered.  12 A. You know, I think that that's  13 an overly simplistic portrayal of what  14 actually goes on. I have no idea, you  15 know, the circumstances of any individual  16 of presenting that.  17 If it was presented  18 concomitantly with other publications  19 that present it in a different manner,  20 with a genuine sense of uncertainty, it  21 could potentially not constitute that.  22 The setting that it's often presented is  23 with a desired outcome, and so it depends  24 on the circumstance.  25 Q. What is the desired outcome</p>	<p style="text-align: right;">Page 201</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Again, I am serving in this  3 case as a physician-scientist and  4 focusing as best I can on the scientific  5 studies, but acknowledging much of the  6 discussion is going on in public.  7 I think that all the  8 information is -- I don't support banning  9 differing points of view, but I do  10 encourage active discussion based upon  11 relevant scientific facts, consideration  12 of alternative hypotheses, so that the  13 conversations of the information that's  14 being presented is not necessarily the  15 problem, it is the assertion that it is  16 the only approach and that anything  17 contrary to that is harmful. And that is  18 explicitly stated by a number of the  19 political advocacy groups that if anyone  20 presents anything other than a book like  21 I Am Jazz, for example, if one presented  22 to a preschool child a book that  23 presented human sexuality contrary to  24 that as presented in I Am Jazz that that  25 would be labeled as problematic. And that</p>

<p style="text-align: right;">Page 202</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 is of high concern to be able to engage  3 in the proper dialogue related to this  4 very complex question.  5 Q. Do you think presenting  6 children with books that include same-sex  7 couples actively encourages gay identity?  8 MS. LAND: Objection to form  9 relevancy and scope.  10 A. Well, okay, so are you asking  11 this in terms of the association between  12 the desisting patients and same-sex  13 attraction as it's relevant to this case?  14 Q. No. I'm asking generally about  15 how children's books actively encourage  16 things.  17 So I'm trying to understand if  18 you believe that presenting a child with  19 a book that includes same-sex parent  20 family actively encourages gay identity?  21 MS. LAND: Objection to form,  22 relevancy and scope.  23 A. I would draw you back to my  24 response to the prior question and use  25 the exact same understanding, the context</p>	<p style="text-align: right;">Page 204</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 information at an age-appropriate level  3 to allow them to integrate that  4 information at a time of their life where  5 previously they had not had that exposure  6 in -- historically those types of  7 questions did not come up in, you know,  8 the sexualization of prepubertal children  9 was not a topic that needed to be even  10 addressed in a hypothetical manner as  11 you're proposing right now. It is the  12 many cultural shifts that have occurred  13 that have necessitated that discussion.  14 Q. So portraying a children with  15 same-sex couple parents can be  16 inappropriate for a child?  17 MS. LAND: Objection to form,  18 asked and answered.  19 A. I will refer you to my answer  20 to the question on transgender identity  21 and the response is the same.  22 Q. So what age is too young to  23 see a same-sex couple families in books?  24 A. That question cannot be  25 answered because --</p>
<p style="text-align: right;">Page 203</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 of which that literature is being  3 presented to that child and I think the  4 answer would be the same.  5 Q. So assuming that the child  6 also has many examples of books with  7 different-sex parents and this being one  8 example of the book with same-sex  9 parents, is that actively encouraging a  10 gay identity?  11 MS. LAND: Objection to form,  12 asked and answered.  13 A. The situation you're  14 presenting is quite broad and there are  15 situations where those types of materials  16 are not appropriate to be presented to a  17 child of any perspective, and situations  18 where it might be relevant, depending on  19 the age at which it's presented, the  20 context it is, the involvement of the  21 parents in that discussion. And I think  22 that children, as a whole, are being  23 bombarded by very strong ideological  24 messages through social media and to be  25 able to have reliable sources of</p>	<p style="text-align: right;">Page 205</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Objection to form.  3 A. -- it's a hypothetical  4 question that -- it's far too broad for  5 me to be able to opine on.  6 Q. Do you believe that presenting  7 a same-sex couple family -- do you  8 believe that portraying a same-sex couple  9 family is sexualizing information for a  10 child?  11 MS. LAND: Objection to the  12 form of that question and scope.  13 A. To understand the basis for  14 your question, and I'm getting a little  15 bit lost in your line of questioning as  16 relates to this bill and the topic of  17 gender dysphoria, unless you are asking  18 this question in relation to the  19 association of sexual orientation and  20 gender identity but, again, these  21 questions are being asked in a manner  22 that does not adequately allow one to  23 assess the context by which these  24 conversations or the material is being  25 presented to a child. And to be able to</p>

<p style="text-align: right;">Page 206</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 make a blanket statement without  3 considering the circumstances is not  4 possible.  5 Q. So we mentioned a few times  6 about the -- what your view of the  7 evidence supporting the banned  8 interventions under the Arkansas law is.  9 I just want to ask you a few questions  10 about that.  11 Are there other treatments  12 that you provide that are supported by  13 only low or very low quality evidence as  14 defined by the GRADE system?  15 A. I think that the availability  16 of low quality evidence is not unique to  17 the field of gender medicine. What is  18 unique about the field of gender medicine  19 is the confidence that's asserted about  20 proceeding with this form of intervention  21 in light of that uncertainty and without  22 efforts to answer the questions and  23 elevate the quality of that science and,  24 in fact, a desire to prevent one from  25 actually engaging in those studies.</p>	<p style="text-align: right;">Page 208</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. It would be much easier to  3 give me an example and have me opine on  4 that. But if you look through the use of  5 the GRADE system there -- for example, as  6 a pediatric endocrinologist we have  7 many -- in the treatment of diabetes we  8 have treatment approaches that are being  9 proposed based upon limited evidence and  10 usually when we engage with -- when we  11 look specifically at the degree of  12 evidence that we have, that we proceed  13 with caution, that we don't -- that we  14 design the appropriate clinical studies,  15 that we consider this in terms of  16 alternative approaches, and all of these  17 things are generally unique.  18 Q. So taking the diabetes  19 example, when, you know, there are  20 treatments that are supported by only low  21 quality evidence and prescribing them is  22 something that is done routinely; is that  23 right?  24 A. Not -- not in the way that  25 we're talking about. So, again, it</p>
<p style="text-align: right;">Page 207</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 So it's not the fact that we  3 don't have other situations, there are  4 many areas of medicine where we have  5 uncertainty, where we are making  6 recommendations based on low quality  7 evidence. There is ample historical  8 evidence for guidelines that have been  9 put forward by that type of evidence that  10 later had been proven to be completely  11 wrong and the guidelines are completely  12 reversed.  13 So it's not the fact that  14 there is low quality evidence, it's the  15 strength of the assertion that this is  16 the preferred and only approach to  17 proceed to not adequately inform patients  18 about the low quality evidence. All of  19 those factors I think are in many  20 respects unique to the field of gender  21 medicine.  22 Q. Can you give me examples of  23 other treatment that is supported by low  24 quality evidence that you prescribe?  25 MS. LAND: Objection, form.</p>	<p style="text-align: right;">Page 209</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 influences the recommendations that are  3 being made and the relative risks and  4 benefits of intervention. If we have a  5 low quality study that advocates, you  6 know, a particular diet, that's vastly  7 different than a recommendation that  8 company potentially sterilize a child.  9 Again, there are many factors  10 that influence the ability to make  11 recommendations based upon low quality  12 evidence. But the higher the risk the  13 greater the bar is to be able to engage  14 in that practice.  15 And I would say, in  16 particular, in relating to the  17 affirmative approach, when you have an  18 intervention that has the likely outcome  19 of impairing or completely abolishing  20 fertility in a child that hasn't the  21 capacity to understand what they're going  22 through and giving up without proper  23 evidence has a much higher bar in being  24 able to say that this is a prudent  25 approach, than many of the other examples</p>

<p style="text-align: right;">Page 210</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 by which guidelines are put forward with  3 lower quality evidence, with not the same  4 degree of risk that is being put forward.  5 Q. Do you ever make treatment  6 recommendations based on low quality  7 evidence?  8 MS. LAND: Objection to form,  9 asked and answered.  10 A. As I said, that all  11 recommendations that are made for  12 patients are based upon a discussion of  13 relative risks and benefits. And where  14 there is low quality evidence the patient  15 needs to know that, and they need to know  16 about alternatives that are possible as  17 well.  18 Again, that's unique in the  19 gender field that alternative approaches  20 are not presented to patients as -- in  21 the proper context based upon the level  22 of evidence that's available.  23 Q. But I'm not asking about the  24 gender field. I'm asking you in your  25 practice, after advising patients of the</p>	<p style="text-align: right;">Page 212</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Objection to form,  3 asked and answered.  4 A. In situations where the  5 relative risk is minor and the potential  6 benefit is substantial, that I have made  7 recommendations based upon low quality  8 evidence.  9 That is not -- so but -- but  10 in a general sense, independent of gender  11 dysphoria, if there is high risk,  12 uncertain benefit and low quality  13 evidence, I will not recommend that.  14 Q. Do you use puberty blockers to  15 treat precocious puberty in your  16 practice?  17 A. Yes.  18 Q. And do you believe that  19 puberty blockers are safe to treat  20 precocious puberty?  21 A. It depends what you mean by  22 "safe". But the treatment of precocious  23 puberty is intended to restore an  24 individual to the state that they would  25 normally have in the absence of the</p>
<p style="text-align: right;">Page 211</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 relative risks and benefits, do you ever  3 make treatment recommendations based on  4 low quality evidence?  5 MS. LAND: Objection to form,  6 asked and answered.  7 A. I cannot remember a situation  8 with -- that has that degree of risk of  9 inducing, you know, permanent sterility,  10 lifelong osteopenia, with persistent  11 suicidal ideation markedly above the  12 background population where I've  13 advocated for a treatment based on low  14 quality evidence.  15 Q. That wasn't my question. My  16 question wasn't anything related to any  17 specific risk, just based on in your  18 practice, not the gender field that you  19 don't practice in, as you said.  20 So based on your practice,  21 after advising your patients of the  22 relative risks and benefit, and I don't  23 want to know what they are, have you ever  24 made treatment recommendations based on  25 low quality evidence?</p>	<p style="text-align: right;">Page 213</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 condition of central precocious puberty.  3 Q. Are there randomized  4 controlled studies evaluating the  5 long-term use of puberty blockers to  6 treat precocious puberty?  7 A. So, again, broad question. We  8 can talk about specific aspects of the  9 scientific literature that's available  10 for the treatment of precocious puberty,  11 which includes studies about the efficacy  12 in suppressing the gonadal -- pituitary  13 gonadal access, the affects on height,  14 bone age advancement, bone density,  15 metabolic risks and all these other  16 aspects.  17 Again, it's a different story  18 to be able to propose an intervention  19 that restores somebody to the state that  20 they would normally have than to induce a  21 pathologic state that would not normally  22 be present.  23 So in the area of the use of  24 GnRH agonists or puberty blockers to  25 treat central precocious puberty, there</p>

54 (Pages 210 - 213)

<p style="text-align: right;">Page 214</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 is data, that is not necessarily  3 randomized controlled, there are cohort  4 studies that have been done for those  5 that have received GnRH agonists and  6 those that have not on their final  7 height, their age of menarche, and other  8 factors, that drive the prescribing of  9 this class of medication for that  10 purpose.  11 And so, again, this is a great  12 example of your earlier question about  13 relative risk and benefit in applying  14 that to the case of central precocious  15 puberty, where the calculation of  16 relative risk and benefit is vastly  17 different than, for example, doing that  18 same intervention to suppress normal  19 timed puberty.  20 Q. Are there long-term cohort  21 studies evaluating the safety for puberty  22 blockers to treat central precocious  23 puberty?  24 A. The best studies I'm aware of  25 address the question -- so the indication</p>	<p style="text-align: right;">Page 216</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 side-effects.  3 So yes, I would say there are  4 a number of studies that have followed  5 patients long-term, again, for the  6 specific outcome measures that are  7 relevant in treating that condition.  8 Q. Do any of these studies follow  9 these patients into middle or old age to  10 assess bone health?  11 A. I believe there are a few. Let  12 me say, to put it in proper context why  13 bone density issues are quite important,  14 is that there are many people that try to  15 extend the use of a puberty blockade in  16 patients that had precocious puberty  17 longer than is currently recommended for  18 a desire to maximize height. And many  19 oftentimes that was in patients that were  20 diagnosed later with more advanced bone  21 ages.  22 It's well documented that peak  23 bone mineral density is achieved during  24 the adolescent years, into the early 20s.  25 That is the only time in life where you</p>
<p style="text-align: right;">Page 215</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 -- so let me backup.  3 The indications for  4 prescribing puberty blockers in central  5 precocious puberty is both to preserve a  6 final height and to allow an individual  7 to experience puberty at a time that  8 their psychological development is  9 appropriate to be able to navigate the  10 changes of biological puberty and those  11 outcomes have been measured to the point  12 of following children to a final adult  13 height and to be able to follow those  14 children as far as their psychological  15 functioning to the age where puberty is  16 allowed to progress in concert with their  17 peers.  18 There is also data available  19 for the extension of puberty blockers  20 beyond the normal age of puberty for a  21 desire to even further maximize height,  22 for example, studies showing that when  23 you delay puberty beyond the normal time  24 of initiation, that you have adverse  25 effects on bone density and other</p>	<p style="text-align: right;">Page 217</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 have the opportunity to achieve maximal  3 bone density. And those that have low  4 bone density moving at that phase of life  5 are at markedly elevated risk of  6 osteoporosis later in life.  7 Those long-term studies are  8 available. It is the basis for why the  9 recommendations are very specific as far  10 as how long to continue that duration of  11 intervention.  12 Q. Can pubertal suppression  13 impair fertility?  14 A. It depends. So there is no  15 evidence that if you treat central  16 precocious puberty with a GnRH agonist  17 it's going to impair long-term fertility.  18 It's a difficult calculus when  19 you disrupt normally timed puberty and,  20 generally speaking, the reversibility  21 occurs in the reengagement of the  22 pituitary gonadal axis following  23 cessation of that therapy no matter what  24 time one intervenes.  25 The concern are primarily for</p>

<p style="text-align: right;">Page 218</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 those individuals that go from puberty  3 blockers to cross-sex hormones. And in  4 that situation you have not allowed the  5 gonads to fully mature and then you  6 expose them to hormones that they are not  7 designed to see, the gonad, and the  8 expected effect of that is to induce  9 infertility and in many cases lifelong  10 sterility. And that is an expected  11 effect.  12 In fact, what I'm aware of in  13 the consent form process that is one area  14 that is explicitly addressed. It has been  15 addressed in a number of publications  16 with that concern to propose efforts to  17 artificially preserve fertility in the  18 situation where it's been intentionally  19 disrupted. So I think that the context of  20 when these drugs are given and it relates  21 specifically to the effects of the sex  22 steroid hormones in the context of the  23 sexual maturity of the developing gonad.  24 Q. But so does the pubertal  25 blockade on its own, without the</p>	<p style="text-align: right;">Page 220</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. But that wasn't my question,  3 because there are some that don't, even  4 under your theory.  5 So my question is, for those  6 -- so are you aware of any evidence that  7 would suggest that pubertal suppression  8 on its own, without the subsequent  9 administration of cross-sex hormones,  10 impairs fertility?  11 MS. LAND: Objection to form,  12 asked and answered.  13 A. I don't think we have  14 sufficient evidence to definitively  15 answer that.  16 There are many people that  17 have expressed concerns about whether  18 there may be effects. But I would say  19 that in the setting of GnRH agonists  20 alone, given at the time of normal  21 puberty, has pleiotropic effects. There  22 are many different things that are  23 influenced. And one of the concerns  24 that, it's not been established, but  25 there are concerns that there may be</p>
<p style="text-align: right;">Page 219</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 subsequent administration of cross-sex  3 hormone, cannot cause -- does that impair  4 fertility?  5 MS. LAND: Objection to form.  6 Q. The pubertal blockade on its  7 own, without the subsequent  8 administration of cross-sex hormones,  9 does that impair fertility?  10 A. You have stated that in a very  11 definitive way and I would not state it  12 in that way. I think we do not know.  13 Q. Are you currently aware of any  14 evidence suggesting that pubertal  15 suppression without subsequent  16 administration of cross-sex hormones  17 impairs fertility?  18 MS. LAND: Objection to the  19 form asked and answered.  20 A. I am aware of the studies that  21 98 to 100% of the individuals that get --  22 that get pubertal blockade go onto  23 cross-sex hormones, so that your  24 hypothetical situation is not the reality  25 of what's going on.</p>	<p style="text-align: right;">Page 221</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 effects but it's -- it would -- I don't  3 think there's evidence to say that it is  4 guaranteed to lead to a permanent  5 sterility. These drugs have been used in  6 postpubertal individuals in the treatment  7 of cancers, prostate cancer and breast  8 cancer, for example, where the gonads  9 have already been allowed to fully mature  10 and we've been able to shut down the  11 normal signalling from the pituitary  12 gland to the gonads. And we know in  13 that situation that when you stop the  14 pubertal blocker that the function will  15 occur.  16 The question, and the reason I  17 cannot answer it in the definitive manner  18 that you propose, is that when you are  19 engaging in administering this medication  20 in an adolescent who is going through  21 biological puberty, there are many  22 factors about the timing, when it is  23 introduced, the duration for which it is  24 introduced and the other interventions  25 that are occurring concomitantly with</p>

<p style="text-align: right;">Page 222</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that. And there have been no properly  3 controlled trials to definitively or  4 even, you know, in a reliable manner  5 provide causative treatment outcome  6 conclusions to be made.  7 Q. Do oral contraceptives have  8 risks?  9 A. You're talking synthetic  10 estrogen and progesterones that are used  11 to disrupt the normal feedback regulatory  12 mechanism of the ovary and pituitary  13 gland?  14 Q. Yes.  15 A. Yes, they do have effects.  16 Q. And do they have risks?  17 A. Yes, they do.  18 Q. And are the risks -- do oral  19 contraceptives have -- excuse me. What  20 are the risks?  21 A. There are risks of blood  22 clots, blood pressure, metabolic effects  23 and cancer risks. The cancer risk is a  24 mixed bag. Some of them are actually  25 beneficial and some are adverse. There</p>	<p style="text-align: right;">Page 224</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that sexed individual vastly exceed what  3 would physiologically be achieved, often  4 reaching concentrations that we would see  5 in endocrine secreting tumors. And there  6 are very significant consequences, some  7 of which are known, many of them that  8 which are not known in that practice. So  9 they are not the same thing.  10 Q. So the types of blood clots  11 that are a risk in the context of oral  12 contraceptives are the not the same type  13 of blood clots that you identify as a  14 risk in treating gender dysphoria with  15 estrogen?  16 A. Do you mean the same type of  17 risk as far as being -- they're both  18 related to thromboembolic stroke, but the  19 risk of exposure to that hormone is not  20 the same when given to a male versus  21 given to a female. The net effect of  22 leading to thrombosis that could lead to  23 stroke, that could lead to neurological  24 impairment or death is real, but the  25 incidence of that occurring is directly</p>
<p style="text-align: right;">Page 223</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 are very well-documented risks associated  3 with the use of synthetic estrogen and  4 progesterone to regulate ovarian  5 function.  6 Q. And are these some of the same  7 risks you describe in the use of estrogen  8 to treat gender dysphoria?  9 A. No.  10 Q. Why not?  11 A. Because when you're treating  12 gender dysphoria you are giving sex  13 hormones to -- so giving estrogen to a  14 male is not the same thing to giving  15 estrogen to a female. Giving testosterone  16 to a female is not the same thing as  17 giving it to a male. There's -- there is  18 very well-established sex-based  19 differences in every cell of the body due  20 to the differing epigenetics, leading to  21 differential genetic expression that  22 leads to different consequences of that  23 steroid exposure. In the cross-sex  24 hormone administration you are achieving  25 levels of the sex hormone levels that in</p>	<p style="text-align: right;">Page 225</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 related to the mechanism by which those  3 drugs are acting within the sexed nature  4 of the human being due to, again, these  5 epigenetic difference.  6 Q. Can I ask you to go back and  7 open Exhibit 3? This is The Use of  8 Cross-Sex Steroids in the Treatment of  9 Gender Dysphoria. Do you see that up?  10 A. I do have that up.  11 Q. Just to reconfirm, this was  12 published by the National Catholic  13 Bioethics Quarterly?  14 A. That is the journal where it  15 was published, correct.  16 Q. Okay. I am going to ask you to  17 know open what has been marked as Exhibit  18 6.  19 (Exhibit Hruz 6, National  20 Catholic Bioethics Quarterly  21 Submission Guidelines, was received  22 and marked on this date for  23 identification.)  24 A. I do have it up now.  25 Q. Have you seen this before?</p>

<p style="text-align: right;">Page 226</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I seem to recall that it was  3 brought to my attention at a prior  4 deposition.  5 Q. So you have seen it?  6 A. My recollection, yes.  7 Q. And these are the submission  8 guidelines for the National Catholic  9 Bioethics Quarterly, which is where your  10 article, The Use of Cross-Sex Steroids  11 was published; is that correct?  12 A. The paper was published in the  13 NCBC Quarterly; that's correct.  14 Q. And just reading from the top,  15 this says that, "The National Catholic  16 Bioethics Quarterly is the official  17 journal of the National Catholic  18 Bioethics Center, an organization  19 dedicated to research and the analysis of  20 moral issues arising in healthcare and  21 the life sciences. The NCBQ seeks to  22 foster intellectual inquiry on moral  23 issues by publishing articles that  24 address the ethical, philosophical,  25 theological and clinical questions raised</p>	<p style="text-align: right;">Page 228</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. What does it mean to be  3 "consonant with the magisterium of the  4 Catholic Church?"  5 MS. LAND: Object to form.  6 A. Again, I want to be clear in  7 serving as an expert in this case that I  8 am a physician-scientist and pediatric  9 endocrinologist, not a theologian. But  10 what it means is that there are teachings  11 of the church that -- that the teaching  12 authority of the church put forward.  13 Q. Is your article consonant with  14 the magisterium of the Catholic church?  15 MS. LAND: Object to form.  16 A. Again, I'm not opining as a  17 theologian. I have no reason to doubt  18 that it is. But even if it were not,  19 based upon the paragraph that you read  20 and the publication criteria, it would  21 have still allowed it to be for  22 publication in this journal.  23 Q. Going back to your article,  24 which is marked as Exhibit 3, and this is  25 in abstract. So I'm reading from the</p>
<p style="text-align: right;">Page 227</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 by the rapid pace of modern medical and  3 technological progress inspired by the  4 harmony of faith and reason. The NCBQ  5 unites faith in Christ to reasoned and  6 rigorous reflection on the findings of  7 empirical and experimental sciences.  8 While the NCBQ is committed to publishing  9 material that is consonant with the  10 magisterium of the Catholic Church, it  11 remains open to other faiths and secular  12 viewpoints in the spirit of informed  13 dialogue." Did I read that correctly?  14 A. You indeed read that  15 correctly.  16 Q. Were you aware of this mission  17 of the journal when you submitted your  18 article for publication there?  19 A. I don't recall specifically  20 reading the paragraph that you just read,  21 but it was my understanding that this was  22 an ethics journal, that this was an  23 appropriate venue to write the paper that  24 I submitted for publication to that  25 journal.</p>	<p style="text-align: right;">Page 229</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 middle, "From an ethical perspective,  3 this practice administering" -- then this  4 part is not quoted but referring back to  5 administering cross-sex hormones to treat  6 gender dysphoria -- "distorts a proper  7 view of human nature and violates bodily  8 integrity by directly inducing sterility.  9 The use of exogenous cross-sex hormones  10 reenforces rather than alleviates  11 underlying psychiatric dysfunction while  12 significantly increasing the risk of  13 other medical morbidities." Did I read  14 that correctly?  15 A. Yes, you've read that  16 correctly.  17 Q. Can you explain to me what you  18 mean by "this practice distorts a proper  19 view of human nature?"  20 A. I'd be happy to very much  21 explain the context of the statement.  22 This relates to many of the  23 errors that are put forward in describing  24 human sexuality for the purposes of an  25 ideological agenda.</p>

<p style="text-align: right;">Page 230</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 As a physician-scientist one  3 recognizes sex as inherently directed  4 toward the biological process of  5 reproduction, and that is certainly true  6 in humans. And that the assertions  7 ideologically that are made that try to  8 distort that basic -- it can be viewed at  9 multiple levels, some of which might fall  10 into the area of theology or philosophy,  11 but my expertise as a physician-  12 scientist, it even violates the basic  13 understanding of what we mean by sex at  14 the level of what its inherent purpose  15 is.  16 In the ethical or  17 philosophical tradition the term telos is  18 often used to refer to what is the end or  19 purpose of a particular trait and that  20 the statement that is made in this paper  21 is to convey that by many of the  22 ideological assertions that are made  23 people are ignoring the basic fundamental  24 reality of the purpose of sexuality in  25 relation to human reproduction.</p>	<p style="text-align: right;">Page 232</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 question of potential, you know, good  3 versus harm and then does put it within  4 the context of what we know about the  5 human person at multiple levels.  6 My focus is primarily on the  7 biology, but a reader of this journal  8 article may come from a different  9 perspective and gain additional insight  10 into that important -- the contribution  11 that I tried to make in this article.  12 Q. And does medical ethics,  13 generally speaking, have a position on  14 the proper view of human nature?  15 A. Your question is quite broad.  16 I would say there are -- again, we think  17 about the way medicine is conducted or  18 science is performed, that there are  19 varying premises that are put forward,  20 and the merits of those premises are not  21 equal, but we all begin with underlying  22 premises, and that includes understanding  23 of questions of anthropology. It is the  24 basis for which various hypotheses can be  25 generated, and it can serve as a</p>
<p style="text-align: right;">Page 231</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. What do you mean by "from an  3 ethical perspective" in this context?  4 A. Ethics, again, is directed  5 quite broadly about doing good and  6 avoiding harm. And there is a danger in  7 distorting that fundamental understanding  8 of the human person if one does not  9 understand that reproductive purpose.  10 So that, when we talk about  11 ethics, this is something that's not  12 unique, you know, to the discussion of  13 the NCBC. There are ethics boards that  14 are present in all hospitals, there are  15 ethical issues that arise from time to  16 time based upon varied complicated  17 situations making decisions about how to  18 best act. It's always directed at trying  19 to promote the good and preventing harm,  20 and that is the purpose of when we think  21 about the field of ethics, and I think  22 it's vitally important to recognize that.  23 That is why this particular  24 paper was appropriate for an ethics  25 journal because it addresses this</p>	<p style="text-align: right;">Page 233</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 framework by which one designs and  3 conducts research studies to, again,  4 achieve the long-term goal to provide  5 good and avoid harm.  6 Q. Do you think having a gender  7 identity different from one's biological  8 sex violates a proper view of human  9 nature?  10 MS. LAND: Objection to form.  11 A. The statement in this article  12 is related to the assertion that sex has  13 nothing to do with reproduction. And that  14 is what the ideology is putting forward.  15 And many of the hypotheses that are  16 putting forward, or I should say even  17 more fundamental to that, the scientific  18 premises that are at play in those that  19 make hypotheses related to this area very  20 frequently distort that understanding of  21 the human person, they distort the nature  22 of sex in that reproductive goal.  23 VIDEOGRAPHER: This is the  24 videographer. Some time within the  25 next ten minutes we need to take a</p>

<p style="text-align: right;">Page 234</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 media break.  3 MR. STRANGIO: Okay. Just I'll  4 go another five, if that's okay.  5 Q. Do you think being transgender  6 violates a proper view of human nature?  7 MS. LAND: Object to form.  8 A. You're saying being  9 transgender? Are you referring to having  10 the experience of a sex-discordant gender  11 identity?  12 Q. Is that how you understand  13 being transgender?  14 A. I -- I would say that people  15 experience a transgender -- a gender  16 identity that is discordant with their  17 sex and that is ethically and morally  18 neutral, as far as the experience they  19 have.  20 Q. Is sexual activity between  21 same-sex couples consistent with the  22 proper view of human nature?  23 MS. LAND: Objection to form,  24 relevance and scope.  25 A. So speaking with my expertise</p>	<p style="text-align: right;">Page 236</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 nature?  3 MS. LAND: Objection to form.  4 A. Again, are you asking --  5 again, my perspective as a  6 physician-scientist and thinking about  7 the biological purpose of sex, I would  8 say that if you look at the way the body  9 is designed from a sexual standpoint, the  10 sexual organs that are present, the  11 physical form of the body and the  12 physical activity that occurs in sexual  13 union, if you look at the interaction  14 between a male and a female, there is an  15 obvious relationship between that sexual  16 anatomy and the potential to generate new  17 human life. That is not true for other  18 types of interactions in which the sexual  19 organs are engaged in a manner that has  20 -- does not have that reproductive  21 potential.  22 Q. Does that mean that yes,  23 same-sex relationships do violate a  24 proper view of human nature?  25 MS. LAND: Objection, asked</p>
<p style="text-align: right;">Page 235</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 as a physician-scientist and pediatric  3 endocrinologist, with the goal of  4 treating endocrinologic diseases, if one  5 maintains the biological purpose of sex,  6 the purpose of reproduction will not  7 occur with a same-sex union.  8 Q. And what about non-procreative  9 sex, generally?  10 MS. LAND: Objection to form,  11 relevance and scope.  12 A. I guess, what are you asking?  13 Q. Does that violate a proper  14 view of human nature, having  15 non-procreative sex?  16 A. I would say that there are  17 many sexual acts that occur, not every  18 single sexual encounter leads to the  19 production of new human life. So it has  20 to be that -- that question has to be  21 understood in the context of the  22 underlying understanding of human  23 sexuality.  24 Q. Does same-sex relationships  25 generally violate a proper view of human</p>	<p style="text-align: right;">Page 237</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 and answered.  3 A. So you're asking about -- so  4 human nature and we're talking  5 specifically I assume about sexuality,  6 correct?  7 Q. As you use it in your article  8 is what I'm talking about.  9 A. And in my article I'm talking  10 about the understanding of sexuality,  11 human sexuality for its reproductive  12 purpose, which is well established in  13 science and it's not just unique to  14 humans, it's across the animal kingdom,  15 where there are distinct definitions of  16 what constitutes as male and female in  17 participation in that reproductive  18 process.  19 In that context that if one  20 understands that that biological purpose,  21 as far as the nature of the human being,  22 that is very evident, that the  23 interaction of a male with a female is  24 vastly different than the interaction of  25 two males or two females.</p>

<p style="text-align: right;">Page 238</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MR. STRANGIO: I think we can  3 stop here for the videographer and  4 take a five minute break. Let's go  5 off the record.  6 VIDEOGRAPHER: This will end  7 media part 3 and we are off the  8 record at 1:47 p.m.  9 (Recess is taken.)  10 VIDEOGRAPHER: We are back on  11 the record at 1:59 p.m. This will  12 begin media part 4. Please proceed.  13 Q. So in the passage that we were  14 last discussing you wrote, "The use of  15 exogenous cross-sex hormones reinforces  16 rather than alleviates underlying  17 psychiatric dysfunction." What is your  18 basis for saying that?  19 A. I would draw your attention to  20 the existing literature. For example,  21 the paper by Steensma, looking at the  22 effects of pubertal blockade and  23 progression under cross-sex hormones, the  24 evidence that is evolving right now that  25 the changing demographics of people,</p>	<p style="text-align: right;">Page 240</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 difficulties that these patients  3 experience.  4 Q. But it's your view that it  5 reinforces underlying psychiatric  6 dysfunction?  7 A. My opinion is that there is  8 evidence here that leads them to proceed  9 on to later interventions. And that is  10 borne out by the studies that are coming  11 out right now of those that are going --  12 proceeding on to later stage  13 interventions, once they've been  14 affirmed, beginning with the puberty  15 blockade and then proceeding onto  16 cross-sex hormones.  17 Q. Are there any studies besides  18 the Heil-Gorman study that you believe  19 show that hormone therapy has these  20 negative effects?  21 A. Certainly. I'll draw your  22 attention to the Bränström study that was  23 discussed at length within my  24 declaration. Again, this is a  25 population-based study that concluded</p>
<p style="text-align: right;">Page 239</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 again, it solidifies an understanding  3 rather than if we think, go back to those  4 three approaches that we discussed  5 earlier, that it puts forward a path for  6 many individuals that makes it very  7 difficult for them to have other outcomes  8 once this is engaged upon.  9 Q. So by psychiatric dysfunction  10 here you're referring to gender identity  11 sex discordance?  12 A. No. I'm talking about the  13 constellation of factors that affect the  14 wellbeing of these individuals and their  15 underlying suffering. If, for example, I  16 can address the Heil-Gorman paper that  17 looked at psychiatric medication use and  18 need for psychotherapy following gender  19 affirmation for cross-sex hormones  20 showing that there was no benefit in  21 reducing mental health needs.  22 So there is objective  23 information that suggests proceeding with  24 cross-sex hormones does not lead to  25 resolution of the underlying psychiatric</p>	<p style="text-align: right;">Page 241</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 even in the original publication that  3 cross-sex hormones provided no benefit  4 long-term in the psychological  5 functioning of these individuals.  6 It made a false claim  7 initially that surgeries had benefit, but  8 as a result of that paper being published  9 and multiple physician-scientists drawing  10 attention to the inaccuracies and  11 falsehoods in the way the data was  12 analyzed ultimately led to the conclusion  13 that neither cross-sex hormones or  14 gender-affirming surgeries improved the  15 psychological health of these individuals  16 and there are others as well.  17 Those are two studies I think  18 that I cited within my declaration. And  19 you can even draw upon the earlier study,  20 the PLoS ONE Swedish study of Dane, which  21 showed outcomes long-term in a patient  22 population-based sample. And we can talk  23 about that you'd like, about the data,  24 the limitations of that study. But there  25 is literature that clearly demonstrates a</p>

<p style="text-align: right;">Page 242</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 lack of benefit.  3 Q. Do you think a lack of benefit  4 is the same as making patients worse?  5 MS. LAND: Object to form.  6 A. So, again, you have to know  7 the evidence that we have because many --  8 most of the studies were not randomized  9 controlled studies. You can't -- and if  10 they're not controlled you can't assess  11 the intervention, itself, on the outcome.  12 You can only state that the outcome was  13 not improved.  14 This example in the Bränström  15 paper, when they actually did have the  16 information available of those that  17 received and those that did not receive  18 the gender-affirming affirmation there  19 was actually a worsening of the reported  20 effects. Now, it's not a completely  21 accurate, you know, presentation because  22 there could be factors of how they were  23 segregated into the two groups.  24 So I think there is evidence  25 that actually it increases, but certainly</p>	<p style="text-align: right;">Page 244</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 neutral or actually adverse.  3 Q. Can we turn back to your  4 paper, Exhibit 3, page 662, top of the  5 page, it's a sentence that begins "In  6 stark contrast."  7 A. Okay.  8 Q. The sentence, "In stark  9 contrast to Pope St. John Paul II's  10 teaching on the theology of the body  11 which illuminates teleological  12 complementarity between male and female  13 forms and an inseparable unity of body,  14 mind and soul it is now openly argued  15 that the mind alone can and in some  16 circumstances should determine or at  17 least influence reality in medical  18 practice." Did I read that right?  19 A. You did indeed read that  20 correctly.  21 Q. How does Pope John Paul  22 II's -- how Pope St. John Paul II's  23 teaching come into scientific analysis?  24 MS. LAND: Object to form.  25 A. Again, I will draw attention</p>
<p style="text-align: right;">Page 243</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 does not improve. You can see that  3 actually in the Turban paper as well from  4 Pediatrics in 2000 when the claim was  5 made, not by the author but by the media,  6 that the exposure to pubertal blockade  7 reduced suicide.  8 What that paper showed is that  9 lifetime suicidality was different,  10 ignoring the fact that it may have been  11 the basis by which a patient was offered  12 or not offered puberty blockers. But when  13 you looked in the actual raw data of that  14 paper you could see that recent, meaning  15 last year's suicidal attempts, were  16 actually higher in those that actually  17 received that gender-affirmation  18 treatment.  19 The nature of the way that  20 study was done only allowed for  21 associative data to be gained, it could  22 not give a causal relationship, it was  23 completely erroneous, and the claim said  24 that it was beneficial and, in fact, the  25 raw data suggests that it was either</p>	<p style="text-align: right;">Page 245</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to the fact that I am serving the court  3 in this case as a physician-scientist and  4 pediatric endocrinologist and not as a  5 philosopher or a theologian.  6 It's relevant to consider that  7 teaching in relation to our prior  8 conversation about the nature of human  9 sexuality in male and female forms.  10 What is put forward in that  11 teaching is the complementarity between  12 male and female forms and it can be  13 readily apparent to a casual bystander  14 that merely by looking at the appearance  15 of the human body, that there is a  16 complementarity for unity where the male  17 parts go in relation to the female parts.  18 And that is the relevant aspect that's  19 important about the statement in relation  20 to how we're engaging in medical  21 practice.  22 So that this addresses  23 directly the conversation that we had in  24 the previous line of questioning in our  25 last session, by which the failure to see</p>

<p style="text-align: right;">Page 246</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that the purpose of sexuality, the actual  3 form of the human body in relation to  4 that sexual act leads to distortions.  5 The argument being moving away from an  6 empiric observation of what we can see  7 from the biological form to assertions  8 that are made purely on ideological  9 grounds that what one believes determines  10 reality. And that as a  11 physician-scientist one needs to be aware  12 of that and to question the veracity of  13 that world view.  14 Q. Are these views about the  15 complementarity of male and female forms  16 medical opinions?  17 MS. LAND: Object to form.  18 A. I would say they're objective  19 biological facts.  20 Q. And are Pope St. John Paul  21 II's teachings recording complementarity  22 -- excuse me. Let me take that back.  23 Does Pope St. John Paul II's  24 teaching inform your treatment for  25 treatment of gender dysphoria?</p>	<p style="text-align: right;">Page 248</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 take into account biological reality, as  3 you've described it?  4 MS. LAND: Object to form.  5 A. If your question is; do we  6 need to operate medicine according to  7 reality? The answer is yes.  8 Q. I think if I'm looking exactly  9 at the transcript it's, "Would any  10 medically prudent approach to treatment  11 of gender dysphoria need to take into  12 account biological reality with respect  13 to male and female forms, as you've just  14 described it?"  15 MS. LAND: Object to form,  16 asked and answered.  17 A. Are you asking broadly about  18 any medical intervention or specifically  19 related to questions that impact human  20 sexuality?  21 Q. I'm asking specifically about  22 treatment for gender dysphoria. Let's be  23 more specific.  24 For example, would your  25 assessment of the treatment of gender</p>
<p style="text-align: right;">Page 247</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Object to form.  3 A. I will restate the important  4 aspects in relation to this question  5 about the most prudent approach to  6 addressing and alleviating suffering in  7 people that experience gender dysphoria  8 needs to be grounded in the biological  9 reality.  10 The teachings, themselves,  11 that go far beyond the biological  12 understanding are -- are -- can have  13 value for those that choose to explore  14 that in relation to philosophical and  15 theological dimensions. But I think  16 merely on the biological level it is  17 relevant to how we understand how this I  18 would say relativistic understanding that  19 is based not upon scientific fact, but  20 rather based on ideology, has allowed  21 these assertions, these ideological  22 assertions to have been made.  23 Q. And as you described it, would  24 any medically prudent approach to  25 treatment of gender dysphoria need to</p>	<p style="text-align: right;">Page 249</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dysphoria in the context of, say,  3 prescribing hormone therapy to an  4 adolescent biological male need to take  5 into account the biological reality of  6 male and female forms, as you've just  7 described them?  8 MS. LAND: Object to form.  9 A. I will go back to how I have  10 repeatedly described the way that  11 scientific investigation is conducted; to  12 begin with scientific premises that lead  13 to the generation of testable hypotheses  14 in the design and conduct of the research  15 study.  16 This is a question related to  17 scientific premise and I think it is  18 directly relevant to the merit of any  19 hypotheses that are put forward that will  20 lead to the conduct of the trials.  21 So I think it needs to be --  22 one needs at least to be aware that there  23 are different premises that are at play  24 and they can be competing premises. There  25 can be people that begin with a</p>

<p style="text-align: right;">Page 250</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 non-scientific ideological premise that  3 directs the generation of their  4 hypothesis. It doesn't mean it needs to  5 be rejected but it should be considered  6 in the context by which that hypothesis  7 is being put forward. And a hypothesis  8 that claims that you can have benefit in  9 altering the appearance of the human  10 body, based upon a premise that ignores  11 the biological reality, will have  12 consequences as to the merit of that  13 hypothesis, and the likelihood by which  14 one will be able to disprove the null  15 hypothesis as a scientific study is  16 conducted.  17 In my experience in working on  18 the NIH study section we often will  19 evaluate that because we don't want to  20 spend millions of dollars on a study that  21 shows an effect that was likely to not be  22 proven based upon a faulty premise.  23 Q. Okay. I may come back to that.  24 But for now I'm going to ask you, so is  25 the unity of body, mind and soul a</p>	<p style="text-align: right;">Page 252</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the ones that are able to understand and  3 incorporate that holistic view of the  4 human person in every encounter that they  5 have.  6 Q. And can we go to page 671 of  7 this same article?  8 A. Okay.  9 Q. And this is just under Future  10 Directions here. The second clause after  11 the comma but first sentence you write,  12 "It is clear that the use of cross-sex  13 hormones for the treatment of gender  14 dysphoria is immoral." Is that a medical  15 assessment?  16 MS. LAND: Object to form.  17 A. It is an ethical assessment  18 based upon the scientific evidence and  19 the medical aspects related to my  20 analysis of this question of the use of  21 this intervention.  22 Q. Is it a medical ethics  23 assessment?  24 MS. LAND: Object to form,  25 asked and answered.</p>
<p style="text-align: right;">Page 251</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 medical concept?  3 MS. LAND: Objection to form,  4 vague.  5 A. Well, I'd say your question is  6 fairly broad, but I think --  7 Q. I'm referring back to what you  8 wrote, which is that "inseparable unity  9 of body, mind and soul", is that a  10 medical concept?  11 A. So any practitioner is going  12 to approach their patient who's present  13 in their clinic and be able to look at  14 that person holistically, they need to  15 understand and respect their values, they  16 need to understand and address  17 psychological functioning, they need to  18 recognize and understand biological  19 variation. All those elements; body,  20 soul and unity are components by which  21 every single practitioner that engages in  22 medical practice, whether they're aware  23 of it or not, has to address, some more  24 effectively than others.  25 The best physicians I know are</p>	<p style="text-align: right;">Page 253</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. Again, you know, we don't  3 conduct medicine in a vacuum. We  4 always -- again, to reiterate, when we're  5 talking about ethics we're trying to  6 maximize good and avoid bad.  7 So the assessment of based  8 upon the analysis that was conducted as  9 the basis for this manuscript, the  10 conclusion that was made is that there is  11 a disproportionate harm in relation to  12 benefit. And that is how it is stated.  13 As far as whether you say moral or  14 ethical, that conclusion it's not  15 supported based on the evidence that's  16 available.  17 Q. Is it your view that it's  18 morally wrong to administer cross-sex  19 hormones to treat gender dysphoria  20 regardless of a patient's age?  21 MS. LAND: Object to form.  22 A. Again, I will say that if  23 we're going to adequately address the  24 question we need to see this in terms of  25 risk versus benefit, which changes</p>

<p style="text-align: right;">Page 254</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 throughout the lifetime. It is different  3 in any individual. It differs for a  4 variety of factors, that there are many  5 situations where the same intervention is  6 done for a particular purpose or a  7 differing purpose, so it's -- let me  8 phrase it this way, that when you are  9 assessing the ethics of any act there is  10 a component of it; what is the actual  11 nature of the act; what is the intention  12 of the act; and what is the circumstance  13 surrounding that act?  14 That is a basic fundamental  15 paradigm that people use in generating  16 ethical decisions that's used every day  17 in hospitals throughout the country on  18 ethics boards to try and make decisions  19 about complex cases. And so that to make  20 a definitive statement in any one  21 individual, without consideration of all  22 of those aspects of what is necessary for  23 making an ethical choice, it just  24 requires attention to all of those  25 components and the specifics. And the one</p>	<p style="text-align: right;">Page 256</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 we were reading, the next sentence  3 begins, "Nevertheless".  4 "Nevertheless, there remains a  5 need for ethically permissible  6 alternative interventions in attempting  7 to address this pressing knowledge  8 deficit. The limits of bodily  9 manipulation must be recognized and  10 upheld."  11 What did you mean by "the  12 limits of bodily manipulation must be  13 recognized and upheld?"  14 A. The statement about limits of  15 bodily limitation is to recognize the  16 consequence of the affirmative approach  17 and we've already addressed some of  18 those. I think the most pressing is the  19 effect on a lifelong fertility in these  20 individuals and, in particular, as we're  21 discussing care to adolescents, that the  22 induction of sterility in these patients  23 is not insignificant.  24 In fact, for the -- in the  25 ethical analysis it involves the lifetime</p>
<p style="text-align: right;">Page 255</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that's most problematic all the time are  3 the circumstances.  4 We can objectively look at the  5 nature of what is being done and the  6 intent of what's being done and then  7 there are many differing opinions and  8 factors that will influence that last  9 component.  10 Q. Is it your view, based on the  11 risks and benefits of hormone therapy,  12 that that would make -- let me withdraw  13 that.  14 Okay. So in your view, in some  15 circumstances providing hormone therapy  16 for adults with gender dysphoria is  17 ethical?  18 MS. LAND: Object to form.  19 A. I would say one needs to  20 consider all of those aspects of the  21 ethics to make that decision. And I would  22 think that it would be wrong to make a  23 definitive statement without first  24 considering all of those factors.  25 Q. Okay. And going back to where</p>	<p style="text-align: right;">Page 257</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 of the patient. And there's actually good  3 data that suggests or that shows that  4 when one is presented with a likelihood  5 of inducing lifelong sterility and you  6 offer artificial means to preserve  7 fertility in an adolescent, fewer than 5%  8 will accept that offer.  9 When you look at the  10 scientific studies as to in adults after  11 they've had full brain maturation and  12 psychosocial development and you ask  13 them; do you desire to have biological  14 children? Approximately 50% have a  15 strong desire to be able to have  16 biological children.  17 So the difference between less  18 than 5% and 50%, as far as desire for  19 children, highlights the important  20 consequence of bodily manipulation that  21 leads to permanent sterility. It's a very  22 relevant topic and very important in  23 assessing the ethics of this particular  24 intervention.  25 Q. Would you consider any medical</p>

<p style="text-align: right;">Page 258</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 intervention that could affect fertility  3 to be a bodily manipulation?  4 MS. LAND: Object to form.  5 A. So I would say yes, as far as  6 bodily manipulation. But I would not say  7 that it is inherently immoral or  8 unethical to do that.  9 In fact, in the very first  10 sentence of this conclusion paragraph, I  11 outline the ethical principles that could  12 potentially be used to justify that  13 disruption of bodily function, the  14 principles totality and double effect.  15 Q. In that same sentence you  16 refer to "ethically permissible  17 alternative interventions." What would  18 those be?  19 A. Well, again, I think that many  20 of the alternative hypotheses that have  21 been put forward to provide benefit for  22 these individuals that suffer from gender  23 dysphoria, many of which have not been  24 explored in the rigorous scientific  25 manner for which they deserve, could</p>	<p style="text-align: right;">Page 260</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 population. I've mentioned that, I  3 believe in my declaration, that many of  4 these patients experience significant  5 anxiety. Cognitive behavioral therapy  6 has been shown to be very effective in  7 alleviating anxiety. It's not been  8 rigorously studied in this patient  9 population in terms of how that might  10 influence outcomes in these patients.  11 So there's -- these are just  12 examples, but there are many more and  13 there are a multitude of alternative  14 hypotheses and treatment approaches that  15 could be pursued if one would accept that  16 the scientific basis for the  17 affirmation-only approach has not been  18 proven and has significant limitations  19 and one would engage in the proper  20 research to address all of these  21 alternative hypotheses.  22 Q. And are these alternative  23 hypotheses for minors or adults or both?  24 A. They could be for both. Again,  25 the merits of the hypotheses are going to</p>
<p style="text-align: right;">Page 259</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 potentially fall within the category of  3 ethically permissible. Again, as we talk  4 about ethics, we're trying to maximize  5 good and avoid bad for the affected  6 individuals --  7 Q. I just asked -- sorry to  8 interrupt but it was a simple question.  9 What are those alternative interventions  10 in your view?  11 A. Sorry. Thank you.  12 So, for example, they're not  13 exhaustive, but I would say primary  14 psychological approaches that would fall  15 under the other treatment paradigms,  16 whether that is reparative or watch and  17 wait, to address underlying psychological  18 distress, to be able to identify and  19 treat underlying depression, anxiety,  20 body dysmorphia, you know, things that  21 predated the onset of gender dysphoria  22 where that is present.  23 There are many modern  24 psychological approaches that have not  25 been adequately studied in this</p>	<p style="text-align: right;">Page 261</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 differ depending on the circumstance and  3 the group and all sorts of mitigating  4 factors but they certainly could apply to  5 both.  6 Q. And are they all just  7 hypotheses?  8 A. I would say that they're --  9 because they've not been rigorously  10 studied, until you do the studies they  11 remain hypotheses.  12 There is emerging evidence  13 that would support that. That is -- but,  14 again, as I said repeatedly, this is an  15 area of medical interventions that is  16 based upon very limited quality evidence,  17 so it's still experimental.  18 Q. And what is the emerging  19 evidence that you just referred to?  20 A. The emerging evidence related  21 to the lack of long-term benefit of the  22 affirmation approach.  23 Q. Do you have personal religious  24 views about gender transition?  25 MS. LAND: Object to form and</p>

<p style="text-align: right;">Page 262</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 relevance.  3 A. So you are asking what are the  4 bases of my scientific premises that I  5 use in formulating --  6 Q. No. I'm not asking about the  7 basis of your scientific premise. I'm  8 just asking about your personal religious  9 views.  10 A. I have religious views. I  11 think everyone does. If one does not,  12 they are ignoring reality.  13 Q. So what are your personal  14 religious views about gender transition?  15 MS. LAND: Objection to form,  16 relevance and scope.  17 A. I am a physician-scientist,  18 and I'm a pediatric endocrinologist. I  19 look at all of -- again, this gets back  20 to your question earlier about the  21 relationship between faith and reason.  22 And I have repeatedly stated in many  23 venues that there is no contradiction  24 between faith and reason. Yet my focus  25 is on science, which would fall in the</p>	<p style="text-align: right;">Page 264</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 in my entire life, in my professional  3 career, ever experienced that conflict  4 and I doubt very highly that that would  5 ever occur. But I, again, am a  6 physician-scientist and I follow the  7 facts where they lead.  8 Q. So I just -- since we're  9 allowed to ask -- sorry -- I just want to  10 ask again because you didn't answer the  11 question; do you have personal religious  12 views about gender transition separate  13 from what you explained about your  14 medical views?  15 MS. LAND: Objection to form,  16 asked and answered.  17 A. It doesn't occur in a vacuum.  18 So my religious views cannot be  19 disassociated from my scientific views.  20 But I've already answered your question  21 that I do have religious views.  22 Q. And what are they?  23 MS. LAND: Objection to form,  24 asked and answered.  25 A. They are in consonant from</p>
<p style="text-align: right;">Page 263</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 category of reason.  3 So that I don't see any  4 conflict between what I can know by  5 science versus what others can understand  6 on the basis of a faith understanding.  7 But they're not mutually exclusive and  8 everything that I have seen from a  9 rigorous attempt at unbiased assessment  10 of the scientific evidence is in concert  11 with those statements that are made in  12 nonscientific rounds related to theology  13 or philosophy.  14 Q. So let's say there were a  15 dozen studies, including randomized  16 trials that met the standards that you  17 believe for rigorous assessment and  18 institutional review board oversight that  19 demonstrated the effectiveness of  20 cross-sex hormone therapy to treat gender  21 dysphoria, would you support the  22 treatment even though it's still distorts  23 biological reality, as you describe it?  24 MS. LAND: Objection to form.  25 A. My understanding, I have never</p>	<p style="text-align: right;">Page 265</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 what I've learned from science that I  3 described in very much detail within my  4 declaration and throughout this  5 deposition.  6 Q. What are they with respect to  7 gender transition?  8 MS. LAND: Objection to form,  9 asked and answered.  10 A. I would say there is an  11 intrinsic teleologic relationship between  12 male and female for the purpose of  13 reproduction. That's a basic scientific  14 fact. It can also be understood from a  15 theological or philosophical perspective.  16 They are not in conflict with each other.  17 There are approaches to  18 medical care that seek to preserve the  19 integrity of the human person, and that  20 understanding of that teleologic  21 relationship again where the science that  22 I've seen thus far has been entirely in  23 concert with statements that are made  24 from a philosophical or theological  25 perspective.</p>

<p style="text-align: right;">Page 266</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 All of the things that I put  3 forward are not in contradiction, yet --  4 and thus, in no way have felt any  5 conflict in putting forward my scientific  6 understanding based upon the scientific  7 premises for hypotheses that any  8 physician-scientist would attempt to do  9 to address a very complex and important  10 problem.  11 Q. Okay. So are there any medical  12 treatments -- are there any  13 pharmacological treatments that you  14 support to treat adults with gender  15 dysphoria based on the current state of  16 the science?  17 MS. LAND: Objection, form.  18 A. Well, again, my perspective --  19 are you asking in my clinical experience  20 or in my research that I have done in the  21 medical literature?  22 I would say that the same  23 objections that I have for the quality of  24 the evidence. In fact, really the most  25 solid evidence that we have on long-term</p>	<p style="text-align: right;">Page 268</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 of engaging in medical interventions,  3 given the inability of children to give  4 informed consent, are certainly relevant.  5 Q. But generally speaking, your  6 concerns about the treatment are not  7 based on age alone?  8 A. That is correct.  9 Q. And if Arkansas had proposed a  10 law banning hormone treatment and  11 surgical treatment with gender dysphoria  12 in patients of any age, would you support  13 that?  14 MS. LAND: Objection to form  15 and scope.  16 A. Again I will reiterate that I  17 am serving this court as a  18 physician-scientist and pediatric  19 endocrinologist. I don't profess to be a  20 politician or a legislator and,  21 therefore, I leave to those that are.  22 However, I would say that they  23 are not the same situation when you  24 address the engagement of this  25 affirmation approach in adults versus</p>
<p style="text-align: right;">Page 267</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 outcomes actually apply to adults, not  3 children. We don't have the long-term  4 studies on the long-term effects of this  5 gender-affirming approach when it's  6 applied to children, and it is the basis  7 for the concern that when we look at the  8 adult population, that is where the  9 evidence suggests -- actually doesn't  10 suggest, it actually demonstrates that  11 there remains a very significant  12 morbidity. It's often quoted and I think  13 correctly from the Swedish study where  14 the completed suicide rate is 19.1 times  15 the background population. So I would  16 say that the same concerns that I have  17 apply to the adult population.  18 Now, where it differs is that  19 in context of the risks and the lack of  20 benefits, there are different factors as  21 far as -- and we do this all the time in  22 medicine -- as far as the ability to do  23 things in children versus in adults the  24 bar is always higher in conducting  25 research studies in children. The ethics</p>	<p style="text-align: right;">Page 269</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 children. And primarily it's based upon  3 completed psychosocial development in  4 adults, where it's still evolving in  5 children into the early 20s. And we  6 allow adults to do things that we don't  7 allow children to do.  8 For example, we allow knowing  9 the risks of smoking leading to lung  10 cancer is something that we recognize  11 occurs equally in children and adults. We  12 allow adults to buy cigarettes, we don't  13 allow children to buy cigarettes. It's a  14 distinction that we make in many other  15 areas. And even though I have concerns  16 about the relative risk and benefit and  17 the efficacy of that approach, it does  18 not mean those two populations, from a  19 legislative standpoint, would have the  20 same factors at play.  21 Q. And what is your understanding  22 of what social transition is?  23 A. Well, we've already addressed  24 many of those components. It includes  25 allowing an individual to use a desired</p>

<p style="text-align: right;">Page 270</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 name, pronouns, bathroom access, dress,  3 you know, in their interactions with  4 society.  5 Q. Do you think permitting social  6 transition is harmful in adolescents?  7 MS. LAND: Object to form and  8 scope.  9 A. So in the context of the three  10 different paradigms we need to consider  11 the relative merits of those different  12 approaches and I would say that social  13 affirmation is not a neutral  14 intervention.  15 Q. What is -- what do you think  16 about social transition? Do you think  17 social transition is harmful in  18 adolescents?  19 MS. LAND: Objection to form  20 and vague.  21 A. Looking at the scientific  22 evidence there are many concerns. And  23 this is -- if you look at the Endocrine  24 Society guidelines specifically for that  25 same concern, they caution against social</p>	<p style="text-align: right;">Page 272</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 hypotheses about how social affirmation  3 might influence the overall health  4 long-term and trajectory that they have?  5 I do have hypotheses based  6 upon the existing evidence that would  7 lead me to raise that hypothesis. Again,  8 it's not a neutral intervention and it  9 may influence the natural trajectory of  10 what is going forward.  11 Q. Your answer referred to the  12 Endocrine Society guidelines referenced  13 prepubertal children. I'm asking about  14 adolescents.  15 So do you have a hypothesis  16 that based on existing evidence that  17 social transition in adolescents is  18 harmful?  19 MS. LAND: Objection, form,  20 asked and answered.  21 A. I would extend the statement I  22 made about the Endocrine Society  23 guidelines and to extend that into the  24 adolescent period, that the social  25 affirmation is not a neutral intervention</p>
<p style="text-align: right;">Page 271</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 affirmation in prepubertal children for  3 the same reason that I have concerns  4 about whether it may alter the normal  5 trajectory. So I would say that it's not  6 a neutral intervention, and it needs to  7 be understood as such.  8 Q. So are you opposed to social  9 transition -- excuse me.  10 Do you believe that social  11 transition and not a neutral intervention  12 is harmful in adolescents?  13 MS. LAND: Objection, form,  14 asked and answered.  15 A. Well, again, you use the word  16 "believe" and as a physician-scientist I  17 tend to avoid that term. I look at; is  18 there evidence that actually, you know,  19 influences the potential outcome? That's  20 an objective which I do as a  21 physician-scientist rather than base  22 opinions on just, you know, gut beliefs.  23 If you are going to address it  24 from a scientific perspective, hypotheses  25 is the best way to phrase that; do I have</p>	<p style="text-align: right;">Page 273</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 and there are many questions that can be  3 asked about what the influence of that  4 is. And, again, if I'm going to be a  5 physician-scientist, just unlike many of  6 the ideologists that are engaged in this  7 field, who have a preconceived conclusion  8 and then look for evidence to support  9 that conclusion, I don't operate science  10 that way.  11 I look at the hypothesis and  12 try to find objective evidence to really  13 support or refute that hypothesis.  14 Q. Would you extend that to  15 adults?  16 A. One can -- so one can -- one  17 can extend the hypothesis to adults but,  18 as I stated previously, they are a  19 different population and there are  20 different factors. And to raise the  21 hypothesis in prepubertal versus  22 adolescent children to adults, that would  23 require three distinct hypotheses and I  24 would also venture, you know, three  25 different studies that would need to be</p>

<p style="text-align: right;">Page 274</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 done to be able to obtain a conclusion on  3 the effect.  4 Q. I'm going to ask you to go  5 back, we are going to upload another  6 exhibit. This I will mark as Exhibit 7.  7 (Exhibit Hruz 7, Amicus Brief  8 re: Nicholas Meriwether was  9 received and marked on this date  10 for identification.)  11 Q. Is it showing up for you?  12 A. This is the Sixth Circuit  13 Court of Appeals, Meriwether?  14 Q. Yes.  15 A. Okay.  16 Q. Are you familiar with the case  17 of Meriwether versus the Trustees of  18 Shawnee State University?  19 A. I'm trying to refresh my  20 memory on this. It's not immediately  21 coming to mind, so I'll have to scroll  22 through here.  23 Q. It's okay. You can scroll and  24 just so -- your name is listed on the  25 disclosure statement and then the table</p>	<p style="text-align: right;">Page 276</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 just trying to remember the context here.  3 Q. And would it help if I  4 reminded you that it involved a teacher  5 and the use of pronouns in a classroom?  6 A. Yes. That's very helpful for  7 me.  8 Q. Based on your recollection, do  9 you agree with what you submitted to the  10 court as amicus?  11 MS. LAND: Objection, form and  12 scope.  13 A. I'm going to have to read  14 through the entire document to refresh my  15 memory. I apologize for that, but it's  16 been a while and so much that has  17 happened since then.  18 Q. You don't need to read through  19 the whole document.  20 Would you agree, based on what  21 you've seen on the front page, that you  22 did, in fact, sign the brief?  23 MS. LAND: If we're going to  24 be asking questions about this  25 document he needs time to review</p>
<p style="text-align: right;">Page 275</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 of contents that follows that.  3 A. I think of this in my mind --  4 I'm trying to figure out find where the  5 date of this was to be able the place it  6 in the context of my research here.  7 Maybe it's at the very end.  8 Q. It was filed June 6, 2020. You  9 can see that at the top, the first page.  10 A. 2016?  11 Q. 2020.  12 A. 2020. Okay. I have it in front  13 of me.  14 Q. Do you recall joining this  15 amicus brief in support of the plaintiff,  16 Dr. Meriwether?  17 A. Again, I'm trying to remember.  18 I'm aware of several amici that I signed  19 onto. I'm just trying to place this one  20 here. So I'm just trying to -- I have a  21 number of things that I've been involved  22 with. But this -- what I'm reading  23 through, what I'm seeing through here  24 would be consistent with some of the  25 other amici that I have been in. So I'm</p>	<p style="text-align: right;">Page 277</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 it. He's not remembering it.  3 A. I believe that this is around  4 the time where I had about ten other  5 things going on. I just want to make sure  6 that I am remembering this correctly  7 before we get into specific questions  8 here.  9 I'm looking through the  10 document, and at least scrolling through  11 there, there's -- the statements that are  12 being made, generally speaking, are in  13 agreement with the things that I've  14 included in my declaration.  15 Q. Go ahead. Continue.  16 A. I'm just trying to -- I'm only  17 on page 26 right now and I'm not reading  18 the whole thing. I'm just trying to  19 scroll through here. I'm ready to  20 proceed.  21 Q. Okay. If I could ask you to  22 turn to page 23.  23 A. Page 3?  24 Q. Page 23, two-three. And it's  25 the paragraph just before the Roman V</p>

70 (Pages 274 - 277)

<p style="text-align: right;">Page 278</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 section. This paragraph reads, "This  3 ideological displacement of science leads  4 to the position evidently asserted by the  5 Complainant in this case, namely that  6 what he feels and thinks about himself  7 constitutes the truth about him, which  8 the University would force the entire  9 campus community to accept and to treat  10 as real. By so weaponizing Complainant's  11 solecism the University endangers the  12 integrity of scientific knowledge and  13 research." Do you still agree with that  14 general idea?  15 MS. LAND: Objection to form  16 and scope and relevance.  17 A. So, again, I wanted to be able  18 to read this in the context, but in  19 general, you know, speaking to what we've  20 already discussed, that I think it's  21 absolutely essential for one to  22 understand that when one is making an  23 argument in the area -- an ideological  24 statement that is contrary to science or  25 ignores science, that there are inherent</p>	<p style="text-align: right;">Page 280</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 in. And we're going to find long-term  3 likely that it is going to have  4 significant consequences.  5 Q. Do you think an adult person  6 who has a sex-discordant gender  7 identity's use of pronouns consistent  8 with their gender identity is ignoring  9 science?  10 MS. LAND: Objection. Object  11 to form.  12 A. You have to -- the statement  13 is being made in the context of what is  14 being asked.  15 So it is my recollection,  16 although I would have to read the  17 document in its entirety and be able to  18 place it within the context of the way  19 that the science is made, my  20 recollection, based upon a review very  21 superficially of a document that was  22 generated several years ago, is -- I  23 would agree with the statement that there  24 are dangers in forcing scientists to  25 operate on ideological principles without</p>
<p style="text-align: right;">Page 279</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 dangers in that.  3 It's something that I have  4 repeatedly addressed in other questions,  5 to see this displacement. And I think the  6 term "ideological displacement of  7 science" is an accurate way to describe  8 some of the corruption or distortion of  9 the natural scientific method that we  10 have long held as academicians and there  11 are definitely dangers associated with  12 that. And it's not only the fact that  13 one can hold a contrary opinion that is  14 not in concert with science, but there is  15 a growing requirement that those that  16 want to maintain the scientific basis of,  17 you know, looking at objective,  18 verifiable information, which is the  19 domain of science, to adopt these  20 ideological assumptions. And that's -- I  21 would say that that is a significant  22 danger. It extends far beyond the  23 question of gender dysphoria into the  24 conduct of all scientific investigations  25 and it's a general trend that is seeping</p>	<p style="text-align: right;">Page 281</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 reference to objective reality.  3 Q. Sorry. I was asking separate  4 and apart from this document entirely,  5 you had just previously stated a concern  6 about ignoring science.  7 So my question is generally,  8 for an adult person with a sex-discordant  9 gender identity, does it ignore science  10 for that person to use a pronoun  11 consistent with their gender identity?  12 MS. LAND: Objection, form.  13 A. Okay. If I'm understanding  14 your question correctly, you're asking  15 whether a scientist that is being  16 required to use preferred pronouns that  17 convey an understanding of human  18 sexuality, that is different than what  19 can be observed from the biological  20 nature of the person that presents in  21 front of them? Is that the question you  22 are asking?  23 Q. I'm not asking about anyone  24 being forced to do anything. I'm asking  25 just generally if the person with the</p>

<p style="text-align: right;">Page 282</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 sex-discordant gender identity themselves  3 uses pronouns consistent with their  4 gender identity, does that ignore  5 science?  6 MS. LAND: Objection, form,  7 vague.  8 A. You know, that -- the reasons  9 for why an individual may do that or not  10 is not something that I would be able to  11 judge in relation to this particular  12 amicus brief. It is in relation to  13 requiring somebody else to use those same  14 pronouns.  15 So what is going on here -- so  16 I have no way to judge the basis for  17 which another individual, from their own  18 personal standpoint, wants to use  19 whatever term they want to use.  20 Q. If a science professor  21 addresses a person with a sex-discordant  22 gender identity with their preferred  23 pronouns, are they ignoring science?  24 MS. LAND: Objection to form.  25 A. Again, I would use the same</p>	<p style="text-align: right;">Page 284</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. If a person asked -- if a  3 person with a sex-discordant gender  4 identity asked you to use their gender  5 identity preferred pronouns, would you do  6 it?  7 MS. LAND: Objection to form,  8 relevance and scope.  9 A. I can share with you my  10 experience that I've encountered in my  11 clinical practice where the circumstances  12 have arisen. And what I have discovered  13 that as a physician there are -- when I'm  14 confronted with a medical problem I often  15 need to generate a differential diagnosis  16 and effective treatment plan. That  17 necessitates one recognizing the sexed  18 nature of the individual that is  19 presenting for my care. And this is not  20 my opinion, this is well recognized by  21 our National Institute of Health. In  22 fact, the Endocrine Society as a whole  23 has put out a statement of recognizing  24 sex as a biological variable.  25 If one uses pronouns that</p>
<p style="text-align: right;">Page 283</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 response to the individual that I  3 previously answered in the last question.  4 The relevant question that I  5 am able to answer is if one were to  6 ask -- you know, I mean, I can only  7 explain it from my standpoint of what is  8 being conveyed by that.  9 There are many people that are  10 recognizing the ask to be able to use  11 preferred pronouns that do not accept  12 that that is conveying a reality of the  13 person that is requesting that pronoun  14 usage. Some will argue that -- that it  15 may be something that can be  16 compassionate for that individual. Some  17 will argue otherwise.  18 So I think, you know, the  19 question is fairly broad and the  20 specifics by which one is addressing that  21 question can be influenced upon the  22 circumstances, whether it's an individual  23 request, whether it's in relation to a  24 broader question or public policy or even  25 the conduct of scientific study.</p>	<p style="text-align: right;">Page 285</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 suggest an identity for that person that  3 is not -- that is discordant with the  4 biology that is present, it alters one's  5 thinking often in generating those  6 hypotheses and can lead to errors. And  7 therefore, there is a practical reason,  8 it's not based on ideology, it's based on  9 best principles of medical practice as to  10 why some individuals may think that it's  11 not a good idea to ignore the biological  12 reality of the individual, despite the  13 request for preferred pronoun usage.  14 Q. And separate and apart from  15 medical records and documenting their  16 physiological characteristics --  17 (Internet disruption.) Sorry. I wasn't  18 sure if that was happening -- okay.  19 Separate and apart from  20 medical records and documenting a  21 patient's physiologic characteristics, in  22 interactions with the person and their  23 parents, let's say, would you use their  24 preferred pronouns?  25 A. Again, you know, there are</p>

<p style="text-align: right;">Page 286</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 effects of that practice, whether it's in  3 writing, reading or a conversation that  4 can have significant effect on the way  5 that one approaches the care of that  6 patient.  7 Different practitioners will  8 have different conclusion about it. My  9 own personal experience that I've  10 encountered is it does change the way one  11 looks at that individual and many times  12 leads to potential for error in making  13 that objective assessment for the best  14 care for that individual. And, again,  15 this is independent of questions related  16 to gender dysphoria.  17 Q. So you wouldn't refer to the  18 patient based on their preferred pronoun,  19 if I'm understanding from what you just  20 said?  21 MS. LAND: Objection to form  22 and asked and answered.  23 A. So you are making an absolute  24 statement that I would not make. I would  25 state that my experience is that in</p>	<p style="text-align: right;">Page 288</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 suffering. To effectively do that one  3 needs to establish a relationship with a  4 patient.  5 Many times in pediatric  6 endocrinology we address areas of a very  7 sensitive nature; we ask them to do  8 things that are very challenging; there  9 needs to be an establishment of trust;  10 there needs to be, you know, ability not  11 only to give them the technical advice  12 but to be able to give them the  13 encouragement and the motivation to  14 accept the recommended form of  15 intervention. And so to make a statement  16 about in that context of weighing the  17 relative factors about whether it's going  18 to be a benefit or detriment to that  19 individual patient will differ based upon  20 the circumstances of that patient.  21 Q. And have you ever used the  22 preferred pronouns of one of your  23 patients with gender dysphoria?  24 A. Everything I just shared to  25 you is my experience, was based upon</p>
<p style="text-align: right;">Page 287</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 making -- you know, providing the best  3 care for an individual and, again, it  4 affects the circumstances by which you're  5 interacting with that patient, you know  6 -- for example, you know that there are  7 certain ways that I interpret laboratory  8 studies based upon normal reference  9 ranges that are different between males  10 and females and this can occur  11 independent of hormone exposure.  12 There are screening tests that  13 I recommend for my patients that are  14 dependent upon the sex nature of that  15 individual. And in those circumstances  16 where that is -- and many times it creeps  17 up in areas where I would not have  18 expected.  19 The net effect of using those  20 pronouns changes the way one thinks about  21 that individual and may lead to medical  22 errors. And it's on that basis. It's not  23 an absolute statement.  24 You know, the desire for any  25 physician, again, is to alleviate</p>	<p style="text-align: right;">Page 289</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 using those pronouns. I would have no  3 experience of being able to make the  4 statement that it changes the way I think  5 about a patient if I have not engaged in  6 that, and that has been my experience.  7 Q. So you have used preferred  8 pronouns --  9 MS. LAND: Objection to --  10 Q. -- in reference to a patient?  11 MS. LAND: -- form. Objection  12 to form.  13 A. I had a very lengthy answer to  14 your question that answered the question  15 that you just asked. So did I not make  16 myself clear?  17 Q. I don't think that you did.  18 You said I made an absolute statement  19 before and you couldn't make absolute.  20 So I'm asking you a specific question  21 which is; as to the patients that you  22 have actually had, have you ever referred  23 to a patient with a sex-discordant gender  24 identity by their preferred pronoun?  25 MS. LAND: Objection to form.</p>

<p style="text-align: right;">Page 290</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. The basis by which I can make  3 the statement that it alters the way one  4 thinks about a patient is based on my own  5 personal experience of using that  6 language and seeing the effects of using  7 those pronouns in changing the way I  8 think about that patient.  9 Q. So -- so -- excuse me. Using  10 a patient's preferred pronouns has  11 affected the way you think about the  12 patient?  13 A. It is essential for me in my  14 practice in generating treatment plans,  15 differential diagnoses, to acknowledge  16 sex-based differences and disease  17 susceptibility in responses to treatment.  18 The bigger example of this is  19 actually in the area of disorders of  20 sexual development. Decades ago when I  21 first started working with DSDs, there  22 was a belief that making a definitive  23 determination of the sexed identity of  24 that individual would be irreversible and  25 we would engage in entire conversations</p>	<p style="text-align: right;">Page 292</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 in being able to use those pronoun  3 usages. And many times one can avoid  4 using pronouns altogether. I have no  5 problem using a preferred name, and many  6 times that's how we resolve that.  7 The other way that we address  8 this, and many of the patients accept  9 this very well, that we have a discussion  10 about the condition they have and about  11 the best way that we can approach it.  12 Most of my colleagues that do  13 engage in the practice of using preferred  14 pronouns very frequently make errors in  15 -- because they're attempting to think  16 about this individual in their sexed  17 identity in relation to disease. We've  18 had conversations about that as well.  19 Most patients will accept that  20 and they will understand that if you  21 provide the basis for why you are or are  22 not using those specific pronouns.  23 Q. So are you saying you have in  24 the past used the preferred pronouns and  25 found that it had effects that you were</p>
<p style="text-align: right;">Page 291</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 where we would use gender neutral terms  3 to be able to avoid that. That was a  4 standard practice in pediatric  5 endocrinology when I had my fellowship  6 training in the early phases of my  7 training.  8 We've subsequently learned  9 that that concern is not validated and  10 that we can certainly share with the  11 patients the basis for the genital  12 ambiguity that occurs and that we can  13 have that conversation in relation to all  14 of the other aspects of understanding the  15 sexed identity of that individual and how  16 they are going to live their life.  17 But there are many  18 circumstances in which I've, I would say,  19 experimented with differing ways to  20 address individuals in relation to gender  21 identity to try to provide the best care  22 to those individuals. And the  23 conclusions that I've reached on the  24 topic, independent of DSDs, with gender  25 dysphoria is that there are clear risks</p>	<p style="text-align: right;">Page 293</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 concerned about and so now you don't use  3 preferred pronouns but you do utilize  4 these other methods that you just  5 described?  6 A. Again, I will state once again  7 that there is not a set definitive  8 approach to addressing these patients  9 that I use, that I try to approach them  10 with compassion to enter into  11 conversation to build trust with them in  12 the way that best serves them, that also  13 includes being able to recognize and  14 diagnose a disease and provide the most  15 effective therapy.  16 That will depend upon the  17 patient, the circumstances, the nature of  18 my interaction and so there's -- there's  19 many different approaches that have been  20 attempted. I've found that some are more  21 effective than others. And I would say  22 the majority of the patients that I  23 interact with now I am able to interact  24 with them in a very effective manner by  25 using gender neutral terms, which could</p>

<p style="text-align: right;">Page 294</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 include a preferred name, you know,  3 talking to the parent in other ways, that  4 conveys my concern for why they are here  5 in my clinic, how I can best serve them  6 without distorting my ability to provide  7 effective care by ignoring the biological  8 sexed nature of the individual that's in  9 front of me.  10 Q. What about outside your  11 medical and clinical practice, just  12 interacting with, say, a colleague who is  13 -- who has a sex-discordant gender  14 identity, would you honor that person's  15 request to use their preferred pronouns?  16 MS. LAND: Objection to form,  17 scope and relevance of that  18 question.  19 A. You know, it's a very vague  20 question. I'd have to look back at my  21 conversations with other individuals.  22 But I would say that same principle of  23 maintaining respect is present, you know,  24 in all my conversations with individuals.  25 And there are many circumstances where</p>	<p style="text-align: right;">Page 296</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 it's presented before me.  3 Q. So you mentioned your  4 approach.  5 Is your approach to generally  6 avoid pronoun uses when dealing with  7 these individuals?  8 MS. LAND: Objection to form.  9 A. As I've already stated, that I  10 would not make a definitive statement. It  11 depends on the circumstances of the  12 individual and the role that I have in  13 that conversation.  14 I have found most often, and  15 this is most often not even a conscious  16 deliberate attempt, that I don't find  17 myself presented with a situation where  18 I'm required to do so.  19 I do remember many times in  20 patient case conferences where a  21 transgendered individual is being  22 discussed and having difficulty following  23 the conversation, in particular, using  24 the pronoun "they", as it's being  25 presented and thinking in terms of plural</p>
<p style="text-align: right;">Page 295</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 it's not necessary to make this an issue.  3 I think there are many people  4 that want to make it an issue when it  5 doesn't necessarily need to be an issue  6 to be able to have those collegial  7 interactions, to be able to even have  8 those random associations that everyone  9 has every day.  10 I've not been confronted with  11 somebody that demands that I use any  12 particular pronoun. Most of my  13 interactions with colleagues and friends  14 and those that I have spoken with, and  15 I've spoken to a number of individuals  16 that experience sex-discordant gender  17 identity throughout the time that I've  18 been doing my due diligence about  19 understanding the condition and trying to  20 do the analyses. And in all of those  21 interactions I've not encountered any  22 hostility in my approach to be able to  23 deal with them with respect and but also  24 allow myself to maintain that  25 understanding of their sexual identity as</p>	<p style="text-align: right;">Page 297</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 versus singular, and that's just an  3 observation which I think many of my  4 colleagues that I work with have shared  5 similar difficulties. But it's not a  6 rigorous ideological statement, it's just  7 merely a; what is the best way to  8 approach that person, that allows us to  9 have those interactions in a way that is  10 most fruitful.  11 Q. And what would be -- sorry.  12 Why don't you want to use a  13 transgender person's preferred pronouns  14 outside of the medical context, say, in a  15 social setting?  16 MS. LAND: Objection to form.  17 A. I don't think that I said  18 that. So -- but I find myself -- you  19 know, that the way that one interacts  20 with people -- you know, I'm a physician  21 and I spend most of my time -- much of my  22 time in the clinical arena, and it's not  23 surprising to me that what I've done in  24 the clinical arena will spill over into  25 my other interactions. And, again, it's</p>

75 (Pages 294 - 297)

<p style="text-align: right;">Page 298</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 not an ideological assertion, it's merely  3 what is in the best -- you know, it's  4 just the way that I act, and I have not  5 found it to be a problem.  6 I think in the line of  7 questioning that others -- I'm not  8 necessarily saying that you are -- want  9 to make it a big issue and it's not. It  10 is something that is -- it's important,  11 it's important to recognize in medical  12 care and I think it actually can  13 influence interactions in other settings  14 as well to understand. But it's -- you  15 know, you're asking the question in a  16 more dogmatic stance and that is not the  17 way that I look at it.  18 Q. Do you recall speaking to a  19 trans man outside the medical context and  20 using the honorific "Mr."?  21 MS. LAND: Objection to form  22 and relevance.  23 A. Again, you know, similar to  24 previous to questions about various  25 conversations, I've had so many</p>	<p style="text-align: right;">Page 300</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 through and read it again.  3 Q. Do you want to just quickly  4 scan through the document to refresh your  5 recollection of the case?  6 A. Thank you. Yes, I do.  7 (Deponent reviews the  8 document.)  9 A. I'm almost at the end of it  10 here. So thank you for allowing me to  11 review it. Okay. Yes.  12 Q. And I'm actually going to have  13 you look at the very last paragraph of  14 the document on page 22.  15 A. Okay.  16 Q. So it concludes, "We agree  17 with the American College of  18 Pediatrician's conclusion that  19 conditioning children into believing that  20 a lifetime of impersonating someone of  21 the opposite sex, achievable only through  22 chemical and surgical interventions, is a  23 form of child abuse." Did I read that  24 correctly?  25 A. You did read that correctly.</p>
<p style="text-align: right;">Page 299</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 conversations with so many people in so  3 many different settings that I don't know  4 that I can actually answer that question.  5 Q. Okay. I'm going to mark  6 another exhibit.  7 (Exhibit Hruz 8, amicus brief  8 re: Gloucester County School Board  9 v. Deirdre Grimm, was received and  10 marked on this date for  11 identification.)  12 Q. This is going to be Exhibit 8.  13 This is an amicus brief filed at the  14 United States Supreme Court January 2017.  15 Do you recognize this document?  16 A. I'm surprised that that's an  17 older amicus and I actually remember this  18 more. I think it was the very first  19 amicus that I ever filed or signed onto.  20 Q. Do you recall the case that  21 this brief was filed in?  22 A. Very briefly. It was so many  23 years ago but I believe it was one of  24 these cases on bathroom use or something  25 of that nature, but I'd have to go</p>	<p style="text-align: right;">Page 301</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. And do you agree with that  3 statement?  4 MS. LAND: Objection to the  5 form of that question and it's  6 outside the scope.  7 A. At the time that this was put  8 forward I do remember actually the  9 conversation about the terminology that  10 was used.  11 The message that it's  12 conveying, as far as being harmful to the  13 children based upon the evidence that was  14 available at that time and really has  15 been reinforced over time, is accurate.  16 But I do remember there was a  17 conversation about the exact wording. But  18 I think it conveys the reality of the  19 concern that it is harming children. And  20 if you understand abuse as harm, then I  21 think that would be in concert with  22 everything that I've said in my  23 declaration as far as the concerns about  24 the affirmative approach.  25 Q. Do you believe that a parent</p>

<p style="text-align: right;">Page 302</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 who consents to gender-affirming hormone  3 therapy for their adolescent child is  4 engaging in a form of child abuse?  5 MS. LAND: Objection to  6 relevance and scope.  7 A. So I would say that there are  8 many factors that influence a parent's  9 acceptance of the affirmative approach.  10 Most often what I have encountered are  11 parents who have significant concerns  12 about this approach but are told by the  13 practitioners that this is a necessary  14 intervention and that they will be  15 harming their children if they do not go  16 ahead with affirmation. So that's -- and  17 you couldn't accuse a parent who is being  18 told by their medical professional that  19 they're supposed to do this is without a  20 basis for them questioning this. Again,  21 in relation to our conversation earlier  22 about consent and the information that is  23 shared with these individuals, that could  24 not constitute that the parents,  25 themselves, were abusing the children.</p>	<p style="text-align: right;">Page 304</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 risks, as I've stated in my declaration,  3 then we need to acknowledge that.  4 Q. And are the practitioners who  5 are prescribing -- is it your belief that  6 the practitioners who are prescribing the  7 gender-affirming hormone therapy to  8 adolescents with gender dysphoria are  9 engaging in child abuse?  10 MS. LAND: Objection to  11 relevance and scope.  12 A. It's a very broad question and  13 we would have to have specific examples  14 of specific practitioners with specific  15 information about the information that  16 they're presenting to the parents to be  17 able to make a conclusion based on that.  18 I would not care to make a general  19 assertion.  20 I do -- I am aware there are  21 circumstances by which ideologically  22 oriented individuals are encouraging the  23 affirmation approach without the  24 presentation of the lack of evidence or  25 the poor quality evidence that would</p>
<p style="text-align: right;">Page 303</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 However, there are situations  3 that I'm aware of and, in fact, that I  4 participated in litigation where patients  5 are -- parents are going through a  6 divorce and they are playing the child  7 off in that divorce proceeding in a way  8 that is, by an objective observer, could  9 be characterized as certainly not helping  10 and probably harming that child. It's  11 listed in my declaration, the Texas case  12 that I was involved in, where some of  13 those dynamics were present.  14 Again, you know, to be able to  15 make a definitive conclusion in any one  16 situation there are many factors. I would  17 say some parents are proceeding based  18 upon erroneous information and that would  19 not constitute abuse. But certainly if  20 they're using it for other motives or,  21 you know, from an ideological  22 perspective, the net effect, if the  23 concerns that I have related to the  24 affirmative approach are leading to harm,  25 you know, lack of benefit and significant</p>	<p style="text-align: right;">Page 305</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 certainly raise questions about -- you  3 know, in relation to harming that child.  4 Q. Are you aware that Governor of  5 Texas issued a directive declaring that  6 treating minors with gender dysphoria  7 with hormone therapy and puberty blockers  8 is a form of child abuse?  9 MS. LAND: Objection to form,  10 relevance and scope.  11 A. I am familiar with what you  12 are referring to only from what's  13 presented in the media.  14 Q. And were you asked by the  15 State of Texas to be an expert in that  16 case?  17 A. No.  18 Q. Is it your view that someone  19 with a sex-discordant gender identity who  20 lives in accordance with that gender  21 identity is impersonating someone of the  22 opposite sex?  23 A. I probably wouldn't currently  24 use that language. I'm certainly aware of  25 -- this is a general area of concern in</p>

<p style="text-align: right;">Page 306</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the entire conversation of the way that  3 words are being used, some in a helpful  4 way but often in a harmful way, and I  5 think it works throughout the  6 conversation.  7 You know, "impersonation"  8 implies knowledge, you know, conclusions  9 that one would make about the motivation  10 for an individual acting in that manner.  11 And I think that as a general statement  12 most of the time that that information is  13 not available.  14 They are certainly acting in a  15 way that is discordant with the  16 biological reality of their bodies and  17 there is some accuracy in the statement  18 but there is also ways that it could be  19 misinterpreted.  20 So there are probably other  21 ways that one could convey that important  22 point. But I think that, you know, those  23 that choose to use that language are  24 attempting to acknowledge the fact that  25 the way that they are acting is</p>	<p style="text-align: right;">Page 308</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I was aware of the news  3 reports when this came out and the links  4 that came out on the internet. First time  5 I saw it was after this came out and,  6 yeah, that was the first time I saw it.  7 Q. And this is new guidance from  8 the Florida Department of Health entitled  9 Treatment of Gender Dysphoria For  10 Children and Adolescents, dated April  11 20th, 2022; is that right?  12 A. That's correct.  13 Q. And you see in the first  14 bullet under the general -- under the  15 bullets it says, "Social gender  16 transition should not be a treatment  17 option for children or adolescents." Do  18 you see that?  19 A. I do see that.  20 Q. And I'm reading that  21 correctly?  22 A. That's what the text says,  23 yes.  24 Q. Based on your expert medical  25 opinion do you think social transition</p>
<p style="text-align: right;">Page 307</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 discordant with their sexual identity  3 from a biological perspective.  4 Q. I'm going to ask you to go  5 back for another exhibit.  6 Mike, how are we doing on the  7 video?  8 VIDEOGRAPHER: We need to take  9 a break within 15 minutes.  10 MR. STRANGIO: Okay. I'll just  11 do one more line of questioning and  12 we'll take a break.  13 So this will be Exhibit 9.  14 (Exhibit Hruz 9, statement  15 from Florida Department of Health  16 re: Treatment of Gender Dysphoria  17 for Children and Adolescents dated  18 April 20, 2022, was received and  19 marked on this date for  20 identification.)  21 Q. It should be up now. Have you  22 seen this document?  23 A. Yes, I have.  24 Q. In what context have you seen  25 it?</p>	<p style="text-align: right;">Page 309</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 for minors should be prohibited?  3 MS. LAND: Object to form.  4 A. Well, my opinion on social  5 gender transition is contained within my  6 declaration and I've already discussed at  7 length in our deposition today my concern  8 that it's not a neutral intervention, but  9 it is listed here as a fairly definitive  10 statement.  11 I think that there are  12 certainly serious questions that can be  13 raised about the influence of social  14 gender transition and the effects it has  15 on individuals. And as we discussed  16 already, you know, that is how I would  17 approach the question from a  18 physician-scientist standpoint, by  19 generating hypotheses about the effects  20 of that. This looks like to be a  21 definitive conclusion.  22 I will state that in my search  23 for randomized controlled trials on  24 gender transition I have found zero that  25 have been conducted and published and I</p>

<p style="text-align: right;">Page 310</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 certainly have concerns that the  3 investigation of the effects has not been  4 adequately studied.  5 Q. Do you think that parents  6 should ever be -- let me take that back.  7 MR. STRANGIO: I think let's  8 take a break here.  9 VIDEOGRAPHER: This will end  10 video part 4 and we are off the  11 record at 3:18 p.m.  12 (Recess is taken.)  13 VIDEOGRAPHER: We are back on  14 the record at 3:27 p.m. This will  15 begin media part 5. Please proceed.  16 Q. Okay. So are you aware that  17 there are three minor Plaintiffs in this  18 case that are currently receiving hormone  19 therapy to treat gender dysphoria?  20 A. I was given a copy of the  21 Complaint, yes.  22 Q. And in your view -- excuse me.  23 In your view would you say  24 that it's in the best interests of all  25 of these minor Plaintiffs to</p>	<p style="text-align: right;">Page 312</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 have full opportunity, as far as my  3 understanding, to be able to receive the  4 care in all of the other areas that we've  5 already discussed here, in addressing  6 underlying psychological comorbidities  7 and other difficulties. You know, that  8 there's much that can be provided for  9 these individuals to support them and to  10 continue to strive for that goal of  11 achieving significant and sustained  12 alleviating of their distress.  13 Q. But as to an individual  14 patient it would have to be a  15 case-by-case basis in order to determine  16 what medical treatment was in their best  17 interests?  18 A. I would say --  19 MS. LAND: Objection to form.  20 A. -- I have already opined in  21 this case here that, based upon the  22 evidence of significant risks and  23 unproven benefits, that any care that  24 should be that -- to be provided to these  25 individuals would best be served in the</p>
<p style="text-align: right;">Page 311</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 discontinue the care they are  3 receiving?  4 MS. LAND: Object to form.  5 A. You know, I think that I'm not  6 able to comment on the specific  7 Plaintiffs, not having evaluated all of  8 the medical records. And that was really  9 -- my participation as an expert witness  10 is related to the scientific literature  11 and the relative risks and benefits in  12 this affirmative treatment model.  13 So, therefore, I don't have a  14 basis to make a treatment recommendation,  15 nor is that something that I would be  16 able to do in this area.  17 All I can say is that based  18 upon the scientific information that's  19 available right now, the affirmative  20 model is based on low quality scientific  21 evidence with significant risks and  22 unproven benefits. And what is entirely  23 unexplored are alternative means of  24 intervention and that individuals that  25 are affected by this legislation would</p>	<p style="text-align: right;">Page 313</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 setting of an experimental trial, similar  3 to the way it is being proposed to be  4 done in Sweden.  5 Q. But as to an individual with  6 respect to discontinuation of treatment,  7 would that be a case-by-case basis to  8 determine what would be in their best  9 interests?  10 MS. LAND: Object to form.  11 A. So I think you're asking about  12 specifics. So there's much that should  13 -- so it's not -- so the way that the  14 question is being phrased, at least as I  15 interpret it, maybe incorrectly, is that  16 you're proposing that we abandon all  17 treatment. And I don't think that that's  18 the intent nor the effect of the  19 legislation, that these individuals would  20 continue to have access to various forms  21 of intervention with limitations about  22 what type of intervention that may be  23 until they reach the age of majority, and  24 that there is a significant opportunity  25 to be able to advance the field to</p>

<p style="text-align: right;">Page 314</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 address the questions that we've  3 discussed in this deposition.  4 Q. Just getting a little more  5 specific then. So for every minor in  6 Arkansas, let's say, who is a biological  7 female receiving testosterone therapy to  8 treat gender dysphoria, would it be in  9 their best interest to discontinue  10 treatment?  11 MS. LAND: Object to form.  12 A. So, again, that's a broad  13 question that you've asked. And I would  14 say based upon the evidence that we have  15 available, that there is unproven benefit  16 and significant risk.  17 The mitigation of that risk  18 and the search for alternative  19 interventions to alleviate their  20 suffering would be in the best interests  21 of those patients.  22 Q. Is there any potential harm in  23 discontinuing hormone therapy for minors  24 who are currently receiving it to treat  25 gender dysphoria?</p>	<p style="text-align: right;">Page 316</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 those conditions and achieving those  3 physiologic levels of sex steroid  4 hormones that are exposed to in the  5 setting of their underlying epigenetics  6 and responses to treatment that may be --  7 it's likely to be required for those  8 individuals.  9 The abrupt cessation of the  10 sex steroid hormones is likely to cause  11 significant disruption. We do this in  12 initiating hormone treatment to people  13 who are hypogonadal. And I think you can  14 look at this in reverse, as far as taking  15 them off the cross-sex hormones in a  16 stepwise manner. So you wouldn't want to  17 abruptly disrupt that. That has been  18 discussed many times.  19 The effective protocols that  20 are going to be needed to do this is  21 another opportunity for the  22 investigation, scientific investigation,  23 on the most optimal way to achieve that  24 goal.  25 At the same time, you know, to</p>
<p style="text-align: right;">Page 315</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 MS. LAND: Object to form.  3 A. So the question is whether  4 there are harms, and it depends on the  5 stage of intervention. Many of these  6 individuals that have reached the stage  7 of gender affirmation interventions that  8 disrupt their normal gonadal function are  9 going to be rendered hypergonadal. And  10 not having sex hormones is a significant  11 risk. We see other patient that don't  12 have gender dysphoria that have  13 hypogonadism with all of the attendant  14 risks.  15 So there would be a need for  16 those individuals that lack gonadal  17 function that have been rendered sterile  18 and incapable of producing endogenous sex  19 hormones to be able to provide that to  20 that individual.  21 If that is provided in concert  22 with the way that we treat individuals,  23 for example, females with estrogen and  24 testosterone to males, we do have  25 experience in treating hypogonadism in</p>	<p style="text-align: right;">Page 317</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 be providing the psychological support  3 and care, to be able to continue to work  4 and perhaps even dig more deeply into  5 many of the other factors that are  6 contributing to the dysphoria, itself, or  7 in peer relationships and other aspects  8 of their life would certainly need to be  9 provided and should be provided anyway,  10 even independent of this legislation.  11 Q. You mentioned a few times that  12 the studies into the efficacy of this  13 treatment are insufficient to prove  14 efficacy with respect to the  15 pharmacological interventions to treat  16 gender dysphoria. But does that mean that  17 you know for sure that this treatment is  18 not helping anyone?  19 MS. LAND: Objection, form.  20 A. So in the statement you've  21 actually answered the question in the --  22 you've answered it in the way that you  23 phrased the question.  24 The problem is with most of  25 these studies is at best what we can</p>

<p style="text-align: right;">Page 318</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 conclude from them, particularly the ones  3 that are cross-sectional, is there may be  4 an association between intervention and  5 an outcome measure.  6 What we're not certain about  7 is that there is a causal relationship  8 between the two, that we've not been able  9 to establish there's benefit. And when  10 you look at any experimental protocol,  11 any intervention at all, there is  12 heterogeneity in response.  13 One of the concerns that I  14 have about the literature is that we  15 don't fully understand the etiology of  16 sex-discordant gender identity. Based  17 upon the evidence that I've seen, it  18 would be most reasonable to put forward a  19 hypothesis that it is a multifactorial  20 condition, where the emergence of gender  21 dysphoria occurs by different reasons to  22 different -- in nature and degree in any  23 one individual.  24 When one looks at some of the  25 studies that have been done in small</p>	<p style="text-align: right;">Page 320</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 potential that we may uncover what those  3 factors might be, so that we would have a  4 better prognostic value in who would not  5 be harmed and who might actually achieve  6 benefit.  7 Q. Can I stop you there? So  8 there are people who might achieve  9 benefit from the medical interventions?  10 A. So as a physician-scientist I  11 don't begin with the preconceived  12 conclusion. I ask a hypothesis and I test  13 the information.  14 So if I'm going to opine on  15 what the effect is, I need to recognize  16 that as we're going to conduct a  17 scientific investigation the reason --  18 the whole reason that we have equipoise  19 and we actually conduct the scientific  20 investigation is because we don't know  21 for certain what that outcome is going to  22 be. So that's the way all science is  23 done. If there was no reason to doubt  24 that you knew the outcome, there would be  25 no reason to perform the study.</p>
<p style="text-align: right;">Page 319</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 patient populations, there is a very  3 immediate concern about generalized  4 ability of findings. And there is no  5 method here to be able to determine who  6 would and would not benefit, you know,  7 from an intervention, who would or would  8 not suffer a particular adverse outcome  9 effect.  10 You can look at, for example,  11 the risk of stroke, a three to five fold  12 increase in males that get estrogen, that  13 that doesn't mean there's 100% to the  14 patients that have that effect. If there  15 are a way to predict who would have that  16 adverse effect, you know, both from a  17 physiologic or pathophysiologic  18 mechanism, that would be incredibly  19 useful. We don't have a biological test  20 or even a way to predict who would and  21 would not respond.  22 If the trials are conducted in  23 the rigorous manner that they need to be  24 performed, there may -- there's  25 potential, there's no guarantee, there is</p>	<p style="text-align: right;">Page 321</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Q. Have you read the expert  3 reports of Dr. Karasic and Dr. Adkins in  4 this case?  5 A. Yes, I have.  6 Q. And are you aware that they  7 report that hormone therapy had a  8 significant positive impact on the mental  9 health of their patients?  10 A. Anecdotal, unsupported, weak  11 science. There is much I can say about  12 those assertions that are being made, not  13 only, you know, just their -- for  14 example, Dr. Adkins makes many statements  15 that she's not verified with any  16 scientific information and those things  17 that she does cite have very serious  18 methodologic flaws.  19 So that, you know, to even  20 make the conclusion that there is a  21 causal relationship between what was done  22 and the effect is not possible. You know,  23 the lowest level of scientific evidence  24 is the case report. And these anecdotal  25 stories are, at best, means for</p>

<p style="text-align: right;">Page 322</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 hypothesis generation, and they cannot be  3 used to make a definitive conclusions  4 about causal relationships between  5 intervention outcomes. That's well  6 recognized in science. And for one to  7 rely upon an opinion on a personal  8 experience that is not controlled and  9 there is no way to be able to know the  10 factors that led to that observation,  11 whether it has anything to do with the  12 intervention, itself, is highly  13 problematic.  14 Q. But do you have any reason to  15 dispute the anecdotal observation that  16 they have made?  17 A. If they have an anecdotal  18 observation that they observe an outcome  19 I have every reason to question what is  20 the basis for that outcome and whether it  21 had anything to do with the intervention.  22 The way it's being presented,  23 the experience is the experience but we  24 don't know why, we don't know the  25 circumstances, and we don't -- and then</p>	<p style="text-align: right;">Page 324</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 interventions, or whether they completed  3 suicide.  4 So from that vantage point, to  5 -- to not dismiss their personal  6 observation, but merely to question the  7 conclusions that are reached by that  8 personal observation, I would say, at  9 best, those anecdotal reports can be used  10 to generate testable hypotheses using the  11 more rigorous methods to be able to  12 establish a causal relationship between  13 the intervention and outcome.  14 Q. And what strong scientific  15 non-anecdotal evidence exists  16 demonstrating the effectiveness of  17 psychological interventions alone to  18 treat gender dysphoria in adolescents?  19 A. I will be the first to be able  20 to acknowledge that this is an area that  21 has been understudied and underutilized  22 and that if one is to pursue these modern  23 psychological tools that have not been  24 applied to the area of gender dysphoria,  25 that that is a part of what I propose in</p>
<p style="text-align: right;">Page 323</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the other -- and this is covered in my  3 declaration quite clearly, you know  4 they're looking at relatively short time  5 points. And I think that there is  6 evidence of short-term alleviating of  7 anxiety that -- and that's what they're  8 likely reporting, in the absence of  9 long-term followup.  10 They certainly have -- well,  11 I'm not going to speak for them  12 specifically. But in the studies that  13 have been conducted where they have tried  14 to do this in a longitudinal manner,  15 there have been very very significant  16 number of patients that are lost to  17 followup. There is no way to assess what  18 those outcomes were, whether those  19 patients were dissatisfied with the care  20 they received and chose not to return to  21 their providers, which is actually  22 surprising because many of the  23 interventions tether them to the medical  24 establishment and require them to  25 continue to receive hormonal</p>	<p style="text-align: right;">Page 325</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the investigation scientifically.  3 We do have evidence that's  4 based upon established studies about the  5 comorbidities, you know, the  6 effectiveness, for example, I mentioned  7 of cognitive behavioral therapy in  8 alleviating anxiety. We do have  9 approaches to addressing underlying  10 depression. We do have very longstanding  11 evidence in treating, independent of  12 gender dysphoria, those that experience  13 anorexia. We do have emerging evidence  14 on how to best care for individuals that  15 have autism spectrum disorder, many  16 questions that still remain in that  17 domain.  18 So what is needed is to be  19 able to take that experience, in other  20 conditions, to use that in the generation  21 of testable hypotheses and apply that to  22 the care of individuals that have sex  23 discordant gender identity. And if the  24 hypothesis is proven correct, that there  25 is benefit in pursuing those types of</p>

<p style="text-align: right;">Page 326</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 interventions, that the addressing of  3 underlying psychological distress that  4 might have been from prior sexual or  5 physical abuse, dysfunctional family  6 relationships, disordered peer  7 interactions, experiences that predated  8 the onset of gender dysphoria, that that  9 would have a means to address the  10 underlying dysphoria. And I would say  11 that even if the dysphoria, itself,  12 cannot be entirely mitigated, and the  13 evidence suggests with the affirmation  14 approach that there is a continuing  15 morbidity, whether there is improved  16 efficacy in alleviation of suffering with  17 the mitigation of risk. So that is --  18 really, I've been trying to convey that  19 to this court throughout this proceeding  20 and in my declaration.  21 There is much more I can say  22 about that but this is how I view this  23 and this is the conclusions I have  24 reached in addressing that question.  25 Q. But at this time there is no</p>	<p style="text-align: right;">Page 328</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 approach. And there is a need across the  3 entire spectrum of scientific  4 investigation to elevate the quality of  5 the science that is being put forward.  6 Q. Are there studies indicating  7 that there are interventions that can  8 cause a minor to desist and end up  9 identifying with their biological sex?  10 A. I would say that many of the  11 -- so the literature that I'm most  12 familiar with is looking at the natural  13 history.  14 If you look at -- again, we  15 mentioned previously Dr. Zucker and his  16 program and the experience that he's had  17 in having some individuals that have that  18 realignment of their gender identity with  19 their sex has occurred, but I think all  20 of those studies have limitations and  21 weaknesses and, you know, I think that  22 there is evidence.  23 Is it the best evidence or is  24 there opportunity to study this in a more  25 rigorous way? And I've said consistently</p>
<p style="text-align: right;">Page 327</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 scientific evidence demonstrating that  3 psychological interventions alone are  4 effective at treating gender dysphoria;  5 is that right?  6 MS. LAND: Objection to form,  7 asked and answered.  8 A. I would not say that there is  9 no evidence. I would say there is the  10 same limitations in the quality of  11 evidence that is available.  12 I would stress that in the  13 WPATH guidelines, SOC 7, you know,  14 there's many statements that are made in  15 that Standard of Care document where they  16 make claims that alternative approaches  17 are -- have been demonstrated to be  18 ineffective and are harmful. And if one  19 actually looks at those studies, there  20 are case reports within that literature  21 that actually showed patients that  22 actually showed benefit.  23 Is it quality science? It has  24 the same limitations as the research that  25 is being used to support the affirmative</p>	<p style="text-align: right;">Page 329</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 that I think there is tremendous  3 opportunity to be able to engage in these  4 areas of investigation to get answers to  5 those questions.  6 Q. So at this time would you say  7 that your preferred treatment approach is  8 not supported by any of the best evidence  9 either?  10 MS. LAND: Objection to form.  11 A. I don't recall that I have  12 shared with you a preferred treatment  13 approach. I've presented three potential  14 treatment approaches or at least  15 paradigms. I presented to you the  16 limitations of the claim that the  17 affirmative model is the necessary model  18 that needs to be put forward. I've shared  19 with you the lack of evidence to even  20 consider the alternative hypotheses in  21 the other treatment paradigms. There has  22 been a mischaracterization of those other  23 treatment approaches by many individuals  24 linking them to studies that were done  25 decades ago for a different condition,</p>

<p style="text-align: right;">Page 330</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 with methods that everyone would  3 acknowledge are unethical. I'm talking  4 specifically about the reference to  5 conversion therapy.  6 So there is many areas that  7 need investigation. And so if I were to  8 opine, based upon the low quality of  9 evidence that we have, that there is a  10 preferred method, then I would be falling  11 into the same danger, the trap, the error  12 that the Plaintiff experts are putting  13 forward about having a conclusion and  14 looking for evidence to support their  15 conclusion.  16 I look at science in a more  17 objective manner, and look for the  18 scientific evidence that supports the  19 veracity of the hypotheses that are put  20 forward.  21 Q. Do you have a view of how  22 adolescents with gender dysphoria should  23 be treated?  24 MS. LAND: Objection to form,  25 asked and answered.</p>	<p style="text-align: right;">Page 332</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 Nevertheless, because it's  3 unanswered which approach is going to  4 have the most significant and sustained  5 long-term benefit for a patient, that  6 there needs to be an ability to put  7 forward a variety of alternative  8 hypotheses.  9 Q. So you're giving me an answer  10 about how we assess the relative risks  11 and benefits moving forward.  12 What is your view on how  13 patients should be treated right now?  14 MS. LAND: Objection to form,  15 asked and answered.  16 A. You know, I will reiterate  17 what I've said previously, that there are  18 many areas of established recognized  19 benefits of addressing underlying  20 comorbidity, investigating and searching  21 for potential precipitating factors that  22 may include underlying autism, underlying  23 psychological distress from family  24 dynamics, from prior abuse, from many  25 other aspects. Those are all</p>
<p style="text-align: right;">Page 331</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. So I will again reiterate that  3 there is -- the question about the  4 preferred approach in treating  5 individuals that experience  6 sex-discordant gender identity needs to  7 include an assessment of relative risk  8 and relative benefit, and it needs to be  9 done not only in the context of  10 short-term benefit but long-term  11 sustainability, the influence that is  12 least damaging and most beneficial for  13 the most number of patients. That is  14 what I would advocate for is the search  15 for what that intervention is.  16 Many of the hypotheses that  17 are put forward for psychological  18 assessment have inherently, in the  19 approach or lack the concerns about the  20 bodily effects, often irreversible, that  21 is consequent to using hormonal and  22 surgical interventions. So at the  23 outset, by asking the question, there are  24 differences in relative potential risks  25 and benefits from different approaches.</p>	<p style="text-align: right;">Page 333</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 interventions that can be engaged and  3 really should be engaged with within the  4 current knowledge base that we have at  5 this time to alleviate suffering in those  6 affected individuals while we are  7 searching for effective long-term  8 solutions.  9 So that is the general  10 framework that I believe needs to be  11 engaged in and one of the -- and we're  12 actually seeing this more in Europe as we  13 move forward. Exactly what I've put  14 forward is in recognition of the low  15 quality evidence is being put forward as  16 a prudent approach; the prioritization of  17 psychological assessment over hormonal  18 and surgical interventions in the  19 experimental setting.  20 Q. Is it your view that a patient  21 -- sorry. Let me restart that. Let me  22 back up.  23 Do you believe that all  24 patients with gender dysphoria have  25 comorbidity conditions?</p>

<p style="text-align: right;">Page 334</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 A. I'm very careful about using  3 universal statements like that and I  4 don't think that's the case in what I've  5 seen, but it's a substantial number of  6 patients and that have varying degrees of  7 this -- of these comorbidities.  8 Q. And in your description of  9 what we can do right now you mentioned  10 treating comorbidities.  11 When there are no  12 comorbidities, how should the gender  13 dysphoria, itself, be treated in an  14 individual with no comorbidities no child  15 trauma and an intact, healthy family?  16 MS. LAND: Object to form.  17 A. You are asking how we treat  18 sex-discordant gender identity when there  19 is no dysphoria?  20 Q. I'm asking when the only  21 diagnosis is gender dysphoria, there is  22 no comorbidities, and there is no history  23 of trauma or childhood sexual abuse, what  24 would you recommend as a current  25 treatment for that individual with the</p>	<p style="text-align: right;">Page 336</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 been able to find means to be able to  3 navigate that gender dysphoria and with  4 significant benefit, in the absence of  5 the affirmative approach.  6 Q. So my understanding is that  7 your current recommendation is similar or  8 is to follow the approach of Sweden and  9 other European countries that are  10 prioritizing psychological support.  11 You are aware in Sweden and  12 those other countries if gender dysphoria  13 is not resolved by the psychological  14 interventions puberty blockers and  15 hormone therapies can be provided, right?  16 MS. LAND: Objection, form.  17 A. Under an experimental  18 protocol.  19 Q. And do you disagree with that  20 approach?  21 A. I repeatedly stated my desire  22 to see the elevation of the science and  23 that the provision of that type of care  24 within the setting of an experimental  25 protocol under the supervision of an</p>
<p style="text-align: right;">Page 335</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 gender dysphoria?  3 MS. LAND: Objection to form.  4 A. As an investigative hypothesis  5 and, you know, experimental approach I  6 would adopt or recommend adopting the  7 approach that Sweden has taken and the  8 European countries, prioritizing -- even  9 if there is not diagnoseable depression,  10 diagnosable anxiety disorder, there can  11 still be potential benefit and  12 psychological support to be able to allow  13 an individual -- again, if you think  14 about the field of psychiatry or  15 psychology, you know, there are threshold  16 criteria to establish a diagnosis, but  17 that is often presented on a spectrum and  18 there are certainly opportunity to  19 address underlying difficulties that one  20 has in peer relationships. One can  21 certainly assist that individual in --  22 even if it's not possible to eliminate  23 the gender dysphoria, the -- again, the  24 low quality science anecdotal reports,  25 case reports of individuals that have</p>	<p style="text-align: right;">Page 337</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 institutional review board. A review  3 board is what is indicated.  4 Q. So you agree with that  5 approach?  6 MS. LAND: Objection, form.  7 A. I've repeatedly stated the  8 rationale for experimental investigation.  9 Q. In your current practice do  10 you ever prescribe medications off label?  11 MS. LAND: Objection, form,  12 relevance, scope.  13 A. So the question related to the  14 prescribing of drug off-label. It is  15 very common in medical practice with the  16 appropriate recognition for the basis for  17 which one is using the off-label  18 indication.  19 Many times in pediatrics there  20 is very well established data in the  21 adult population and there have not been  22 clinical trials that are done in the  23 pediatric population. There are  24 situations where the relative  25 risk/benefit profile is very well</p>

<p style="text-align: right;">Page 338</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 established, where there indeed have been  3 randomized controlled studies of the  4 intervention in other patient populations  5 that we can draw upon. The use of --  6 Q. This was just a yes or no  7 question. I don't need a full background.  8 Yes or no; do you prescribe  9 medication off-label in your current  10 practice?  11 A. I think it's necessary --  12 MS. LAND: Objection --  13 A. It's necessary in pediatrics  14 on frequent occasions to be able to  15 prescribe medicines that have not been  16 specifically approved for the use in  17 children but have been approved for other  18 indications with good knowledge of the  19 risks and benefits.  20 Q. Okay. So as a general -- I'll  21 stop there.  22 Let's take another five minute  23 break if we could. Thanks.  24 VIDEOGRAPHER: We're off the  25 record at 3:57 p.m.</p>	<p style="text-align: right;">Page 340</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 proceed with the utmost of caution when  3 you have greater risk and unproven  4 benefit.  5 Now, in this particular area  6 we have not only seen significant risks,  7 we have seen evidence that's mounting  8 that there is no benefit and that there  9 may be potential harms. It's not entirely  10 neutral. And what I would like to see as  11 a minimum of being able to see a study  12 that is adequately powered with the  13 proper experimental design, with enough  14 power to be able to establish a  15 conclusion about the causal relationship  16 between the intervention and the outcome  17 and be able to show that that had the  18 intended benefit. And I think that those  19 trials are often done initially as pilot  20 trials that are extended into larger  21 trials to be able to increase the power  22 to be able to increase the  23 generalizability.  24 So I would like to see a study  25 that was done with that rigor, that is --</p>
<p style="text-align: right;">Page 339</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 (Recess is taken.)  3 VIDEOGRAPHER: We are back on  4 the record at 4:12 p.m. Please  5 proceed.  6 Q. So Dr. Hruz, what kind of data  7 would you need to see demonstrating the  8 effectiveness of gender-affirming medical  9 care in adolescents in order to be  10 willing to deem it appropriate care?  11 MS. LAND: Objection to form.  12 A. Okay. We'll come back to,  13 maybe flesh out a little bit more some of  14 the things that I said previously.  15 I think that there needs to be  16 a recognition of relative benefit versus  17 relative risk and the approach that needs  18 to be put forward needs to have  19 consideration of alternative hypotheses  20 of other interventions in comparison to  21 that.  22 So, you know, I think that  23 it's not to say that we don't engage in  24 medical interventions that we don't have  25 the full answers to, but we always</p>	<p style="text-align: right;">Page 341</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 has a properly designed control group,  3 that has definable definitive hypothesis  4 and outcome measure that one can get that  5 information for. And I should stress  6 that, to be able to conduct that clinical  7 trial, it is not, as it's often  8 portrayed, that you have a control group  9 that you do nothing to. That is not the  10 way science is done.  11 Science is conducted by which  12 you take all of the variables that are  13 present in your study population, both  14 the control and the intervention group,  15 and you make both groups equal with the  16 exception of what's called the  17 independent variable, the thing that  18 you're going to intervene with that's  19 going to be different between the  20 treatment group and the control group.  21 I've not seen those studies  22 designed in this patient population. I've  23 not seen demonstration that alleviates my  24 concern for the persistence of  25 significant morbidity, use of psychiatric</p>

<p style="text-align: right;">Page 342</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 medications, suicidality current, not  3 lifetime, in this population after  4 they've achieved affirmative care.  5 If it were demonstrated that  6 we had that evidence available, again,  7 with caution, depending on the strength  8 of that information, that as we do in  9 other areas of medicine, that  10 acknowledging the data that's available,  11 that we would be able to engage in that  12 particular intervention. If we're --  13 and, again, there are so many different  14 caveats to that as it pertains to gender  15 dysphoria that have not been yet  16 explored.  17 So it doesn't mean that you  18 have to have a definitive answer with a  19 gold standard study that was done in a  20 thousand patients, you know, with  21 generalizability to the entire  22 population. That's not what I would  23 propose.  24 But there has been a failure  25 of the medical establishment to, you</p>	<p style="text-align: right;">Page 344</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 the alternative hypotheses that have been  3 proposed, would like to see a controlled  4 trial where one compares the affirmative  5 approach with a primary, you know,  6 psychological approach, which isn't being  7 done. That would be a very important  8 study.  9 Even asking simple questions  10 at this point in time about the effect of  11 pubertal blockade on persistence is  12 certainly a trial that can ethically be  13 conducted. There is actually existing  14 data from previously published papers  15 that wasn't controlled, randomized, where  16 one has compared delay in pubertal  17 blocker initiation versus immediate,  18 showing that both groups showed benefit.  19 The way -- that that's a paper  20 by Costa that I think I mentioned in my  21 declaration. This is a paper that, based  22 upon very inadequate data, allows one to  23 ask a hypothesis that if both  24 intervention groups -- if both the group  25 that did and did not receive the puberty</p>
<p style="text-align: right;">Page 343</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 know, apply the basic principles of  3 evidence-based medicine in this regard.  4 And because of the emerging data showing  5 the significant risk, the lack of  6 long-term benefit, and emerging data  7 showing that there may be actually  8 significant effects of that intervention,  9 in that setting I think that the ethics  10 prevent one from endorsing that model.  11 Q. So if you had that, say, one  12 of those -- and let's say you had a few  13 of those rigorous studies that is  14 designed, as you describe, that did show  15 benefit to patients, then would you  16 prescribe puberty blockers and hormone  17 therapy to treat gender dysphoria?  18 MS. LAND: Objection to form.  19 A. As I have always approached  20 this as a physician-scientist, again, in  21 the way we approach all areas of  22 medicine, that one needs to take the lead  23 of the evidence that's available.  24 In particular, based upon my  25 extensive reading of the literature and</p>	<p style="text-align: right;">Page 345</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 blocker, but both groups received  3 psychological support had a similar  4 regression, either regression to the mean  5 or improvement in overall global  6 functioning, that that would be in a  7 controlled trial that one could be able  8 to propose a study for a defined period  9 of time to begin getting this data.  10 The type of data that needs to  11 be generated is acknowledged to take  12 significant time. And as I've mentioned  13 previously, if the science were to show  14 that this is the only effective treatment  15 that has proven benefit and acceptable  16 risk profile, that would be on par with  17 other areas of medicine where we engage  18 in this intervention.  19 At the current moment we don't  20 have that information and we have much  21 information that leads to questions  22 whether that really is achieving the  23 effect that one says is being achieved.  24 Q. So you would only support it  25 if it was the only effective intervention</p>

<p style="text-align: right;">Page 346</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 to treat gender dysphoria?  3 MS. LAND: Objection to form.  4 A. I would choose the option that  5 had the least risk and maximal benefit.  6 I've said that repeatedly and I will say  7 it again.  8 If there was two  9 interventions, both that were efficacious  10 in alleviating gender dysphoria, one  11 resulted in a loss of sexual function,  12 exposure to risks of osteopenia, stroke,  13 metabolic effects, and the other did not  14 have any of those consequent effects by  15 not being exposed to those treatments,  16 the superior and preferred treatment  17 group would be the one that has the lower  18 risk.  19 Where it becomes more  20 difficult is if the intervention is not  21 equal as far as the response and weighing  22 the relative risks and benefits, and that  23 would have to be determined after the  24 trial and the information is available to  25 weigh those relative risks and benefits.</p>	<p style="text-align: right;">Page 348</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 acceptable and the desired outcome was  3 achieved, and we do this in many other  4 areas, and we can apply many of those  5 ethical principles that I mentioned that  6 we didn't discuss, including, for  7 example, the principle of totality or  8 double effect in assessing whether to  9 engage in that that -- again, you know,  10 looking at the scientific premise is  11 going to influence the likelihood of  12 whether we're able to see that. But if  13 it's done rigorously, then that's what we  14 do in medicine. And we do this in all  15 other areas of medicine and we certainly  16 have interventions.  17 If you think about the  18 treatment of people with cancer, there  19 are many interventions that we do that  20 have very significant risks, but it's  21 necessary in that circumstance -- and,  22 again, I would say that in most of those  23 cases we are doing this in the conduct of  24 research trials, in the rigorous manner  25 that I am proposing, where there can be</p>
<p style="text-align: right;">Page 347</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 At the current moment, what we  3 have available is a model that claims  4 erroneously that the conclusion has  5 already been reached and that alternative  6 approaches have been proven to be  7 ineffective. And those are false  8 statements that need to be addressed.  9 And so that is how I approach that  10 question.  11 Q. And as we've been discussing,  12 if the data were to show in the future,  13 understanding it could take a long time,  14 that these interventions did improve the  15 health and wellbeing of adolescents with  16 gender dysphoria, would you support them,  17 even though they could be based on a  18 premise that ignores the biological  19 reality as you have previously described  20 it?  21 MS. LAND: Objection to form.  22 A. Again, the goal of medicine is  23 to alleviate suffering. And if it was  24 proven that this was the most effective  25 intervention, that the risks were</p>	<p style="text-align: right;">Page 349</p> <p>1 PAUL W. HRUZ, M.D., Ph.D.  2 harms that are induced, but they're  3 engaged with a better knowledge of the  4 relative risks and benefits because  5 they've had the higher quality clinical  6 studies performed.  7 Q. Do you support surgical  8 interventions to change the appearance of  9 an infant's genitals when the infant has  10 certain disorders of sexual development?  11 MS. LAND: Objection to form.  12 A. So your question is related to  13 the care of individuals with disorders of  14 sexual development and I didn't have a  15 chance previously with your question to  16 address that aspect of the evolution of  17 care over time. But together, with the  18 question related to how we refer to the  19 individual, the initial presumption was  20 that we needed to definitively alter the  21 appearance of the genitalia to conform to  22 our best understanding of sexual  23 identity. And it's clearly not the  24 paradigm that is used currently. And I  25 think the best recommendations are to</p>


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1 PAUL W. HRUZ, M.D., Ph.D.  
2 defer those surgeries until later in  
3 life.  
4 The only exceptions would be  
5 if there are medical reasons that would  
6 necessitate earlier surgery. For  
7 example, an area of disordered sexual  
8 development that would lead to markedly  
9 increased risk of cancer or infection,  
10 urinary retention, there are conditions  
11 where you need to intervene.  
12 But for the goal of changing  
13 the appearance of the genitalia to allow  
14 the function to coincide with the sexual  
15 identity of that individual, I think  
16 most, including our institution that  
17 participates in that care, recognizes  
18 that that is a decision that does not  
19 need to be made in the newborn period.  
20 That it is apparent both from  
21 understanding the natural history of the  
22 condition as the child ages but also to  
23 acknowledge the other factors and  
24 allowing for that consent for that  
25 procedure to have that procedure done at

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1 PAUL W. HRUZ, M.D., Ph.D.  
2 a later stage of life.  
3 MR. STRANGIO: I think we are  
4 all set on this end.  
5 Thank you for your time, Dr.  
6 Hruz. I'll pass the witness.  
7 MS. LAND: Can we take a five  
8 minute break?  
9 VIDEOGRAPHER: We're off the  
10 record at 4:26 p.m.  
11 (Recess is taken.)  
12 VIDEOGRAPHER: We're back on  
13 the record at 4:33 p.m. Please  
14 proceed.  
15 MS. LAND: Thank you. No  
16 further questions from us but we  
17 would like to review and sign.  
18 VIDEOGRAPHER: Okay. This will  
19 complete the deposition. We're off  
20 the record at 4:33 p.m.  
21 (The proceedings were  
22 adjourned at 4:33 p.m.)  
23  
24  
25

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1 C E R T I F I C A T E  
2 I, MAUREEN M. RATTO, a  
3 Registered Professional Reporter, do  
4 hereby certify that prior to the  
5 commencement of the examination, PAUL  
6 W. HRUZ, M.D., Ph.D. was sworn by me to  
7 testify the truth, the whole truth and  
8 nothing but the truth.  
9 I DO FURTHER CERTIFY that the  
10 foregoing is a true and accurate  
11 transcript of the proceedings as taken  
12 stenographically by and before me at  
13 the time, place and on the date  
14 hereinbefore set forth.  
15 I DO FURTHER CERTIFY that I am  
16 neither a relative nor employee nor  
17 attorney nor counsel of any of the  
18 parties to this action, and that I am  
19 neither a relative nor employee of such  
20 attorney or counsel, and that I am not  
21 financially interested in this action.  
22  
23  
24   
25 MAUREEN M. RATTO, RPR  
License No. 817125

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1 I N D E X  
2 WITNESS: PAUL W. HRUZ, M.D., 7  
3 Ph.D.  
4 DIRECT EXAMINATION MR. STRANGIO 8  
5  
6 E X H I B I T S  
7 Exhibit Hruz 1, Expert Report of 18  
8 Paul Hruz, dated December 10,  
9 2021,  
10 Exhibit Hruz 2, Expert Rebuttal 21  
11 Report dated February 10th,  
12 2022,  
13 Exhibit Hruz 3, Abstract re: The 77  
14 Use of Cross-Sex Steroids in the  
15 Treatment of Gender Dysphoria by  
16 Paul W. Hruz  
17 Exhibit Hruz 4, article from New 78  
18 Atlantis entitled Growing Pains,  
19 Exhibit Hruz 5, article from 83  
20 NCBC entitled Experimental  
21 Approaches to Alleviating Gender  
22 Dysphoria in Children by Paul W.  
23 Hruz, MD  
24 Exhibit Hruz 6, National 225  
25 Catholic Bioethics Quarterly

<p style="text-align: right;">Page 354</p> <p>1 Submission Guidelines,  2 Exhibit Hruz 7, Amicus Brief re: 274  3 Nicholas Meriwether  4 Exhibit Hruz 8, amicus brief re: 299  5 Gloucester County School Board  6 v. Deirdre Grimm,  7 Exhibit Hruz 9, statement from 307  8 Florida Department of Health re:  9 Treatment of Gender Dysphoria  10 for Children and Adolescents  11 dated April 20, 2022  12  13  14  15  16  17  18  19  20  21  22  23  24  25</p>	<p style="text-align: right;">Page 356</p> <p>1 Brandt, Dylan Et Al v. Rutledge, Leslie Et Al.  2 Paul Hruz , M.D. (#5163582)  3 E R R A T A S H E E T  4 PAGE____ LINE____ CHANGE____  5 _____  6 REASON_____  7 PAGE____ LINE____ CHANGE____  8 _____  9 REASON_____  10 PAGE____ LINE____ CHANGE____  11 _____  12 REASON_____  13 PAGE____ LINE____ CHANGE____  14 _____  15 REASON_____  16 PAGE____ LINE____ CHANGE____  17 _____  18 REASON_____  19 PAGE____ LINE____ CHANGE____  20 _____  21 REASON_____  22 _____  23 _____  24 Paul Hruz , M.D. Date  25</p>
<p style="text-align: right;">Page 355</p> <p>1 Amanda Land, Esq.,  2 aland@arkansasag.gov  3 June 3, 2022  4 RE: Brandt, Dylan Et Al v. Rutledge, Leslie Et Al.  5 5/25/2022, Paul Hruz , M.D. (#5163582)  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 erratas-cs@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</p>	<p style="text-align: right;">Page 357</p> <p>1 Brandt, Dylan Et Al v. Rutledge, Leslie Et Al.  2 Paul Hruz , M.D. (#5163582)  3 ACKNOWLEDGEMENT OF DEPONENT  4 I, Paul Hruz , M.D., 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 Paul Hruz , M.D. 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</p>

[&amp; - ability]

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[actively - affirmation]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, 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.

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# Exhibit 6

1 THE UNITED STATES DISTRICT COURT

2 EASTERN DISTRICT OF ARKANSAS

3 CENTRAL DIVISION

4 CASE NO. 4:21-CV-00450-JM

5 -----x

6 DYLAN BRANDT, by and through his

7 Mother, JOANNA BRANDT, et al.,

8 Plaintiffs,

9 V.

10 LESLIE RUTLEDGE, in her official

11 capacity as the Arkansas

12 Attorney General, et al.,

13 Defendants.

14 -----x

15 CONTAINS CONFIDENTIAL PORTIONS

16  
17 REMOTE/ORAL/WEB VIDEOCONFERENCE

18 VIDEOTAPED DEPOSITION OF

19 STEPHEN B. LEVINE, M.D.

20 May 26, 2022

21 9:20 a.m. CDT

22  
23  
24 Reported by:

25 Maureen Ratto, RPR, CCR

<p>1                   * * *</p> <p>2</p> <p>3       Videotape deposition of Stephen B.</p> <p>4 Levine, M.D. held virtually via Zoom</p> <p>5 Teleconference, hosted from Veritext</p> <p>6 Legal Solutions, pursuant to notice,</p> <p>7 before Maureen Ratto, Certified Court</p> <p>8 Reporter, License No. XI01165,</p> <p>9 Registered Professional Reporter,</p> <p>10 License No. 817125, and Notary Public.</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>Page 2</p> <p>1 A P P E A R A N C E S, continued:</p> <p>2 Co-counsel for Plaintiffs:</p> <p>3 GILL RAGON OWEN, PA</p> <p>4 425 West Capitol Avenue</p> <p>5 Little Rock, Arkansas 72201</p> <p>6 BY: BETH ECHOLS, ESQ.</p> <p>7 echols@gill-law.com</p> <p>8</p> <p>9 Counsel for the Defendants:</p> <p>10 SENIOR ASSISTANT ATTORNEY</p> <p>11 GENERAL, PUBLIC PROTECTION DIVISION</p> <p>12 OFFICE OF ARKANSAS ATTORNEY GENERAL</p> <p>13 323 Center Street</p> <p>14 Little Rock, Arkansas 72201</p> <p>15 BY: MICHAEL CANTRELL, ESQ.</p> <p>16 michael.cantrell@arkansasag.gov</p> <p>17 AMANDA LAND, ESQ.</p> <p>18 aland@arkansasag.gov</p> <p>19</p> <p>20 ALSO PRESENT:</p> <p>21 JASON ELY, Legal Video Specialist</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p>Page 4</p>
<p>1 A P P E A R A N C E S:</p> <p>2 Counsel for the Plaintiffs:</p> <p>3 SULLIVAN &amp; CROMWELL, LLP</p> <p>4 125 Broad Street</p> <p>5 New York, New York 10004</p> <p>6 BY: BRANDYN RODGERSON, ESQ.</p> <p>7 rodgersonb@sullcrom.com</p> <p>8 EMILY ARMBRUSTER, ESQ.</p> <p>9 armbrustere@sullcrom.com</p> <p>10 SOPHIA MATTHEWS, ESQ.</p> <p>11 matthewss@sullcrom.com</p> <p>12</p> <p>13 AMERICAN CIVIL LIBERTIES UNION</p> <p>14 125 Broad Street</p> <p>15 New York, New York 10004</p> <p>16 BY: LESLIE COOPER, ESQ.</p> <p>17 lcooper@aclu.org</p> <p>18 CHASE STRANGIO, ESQ.</p> <p>19 cstrangio@aclu.org</p> <p>20</p> <p>21 ACLU OF ARKANSAS</p> <p>22 904 West 2nd Street</p> <p>23 Little Rock, Arkansas 72201</p> <p>24 BY: GARY SULLIVAN, ESQ.</p> <p>25 gsullivan@aclu.org</p> <p>Page 3</p>	<p>1 VIDEOGRAPHER: Good morning.</p> <p>2 We are going on the record at 9:25</p> <p>3 a.m. on May 26th, 2022.</p> <p>4 This is Media Unit 1 of the</p> <p>5 video-recorded deposition of</p> <p>6 Dr. Stephen Levine taken by counsel</p> <p>7 for Plaintiff in the matter of</p> <p>8 Dylan Brandt, et al versus Leslie</p> <p>9 Rutledge, et al, filed in the</p> <p>10 United States District Court,</p> <p>11 Eastern District of Arkansas, Case</p> <p>12 No. 4:21-CV-00450-JM.</p> <p>13 Will counsel please identify</p> <p>14 themselves for the record?</p> <p>15 MS. COOPER: Leslie Cooper,</p> <p>16 from the ACLU for Plaintiffs</p> <p>17 appearing in New York.</p> <p>18 MR. STRANGIO: Chase Strangio,</p> <p>19 from the ACLU for Plaintiffs, also</p> <p>20 appearing in New York.</p> <p>21 MR. ROGERSON: Brandyn</p> <p>22 Rogerson, from Sullivan Cromwell</p> <p>23 for the Plaintiffs, appearing in</p> <p>24 New York.</p> <p>25 MS. ARMBRUSTER: Emily</p> <p>Page 5</p>

<p style="text-align: right;">Page 6</p> <p>1 Armbruster, from Sullivan &amp; 2 Cromwell, for the Plaintiffs. 3 MS. MATTHEWS: Sophia 4 Matthews, Sullivan &amp; Cromwell, for 5 the Plaintiffs in New York. And 6 I'm joined by one of our summer 7 associates. 8 VIDEOGRAPHER: Mr. Cantrell, 9 can we get your appearance here? 10 MS. ECHOLS: Beth Echols, 11 Bill Ragon Owen, for the 12 Plaintiffs, in Little Rock. 13 MR. CANTRELL: I'm Michael 14 Cantrell, with the Arkansas 15 Attorney General's Office, for the 16 Defendants. 17 VIDEOGRAPHER: The witness 18 will now be sworn in by the 19 reporter. 20 * * * 21 STEPHEN B. LEVINE, M.D., having been 22 first duly sworn according to law by 23 the Officer, testifies as follows: 24 DIRECT EXAMINATION BY MS. COOPER: 25 MS. COOPER: We did not hear</p>	<p style="text-align: right;">Page 8</p> <p>1 STEPHEN B. LEVINE, M.D. 2 one another. So if you can let me finish 3 my question before you begin to answer, 4 then even if you anticipate the end of my 5 question it makes for a much cleaner 6 record if you let me finish the question 7 and you then answer and I will do my best 8 to wait until you completed your answer 9 before asking another question. Okay? 10 A. Okay. 11 Q. And it's important because 12 your testimony needs to be typed, that 13 you answer verbally, so nods can't be 14 picked up by the court reporter and also 15 words like a-hum are hard to transcribe. 16 So just be mindful of that, please, okay? 17 A. Okay. 18 Q. If I ask a question that is 19 not clear to you or you need 20 clarification, please just ask and I will 21 try to ask the question in a clearer way. 22 But if you answer the question I will 23 assume that you've understood it. Okay? 24 A. Okay. 25 Q. And we will likely need to</p>
<p style="text-align: right;">Page 7</p> <p>1 STEPHEN B. LEVINE, M.D. 2 sound when Dr. Levine said "I do". 3 THE WITNESS: I do. 4 Q. Thank you. Good morning, Dr. 5 Levine. 6 I know we've met before but 7 it's been a very long time so I'll 8 reintroduce myself. 9 My name is Leslie Cooper and 10 I'm with the ACLU, counsel for 11 Plaintiffs, and I'll be taking your 12 deposition this morning or today. 13 So let's start out, just for 14 the record, can you please state your 15 full name? 16 A. Stephen Barrett Levine. 17 Q. So I know you've been deposed 18 a number of times before, but just so 19 we're clear, I'll go through the 20 groundrules so that we make sure we get a 21 clean record and the court reporter is 22 able to transcribe my questions and your 23 answers. 24 So first ground rule is let's 25 both do our best to avoid speaking over</p>	<p style="text-align: right;">Page 9</p> <p>1 STEPHEN B. LEVINE, M.D. 2 take some breaks during the course of the 3 day. I will certainly call some but if 4 there is any point which you need a break 5 just let me know and if I have a pending 6 question we'll just ask that you answer 7 that question and I'll try to find a good 8 breaking point, okay? 9 A. Okay. 10 Q. Is there anything that would 11 prevent you from providing competent or 12 complete and competent testimony today? 13 A. I can't think of anything. 14 Q. Okay. Is there any material 15 you're consulting in connection with your 16 deposition today, anything in front of 17 you? 18 A. Nothing is in front of me. 19 Q. Okay. Did you do anything to 20 prepare for the deposition today? 21 A. Yes. 22 Q. What did you do? 23 A. I reread my original expert 24 opinion report, I read some of the other 25 Plaintiffs' experts report, I reread my</p>

3 (Pages 6 - 9)

<p style="text-align: right;">Page 10</p> <p>1       STEPHEN B. LEVINE, M.D.  2 recent article on informed consent,  3 things like that.  4       It's hard for me to answer  5 that question explicitly because I'm  6 constantly reading things on this  7 subject.  8       Q.   You mention you read some of  9 the Plaintiffs' expert reports. Which  10 ones?  11       A.   I read part of Dr. Adkins'  12 report again and I read Dr. Anton Maria.  13       Q.   Is that it?  14       A.   I read a very brief report  15 from -- like a three-page report from I  16 think an endocrinologist. Hutchison was  17 it perhaps?  18       Q.   Did you read a report from  19 Dr. Karasic?  20       A.   I originally read Karasic's  21 report but I didn't do it in preparation  22 for today.  23       Q.   Okay. And what about  24 Dr. Turban's report?  25       A.   I didn't read that yesterday</p>	<p style="text-align: right;">Page 12</p> <p>1       STEPHEN B. LEVINE, M.D.  2       VIDEOGRAPHER: We're going  3 back on the record. The time is  4 9:59.  5       Q.   Thank you. When we left off I  6 was asking about anything you did to  7 prepare for the deposition. I just have  8 one last question about that.  9       Did you speak with anyone  10 other than counsel about your testimony  11 today?  12       A.   No.  13       MR. CANTRELL: Give us one  14 second. We had a technical issue.  15       A.   No.  16       Q.   I want to ask some questions  17 about your background as a psychiatrist  18 and your treatment of patients.  19       I understand you've been a  20 psychiatrist for quite some time. Can you  21 give me an idea of approximately how many  22 patients you've treated in your career?  23       A.   Well, if my career begins when  24 I was finished my residency, I have been  25 practicing psychiatry full-time since</p>
<p style="text-align: right;">Page 11</p> <p>1       STEPHEN B. LEVINE, M.D.  2 either, but I've read it in the past.  3       Q.   Okay. Did you meet with  4 counsel to prepare for your deposition?  5       A.   I did.  6       Q.   When did you do that?  7       A.   7:30 this morning.  8       Q.   Was that the only meeting that  9 you had to prepare?  10       A.   That's right.  11       MS. COOPER: I just want to  12 pause for a moment. We're having  13 some sound issues again.  14       Can we -- do we need to go off  15 the record to clear this up? It's  16 been fuzzy.  17       THE WITNESS: I spoke very  18 softly the last time.  19       MS. COOPER: Can we go off the  20 record? I think it's more than  21 that.  22       VIDEOGRAPHER: Off the record  23 at 9:32.  24       (Discussion is held off the  25 record.)</p>	<p style="text-align: right;">Page 13</p> <p>1       STEPHEN B. LEVINE, M.D.  2 1973, July 1st. I've never actually  3 counted up the numbers of patients I've  4 seen, but I work an average of 35 hours a  5 week with patients. So you multiply that  6 by four and then multiply that by 12 and  7 then multiply that by 49, I think you'll  8 have the answer. I'm not that good with  9 math anymore in my head.  10       Q.   All right. So sounds like  11 we're talking about potentially more than  12 a thousand patients. Does that sound  13 right?  14       A.   I trust your math.  15       Q.   Okay. And can you give me an  16 approximate number of patients you see  17 within a year? Is it the same math that  18 you just described, about 35 patient  19 hours a week with four days a week, 12  20 months a year?  21       A.   Five and a half days a week  22 for most of those years.  23       Q.   Okay. So say in the past year,  24 is that five and a half days a week?  25       A.   No. In the past year I've seen</p>

<p style="text-align: right;">Page 14</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- I've worked from ten a.m. to six p.m.  3 only five days a week, and most of those  4 hours are spent with patients.  5     Q.   Okay. In your practice, do I  6 understand right, most of your patients  7 are adults?  8     A.   Teenagers and adults.  9     Q.   And by teenager, do you mean  10 under 18 or would you include 18 and  11 19-year-olds in that?  12     A.   No. I see sometimes 15, 16,  13 17-year-olds.  14     Q.   And I believe you recently  15 testified that you've seen about 50  16 adolescent minor patients in your career.  17 Is that still about right?  18     A.   All these are guesstimates,  19 Ms. Cooper. I don't think I've changed my  20 estimate since the last deposition.  21     Q.   Okay. So it would be fair to  22 say the overwhelming majority of your  23 patients are adults and a small, much  24 smaller number are minors?  25     A.   That's correct.</p>	<p style="text-align: right;">Page 16</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Well, I run teaching  3 conferences and sometimes a child is  4 presented with a parent at a teaching  5 conference, so...  6     Q.   So, but of your patients that  7 you've seen and treated, there's about  8 six prepubertal children total, all of  9 whom were there for gender  10 identity-related issues?  11     A.   Yes.  12     Q.   So that's a good pivot to  13 focusing in on your treatment of patients  14 with gender dysphoria or gender  15 identity-related issues. And I know  16 you've been asked about that at a number  17 of depositions, so I just want to follow  18 up a little bit to make sure I have that  19 clear.  20         Can you give me an approximate  21 number of adult patients you've  22 personally treated in the past year that  23 have gender dysphoria?  24     A.   I am hesitating because of the  25 word "treatment" or "treated".</p>
<p style="text-align: right;">Page 15</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Speaking of prepubertal  3 children, I believe you most recently  4 that I saw testified that you've seen  5 about six prepubertal children. Is that  6 about right still?  7     A.   That's about right, still.  8     Q.   And that's for any condition?  9     A.   No. Those are all  10 gender-identified children.  11     Q.   Okay.  12     A.   I'm sorry. I hear about other  13 children, I mean children with other  14 problems, since adults often talk about  15 troubles with their children.  16     Q.   But as far as your own  17 patients, you've seen about six  18 prepubertal children and all of them had  19 gender identity-related issues; is that  20 right?  21     A.   That is right.  22     Q.   You didn't see prepubertal  23 children for other conditions?  24     A.   Not generally.  25     Q.   Ever?</p>	<p style="text-align: right;">Page 17</p> <p>1       STEPHEN B. LEVINE, M.D.  2         Do you mean how many people  3 I've actually seen with a gender problem  4 versus somebody I'm actively regularly  5 trying to help with one problem or  6 another or do you mean all of the above?  7     Q.   Thank you. That's a good  8 question. Let's break it down.  9         So how many patients have you  10 seen in the past year who have had a  11 gender problem, I think is the language  12 you used?  13     A.   I would guess about ten.  14     Q.   And of those ten, how many  15 would you put in that other category of  16 regularly treating?  17     A.   Well, regularly treated  18 sometimes means regularly twice a year,  19 sometimes it means once a week, sometimes  20 it means someone coming for a three or  21 four hour consultation and there the  22 evaluation and the treatment get all  23 mixed up.  24         So I would say about the ten,  25 to use a concept of treatment of trying</p>

<p style="text-align: right;">Page 18</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to influence in one way or another,  3 clarify something, to be helpful to the  4 patient.  5       I've always tried to be  6 helpful. So I would say I've been  7 treating 100% of those people, but many  8 of them come for a one-time evaluation or  9 a followup.  10       So I think in the last year  11 probably most everyone I've seen has been  12 for a short-term intensive followup and  13 three or four of them may have been just  14 coming back every six months or three  15 months, something like that. Obviously, I  16 don't keep track of these numbers.  17       Q. Understood. And when you say a  18 short-term intensive followup, is that  19 different than an evaluation?  20       A. Well, it's someone I've  21 evaluated years before, you see.  22       Q. And then they come back for  23 another evaluation several years later?  24       A. No. They come back for  25 medication or some emotional issue</p>	<p style="text-align: right;">Page 20</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about your supervision of others, but  3 before we get to that. So I've just  4 asked you about in the past year.  5       Can you give me an  6 approximation of the number of patients  7 you've seen with gender dysphoria in the  8 past five years?  9       A. I would say that I have  10 contacts with families or patients  11 directly with gender dysphoria about ten  12 times a year. And I don't think that has  13 changed much in the last five years.  14       Q. And are some of those patients  15 people who -- let me rephrase that.  16       Do I correctly assume it's not  17 necessarily ten new patients each year,  18 that some of them are ongoing over a  19 course of more than one year?  20       A. Some of them, yes.  21       Q. Okay. And have patients with  22 gender dysphoria always been, you know, a  23 similar percentage of your practice,  24 these small numbers?  25       A. They've never been the</p>
<p style="text-align: right;">Page 19</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they're having.  3       Q. I see but -- I'm sorry. Go  4 ahead.  5       A. Someone, some 40-year-old  6 trans person just had renal cancer and he  7 came to discuss -- she came to discuss  8 that process.  9       Q. I see. So of the patients who  10 you were providing sort of ongoing  11 therapy for, would it be about three or  12 four in the past year who have had gender  13 dysphoria?  14       A. Most of my work in the past  15 year has been supervising other people  16 who have had patients with gender  17 dysphoria.  18       Q. I'll ask you about that. But  19 before we do that, of your own patients  20 is it about three or four that you've  21 seen that you're doing ongoing therapy  22 with in the past year?  23       A. I think it would be closer to  24 two to three.  25       Q. Okay. And I will be asking</p>	<p style="text-align: right;">Page 21</p> <p>1       STEPHEN B. LEVINE, M.D.  2 majority of my practice. It's varied from  3 year to year. You need to understand that  4 I used to be -- I started the first  5 gender identity clinic in Cleveland, Ohio  6 in 1974. And so in those days we were  7 keeping track of the numbers of people  8 and by 1989 we had -- I think we had 325  9 evaluations done and we stopped keeping  10 track when we stopped keeping track.  11       Would you repeat the question,  12 please? I don't think I answered it.  13       Q. Well, no, thank you. I was  14 asking whether the -- whether gender  15 dysphoria patients have always been a  16 similar percentage of your entire patient  17 pool?  18       A. My specialty from 1973 on was  19 human sexual problems, and gender  20 problems were just one of five or six  21 different categories of problems that  22 I've been involved with.  23       So I would say not more than  24 15% of my time over the course of my  25 career has been spent with gender</p>

<p style="text-align: right;">Page 22</p> <p>1       STEPHEN B. LEVINE, M.D.  2 problems. The rest of the time has been  3 spent with other ways that human beings  4 suffer sexually.  5     Q.   So let's turn to your  6 supervision of the work of others dealing  7 with gender issues.  8       Whose work do you supervise in  9 this area?  10    A.   I've always supervised all the  11 staff that has worked with me and so I've  12 always had a staff from 1973 on. So  13 basically, I've been the senior person  14 and on these -- so everyone who got  15 presented to our gender clinic eventually  16 got presented to me and many of the times  17 I've interviewed those people.  18       I now currently supervise six  19 people in the transgender team. Actually  20 someone just got added, so it would be  21 seven. And I also now supervise a  22 psychiatrist, child psychiatrist in New  23 York who calls me for supervision every  24 two weeks and we talk about her teenage  25 gender patients.</p>	<p style="text-align: right;">Page 24</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to gender dysphoria. And so I would say  3 -- are you asking for a number?  4     Q.   Yeah.  5     A.   I would say at any given time  6 there's probably a dozen people in our  7 practice with a gender identity issue.  8     Q.   The Transgender Team or -- the  9 Gender Diversity Team is the proper name  10 for it; is that correct?  11    A.   Yes.  12    Q.   Are they affiliated with any  13 other institution besides your private  14 practice?  15    A.   No.  16    Q.   Not with any university?  17    A.   No. I am but they are not.  18    Q.   And those folks who you  19 supervise who have seen about 12 patients  20 at any given time with gender identity  21 issues, are they a mixture of minors and  22 adults?  23    A.   Are you asking about the  24 patients or the staff?  25    Q.   The patients.</p>
<p style="text-align: right;">Page 23</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   So your staff at your  3 practice, you said there's seven people  4 on the trans team?  5     A.   Yes.  6     Q.   What is the trans team?  7     A.   We call it their Gender  8 Diversity Program. And so children,  9 teenagers and adults with these issues  10 present to our general outpatient mental  11 health practice.  12    Q.   And all seven providers in  13 that group see patients with gender  14 identity-related issues?  15    A.   Yes.  16    Q.   And approximately how many  17 patients with gender dysphoria has that  18 team seen in the past year, say?  19    A.   I don't -- I don't exactly  20 know, but they present cases to me at  21 this point once a month. It used to be a  22 little bit further -- I mean more often,  23 but in the last six months it's been once  24 a month. So almost every one of them has  25 patient or two who have some relationship</p>	<p style="text-align: right;">Page 25</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Yes.  3     Q.   And when you described these  4 other clinicians present a case to you  5 once a month, what does that mean, to  6 present a case?  7     A.   Well, they spend about 30  8 minutes telling us the story of their  9 patients and then the group of us discuss  10 the meaning of the story and we try to  11 help the therapist understand what is  12 going on a little more clearly and  13 sometimes we give guidance about what to  14 do next. That's what it means.  15    Q.   And do you have -- well, let  16 me ask it differently.  17       For all of the patients who  18 are being seen by these seven people on  19 the -- in the Gender Diversity Program,  20 do you have cases of every one of those  21 patients presented to you?  22    A.   Well, I have -- I have  23 clinicians of varying vintages of  24 experience and so perhaps the most  25 experienced person focuses mostly on</p>

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<p style="text-align: right;">Page 26</p> <p>1       STEPHEN B. LEVINE, M.D.  2 children and young teenagers. I'm not so  3 sure she feels it's necessary to present.  4       In general, we ask our  5 professionals, our colleagues to present  6 cases that present problems for them,  7 either diagnostic problems or therapeutic  8 problems or ethical problems.  9       So the more experienced person  10 doesn't necessarily feel the need to  11 present to us. Generally speaking, we  12 encourage our staff when they're  13 uncomfortable with the processes that are  14 happening between them and their  15 patients, we ask them to present. That's  16 always been the case in our conferences.  17       You should understand that I  18 run two conferences a week and have done  19 that since 1977 for staff for these  20 purposes. When the professional is  21 uncomfortable for any reason in dealing  22 with a patient, we ask that person to  23 present to the staff.  24       While I am the leader of the  25 staff, many -- the rest of the staff is</p>	<p style="text-align: right;">Page 28</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you were to put together the other  3 patients in your practice who have gender  4 dysphoria-related issues, how many in a  5 year?  6       A. For the entire staff?  7       Q. Yeah.  8       A. I have no confidence in the  9 answer to that question. Since -- if  10 there are 12 at any given time, I would  11 imagine that over the course of a year  12 there may be as many as 20. Our patients  13 tend to stay, you see, so it may be 20,  14 25.  15       Come to think of it -- I'm  16 hesitating because for some reason within  17 the last year I ran some data on -- let  18 me back up.  19       My computer system that keeps  20 track of diagnoses only goes back to  21 2017. And I think we had 182 people with  22 a diagnosis, one of the gender identity  23 diagnoses. And I think there was  24 something like 60 that were my patients.  25 But, again, please, I'm not sure I</p>
<p style="text-align: right;">Page 27</p> <p>1       STEPHEN B. LEVINE, M.D.  2 present and so we have a group discussion  3 about what the issue is.  4       Q. And who was that experienced  5 person you mentioned who focuses on  6 children and younger teens?  7       A. Who is it?  8       Q. Yes. What is their name?  9       A. Her name is Anna Novak.  10       Q. She's the person in your  11 practice who sees the most minors with  12 gender dysphoria; is that correct?  13       A. I would say so, yes.  14       Q. You mentioned -- I'm just  15 trying to get a sense of the patients in  16 your practice.  17       You mentioned that at any  18 given time there's about 12 people,  19 patients in your practice who are dealing  20 with gender identity issues.  21       Can you tell me over the  22 course of a year how many patients that  23 would be?  24       You mentioned that for  25 yourself it might be about ten. But if</p>	<p style="text-align: right;">Page 29</p> <p>1       STEPHEN B. LEVINE, M.D.  2 remember these numbers correctly.  3       Q. Okay. Understood. And just  4 going back to the supervision and your  5 role in supervising the care of these  6 patients, do I understand correctly that  7 you hear about issues with these patients  8 only when the clinician has problems or  9 issues that they want to discuss with  10 others in the practice; is that right?  11       A. The therapist is asked to  12 clarify what question they would like the  13 conference to address. So that is the  14 ideal way the conference begins; I'm  15 having a problem with this aspect or that  16 aspect, so we then try to address that  17 aspect.  18       Q. So you are not necessarily  19 brought into the care decisions for all  20 of the patients with gender dysphoria  21 issues at your practice; is that right?  22       A. No. I am -- well, in some  23 sense, yes, I am talking about the care  24 and decisions that are made, but it's a  25 lot more subtle than I think your</p>

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<p style="text-align: right;">Page 30</p> <p>1       STEPHEN B. LEVINE, M.D.  2 question implies.  3     Q.   But it wouldn't be for all  4 care decisions for all patients, it would  5 be -- only be for one that there is an  6 issue that the clinician wants to discuss  7 with the group; is that right?  8     A.   These are all credentialed  9 professionals. They make many many  10 decisions that they never consult anyone  11 about.  12     Q.   So focusing in now, I was  13 asking generally about patients with  14 gender dysphoria, sort of lumping  15 together adults and minors, and if we can  16 just focus in on minors now.  17       Of the I think you said  18 approximately ten people you've seen in  19 the past year, and I think you said two  20 to three in a recurring way, how many of  21 those gender dysphoria patients were  22 minors?  23     A.   A minor being somebody in the  24 teenage years?  25     Q.   Under 18.</p>	<p style="text-align: right;">Page 32</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the child or of the teenager, the  3 adolescent. So I don't know, you know,  4 how to answer your question. I don't  5 really consider the evaluation of a  6 teenager or adolescent complete without  7 an evaluation of their family  8 circumstances. And some of that  9 evaluation work is done without the  10 patient, the teenager present.  11       So I want you to understand  12 that I'm answering your question in terms  13 of that whole system, the family system,  14 not simply the 14-year-old.  15     Q.   Understood. So if the patient  16 is the 14-year-old I understand you would  17 likely see the patient as well as the  18 patient's parent and that would count as  19 one evaluation, right?  20     A.   Yes. And sometimes it's more  21 than one session with the parent.  22     Q.   But one -- sorry. That would  23 count at one minor patient who you were  24 treating?  25     A.   One family. I think about a</p>
<p style="text-align: right;">Page 31</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Yes. I would say the majority  3 of them in the past 12 months, have been  4 teenagers.  5     Q.   So again, that's about ten  6 total and two or three who you saw in a  7 regular way?  8     A.   Yes.  9     Q.   And then if we can expand that  10 to the past five years of the patients  11 that you've seen who have gender  12 dysphoria, can you give me an idea how  13 many are minors?  14     A.   I think you should multiply  15 times five of the answer I've previously  16 gave.  17     Q.   So would that be a total of  18 about 50 who you may have seen perhaps  19 once and 10 to 15 who you've seen in an  20 ongoing relationship; does that sound  21 right?  22     A.   Yes. Part of the -- part of my  23 hesitation here is I sometimes hear about  24 minors from their parents or I spend time  25 with parents as part of the evaluation of</p>	<p style="text-align: right;">Page 33</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient and a family as one.  3     Q.   Okay. So then in terms of the  4 number of minor patients, and including  5 their family, to estimate how many you've  6 seen in the past five years, does that  7 sound good?  8     A.   It would be -- I was just  9 clarifying the number 50 for you.  10     Q.   Okay. So that sounds about  11 right. In the past five years, and most  12 of them being a single evaluation, and 10  13 to 15 being ongoing treatment?  14     A.   Again, I want to use the word  15 guesstimate here.  16     Q.   A-hum. How many prepubertal  17 children with gender dysphoria have you  18 seen in the last year, if any?  19     A.   In the last year, prepubertal?  20 I think none.  21     Q.   And in the last five years  22 would that be the six you mentioned or  23 were they spread out over time?  24     A.   I don't think that I can  25 answer that question. I think -- you</p>

<p style="text-align: right;">Page 34</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know.  3     Q.   That's fine. You mentioned you  4 supervise a New York psychologist, I  5 think you said psychiatrist, a child  6 psychiatrist?  7     A.   A child psychiatrist.  8     Q.   What's their name?  9     A.   Pardon me?  10    Q.   What is that person's name?  11    A.   Must I answer that?  12       MR. CANTRELL: We can  13 designate information confidential.  14       MS. COOPER: We can  15 temporarily designate it  16 confidential and discuss that  17 later.  18    A.   Her name is Dr. Miriam  19 Goodman. I'm sorry. That's not right.  20 Grossman, Miriam Grossman.  21    Q.   And is that a common thing to  22 do in your field, to supervise somebody  23 from another practice somewhere?  24    A.   Oh, yes.  25    Q.   And I understand she pays you</p>	<p style="text-align: right;">Page 36</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I think she's primarily  3 interested in the forming a  4 psychotherapeutic relationship with these  5 people and talking about their  6 development and their motives and their  7 options. She is not an affirmative care  8 doctor. She is much more psychodynamic;  9 "I want to investigate this with the  10 patient" doctor.  11    Q.   Does she refer any of her  12 patients for hormone therapy?  13    A.   Some of her patients are on  14 hormone therapy. I don't -- I would guess  15 she's not the person to refer. She  16 doesn't discriminate against patients,  17 she doesn't try to stop them, she tries  18 to recognize that it's their option and  19 they need to consider their motives for  20 it and their fears about it and the  21 consequences of it.  22       MR. CANTRELL: Leslie, we will  23 designate the testimony about this  24 child psychiatrist as confidential.  25       MS. COOPER: All right. We can</p>
<p style="text-align: right;">Page 35</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for that supervision?  3     A.   She does, yes.  4     Q.   And that's a typical thing  5 that's done?  6     A.   Well, I don't know how  7 typical. You know, usually experienced  8 people don't want to pay for supervision,  9 but she read some of my papers and she  10 sought me out and we've been talking  11 every two weeks for probably six months,  12 maybe eight months.  13    Q.   And she treats patients with  14 gender dysphoria?  15    A.   Now her specialty is  16 adolescents with gender dysphoria.  17    Q.   And approximately how many  18 patients who are adolescents with gender  19 dysphoria does she see that you supervise  20 that care?  21    A.   I think she's probably talked  22 to me about six people.  23    Q.   Does she have a view about the  24 appropriateness of ever providing hormone  25 therapy for adolescents?</p>	<p style="text-align: right;">Page 37</p> <p>1       STEPHEN B. LEVINE, M.D.  2 review that later, but fine.  3     Q.   And I believe at a recent  4 deposition you mentioned that you  5 supervised another, I think a counselor  6 who was not part of your practice; is  7 that right? Was there a second person you  8 supervised, paid you for supervision?  9     A.   There is, but I don't recall  10 that that supervision was about a gender  11 -- well, it wasn't directly about a  12 gender case. Oftentimes, there are hidden  13 gender issues behind the presentation.  14    Q.   What is the name of that  15 counselor?  16    A.   Again, I'm not even sure I  17 remember her last name. Her first name is  18 Sherry.  19    Q.   And you don't remember her  20 last name?  21    A.   It's I think Katz.  22    Q.   Do you no longer supervise  23 her?  24    A.   She said she would get back to  25 me when she needed me and I haven't heard</p>

<p style="text-align: right;">Page 38</p> <p>1       STEPHEN B. LEVINE, M.D.  2 from her in about four months.  3     Q.   And she hasn't had any  4 patients with gender dysphoria issues  5 that she's discussed with you; is that  6 right?  7     A.   Well, she has a patient who  8 doesn't like sexual behavior with her  9 husband. And so part of that  10 investigation is helping her to know what  11 questions to ask involves the subtle  12 aspects of one's sexual identity.  13     Q.   Have you diagnosed any minor  14 patients with gender dysphoria?  15     A.   Ms. Cooper, patients come in  16 and tell the doctor that they have gender  17 dysphoria. This idea of diagnosing people  18 with gender dysphoria seems really formal  19 and physician-like. But the truth is  20 people come in and they tell you what  21 they have and that's -- they know the  22 diagnostic criteria for gender dysphoria.  23 And so the answer is yes, I have  24 diagnosed people with gender dysphoria,  25 but that really isn't such a difficult</p>	<p style="text-align: right;">Page 40</p> <p>1       STEPHEN B. LEVINE, M.D.  2 able to assess somebody for gender  3 dysphoria to be able to do that?  4     A.   I don't understand your  5 question but I forgot -- I didn't answer  6 your previous question completely.  7       Since 2006 I have supervised  8 the Gender Identity Team at the  9 Massachusetts Department of Corrections,  10 all of their inmates who have gender  11 dysphoria, so that's been 16 years. And  12 the supervision of those cases have been  13 ongoing and very numerous. I forgot that.  14       So the number of people I  15 supervise on the treatment of gender  16 dysphoria, these are adults, but they  17 number in the hundreds at this point. And  18 I'm sorry, I forgot that when you were  19 asking me the question.  20     Q.   Thank you.  21     A.   So would you repeat the last  22 question, please?  23     Q.   Sure. You had -- I had  24 previously asked you if you diagnosed any  25 patients with gender dysphoria and I</p>
<p style="text-align: right;">Page 39</p> <p>1       STEPHEN B. LEVINE, M.D.  2 process, since the patient tells you they  3 have it. And then you ask them a question  4 or two and then -- and then they meet  5 criteria generally.  6       Sometimes when they don't meet  7 criteria it's because they feel like they  8 have gender dysphoria for the last three  9 months and as you know that the criteria  10 is six months.  11     MR. CANTRELL: Leslie, just  12 for the record, I want it to be  13 clear that we were designating as  14 confidential the discussion of both  15 of the individuals who Dr. Levine  16 has supervised.  17     MS. COOPER: Outside of his  18 practice? Ms. Katz and Dr. Goodman,  19 that's who you are referring to,  20 right?  21     MR. CANTRELL: The two, the  22 two individuals, yes.  23     MS. COOPER: Okay.  24     Q.   So is it your view you don't  25 need to be a mental health provider to be</p>	<p style="text-align: right;">Page 41</p> <p>1       STEPHEN B. LEVINE, M.D.  2 believe you said yes, but that they  3 actually know themselves or diagnose  4 themselves.  5       Are you saying that one  6 doesn't need to be a mental health  7 provider to be able to assess whether  8 somebody has gender dysphoria?  9     A.   Well, I'm sure the primary  10 care physician, the nurse practitioner,  11 the cardiac surgeon, a physician, someone  12 who has a license, who has a credential  13 to make psychiatric diagnoses, which  14 would be any physician, could make a  15 diagnosis. But the diagnosis is based on  16 patient's self-report and to some extent  17 what the doctor or the licensee  18 perceives. And so one doesn't have to be  19 a mental health professional to make the  20 diagnosis. This is part of the problem,  21 you know.  22     Q.   Does your -- you mention that  23 you meet with the parents too. Does that  24 contribute to your assessment whether  25 somebody meets criteria for gender</p>

<p style="text-align: right;">Page 42</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria, what's reported by the  3 parents?  4     A.   Of course.  5     Q.   So you touched on -- I'm  6 sorry. You mention that if a patient  7 doesn't meet criteria it's usually  8 because it's just been three months and  9 the diagnostic criteria is six months.  10       Is that the only time you've  11 ever concluded that a patient did not  12 meet diagnostic criteria, is that the  13 length of time wasn't sufficient under --  14       MR. CANTRELL: Object to form.  15     A.   The purpose of a psychiatric  16 evaluation is to get a picture of the  17 person as a whole and not just the aspect  18 of that person's gender identity. And  19 oftentimes the diagnosis of a patient  20 carries much more serious concerns than  21 the gender identity issues or the sexual  22 identity or the orientation issues or the  23 paraphilic issues of the patients. It has  24 to do with their general mental health,  25 their depression, their suicidality,</p>	<p style="text-align: right;">Page 44</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Have you ever had patients,  3 adult or minors, who come to you because  4 maybe they already had a gender dysphoria  5 diagnosis, maybe they didn't, but their  6 goal is to get a diagnosis that -- and a  7 letter to be able to get hormone therapy?  8 Have you ever had patients like that?  9     A.   Oh, yes. Oh, yes.  10    Q.   Yes. And does that include  11 minors?  12    A.   Well, minors have asked for  13 that, yes. It includes minors.  14    Q.   Is it fair to assume that if a  15 minor has asked for that that you would  16 not provide a gender dysphoria diagnosis  17 if you did not think they met the  18 criteria?  19       MR. CANTRELL: Object to form.  20    A.   I think you better repeat that  21 question for me. There was something  22 about that question that seemed strange  23 to me.  24    Q.   Okay. Is it correct that if a  25 minor comes to you seeking a diagnosis</p>
<p style="text-align: right;">Page 43</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their self-harming, their anxiety states,  3 their social isolation, their autism,  4 their developmental physical activities,  5 their bedwetting, so forth.  6       So it's very important to  7 understand that I'm trying to get the  8 people I supervise to see the patient as  9 a whole, not just as a gendered person  10 because the treatment and the decisions  11 that ultimately are made by the family  12 has to do not simply with gender identity  13 but with how the person is doing in  14 general in the world. So that's the  15 answer to the question. It's much more  16 comprehensive.  17       Sometimes I make the diagnosis  18 that it's apparent that the person has  19 some kind of gender identity problem of  20 some duration. But I'm also very  21 sensitive to the other -- the other  22 emotional difficulties that they're  23 having at the same time or often what  24 preceded those; the diagnosis or the  25 crystallization of a trans identity.</p>	<p style="text-align: right;">Page 45</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and a letter for approval for hormone  3 therapy, that if you did not believe that  4 that minor had gender dysphoria and met  5 the diagnostic criteria you would not  6 give them that diagnosis; is that  7 correct?  8     A.   I would not write a letter in  9 support of hormone therapy if I didn't  10 believe that they had gender dysphoria.  11 Is that answer to your question?  12    Q.   It does answer. Thank you.  13       And have you ever had a  14 patient come in asking for a letter for  15 hormone therapy where you did not feel  16 they had gender dysphoria?  17    A.   Well, the patient tells me  18 that he or she has gender dysphoria. I  19 often see other issues and oftentimes  20 their parents see other issues.  21       So I generally don't meet a  22 person and write a letter for hormones. I  23 meet a person and I meet a person and I  24 meet a person and I meet a person and  25 then eventually I, if I feel it's in</p>

<p style="text-align: right;">Page 46</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their best interests and they understand  3 the pros and cons of this, and they  4 understand the nature of what is known  5 and what is not known, and they  6 understand what the problems are of adult  7 transsexual people, then I will sometimes  8 write a letter for them.  9     Q.   And are there people for whom  10 you would not write a letter, in -- let  11 me ask that in a clearer way.  12       Have there been people who  13 have sought a letter where you declined  14 to write a letter?  15     A.   Yes.  16     Q.   And were any of them  17 adolescents, minors?  18     A.   Well, actually the adolescent  19 tells me that they would like to take  20 hormones. They often don't tell me I want  21 a letter now. Adults have told me I want  22 a letter now, but teenagers generally  23 don't say those things to me. They say  24 they would like to have hormones or they  25 would like to have their genitals or</p>	<p style="text-align: right;">Page 48</p> <p>1       STEPHEN B. LEVINE, M.D.  2 adolescents tend to not be insistent on a  3 letter right now. But have you ever had  4 an adolescent patient at whatever point  5 in time, whether it was immediately or  6 into the therapeutic relationship, asked  7 for a letter and you did not feel it was  8 appropriate to provide that?  9     A.   You know, a person comes to  10 mind who was talking to me about getting  11 a letter from me eventually. Then in the  12 course of about six months of talking had  13 confessed to me that he is already taking  14 testosterone. And so I would not have  15 given that person a letter at that point,  16 in part, because that person had five  17 psychiatric hospitalizations by the time  18 he or she, depending on where they were  19 at the time, before they were 16 years of  20 age. But then at 17 surreptitiously was  21 taken testosterone but withheld that  22 information from me for a while.  23       So I guess the answer to your  24 question is there would be people with  25 gender dysphoria, claimed to have gender</p>
<p style="text-align: right;">Page 47</p> <p>1       STEPHEN B. LEVINE, M.D.  2 breasts redone and they agree to talk to  3 me over time. And sometimes -- well, I  4 could speak more directly to older people  5 who are very insistent, this is the only  6 thing they want from me and they don't  7 get the letter from me, they get the  8 letter sometimes from some of my staff,  9 but it's not exactly with my blessing.  10 But they're independent people and so I  11 have nothing to -- you know. It's their  12 clinical judgment.  13     Q.   Staying within the patients  14 who are minors, then do I understand  15 correctly that it's never been an  16 adolescent who has sought a letter that  17 you've declined to provide, only adults;  18 is that right?  19       MR. CANTRELL: Object to form.  20     A.   I -- again, I'm not grasping  21 your question.  22     Q.   Let me try to ask it  23 differently.  24       Has there ever been an  25 adolescent -- I understand that you say</p>	<p style="text-align: right;">Page 49</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria that I would not give a letter  3 for hormones at that point. I think  4 that's the answer to your question. Does  5 it seem like --  6     Q.   Yes. I think you've answered  7 my question. Thank you.  8       Have you ever had an  9 adolescent patient who you believed was  10 asserting a trans identity based on  11 social influence?  12     A.   Oh, yes.  13     Q.   Can you tell me about -- how  14 many times has that happened?  15     A.   Well, if you know anything  16 about -- and I'm sure you do -- about  17 adolescents and their involvement with  18 the internet and how teenagers going  19 through early puberty and having angst  20 about their body and their future body  21 and their degree of beauty or  22 handsomeness or masculinity or femininity  23 and how people spend what they do calling  24 "research" which means emersion in trans  25 websites and listening to trans guru and</p>

<p style="text-align: right;">Page 50</p> <p>1       STEPHEN B. LEVINE, M.D.  2 trans animae. So this is a very common  3 experience, I would say a universal  4 experience, in my clinical experience.  5       So that would be the cultural  6 influences of the typical trans teenager  7 that we hear about in our clinic. And as  8 far as I can see talking to colleagues  9 nationally and internationally, it's the  10 same thing.  11     Q.   And of those patients,  12 understanding that many of them look at a  13 lot of social media, did you believe any  14 of them were influenced to become  15 transgender or identify as transgender  16 who would not have otherwise --  17     MR. CANTRELL: Object to form.  18     Q.   -- except for social media?  19     A.   Well, in order to answer that  20 question I have to speculate. You're  21 really asking me; do I understand that  22 social media, cultural exposure,  23 education or miseducation or  24 indoctrination is an influence in some  25 teenager's new identification as a trans</p>	<p style="text-align: right;">Page 52</p> <p>1       STEPHEN B. LEVINE, M.D.  2 orientation and intention. And there  3 often are excursions into one or more  4 combinations of those three dimensions.  5 And so social media has helped many  6 people define themselves as, in some way,  7 as an atypical sexual identity before  8 they've had any social experience,  9 intimate experience, romantic experience  10 and even social experience with peers and  11 friendship patterns. So social media must  12 be considered as one of the developmental  13 influences on trans teenager gender  14 identity.  15     Q.   And you have supported  16 patients' social transition; is that  17 right?  18     A.   I -- yes.  19     Q.   And you've counseled some  20 parents to support the transgender  21 identification of their children?  22     A.   I've tried to at times, yes.  23     Q.   And looking at your patients  24 who have had gender dysphoria, have most  25 of them medically transitioned in some</p>
<p style="text-align: right;">Page 51</p> <p>1       STEPHEN B. LEVINE, M.D.  2 person? Then I would speculate yes.  3     Q.   And has there been any patient  4 you had who you felt that was what was  5 going on and did not diagnose them with  6 gender dysphoria as a result?  7     A.   That would not be a reason not  8 to diagnose them. That's a question about  9 where this came from or the developmental  10 influences on the patient's  11 crystallization of their identity as a  12 trans person.  13       You know, their identity  14 before they were a trans person have  15 oftentimes had -- they were something --  16 first they thought themselves to be  17 bisexual or lesbian or homosexual and  18 they were gay or not gay any longer or  19 not lesbian any longer. So you see that  20 adolescence is normally a change, a  21 change phenomenon over six, seven years.  22 And people assume different identities,  23 different dimensions of sexual identity.  24       There are three dimensions of  25 sexual identity; gender identity,</p>	<p style="text-align: right;">Page 53</p> <p>1       STEPHEN B. LEVINE, M.D.  2 way?  3     MR. CANTRELL: Object to form.  4     A.   I think you need to clarify  5 the question if you're only talking about  6 minors. Because if you're talking about  7 adults, the answer is very different.  8     Q.   All right. Let's break it  9 down. I think that's helpful.  10       Let's start with adults. Of  11 your adult gender dysphoria patients,  12 have most of them medically transitioned  13 in some way, either hormone therapy or  14 surgery or both?  15     A.   Yes. If I could just modify  16 "most", guessing, because some people  17 come to me thinking about it and then --  18 and some people come to me already on it  19 and some people I've written letters for  20 hormones for and surgery.  21     Q.   And of the patients, the adult  22 patients with gender dysphoria that you  23 have seen in the past year -- and I'm  24 trying to go back to find what your  25 estimate was of that number, I believe</p>

<p style="text-align: right;">Page 54</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you said about ten, but a smaller number  3 of whom you saw on a regular basis -- of  4 those patients, how many did not have any  5 medical transition?  6     A. I don't think in the past  7 year, I don't think in the past year I've  8 -- I've not seen anyone who was  9 contemplating medical transition but had  10 not transitioned. You know, I may have  11 been 18 months ago or 24 months ago, you  12 know, I can't -- I'm sorry. I think the  13 answer is probably zero or close to zero.  14     Q. And actually, now I'm  15 reviewing my notes, and I think, tell me  16 if I'm getting this right, that most of  17 your patients, when you said you had  18 about ten gender dysphoria patients in  19 the past year, two to three of whom were  20 on a recurring basis, that most of those  21 patients were minors; is that right?  22     A. Meaning, yeah, adolescents,  23 right.  24     Q. Under 18?  25     A. Yeah.</p>	<p style="text-align: right;">Page 56</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q. Okay.  3     A. And my brain does not work in  4 12-month intervals. So I've already  5 illustrated that I forgot a whole series  6 of work that I do in answering your  7 question. So your continuing to ask me  8 these numbers continues to make me feel  9 uncertain about my answers.  10     Q. All right. Let me try asking  11 it a different way.  12       Of the approximately ten or so  13 adolescent patients you've seen with  14 gender dysphoria, how many had medically  15 transitioned in some way?  16     A. Had medically transitioned? Is  17 that what you --  18     Q. Yes, medically.  19     A. Well, can I ask you if the  20 person who is surreptitiously taking  21 testosterone, would that be a medical  22 transition person?  23     Q. Sure. Let me ask it  24 differently.  25       Of the approximately ten</p>
<p style="text-align: right;">Page 55</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q. Okay. And so of those  3 adolescent patients, have most of those  4 patients also medically transitioned?  5     A. No. Most of them expressed the  6 desire to one day have medical transition  7 and most of their patients' parents are  8 horrified by it, about it and we were --  9 the teenager and I were talking.  10     Q. So of that ten that you've  11 seen altogether, and I know that's a  12 rough number because that includes  13 adults, is there any way to tease out, by  14 the way, just for clarity of our  15 conversations, of the approximately ten  16 people you've seen in the past year for  17 gender dysphoria, how many of them were  18 minors or under 18?  19     A. I think we already established  20 that they were mostly minors.  21     Q. Okay. But you can't say if it  22 was all?  23     A. You know, you're pursuing a  24 line of numerical questioning that I  25 already told you is a guess.</p>	<p style="text-align: right;">Page 57</p> <p>1       STEPHEN B. LEVINE, M.D.  2 adolescents you've seen with gender  3 dysphoria in the past year, how many of  4 them were taking hormone therapy, one way  5 or the other?  6     A. I think two.  7     Q. So one of them was the patient  8 you mentioned who was surreptitiously  9 taking testosterone; is that right?  10     A. Yes. But I think you should  11 understand that it is possible to get  12 hormones in ways that are not medically  13 approved and that this is one of the  14 great temptations that trans people have  15 when they're 15 and 16. And there is  16 another patient that was discovered to  17 have been trying to import estrogen from  18 China and it was discovered by his  19 parents. And it leaves me with the  20 feeling that even though some of the  21 people I've seen said they weren't on  22 hormones, there's at least the  23 possibility that they prematurely  24 transitioned without medical approval.  25       So this is just one of the</p>

15 (Pages 54 - 57)

<p style="text-align: right;">Page 58</p> <p>1       STEPHEN B. LEVINE, M.D.  2 great uncertainties we have in this field  3 about people telling the truth when they  4 go see a mental health professional with  5 this issue.  6     Q.   Okay. So did you have any, of  7 your ten or so adolescent patients you've  8 seen for gender dysphoria in the past  9 year, have medically approved hormone  10 therapy?  11    A.   Yes, one of them got hormones  12 got after 45 minutes with the first  13 doctor and I guess you would say that  14 that was medically approved.  15    Q.   So that was someone who saw  16 another doctor, got approved for hormones  17 by that other doctor and then saw you  18 later?  19    A.   Yes.  20    Q.   So of the ten or so  21 adolescents you've seen for gender  22 dysphoria, or who have had gender  23 dysphoria in the past year, you mentioned  24 one that you know of surreptitiously  25 receiving hormones, you know of one who</p>	<p style="text-align: right;">Page 60</p> <p>1       STEPHEN B. LEVINE, M.D.  2 taking hormone therapy but you don't know  3 for sure; is that right?  4     A.   Well, to my knowledge they're  5 not taking hormone therapy.  6     Q.   Okay.  7     A.   And one can never be sure  8 about any particular patient whether one  9 gets the whole truth.  10       Ms. Cooper, while you're  11 planning the next question can we take a  12 one minute break for mother nature?  13       MS. COOPER: Yes. Let's go off  14 the record.  15       VIDEOGRAPHER: Going off the  16 record. The time is 11:00.  17       (Recess is taken.)  18       VIDEOGRAPHER: Going back on  19 the record. The time is 11:06.  20     Q.   When we spoke earlier you  21 mentioned someone in your practice, I  22 think you said her name is Anna Novak; is  23 that right?  24     A.   N-o-v-a-k.  25     Q.   And is she a social worker?</p>
<p style="text-align: right;">Page 59</p> <p>1       STEPHEN B. LEVINE, M.D.  2 was approved in the 45 minute approval  3 process from another doctor.  4       Are there any others who you  5 know were receiving hormone therapy?  6     A.   Yes. And there was the one --  7 actually that person is sadly now  8 deceased -- who tried to import hormones  9 and I don't know whether the parents  10 discovered the first time or the second  11 time, and so I'm just not sure about that  12 particular person.  13       Oh, and I just -- I just --  14 again you're jogging my memory. There  15 was another person that went to the  16 University of Pittsburgh and had a  17 one-hour evaluation and was given a  18 testosterone prescription. So I forgot  19 about that. You see the longer you talk  20 to me the more I remember.  21     Q.   Good.  22     A.   So that would be I guess four  23 of people.  24     Q.   And of the other approximately  25 six, to your knowledge, they're not</p>	<p style="text-align: right;">Page 61</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   She's a Social Worker-S,  3 supervisor.  4     Q.   What does that mean?  5     A.   That means she's experienced  6 and has the license to supervise other  7 people in social work.  8     Q.   And is she I believe is the  9 person you said is most experienced in  10 your practice, of your staff, for the  11 treatment of adolescents with gender  12 dysphoria; is that right?  13     A.   No. In particular, with  14 children and young adults, yes. Well,  15 it's true what you said but I just want  16 to add also children.  17     Q.   A-hum. Is there anyone else on  18 your staff, besides yourself, that is  19 more experienced with adolescents with  20 gender dysphoria than Anna Novak?  21     A.   Nobody.  22     Q.   Okay.  23     A.   Although, most of the patients  24 we see these days are adolescents.  25     Q.   And she is able to make A</p>

<p style="text-align: right;">Page 62</p> <p>1       STEPHEN B. LEVINE, M.D.  2 diagnosis of gender dysphoria among her  3 patients where appropriate?  4     A.   Yes.  5     Q.   And is she able to recommend  6 treatment for those patients?  7     A.   Well, of course.  8     Q.   The fact that she's a social  9 worker doesn't preclude her from having  10 that ability to do that?  11       MR. CANTRELL: Object to form.  12     A.   Well, if there is a problem,  13 you know, she will present her case to  14 the group. But when she's seeing  15 children, the treatment is -- you know,  16 relates to the child's problems, the  17 family relationships. So she sees the  18 parents, she sees the child and when --  19 and that's true for her when her patient  20 is a teenager as well.  21       The treatment is to the extent  22 of the valuation and the  23 psychotherapeutic relationship, so she is  24 certainly able to recommend treatment.  25     Q.   And for any of her adolescent</p>	<p style="text-align: right;">Page 64</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   How many of those letters have  3 you co-signed for adolescent minor  4 patients?  5     A.   Very few. Over the course of  6 probably 20 years, a handful.  7       MS. COOPER: I'd like to mark  8 our first exhibit, which is tab 1.  9       (Exhibit Levine 1, Declaration  10 of Stephen B. Levine, MD, dated  11 February 23, 2022, was received and  12 marked on this date for  13 identification.)  14     Q.   We'll get to have some  15 practice with Exhibit Share. I'll let you  16 know when we have it uploaded.  17       THE WITNESS: What are we  18 doing?  19       MR. CANTRELL: She's marking  20 an exhibit and we're waiting for it  21 to be uploaded.  22       MS. COOPER: It should be  23 available now. You have to hit the  24 refresh button on your screen.  25       MR. CANTRELL: You can scroll</p>
<p style="text-align: right;">Page 63</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patients, have they been provided hormone  3 therapy?  4     A.   In recent years, no, from her  5 recommendation. I think some of the  6 families and some of the families then go  7 to another -- to an endocrinologist and  8 get the treatment. I'm not aware in the  9 last couple of years whether Mrs. Novak  10 has sent anyone for or recommended  11 hormone therapy treatment because I  12 generally sign letters with the therapist  13 for hormones and I don't recall her  14 bringing a letter to me. But we are doing  15 treatment, you understand, we're doing  16 treatment.  17     Q.   I understand. So you say in  18 the last few years you don't recall her  19 bringing a letter for hormone therapy for  20 a minor patient. Has she in the past?  21     A.   Yes.  22     Q.   And you've approved those  23 letters?  24     A.   I have signed, I've co-signed  25 a letter.</p>	<p style="text-align: right;">Page 65</p> <p>1       STEPHEN B. LEVINE, M.D.  2 up and down.  3       THE WITNESS: That's my expert  4 opinion report.  5     Q.   Dr. Levine, are you able to  6 see what's been marked as Exhibit 1?  7     A.   I can see it, yes.  8     Q.   And do you recognize this  9 document?  10     A.   I do.  11     Q.   Is this the declaration you  12 filed in the case BPJ in West Virginia?  13     A.   Yes.  14     Q.   And that was in February 2022,  15 according to the first page there; is  16 that right?  17     A.   Yes.  18     Q.   If you can scroll down to  19 paragraph 6 you'll see some highlighted  20 text there. Let me know when you've found  21 that.  22     A.   I have it.  23     Q.   Okay. I'm just going to read  24 and if you'll read along with me it says,  25 "In the course of my five decades of</p>

<p style="text-align: right;">Page 66</p> <p>1       STEPHEN B. LEVINE, M.D.  2 practice treating patients who suffered  3 from gender dysphoria I have at one time  4 or another recommended or prescribed or  5 supported social transition, cross-sex  6 hormones and surgery for particular  7 patients, but only after extensive  8 diagnostic and psychotherapeutic work."  9 Did I read that correctly?  10    A.   Yes.  11    Q.   Just a couple of questions  12 about terminology here.  13       When you say "prescribed", can  14 you tell me what you're referring to? Do  15 you mean actually writing prescriptions  16 or is something else?  17    A.   I mean writing a letter so the  18 endocrinologist can evaluate the  19 patient's physical status and make a  20 decision whether hormones are  21 contraindicated or not.  22    Q.   And when you say  23 "recommended", is that something  24 different?  25    A.   Different than what?</p>	<p style="text-align: right;">Page 68</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria, you need this treatment, it's  3 medically necessary.  4       So in a sense I've  5 recommended, I've gone along with, I've  6 said, well, if this is what you want to  7 do and I've assured myself, I've talked  8 to you about my concerns about this, and  9 I've agreed that if you go through  10 therapy and we think about this together,  11 and it's your decision, you have autonomy  12 about this, then I write a letter, I  13 recommend.  14       I don't recommend in the  15 former sense, I recommend in the latter  16 sense, that I've been with you for a long  17 time, and I respect your right to make  18 this decision.  19    Q.   Thank you. And I see in some  20 of your reports and depositions you've  21 used the word "approved" patients for  22 hormone therapy. Is that the same or do  23 you mean something different by that?  24    A.   No. You know, it's hard to --  25 it's efficient to use a word like</p>
<p style="text-align: right;">Page 67</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Than writing a letter for  3 somebody. I'm just trying to understand  4 what you mean by these terms.  5       Maybe there is no difference,  6 but I want to understand if there is a  7 meaningful difference when you say  8 "recommended", "prescribed" and you also  9 have the word "supported" in that  10 sentence, do those terms have different  11 meanings here?  12    A.   Well, I guess I'm hedging the  13 meanings of these words by using "or".  14    Q.   Okay.  15    A.   Really, what I really am  16 saying is that it's the patient's choice  17 at this point and I recognize that I've  18 done what I can to educate the person  19 about this and if the pattern wants to do  20 this, as the person does, then I write a  21 letter with my imprimatur as MD and  22 psychotherapist and experienced person in  23 the field.  24       It's not like I've seen the  25 person and I said, oh, you have gender</p>	<p style="text-align: right;">Page 69</p> <p>1       STEPHEN B. LEVINE, M.D.  2 "approved" or "recommended" or  3 "prescribed", without writing a paragraph  4 about the limitations of that.  5    Q.   But just to make sure I'm  6 understanding what you're referring to  7 when you would write a letter for  8 somebody after having a relationship with  9 them and determine that you've satisfied  10 yourself that you can write that letter  11 for them to take to an endocrinologist;  12 is that right?  13    A.   Yes.  14    Q.   Okay. You've also approved,  15 using the term in the same way, some of  16 your gender dysphoria patients, adult  17 patients that is for surgery; is that  18 right?  19    A.   Yes.  20    Q.   And when is the last time you  21 did that?  22    A.   Probably 16 months ago, 17, 18  23 months ago.  24       MS. COOPER: Okay. I'd like to  25 mark as the next exhibit what is</p>

<p style="text-align: right;">Page 70</p> <p>1       STEPHEN B. LEVINE, M.D. 2    tab 3. 3       We'll let you know when it's 4    uploaded. That's now available. Let 5    me know when you can see that. 6       (Exhibit Levine 2, excerpt of 7    the deposition of Stephen B. 8    Levine, MD re: Reilyn Keohane v. 9    Julie Jones was received and marked 10   on this date for identification. 11       THE WITNESS: It's a different 12   exhibit now? 13       MR. CANTRELL: Yes. It's a 14   different exhibit. 15    Q.   Are you able to see Exhibit 2, 16   Dr. Levine? 17    A.   I can see it, yes. 18    Q.   And do you recognize this as a 19   deposition you gave in the case of Reilyn 20   Keohane versus Julie Jones May of 2017? 21    A.   Actually, the last time I was 22   asked about this I didn't remember giving 23   a deposition. I only remembered being in 24   the courtroom at the trial but I presume, 25   I just don't remember the deposition.</p>	<p style="text-align: right;">Page 72</p> <p>1       STEPHEN B. LEVINE, M.D. 2    hormones very quickly and we are much 3    more cautious. We will give adolescents 4    hormones but not as quickly as the 5    Standards of Care would like." 6       Did I read that correctly? 7    A.   Umm. 8    Q.   Is that a yes? 9    A.   That is a yes. I'm trying not 10   to be funny. 11   Q.   Okay. 12   A.   I just want to compliment you 13   in your capacity to read. 14   Q.   Thank you so much. 15       So when you say there, just 16   for clarity, "I don't exactly follow the 17   Standards", do I understand correctly you 18   are referring to the WPATH Standards of 19   Care, 7th Edition? 20   A.   Yes, you are correct. 21   Q.   And when you say "we're much 22   more cautious" -- well, actually let me 23   ask it -- let me backup. 24       At the beginning of the 25   sentence you say in your "Center", is</p>
<p style="text-align: right;">Page 71</p> <p>1       STEPHEN B. LEVINE, M.D. 2    Q.   You remember being a witness 3   in that case; is that correct? 4    A.   Yes, I do. 5    Q.   Okay. If you could please 6   scroll down to page 59, and I think we've 7   only provided excerpts because we only 8   have one passage to show you. Okay? 9    A.   Yeah. 10   Q.   And I want to give you time to 11   read the surrounding text to make sure 12   that the context is clear to you. But do 13   you see that I've highlighted in blue 14   some text on page 59? Why don't you take 15   a moment to read the surrounding text, 16   including that and then we'll review it. 17       (Deponent reviews the 18   document.) 19   A.   Okay. I think I -- 20   Q.   Okay. I'm just going to read 21   now the highlighted passage that says, 22   "And so in my Center I recommend 23   psychotherapy to people, so I don't 24   exactly follow the Standards. The 7th 25   Edition wants to give adolescents</p>	<p style="text-align: right;">Page 73</p> <p>1       STEPHEN B. LEVINE, M.D. 2    that your medical practice that you're 3   referring to? 4    A.   Repeat the last sentence. In 5   the what? 6    Q.   Sure. At the first passage 7   there -- I'm sorry -- the first sentence 8   there "And so in my Center". And I just 9   want to clarify, in your Center, is that 10   your medical practice? 11   A.   Yes. 12   Q.   Okay. And do I understand 13   correctly that you are saying that you, 14   in your practice, in your center are much 15   more cautious in terms of timing and when 16   you would give hormones to adolescents, 17   compared to what the WPATH Standards of 18   Care 7 says? 19   A.   Yes. 20   Q.   And just, again, going back to 21   terminology, the phrase "we will give 22   adolescents hormones", do you mean 23   approve or write a letter, as you 24   described before? 25   A.   Exactly.</p>

<p style="text-align: right;">Page 74</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Q.   I think you mentioned a few</p> <p>3 minutes ago that over the course of your</p> <p>4 career or I guess -- strike that. I want</p> <p>5 to be more precise.</p> <p>6       I believe you testified over</p> <p>7 the past 20 years or so you've approved</p> <p>8 hormones for a handful of adolescents; is</p> <p>9 that correct?</p> <p>10      A.   Yes.</p> <p>11      Q.   Okay. And when was the last</p> <p>12 time you did that?</p> <p>13      A.   In August 2020. The reason I</p> <p>14 remember that is that in March 2021 this</p> <p>15 person died and so it's fixed in my mind</p> <p>16 these sequences.</p> <p>17      Q.   And is this a patient who died</p> <p>18 by suicide?</p> <p>19      A.   Well, it's not clear. He died</p> <p>20 of a heroin overdose and probably with</p> <p>21 fentanyl, but when I was seeing him there</p> <p>22 was no hint he was on heroin.</p> <p>23       He only went on heroin when he</p> <p>24 went to college and, as a trans person,</p> <p>25 and couldn't find a roommate. And then</p>	<p style="text-align: right;">Page 76</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A.   I'm not certain. If the answer</p> <p>3 is affirmative, like one, two or three,</p> <p>4 it certainly is an unusual thing.</p> <p>5       I think our center is known to</p> <p>6 be a place for people who want to think</p> <p>7 about this when they have gender</p> <p>8 dysphoria. We do occasionally see people,</p> <p>9 they are not necessarily adolescents,</p> <p>10 they could be 20, 21, 25, 26, 40, who</p> <p>11 feel like they want to have, you know,</p> <p>12 they know what they want. But what's</p> <p>13 happened, in 19 -- I would say for 20</p> <p>14 years in the Cleveland metropolitan area</p> <p>15 we were the only show in town that had</p> <p>16 expertise and interest in this problem.</p> <p>17 But subsequently other places have arisen</p> <p>18 and places associated with hospitals and</p> <p>19 individuals who are, quote, "gender</p> <p>20 specialists" in town. And so, generally</p> <p>21 speaking, when adolescents want hormone</p> <p>22 treatment and they have their parents</p> <p>23 consent or they go somewhere else. So our</p> <p>24 center these days selects people who want</p> <p>25 a more thoughtful, conservative, careful,</p>
<p style="text-align: right;">Page 75</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 eventually found a trans roommate that he</p> <p>3 didn't get along with, and then he didn't</p> <p>4 study, this kid who was brilliant, and</p> <p>5 then he left college and then started at</p> <p>6 a new college and by the time he --</p> <p>7 before he transferred to the new college</p> <p>8 he, unknown to me and to his parents, he</p> <p>9 was using heroin. And I think he had one</p> <p>10 Narcon revival in his home before he died</p> <p>11 in his dorm room at Ohio State.</p> <p>12       So whether this is suicide or</p> <p>13 just a product of bad judgment because of</p> <p>14 his pain, his ongoing pain, and then he</p> <p>15 died of a drug overdose, I'm not sure.</p> <p>16      Q.   And when was the last time you</p> <p>17 were asked to provide a letter for</p> <p>18 hormone therapy for an adolescent? Was it</p> <p>19 that patient?</p> <p>20      A.   I think that was the last</p> <p>21 time, yes.</p> <p>22      Q.   And have any of the providers</p> <p>23 that you supervise recommended or</p> <p>24 approved anyone under 18 for hormone</p> <p>25 therapy in the last five years?</p>	<p style="text-align: right;">Page 77</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 slow approach.</p> <p>3       So I would say that my career</p> <p>4 experience has to be divided into when we</p> <p>5 were the only show in town and when we</p> <p>6 became known as the place who is more</p> <p>7 conservative.</p> <p>8      Q.   I think you mentioned before</p> <p>9 that Ms. Novak at least has approved some</p> <p>10 minor patients for hormone therapy; is</p> <p>11 that right?</p> <p>12      A.   Yes. Yes.</p> <p>13      Q.   And any other providers at</p> <p>14 your center?</p> <p>15      A.   We're just talking about</p> <p>16 minors now?</p> <p>17      Q.   Yes.</p> <p>18      A.   I think I'm the one that sees</p> <p>19 most of the minors, Mrs. Novak and</p> <p>20 myself. Well, we have a child</p> <p>21 psychiatrist who participates in the</p> <p>22 evaluation of these adolescents, but</p> <p>23 basically she doesn't do the</p> <p>24 psychotherapy. She does sort of diagnosis</p> <p>25 of anxiety and depression and autism and</p>

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<p style="text-align: right;">Page 78</p> <p>1       STEPHEN B. LEVINE, M.D.  2 so forth.  3       Q.   So between you and Mrs. Novak  4 there have been a handful of cases in the  5 past, say, five years where you have  6 approved hormone therapy for minors; is  7 that right?  8       A.   These are particularly  9 fraught, difficult circumstances, yes.  10       Q.   Can you say what you mean by  11 that?  12       A.   Well, many of the people with  13 gender dysphoria have what others call  14 comorbid conditions. And sometimes we  15 have very disturbed people who are very  16 insistent and we don't seem to be able to  17 get anywhere in understanding their lives  18 with them until they get what they want,  19 so to speak.  20       So as I've said in some of my  21 publications, the ethical problems  22 involved with these patients are  23 sometimes very complicated and one has to  24 make decisions that one is uneasy about.  25       I, for one, am very sensitive</p>	<p style="text-align: right;">Page 80</p> <p>1       STEPHEN B. LEVINE, M.D.  2 treatment programs at three special  3 gender programs in Cleveland, when people  4 want hormones they often go to those  5 places and they get their hormones.  6 Those places don't often even ask us for  7 a letter of recommendation.  8       So the scene in my region is  9 perhaps different than the scene in  10 Little Rock or New York and so forth. And  11 -- that's all.  12       Q.   Have you ever written letters  13 of authorization for minor patients to --  14 minor patients with gender dysphoria to  15 receive puberty blockers?  16       A.   To what puberty blockers?  17       Q.   To receive puberty blockers.  18       A.   Never.  19       Q.   What about Mrs. Novak or  20 others in your practice?  21       A.   Never.  22       Q.   Have you ever written a letter  23 of authorization for any minor patient  24 for top surgery?  25       A.   Meaning less than 18?</p>
<p style="text-align: right;">Page 79</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to the long-term consequences of  3 medicalizing this problem because I'm  4 perhaps more aware of anyone in my unit  5 of the literature in this field. So I  6 find myself being ethically comfortable  7 talking with and not immediately giving  8 hormones to people immediately, meaning  9 quickly. I don't mean in 40 minutes or 60  10 minutes, I mean over a course of months.  11 So I think that's the answer to your  12 question.  13       Q.   Understood. But just in terms  14 of timeframe, I'm trying to get an  15 understanding, that I think you testified  16 both you and Mrs. Novak have approved  17 minor, some minor patients for hormone  18 therapy, and has that happened within the  19 past five years?  20       A.   What I'm saying -- I'm not  21 sure. I think -- I think it probably has  22 on rare occasion.  23       What you need to understand,  24 given the reputation that we have and the  25 availability of specialized gender</p>	<p style="text-align: right;">Page 81</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Q.   Yes.  3       A.   Never.  4       Q.   And what about others in your  5 practice?  6       A.   As far as I know, never.  7       Q.   And as patients come to you  8 now, going forward, current patients and  9 potentially new patients who are minors  10 with gender dysphoria, would you consider  11 writing a letter for them, if after that  12 careful, lengthy, exploratory period, you  13 felt it was appropriate?  14       MR. CANTRELL: Object to form.  15       A.   Ms. Cooper, as I said before,  16 I view gender dysphoria as one aspect of  17 a person's life, and I'm very sensitive  18 to finding other aspects of a person's  19 life, in particular, when they're  20 dysfunctional or highly symptomatic, as  21 some of the patients that we get to see  22 are, as most of the patients that we get  23 to see happen to be. So it's not a matter  24 of, here is the diagnosis, here is the  25 treatment. It's, here is the person who</p>

<p style="text-align: right;">Page 82</p> <p>1       STEPHEN B. LEVINE, M.D.  2 has gender dysphoria, who is autistic,  3 who is self-harming, who is not going to  4 school. And when I look at the whole  5 person I can't -- it's such a different  6 thing than what you're asking me.  7       You're asking me about when  8 gender dysphoria exists in a whole  9 person, do I recommend hormones or  10 surgery?  11     Q.   That is not what I meant to  12 ask you. So maybe I should clarify the  13 question.  14     A.   Thank you.  15     Q.   I understand from your  16 testimony that you have for some patients  17 written letters approving them for  18 hormone therapy.  19       I'm just trying to understand  20 whether that is something that you would  21 still consider at any point for future  22 patients? Or put another way, have you  23 taken that off the table and would no  24 longer consider that, regardless of the  25 circumstances?</p>	<p style="text-align: right;">Page 84</p> <p>1       STEPHEN B. LEVINE, M.D.  2 theoretically, if various factors were in  3 place, could see approving you said  4 someone who was 18 for hormone therapy.  5 Have you now ruled out for 17-year-olds  6 in the similar scenario you described?  7       MR. CANTRELL: Object to form.  8     A.   I haven't in an absolute sense  9 ruled out, but I am particularly inclined  10 to be wanting to delay the use of these  11 medications and certainly of surgeries  12 until I believe the person has had enough  13 maturity and enough life experience to  14 realize what the consequences of this  15 will be in the short term and in the  16 long-term.  17       So I am biased to provide  18 psychotherapeutic treatment as opposed to  19 hormonal treatment and I'm much quicker  20 to recommend psychotherapeutic treatment  21 than I am medical or surgical treatment  22 in minors, and in majors as well.  23     Q.   And by "majors", I assume you  24 mean adults, just for the record; is that  25 correct?</p>
<p style="text-align: right;">Page 83</p> <p>1       STEPHEN B. LEVINE, M.D.  2       MR. CANTRELL: Object to form.  3     A.   Those are two questions. So  4 I'll answer the first question.  5       On a theoretical basis, if I  6 had an opportunity to consider the whole  7 patient and the family and had an  8 opportunity to address the adversities in  9 the person's past and improve some  10 things, and if I thought that this person  11 was cognitively free enough from the  12 psychopathology to make an informed  13 decision and was 18-years-old, I could  14 theoretically say I will write a letter  15 in support of hormone therapy. That was  16 the answer to your first question.  17       That doesn't happen very  18 often. And as I already told you, the  19 last time I did that I've had to deal  20 with the parents grieving in my office.  21       Now, if you could repeat the  22 second question, I'll answer that.  23     Q.   Well, let's drop that one. I  24 want to follow up here.  25       Now, you mention that you</p>	<p style="text-align: right;">Page 85</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   For the record.  3     Q.   For the record.  4       So in the past when you have  5 approved people under 18 for hormone  6 therapy, had you determined that they had  7 the maturity to understand all the  8 implications that you were describing and  9 you made the judgment that it was  10 appropriate to author that letter?  11       MR. CANTRELL: Object to form.  12     A.   I don't think so. That's what  13 I mean, these things are ethically  14 fraught. One cannot be sure a  15 15-year-old, a 16-year-old, a 18-year-old  16 is mature enough. These are fraught --  17 these cause anguish in the souls of the  18 doctors. Or if they don't, I worry why  19 they don't.  20     Q.   When you've written letters  21 for adolescents in the past, did you  22 first determine that they had  23 long-standing stable -- a long-standing  24 stable gender identity?  25       MR. CANTRELL: Object to form.</p>

22 (Pages 82 - 85)

<p style="text-align: right;">Page 86</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A.   Yes. I would be very</p> <p>3 disinclined to write a letter for</p> <p>4 hormones if somebody had this for six</p> <p>5 months or seven months.</p> <p>6       MS. COOPER: Let's mark as</p> <p>7 Exhibit 3, tab 4, please.</p> <p>8       (Exhibit Levine 3, article re:</p> <p>9 Reconsidering Informed Consent</p> <p>10 written by Stephen B. Levine, MD,</p> <p>11 in the Journal of Sex &amp; Marital</p> <p>12 Therapy, was received and marked on</p> <p>13 this date for identification.)</p> <p>14 Q.   It should be available now.</p> <p>15 A.   Exhibit 3, I'll open 3?</p> <p>16 Q.   Yes. Let me know when you're</p> <p>17 able to see it.</p> <p>18 A.   I'm there.</p> <p>19 Q.   Do you recognize this</p> <p>20 document, Doctor?</p> <p>21 A.   I do.</p> <p>22 Q.   Is this your article</p> <p>23 Reconsidering Informed Consent for</p> <p>24 Trans-Identified Children, Adolescents</p> <p>25 and Young Adults?</p>	<p style="text-align: right;">Page 88</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       So when we socially transition</p> <p>3 a child or a teenager, that pretty much</p> <p>4 increases -- that increases their chance</p> <p>5 of getting medically transitioned in the</p> <p>6 future with all those consequences.</p> <p>7       So what I'm saying is parents</p> <p>8 need to be more fully understanding of</p> <p>9 what science knows and what science</p> <p>10 doesn't know, you see. And they need to</p> <p>11 understand what we're worried about with</p> <p>12 adults who have already made this</p> <p>13 transition and what the indicators of</p> <p>14 their dysfunction is as a group. So</p> <p>15 that's what informed consent, that's what</p> <p>16 this is about, you see.</p> <p>17       Are we, number one, evaluating</p> <p>18 these children correctly? Number two, do</p> <p>19 the doctors know the facts in this field?</p> <p>20 And three, are people being told what</p> <p>21 science knows and what science doesn't?</p> <p>22 And four, what -- do parents understand</p> <p>23 what the -- what the social, medical and</p> <p>24 psychological problems are of adults who</p> <p>25 have been well transitioned -- have been</p>
<p style="text-align: right;">Page 87</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A.   Yes, it is.</p> <p>3       Q.   And this was published in --</p> <p>4 this year, 2022, correct?</p> <p>5       A.   March 17th.</p> <p>6       Q.   I've read the article and as I</p> <p>7 understand it, and tell me if I'm getting</p> <p>8 this right, that you are recommending</p> <p>9 some specifics of an informed consent</p> <p>10 process that you think providers should</p> <p>11 undertake before authorizing hormone</p> <p>12 therapy for medical transition for</p> <p>13 minors; is that right?</p> <p>14 A.   And surgical transition, yes.</p> <p>15 Q.   Surgical transition. Okay.</p> <p>16 A.   And social transition.</p> <p>17 Q.   Okay. Thank you.</p> <p>18 A.   So let's be clear. To socially</p> <p>19 transition a person has enormous lifetime</p> <p>20 consequences. To add hormones as</p> <p>21 additional lifetime consequences and to</p> <p>22 remove bodily tissues that are healthy,</p> <p>23 have also have additional psychological</p> <p>24 consequences and parents need to</p> <p>25 understand all of the above.</p>	<p style="text-align: right;">Page 89</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 long transitioned. You see, that's what</p> <p>3 this article is about.</p> <p>4       Q.   Okay. And is it a description</p> <p>5 of the process for informed consent that</p> <p>6 you would apply with patients who are</p> <p>7 adolescents seeking social transition or</p> <p>8 medical transition?</p> <p>9       A.   I'm sorry. Would you repeat</p> <p>10 that, the first part?</p> <p>11 Q.   Sure. What you describe in</p> <p>12 this article, is it a process for</p> <p>13 obtaining informed consent that you would</p> <p>14 apply with patients who are minors</p> <p>15 seeking social transition or medical</p> <p>16 transition?</p> <p>17 A.   Yes. It would be a process</p> <p>18 with the parents and the minor. Yes,</p> <p>19 exactly.</p> <p>20 Q.   You anticipated my next</p> <p>21 question, whether that process includes</p> <p>22 the parents. So that's a "yes"?</p> <p>23 A.   The parents are the only</p> <p>24 people that can legally can give consent.</p> <p>25 Of course it has to involve the parents.</p>

<p style="text-align: right;">Page 90</p> <p>1 STEPHEN B. LEVINE, M.D.  2 Q. Right. And you would gauge,  3 according to your recommendation in this  4 article, gauge whether the minor  5 comprehends all the information that  6 you're providing them; is that right?  7 MR. CANTRELL: Object to form.  8 A. To the extent that one can  9 accurately assess whether a minor can, a  10 13-year-old, a 14-year-old can appreciate  11 a list of medical and psychosocial and  12 psychosexual problems of being 30. You  13 see, that's why we want to emphasize the  14 parents, not the child.  15 I don't really think the  16 typical 14-year-old has the capacity.  17 They have the passion; they have the  18 zeal; they have the "I can't live without  19 this" quality; they have the overvalued  20 idea. They don't have the life  21 experience to appreciate what this means.  22 Q. I see your coauthors listed  23 here are E. Abbruzzese. Am I saying that  24 right? I'm going to spell it for the  25 court reporter Abbruzzese</p>	<p style="text-align: right;">Page 92</p> <p>1 STEPHEN B. LEVINE, M.D.  2 economist and a methodologist, she's an  3 expert in analyzing material relating to  4 health and she works for a health  5 organization, but I don't think she's  6 affiliated with a university, if that's  7 what you're asking.  8 Q. No. I was just trying to  9 understand her background. And what do  10 you know about Julia Mason?  11 A. She's a pediatrician who has  12 some experience with gender patients and  13 conservative, "let's be thoughtful about  14 this" approach. She doesn't -- I don't  15 think she agrees with some of her  16 colleagues in pediatrics who think social  17 transition of six-year-olds is a good  18 idea.  19 Q. And I understand that she's  20 also affiliated with SEGM. Is it okay if  21 I use those initials?  22 A. SEGM. I think we -- we call it  23 SEGM.  24 Q. SEGM, happy to use that. Is  25 she also affiliated with SEGM?</p>
<p style="text-align: right;">Page 91</p> <p>1 STEPHEN B. LEVINE, M.D.  2 A-b-b-r-u-z-z-e-s-e?  3 A. Yes.  4 Q. That's one. And the other is  5 Julia W. Mason; is that correct, they're  6 your coauthors of this paper? Okay.  7 A. Your reading skills continue  8 to be excellent.  9 Q. Who is E. Abbruzzese?  10 A. Who is she?  11 Q. Well, does that person go by E  12 or is that a full name?  13 A. She prefers to go by E.  14 Q. Okay. I see on this paper her  15 affiliation listed is SEGM, the -- I'm  16 going to say that wrong.  17 A. I'll say it for you.  18 Q. Say it for me. Thank you.  19 A. The Society For Evidence-Based  20 Gender Medicine.  21 Q. That is the affiliation. Do  22 you know if E. Abbruzzese is affiliated  23 with any university or any other  24 organization as well?  25 A. Well, she is -- she's a health</p>	<p style="text-align: right;">Page 93</p> <p>1 STEPHEN B. LEVINE, M.D.  2 A. I think she -- yes.  3 Q. How did you come to partner  4 with these two authors on this paper?  5 A. People have read some of my  6 writing and asked me to join. Sometimes I  7 get invitations for this or that based on  8 what people have read that I've written  9 and E invited me to be part of a  10 psychotherapy group of mental health  11 professions who were looking at the  12 possibility of alternate approaches to  13 this because many of them have seen  14 negative consequences in patients to  15 transitions premature -- what they call  16 premature transitions.  17 So I joined a  18 once-every-two-weeks, one-and-a-half-hour  19 discussion on the internet with people  20 from Australia and England and Ireland  21 and Canada and various parts in the  22 United States. And so we talked about --  23 we were talking about these issues and  24 talking about cases and talking about the  25 difficulties in doing various forms of</p>

24 (Pages 90 - 93)

<p style="text-align: right;">Page 94</p> <p>1       STEPHEN B. LEVINE, M.D.  2 work and talking about the general trust  3 -- thrust of how science has been ignored  4 and a treatment fashion has taken over,  5 and there has been a political  6 indoctrination that's been amazingly  7 successful, and there's been a confusion  8 of medical science with political  9 concepts and civil rights.  10       So we got together to start  11 talking about these issues and people  12 were impressed that I have written of the  13 issues that they were talking about, so  14 they invited me to join the discussion.  15 And during those discussions it was  16 proposed, since I have had this interest  17 in informed consent and feeling like  18 there has been ethical problem in not  19 having the elements of informed consent,  20 that SEGM decided they would like me to  21 write a paper on this subject. And  22 starting I would say in January 2021 I  23 began writing a paper and SEGM actually  24 gave me a grant to, \$5,000, for the  25 effort to develop a paper.</p>	<p style="text-align: right;">Page 96</p> <p>1       STEPHEN B. LEVINE, M.D.  2 them I never heard back from them. But I  3 did write a letter authorizing a  4 mastectomy for a 26-year-old engaged  5 person, who is living together with her  6 fiancé, his fiancé.  7       Q. I believe you testified in  8 another case that you've written letters  9 for gender-dysphoric adults more than 50  10 times; is that right?  11       A. Over the course of a lifetime,  12 you know, I just use the word guesstimate  13 again to remind you of my previous  14 testimony.  15       In 1974, 1984 and 1994 the  16 field was very different. Our  17 understanding was very very different.  18 The situation, the landscape has changed  19 dramatically.  20       In the early years, in the  21 early decades we were dealing primarily  22 with adults and primarily with male  23 adults. But now the landscape, as you  24 well know, is a very different thing.  25       Q. But is that right, that you've</p>
<p style="text-align: right;">Page 95</p> <p>1       STEPHEN B. LEVINE, M.D.  2       That paper occupied me for, I  3 would say, 15 months of my time, and I  4 probably worked at the level of getting  5 \$2 an hour for the amount of time I spent  6 in developing this paper. So that's sort  7 of the background.  8       Q. Okay. Thank you. Have you  9 written letters of authorization for  10 adult gender dysphoria patients to get  11 gender-confirming surgeries?  12       A. I recently wrote a paper --  13 sorry. I wrote a letter of support most  14 recently for two people; one, the woman I  15 mentioned who developed renal cancer for  16 an orchiectomy, which she never went  17 through with, not because of the cancer  18 but for other reasons; and I wrote a  19 letter for a mastectomy to a 26-year-old  20 person who is engaged to a woman and I  21 had interviewed both the patient three  22 times and the fiancé. And I got a  23 promise from that person that I would see  24 them back three months after their  25 mastectomy. And despite my contacting</p>	<p style="text-align: right;">Page 97</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- does that sound about right, that  3 you've recommended or approved surgery at  4 least 50 times?  5       A. Well, if we could count it and  6 it turned out to be 36 or 61 it wouldn't  7 surprise me.  8       Q. Okay. Fair enough. So we've  9 talked about letters authorizing hormone  10 therapy. What do you say in these  11 letters?  12       A. What I say in these letters is  13 very different than what I've seen  14 recommended in these letters.  15       Q. What do you say?  16       A. I talk about the evaluation  17 that I've done, I talk about the person,  18 I talk about their strengths, their  19 weaknesses or their limitations, I talk  20 about their symptoms bearing, I talk  21 about their reasons for doing this, I  22 talk about my unease, if I have unease,  23 and I usually have unease. You see, so I  24 give a picture. So I've heard from  25 people that these are the most</p>

25 (Pages 94 - 97)

<p style="text-align: right;">Page 98</p> <p>1       STEPHEN B. LEVINE, M.D.  2 comprehensive and helpful letters I've  3 ever received from anybody.  4       I've written a book written by  5 -- published by the American Psychiatric  6 Association on transgender healthcare and  7 I saw the sample letters that people were  8 recommending and, basically; I have seen  9 this person and I think they're  10 cognitively prepared for this, they  11 understand the limitations and it's my  12 recommendation that they be given  13 hormones.  14       This is not the letter that I  15 have ever written or co-signed. The  16 letters that we write talk about the  17 elements of the evaluation and the whole  18 person and that we have discussed these  19 matters with the patient, and they're  20 usually a minimum of three page, two to  21 three page letter.  22     Q.   And do you say in the letters  23 that you believe that treatment is likely  24 to benefit the patient?  25     A.   No. I generally say that the</p>	<p style="text-align: right;">Page 100</p> <p>1       STEPHEN B. LEVINE, M.D.  2       The answer to your question, I  3 think in a briefer way, is that of course  4 I wouldn't write a letter thinking it's  5 going to harm them. I do -- I guess what  6 I said is sometimes I'm not sure it's  7 going to benefit them.  8     Q.   You mention some people are  9 lost to followup. Is that a common thing  10 in medical care in the United States?  11       MR. CANTRELL: Object to form.  12     A.   It's not a common thing in  13 ideal medical care, but it's certainly a  14 common thing in trans care.  15     Q.   So it's not a common thing  16 with your other kinds of patients who you  17 have for other conditions?  18     A.   Oh, I'm sure you can find  19 countless examples where there is a short  20 intervention with a patient and the  21 doctor never sees the patient again, of  22 course. But this is a chronic condition,  23 you know, gender dysphoria. It's not  24 really a curable condition for most  25 people. And if you recall the important</p>
<p style="text-align: right;">Page 99</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient believes that it's going to  3 benefit them and that we do not see any  4 reason to stand in the way of this and,  5 therefore, we are referring this patient  6 for hormone therapy.  7     Q.   Would you ever approve a  8 letter or do a letter if you felt that  9 treatment would be harmful to the person?  10     A.   If it was not going to benefit  11 the person, is that what you said?  12     Q.   I said would be harmful to the  13 person.  14     A.   Well, I have -- I can remember  15 a particular person, it was actually -- I  16 think it was for surgery, that we weren't  17 sure that this was going to help the  18 person, but we didn't know what else to  19 do for this person, and we outlined our  20 concerns about the mental state of this  21 person. So the person underwent surgery  22 and then we never heard back from them  23 again. It's the typical thing in the  24 United States, people are lost to  25 followup.</p>	<p style="text-align: right;">Page 101</p> <p>1       STEPHEN B. LEVINE, M.D.  2 study published by Sweden in 19 -- in  3 2011, the recommendation was for lifelong  4 psychiatric care. It's easy to make  5 recommendations like that. Those things  6 usually don't happen.  7     Q.   Just to go back then, when you  8 write these letters for patients with  9 gender dysphoria to approve hormone  10 treatment, you don't say whether or not  11 you think the treatment will be  12 beneficial to them?  13       MR. CANTRELL: Object to form.  14     A.   No. I say the patient wants  15 hormone treatment. I say that I've had an  16 opportunity to discuss hormone treatment  17 and his or her life in more detail; these  18 are things I know about this person; here  19 are the person's strengths, for example,  20 high intelligence; and here are the  21 person's limitations, chronic depression,  22 social isolation, anxiety states,  23 tendency to be dependent on marijuana;  24 and the patient and I have had a year,  25 year and a half of opportunities and I've</p>

<p style="text-align: right;">Page 102</p> <p>1       STEPHEN B. LEVINE, M.D.  2 met with them 23 times or 30 times or 18  3 times, and the person is now 18 years of  4 age and still persists in wanting to have  5 hormone surgery and I promised the person  6 that I would write a letter for them if  7 they cooperated with me to discuss this  8 and at great length and the patient has  9 met my criteria and she still wants to  10 take estrogen, and so I'm writing this  11 letter informing you that she has done  12 her psychiatric preliminary work and, no,  13 I'm not saying I think this is going to  14 benefit the person.  15     Q.   Are these letters needed  16 because some endocrinologist won't  17 provide the care without a letter from a  18 mental health provider?  19     A.   Well, that's not always true,  20 I'm sad to report. But generally  21 speaking, the people who say that they  22 follow the Standards of Care from WPATH  23 do require a mental health assessment.  24 They don't -- they don't really define  25 what that should be or how comprehensive</p>	<p style="text-align: right;">Page 104</p> <p>1       STEPHEN B. LEVINE, M.D.  2 other symptoms of mental illness.  3       So this is part of the ethical  4 problem, Ms. Cooper, that the surgeon  5 wants to assume that the ethics have been  6 worked out by the endocrinologist and the  7 endocrinologist wants to assume that the  8 ethics problem and the criteria have been  9 worked out by the mental health  10 professional.  11       So everyone is sort of passing  12 the buck here to the mental health  13 professional and that's why, you know,  14 very conservative people, like myself,  15 need to take time and thoughtfulness and  16 need to have a relationship with the  17 patient and the family and we need to  18 represent accurately what science knows  19 and what science doesn't know, and we  20 need to accurately represent what are the  21 problems, the well-known problems of the  22 marginalized, vulnerable, often substance  23 abusing, and chronically suicidal people  24 in adult life are. So that's my  25 long-winded answer to your question.</p>
<p style="text-align: right;">Page 103</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or how sophisticated, but they do want a  3 letter from a mental health professional.  4       The reason they want a letter  5 is they don't want to take ethical  6 responsibility for making this decision,  7 this is a fraught, difficult decision,  8 they want -- they want to say, well, the  9 psychiatrist or the social worker or the  10 mental health professional said it's  11 okay, therefore, I'm just doing this, and  12 I'm just going to assure myself that the  13 patient knows what the side-effects are  14 and knows when to call me or when to go  15 to the emergency room if this happens or  16 that happens, you see. But the ultimate  17 decision whether I should give hormones  18 or not is made by the mental health  19 professional. And as you may or may not  20 know, many endocrinologists have felt  21 very uneasy about this on an ethical  22 basis because they don't know whether  23 gender dysphoria is a mental illness or  24 not, even though some people say it's  25 not, because many of these people have</p>	<p style="text-align: right;">Page 105</p> <p>1       STEPHEN B. LEVINE, M.D.  2       MS. COOPER: This is a good  3 time for a break. Does this work as  4 a good lunch break time for folks?  5       MR. CANTRELL: Sure.  6       MS. COOPER: Let's go off the  7 record.  8       VIDEOGRAPHER: Going off the  9 record. The time is 12:05.  10       (Lunch recess is taken.)  11       VIDEOGRAPHER: Back on the  12 record. The time is 12:46.  13     Q.   I understand that for at least  14 some of your minor patients who have  15 gender dysphoria they're being treated  16 with psychotherapy alone, without, to  17 your knowledge, any hormone therapy,  18 correct?  19     A.   I think that's true for most  20 of them, yes.  21     Q.   And what is your approach to  22 psychotherapy to address gender dysphoria  23 with these patients?  24       MR. CANTRELL: Object to form.  25     A.   Would you like me to talk</p>

<p style="text-align: right;">Page 106</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about the general principles I think of  3 psychotherapy with patients? Is that what  4 the question is about?  5     Q. Fair enough. Let me ask it  6 differently.  7       Is it fair for me to assume  8 that based on your past testimony that at  9 least some of your minor patients with  10 gender dysphoria have comorbidities,  11 psychological comorbidities; is that  12 correct?  13     A. That's correct.  14     Q. Are there some who don't?  15     A. I don't think I met one yet.  16     Q. Over your career, you're  17 saying; is that right?  18     A. Yes.  19     Q. Are there people who have  20 gender dysphoria outside of your patient  21 pool who have gender dysphoria but don't  22 have comorbidities?  23     A. That depends on the evaluator.  24     Q. Okay. What I'm trying to  25 understand is what kind of psychotherapy</p>	<p style="text-align: right;">Page 108</p> <p>1       STEPHEN B. LEVINE, M.D.  2 don't have to change the gender identity  3 if we address the underlying processes,  4 whereby, the person decided that they  5 must be trans, if we can address their  6 social isolation, their uneasiness with  7 their body, the fact that they've been  8 sexual abused or something terrible has  9 happened in their family, we can deal  10 with those processes. We let the child  11 then decide over time, as they proceed  12 during adolescence, to try on various, as  13 most adolescents do have different  14 passions and sometimes the gender  15 dysphoria begins to fade away and they  16 develop a different identity, maybe a  17 lesbian identity or a gay male identity,  18 or they get interested in some other  19 topic entirely unrelated.  20       So the psychotherapy is; one,  21 an attempt to understand the motivations;  22 two, to understand the adversities and  23 the things that the person is troubling  24 with and to address those things; and  25 three, to recognize that this person is</p>
<p style="text-align: right;">Page 107</p> <p>1       STEPHEN B. LEVINE, M.D.  2 can address the gender dysphoria,  3 understanding there may be psychotherapy  4 needed to address other issues for other  5 patients, but how can psychotherapy  6 address the gender dysphoria?  7     A. That's an excellent question  8 and it probably requires an hour's answer  9 but I will try to be succinct.  10       One concept is that one's  11 identity is the product of other  12 processes. In other words, if I can use a  13 big word, it's a epiphenomena. And so  14 what we're interested in is the  15 antecedents to the crystallization of  16 this particular identity. And we're  17 interested in understanding the  18 developmental challenges that this child  19 has had from birth on or even during from  20 pregnancy on.  21       And so we try to address the  22 vulnerabilities that the child has and  23 help them deal with the underlying  24 challenges. Assuming that we don't have  25 to try to cure the gender identity, we</p>	<p style="text-align: right;">Page 109</p> <p>1       STEPHEN B. LEVINE, M.D.  2 more than their gender identity, and that  3 every human being is more complex than  4 their one aspect of their identity.  5       As you may know, Toni Morrison  6 has said there are hundreds of pieces of  7 me, when someone asked her. And there  8 are many pieces of your identity and my  9 identity and we try to introduce patients  10 to their richness, their complexity and  11 not to have them reduce everything in  12 their life to one thing.  13       In other words, we're  14 thoughtful and all this thoughtfulness  15 must depend upon a trusting relationship  16 between the patient, the family and the  17 doctor.  18       Now, one other thing that  19 happens in psychotherapy is what you --  20 the last exhibit you put up is the  21 informed consent process. So without  22 trying to proselytize, without trying to  23 warn or to scare, we just try to  24 represent what is known and what is not  25 known and to -- even though we recognize</p>

<p style="text-align: right;">Page 110</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that patients may be certain, most human  3 beings -- it's dangerous for most human  4 beings to be certain about anything. You  5 say, I'm certain I've fallen in love with  6 you and I'm going to marry you and I  7 can't live without you and two years  8 later after I married you I want to  9 divorce you. So we distrust certainty in  10 all human beings. So these are -- that's  11 my four-minute summary of my issues on  12 psychotherapy.  13       I also try to represent in the  14 process of that therapy what science  15 knows and these days, now that we have  16 countries that have said psychotherapy  17 ought to be the first approach because  18 the outcomes are not very clear when we  19 do medical, as the first approach, these  20 people need to know that.  21       Q.   Okay. Thank you. That was  22 helpful.  23       Of your gender dysphoria  24 patients who have been treated with  25 psychotherapy alone, whether adolescents</p>	<p style="text-align: right;">Page 112</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Q.   And you're using the word  3 desist. Is this person you were talking  4 about, in the examples you're talking  5 about, prepubertal kids or are these  6 adolescents and adults?  7       A.   Adolescents. I've seen  8 prepubertal children desist as well.  9       Q.   So of your patients with  10 gender dysphoria how many who are  11 adolescents who are older have come to  12 identify with their natal sex?  13       A.   Have come to identify with  14 what?  15       Q.   That are natal sex, with  16 psychotherapy alone.  17       A.   I don't know.  18       Q.   How many that you are aware  19 of?  20       A.   How many am I aware? I'm aware  21 of a six-year-old who has desisted.  22       Q.   I'm talking adolescent and  23 older.  24       A.   Okay. I'm trying to think.  25 I've certainly reviewed case histories of</p>
<p style="text-align: right;">Page 111</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or adults, have any come to identify as  3 their natal sex?  4       A.   I think in late January of  5 this year parents came to me about their  6 15-year-old and we talked about their  7 concerns about announcement that he's a  8 trans woman and we -- the parents and I  9 talked about this and they came back to  10 see me about three weeks ago and their  11 son seems to be more comfortable being a  12 son now. And so, I've never seen their  13 son personally, I've done the parent  14 guidance.  15       So I think if you take my work  16 as both with parents alone, with kids  17 alone, with parents and kids together,  18 I've seen people desist and I've  19 certainly talked to other people,  20 colleagues who do psychotherapy that  21 they've seen people desist sometimes  22 before medical treatment and sometimes  23 during medical treatment and sadly  24 sometimes after medical surgical  25 treatment.</p>	<p style="text-align: right;">Page 113</p> <p>1       STEPHEN B. LEVINE, M.D.  2 people who have desisted.  3       Q.   Your patients, I'm asking.  4       A.   I know your question. I'm  5 just trying to review a lifetime of  6 experience.  7       Well, the one who comes to  8 mind who saw me first with his parents  9 who wouldn't come back because he said he  10 hated me and then he came back to me  11 three months later and said that what I  12 said during that initial evaluation has  13 haunted him and he hated me and now he  14 thinks I was right and he has returned to  15 living as a male. So that's one. I often  16 think about him.  17       I am dealing with another  18 child, teenager, who has moved a little  19 bit away from the trans world into the  20 sadomasochistic world and is experiencing  21 the pleasures of masochistic kink. I  22 have seen --  23       Q.   Before you move on, that  24 person no -- their gender identity is  25 different than it was?</p>

<p style="text-align: right;">Page 114</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I think -- I think the gender  3 identity is weakening about that, right.  4 And another person who -- the one that I  5 made mention to before, who had five  6 hospitalizations or four psychiatric  7 hospitalizations, who was taking  8 testosterone, I'm not sure that the  9 degree of certainty about the stability  10 of this gender identity seemed to be  11 weakening when I enabled this person to  12 psychotherapy to get his GED and then he  13 moved out of state to go to art school.  14 So I'm not -- I'm not exactly sure. I  15 can't say that's one who's desisted, but  16 I've watched this -- I've watched the  17 certainty become uncertainty, which I  18 consider to be a much more reasonable  19 human position, to be uncertain about  20 things, especially when one is an  21 adolescent.  22     Q.   What about adults, have you  23 had any adults come to identify with  24 their natal sex, your gender dysphoria  25 patients?</p>	<p style="text-align: right;">Page 116</p> <p>1       STEPHEN B. LEVINE, M.D.  2 feminine in their behavioral expressions.  3       It's really hard for me to  4 answer this because I don't see the world  5 simply as trans or non-trans. And I guess  6 I'm a student of the human psychology and  7 human psyche and I like to talk about  8 that every human being has a mosaic of  9 sexual identity identifications. We're  10 not what we appear, we are not  11 subjectively what we socially present  12 ourselves to be. And so I'm used to  13 talking about, say, just taking males,  14 for example, I'm used to talking about  15 feminine expressions and feminine  16 features in males and sometimes their  17 struggle or misunderstanding or lack of  18 understanding about the normality of  19 having a sexual identity mosaic of  20 masculine and feminine, gay and straight,  21 and kink and non-kinky aspirations,  22 sexual intentions.  23       So I can't really answer that  24 question because I don't see the world in  25 the terms that you're using.</p>
<p style="text-align: right;">Page 115</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I've seen prisoners reidentify  3 several times. I've seen the phenomenon  4 of trans in prison and bisexual and  5 straight out of prison.  6       Let me see about adults. I've  7 certainly seen adults who have thought --  8 who have come to me with this who are  9 terribly ambivalent and may have been  10 playing at this process, who then go back  11 into not playing, not expressing it.  12       You need to understand that  13 it's not a rare thing for people to have  14 a mosaic of combination of male and  15 female identifications in their psyche  16 and sometimes they give voice to or give  17 behavioral expression to the feminine and  18 sometimes to the masculine, and they have  19 considerable conflict about that. And  20 many adults who come to see me discuss  21 these things with me. So they're not  22 necessarily out as a trans person and  23 desist but they fluctuate between  24 masculine expressions or masculine  25 acceptance of their body and wishes to be</p>	<p style="text-align: right;">Page 117</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Are any of your patients who  3 have received hormone therapy, have you  4 seen benefits to their mental health as a  5 result of that treatment?  6     A.   Have I seen people benefit  7 from the results of my treatment?  8     Q.   From hormone therapy.  9     A.   I've seen people being very  10 happy instantly upon swallowing their  11 first treatment and for months, as  12 they're looking for breast development or  13 looking for oily skin and lowering of the  14 voice, they're immensely happy,  15 absolutely.  16       You know, in medicine,  17 especially in mental health medicine, we  18 have an enormous influence of the placebo  19 effect. Depressed people get a pill and  20 they start feeling better and the  21 question is, and why we do controlled  22 studies, is we try to separate the  23 placebo effect in the control group from  24 the true drug effect, you see.  25       So it's clearly, since we</p>

<p style="text-align: right;">Page 118</p> <p>1       STEPHEN B. LEVINE, M.D.  2 don't -- since we don't have any  3 controlled studies in this field of  4 taking hormones and so many people are so  5 much happier once they're getting  6 hormones because they wanted hormones for  7 years, for example, they're happy or  8 happier. The question is, are they  9 functioning better? Is there mental  10 health better a year later or six months  11 later or five years later?  12     Q.   That's my question for you. Do  13 you know whether any of your patients,  14 after six months or a year, five years,  15 their mental health was better after  16 taking hormones?  17     A.   Well, it depends what you mean  18 by mental health.  19     Q.   Whatever you meant when you  20 just said it.  21     A.   Well, if you mean are they  22 happy they're taking -- are they happy  23 taking hormones? Many are happy taking  24 hormones, they're happy with the  25 feminization, they're happy with the</p>	<p style="text-align: right;">Page 120</p> <p>1       STEPHEN B. LEVINE, M.D.  2 testified to, I've already told you this,  3 but in terms of their functional  4 capacities in the world there is not  5 evidence that that really improves them.  6       Now, I know some people are  7 improved but I also have seen patients  8 who take hormones and get terribly  9 depressed. You see, that's why we need  10 the science, because the doctors'  11 experience is so much heavily colored by  12 the last patient he's seen, you see. So  13 it's not focusing on the issue of, what  14 have you seen, Dr. Levine? It's what do  15 we know from the collective scientific  16 experience in this field. And that's why  17 we're having a contentious argument in  18 this courtroom, I mean in this issue,  19 because science tells us one thing and  20 people have other opinions. Doctors often  21 have other opinions from the science. And  22 as far as I can see, many of these  23 doctors don't know the science, they  24 don't --  25     Q.   When you say you've known --</p>
<p style="text-align: right;">Page 119</p> <p>1       STEPHEN B. LEVINE, M.D.  2 masculinization.  3     Q.   Do you think it relieved their  4 distress and anxiety for some patients?  5     A.   Well, you know, the U.K.,  6 Finland, Sweden, France have all tried to  7 -- and the Cochrane Reviews, they've all  8 tried to assess the answer to your  9 question, and it's not clear that these  10 people have better mental health after  11 taking hormones for a long period of  12 time.  13     Q.   I'm asking about your  14 patients, not the research. You're a  15 psychiatrist. Can you not evaluate their  16 mental health and whether it's improving  17 or deteriorating or staying the same?  18       MR. CANTRELL: Objection,  19 argumentative.  20     A.   Well, listen, I'm a  21 psychiatrist, I'm informed by the  22 science. Please, I think all doctors need  23 to be informed by the science. And I  24 certainly can evaluate certain aspects of  25 a person's life. And I've already</p>	<p style="text-align: right;">Page 121</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know some people have improved, how  3 do you know that?  4     A.   Because I see them, because  5 they liked the hormones, because they  6 like being feminized, for example, and  7 they like being masculinized, whether  8 they're still cutting themselves or still  9 not going to school or not working or  10 still getting depressed or if you talk to  11 -- if you talk to anyone who runs an  12 inpatient service, psychiatric service,  13 they're frequently getting people who are  14 trans identified who are on hormones who  15 are in there for depression or suicide  16 attempt and so forth. So, look, it's not  17 that if you give hormones and everyone is  18 guaranteed to be happy.  19     Q.   That's not my question. My  20 question is have any of your patients who  21 received mental health improvement as a  22 result of hormones? And as a psychiatrist  23 I thought psychiatrists could evaluate  24 the state of someone's mental health.  25       MR. CANTRELL: Object to form.</p>

<p style="text-align: right;">Page 122</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A. I have -- I have people who  3 have been on hormones for years and who  4 are functioning they think better.  5       Now, I can just tell you since  6 I'm psychiatrist seeing one patient, it's  7 taken me three or four years to convince  8 one person that he was worth more than he  9 was getting paid for in his job and  10 during all this time I've been giving him  11 hormones and finally he went from getting  12 \$30,000 a year in his job to a new job at  13 \$90,000 and he's much happier at \$90,000  14 than he is at 30,000. And if you're not  15 careful you might have concluded it's the  16 hormones that's making him happier, when  17 I tell you it's the work that we have  18 done to convince him that he's  19 undervaluing himself because of his  20 negative self views, you see.  21       So if you ask me simply, have  22 I had a patient who is better off on  23 hormones than he was before he was on  24 hormones, I would say yes. But whether  25 it's to be attributed to hormones is an</p>	<p style="text-align: right;">Page 124</p> <p>1       STEPHEN B. LEVINE, M.D.  2 masculine and now that I'm treated with  3 hormones I'm happier. But the question  4 is, are they functioning better and are  5 they mentally well? You see many times  6 we tell ourselves the patient is improved  7 but we don't tell ourselves the patient  8 is healthy, they're just less depressed.  9       Q. Are there any who are healthy  10 who you believe that hormone therapy  11 contributed to that?  12       A. Well, I've certainly heard  13 many accounts of people, sort of public  14 figures who say that they are -- the  15 hormones have really helped them  16 considerably. So I believe -- I believe  17 that's possible, yes. I don't get to see  18 that that often myself, but I hear public  19 pronouncements like that very frequently.  20 People stand up at microphones sometimes  21 and tell you how much better they are.  22       Q. Have you seen that ever in  23 your patients, that they are -- again,  24 their mental health is better? I'm  25 sorry. Was that a yes?</p>
<p style="text-align: right;">Page 123</p> <p>1       STEPHEN B. LEVINE, M.D.  2 entirely different question.  3       Q. So you don't know whether --  4 is it fair to say then you don't know  5 whether hormones have helped any of your  6 patients?  7       A. It's fair to say many of my  8 patients are happy taking hormones, and  9 happiness is an improvement, you see.  10 That doesn't mean they're not still  11 depressed, it's that they're happier,  12 they're happy with. They still may be  13 anxious, they still may be smoking  14 cigarettes, they still may be heavily  15 using drugs, they still may be depressed  16 but they say they're happier taking  17 hormones.  18       Q. Has hormones reduced any of  19 those symptoms like anxiety and  20 depression for any of your patients?  21       A. Temporarily it does, yes, but  22 that's probably the placebo effect. And  23 then there is the effect of I always  24 wanted to experiment, I've always had a  25 mosaic that's heavily feminine or heavily</p>	<p style="text-align: right;">Page 125</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A. No, that wasn't a yes. That  3 was a non-answer. That was an I'm  4 thinking.  5       Q. Oh.  6       A. Well, I'm thinking about a  7 person who's happy expressing himself as  8 a woman, but who is very unhappy because  9 two of his three children won't talk to  10 him.  11       So you see we have to separate  12 the happiness about gender expression  13 from the general overall unhappiness or  14 happiness of a person. And I don't expect  15 hormones to take care of everything that  16 ails a person, you see.  17       That's one of the reasons why  18 I caution young people that they are much  19 more complicated and rich and varied and  20 dimensional than simply gender identity.  21 That's one of the reasons why I think all  22 mental health professionals have to slow  23 down and not rush to medicalize people.  24       Q. When you said a few minutes  25 ago you believe it's possible that</p>

<p style="text-align: right;">Page 126</p> <p>1       STEPHEN B. LEVINE, M.D.  2 hormone therapy can contribute to  3 positive mental health improvements but  4 it's not something you see very often, I  5 want to ask a couple of questions about  6 that.  7       Is that because you don't  8 generally get to follow the patients up  9 or is that because most of your patients  10 who get hormone therapy don't see a  11 benefit, in your experience?  12       MR. CANTRELL: Object to form.  13       A. Well, what we suffer from in  14 this field and what I suffer from as a  15 doctor, is that we don't have followup  16 and we don't have systematic or systemic  17 long-term followup which is, of course,  18 what science requires to know to answer  19 these questions that you're getting at.  20       I think the answer to your  21 question is both, it's not either/or,  22 it's just both. You know, I'm a mental  23 health professional, when people feel  24 that they're happy -- people never come  25 to a mental health professional because</p>	<p style="text-align: right;">Page 128</p> <p>1       STEPHEN B. LEVINE, M.D.  2 gender-affirming medical care for minors,  3 and I wanted to ask, do you believe that  4 the risks of gender-affirming medical  5 care outweigh the benefits for all minors  6 with gender dysphoria?  7       A. If you take out the word "all"  8 from that question it would be easier for  9 me to answer.  10       Would you mind rephrasing that  11 question without the word --  12       Q. I think this is what -- yes. I  13 think I can.  14       Again, you've talked about the  15 risks and benefits of gender-affirming  16 medical care for minors and the need to  17 discuss that fully, right, with patients  18 and their families.  19       So my questions is, is it your  20 view that in every case of a minor with  21 gender dysphoria that the risks of that  22 medical treatment will outweigh the  23 benefits?  24       MR. CANTRELL: Object to form.  25       A. Again, I think you put in a</p>
<p style="text-align: right;">Page 127</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their life is going great. They come to  3 us in crisis, they come to us in despair,  4 they come to us in demoralization, they  5 come to us sometimes in sort of  6 life-threatening circumstances.  7       So, again, I'm working with  8 the whole person here and you're just  9 trying to, you see, cut off a little  10 piece of that whole person and ask a  11 little dimension of them.  12       Q. Is it fair to say you're less  13 likely to hear about the success stories  14 because they're doing great and they  15 wouldn't have reason to come see you  16 again?  17       A. That's right. Successful  18 people don't need to see me, successful  19 in that way. And if they went to another  20 doctor and they're getting hormones and  21 they're living happily ever after, they  22 don't come to visit Dr. Levine.  23       Q. Now, you've talked about the  24 risks and benefits, you know, having to  25 look at the risks and benefits of</p>	<p style="text-align: right;">Page 129</p> <p>1       STEPHEN B. LEVINE, M.D.  2 phrase of three words there that make it  3 similar to "all". If I can rephrase -- I  4 don't know if I'm allowed --  5       Q. Go ahead.  6       A. It's not just Dr. Levine who  7 has estimated that the risks are  8 considerable and the benefits are  9 unclear. Independent reviews by people  10 who are capable of analyzing published  11 studies, and not all physicians or  12 Ph.D.'s are equally capable of analyzing  13 reports, independent reviews, two from  14 the U.K., one from Sweden, and one from  15 Finland, and I'm not sure whether France  16 did an independent review or just changed  17 their policy in February of this year,  18 but these countries who are much more  19 controlled and have much more information  20 than we do in United States with 50  21 separate states, these independent,  22 carefully -- carefully reviewed these  23 people who are skilled in looking at  24 methodologies, they have said that the  25 risks outweigh the benefits and have</p>

<p style="text-align: right;">Page 130</p> <p>1       STEPHEN B. LEVINE, M.D.  2 encouraged their country to no longer  3 create these rapid -- these many  4 treatments of choice or what used to be  5 called best practices for youth.  6       So it's not just a matter of  7 me, based on my clinical experience.  8 Although, my clinical experience is -- my  9 accumulated clinical experience does  10 cause me to be cautious. You need to  11 understand that I base a great deal -- I  12 take a great deal -- I give a great deal  13 of respect to commissions that have  14 independently assessed the data and found  15 the data to be lacking and the benefits  16 to be unclear in the long run, and the  17 risk in the long run to outweigh those  18 benefits.  19       And so that's how I answer  20 your question. Science has answered this  21 question as best that we can, given the  22 fact that it's May 2022. In June 2022 we  23 may have better information, which would  24 either support or make us change our  25 views. But based on today's knowledge,</p>	<p style="text-align: right;">Page 132</p> <p>1       STEPHEN B. LEVINE, M.D.  2 14-year-old or the removing the breasts  3 of a 14-year-old or 13-year-old, these  4 things have long-term risks for people  5 and for their families, and the fact that  6 there is one patient out of ten or one  7 patient out of thirty, you know, who  8 benefits from it and say the rest are  9 either unclear or they have -- they  10 regret. Public policy requires we not  11 look at a case alone but we look at a  12 series of cases and public policy should  13 rest upon what science knows. And that's  14 what I think you and I are discussing,  15 what does science know about this.  16       Q. My question --  17       A. You want to make this what Dr.  18 Levine believes, but Dr. Levine is trying  19 to represent here what science knows, you  20 see, and how many cases --  21       Q. I think we're getting far  22 afield. My question was not about public  23 policy.  24       The question was whether the  25 reason you would not agree that the</p>
<p style="text-align: right;">Page 131</p> <p>1       STEPHEN B. LEVINE, M.D.  2 especially informed by science, I would  3 say that the risks tend to outweigh the  4 benefits and now we have this whole  5 phenomenon of detransition of people who  6 have transitioned with the help of the  7 medical profession who are now saying, I  8 regret this or I'm detransitioning. And  9 you know that data as well as I do.  10       Q. Yes. So the problem with my  11 earlier question was the word "all" and  12 "that in every case."  13       So do I understand that your  14 testimony is that the benefits -- sorry  15 -- the risks of gender-affirming medical  16 care for minors tend to outweigh the  17 benefits, but that you would not agree  18 that that's true in every case?  19       MR. CANTRELL: Object to form.  20       A. When it comes to public policy  21 we can't let one case be the -- generate  22 public policy. If science has said that  23 the risks are exceeding the benefits, and  24 the risk includes tragedies and, for  25 example, permanent sterility of a</p>	<p style="text-align: right;">Page 133</p> <p>1       STEPHEN B. LEVINE, M.D.  2 benefit -- the risks outweigh the  3 benefits in all cases for all minors, was  4 because you didn't want to say that  5 that's true for every minor; is that  6 correct? I'm not asking you about public  7 policy.  8       MR. CANTRELL: Object to form.  9       A. I object that when you talk  10 about "all minors" --  11       Q. You can't agree --  12       A. If you want me to agree that  13 there is a case somewhere that may  14 benefit in the short run, and even in the  15 median-term run and possibly in the long  16 run who might be happy with a transition  17 that they've made, there must be patients  18 like that, of course. Of course there  19 are.  20       Q. Okay. That was my question.  21 And you talked about the European  22 countries determining that risks outweigh  23 the benefits. I believe perhaps you're  24 referring to the statement out of Sweden  25 when you reference that. Is that what</p>

<p style="text-align: right;">Page 134</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you had in mind?  3     A.   Did you say Sweden?  4     Q.   Yes.  5     A.   Yes. Sweden is one of them.  6     Q.   And tell me what other country  7 has said the risks outweigh the benefits,  8 have actually said that?  9     A.   Finland.  10    Q.   Finland said that?  11    A.   Yes.  12    Q.   Who else said that?  13    A.   I think the NICE report from  14 England and the Cass report and I'm  15 actually -- I'm actually a member of the  16 Cochrane Group who's evaluating these  17 subjects. But as the report is not out  18 yet I'm not permitted to talk about that.  19    Q.   And you're aware, right, that  20 in Finland, U.K., France and Sweden, that  21 they have not banned gender-affirming  22 care for minors, right?  23    A.   I'm aware that Sweden has said  24 that and Finland has said that they think  25 no one should have this treatment until</p>	<p style="text-align: right;">Page 136</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that they banned it. I think they've  3 recommended this. And to recommend  4 psychotherapy is to imply that  5 puberty-blocking hormones and cross-sex  6 hormones should not be the initial  7 approach to these kids.  8     Q.   So you are not aware then or  9 is it your understanding that Finland  10 allows minors to receive gender-affirming  11 medical care if the psychotherapy as a  12 first approach is not successful in  13 resolving the condition?  14    A.   I don't know.  15       MR. CANTRELL: Object to form.  16    A.   I'm not -- I don't know the  17 details of, like, how long they have to  18 have psychotherapy and what the  19 parameters of success would be. I think  20 it's a big policy statement if a  21 country -- if a country says this is how  22 we, as a country, are going to approach  23 this within our standardized universal  24 medical system, which is so different  25 than what we do in the United States, so</p>
<p style="text-align: right;">Page 135</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about 26 and that -- and Sweden has said  3 minors can have gender-affirming care if  4 it's part of a scientific protocol, as  5 part of an experiment, what we would call  6 an IRB or government-approved experiment.  7 That's very different than, this is an  8 acceptable treatment for all kids that  9 claim to be gender dysphoric.  10    Q.   So you would agree with  11 Sweden's approach to allow the treatment  12 in the context of clinical trials but not  13 separately?  14    A.   Yes.  15    Q.   And -- sorry.  16    A.   I would agree.  17    Q.   And your understanding is that  18 Finland bans care for anyone under 26  19 gender-affirming medical care?  20       MR. CANTRELL: Object to form.  21    A.   My memory may not be correct,  22 but Finland has recommended that the  23 first approach to gender-dysphoric youth  24 should be a psychotherapeutic approach  25 and not a medical approach. I'm not sure</p>	<p style="text-align: right;">Page 137</p> <p>1       STEPHEN B. LEVINE, M.D.  2 different.  3     Q.   So it your understanding that  4 the U.K. does not allow gender-affirming  5 hormone therapy for minus?  6     A.   I know the U.K. did not go so  7 far as to disallow it but it's certainly  8 -- their recommendations have certainly  9 slowed the number of people getting it.  10       As you are well aware there  11 was -- there were two -- there was a  12 lawsuit that pretty much prohibited --  13 there was a lawsuit that the High Court  14 of London in I think 2019, December 17th,  15 said no one less than 16 could have  16 cross-sex hormone or puberty blockers and  17 anyone from 17, 16 or 17 had to have  18 court approval. And that was -- that  19 last part was reversed in 2020, I think  20 in September, where it said that doctors  21 had to decide, not courts.  22       I think the impact of the  23 first two decisions was that the rapid  24 use of puberty blockers and cross-sex  25 hormones diminished dramatically in the</p>

<p style="text-align: right;">Page 138</p> <p>1       STEPHEN B. LEVINE, M.D.  2 U.K.  3     Q.   Have you read the Cass report  4 out of the U.K.?  5     A.   I have in the past, yes.  6     Q.   Okay. And is it your  7 understanding that that report recommends  8 increasing access to gender-affirming  9 medical care for minors?  10       MR. CANTRELL: Object to form.  11     A.   I don't, I don't recall that.  12     Q.   Is it your understanding that  13 France is prohibiting gender-affirming  14 medical care for minors?  15     A.   No. It's my understanding that  16 France, in February, also recommended  17 psychotherapy as the first approach.  18     Q.   And that they would permit  19 gender-affirming medical care as an  20 alternative approach if psychotherapy is  21 not sufficient?  22       MR. CANTRELL: Object to form.  23     A.   I don't know that one way or  24 the other.  25     Q.   When we were talking about the</p>	<p style="text-align: right;">Page 140</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to be boys when they go through puberty  3 and no one has fully explained this  4 tsunami of increased incidents, that the  5 medical professions' sort of best  6 practices approach to giving medical  7 treatment to all these people before we  8 understand the motivations, both the  9 social sources of the motivations and the  10 psychological sources of the motivations  11 in the person of the children, that this  12 has caused Sweden, Finmark -- Finland,  13 France and the U.K. and some elements in  14 the United States to have some caution  15 about what we're doing because we  16 recognize that adolescence is a time  17 that's a six-, seven-year process of  18 trying to define what one's identity is.  19 And one's identity at 13 is not the same  20 as one's identity as 15 or 16 or 20. And  21 so these are changeable phenomena. And  22 the idea that we're making permanent a  23 13-year-old or 14's gender identity by  24 medicalizing that identity, you see, and  25 supporting that identity, these countries</p>
<p style="text-align: right;">Page 139</p> <p>1       STEPHEN B. LEVINE, M.D.  2 risks and benefits, I got the sense from  3 what you're saying that you, your  4 understanding from the research is that  5 in the vast majority of cases that the  6 risks would outweigh the benefits of  7 care; is that right?  8     A.   I'll repeat.  9     Q.   Sure. I understood from your  10 past testimony that your view is that the  11 risks of gender-affirming medical care  12 for minors outweighs the benefits of such  13 care in the vast majority of cases?  14       MR. CANTRELL: Object to form.  15     A.   No, you misunderstood. I said  16 "I will repeat." I didn't ask you to  17 repeat. I'm sorry. We miscommunicated.  18     Q.   Oh.  19     A.   The scientific review of the  20 literature indicates that the long-term  21 benefits are unclear. There are  22 considerable concerns about the long-term  23 harms and as there has been an  24 increasing, a dramatic increase in the  25 number of girls assigned at birth wanting</p>	<p style="text-align: right;">Page 141</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and these scientific -- the scientific  3 scrutiny has said all this is a stop sign  4 for how we're taking care of people.  5       And so the risks are  6 uncertain, the detransition numbers are  7 increasing, the benefits have not been  8 demonstrated and, therefore, the risks  9 outweigh the benefits. That is what I  10 believe is science talking to you.  11     Q.   And you said the  12 detransitioning is increasing.  13       Are you aware of any data  14 comparing rates of detransition now to  15 some time in the past?  16     A.   No, but we're getting reports  17 of detransition. Do you know that March  18 12th of this year was National and  19 International Detransition Day?  20     Q.   I understand you have some  21 patients who have detransitioned; is that  22 correct?  23     A.   I have already testified to  24 that, right.  25     Q.   Detransition -- well, I don't</p>

<p style="text-align: right;">Page 142</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know if we did that today, but I know you  3 talked about desisted which I know may be  4 an overlap term.  5       Let me be clear. Have you had  6 patients detransition after having  7 received medical transition?  8     A.   I know of those people, yes.  9     Q.   And have any of them  10 retransitioned after detransitioning?  11    A.   Do you know that I wrote a  12 paper about one case?  13    Q.   I do. But I'm asking do you  14 know anyone who retransitioned after they  15 detransitioned?  16    A.   I've heard that that happens  17 sometimes, yes. The answer to your  18 question is I think I know of a prisoner  19 like that who detransitioned when  20 released and got readmitted to  21 incarceration and then returned to living  22 as a trans person. I wouldn't swear to  23 that. I'm not certain, in other words.  24    Q.   And your patients who  25 detransition, was it always because they</p>	<p style="text-align: right;">Page 144</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Okay. And did detransitioning  3 improve their mental health in these two  4 cases?  5     A.   Yes. Oh, yes.  6     Q.   I understand from your  7 writings and testimony, and tell me if  8 I'm not saying this correctly, that you  9 have concerns about I think what you've  10 called rapid affirmation, where doctors  11 prescribe medical transition too quickly.  12 Is that a fair statement?  13    A.   Yes. That's a fair statement.  14    Q.   And I understand from your  15 Reconsidering Informed Consent paper you  16 think it's important for clinicians to  17 take the time to really get to know the  18 patient and also to make sure to  19 thoroughly inform patients, and when  20 they're minors their parents, of the  21 risks associated with care and what is  22 known in the science; is that correct?  23    A.   That's correct, yes. It's also  24 correct that it's important for the  25 doctors to know, to actually know what</p>
<p style="text-align: right;">Page 143</p> <p>1       STEPHEN B. LEVINE, M.D.  2 came to identify with their natal sex or  3 were there other reasons?  4     A.   I'm sorry?  5     Q.   I can speak up.  6       Of your patients who  7 detransitioned, was it always due to them  8 coming to identify with their natal sex  9 or were there other reasons for the  10 medical detransition?  11    MR. CANTRELL: Objection.  12    A.   Two come to mind and they  13 detransitioned to reidentify with their  14 natal sex assigned at birth.  15    Q.   You've had two of your  16 patients detransition, is that what  17 you're saying?  18    A.   Yes.  19    Q.   Have you had just two or have  20 there been others?  21    A.   Well, that's one -- one I  22 wrote a paper about and one I already  23 talked to you about. And at the moment I  24 can't think of a third but, you know, I'm  25 slow to retrieve memories these days.</p>	<p style="text-align: right;">Page 145</p> <p>1       STEPHEN B. LEVINE, M.D.  2 science knows and to separate their  3 personal beliefs from what science knows.  4 I would have you add that to your  5 summary.  6     Q.   Okay. And is it your  7 understanding that all clinicians who are  8 providing care to minors with gender  9 dysphoria -- actually, me ask that  10 differently.  11       Is it your understanding that  12 all clinicians who are referring minors  13 for gender-affirming medical care or  14 providing themselves gender-affirming  15 medical care to minors, are doing it  16 without taking the time to do the  17 thorough evaluations and provide the  18 thorough information for informed  19 consent?  20    MR. CANTRELL: Object to form.  21    A.   Ms. Cooper, if you use the  22 word "all" in any one of your questions I  23 cannot answer it yes or no because I  24 object to the idea that the heterogeneity  25 of everything can be summarized as all or</p>

<p style="text-align: right;">Page 146</p> <p>1       STEPHEN B. LEVINE, M.D.  2 none.  3       Q. All right. Let me ask you a  4 question.  5       Is it true that -- is it your  6 understanding that a majority of  7 clinicians are providing care without  8 taking time to evaluate fully the  9 patients and thoroughly engage in the  10 informed consent process that you say is  11 important?  12       MR. CANTRELL: Object to form.  13       A. What I am saying in the  14 Reconsidering Informed Consent paper is  15 that these are the elements of informed  16 consent. I'm not sure how this  17 practitioner or this clinic does it  18 because there are 50 or more clinics in  19 the United States and many more clinics  20 around the world.  21       I'm trying to set the  22 standards for informed consent. I can't  23 make a judgment of whether it's 38% or  24 79%. I'm trying to articulate the  25 standards that would help somebody</p>	<p style="text-align: right;">Page 148</p> <p>1       STEPHEN B. LEVINE, M.D.  2 recommended having going on hormones.  3       So I have these experiences  4 and these experiences have helped me  5 write these two papers over the years  6 about informed consent. I'm not -- I'm  7 not testifying about all or none or  8 12.7%. I'm telling you, this is what I  9 think are the standards.  10       Now, I can tell you that as of  11 this morning 27,000 people downloaded  12 this article since March the 17th. So  13 it's not about my accusation in this  14 percentage of people. I'm trying to set  15 the standards. I'm trying to have it  16 based on science, and science is limited  17 here. And because it's limited we need  18 informed consent, and because we need  19 informed consent, it has to be honest,  20 and it has to separate the doctor's  21 belief from what science knows. So your  22 line of questioning somehow is -- is  23 missing my point.  24       Q. Do you have any knowledge  25 about how gender-affirming medical care</p>
<p style="text-align: right;">Page 147</p> <p>1       STEPHEN B. LEVINE, M.D.  2 ethically make the recommendation to a  3 family about this matter, period. These  4 are the ethical requirements, this paper  5 argues, for how to do this, considering  6 that science does not have the answer,  7 people -- doctors have to inform people  8 about the state of science, the state of  9 our knowledge, you see. And so I'm not  10 -- I can't answer your question by  11 majority, all or 12.6%.  12       I'm saying this paper  13 articulates what I hope will be the  14 standard for understanding informed  15 consent obligations for the individual  16 practitioner and, therefore, I hope it  17 will change how various institutions and  18 programs and individual doctors think  19 about this and approach their patients  20 and I hope it will change the process  21 whereby I won't have to have patients  22 come to see me saying, my son went to  23 this clinic and after one hour they said  24 this child is trans. They didn't know  25 the child is autistic, you see, and they</p>	<p style="text-align: right;">Page 149</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is provided to minors in Arkansas?  3       A. No, I'm not an expert. But I  4 don't think that there is any studies  5 going on in Arkansas, or least not that  6 I've heard of. And Arkansas, I think, has  7 a children's clinic and probably has  8 individual practitioners, but I don't  9 want to represent myself as very  10 knowledgeable about what's happening in  11 Arkansas. I think what's happening in  12 Arkansas is probably not that different  13 from what's happening elsewhere.  14       Q. You don't know what kind of  15 protocols the doctors there follow in  16 terms of providing this treatment to  17 minors?  18       A. No. I'm ignorant of that.  19       Q. Let's look again at what's  20 been marked as Exhibit 3, your  21 Reconsidering Informed Consent paper, and  22 if we can scroll down to page 2. Are you  23 there? There's some blue highlighted  24 text. Do you see that?  25       A. Yes, I'm there.</p>

<p style="text-align: right;">Page 150</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   I'm going to jump to the  3 second paragraph that's highlighted. If  4 you want to take a minute to  5 contextualize where that is, I'll give  6 you a moment to do that.  7     A.   Okay.  8     Q.   I want to read that second  9 blue highlighted paragraph. Just follow  10 with me. "Social transition, hormonal  11 interventions and surgery have profound  12 implications for the course of the lives  13 of young patients and their families. It  14 is incumbent upon professionals that  15 these consequences be thoroughly,  16 patiently clarified over time prior to  17 undertaking any element of transition.  18 The informed consent process does not  19 preclude transition, it merely educates  20 the family about the state of the science  21 underpinning the decision to transition.  22 Social transition, hormones and surgeries  23 are unproven in the strict scientific  24 sense and as such to be ethical require a  25 thorough and fully informed consent</p>	<p style="text-align: right;">Page 152</p> <p>1       STEPHEN B. LEVINE, M.D.  2 have articulated.  3       Many times doctors and systems  4 think they are doing informed consent,  5 but in our view they're not doing a  6 thorough informed consent.  7       For example, if somebody  8 mentions to the family of a 13-year-old  9 that they could do fertility preservation  10 or we can take sperm and take eggs and  11 save them and, therefore, we've covered  12 the informed consent process about this  13 sterilizing effect of surgery or  14 hormones. I don't really think most  15 families can consider what this means.  16 And, for example, if the family is on the  17 lower socioeconomic group and is on  18 Medicaid, they're not going to be able to  19 afford or maintain at 15 years of  20 payments to a fertility -- to a freezer  21 where these things are spent.  22       So the issue really is, can a  23 family understand what the doctor is  24 talking about? And I've been familiar  25 with what I consider to be perfunctory</p>
<p style="text-align: right;">Page 151</p> <p>1       STEPHEN B. LEVINE, M.D.  2 process."  3       Okay. I'm not going to ask  4 you if I read that right because I'm  5 going to just assume that I did.  6       A couple of questions about  7 this. I want to make sure I understand.  8 I think this is sort of a version of what  9 you've been saying in the last few  10 minutes. But do I understand correctly  11 that in your view it is ethical to  12 provide gender-affirming hormone therapy  13 to minor patients if the doctors do  14 engage in that thorough evaluation  15 process you've described and do engage in  16 that thorough informed consent process  17 that fully informs patients and their  18 parents of the risks and the state of the  19 science? Is that a fair description of  20 your view?  21       MR. CANTRELL: Object to form.  22     A.   The answer to your question is  23 yes, presuming that the doctors actually  24 do these things and whether they would  25 meet the criteria that I and my coauthors</p>	<p style="text-align: right;">Page 153</p> <p>1       STEPHEN B. LEVINE, M.D.  2 informed consent processes.  3       So the answer to your question  4 is, if the doctor does the process over  5 time, over a long period of time, and  6 works with the parents to understand the  7 implications of what we're talking about  8 and the parents and the doctor all think  9 that this circumstance with this family,  10 with the absence of major  11 psychopathology, or with the fact that  12 there hasn't been sexual abuse of the  13 child that the family is trying to cover  14 up, you see, then I think yes, yes, we  15 can do this. But I want to be careful  16 because of the long-term consequences for  17 everyone in the family, not just the  18 patient.  19       So if you force me I could say  20 yes, I believe -- I wrote the paragraph,  21 I believe in the paragraph, you see. But  22 I want -- I'm urging caution and you are  23 telling me that I am -- I am supporting,  24 and you could give puberty blockers to  25 kids if you did informed consent, and I'm</p>

<p style="text-align: right;">Page 154</p> <p>1       STEPHEN B. LEVINE, M.D.  2 saying, whoa, whoa, whoa. I'm saying the  3 standards for informed consent are very  4 high and I don't think they're being met  5 throughout the world. And you know this  6 has gone through peer review, this is not  7 just Levine's opinion.  8       Q. In this article then, I mean,  9 is it fair to say you're offering -- I  10 think you said you want this to be the  11 standard that practitioners follow what  12 you describe in this article; is that  13 right?  14       A. I'm saying that we have a  15 field called medical ethics. It's an  16 umbrella under which physicians need to  17 operate. So I am emphasizing the umbrella  18 here. That's what I'm saying. It's an  19 umbrella. It's a legal and it's an  20 ethical and it's a moral umbrella that  21 people should know what they're getting  22 into.  23       I think there is a long legal  24 precedent in the United States law that  25 says doctors just can't do anything, they</p>	<p style="text-align: right;">Page 156</p> <p>1       STEPHEN B. LEVINE, M.D.  2 standards and I think higher standard for  3 how care is provided to adolescents and  4 younger people with this diagnosis. Yes,  5 I'm trying to benefit those people.  6       Q. And in this article you don't  7 take the position that gender-affirming  8 -- let me ask it differently.  9       You don't argue in this  10 article that gender-affirming medical  11 care should be categorically prohibited  12 for minors, right?  13       A. No. I am saying that given the  14 uncertainties that science has clarified,  15 that it behooves the physician to; number  16 one, know what science has clarified; it  17 behooves the physician to separate his  18 personal beliefs, his personal passionate  19 beliefs from what science knows and to be  20 a trustworthy informer of the family over  21 time what is known and what is not known;  22 and what the implications are of social  23 transition, puberty-blocking hormones,  24 you know, cross-sex hormones and various  25 surgical interventions. And I think the</p>
<p style="text-align: right;">Page 155</p> <p>1       STEPHEN B. LEVINE, M.D.  2 need to teach the people what they're  3 about to do and get their consent. That's  4 been evolving in the law for, you know  5 better than I do, for decades.  6       I'm just reminding the world  7 of -- I'm sorry, I'm sounding very  8 narcissistic -- but my colleagues and I  9 are reminding the world of the standards  10 of informed consent and we're trying to  11 refine them and define them and we hope  12 to have an influence on being safe and  13 not harming people.  14       Q. Is it fair to say part of your  15 aim is to try to improve how care is  16 provided to minors with gender dysphoria  17 by writing this article?  18       A. Sorry. If you take your hand  19 away from your mouth --  20       Q. Sorry. I will try to speak  21 closer to the mic as well.  22       Through this article are you  23 trying to improve how care is provided to  24 minors with gender dysphoria?  25       A. I'm hoping to set the</p>	<p style="text-align: right;">Page 157</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctors, especially the pediatricians,  3 the doctors who are focused in pediatric  4 age groups need to pay attention to what  5 we know about adults with whom they've  6 had very little experiences. And after  7 they turn 18 pediatricians generally do  8 not get involved with people.  9       So the thing is that the  10 pediatric world tends to not be as  11 conversant with the adult world of the  12 trans people as they need to be in order  13 to inform parents of what the  14 implications are.  15       Q. So is it your view then if  16 parents are truly fully informed in the  17 way you say they need to be, that the  18 parents should be the ones to make the  19 decision about whether their adolescent  20 children undergo gender-affirming medical  21 care?  22       MR. CANTRELL: Object to form.  23       A. Gee, I thought I made these  24 things clear repeatedly already today.  25 But the parents have to give legal</p>

40 (Pages 154 - 157)

<p style="text-align: right;">Page 158</p> <p>1       STEPHEN B. LEVINE, M.D.  2 consent, the parents are in charge, you  3 see. Those views have to be taken into  4 consideration. The parents -- the ideal  5 set of parents knows the patient better  6 than the doctor will ever know the  7 patient, right?  8       The legal requirements for the  9 parents to make this decision are in  10 place because they have a brain  11 maturational process and life experience  12 process and fertility process, pregnancy  13 process, raising children process that  14 the child or the teen doesn't have. And  15 of course their judgment is crucial here.  16 But in order for them to make this very  17 difficult decision -- this is not an easy  18 decision for any parent, you see. In  19 order to make this decision, they have to  20 be informed.  21       And the problem is that many  22 of the doctors believe passionately, they  23 believe passionately in what they're  24 doing, but they don't know what science  25 says or they don't accept what science</p>	<p style="text-align: right;">Page 160</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is there to inform, not to recommend.  3       I think if it's truly an  4 informed consent, you see, the doctor  5 tells the facts and because things are  6 uncertain, the patient get -- that is the  7 unit patient, that is the parents and the  8 child, they get to decide based upon an  9 accurate set of facts, and the facts  10 include that we don't know about these  11 things, you see.  12       Now, I am different than  13 pediatricians. Pediatricians feel  14 obligated sometimes to recommend a  15 treatment, whereas, I feel the obligation  16 is to recommend the options and have --  17 to inform people of the options and help  18 the parents to decide which is best for  19 their family unit. It's different than  20 "the doctor recommends", you see. Now, I  21 think I'm different than many  22 pediatricians because I have that view.  23       MS. COOPER: How is everyone  24 doing in terms of breaking? This  25 looks like a fine time to break if</p>
<p style="text-align: right;">Page 159</p> <p>1       STEPHEN B. LEVINE, M.D.  2 says or they say, well, this study is BS,  3 you see. But that's what I think I've  4 been saying to you over an hour,  5 Ms. Cooper.  6       Q. Okay. And again, just  7 sometimes we need to get things clear for  8 the record.  9       Then assuming that the doctors  10 provide that full information that you've  11 described as necessary, is it your view  12 that the decision should be left with the  13 parents for the care of their minor child  14 with respect to gender-affirming medical  15 care?  16       MR. CANTRELL: Object to form.  17       A. In that individual case, if  18 the state allows this to happen, then it  19 is, yes, the answer is yes, the parents  20 and the child and the doctor, that's a  21 team, right, the parent, the child, the  22 doctor, that's a unit, that's a team and  23 sometimes the doctor is a set of  24 professionals, they are the team. And  25 what you may not know, I think the doctor</p>	<p style="text-align: right;">Page 161</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they need one or if you need to go  3 on.  4       THE WITNESS: My bladder would  5 like one minute.  6       MS. COOPER: Let's take a  7 break.  8       VIDEOGRAPHER: Going off the  9 record. The time is 1:51.  10       (Recess is taken.)  11       VIDEOGRAPHER: Back on the  12 record. The time is 2:02.  13       Q. Dr. Levine, is it right that  14 in this case you've been asked to provide  15 expert testimony about the state of the  16 scientific evidence about  17 gender-affirming medical care for minors?  18       A. Yes.  19       Q. And that's what you've  20 discussed in your reports in this case?  21       A. Well, you read the report.  22       Q. So that's a "yes"?  23       A. I hope it's a yes.  24       Q. Do you understand -- well, let  25 me ask you, have you ever read the</p>

<p style="text-align: right;">Page 162</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Arkansas law at issue in this case?  3       A.   I did, yes.  4       Q.   So you understand that the law  5 prohibits gender-affirming medical  6 interventions for minors which suffer  7 from gender dysphoria in all cases,  8 regardless of circumstances?  9       MR. CANTRELL: Object to form.  10      A.   I think that's what the law  11 says at this point in the history of the  12 law, yes.  13      Q.   Can you say what you mean by,  14 "at this point in the history of the  15 law?"  16      A.   Well, you know, if you  17 interpret the law as any doctor -- every  18 doctor has to stop prescribing hormones  19 to people who have been on hormones for  20 two years or three years, I really don't  21 think that's going to happen. I think the  22 law will be modified or that doctors will  23 get together and recommend a process  24 whereby people can be discontinued from  25 hormones.</p>	<p style="text-align: right;">Page 164</p> <p>1       STEPHEN B. LEVINE, M.D.  2 are currently on these treatments.  3       So that's a psychological and  4 medical problem that needs to be solved  5 if the law goes into effect. But I do  6 think the intent of the law is not so  7 much with the people who are currently  8 being treated, but the people who might  9 be treated after the law goes into  10 effect. That's my understanding.  11      Q.   Okay. When you talk about the  12 problem of the people who already are  13 17-year-olds and have been on hormone  14 therapy for a few years, do you think it  15 would be a problem to require them to  16 discontinue hormone therapy?  17      MR. CANTRELL: Object to form.  18      A.   I think there's a physiologic  19 problem and I think there's a  20 psychological problem and I think the  21 team of doctors that include, I hope  22 still, a mental health professional,  23 although I doubt if any of them have a  24 mental health professional, I think that  25 team of the endocrinologist or the</p>
<p style="text-align: right;">Page 163</p> <p>1       STEPHEN B. LEVINE, M.D.  2       I do think the writing of the  3 law was more about the future than it is  4 about the current situation and that the  5 current patients on hormones who are in  6 the process, say, 17-year-olds, 17 and a  7 half-year-olds, I don't think the law  8 will be literally interpreted for those  9 people as they will be interpreted for  10 the 13-year-old who comes with gender  11 dysphoria, who then would be offered in  12 Arkansas a different kind of approach.  13       I don't really think Arkansas  14 is trying to stop the treatment of kids  15 with gender dysphoria. I think they're  16 trying to stop the treatments with  17 scientifically unclear value and dangers  18 with children with gender dysphoria.  19       So as far as I understand, the  20 law says that we, we physicians in  21 Arkansas must desist from giving these  22 treatments, but I think doctors are going  23 to get together, and perhaps even with  24 the blessing or of another law in  25 Arkansas, to deal with the patients who</p>	<p style="text-align: right;">Page 165</p> <p>1       STEPHEN B. LEVINE, M.D.  2 primary care doctor or the pediatrician  3 and the mental health professional who's  4 been interested in gender dysphoria, will  5 have to get together and to think about  6 how best to do this, to live within the  7 law.  8       Now, if it's six months  9 before, you know, the person is 18,  10 they'll find some solution. And then if  11 the child is 16 and they're two years,  12 there will be a different kind of  13 solution to it. And so, it's not like the  14 medical profession can't respond to this  15 law, to live within the law and I don't  16 really think that the Attorney Generals  17 -- of the people in the Attorney  18 General's Office and the Prosecutor's  19 Office are going to be unsympathetic to  20 the situations that you and I are making  21 reference to.  22       The law, itself, you see, I  23 think is primarily about the future. But  24 it does have a problem now for what are  25 we going to do with these kids? And I</p>

<p style="text-align: right;">Page 166</p> <p>1       STEPHEN B. LEVINE, M.D.  2 trust the medical profession -- I trust  3 the medical profession to be sensitive to  4 the physical and the psychological and  5 the social needs of these children, and  6 they'll find a way.  7       Q. You talk about finding  8 solutions that stay within the confines  9 of the law. Do you mean find solutions  10 about how to detransition them in a way  11 that stays within the confines of the law  12 or to find a way to not detransition?  13       MR. CANTRELL: Object to form.  14       A. No. I don't imply it's going  15 to cause them to detransition. Gender  16 identity is a psychological thing. It  17 isn't dependent on taking hormones, you  18 see.  19       Q. Let me rephrase that question  20 then, understanding why that was  21 confusing.  22       When you were talking about  23 the medical community coming up with  24 solutions, do you mean solutions about  25 how to take them off of the hormone</p>	<p style="text-align: right;">Page 168</p> <p>1       STEPHEN B. LEVINE, M.D.  2 identity, which has been stable for four  3 years, is not going to disappear because  4 the child is not on hormones for six  5 months or can be on a lesser dose of  6 hormones, you see.  7       Now, spironolactone, for  8 example, is not a hormone, but it's  9 commonly used to suppress androgens and  10 to increase estrogen in the body. So  11 they'll figure out how to deal with this  12 if the law becomes the law, you see.  13       The doctors will work with the  14 law and they'll find a way. The law  15 doesn't apply to 18-year-olds. And so, I  16 just think the law, itself, is aimed at  17 preventing treatments that are not  18 scientifically established for young  19 people.  20       But this is a group that you  21 and I are now talking about that will be  22 -- will require some additional thinking,  23 which the law does not provide for at  24 this point. But I trust the medical  25 profession and their belief in if the</p>
<p style="text-align: right;">Page 167</p> <p>1       STEPHEN B. LEVINE, M.D.  2 therapy or solutions about how to not  3 take them off the hormone therapy? I'm  4 not sure what you meant by "solutions".  5       MR. CANTRELL: Object to form.  6       A. I'm saying that since medicine  7 ideally is on a case-by-case basis, the  8 team of physicians who are involved with  9 this, which I hope will be the endocrine  10 expert, and that may be the pediatrician,  11 him or herself, and the mental health  12 professional, and the team that has been  13 involved, let's say there's a children's  14 hospital that does this in Little Rock,  15 you know, those people will get together  16 and will think about this, both as a  17 policy; that is how we're going to  18 generally approach this and how we're  19 going to individually approach this for  20 this case versus that case, and they will  21 find a solution. And it is not -- it  22 doesn't necessarily mean detransitioning  23 the child. It may mean decreasing their  24 hormones or using something else or  25 reassuring the family that gender</p>	<p style="text-align: right;">Page 169</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient, in fact, is -- is doing better,  3 they may come to realize the person is  4 still not doing better and maybe the  5 treatment for the last three years hasn't  6 really amounted to an upgrade in  7 improvement, so the family and the  8 patient and the law sort of will be  9 cooperating to make an individual  10 decision that you may eventually call  11 detransition. But I don't know what that  12 will be, it's uncertain.  13       Q. If you have a 16-year-old  14 who's been on hormone therapy and by all  15 accounts the patient, parent and doctor  16 agree that has been a beneficial  17 treatment, and then the law goes into  18 effect tomorrow and the doctors can't  19 continue to provide hormone therapy for  20 two more years while the patient is a  21 minor, could that cause harm to that  22 minor, psychologically --  23       MR. CANTRELL: Object to form.  24       Q. -- physically?  25       A. Theoretically, it could cause</p>

<p style="text-align: right;">Page 170</p> <p>1       STEPHEN B. LEVINE, M.D.  2 distress. It would cause the family to  3 have to find a solution. It may be to go  4 to Kentucky or Missouri or Oklahoma or it  5 may, if it's a politically active family,  6 it may cause a conversation with the  7 legislature who will provide a secondary  8 bill, a bill that perhaps can pass very  9 quickly that only applies to those  10 16-year-olds, like those kids like you  11 are just making reference to, that would  12 be much more, you know, thoughtful about  13 how do we deal with the already  14 transitioned people who are doing well.  15       So if there are already  16 transitioned kids who are not doing well,  17 this may be, in fact, a benefit. But  18 there are kids who -- I will presume with  19 you that there are children who are doing  20 better or who are functioning well in  21 their new role and who want to continue,  22 and I think solutions will be found. You  23 know, I would prefer this law to have  24 made provisions already for that but that  25 wasn't in -- I wasn't consulted.</p>	<p style="text-align: right;">Page 172</p> <p>1       STEPHEN B. LEVINE, M.D.  2 banning new treatments.  3       Q.   And are some of those, the  4 ones that are considering it, like  5 Arkansas, banning continued care for  6 those already receiving treatment?  7       MR. CANTRELL: Object to form.  8       A.   I'm sorry. The two of you  9 heard that better than I did.  10      Q.   When you -- you mentioned you  11 had some concerns about what's going on  12 in other states. Are there proposals  13 you're concerned about that, like  14 Arkansas, would prohibit not just  15 forward-looking treatment for new  16 patients but treatment being continued  17 for those currently receiving  18 gender-affirming hormone therapy?  19      MR. CANTRELL: Object to form.  20      A.   What I'm saying is that the  21 social circumstances of children who are  22 gender dysphoric but haven't been  23 socialized into a new gender or haven't  24 been given one of the hormone treatments  25 is one set of issues. And what you are</p>
<p style="text-align: right;">Page 171</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Q.   And just to clarify, when you  3 say you would prefer that the law would  4 have made provisions already for that,  5 you mean, are you suggesting some kind of  6 a carveout for adolescents who are  7 already receiving gender-affirming  8 hormone therapy?  9       A.   I would have liked the law to  10 have talked about the present -- the  11 future treatments of this as of the time  12 the law was passed and recognizing the  13 social, psychological circumstances of  14 the children who already have been  15 stabilized in their new social gender,  16 their new gender, to think about those  17 kids. I don't think the law has thought  18 about those kids sufficiently. So I'm a  19 little concerned about that, and it's not  20 just in Arkansas, you know.  21      Q.   Where else are you concerned  22 about that?  23      A.   Well, as you know better than  24 I, other states are considering or have  25 -- you know, are considering similar</p>	<p style="text-align: right;">Page 173</p> <p>1       STEPHEN B. LEVINE, M.D.  2 raising appropriately is, what about the  3 children who already have spent years in  4 treatment, what are we to do about those  5 people? And I am trying to be kind and  6 understanding and compassionate about the  7 situations and those families.  8       I don't think this is a reason  9 to ban the law, so to speak. I think  10 it's a reason to think about those people  11 as a separate category of people, and to  12 be compassionate about them and  13 compassionate to the doctors and  14 compassionate to the parents, and to make  15 an individual -- to make -- as I already  16 said, I think there are two dimensions to  17 the response to that group of people;  18 one, is the teams of doctors who have  19 been involved with this need to get  20 together and think about what is  21 necessary in general for this group of  22 people; and then the individual doctors  23 taking care of this child and these set  24 of parents, you see, need to think about,  25 what are we going to do in this case? And</p>

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1       STEPHEN B. LEVINE, M.D.  
2 I have more optimism that the good nature  
3 of that process, the medical process,  
4 they'll find solutions for this, you see.  
5 And I hope one of the solutions will be  
6 to approach the legislature to create --  
7 to not put doctors in harm's way if they  
8 -- if they're taking care of people who  
9 they've previously committed to this  
10 treatment.  
11       If someone is taking four  
12 years of an anti-cancer drug, and it's  
13 now proven that this anti-cancer drug has  
14 negative -- negative consequences, well,  
15 the doctors can easily stop that, you  
16 see. But here we're imposing -- we  
17 recognize that if we stop the cancer  
18 drug, there's a certain benefit to it and  
19 there is a certain risk to it and the  
20 doctors will modify that decision based  
21 upon their understanding of the risks and  
22 the benefits of the drug. What else can  
23 we do?  
24       So, you know, we want our  
25 doctors to be preoccupied with the

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1       STEPHEN B. LEVINE, M.D.  
2 welfare of the child, of our patients,  
3 and I believe that doctors are  
4 preoccupied with that. So we'll find a  
5 way. We'll find a way. It's not just,  
6 okay, it's going to stop and then doctors  
7 are going to turn their back on these  
8 people. I don't think that's going to  
9 happen at all.  
10       Q. Now, in your view, would it be  
11 best for an individual case-by-case  
12 determination to be made for what to do  
13 with each of those teens who is already  
14 on gender-affirming medical care?  
15       MR. CANTRELL: Object to form.  
16       A. You know, I've already  
17 answered that question. I'll do it a  
18 third time.  
19       I think it will take two  
20 forms; one, what are we going to do in  
21 general about this problem because it's  
22 new; and two, what are we going to do  
23 about John Jones? They can be separate.  
24 I mean, John Jones is going to fall  
25 within the umbrella but it's going to be

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1       STEPHEN B. LEVINE, M.D.  
2 different what we're going to do with Tom  
3 Burch. Am I clear? I think so.  
4       Q. So going back then to your  
5 reports that discuss the scientific  
6 evidence regarding gender-affirming  
7 medical care for adolescents, by  
8 submitting those reports in this case was  
9 it your intention to express support for  
10 banning gender-affirming medical care  
11 across the board for minors?  
12       MR. CANTRELL: Object to form.  
13       A. You are talking about this  
14 article?  
15       Q. No. No. Sorry. Your reports  
16 that you submitted in this case, your  
17 expert reports, your declarations.  
18       MR. CANTRELL: Object to form.  
19       THE WITNESS: You want me to  
20 answer this?  
21       MR. CANTRELL: You can answer.  
22       Q. Actually, let me back up. I  
23 don't want there to be confusion here.  
24       You recall submitting expert  
25 reports in this case, correct?

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1       STEPHEN B. LEVINE, M.D.  
2       A. Of course.  
3       Q. Okay. And so my question  
4 relates to those reports.  
5       By submitting those reports in  
6 this case was it your intention to  
7 express support for banning  
8 gender-affirming medical care across the  
9 board for minors in Arkansas?  
10       MR. CANTRELL: Object to form.  
11       A. I thought that the Attorney  
12 General's Office hired me to give the  
13 state -- to articulate the state of  
14 science in this field. That's what I was  
15 hired to do. I am not a proponent or an  
16 opponent to this, to the law.  
17       I have already told you my  
18 concerns about the law. I'm not a  
19 legislator, I'm not a politician, I don't  
20 consider myself an expert in public state  
21 policy, policy on state levels.  
22       I do feel my expertise is in  
23 my knowledge of the state of science in  
24 this field, and I believe I'm being hired  
25 to testify only to that.

<p style="text-align: right;">Page 178</p> <p>1       STEPHEN B. LEVINE, M.D.  2       I don't present -- I don't  3 presume that I'm an expert in the wisdom  4 of the law. I hope I have a certain  5 degree of cogency and grasp of the state  6 of science, and that's what I believe  7 I've been hired to testify to. Is that an  8 answer to your question?  9       Q. I think it was. And from  10 earlier in the deposition we talked about  11 your articles Reconsidering Informed  12 Consent, and your views about how care  13 should be provided in this area. So I  14 just want to make sure I understand  15 correctly.  16       Is it your position, not that  17 care -- sorry. I'll start again. Is it  18 your position -- I'm sorry. I'm asking  19 this in a very awkward way.  20       Do I understand correctly that  21 it is not that you oppose ever providing  22 gender-affirming medical care to minors,  23 but that it should be done with a lot  24 more caution and according to standards  25 that you articulate in your revisiting</p>	<p style="text-align: right;">Page 180</p> <p>1       STEPHEN B. LEVINE, M.D.  2 position is scientifically and  3 personally, based on my experience, there  4 are considerable concerns, legitimate  5 concerns about the long-term implications  6 of what we're doing by medicalizing a  7 child's gender identity, you see, because  8 it makes -- it causes permanent damage.  9       Generally, "this above all, do  10 no harm" is the major medical principle  11 of ethics. And the penis is normal, the  12 breast tissue is normal, menstruation is  13 normal, you see, and interfering with  14 these things on the hope that the  15 long-term outcome will lead to mental  16 healthy, highly functional, loving  17 people. The hope. The science says,  18 well, what is the evidence that your hope  19 has been realized?  20       So my position is, as long as  21 you believe this, that it's an important  22 thing to do and there are things like  23 true transsexual people, which I'm not  24 sure exists, you see, then if you're  25 going to do these things, at least you</p>
<p style="text-align: right;">Page 179</p> <p>1       STEPHEN B. LEVINE, M.D.  2 informed consent article?  3       MR. CANTRELL: Object to form.  4       A. It's my position that there  5 are serious, serious concerns about the  6 wisdom of medicalizing gender identity in  7 a child and in a adolescent, and that the  8 evidence that this is beneficial to the  9 child, him or herself, and to the family  10 you see, in the long run and that it  11 improves the ability to function  12 socially, vocationally, educationally,  13 and sexually, these things are -- there  14 are indications that these things are not  15 health-promoting.  16       So given the state of science  17 I have concerns about the wisdom of this  18 and I hope that the doctors have the  19 concerns about the wisdom of this  20 treatment and apparently, the legislature  21 has concerns about the wisdom of these  22 treatments as well.  23       So if you understand my  24 testimony, I think you keep asking me  25 about, you know, what is my position? My</p>	<p style="text-align: right;">Page 181</p> <p>1       STEPHEN B. LEVINE, M.D.  2 should do it within the ethical framework  3 that this article discusses.  4       I don't know if I'm ever going  5 to be able to answer your question.  6       MS. COOPER: Can we mark  7 exhibit tab 17 as the next exhibit.  8       (Exhibit Levine 4, transcript  9 re: Presentation on Healthcare  10 Models For Transgender Adolescents,  11 dated March 12, 2020, was received  12 and marked on this date for  13 identification.)  14       Q. Okay. That should be up.  15       Dr. Levine, this is a  16 transcript of testimony from a  17 legislative hearing in Pennsylvania.  18       Do you recall testifying in  19 2020 at a legislative hearing in  20 Pennsylvania?  21       A. Yes, I do recall that.  22       Q. And am I right that that was  23 about state medical insurance coverage  24 for gender-affirming medical care for  25 minors? Is that the issue you were</p>

<p style="text-align: right;">Page 182</p> <p>1       STEPHEN B. LEVINE, M.D.  2 talking about?  3     A.   I think there was a health  4 subcommittee and they were trying to  5 decide whether Medicaid should cover  6 these treatments.  7     Q.   For minors; is that right?  8     A.   Yes, for minors.  9     Q.   Okay. If you could scroll down  10 with me to page 59, please.  11     A.   Okay. 59, yes. You didn't  12 highlight this page.  13     Q.   No. Sorry. Actually, let's go  14 to 58 because I want to make sure 57 --  15     A.   57?  16     Q.   Yes. If you could read,  17 there's an exchange between Dr. Levine  18 and Representative Cox where he asks a  19 question at the bottom of page 57. Do you  20 see that? Starting with, "If I might,  21 Mr. Chairman"?  22     A.   Yes. Okay. I'm there.  23     Q.   I just want to make sure you  24 can have the context. So why don't you  25 read there through page 59.</p>	<p style="text-align: right;">Page 184</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Okay. Just making sure we're  3 on the same page.  4       So at the top of 59 I want to  5 ask about a passage that says, "I'm not  6 asking the committee to outlaw sexual  7 assignment surgery, I'm not asking the  8 committee to outlaw the judicious use of  9 endocrine treatment, I'm just raising  10 questions for you about the wisdom of  11 encouraging puberty blocking, the way I  12 understand it happens in urban centers  13 that process many many kids, increasing  14 numbers of children." I'll stop there.  15       What did you mean by "the  16 judicious use of endocrine treatments"  17 there?  18     A.   Ms. Cooper, I know you're a  19 very intelligent person. And "judicious"  20 is a word you understand. So I'm a little  21 perplexed that you are asking me what I  22 meant by "the judicious use of endocrine  23 treatment."  24       I guess you mean, am I saying  25 that doctors need to be thoughtful, make</p>
<p style="text-align: right;">Page 183</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I have now read to the top of  3 page 59. Do you want me to read through  4 59?  5     Q.   Yes, please.  6     A.   Okay.  7       (Deponent reviews the  8 document.)  9     A.   Okay.  10     Q.   So I wanted to ask you, this  11 was about whether to cover  12 gender-affirming medical care for minors  13 as part of the state Medicaid coverage?  14     A.   Well, Ms. Cooper, this is the  15 first time since March 12th, 2020 I read  16 those words, so you'll forgive whatever I  17 say next because I'm not exactly, you  18 know -- this was me two years ago and six  19 months ago. I've had a lot of experience  20 in the last 26 months. I've reviewed a  21 lot of data in the last 26 months.  22     Q.   But the topic you're talking  23 about is gender-affirming medical care  24 for minors, right?  25     A.   Right.</p>	<p style="text-align: right;">Page 185</p> <p>1       STEPHEN B. LEVINE, M.D.  2 good judgment? Yes, that's what I mean.  3       We've already spent a great  4 deal of time of what goes into judicious,  5 informed consent, based on science, based  6 on the families' education and ability to  7 comprehend, based on the psychopathology  8 of the family, the psychopathology of the  9 family, the psychopathology of what the  10 child has endured in life and is still  11 suffering from. That's what I mean by  12 judicious.  13       Now, I'm not saying that there  14 is no child that a therapist might  15 actually think it may not harm, it may  16 not help, but I think it's worth a try,  17 that would be judicious. That would be  18 judicious as of March 12th, 19 -- 2020.  19     Q.   Is it different now?  20     A.   I think it may be different  21 now that we've had additional reviews  22 about the risk/benefit ratios, but still  23 I would always want -- I would always  24 want the word judicious to modify what  25 doctors do.</p>

<p style="text-align: right;">Page 186</p> <p>1       STEPHEN B. LEVINE, M.D.  2       So I would never say -- I  3 mean, I'm not going to delete that word  4 and I don't think when you get medical  5 care you would want your doctor to be  6 non-judicious. So it's judicious.  7       Now, the question is, is it  8 really judicious to take a 13-year-old  9 and put them on hormones, say, puberty  10 blockers, and then a year later put them  11 on either testosterone or estrogen.  12 Today, given the science, it would  13 probably be even less judicious than it  14 was two years ago to do that. And again,  15 science is ever-changing, facts are  16 ever-evolving, and who knows what a year  17 from now we will know.  18       I don't think if we get new  19 knowledge it won't be from the United  20 States, it will be from other countries  21 who are more apt to be cautious and to do  22 studies like Sweden, for example.  23       Q.   You give the example of a  24 13-year-old, that maybe today it wouldn't  25 not be judicious to provide certain</p>	<p style="text-align: right;">Page 188</p> <p>1       STEPHEN B. LEVINE, M.D.  2 experiences and loving and falling in  3 love and having sexual experiences and  4 entering into a romantic relationship  5 with or without sex and understanding the  6 complexities of it, the nuances of it,  7 and to realize that I'm more than my  8 gender identity, and my body responds  9 with pleasure in ways that I didn't know  10 that I had before. That these things are  11 -- these things can change a child's  12 attitude towards the self, which is what  13 gender dysphoria is, you know, it's a  14 problem in one's attitude towards the  15 bodily self and the psychological self,  16 as represented in your own gender, your  17 concepts about your own gender.  18       So judicious also means the  19 judicious use of the doctor as a  20 maturational promoting agent, you see.  21 So much of the psychotherapy of these  22 children are -- is aimed at facilitating  23 maturation and not getting stuck on one  24 issue, you see.  25       So I think there the tradition</p>
<p style="text-align: right;">Page 187</p> <p>1       STEPHEN B. LEVINE, M.D.  2 medical transition treatment to a  3 13-year-old.  4       Could it in your view be  5 judicious in 2022 to ever provide hormone  6 therapy to a 16-year-old?  7       MR. CANTRELL: Object to form,  8 vague.  9       A.   Well, it wouldn't be judicious  10 if it was outlawed in the state. It  11 wouldn't be judicious to put the doctor  12 into some kind of jeopardy.  13       Q.   Let's put that aside. As a  14 medical question?  15       A.   As a medical question, if we  16 had a chance to do what Dr. Levine  17 suggests, not just today but in papers  18 I've written about understanding all the  19 things I've already said several times, I  20 think it is possible that there may be a  21 case or two that we could be planning for  22 ultimate endocrine treatment in the  23 future. I don't know that it has to  24 happen at 16, for example. I think at 16  25 it's possible to begin to have intimate</p>	<p style="text-align: right;">Page 189</p> <p>1       STEPHEN B. LEVINE, M.D.  2 of psychotherapy and the state of science  3 comes together to perform a powerful  4 argument that we should not be giving,  5 especially when there is high pressure on  6 institutions to process or have what I  7 call high throughput, move kids through  8 the system very quickly. I think that's  9 a very strong argument to not giving  10 hormones to the average 16-year-old who's  11 been identified for two years as a trans  12 person, you see. They can keep their  13 identity as a trans person, they can keep  14 that identity, but they need to have this  15 process that will help them participate  16 in the world as though they're a more  17 complicated person than just a trans  18 person.  19       So I think science and  20 psychology and the knowledge of  21 psychological development through  22 adolescence all come together to say  23 caution, caution, careful, don't harm  24 this kid, just because he wants this.  25       MS. COOPER: I'd like to mark</p>

<p style="text-align: right;">Page 190</p> <p>1 STEPHEN B. LEVINE, M.D.  2 tab 8 as the next exhibit.  3 (Exhibit Levine 5, transcript  4 of Stephen B. Levine, M.D. Monday,  5 December 21, 2020 re: Juli Claire  6 v. Florida Department of Management  7 Services was received and marked on  8 this date for identification.)  9 Q. Exhibit 5 is now up. Are you  10 able to open the document?  11 A. Did you ask me a question?  12 Q. Can you see the document?  13 A. Yes.  14 Q. This is a transcript of a  15 deposition of you taken in the case  16 Claire against Florida Department of  17 Management Services. Do you recall being  18 deposed in that case?  19 A. Vaguely.  20 Q. Okay. According to the cover  21 page here that was in December of 2020;  22 is that correct?  23 A. I trust the accuracy of that.  24 Q. Can you please scroll down,  25 it's page 152 I put to point you to.</p>	<p style="text-align: right;">Page 192</p> <p>1 STEPHEN B. LEVINE, M.D.  2 Q. I wanted to just ask you to  3 read with me, I'm going to read the  4 answer highlighted. You say "Because  5 categorical" -- actually, sorry. I'm  6 going to go up to the first prior answer,  7 "Listen, I'm going to answer all your  8 questions. I don't believe generally in  9 categorical bans of hormone treatment and  10 surgical treatment for individual  11 patients. Why is that? Because  12 categorical bans is an absolute thing and  13 I've already established that people have  14 different needs and I don't want to  15 deprive certain people, even though I  16 think it's a bad idea for other people.  17 That's what I take when you say  18 categorical bans."  19 And I understand this was a  20 case about adults that you were talking  21 about, so I don't want to confuse things.  22 But is that still your view in general,  23 about what you said there, that you don't  24 believe generally in categorical bans of  25 hormone therapy for certain patients?</p>
<p style="text-align: right;">Page 191</p> <p>1 STEPHEN B. LEVINE, M.D.  2 A. 152, I'm almost there. I'm  3 surprised. And you highlighted it.  4 Q. All right. Let's -- I want to  5 make sure I give you time to read the  6 relevant context.  7 If you go to page 151, the  8 first question at the bottom I think is  9 the beginning of this question. If you  10 can read that through page 152.  11 A. Where do you want me to begin?  12 Q. Very bottom of page 151.  13 A. "I am mindful of the time."  14 Q. That's the question. Let's go  15 to the next page.  16 A. Bates number.  17 (Deponent reviews the  18 document.)  19 A. Where did you want me to stop,  20 with the highlight?  21 Q. You can finish page 152. I  22 don't know if you need to read the  23 lawyer's objection. The end of your  24 testimony on that page.  25 A. Okay.</p>	<p style="text-align: right;">Page 193</p> <p>1 STEPHEN B. LEVINE, M.D.  2 MR. CANTRELL: And just for  3 the record, the question beginning  4 where right before you started  5 reading, Leslie, says "Let's move  6 it to adults."  7 MS. COOPER: Yes. That's what  8 I was trying to clarify before,  9 perhaps not clearly.  10 MR. CANTRELL: Okay. I just  11 wanted to make sure we were clear  12 on that.  13 MS. COOPER: We're clear.  14 MR. CANTRELL: Okay.  15 A. Ms. Cooper, I've been aware,  16 based on two recent studies, whose  17 prefaces have said it's unclear what the  18 mental health benefits are of sex  19 reassignment surgeries, they call it  20 sometimes gender-confirming or  21 gender-conforming surgeries. Two  22 studies by profound advocates of sex  23 assignment surgery began by saying it's  24 unclear, and I would add after 60 years  25 of doing these kind of surgeries, what</p>

<p style="text-align: right;">Page 194</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the mental health benefits of these  3 treatments, these surgical treatments  4 actually are.  5       Both of the studies -- one of  6 the studies, the most well known of the  7 studies is the Bränström-Panchankis Study  8 in the August American Journal of  9 Psychiatry, both of these studies have  10 been roundly attacked and the conclusions  11 of the study have been agreed upon by  12 others to not be based upon the data that  13 the study is purported to demonstrate.  14 And so the idea that the treatment of  15 adults is well established is -- is not  16 correct. The science is unclear even in  17 this arena of adults. And this is very  18 very relevant to the treatment of all  19 transgender people when, after 60 years  20 of experimenting or at least offering  21 these treatments, we can't be certain of  22 the mental health benefits and we are  23 aware of the high risk of suicides in  24 adults after the complete package of  25 medical treatment of the trans people. So</p>	<p style="text-align: right;">Page 196</p> <p>1       STEPHEN B. LEVINE, M.D.  2 I'm for informed consent and for people  3 whose brains are mature, as mature as  4 they're going to be. They get to decide,  5 you see.  6       So this was before, and I hold  7 the right to continue to evolve as a  8 professional in my understanding of  9 things. It's my right to mature as a  10 professional. It's my right to change my  11 mind and it's my right to phrase things  12 differently from every two years or every  13 two days, you see. Because, like  14 children, all adults mature, continue to  15 mature theoretically and professionals  16 mature.  17    Q.   So is your view no longer --  18 where you say, "I don't believe generally  19 in categorical bans on hormone treatment  20 or surgical treatment for individual  21 patients", is that no longer your view  22 after the new information you've learned  23 in the last two years?  24    A.   I'm not in favor of  25 categorical bans on surgery for</p>
<p style="text-align: right;">Page 195</p> <p>1       STEPHEN B. LEVINE, M.D.  2 in 2000 when I made this testimony I  3 didn't have access to those two studies.  4       So now I know that I'm even  5 more uncertain of the long-term wisdom of  6 doing these things with people just  7 because they want to. However, adults are  8 responsible, they're old enough to be  9 responsible for making decisions. And I  10 try to help them understand the data, but  11 if they still want to do this, they still  12 want to have their breasts removed or  13 they still want to have their  14 vaginoplasty, you see, if they understand  15 that their pleasure in masturbation, for  16 example, using their penis will disappear  17 and I can't guarantee they will be able  18 to have orgasm with masturbation or with  19 a partner when they female genitalia --  20 female-looking genitalia. Well, they get  21 to choose that, I don't get to ban that  22 for them, you see.  23       So I'm not exactly  24 categorically against things, as I've  25 testified I hope articulately already.</p>	<p style="text-align: right;">Page 197</p> <p>1       STEPHEN B. LEVINE, M.D.  2 transgender adults. I'm not in favor of  3 categorical bans. I'm just in favor of  4 the judicious -- of physicians doing  5 judicious decisionmaking based on correct  6 information. And I do think physicians  7 need not to disregard studies that they  8 don't happen to agree with because it is  9 not in keeping with their zeitgeist. So  10 maybe ask me that question again.  11    Q.   Well, I was asking whether  12 your opinion where you state here, "I  13 don't believe generally in categorical  14 bans of hormone treatment or surgical  15 treatment for individual patients",  16 whether that has changed?  17    A.   Well, actually I think it  18 makes more sense to categorically ban  19 puberty-blocking hormones in young people  20 than it does genital surgeries in  21 40-year-olds.  22    Q.   You would not at this point  23 favor categorical ban of hormone  24 treatment or surgical treatment for  25 adults for gender dysphoria?</p>

50 (Pages 194 - 197)

<p style="text-align: right;">Page 198</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   That's right.</p> <p>3     Q.   And you think it might make</p> <p>4 more sense to categorically ban puberty</p> <p>5 blockers for minors with gender</p> <p>6 dysphoria?</p> <p>7     A.   Right.</p> <p>8     Q.   And what about hormone</p> <p>9 treatment for minors with gender</p> <p>10 dysphoria?</p> <p>11    A.   I think it makes -- I think</p> <p>12 there is a very strong argument, which</p> <p>13 I've already tried to tell you the</p> <p>14 science has made, that this is -- the</p> <p>15 risks are too great to promote this as a</p> <p>16 standard treatment and certainly</p> <p>17 promoting this as a standard or what is</p> <p>18 called best practices, unquote -- quote</p> <p>19 best unquote practices.</p> <p>20       The idea that promoting this</p> <p>21 as the best practice is not only</p> <p>22 scientifically not correct, it's</p> <p>23 ethically not correct. And if it's</p> <p>24 ethically not correct, then it might not</p> <p>25 be legally correct.</p>	<p style="text-align: right;">Page 200</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 dysphoria, do I understand correctly that</p> <p>3 you would support the thorough informed</p> <p>4 consent process that you outlined in your</p> <p>5 article for that kind of treatment?</p> <p>6       MR. CANTRELL: Object to form,</p> <p>7 asked and answered.</p> <p>8     A.   I think I already expressed my</p> <p>9 ambivalence of categorical bans and I've</p> <p>10 already told you about the requirements</p> <p>11 for informed consent, but I think what I</p> <p>12 need to tell you now is that I believe</p> <p>13 that if doctors and parents and children</p> <p>14 knew, were given the facts on the ground,</p> <p>15 there probably would not be as much of a</p> <p>16 need for a law, you see, because I think</p> <p>17 the evidence suggests that the risk to</p> <p>18 this child is too great, and the</p> <p>19 consequence is not just for the child,</p> <p>20 the consequence is for the parent to have</p> <p>21 a mentally ill child or mentally ill</p> <p>22 adult is -- and that sometimes happens,</p> <p>23 you know, because we don't really pay</p> <p>24 attention to the underlying mental</p> <p>25 illness of the child. We say that all</p>
<p style="text-align: right;">Page 199</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   But putting aside the question</p> <p>3 of promoting hormone therapy as best</p> <p>4 practice, I'm just asking about</p> <p>5 categorically banning it for minors with</p> <p>6 gender dysphoria, are you in favor of</p> <p>7 that or does that fit into where you say</p> <p>8 -- let me ask it again.</p> <p>9       MR. CANTRELL: Object to form.</p> <p>10      MS. COOPER: I'm striking it.</p> <p>11    A.   Ms. Cooper, can I just ask you</p> <p>12 to face me when you --</p> <p>13    Q.   I'm sorry.</p> <p>14    A.   Because when your face is</p> <p>15 down, and I'm hard of hearing, I miss</p> <p>16 every third word.</p> <p>17    Q.   I'm sorry. Yeah, we don't</p> <p>18 want that.</p> <p>19       You talked about, for adult</p> <p>20 treatment, you're not favor in</p> <p>21 categorical bans you're for informed</p> <p>22 consent, I think is the way that you put</p> <p>23 it.</p> <p>24       And so my question is, for</p> <p>25 hormone therapy for minors with gender</p>	<p style="text-align: right;">Page 201</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 gender identities are normal but they</p> <p>3 have comorbidity. Their comorbidity may</p> <p>4 determine their mental illness at 22 and</p> <p>5 then for the parents they have a</p> <p>6 22-year-old child who is failing to</p> <p>7 launch and they may be happy taking</p> <p>8 hormones, you see, but they're not</p> <p>9 functioning very well.</p> <p>10      So what I'm saying is, we --</p> <p>11 it's not a matter of categorical bans</p> <p>12 alone, it's a matter of understanding</p> <p>13 what the profile of a child is and too</p> <p>14 many doctors have focused only on the</p> <p>15 gender dysphoria and they have believed</p> <p>16 that the best practice is hormones. And</p> <p>17 because they don't know the facts, people</p> <p>18 like state legislators are worrying about</p> <p>19 what they're doing to the next generation</p> <p>20 of children.</p> <p>21      And so that's where we are.</p> <p>22 And I don't know how to say this more</p> <p>23 clearly. You know, I think my attorney</p> <p>24 just said asked and answered. I think we</p> <p>25 could have said that three times already</p>

<p style="text-align: right;">Page 202</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or four times. This is a really fraught  3 area. All of us are concerned about this.  4     Q. I'm wondering, since you've  5 talked about -- you've got your article  6 about revisiting informed consent,  7 describing what I think you said would be  8 -- you feel is an appropriate standard to  9 be applied when considering  10 gender-affirming medical care for minors,  11 would in your view, if Arkansas passed a  12 law or regulation that required  13 clinicians to follow that kind of  14 rigorous process, would that be a better  15 choice than banning care across the board  16 no matter how that care is provided?  17       MR. CANTRELL: Object to form.  18     A. Maybe I'm getting too  19 fatigued. I don't think I grasped what  20 you were just asking me.  21     Q. Okay. So I understand from  22 your testimony that the concern you have  23 is providers not being cautious and  24 providing gender-affirming medical care  25 too quickly without thoroughly evaluating</p>	<p style="text-align: right;">Page 204</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctor's state of knowledge, not with  3 this doctor's state of belief --  4     Q. But a doctor -- sorry.  5     A. -- because beliefs are  6 determined not simply by scientific  7 knowledge, they're determined by many  8 other factors, including what someone  9 above them that they respect has taught  10 them, which may not be true at all, what  11 I like refer to as the chain of trust in  12 medical education. And we all have to  13 trust what we're taught, but we know the  14 soul of science is skepticism but we have  15 to learn so many things about so many  16 disorders that we just practically trust  17 what we're taught.  18       So I'm saying that people in  19 this arena often have strong beliefs that  20 they're on the side of angels and that  21 there's more benefit than there are harms  22 and that's not what science knows, and  23 they don't know that.  24       So what I'm saying is, when  25 you've asked that question you must</p>
<p style="text-align: right;">Page 203</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and getting to know the patients and  3 without thoroughly informing families of  4 everything you feel they need to know  5 about the risks and state of science,  6 that's a concern you've repeatedly  7 raised?  8     A. Can I stop you there?  9     Q. Yes.  10    A. Yes. That's right. But you  11 want to add one thing to your statement,  12 I'm also concerned that the doctors don't  13 know what the state of science is. So  14 their interactions with the patients,  15 meaning the family and the patient, are  16 based upon a positive view of the  17 potential of having a problem-free life  18 in the face of this child's history where  19 there are all these comorbidities. So if  20 the doctor does not know the facts on the  21 table circa May 26, 2022, then they can't  22 really give informed consent and if you  23 understand my article, which I think you  24 really do, these are the requirements for  25 informed consent. It begins with the</p>	<p style="text-align: right;">Page 205</p> <p>1       STEPHEN B. LEVINE, M.D.  2 include that the doctors need to know  3 what the truth is as scientifically  4 established, and that's whatever you said  5 accurate minus that point.  6     Q. So if the doctor knows what  7 the truth is, as you understand it, do  8 you believe a doctor could provide that  9 informed consent process to a family and  10 a family could choose to provide  11 gender-affirming medical care to a minor?  12       MR. CANTRELL: Object to form,  13 vague.  14     A. If there isn't a law  15 prohibiting it then I think, yes, under  16 certain circumstances. If a team of  17 doctors have had a thoughtful  18 deliberation process among themselves and  19 among the family, I think it's possible  20 to make this judicious decision. And  21 whether it would prove right or wrong,  22 the doctor may not know because it may  23 prove right in two months and be wrong in  24 two years. And so that's where science  25 comes in. We say, where is the long-term</p>

<p style="text-align: right;">Page 206</p> <p>1       STEPHEN B. LEVINE, M.D.  2 followup, folks? And the answer is, in  3 America we don't have any.  4       So we don't know whether this  5 judicious decision to say yes to hormones  6 has proven to be, in fact, judicious or  7 it may have been judicious then but  8 whether it's right in two years or five  9 years, we don't know. And you know if  10 this were your child you would want to  11 know what other people who went on  12 hormones five and ten years ago, how are  13 they doing? And the answer, if you ask  14 that to your doctor, for your child, the  15 doctor should say I don't know, I don't  16 know.  17   Q.   Could doctors have clinical  18 experience that would allow them to see  19 benefits to those kids in five years?  20   A.   Well, if it's a pediatrician  21 or pediatric endocrinologist who then  22 punts the child to an adult  23 endocrinologist or adult internist or  24 primary care doctor, they wouldn't know.  25 I mean, I've had -- I've talked to a</p>	<p style="text-align: right;">Page 208</p> <p>1       STEPHEN B. LEVINE, M.D.  2 expert is in the state of science.  3       It's not about support of a  4 law or against a law or whether an  5 insurance company should do this or  6 should not.  7   Q.   Let me ask you differently.  8 Have you testified about legislation that  9 bans gender-affirming medical care for  10 minors in any state?  11       MR. CANTRELL: Object to form.  12   A.   Have I testified in favor --  13   Q.   Have you testified in any  14 state legislative --  15   A.   No.  16   Q.   -- process?  17   A.   No. You have already seen my  18 Pennsylvania thing. I thought I was just  19 giving information. I wasn't testifying  20 for or against something.  21   Q.   You didn't testify in Alabama  22 about -- relating to a law about  23 gender-affirming medical care there?  24   A.   No.  25   Q.   Have you been asked to give</p>
<p style="text-align: right;">Page 207</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctor who thinks he's helping people  3 live long, happy, successful, vocational  4 and romantic lives and he's a child  5 psychiatrist who doesn't see kids after  6 17 or 18. So he just believes it. He just  7 believes it. Okay. What's the basis of  8 it? Well, I'm doing this, I have to  9 believe it, I believe it. But he's  10 teaching that to parents.  11   Q.   Have you ever been asked to  12 testify in support of a law banning  13 gender-affirming medical care for minors?  14       MR. CANTRELL: Object to form.  15   A.   I have been asked to give the  16 state of science in states that have --  17 are considering limiting insurance  18 coverages. And I don't know the answer  19 to your question of -- maybe in -- no one  20 has asked me to testify in favor of  21 banning a law. Everyone has asked me,  22 because I've been very clear with these  23 people, the only thing I'm relatively  24 knowledgeable about or what you would  25 called qualified as a Daubert qualified</p>	<p style="text-align: right;">Page 209</p> <p>1       STEPHEN B. LEVINE, M.D.  2 testimony related to a similar measure in  3 your state of Ohio?  4   A.   Yes, and I refused.  5   Q.   Why did you refuse?  6   A.   Because I'm not an expert in  7 these things. I think -- I refused  8 because this is what I know and I don't  9 want to be used for political -- I don't  10 want to be a pawn in political purposes.  11 These things are highly politicized. It  12 makes thinking very unclear.  13       I've come to learn that my  14 testimonies are public things that I  15 never imagined would be reading my expert  16 opinion reports, are reading my expert  17 opinion reports and calling me names  18 based on what they think. They call me  19 sometimes anti-trans or something. So I  20 don't want to be part of the public fray  21 but unfortunately I guess I am.  22   Q.   Do you think a law like  23 Arkansas, if it passed in Ohio, would be  24 beneficial to your minor patients with  25 gender dysphoria?</p>

<p style="text-align: right;">Page 210</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   If they pass this -- you say</p> <p>3 if they passed it in Ohio?</p> <p>4     Q.   Right.</p> <p>5     A.   Then I would say that it might</p> <p>6 be very beneficial for the future of</p> <p>7 trans-identified children in getting them</p> <p>8 what I consider to be reasonable</p> <p>9 appropriate care, because they have a</p> <p>10 psychological problem and they would then</p> <p>11 be treated like any other psychological</p> <p>12 problem by reviewing the patient's</p> <p>13 history and approaching the problems that</p> <p>14 the child has psychologically with or</p> <p>15 without some medication, like an</p> <p>16 antidepressant or anti-anxiety agent and</p> <p>17 we would have the same problem that you</p> <p>18 and I have discussed for 20 minutes about</p> <p>19 what to do with the children who already</p> <p>20 have been supported by the medical</p> <p>21 profession and I would urge then the Ohio</p> <p>22 legislature to have a bill that would</p> <p>23 take into consideration that which you</p> <p>24 and I have already discussed --</p> <p>25     Q.   So you wouldn't -- sorry.</p>	<p style="text-align: right;">Page 212</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 people the conservative treatment that</p> <p>3 might benefit them and then when they're</p> <p>4 older, if they want to do this, then</p> <p>5 they're responsible for themselves to do</p> <p>6 it.</p> <p>7       The state has an interest, I</p> <p>8 think, in protecting the vulnerable young</p> <p>9 and clearly, the transgendered</p> <p>10 populations are vulnerable people.</p> <p>11 They're not healthy people.</p> <p>12     Q.   So and in this case of</p> <p>13 gender-affirming hormone therapy for</p> <p>14 minors, you would prefer a categorical</p> <p>15 ban on care to an individual case-by-case</p> <p>16 determination with proper informed</p> <p>17 consent?</p> <p>18     A.   I would prefer that a higher</p> <p>19 quality mental health approach, first</p> <p>20 approach, be done with these children</p> <p>21 because I believe that if a high quality</p> <p>22 therapeutic process involving the</p> <p>23 children and the family process, that we</p> <p>24 would be able to help children find more</p> <p>25 comfort in how to live, than being</p>
<p style="text-align: right;">Page 211</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   -- benefiting from what we're</p> <p>3 talking about today.</p> <p>4     Q.   So if they did have a bill</p> <p>5 that they amended to say it doesn't apply</p> <p>6 to minors who are already currently</p> <p>7 receiving such treatment, you wouldn't</p> <p>8 have any concerns about that law, you</p> <p>9 think that would be in the best interests</p> <p>10 of minors with gender dysphoria in Ohio?</p> <p>11       MR. CANTRELL: Object to form.</p> <p>12     A.   You see, based on the</p> <p>13 assumption behind your question is that</p> <p>14 these treatments are really beneficial,</p> <p>15 that they're really helpful, that they</p> <p>16 cure many things and that they prevent</p> <p>17 suffering from depression and anxiety and</p> <p>18 substance abuse and suicidality, you see.</p> <p>19       That's what is behind your</p> <p>20 question, that there is something really</p> <p>21 positive about that. And these damn</p> <p>22 states that are trying to get rid of</p> <p>23 this, these are -- these are actions to</p> <p>24 harm people, you see. Whereas, I think</p> <p>25 they are actions trying to give these</p>	<p style="text-align: right;">Page 213</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 preoccupied solely with transforming</p> <p>3 their bodies.</p> <p>4       So all this business about</p> <p>5 categorical bans, I think because science</p> <p>6 is so uncertain and because other people</p> <p>7 feel profoundly, based on knowledge and</p> <p>8 intuition, that this is not a good thing</p> <p>9 to do to remove the breasts of 13- and</p> <p>10 14-year-old girls no matter what they</p> <p>11 say. We wouldn't take a 14-year-old who</p> <p>12 says, I don't ever want to have children</p> <p>13 and remove her ovaries. We wouldn't</p> <p>14 sterilize a 15-year-old girl or boy</p> <p>15 because they didn't -- they don't want to</p> <p>16 have children if that were cis. But we</p> <p>17 can somehow do that if they're trans and</p> <p>18 that doesn't make a lot of sense to many</p> <p>19 people.</p> <p>20     Q.   If somebody -- actually,</p> <p>21 strike that.</p> <p>22       MR. CANTRELL: Leslie, are we</p> <p>23 getting close a break?</p> <p>24       MS. COOPER: In a couple of</p> <p>25 minutes I think we can.</p>

<p style="text-align: right;">Page 214</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   So do I understand then that</p> <p>3   your view is that if a minor patient,</p> <p>4   their parents and their doctor agree that</p> <p>5   hormone therapy would be beneficial to</p> <p>6   the patient, and the family is provided a</p> <p>7   thorough informed consent process about</p> <p>8   the risks basis -- the risks and benefits</p> <p>9   of treatment and the state of the</p> <p>10  evidence, that the government should</p> <p>11  override that decision that the parents</p> <p>12  make?</p> <p>13       MR. CANTRELL: Object to form,</p> <p>14   asked and answered.</p> <p>15   A.   There is something about that</p> <p>16  long question that --</p> <p>17   Q.   Let me break it down.</p> <p>18   A.   -- I think you left something</p> <p>19  out.</p> <p>20   Q.   Maybe I did. Let me restate</p> <p>21  it. Thank you.</p> <p>22       So if a minor patient, their</p> <p>23  parents and their doctor agree that</p> <p>24  hormone therapy is appropriate for the</p> <p>25  patient, after the family is fully</p>	<p style="text-align: right;">Page 216</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2  Swedish study from 2011 and the Bränström</p> <p>3  study in 2020 that demonstrated these</p> <p>4  problems with suicide, you see.</p> <p>5       So what happens is if we're</p> <p>6  going to inform the -- if the doctor or</p> <p>7  the pediatrician informs the patient</p> <p>8  about the benefits of hormones, you'll</p> <p>9  feel better, it will stabilize your</p> <p>10 sexual -- your gender identity, you see,</p> <p>11 your voice will get lower or you will</p> <p>12 grow breasts, and the risks are you'll</p> <p>13 get a blood clot or you'll weight gain or</p> <p>14 your blood counts will go up, you see,</p> <p>15 and your serum cholesterol will go up and</p> <p>16 your high triglycerides, they don't say</p> <p>17 these things will predispose you to death</p> <p>18 from cardiovascular disease, it's not a</p> <p>19 lifecycle -- it's not a lifecycle</p> <p>20 perspective. It's about the known medical</p> <p>21 effects of hormones. That's not informed</p> <p>22 consent, that's only a part of informed</p> <p>23 consent. And that's why I don't like how</p> <p>24 you phrased that sentence because it's</p> <p>25 about, oh, well, we talk about the risk</p>
<p style="text-align: right;">Page 215</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2  informed about the risks and benefits of</p> <p>3  treatment, do you think the government</p> <p>4  should override that medical decision</p> <p>5  made by the parents?</p> <p>6       MR. CANTRELL: Same</p> <p>7   objections.</p> <p>8   A.   All right. The risk and</p> <p>9  benefits of treatment is what stopped me</p> <p>10 the first time because I happen to know</p> <p>11 that the risk of benefit treatment is</p> <p>12 that the benefits are not really written</p> <p>13 down, but the risks are thromboembolism,</p> <p>14 you know, weight gain, future</p> <p>15 cardiovascular disease, right. They're</p> <p>16 not talking about the risks that I'm</p> <p>17 talking about, you see. They're not</p> <p>18 talking about the long-term life course</p> <p>19 outcomes. They're not talking about the</p> <p>20 elevated suicide rate.</p> <p>21       I've never seen an informed</p> <p>22 consent that talked about the elevated</p> <p>23 suicide rate of adults who are fully</p> <p>24 transitioned. I've never -- I've never</p> <p>25 heard of a doctor talking about the</p>	<p style="text-align: right;">Page 217</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2  and benefits of the treatment. You're not</p> <p>3  talking about the risk of the treatment</p> <p>4  because you don't have a lifetime</p> <p>5  perspective. And when you give -- when</p> <p>6  you give a 15-year-old hormones you're</p> <p>7  changing their life trajectory and you're</p> <p>8  shortening their lives.</p> <p>9     Q.   It sounds like you're of the</p> <p>10 view that these treatments can never be</p> <p>11 beneficial. So why did you write an</p> <p>12 article about how to approach it through</p> <p>13 informed consent rather than an article</p> <p>14 about banning the treatment?</p> <p>15       MR. CANTRELL: Object to form,</p> <p>16   argumentative.</p> <p>17   A.   I wrote an article to be</p> <p>18 helpful, to represent what doctors know</p> <p>19  and what doctors don't know. And I leave</p> <p>20  it to the medical profession and for</p> <p>21  anyone else who wants to read the</p> <p>22  article, like lawyers and legislatures,</p> <p>23  to think about the implications of this.</p> <p>24       I'm not -- I don't have the</p> <p>25  wisdom to ban everything. I don't know</p>

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<p style="text-align: right;">Page 218</p> <p>1       STEPHEN B. LEVINE, M.D.  2 who benefits and who doesn't benefit. I  3 don't know the rate of unhappiness at  4 five years. I don't know -- I don't know  5 how society is to answer the question;  6 how many negative outcomes versus  7 positive outcomes would make us want to  8 continue or want to ban the treatment?  9       For example, if I ask you the  10 question, if you were a legislator or a  11 governor, if 15% of people are harmed and  12 50% are benefited and the rest, the 35%  13 are neutral, they don't know the answer,  14 would you ban it? And what happens if 60%  15 are harmed but 40 are helped, would you  16 ban it? You see, at what level? It's not  17 doctors who could decide this, you know,  18 it's legislatures or governors,  19 politicians can decide these things. But  20 you see as a doctor our medical  21 profession does not know what the actual  22 rate of harm is. And when these -- these  23 reviews in other countries have said it  24 looks like the risk of harm exceeds the  25 benefit, the benefits be cautious.</p>	<p style="text-align: right;">Page 220</p> <p>1       STEPHEN B. LEVINE, M.D.  2 take a pause and think about this.  3       I know lawyers have to win and  4 lose cases. But on a larger sense, I'm  5 trying to influence everyone to  6 understand what science is. And you guys  7 can fight it out.  8       Q.   Would you be comfortable if  9 every state in the country passed a law  10 banning gender-affirming medical care for  11 minors?  12       MR. CANTRELL: Object to form,  13 calls for speculation.  14       A.   You see, I think medical care  15 includes psychological care. So I don't  16 even think that your statement makes any  17 sense.  18       Q.   Let me rephrase the question.  19 Would you feel comfortable with a law  20 banning gender-affirming hormone therapy  21 for minors with gender dysphoria?  22       MR. CANTRELL: Same  23 objections.  24       A.   I would say based on what I  25 know today, that there would be a certain</p>
<p style="text-align: right;">Page 219</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Now, in ten years we may know  3 that this treatment helps 83%, harms 10%  4 and 7% unclear. Well, if we -- if we knew  5 that 83% of people benefited, I would be  6 in favor of taking certain kids who met  7 certain criteria and putting them on this  8 path. But if it were reversed and only  9 13% were helped and 87% or 80% were  10 harmed, then I would say don't do this,  11 don't do this, please. I'm looking at --  12 we're talking about millions of people  13 here.  14       Q.   So given what we know how,  15 you're comfortable with your report being  16 used to help the state support and defend  17 a ban on care for minors --  18       MR. CANTRELL: Object to form.  19       Q.   -- ban on gender-affirming  20 medical care for minors?  21       MR. CANTRELL: Object to form.  22       A.   I believe my report is helping  23 you to think about the problem that  24 you're trying to defend. I believe I'm  25 helping everyone who reads the report to</p>	<p style="text-align: right;">Page 221</p> <p>1       STEPHEN B. LEVINE, M.D.  2 prudence to that and yet a certain  3 imprudence to that, and I don't know how  4 to balance those two things and I don't  5 really think, given what my -- what the  6 state of science has and where we are,  7 that it's up to us to make that decision.  8       I'm generally not -- I'm  9 generally not for statements like "all"  10 or "always" and "never". I've been a  11 doctor too long to know that even great  12 adversities today sometimes have good  13 outcomes and good things today have bad  14 outcomes.  15       So it's really hard for me to  16 take these kind of positions that I think  17 you're trying to box me into. So please,  18 please respect the complexity of my  19 views, at least as I experience them.  20       Q.   And just to wrap up and we can  21 take a break, is some of your discomfort  22 in answering these -- hold on. We're  23 having an audio problem message. Can you  24 hear me?  25       A.   I hear you fine.</p>

<p style="text-align: right;">Page 222</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Q.   Is your discomfort with the</p> <p>3 sort of "all" questions that as a general</p> <p>4 matter medical decisions would be made on</p> <p>5 a case-by-case basis as opposed to</p> <p>6 blanket rule about care?</p> <p>7       MR. CANTRELL: Object to form.</p> <p>8       A.   If I may go back to breast</p> <p>9 cancer for a minute, these case-by-case</p> <p>10 decisions are part of a larger umbrella</p> <p>11 of what science knows.</p> <p>12       So what science knows about</p> <p>13 the treatment of a particular form of</p> <p>14 breast cancer has to be modified because</p> <p>15 this woman with breast cancer or this man</p> <p>16 with breast cancer has an associated</p> <p>17 medical problem. So that treatment is on</p> <p>18 a case-by-case basis. But that's an</p> <p>19 exception to the umbrella of how we treat</p> <p>20 breast cancer. And that applies to</p> <p>21 everything. That applies to depression,</p> <p>22 that applies to schizophrenia, that</p> <p>23 applies to eczema.</p> <p>24       MS. COOPER: This would be a</p> <p>25 fine time to take a break. How much</p>	<p style="text-align: right;">Page 224</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 turned to the black market to try to</p> <p>3 access hormone therapy and you mentioned</p> <p>4 that that was a source of concern. Can</p> <p>5 you say why that was concerning or would</p> <p>6 be concerning?</p> <p>7       A.   Because the patient was lying</p> <p>8 to his parents and the patient had taken</p> <p>9 his 12-year-old sister and sort of</p> <p>10 colluded with her to keep this private</p> <p>11 and somehow he used her in this scheme</p> <p>12 and the parents were not only mad at the</p> <p>13 son for surreptitiously getting hormones</p> <p>14 from China, but of his younger, more</p> <p>15 naïve sister and putting her into a</p> <p>16 loyalty of conflict between the love for</p> <p>17 her parents and the love for her brother,</p> <p>18 and they found that to be morally</p> <p>19 reprehensible.</p> <p>20       Q.   Did you have any physical</p> <p>21 health concerns for your patients taking</p> <p>22 black market hormones?</p> <p>23       A.   Absolutely.</p> <p>24       Q.   Like?</p> <p>25       A.   One, that person is the person</p>
<p style="text-align: right;">Page 223</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 time would you like? Let's go out</p> <p>3 off the record.</p> <p>4       VIDEOGRAPHER: Going off the</p> <p>5 record. The time is 3:17.</p> <p>6       (Recess is taken.)</p> <p>7       VIDEOGRAPHER: Going back on</p> <p>8 the record. The time is 3:31.</p> <p>9       MS. COOPER: Can we go off?</p> <p>10 Sorry. I forgot to do something.</p> <p>11       VIDEOGRAPHER: Time is 3:32.</p> <p>12 We're off the record.</p> <p>13       (Discussion is held off the</p> <p>14 record.)</p> <p>15       VIDEOGRAPHER: Back on the</p> <p>16 record. The time is 3:32.</p> <p>17       Q.   Dr. Levine, do you think the</p> <p>18 Arkansas law were to go into effect that</p> <p>19 adolescents currently receiving care will</p> <p>20 find some way to get access to hormone</p> <p>21 therapy?</p> <p>22       MR. CANTRELL: Object to form.</p> <p>23       A.   I think some will.</p> <p>24       Q.   You mentioned earlier in the</p> <p>25 day at least one of your patients had</p>	<p style="text-align: right;">Page 225</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 who ultimately died of probably fentanyl.</p> <p>3       Q.   So is there --</p> <p>4       A.   So there is the naivete of the</p> <p>5 person who thinks I'm taking estrogen,</p> <p>6 I'm taking heroin, they think they know</p> <p>7 what they're taking and heroin -- I'm</p> <p>8 sorry -- words -- opioids are a perfect</p> <p>9 example of the dangers that society faces</p> <p>10 when we don't do science, when we just do</p> <p>11 what somebody or some group of people</p> <p>12 think is the best thing to do and we</p> <p>13 don't allow science to lead us. And now</p> <p>14 we have these incredible death rates from</p> <p>15 opioids throughout America, which is not</p> <p>16 abating, by the way.</p> <p>17       But this is a perfect example,</p> <p>18 I think, that all of us need to worry</p> <p>19 about when science does not lead</p> <p>20 therapeutics.</p> <p>21       Q.   Going back to hormone therapy,</p> <p>22 do you have any concerns that adolescents</p> <p>23 in Arkansas who are currently receiving</p> <p>24 hormone therapy under a doctor's care, if</p> <p>25 they had had to stop doing that because</p>

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<p style="text-align: right;">Page 226</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the law took effect, would pursue  3 hormones from the black market?  4       MR. CANTRELL: Object to form,  5 calls for speculation.  6     A. I think some would get some  7 benefit from it because it would cause  8 them to rethink their situation and some  9 people would use black market and some  10 people would get a friend's oral  11 contraceptives, there will be all kinds  12 of ways of dealing with this and not all  13 necessarily bad and certainly not all  14 necessarily good.  15     Q. But using black market  16 hormones without a doctor's supervision,  17 is that necessarily bad?  18     A. Yes.  19     Q. We talked several hours ago I  20 think at this point about you and your  21 colleague, Ms. Novak, having written  22 letters of authorization for some minors  23 to receive gender-affirming hormone  24 therapy. I don't think I asked a followup  25 question. If you or Ms. Novak were --</p>	<p style="text-align: right;">Page 228</p> <p>1       STEPHEN B. LEVINE, M.D.  2 thinking that they're transgender.  3     Q. So I'm not sure if that  4 answers my question.  5       Have you made a decision to no  6 longer provide letters --  7     A. Oh, I'm sorry. No, I haven't  8 made that decision.  9     Q. So would it be a case-by-case  10 basis, if there were a patient that you  11 felt it was appropriate for you would  12 consider doing it, say, a 17-year-old or  13 16-year-old?  14       MR. CANTRELL: Object to form.  15     A. I don't have a -- yes. The  16 answer to your question is yes.  17     Q. Do you think it would be  18 beneficial to have clinical trials on the  19 safety and effectiveness of  20 gender-affirming medical care for minors?  21     A. Absolutely, yes.  22     Q. And does that mean you would  23 favor allowing minors to receive  24 treatment in the context of -- let me ask  25 you in a better way.</p>
<p style="text-align: right;">Page 227</p> <p>1       STEPHEN B. LEVINE, M.D.  2 well, let me ask it differently.  3       Have you made a decision to no  4 longer consider hormone therapy for  5 anybody who has not reached their 18th  6 birthday since you provided those  7 letters?  8     A. I've made a decision to be  9 very cautious and to put a period of time  10 in therapy between me and the letter.  11 That's the decision I've made. I've also  12 made the decision, based upon two parents  13 I've seen who wanted their child to be  14 given puberty blockers, that oftentimes  15 it is the mother who needs therapy rather  16 than the child.  17       So my policy, and I think and  18 my team, none of us are interested in  19 providing puberty-blocking hormones based  20 upon our limited experience with this.  21 And I think, generally speaking, we want  22 to have the evaluation psychotherapy  23 process, that I've already described to  24 you, as a matter of therapeutic approach  25 to children, adolescent children who are</p>	<p style="text-align: right;">Page 229</p> <p>1       STEPHEN B. LEVINE, M.D.  2       You would be supportive of  3 clinical trials that would, as I  4 understand it, necessarily mean that some  5 minors would be receiving  6 gender-affirming medical care as part of  7 those trials, correct?  8     A. I'm all in favor of a  9 national, multisite, carefully designed  10 study to answer the questions that we've  11 been struggling over for the last four  12 hours and 30 minutes. I have great  13 respect for the processes of science,  14 even though I know that science too has  15 limitations. But the limitations of  16 science are far less than the limitations  17 of individual doctors and their  18 passionate beliefs.  19     Q. So just to make sure I  20 understand it, a clinical trial  21 necessarily entails minor patients being  22 provided that treatment and then compared  23 to a control group that would not be  24 providing the hormone therapy, do I  25 understand that correctly?</p>

<p style="text-align: right;">Page 230</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   A clinical trial, it begins</p> <p>3 with a question and it -- it begins with</p> <p>4 a question and then it has a primary</p> <p>5 endpoint and then a set of secondary</p> <p>6 endpoints. And it has a means of</p> <p>7 evaluating those -- the primary and</p> <p>8 secondary endpoints that are agreed upon</p> <p>9 in advance, and in addition, it has a</p> <p>10 decision about when that -- those primary</p> <p>11 endpoints are going to be looked into,</p> <p>12 and when the secondary endpoints are</p> <p>13 going to be looked into, and there is an</p> <p>14 informed consent process to enter into</p> <p>15 the treatment process, and it has</p> <p>16 different groups, or what we call in</p> <p>17 methodology, different arms of the study,</p> <p>18 you see, and it often -- it sometimes has</p> <p>19 a placebo-controlled period, and then an</p> <p>20 arm where it divides into more placebo or</p> <p>21 this kind of treatment, and then this</p> <p>22 kind of treatment, you see.</p> <p>23       So I think in order to get the</p> <p>24 numbers that scientists would respect as</p> <p>25 having a robust what we call "N" or</p>	<p style="text-align: right;">Page 232</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 exception for minors who participate in</p> <p>3 clinical trials?</p> <p>4       MR. CANTRELL: Object to form.</p> <p>5     A.   I don't think that's what's in</p> <p>6 that law. I think if we had that study</p> <p>7 the prosecutors would bless that study.</p> <p>8     Q.   Right. So you think the law</p> <p>9 allows for those kind of clinical trials,</p> <p>10 that's your reading of the law?</p> <p>11    A.   I don't think in America --</p> <p>12 what I just said about the study is not</p> <p>13 an idea that is part of the dialogue of</p> <p>14 -- the culture war dialogue that's going</p> <p>15 on in America. It's much more a European</p> <p>16 concept. It's like science doesn't matter</p> <p>17 in this subject, it's only therapeutic</p> <p>18 fashion and it's only the passionate</p> <p>19 conviction of doctors that matter here.</p> <p>20       So I think that if we could --</p> <p>21 if on a national basis or on a multistate</p> <p>22 basis we could get together a group of</p> <p>23 research centers to do this, places like</p> <p>24 Arkansas would sign onto it and if we</p> <p>25 needed an exception -- if we needed a</p>
<p style="text-align: right;">Page 231</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 numbers we would have to have a</p> <p>3 multistate or multicenter study using the</p> <p>4 same protocol, approved by what's called</p> <p>5 an IRB, and that is a review body, to see</p> <p>6 to the efficacy of the study, the wisdom</p> <p>7 of the study and the morality of the</p> <p>8 study, the ethics of the study. I'm all</p> <p>9 in favor of that, because that's the way</p> <p>10 we advance, you see. And we also -- that</p> <p>11 study has to have a prolonged followup.</p> <p>12       So an individual place, you</p> <p>13 know, an individual child clinic can</p> <p>14 publish its results, but it can't do the</p> <p>15 same thing as a multisite study can do.</p> <p>16 And in the United States this is so</p> <p>17 cryingly necessary. And the trouble is</p> <p>18 the government has to fund this. These</p> <p>19 are very expensive things but it's</p> <p>20 certainly a worthy study to undertake.</p> <p>21 And yes, that is something I would be</p> <p>22 advocate, that's something I would</p> <p>23 advocate for.</p> <p>24     Q.   And are you aware that the</p> <p>25 Arkansas law in this case doesn't make an</p>	<p style="text-align: right;">Page 233</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 ruling from the Attorney General of this</p> <p>3 state or that state, I can't imagine the</p> <p>4 Attorney General would say no to a study.</p> <p>5 Because I think this law is saying you,</p> <p>6 doctors, are not studying this subject</p> <p>7 and, therefore, we're going to ban this</p> <p>8 because there is a lot of indications</p> <p>9 that we're harming our youth, you see.</p> <p>10 But if you give them the science and say</p> <p>11 we can restrict this, we can restrict the</p> <p>12 treatment to families who qualify for the</p> <p>13 protocol so we can answer the question in</p> <p>14 five years and it's going to take three,</p> <p>15 four, five years to begin the first step</p> <p>16 in answering the question, then I think</p> <p>17 probably whatever state you're talking</p> <p>18 about would be very susceptible, would be</p> <p>19 amenable to this.</p> <p>20       Now, I don't have a crystal</p> <p>21 ball and maybe I don't understand the</p> <p>22 politics of various states, obviously I</p> <p>23 don't, but that's my opinion or that's my</p> <p>24 speculation.</p> <p>25     Q.   So if you were involved or if</p>

<p style="text-align: right;">Page 234</p> <p>1       STEPHEN B. LEVINE, M.D.  2 somebody were to ask you about a law like  3 this would you favor having an exception  4 for participation in clinical trials?  5       MR. CANTRELL: Object to form.  6       A. If -- if some legislator asked  7 me for my opinion I would be happy to  8 share a similar opinion that I just gave  9 you.  10       MS. COOPER: Okay. Let's mark  11 tab 10, please.  12       (Exhibit Levine 6, Declaration  13 of Dr. Stephen B. Levine, dated  14 July 2021, was received and marked  15 on this date for identification.)  16       A. You're preparing a new  17 exhibit?  18       Q. Yes. We'll let you know. Okay.  19 It's available now. If you can open  20 Exhibit 6.  21       A. It's open.  22       Q. Okay. Great. We're looking at  23 Exhibit 6. Do you recognize this  24 document?  25       A. I do.</p>	<p style="text-align: right;">Page 236</p> <p>1       STEPHEN B. LEVINE, M.D.  2 identification for genetically male boys,  3 adolescents, and men or return to female  4 identification for genetically female  5 girls, adolescents, and women."  6       I know you wrote this about a  7 year ago. Is that still your view, is  8 that still correct?  9       A. Well, there has been more  10 anecdotal evidence since that time but in  11 the strict scientific way, in the way  12 that you and I were just talking about, a  13 future study for medical intervention, we  14 still have the same paucity of  15 information, we have still only anecdotal  16 reports, even though some people collect  17 a series of cases in their anecdotal  18 reports but they still are scientifically  19 anecdotal only.  20       The field of psychotherapy  21 finds it more difficult to do controlled  22 studies but there have been controlled  23 studies than medication treatments.  24 Because medication treatments often have  25 to do with this drug versus various doses</p>
<p style="text-align: right;">Page 235</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Q. Is this a declaration you  3 submitted in this case back in July of  4 '21?  5       A. Yes.  6       Q. If we can scroll all the way  7 down to paragraph 35, let me know when  8 you found that.  9       A. I just bypassed it. 35.  10       Q. Why don't you take a moment to  11 read the full paragraph. If you could  12 just read the paragraph.  13       A. Sorry. Say that again?  14       Q. If you could just read the  15 full paragraph.  16       A. To myself, item 35? Just that  17 paragraph, right?  18       Q. Just that paragraph. Have you  19 finished reading?  20       A. I've read it.  21       Q. I want to read together just  22 the first sentence, "To my knowledge,  23 there is no credible scientific evidence  24 beyond anecdotal reports that  25 psychotherapy can enable a return to male</p>	<p style="text-align: right;">Page 237</p> <p>1       STEPHEN B. LEVINE, M.D.  2 of drugs or drugs versus placebo. It's,  3 you know, hard to do placebo-controlled.  4       In psychotherapy studies  5 placebo controls are really weightless  6 placebo. But the answer is yes, it's  7 still -- actually, I wrote the same thing  8 in the article that was published six  9 weeks ago, so...  10       Q. But it's not outdated, I just  11 wanted to check; is that right?  12       A. Sorry. I didn't understand  13 your question.  14       MR. CANTRELL: We're having a  15 little bit of trouble understanding  16 you. I'm not sure what has  17 happened.  18       MS. COOPER: Okay. I'll try  19 again. So far so good?  20       THE WITNESS: As long as your  21 head is straight. You see when you  22 look down I have trouble.  23       Q. I need a little podium.  24       So I just wanted to confirm  25 that, and I think you have, that the</p>

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<p style="text-align: right;">Page 238</p> <p>1       STEPHEN B. LEVINE, M.D.  2 statement that there is no credible  3 scientific evidence beyond anecdotal  4 reports that psychotherapy can enable a  5 return to male identification for  6 genetically male boys, adolescents or men  7 or return to female identification for  8 genetically female girls, adolescents and  9 women, that that's still the state of the  10 science?  11     A.   Yes. I just came from a  12 symposium two days ago where two people  13 talked about their psychotherapy helping  14 people to desist, what we call desist or  15 detransition through psychotherapy. So  16 these are, again, anecdotal reports.  17 Basically psychiatry has a lot of those  18 anecdotal reports.  19     Q.   Who were those clinicians or  20 those that spoke about their experience?  21     A.   You want their names?  22     Q.   Yes, please.  23     A.   One was Sasha Ayad and the  24 other was Lisa Marchiano.  25       MS. COOPER: Can we mark as</p>	<p style="text-align: right;">Page 240</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Okay.  3     Q.   And in this paragraph -- well,  4 why don't you take a minute to read the  5 paragraph.  6     A.   Actually, I'm pretty familiar  7 with that.  8     Q.   Okay. Yes, we discussed  9 different types of scientific evidence,  10 correct?  11     A.   It's a hierarchy of the  12 trustworthy evidence, the risk or the  13 chances the evidence will prove to be  14 factually valid. In that sense it's a  15 hierarchy.  16     Q.   Understood. The anecdotal  17 evidence you described a few moments ago  18 regarding psychotherapy, helping patients  19 have a return to their natal gender  20 identity, is that -- does that fit within  21 B, a single case or a series of cases  22 what could be called anecdotal evidence?  23 Is that how you would describe that?  24     A.   Well, you see A and B are  25 pretty low. But at least when someone</p>
<p style="text-align: right;">Page 239</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the next exhibit tab 6?  3       (Exhibit Levine 7, Declaration  4 of Stephen B. Levine, MD dated  5 December 9, 2021 was received and  6 marked on this date for  7 identification.)  8     Q.   You can refresh and it will be  9 there, Exhibit 7.  10     A.   It's not there yet.  11     Q.   So Exhibit 7, do you recognize  12 that as a declaration that you submitted  13 in this case -- I'm scrolling down to the  14 signature block, on page 93, December 9th  15 2021?  16     A.   I don't have the date in front  17 of me, but I trust you.  18     Q.   If you go to page 93 you can  19 see. I'm sorry, page 93 on the document.  20     A.   Oh, that's the date. That's  21 what you had me see.  22     Q.   I just wanted you to look at  23 that and understand what you're looking  24 at here. Now, I'd like you to go to  25 paragraph 88.</p>	<p style="text-align: right;">Page 241</p> <p>1       STEPHEN B. LEVINE, M.D.  2 publishes a case history, especially case  3 history that's not a paragraph but an  4 extended case history, where the readers  5 can understand the dynamic forces  6 involved in the patient's life, that's  7 much better than a person like me  8 pontificating, or a patient like one of  9 your Plaintiffs' experts pontificating  10 based on what they think exists in the  11 world.  12       So I know lay people don't  13 understand this, but they think he's an  14 expert, you know, he's a doctor, he's an  15 expert. But lay people often don't  16 understand the limitations of what  17 doctors know or experts know. But you  18 have a different sense of what expert  19 means in the law. You have to qualify to  20 be an expert in the law. But in terms of  21 reliability of information, a single case  22 history and even a series of case  23 histories, is still anecdotal evidence.  24     Q.   And that's the category that  25 the evidence you talked about regarding</p>

<p style="text-align: right;">Page 242</p> <p>1       STEPHEN B. LEVINE, M.D.  2 psychotherapy, allow return to --  3     A.   Well, it's also the same kind  4 of evidence that passionate believers in  5 the hormone therapy have, based on their  6 case experience, even if they write it  7 up, so to speak.  8     Q.   Well, I wasn't asking about  9 that. I'm just asking about your -- the  10 evidence you talked about regarding --  11 that you call anecdotal evidence about  12 returning to your natal -- having a  13 gender identity that matches your natal  14 sex, that is the level of evidence we  15 have at this point, correct?  16     A.   Are you talking about my case  17 history that I published?  18     Q.   No. I'm talking about the body  19 of existing scientific evidence showing  20 that psychotherapy can cause a return to  21 your gender identity that matches your  22 sex assigned at birth, is that limited to  23 --  24     A.   Yeah, sometimes that's called  25 --</p>	<p style="text-align: right;">Page 244</p> <p>1       STEPHEN B. LEVINE, M.D.  2 received hormone blocking --  3 puberty-blocking hormones. And based on  4 the results of those studies there was  5 total inconsistency from one study to  6 another about the results. There was --  7 there was no appreciation that along with  8 puberty blocking agents, other things  9 were being given to the patient, like  10 antidepressants, for example. There was  11 very little appreciation of the effects  12 of maturation and there was no control  13 group to effect -- to see how kids mature  14 between, say, 11 and 14. And so the  15 results of that cohort study, which is  16 higher than a case report because it's a  17 series of cases and multiple studies of a  18 series of cases from various centers, the  19 results were that, at best, the results  20 of puberty-blocking hormones were  21 inconclusive and they certainly didn't  22 demonstrate with scientific certainty  23 that puberty-blocking hormones were  24 beneficial.  25       So you can see that even if</p>
<p style="text-align: right;">Page 243</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Let me finish the question,  3 I'm sorry, just for the record.  4       That would fall within under  5 B, a single case or series of cases what  6 could be called anecdotal evidence?  7     A.   Yes.  8     Q.   Okay. Now, you had started to  9 talk about the research we have on --  10 maybe not the research but the use of  11 hormone therapy to treat minors with  12 gender dysphoria.  13       Which categories of research  14 or evidence do we have that shows or  15 addresses -- let me ask that again. I  16 muddled it. I'm sorry.  17       What categories of your  18 categories A through G, that you conclude  19 here, do we have assessing  20 gender-affirming medical care for minors?  21     A.   Well, if you look at some of  22 the reviews for puberty-blocking  23 hormones, I think one of the reviews  24 looked at ten studies. These were cohort  25 studies, that is groups of people who</p>	<p style="text-align: right;">Page 245</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you go from up to a cohort study, but if  3 the cohort study doesn't have a control  4 group, I guess it's not really -- it's a  5 series of cases without a control group,  6 it really doesn't -- it doesn't give you  7 a lot of certainty that this is correct.  8       And you see, in our field of  9 transgender care, we don't have -- we  10 don't have E, and I'm not even sure -- we  11 don't have a cohort study with a serious  12 control group. And so we're really left  13 at the level somewhere B+ perhaps or C-,  14 because we don't have a control group.  15 This is still a low level, Ms. Cooper,  16 this is not -- this is not robust.  17     Q.   So you don't have cohort  18 studies, B?  19     A.   We don't have cohort studies  20 with control groups.  21     Q.   By B you meant cohort study  22 with control group, is that in the  23 definition of cohort study that would be  24 involved?  25     A.   Maybe I haven't stated that</p>

<p style="text-align: right;">Page 246</p> <p>1       STEPHEN B. LEVINE, M.D.  2 correctly. Maybe I should have said a  3 cohort study with a control group. But  4 that's generally -- you know, anything --  5 you see from A to -- A to D is just, it's  6 not robust. It's not -- it's not  7 powerful. And one study is not powerful.  8 We need multiple studies from various  9 times and various places from various  10 perspectives and we have that potential  11 in gender medicine. We have Australia and  12 Canada and Amsterdam and Sweden, we have  13 Boston, we have other cities throughout  14 America. This could be done. This could  15 be done. And it's not being done.  16       Anyway, that's not your  17 question, I guess, so ask your question.  18       Q.   It's fine. Now, double-blind  19 clinical trial, that couldn't be done,  20 right, for gender-affirming hormone  21 therapy, right? Could it be blinded? How  22 would that be possible?  23       A.   May I answer that question in  24 detail?  25       Q.   Let's get started and see.</p>	<p style="text-align: right;">Page 248</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A.   I presume you know,  3 Ms. Cooper, that I am a psychiatrist,  4 right?  5       Q.   I do.  6       A.   A psychiatrist. And you know  7 that psychotherapy, psychiatrists my age,  8 my vintage, have been trained in doing  9 therapy with people and some of it is  10 short-term and some of it is long-term.  11 And psychiatrist -- the psychotherapeutic  12 process in therapy has never really been  13 submitted to the rigors of randomized  14 controlled studies.  15       So of course the answer to  16 your question is that I do therapies that  17 are not based on randomized controls.  18       Q.   Do you treat patients with  19 medication?  20       A.   Oh, of course I treat patients  21 with medications, and the medications  22 that are FDA approved for certain  23 indications are the result -- the modern  24 ones, not the ones that were accepted 50  25 years ago, in practice 50 years ago --</p>
<p style="text-align: right;">Page 247</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A.   Well, it's going to take some  3 time. I don't know if you want me to take  4 all this time. I'll be happy to answer --  5       Q.   Let me ask a different  6 question. Do you think it could be  7 blinded?  8       A.   Yes.  9       Q.   Okay. That's fine.  10       Are there treatments that you  11 provide to patients -- well, let me ask  12 it differently.  13       Do you only provide treatments  14 to patients that have the benefit of  15 randomized controlled clinical trials?  16       MR. CANTRELL: Object to form,  17 vague.  18       Q.   Let me restate that. You're  19 right. It was vague.  20       Do you only provide treatments  21 to patients that are supported by  22 evidence that includes randomized  23 controlled clinical trials?  24       MR. CANTRELL: Same  25 objections.</p>	<p style="text-align: right;">Page 249</p> <p>1       STEPHEN B. LEVINE, M.D.  2 but the modern ones are all the process  3 of double-blind placebo triple trials,  4 the kinds of control trials that I  5 already described to you, multisite,  6 different cultures, different dose  7 toggles (sic) and so forth.  8       Q.   Do you never prescribe  9 off-label drugs, drugs for off-label use?  10       MR. CANTRELL: Object to form.  11       A.   Yes. There are times that I've  12 prescribed drugs for off-label use. That  13 is not the same as making me say that all  14 drugs off-label are equally judicious.  15       Q.   Understood. So in your view  16 the fact that a drug is being used for  17 off-label purpose doesn't, by itself,  18 mean it's an improper use of the drug?  19       A.   Does it mean what?  20       Q.   It doesn't, by itself, mean  21 that there is anything wrong with using  22 the drug for that purpose?  23       A.   If we want to use that gross  24 generalization that you made, of course  25 you're right.</p>

<p style="text-align: right;">Page 250</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Q.   Well, help inform me. Let me</p> <p>3       ask it more precisely.</p> <p>4       I think you just said you have</p> <p>5       used drugs for off-label uses; is that</p> <p>6       right?</p> <p>7       A.   I think you and I are</p> <p>8       misunderstanding each other at this</p> <p>9       point. Yes, I said that.</p> <p>10      Q.   Okay. I understand. I'm not</p> <p>11      talking about randomized controlled</p> <p>12      clinical trials. I'm just asking about</p> <p>13      off-label drug use.</p> <p>14      A.   Well, I think you know in</p> <p>15      medicine off-label drug use is very</p> <p>16      common in probably every field, including</p> <p>17      psychiatry. The wisdom of that depends</p> <p>18      on the drug and what's known about it,</p> <p>19      what the benefits and the risks are.</p> <p>20      Q.   Does the fact that a use of</p> <p>21      the drug is off-label necessarily mean</p> <p>22      it's an experimental use of the drug?</p> <p>23      A.   Just that alone does not mean</p> <p>24      it's experimental. It just means that it</p> <p>25      doesn't have the rigor of a scientific</p>	<p style="text-align: right;">Page 252</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       insomnia is a lot different than giving</p> <p>3       somebody a drug that stops their</p> <p>4       menstruation, for example. So we need to</p> <p>5       be judicious about not comparing apples</p> <p>6       to zebras.</p> <p>7       Q.   I want to switch topics and</p> <p>8       talk about the desistance literature.</p> <p>9       Do you know what I mean when I</p> <p>10      refer to the desistance literature?</p> <p>11      A.   The persistence literature, is</p> <p>12      that what you said?</p> <p>13      Q.   The desistance literature.</p> <p>14      MR. CANTRELL: Desistance.</p> <p>15      A.   Desistance, the desistance</p> <p>16      literature?</p> <p>17      Q.   Yes. Does that -- you</p> <p>18      understand what I'm referring to when I</p> <p>19      talk about that body of research?</p> <p>20      A.   Yes.</p> <p>21      Q.   I'm just making sure. I just</p> <p>22      have a few questions about that.</p> <p>23      Is it correct that these</p> <p>24      studies found that most prepubertal</p> <p>25      children who had been diagnosed with</p>
<p style="text-align: right;">Page 251</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       basis for its use.</p> <p>3       So if I use an off-label drug</p> <p>4       to get someone to go to sleep at night,</p> <p>5       because I have experience that the drug</p> <p>6       is helpful in 50% of the time that I give</p> <p>7       it approximately, and I don't really</p> <p>8       think much harm will come unless they</p> <p>9       have nightmares and then they won't use</p> <p>10      the drug again, that's a very different</p> <p>11      thing than using an off-label drug that's</p> <p>12      going to change the physiology of a</p> <p>13      person's life permanently or at least for</p> <p>14      a very long period of time.</p> <p>15      Q.   Okay.</p> <p>16      A.   So I know where you're going</p> <p>17      here, that hormones are used on an</p> <p>18      off-label basis and the FDA has not</p> <p>19      approved them, and they've never been</p> <p>20      treated to a randomized</p> <p>21      placebo-controlled trial. But of course,</p> <p>22      the implications of using a mild</p> <p>23      antidepressant that's soporific to help</p> <p>24      people to sleep that has not been</p> <p>25      approved for insomnia but is used for</p>	<p style="text-align: right;">Page 253</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       gender identity disorder, I believe, had</p> <p>3       desisted by puberty; is that correct?</p> <p>4       A.   If you and I are referring to</p> <p>5       the same body of studies, then that's</p> <p>6       correct. I'm not sure what studies you're</p> <p>7       referring to, but I am aware of a group</p> <p>8       of studies that have shown that under</p> <p>9       certain circumstances, non-intervention,</p> <p>10      that 11 of 11 studies have shown that</p> <p>11      children desist, the majority of children</p> <p>12      desist by the time they're somewhere in</p> <p>13      adolescence. Sometimes that's referred to</p> <p>14      puberty, but I really think it's later in</p> <p>15      adolescence, since puberty is a variable</p> <p>16      period of time.</p> <p>17      Q.   And a number of these studies</p> <p>18      were done by Ken Zucker; is that correct?</p> <p>19      A.   A number of studies?</p> <p>20      Q.   Some of these studies were</p> <p>21      done by Ken Zucker; is that correct?</p> <p>22      A.   Yes. Yes. He was one of the</p> <p>23      coauthors of several followup studies,</p> <p>24      yes.</p> <p>25      Q.   Did any of these studies show</p>

<p style="text-align: right;">Page 254</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that youth who continue to have gender  3 dysphoria in adolescence were likely to  4 desist?  5       A. I think the literature of  6 desistance about the people who begin  7 their gender identity, their transgender  8 identity in adolescence is really far  9 less clear and less developed than what  10 the cross-gender identified younger  11 children, that's what those 11 studies  12 referred to.  13       Q. I think my question maybe  14 wasn't clear because I meant to convey  15 something differently.  16       If you're talking about just  17 the population of people who had gender  18 dysphoria from early childhood, the  19 studies that looked at -- actually, let  20 me take that back.  21       For individuals who have  22 gender dysphoria from early childhood and  23 continue to have gender dysphoria after  24 puberty begins, is there any evidence  25 indicating a likelihood of desistance in</p>	<p style="text-align: right;">Page 256</p> <p>1       STEPHEN B. LEVINE, M.D.  2 has gender dysphoria, say, at age 14,  3 that that would be likely to desist?  4       A. Well, I happen to know of a  5 woman who had gender dysphoria, who now  6 has lived as a woman, a cis woman for  7 years and years and years. And the  8 reason she's sort of studied this subject  9 and is sort of an expert in this subject  10 is that she persisted when during your  11 adolescence for a while. And I happen to  12 know, which I think you probably are  13 aware of, the previous studies among --  14 among male-identified homosexual men,  15 that two-thirds of them have a history of  16 having very strong feminine  17 identifications when they were children.  18 And I don't know if they all had gender  19 dysphoria because when they were younger  20 we weren't really looking at that term,  21 we didn't even have this concept. But  22 feminine -- among homosexual adult males,  23 many of them recognize that they had a  24 long period of time when they wanted to  25 be a girl, and that they behaved in</p>
<p style="text-align: right;">Page 255</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that population of patients?  3       A. You mean if with childhood  4 onset gender dysphoria, we'll just take  5 those 11 studies and summarize them  6 inaccurately as, say, 22% persist, okay?  7 You're asking me, is there any evidence  8 that I'm aware of among those 22 kids who  9 persist, do any of those children  10 subsequently desist? Is that the question  11 you asked me?  12       Q. Let's start there, if you  13 could answer that question?  14       A. I don't know the answer to  15 that question. But I want to be clear,  16 that's what I thought you were asking.  17       Q. Okay.  18       A. So I'm asking you, was that  19 the question you were asking me?  20       Q. It wasn't exactly but I  21 understand that that's what you were  22 answering, so I will ask differently.  23       Are you aware of any evidence  24 indicating that somebody who has gender  25 dysphoria from early childhood and still</p>	<p style="text-align: right;">Page 257</p> <p>1       STEPHEN B. LEVINE, M.D.  2 feminine ways.  3       Now, most of these people, and  4 I can tell you from Richard Green's study  5 published in 1988, The Sissy Boy  6 Syndrome, I think the numbers were -- he  7 followed for 15 years 88 children who  8 were cross-gender identified. The sample  9 came from both New York and from  10 California, he actually worked in both  11 places bi-coastally. And 86 of those  12 children grew up to be non-cross-gender  13 identified, two of them declared  14 themselves to be transgender and I think  15 like a handful declared themselves to be  16 heterosexual, but the majority of those  17 cross-gender identified children grew up  18 to be homosexual in their orientation to  19 men, to their same cisgender people.  20       So that was the Richard Green  21 study from 1988, and I think that begins  22 to answer your question. But none of  23 those children were, you know, affirmed  24 socially trans, you know, no pediatrician  25 said you ought to live as a little girl,</p>

65 (Pages 254 - 257)

<p style="text-align: right;">Page 258</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know, and nobody was giving  3 puberty-blocking hormones.  4     Q.   But they were first assessed  5 during pre-pubertal childhood, right, you  6 would agree?  7     A.   They were all identified as  8 cross-gender identified little boys who  9 wanted to be little girls, yeah.  10    Q.   So you mention there is a  11 woman you know who desisted after  12 adolescence and has been studying the  13 issue.  14       My question was, is there any  15 evidence that it's likely that people who  16 start experiencing gender dysphoria in  17 early childhood and continue to  18 experience it in early adolescence are  19 likely to desist, the way we have that  20 evidence about prepubertal kids?  21    A.   I can only answer that  22 question tangentially.  23       You are aware that there are  24 increasing numbers of people who are  25 coming out of the woodwork saying that</p>	<p style="text-align: right;">Page 260</p> <p>1       STEPHEN B. LEVINE, M.D.  2 treatment, and another 20% were lost to  3 followup, some of whom may have come back  4 for treatment later. And there was a  5 second study by Boyd, et al, the first  6 one I mentioned is by Hall, and that's a  7 group of people who were started on  8 hormones on an average age of 20 and in a  9 five-year followup almost 30% of those  10 people had desisted.  11       So we're beginning to get  12 information about the rate of desistance  13 which in some people's language is the  14 rate of error, although, I'm not sure  15 that is the right language. It's the  16 error rate of making -- the patient  17 decides it was an error, even though some  18 of them say, well, it wasn't really -- I  19 don't want to do this anymore but I don't  20 regret having taken hormones for X years  21 because it's helped me decide who I am  22 and what I want to be now.  23       So you know these are very  24 difficult, complicated, nuanced kind of  25 distinctions that we're making about</p>
<p style="text-align: right;">Page 259</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they have detransitioned and many of  3 those children, many of those adults or  4 older people, older teenagers, many of  5 those kids -- I mean, I don't know what  6 proportion of those children were  7 cross-gender identified as children, many  8 of them probably were -- had onset of  9 transgender identities shortly after  10 puberty.  11       But I think the answer to your  12 question, in a tangential way, is I'm  13 aware that people detransition after  14 prolonged periods of time of medical  15 treatment or even just certain  16 non-medical but cross-gender identified  17 identities. But I can't -- I can tell you  18 about two recent studies that were  19 published and I became aware of them in  20 the beginning of this year, so it's not  21 in my report, they're both from the U.K.  22 and one of them was a 16-month followup  23 after being started on hormones and at 16  24 months there were a total of 10% of the  25 kids had desisted from their hormone</p>	<p style="text-align: right;">Page 261</p> <p>1       STEPHEN B. LEVINE, M.D.  2 regret and desistance and so forth.  3     Q.   Can I ask you -- I think I  4 didn't hear, when you said the rate of  5 desistance in that second study you  6 mentioned by Boyd, what percentage was  7 that? I just didn't hear.  8     A.   I think up to 30% of people  9 were no longer taking treatment with  10 hormones after five years.  11    Q.   The connection busted up right  12 as you said that. Can you repeat it?  13    A.   I said this is the Boyd, et al  14 study from the U.K. published in this  15 year, I think. And I forget the numbers  16 at this point, but actually it's quoted  17 in my paper, and the specific numbers are  18 in my paper. But my general recollection  19 is that there was a five-year followup.  20 The average age of entering -- of getting  21 hormones was 20 and by 25 there was a  22 large, very impressively large dropout  23 rate from hormone treatment. And the  24 authors stated that, given the  25 uncertainties about this, and the</p>

<p style="text-align: right;">Page 262</p> <p>1       STEPHEN B. LEVINE, M.D.  2 difficulties in following up people, it  3 may very well be that we have vastly  4 underestimated the number of people who  5 discontinue hormones just because we  6 don't have these careful followup  7 studies. I believe the Boyd, et al study  8 was basically getting hormones in primary  9 care settings.  10    Q.   And you believe it was a 30%  11 rate of desistance from the numbers they  12 had?  13    A.   I think, you know, I could  14 look it up on my paper, but that's what  15 --  16    Q.   That's okay. Is that right,  17 you don't remember?  18    A.   That's what I remember but,  19 you know, who knows what people remember  20 accurately.  21    Q.   Do you remember whether it was  22 a majority or a minority of the --  23    A.   No. It was about 30. It  24 wasn't 60. It was 30. Maybe it was 28-7,  25 you know.</p>	<p style="text-align: right;">Page 264</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for affirmative care of adolescence  3 actually consider it to be an  4 alternative. It's where there is  5 disagreement, you know.  6       And just to go back to the  7 earlier part of your question, watchful  8 waiting can mean sometimes do nothing but  9 followup the patient in three months or  10 six months, whatever, regularly, to see  11 how this works out, sometimes -- that  12 would be one form of watchful waiting.  13 The other form of watchful waiting would  14 be to take the parents in and talk to the  15 parents and leave the kid alone and then  16 help the parents deal with their  17 intrafamilial issues. The third form of  18 watchful waiting might be to not deal  19 with the child's gender identity, but to  20 deal only in a therapeutic process with  21 the other issues, the other developmental  22 challenges that the child has, but just  23 leave the gender identity alone with the  24 assumption that perhaps gender identity  25 is an epiphenomenon of some other</p>
<p style="text-align: right;">Page 263</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Are you familiar with the  3 watchful waiting approach to minors with  4 gender dysphoria?  5    A.   I know that term, yes.  6    Q.   And do you understand -- what  7 do you understand that term to mean?  8 Let's make sure we're on the same page.  9    A.   Well, I think -- I think you  10 know from my expert opinion. I describe  11 this in my report. So do you want me to  12 repeat that?  13    Q.   Fair enough. I don't need you  14 to do that.  15       As described in your report,  16 is that an approach that is recognized as  17 applying to prepubertal children with  18 gender dysphoria?  19    A.   Well, it depends on the  20 practitioner. Watchful waiting was  21 certainly a concept that began with the  22 child onset gender dysphoria realm. It  23 has been -- it's a concept that's applied  24 to adolescents as well, but it certainly  25 is not a concept of people who advocate</p>	<p style="text-align: right;">Page 265</p> <p>1       STEPHEN B. LEVINE, M.D.  2 underlying problem. And if we can deal  3 with the underlying problem, perhaps the  4 child can one day make a clearer decision  5 about how he or she wants to live his  6 gendered life.  7       So that's my understanding of  8 watchful waiting. So I said three, but  9 sometimes I say it as two versions, but I  10 made a third version for you today  11 because I wanted to emphasize sometimes  12 the child is not getting treated at all,  13 but the parents are getting treated. And  14 then sometimes the parent and the child  15 is treated, but we're not focusing on  16 gender, per se. Whereas, if you do  17 give -- you know, socialize a child,  18 you're certainly treating them for their  19 gender.  20    Q.   Just one moment, I'm going to  21 show you an exhibit.  22       Has Ken Zucker been a leading  23 proponent of watchful waiting in the  24 field?  25    A.   Ken Zucker recently told me he</p>

<p style="text-align: right;">Page 266</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- he thinks he coined the term and he  3 was embarrassed about it.  4     Q.   Why was he embarrassed?  5     A.   It wouldn't be a term he would  6 use today, I think would be my  7 speculation. When he said that, I said I  8 didn't think you actually coined the term  9 "watchful waiting", because he's a  10 psychologist and I'm a physician. And  11 watchful waiting is a term that I think  12 grew up in medicine and in surgery and it  13 has a great deal to do with men's  14 prostate cancer, and when it's mild  15 enough we say that we're going to watch  16 -- we're going to practice watchful  17 waiting, we're not going to have an  18 intervention, we're going to get a --  19 perhaps you're familiar with the PSA  20 test, we're going to do a digital exam  21 and a PSA test every six months. And  22 it's only if your PSA or you get a nodule  23 in your prostate that we will intervene  24 surgically or through radiation.  25       So that has a long tradition</p>	<p style="text-align: right;">Page 268</p> <p>1       STEPHEN B. LEVINE, M.D.  2 within a relatively short period may also  3 be a common outcome for post-pubertal  4 youths who exhibit recently described  5 'rapid onset gender disorder.' I observe  6 an increasingly vocal online community of  7 young women who have reclaimed a female  8 identity after claiming a male gender  9 identity at some point during their teen  10 years. A recent review of  11 detransitioning claimed to have  12 identified 16,000 entries in a search of  13 proliferating websites devoted to this  14 topic. However, data on outcomes for this  15 age group with and without therapeutic  16 interventions is not yet available to my  17 knowledge."  18       So a couple of questions. That  19 16,000 number, that's not 16,000 stories  20 of detransition, is it?  21     A.   No. Those are 16,000 people  22 that Dr. Exposito-Campos identified as  23 being members of various groups with that  24 title. That doesn't tell us that each of  25 those persons have detransitioned. They</p>
<p style="text-align: right;">Page 267</p> <p>1       STEPHEN B. LEVINE, M.D.  2 in prostate medicine, in the urology  3 field. And I wouldn't be surprised --  4 you know, in the leukemia field we have  5 certain kinds of slow-growing leukemic  6 processes that we just watch. And  7 certainly in probably every field we have  8 watchful waiting for one condition or  9 another.  10       Certainly in child psychology  11 there are situations where we watch and  12 we wait and see if people outgrow  13 whatever the issue is.  14     Q.   Let's go back to Exhibit 7,  15 you may have that up, paragraph 78.  16     A.   I didn't -- I didn't  17 understand any word you just said.  18     Q.   That's terrible. Exhibit 7, if  19 you could go back to Exhibit 7, paragraph  20 78.  21       I'll read it together since it  22 is just the highlighted paragraph. It  23 says, "Desistance, (a patient's willing  24 reacceptance of their biological sex  25 through normal developmental processes)</p>	<p style="text-align: right;">Page 269</p> <p>1       STEPHEN B. LEVINE, M.D.  2 could be parents of kids, they could be  3 kids who are thinking about  4 detransitioning, they could be people who  5 have detransitioned, but that's still a  6 large number. And it raises the question  7 for you and I to think about, is  8 detransition is an issue that needs to be  9 thought about very carefully because some  10 of those people who would detransition  11 might regret having undergone these  12 medical treatments or these psychological  13 adaptations.  14       So it's just another  15 indication that I would say to all of us,  16 let's be careful here, this could be a  17 dangerous thing.  18     Q.   That 16,000 number doesn't  19 tell you anything about the number of  20 stories of detransitioners that are  21 included there, is there? Does it?  22       Let me ask you differently.  23 The number 16,000 doesn't tell you  24 about how many detransitioners are in  25 that group, does it?</p>

<p style="text-align: right;">Page 270</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   I think I just said that.</p> <p>3     Q.   Okay. Just making sure we're</p> <p>4   clear.</p> <p>5       Let's go to paragraph 70 in</p> <p>6   the same Exhibit 7. Let me know you're</p> <p>7   there.</p> <p>8     A.   Yes.</p> <p>9     Q.   Why don't you just read the</p> <p>10   paragraph to yourself.</p> <p>11    A.   I read it.</p> <p>12    Q.   Looking at the last sentence</p> <p>13   of the paragraph that's highlighted it</p> <p>14   says, "Two separate valuations, one from</p> <p>15   Canada and one from U.K., reviewed</p> <p>16   WPATH's guidelines and found them</p> <p>17   untrustworthy." And you have there a</p> <p>18   footnote, number 43 that cites a study by</p> <p>19   S. Dahlen, et al and then another one</p> <p>20   after that it says see also</p> <p>21   <a href="https://genderreport.CA/bias-not-evidence">https://genderreport.CA/bias-not-evidence</a></p> <p>22   -dominate-standard-of-care.</p> <p>23    A.   That's right.</p> <p>24    Q.   I'd like to focus on the</p> <p>25   second one. I just had some questions</p>	<p style="text-align: right;">Page 272</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Let's take a look.</p> <p>3     A.   I don't have -- I have that</p> <p>4   article at home.</p> <p>5     Q.   We'll pull it up. Maybe let's</p> <p>6   mark that as Exhibit 8, please.</p> <p>7       (Exhibit Levine 8, Canadian</p> <p>8   Gender Report, dated October 1,</p> <p>9   2019 was received and marked on</p> <p>10   this date for identification.)</p> <p>11    A.   Shall I go to that?</p> <p>12    Q.   It's not quite there yet. All</p> <p>13   right. It's available now.</p> <p>14    A.   Oh, MacRichards not McFarland.</p> <p>15   Sorry.</p> <p>16    Q.   If you read with me, we're</p> <p>17   looking at Exhibit 8, which is just, for</p> <p>18   the record, a document with a heading</p> <p>19   Canadian Gender Report. And then on the</p> <p>20   bottom of the first page it says, "The</p> <p>21   following investigative report was</p> <p>22   contributed by @Lisa MacRichards (a</p> <p>23   pseudonym)." And then goes on to say,</p> <p>24   "Lisa MacRichards works at a Canadian</p> <p>25   hospital and holds a Master of Science</p>
<p style="text-align: right;">Page 271</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2   about that.</p> <p>3       Is that the report from Canada</p> <p>4   that you were referring to?</p> <p>5     A.   Yes.</p> <p>6     Q.   And you've reviewed that</p> <p>7   report, I take it?</p> <p>8     A.   I've read that report, yes.</p> <p>9     Q.   Okay. Was it published by a</p> <p>10   scientific organization?</p> <p>11    A.   The author was a journalist</p> <p>12   and I don't think it was published by a</p> <p>13   scientific organization. But if you read</p> <p>14   that review, it's very cogent and it's</p> <p>15   not -- in a different language form it</p> <p>16   says much of the same thing as the</p> <p>17   Dahlen, et al study.</p> <p>18    Q.   Do you know anything about the</p> <p>19   author?</p> <p>20    A.   No.</p> <p>21    Q.   The author was anonymous,</p> <p>22   right?</p> <p>23    A.   No. No.</p> <p>24    Q.   No?</p> <p>25    A.   Her name is I think McFarland.</p>	<p style="text-align: right;">Page 273</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2   degree from the University of British</p> <p>3   Columbia", and some other text.</p> <p>4       So do you not understand -- is</p> <p>5   Lisa MacRichards her real name? Did I</p> <p>6   read that wrong or misunderstand?</p> <p>7     A.   I presume this is the same</p> <p>8   thing. The one I have at home doesn't</p> <p>9   exactly look like this, but I presume</p> <p>10   it's the same.</p> <p>11    Q.   So by reading, do you</p> <p>12   understand that to mean that Lisa</p> <p>13   MacRichards is not her real name?</p> <p>14    A.   I didn't remember when I told</p> <p>15   you this initially that it wasn't her</p> <p>16   real name, but it probably says that in</p> <p>17   my report too.</p> <p>18    Q.   Does that give you any concern</p> <p>19   about relying on a report if somebody is</p> <p>20   publishing it anonymously?</p> <p>21    A.   Actually, the Dahlen report</p> <p>22   gives me no concerns. The Dahlen report</p> <p>23   is a group of, a team of methodologists</p> <p>24   from different field who are expert in</p> <p>25   reviewing standards of care.</p>

<p style="text-align: right;">Page 274</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   I understand, but I'm asking</p> <p>3     you about this one.</p> <p>4     A.   But you see, the -- there are</p> <p>5     other people who looked at and tried to</p> <p>6     live with and understand the Standards of</p> <p>7     Care and have found them wanting. And so</p> <p>8     I could have easily just given the Dahlen</p> <p>9     report, but I thought it would strengthen</p> <p>10    it a little bit if we see that someone</p> <p>11    else has thought about this from a</p> <p>12    different continent, also looking at</p> <p>13    this.</p> <p>14       I could probably give more</p> <p>15    examples of people who don't follow the</p> <p>16    Standards of Care but to me the most</p> <p>17    important thing is that this report,</p> <p>18    whatever its limitations are, that it's</p> <p>19    not a scientific peer-reviewed journal,</p> <p>20    so to speak, it just happens to say</p> <p>21    similar things as the peer-reviewed</p> <p>22    scientific report says.</p> <p>23       And so, I don't know why --</p> <p>24    whoever Lisa MacRichards really is -- I</p> <p>25    don't know why she wants to use a</p>	<p style="text-align: right;">Page 276</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Standards of Care on the 7th Edition are</p> <p>3     good enough, you see.</p> <p>4       So the fact that there's a</p> <p>5     Lisa MacRichards to me is not just a big</p> <p>6     deal.</p> <p>7     Q.   Okay. You mentioned you</p> <p>8     distinguish this from peer-reviewed</p> <p>9     academic settings.</p> <p>10       What does that mean to be a</p> <p>11    peer-reviewed academic study? I think</p> <p>12    that was the term you used.</p> <p>13    A.   You're asking me what does</p> <p>14    "peer-reviewed" mean?</p> <p>15    Q.   Yeah, what does that mean?</p> <p>16    A.   That means when a person --</p> <p>17    I'll use myself, for example -- when a</p> <p>18    person submits an article to a journal,</p> <p>19    that it's first read by the editor and if</p> <p>20    it is viewed to be a reasonable</p> <p>21    submission, the editor usually sends it</p> <p>22    out to three people who have some</p> <p>23    knowledge of the subject area, and those</p> <p>24    are called the peer reviewers. Hopefully,</p> <p>25    they're really peers and, hopefully, they</p>
<p style="text-align: right;">Page 275</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     pseudonym. In my experience when people</p> <p>3     work for clinics that do trans care they</p> <p>4     sometimes, and they're objecting to it,</p> <p>5     rather than quit their jobs, as many</p> <p>6     people at the Tavistock Clinic quit over</p> <p>7     many years, I think they lost 60</p> <p>8     psychologists over five or ten years</p> <p>9     because of the trans care. So they</p> <p>10    developed a pseudonym and they write --</p> <p>11    they do research and they write what they</p> <p>12    think. And I think that's probably what</p> <p>13    Lisa MacRichards -- maybe her real name</p> <p>14    is McFarland, I don't know. So that's</p> <p>15    what I think.</p> <p>16       So it does give me concern but</p> <p>17    it doesn't -- it wouldn't make me think</p> <p>18    that that disqualifies this idea. I</p> <p>19    think even the committee that's doing the</p> <p>20    WPATH standards have reasons to criticize</p> <p>21    the 7th Edition of the Standards of Care.</p> <p>22       So the idea that the Standards</p> <p>23    of Care are what God has said and this is</p> <p>24    the truth and this is science, even the</p> <p>25    people in WPATH don't think that the</p>	<p style="text-align: right;">Page 277</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     know something about the subject</p> <p>3     material. And then those people write a</p> <p>4     critique, which then the editor puts</p> <p>5     together. So there are usually three</p> <p>6     reviewers to a paper, then the author,</p> <p>7     myself, gets back after several months,</p> <p>8     sometimes after nine months or ten</p> <p>9     months, we get back three critiques,</p> <p>10    three evaluations, independent</p> <p>11    evaluations, anonymous evaluations, I</p> <p>12    don't know who's doing it, and they often</p> <p>13    have criticisms and suggestions.</p> <p>14       Now, they're asked to make a</p> <p>15    decision, and they independently make the</p> <p>16    following decision; reject; have major</p> <p>17    revision; have minor revision, those are</p> <p>18    the choices they're usually given. And if</p> <p>19    the paper is not rejected it is -- if the</p> <p>20    paper is rejected, the author gets</p> <p>21    reasons for the deficiencies of the study</p> <p>22    or whatever the paper is, and they may</p> <p>23    decide to send it to a different journal.</p> <p>24    But if it's major revision, then between</p> <p>25    the three reviewers and the editor</p>

70 (Pages 274 - 277)

<p style="text-align: right;">Page 278</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they're told exactly what's wrong with  3 the paper, even though it has merit, and  4 how they can fix the paper. And if it has  5 minor revisions, a similar thing happens  6 there are less points and they're  7 relatively -- they don't go to the heart  8 of the matter but they are much more to  9 round out the article. And so that's peer  10 review.  11       So what happens is then I, as  12 the journal writer, as the manuscript  13 writer then responds to the reviewer and  14 we make changes, oftentimes we make  15 changes in track changes mode, so that  16 the reviewers and the editor can see what  17 we've changed and we have to justify the  18 changes. And sometimes we agree with the  19 reviewer and sometimes we disagree. And  20 if we disagree, we have to state why we  21 disagree.  22       So we send that back and then  23 the reviewers get that material from us,  24 from me, us, and they then decide to  25 reject, to have another major</p>	<p style="text-align: right;">Page 280</p> <p>1       STEPHEN B. LEVINE, M.D.  2 reviewer who believes in affirmative care  3 and you look at the Panchankis article,  4 you say, look what the authors say, look  5 what they found, it's just -- it confirms  6 what I believe about that. So they're not  7 very critical about it.  8       So the peer review does not  9 guarantee factualness, it's just a way we  10 have to increase the likelihood of being  11 correct, reasonable science.  12       In the Panchankis -- the  13 Bränström-Panchankis study is a beautiful  14 case in point, that there is something  15 wrong within this field that we can't be  16 critical of certain work that's  17 affirmative to trans care.  18       Now, you probably know that  19 there were seven letters to the editor  20 that were so, so correct in pointing out  21 the deficiencies that Dr. Kalin, the  22 editor, then sent this out to two  23 additional reviewers, this would be  24 reviewer four and reviewer five. And  25 those two people looked at this study and</p>
<p style="text-align: right;">Page 279</p> <p>1       STEPHEN B. LEVINE, M.D.  2 modification, to a minor modification or  3 acceptance.  4       And that's the process of peer  5 review, as I understand it, and as I have  6 experienced it in the 152-or-so articles  7 that I have published.  8       Q. Does publication in a journal  9 that uses the peer-review process, is  10 that considered more reliable scientific  11 evidence than material published  12 elsewhere?  13       MR. CANTRELL: Object to form.  14       A. I don't think I understand.  15 Can I repeat the question to see if I  16 understand?  17       Q. I'll ask it differently.  18       Does the peer-review process  19 help insure that the research is  20 reliable?  21       A. Well, as you can tell from the  22 Bränström Panchankis study, sometimes  23 egregious errors are not picked up by the  24 reviewers, you see.  25       The trouble is if you're a</p>	<p style="text-align: right;">Page 281</p> <p>1       STEPHEN B. LEVINE, M.D.  2 said that the results of this study, the  3 conclusions of the study could not be  4 based on the data that were presented,  5 and that led to Dr. Kalin publishing the  6 seven original letters, which I think  7 that were 12 authors, but the two  8 independent statistical authors, which  9 were not published, and Dr. Kalin wrote a  10 little article about the process and  11 about the concerns about the paper, and  12 then the two original authors were asked  13 to write a response to all this and they  14 wrote what some people call a retraction,  15 but when people are -- don't like that  16 term, they wrote that more research was  17 necessary in order to reach the  18 conclusions that we reached in this  19 paper, that our paper did not prove -- we  20 understand it did not prove our  21 conclusions.  22       Q. I want to ask about the  23 peer-review process.  24       A. I think I just explained it.  25       Q. You did. In your field or</p>

<p style="text-align: right;">Page 282</p> <p>1       STEPHEN B. LEVINE, M.D.  2 among scientists is it understood which  3 journals are the peer-reviewed journals  4 and which are not?  5       A. Oh, all the journals are  6 peer-reviewed. There are newspapers  7 that -- you know, like there is something  8 called Psychiatric Times. Psychiatric  9 Times asks me sometimes to write an  10 article and they sometimes send it out to  11 someone else to say it's okay or the  12 editor says, oh, you have to write it  13 differently. That is not what I call peer  14 review. You know, the Psychiatric Times  15 doesn't want to get sued or lose  16 readership or something outrageous, so  17 they check with someone else. And if you  18 look closely they have a board, an  19 editorial board that they send those  20 papers to for a quick "okay". But it's  21 very different than peer-reviewed, as I  22 originally described, and which failed in  23 the process of Bränström and Panchankis.  24       Q. People in your field know the  25 difference between peer-reviewed in a</p>	<p style="text-align: right;">Page 284</p> <p>1       STEPHEN B. LEVINE, M.D.  2 concerns about the rapidity of  3 affirmative care and the lack of  4 evidence. That's why they named it The  5 Society For Evidence-Based Gender  6 Medicine. It's not about medicine, in  7 particular, it's confined to this  8 particular topic.  9       So many -- you know, I don't  10 know if you consider me a scientist, but  11 so there are many people who, like me,  12 are interested in this, are clinically  13 involved and who are interested in  14 exploring the scientific basis of this  15 subject because we, from our clinical  16 work, have developed the kind of worry  17 about what we're doing to people.  18       So I don't know if you would  19 agree that this is a scientific  20 organization. You probably would think  21 that the American Psychiatric Association  22 is a scientific organization, and they  23 would like to think they're a scientific  24 organization, but other people know that  25 it's a trade organization as well, who</p>
<p style="text-align: right;">Page 283</p> <p>1       STEPHEN B. LEVINE, M.D.  2 scientific journal and different kinds of  3 publications?  4       A. Yes, I hope so. I think I  5 answered your question, right?  6       Q. You did. I'm going to switch  7 gears now.  8       I want to talk about SEGM, as  9 you called them, and you cited to a  10 publication, I believe in paragraph 8,  11 SEGM -- I'm going to back to your report,  12 I'm sorry, Exhibit 7.  13       A. Exhibit 7?  14       Q. Yes. I believe you cited in  15 paragraph 8 --  16       A. Sorry. What paragraph are you  17 talking about?  18       Q. Let's close that. I made a  19 mistake.  20       I want to understand a little  21 bit more about SEGM. Are they a  22 scientific organization?  23       MR. CANTRELL: Object to form.  24       A. Well, it's a group of  25 clinicians and scientists who share</p>	<p style="text-align: right;">Page 285</p> <p>1       STEPHEN B. LEVINE, M.D.  2 then talks about science and presents  3 scientific studies.  4       So, you know, the question you  5 just asked needs to be examined closely,  6 and what you mean and what I mean and  7 what the culture means and how naïve all  8 of us can be about what is science and  9 what is not science.  10       Q. Does SEGM have a position  11 about whether gender-affirming medical  12 care for minors should be prohibited  13 across the board?  14       A. Should be prohibited across  15 the board? Actually, I don't think so. I  16 think what SEGM -- I don't know that  17 anyone can say what SEGM -- it has --  18 let's say it has 100 members. I don't  19 think there's a uniformity of belief  20 system among the hundred members, except  21 that there is reason to be skeptical  22 about what is going on and to be worried  23 about what is going on and to wonder  24 whether compassion lies in supporting or  25 not supporting these kind of</p>

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1       STEPHEN B. LEVINE, M.D.  
2 interventions. There is a kind of  
3 uncertainty and a uniformity of desire  
4 for better study and better reasoning and  
5 to separate advocacy from science.  
6       That is what I think that  
7 these people have in common, or I should  
8 say we people since, you know, they paid  
9 me money to write that article. So but I  
10 don't think you're right if you are  
11 asserting that SEGM is against all  
12 care --  
13     Q.   That's not what I'm asking.  
14 I'm definitely not asserting. I'm asking.  
15     A.   Well, it's my opinion that  
16 they don't have a policy that they're  
17 against all trans care for youth.  
18       I think they are saying where  
19 is the science? And when the science is  
20 not there we ought to be cautious.  
21 Please be cautious, world, please, is  
22 probably what they would say.  
23     Q.   Are you still involved with  
24 SEGM?  
25     A.   Not today, I mean, currently

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1       STEPHEN B. LEVINE, M.D.  
2 involved with SEGM? You know, because we  
3 wrote an article, I sometimes write to my  
4 second and third author and say, do you  
5 know how many people have looked at this  
6 lately? You know, there's 27,000.  
7 That's in the top 1% of any article ever  
8 written, and this article must be having  
9 an impact everywhere.  
10    Q.   I understood from a previous  
11 deposition that you gave that you have  
12 been on a committee to develop treatment  
13 guidelines with SEGM. Is that still in  
14 the works?  
15    A.   No.  
16    Q.   What happened with that?  
17    A.   I think SEGM had too many  
18 ideas. They didn't have the manpower,  
19 the energy and the time to -- they were  
20 going to publish -- they were going to  
21 publish in some undisclosed --  
22 unclarified form guidelines for primary  
23 care physicians and guidelines for mental  
24 health professionals where people could  
25 get updates on the latest scientific

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1       STEPHEN B. LEVINE, M.D.  
2 knowledge and the latest recommendations  
3 that a group of people together, had put  
4 together.  
5       I just think that was an  
6 extremely ambitious thing. And if you can  
7 look at how many years delayed the WPATH  
8 8th Standards of Care are, and it's  
9 probably three years past due, how  
10 difficult it is to formulate guidelines  
11 in this controversial area.  
12       So I don't know exactly what  
13 happened because I'm not privileged to  
14 the -- you know, I'm not a decisionmaker  
15 or policy maker in SEGM. I was sometimes  
16 used to participate in this process. But  
17 we worked together on it and then  
18 suddenly we weren't working on it  
19 anymore. So I don't really know the  
20 answer.  
21    Q.   So was there even a framework  
22 developed for what the guidelines would  
23 look like?  
24    A.   Well, SEGM was interested in  
25 the psychotherapeutic approach and how to

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1       STEPHEN B. LEVINE, M.D.  
2 guide mental health professionals, how to  
3 think about doing psychotherapy. We first  
4 had to say there are scientific  
5 limitations and if we're going to have an  
6 alternate treatment we're just not saying  
7 whatever your past experience is, go to  
8 psychotherapy because we don't know what  
9 that was going to result in.  
10       So what we were trying to do  
11 was illustrate processes of therapy and  
12 then principles of therapy. So this is  
13 very hard to teach how to do  
14 psychotherapy, Ms. Cooper, because  
15 generally speaking, we want to -- we can  
16 only give overriding, overarching  
17 principles like, pay attention to the  
18 quality of the relationship, or what  
19 should you do about the name, what name  
20 should you address the patient by? But  
21 when you're lost -- when you have in a  
22 private confidence psychotherapeutic  
23 session you never know exactly what's  
24 going to happen. We can't tell you what  
25 to do in every circumstance.

<p style="text-align: right;">Page 290</p> <p>1       STEPHEN B. LEVINE, M.D.  2       So generally we have to have a  3 certain faith system, in the power of a  4 good relationship, a trustworthy,  5 respectable relationship that illuminates  6 what people feel, what they've been  7 through and what they're conflicted about  8 and what they're worried about.  9       What all psychotherapists  10 share is the belief that that's a  11 maturation -- if you can meet those  12 criteria that's a maturation stimulating  13 process and we think that's important for  14 13, 15 and 17 and 27-year-olds who have  15 this psychological pain called gender  16 dysphoria. And we actually think it's not  17 different than if someone who didn't have  18 gender dysphoria, but had the pain of  19 anxiety or the pain of depression or the  20 pain of feeling that they're low status  21 in their peer group, you see, we would  22 want to do the same thing. And we, SEGM  23 people, or at least the psychotherapy  24 section of SEGM people were very  25 concerned, very concerned that somehow</p>	<p style="text-align: right;">Page 292</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for transgender youth?  3       A. That's a nice paraphrase of  4 it, yes.  5       Q. Would you describe it  6 differently? I can't remember the exact  7 title.  8       A. It wasn't what you just said  9 but it's close enough.  10       Q. And who were your  11 co-presenters?  12       A. I mentioned two of them  13 already and the fourth one was Kenneth  14 Zucker.  15       Q. And the another two, was that  16 Sasha Ayad and Lisa Marchiano?  17       A. Yes.  18       Q. Well, was it a symposium? Did  19 I use the right word when I said that?  20       A. That's what the APA calls it.  21       Q. How big was the audience for  22 this program?  23       A. I'm sorry. What was that?  24       Q. How big was the audience for  25 this program?</p>
<p style="text-align: right;">Page 291</p> <p>1       STEPHEN B. LEVINE, M.D.  2 when a kid announces a trans identity he  3 or she is disqualified based on WPATH's  4 pronouncement in 2013, that he is  5 disqualified from needing this process,  6 which we think is ridiculous.  7       MS. COOPER: I was going to  8 suggest we take a break now. Can we  9 do that?  10       MR. CANTRELL: Okay.  11       MS. COOPER: Let's take five  12 minutes good?  13       MR. CANTRELL: Sure.  14       (Recess is taken.)  15       VIDEOGRAPHER: Going off the  16 record the time is 4:58.  17       (Recess is taken.)  18       VIDEOGRAPHER: Going back on  19 the record. The time is 5:15.  20       Q. Dr. Levine, did you present  21 this month at a symposium at the APA  22 conference?  23       A. Two days ago.  24       Q. Two days ago? And was that a  25 symposium on reexamining best practices</p>	<p style="text-align: right;">Page 293</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A. Well, you know, I'm such a --  3 it was a big room. There were -- there  4 was 11 rows, there was approximately 100  5 people there.  6       Q. Okay. And was this part of a  7 larger conference where there was a  8 series of presentations on other issues  9 related to gender dysphoria?  10       A. Yes. This is the annual  11 American Psychiatric Association  12 conference and there were a few symposia  13 on gender issues, because the theme was  14 Social Determinants of Mental Health Or  15 Mental Illness. And the APA has gone out  16 of its way to specialize and to welcome  17 all forms of mental cultural diversity.  18 And that was the theme and this was just  19 one of perhaps 50 different symposia that  20 were held during a four-day period.  21       Q. So they were not all on gender  22 dysphoria-related issues but some were?  23       A. Most were not gender  24 dysphoria, but there were a handful of  25 papers relating to that.</p>

<p style="text-align: right;">Page 294</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   And just for clarity, I think  3 you said it was the American Psychiatric  4 Association conference; is that right? It  5 wasn't the American Psychological  6 Association?  7     A.   Yes, you're right.  8     Q.   I get confused with the APAs.  9 Did -- excuse me. Let me back up.  10       Sasha Ayad and Lisa Marchiano,  11 are those both members of SEGM?  12     A.   Yes.  13     Q.   And Ken Zucker presented as  14 well, you said?  15     A.   Yes.  16     Q.   And did any of these  17 presenters, including yourself, suggest  18 halting hormonal therapies to treat  19 minors with gender dysphoria?  20     A.   That didn't come up in the  21 symposium.  22     Q.   What did come up? What kind of  23 recommendations were made?  24     A.   Well, I spoke first for about  25 eight minutes, and then Ken Zucker -- and</p>	<p style="text-align: right;">Page 296</p> <p>1       STEPHEN B. LEVINE, M.D.  2 trust -- you want me to talk about what I  3 --  4     Q.   Sure.  5     A.   So I talked about the  6 processes of people at high places,  7 sometimes institutions, sometimes  8 researchers, policymakers, creating a  9 diagnosis and creating a treatment and  10 the reason we do that is we're trying to  11 -- we can recognize suffering based on  12 people's patterns, and so we create  13 diagnoses and we offer treatments.  14 Hopefully some of those treatments are  15 based on science, and then we trickle  16 those things down to educators and  17 educators, in turn, follow this chain of  18 trust down to our students and mostly our  19 students are medical students, our  20 psychology students, our social work  21 students that have some familiarity with  22 the soul of science, which is skepticism,  23 which says; show me what is the evidence  24 for this.  25       So this is the chain of trust</p>
<p style="text-align: right;">Page 295</p> <p>1       STEPHEN B. LEVINE, M.D.  2 I'll tell you what I spoke about if  3 you're interested -- and Ken Zucker then  4 talked about the evidence for the  5 epidemiological shift towards -- across  6 the world towards more children claiming  7 an identity, a trans identity, but the  8 predominance of female girls at birth,  9 what you might call assigned-at-birth  10 girls, and then Dr. Marchiano --  11 Dr. Marchiano talked about the state of  12 science in this field and the limitations  13 of, for example, the DeVries study from  14 what we call the Dutch protocol, which,  15 you know, I wrote about in the paper and  16 she talked about detransitioning and what  17 that means. So she spoke for about 20  18 minutes on those topics about the  19 limitations of science in the field and  20 then Sasha Ayad spoke for the last few  21 minutes about what you and I have already  22 made mention of, which is how to conceive  23 of -- how to do therapies, the principles  24 of psychotherapy for transgender youth  25 and what I spoke about was the chain of</p>	<p style="text-align: right;">Page 297</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that educates physicians, we'll just pick  3 on physicians for a minute. And I said  4 the chain of trust is never entirely  5 trustworthy and sometimes the chain of  6 trust is not trustworthy at all because  7 science changes what is the truth or what  8 is the therapy and what is the problem  9 and what suffering we're going to  10 associate, we're going to focus on.  11       So I started out with the  12 concept of a chain of trust is how  13 medical education works. And I need to  14 remind everybody that the chain of trust  15 is never always trustworthy because  16 today's facts are not tomorrow's facts.  17       So then I talked about ten  18 ideas that are -- I talked about the  19 difference between affirmative treatment,  20 which I don't have to tell you about, and  21 alternate treatment, which I hope I'm  22 beginning to tell you it exists, you see.  23 So I made those distinctions. And then I  24 gave a slide with ten ideas that many  25 people who, in my experience, are in the</p>

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<p style="text-align: right;">Page 298</p> <p>1       STEPHEN B. LEVINE, M.D.  2 affirmative treatment activity process,  3 they actually believe, for example, that  4 it is biologically determined, that it's  5 fixed for life or immutable and that the  6 treatments have already been proven to  7 decrease suicide and increase people's  8 social functioning. Anyway, I had ten  9 things that I believe I've heard and I've  10 read, which I don't believe science has  11 established.  12       So I talked about those ten  13 things. And then I talked about the rise  14 in what I like to call the transgender  15 treatment industry and saying that there  16 are now -- you know, there used to be  17 very few centers in the 1970s and 1980s,  18 there were very few little pockets of  19 clinical work and now there are over 50  20 centers in the United States that  21 specialize in affirmative care. In  22 Cleveland, for example, we have three of  23 them whose name tells you that they're  24 interested in affirmative care.  25       And so that's all I had to say</p>	<p style="text-align: right;">Page 300</p> <p>1       STEPHEN B. LEVINE, M.D.  2 hormone therapy to minors?  3       A. As Dr. Zucker said during the  4 symposium, you know, he sometimes have  5 prescribed puberty blockers to children  6 but certainly I think you summarize what  7 all four of us believe.  8       Q. Would you say that all four of  9 you would be considered dissenting views  10 in the APA world?  11       MR. CANTRELL: Object to form.  12       A. We have dissenting views from  13 the APA's positions, is that what you  14 mean?  15       Q. Well, let me ask it  16 differently.  17       Would you say all four of you  18 on the panel have views that are  19 considered dissenting from the views of  20 the major medical associations, including  21 the American Psychiatric Association?  22       MR. CANTRELL: Object to form,  23 vague.  24       A. Well, there are 28,000  25 psychiatrists in the APA, I think. So</p>
<p style="text-align: right;">Page 299</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and because I was really -- the basic --  3 that was my introductory way of saying,  4 isn't this a time for a paradigm shift?  5 Can we, based upon science, the  6 limitations of science, can we say that  7 this idea of affirmative care is proven  8 and is the best thing to do? Can we have  9 -- can we open our minds to the  10 possibility that the best practices are  11 not necessarily the best practices and we  12 need to be somewhat skeptical and could  13 we even imagine that we have another  14 paradigm shift?  15       And that was my introduction  16 to Dr. Zucker and Dr. Ayad -- Ms. Ayad  17 and Dr. Marchiano. And then we had  18 questions, I mean discussion. That was it  19 -- actually, it was supposed to be 90  20 minutes but it lasted I think almost 115  21 minutes.  22       Q. And Ken Zucker, Lisa Ayad and  23 Lisa Marchiano are people who you would  24 describe as supporting a more cautious  25 approach with respect to providing</p>	<p style="text-align: right;">Page 301</p> <p>1       STEPHEN B. LEVINE, M.D.  2 certainly I don't -- I mean, there are --  3 people in the audience came up to us and  4 say, gee, thank you for saying these  5 things, I didn't have the courage to say  6 these things, and there is so much worry  7 that people were going to be harmed,  8 their reputation would be harmed if they  9 express any dissenting view.  10       The APA, in 2010, in 2010  11 declared that there is no such thing as  12 an abnormal gender identity and was very  13 supportive of all this affirmative care.  14 And that was really before some of the  15 seminal studies have showed up.  16       So they had a political view  17 because the APA has made a terrible  18 mistake in this -- before 1973 when they  19 called homosexual people to be  20 psychopathology, that was a form of I  21 think they called it a psychopathic  22 personality disorder or something, I  23 don't remember exactly. But they were  24 extremely embarrassed about their  25 position that they maintained for years</p>

<p style="text-align: right;">Page 302</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and years and years.  3       You know, all of us in  4 medicine are a little bit aware of  5 mistakes that we've made about social  6 issues. You know, the American  7 Psychiatric -- the American Medical  8 Association used to support eugenics.  9 And, of course, you and I have already  10 talked about the mistake of the opioid  11 crisis and I can go on and on, and so  12 could you, about the --  13     Q.   Maybe we can switch gears.  14     A.   -- about the misadventures.  15 But answer to your specific question, the  16 APA was aware that we were presenting  17 ideas that were not in keeping with the  18 official policies of the APA.  19       In fact, they made that  20 announcement and they asked people -- I  21 mean, they sent a special moderator to  22 our session, unbeknownst to me and I  23 didn't have any special monitor -- I  24 didn't see any APA monitors in any of the  25 other sessions I attended during -- you</p>	<p style="text-align: right;">Page 304</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   And you've not reviewed his  3 expert report in this case?  4     A.   If I have I don't remember it.  5     Q.   So you never heard of him  6 before?  7     A.   Given my memory, put a little  8 asterisk about that, please.  9     Q.   Let me ask it differently. Is  10 it someone you know who works in the area  11 of treatment for gender dysphoria?  12     A.   What is his first name?  13     Q.   Mark.  14     A.   No. Mark, no, I don't know  15 that person. At least at 5:30 I don't  16 know that person.  17     Q.   Do you know who Patrick  18 Lappert is?  19     A.   Patrick, last?  20     Q.   L-a-p-p-e-r-t.  21     A.   That name sounds more familiar  22 but I don't associate it with anything.  23 No, I don't know.  24     Q.   If I were to mention that he  25 also submitted an expert report for the</p>
<p style="text-align: right;">Page 303</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know, during the days I was there, but  3 this woman appeared, who was the head of  4 the program, and she made a little  5 announcement that this was a respectful  6 institution and that people needed to be  7 -- talk nice, and the APA was aware that  8 some of the ideas expressed here were not  9 in keeping with the official policy of  10 the APA.  11       So while we were all talking  12 the group was extremely polite and nobody  13 interrupted and so forth and so on.  14     Q.   Switching gears, do you know  15 who Mark Regnerus is?  16     A.   Sorry. Who? Margaret?  17     Q.   Mark Regnerus.  18     A.   No, I don't know that name.  19     Q.   R-e-g-n-e-r-u-s. He is an  20 expert witness for the State of Arkansas  21 in this case. Does that help ring a  22 bell?  23     A.   R-e-g-n-u-s?  24     Q.   R-e-g-n-e-r-u-s.  25     A.   I don't know that name.</p>	<p style="text-align: right;">Page 305</p> <p>1       STEPHEN B. LEVINE, M.D.  2 State of Arkansas, would that help you  3 remember who he is?  4     A.   I don't remember reading an  5 expert report by Dr. Lappert. Is it Dr.  6 Lappert?  7     Q.   Yes. Okay. Do you know  8 Dr. Paul Hruz, H-r-u-z?  9     A.   Yes.  10     Q.   And do you know him  11 personally?  12     A.   I've met Dr. Hruz somewhere, I  13 think on another case.  14     Q.   Did you ever meet Dr. Hruz at  15 any professional conference?  16     A.   I don't think we go to the  17 same conferences.  18     Q.   Why is that?  19     A.   I'm a psychiatrist.  20     Q.   Gotcha. Is he someone you know  21 to be an expert in the field of gender  22 dysphoria, treatment of gender dysphoria  23 in adolescents?  24     A.   I know him to be a person who  25 has strong negative views about going</p>

<p style="text-align: right;">Page 306</p> <p>1       STEPHEN B. LEVINE, M.D.  2 ahead with hormone treatments without  3 adequate scientific foundation. That's  4 what I know of Dr. Hruz.  5     Q. Did you read his report that  6 he submitted in this case?  7     A. I think I probably did  8 somewhere, nine, ten months ago, yeah.  9     Q. Was there anything that he  10 opined that you disagreed with?  11       MR. CANTRELL: Object to form.  12     A. You may or may not know that  13 I've spent a lot of time editing reports.  14 I'm the senior editor of a major textbook  15 in sexual ideas, sexual health called  16 Handbook of Clinical Sexuality For Mental  17 Health Professionals.  18       And so I'm used very much to  19 taking experts and helping them write  20 more clearly and more succinctly and more  21 powerfully. And I often ask people, what  22 does this mean? Could you say that more  23 clearly?  24       So probably when I read other  25 experts' reports, and let's not pick on</p>	<p style="text-align: right;">Page 308</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know about Michael Biggs?  3     A. He's from the U.K. and he's  4 someone who has a great capacity to  5 analyze data and to recognize, you know,  6 reasonableness and he's someone who digs  7 into data in a far deeper way than most  8 human beings can do and don't have the  9 capacity to do.  10       So I've been very interested  11 in what he has said about various  12 articles, in particular, about  13 Dr. Turban's articles, which many of us  14 have enormous skepticism about, enormous  15 skepticism about.  16       So he recently published a  17 letter to the editor about suicide and  18 gender -- teens with gender dysphoria and  19 looked at the data from the Tavistock  20 Clinic and came up with a rate of suicide  21 that was surprisingly low, considering  22 all the claims that we have to give  23 hormones to kids because they're going to  24 kill themselves if they don't. And he  25 found that in looking at all the data</p>
<p style="text-align: right;">Page 307</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Dr. Hruz specifically, I could say that  3 about many of the expert reports on  4 either side, I wouldn't have said it  5 exactly that way. So I don't remember  6 right now whether I disagree with  7 something he said.  8       I certainly know that a few  9 experts have rebutted some of his  10 concepts. You know, some of your experts  11 don't think that I know what I'm talking  12 about either, or should I say more  13 respectfully, they disagree with  14 something I said.  15     Q. I mean, is there anything in  16 particular you have in mind where you say  17 our experts rebutted some of Dr. Hruz's  18 concepts?  19       MR. CANTRELL: Object to form.  20     A. I think in order to answer  21 that question I would have to read his  22 report again.  23     Q. All right. In your reports in  24 this case I saw some references to  25 publications by Michael Biggs. What do</p>	<p style="text-align: right;">Page 309</p> <p>1       STEPHEN B. LEVINE, M.D.  2 over the years that there were four known  3 suicides of people who registered to the  4 Tavistock Clinic over a ten-year period  5 and two of those kids were in treatment  6 with hormones and two of them were on the  7 waitlist. And he calculated the rates,  8 the suicide rate there and it was .03%,  9 which is so different than, you see, what  10 everyone is afraid of. Because people  11 have a hard time -- maybe if you're in  12 psychiatry you don't have a hard time  13 with this, but outside of psychiatry,  14 people, when they hear about suicidality,  15 they don't make these distinctions.  16     Q. I just want to interrupt  17 because I didn't mean to ask you about  18 Michael Biggs' work --  19     A. I'm sorry. I'm sorry.  20     Q. -- about his background.  21       So do you understand, is he a  22 doctor or psychiatrist?  23     A. No. He's not a psychiatrist,  24 he's not a MD. He has a Ph.D. in  25 Sociology.</p>

<p style="text-align: right;">Page 310</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Is he someone you consider to</p> <p>3   be an expert on treatment of gender</p> <p>4   dysphoria?</p> <p>5     A.   No. He's an expert on the</p> <p>6   analysis of data.</p> <p>7     Q.   And is he a member of SEGM?</p> <p>8     A.   I don't know.</p> <p>9     Q.   Do you know if he's opposed to</p> <p>10  any provision of gender-affirming medical</p> <p>11  care for minors?</p> <p>12    A.   I don't know.</p> <p>13    Q.   Switching gears, as a</p> <p>14  psychiatrist, is it fair to say you treat</p> <p>15  a range of mental health conditions in</p> <p>16  your patients?</p> <p>17    A.   Yes.</p> <p>18    Q.   Would that include depression?</p> <p>19    A.   Of course.</p> <p>20    Q.   Anxiety?</p> <p>21    A.   Of course.</p> <p>22    Q.   Bipolar disorder?</p> <p>23    A.   I'm sorry. What was that?</p> <p>24    Q.   Bipolar disorder.</p> <p>25    A.   Which kind of disorder.</p>	<p style="text-align: right;">Page 312</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   Occasionally -- I'm sorry.</p> <p>3   You reminded me, I can order blood tests</p> <p>4   and certainly -- and I take a medical</p> <p>5   history. Being a doctor it's important</p> <p>6   for me to take a medical history, in</p> <p>7   part, because I know what certain</p> <p>8   diseases mean, whereas, social workers</p> <p>9   may not know.</p> <p>10    Q.   So would a blood test be able</p> <p>11  to detect something like anxiety or</p> <p>12  depression?</p> <p>13    A.   Not a blood test, no.</p> <p>14    Q.   Any physiological tests?</p> <p>15    A.   Well, you can run an EKG and</p> <p>16  you can take a person's pulse, you can</p> <p>17  see their body shake. I mean, I have</p> <p>18  patients who shake in front of me. I</p> <p>19  don't need a blood test to see they're</p> <p>20  nervous, I can hear what they do when</p> <p>21  they're nervous, you know. So -- and when</p> <p>22  they're depressed, you know, there are</p> <p>23  certain -- their face looks depressed,</p> <p>24  their posture looks depressed, their</p> <p>25  attitudes looks depressed, their</p>
<p style="text-align: right;">Page 311</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Bipolar.</p> <p>3       MR. CANTRELL: She's saying</p> <p>4   bipolar.</p> <p>5     A.   Oh, bipolar. Yes.</p> <p>6     Q.   Are there any -- strike that.</p> <p>7       When you are diagnosing</p> <p>8   patients with these conditions, do you</p> <p>9   rely on self-report of the patients?</p> <p>10    A.   Of course I do.</p> <p>11    Q.   Is there any other evidence</p> <p>12  you can look to to verify the evidence</p> <p>13  provided in the patient's self-report?</p> <p>14    A.   Yes.</p> <p>15    Q.   Can you tell me what kinds of</p> <p>16  things?</p> <p>17    A.   I can talk to a spouse, I</p> <p>18  could talk to a parent, I could do a</p> <p>19  psychological test, I could fill out a</p> <p>20  form and have them fill out a form, I can</p> <p>21  read their medical history, I can talk to</p> <p>22  the previous therapist. I think that's</p> <p>23  most of what I can do.</p> <p>24    Q.   Is there any kind of</p> <p>25  physiological verification?</p>	<p style="text-align: right;">Page 313</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2   self-concepts sound depressed.</p> <p>3       So that's all part of the</p> <p>4   first thing a doctor does, first thing we</p> <p>5   learn in how to do physical diagnosis is</p> <p>6   to observe the patient. So we learn a lot</p> <p>7   by looking at the patient.</p> <p>8     Q.   Are there objective -- have</p> <p>9   you used the term objective and</p> <p>10  subjective to refer to methods of</p> <p>11  diagnosing a condition? Is that</p> <p>12  terminology you use?</p> <p>13    A.   Well, the patient talks about</p> <p>14  their subjectivity and we're interested,</p> <p>15  at least in psychiatry, we're interested</p> <p>16  in how they think and how they feel and</p> <p>17  how they suffer from what the problem is.</p> <p>18  And objectively we look at them and we</p> <p>19  hear how they speak and observe what they</p> <p>20  do with their bodies and their eyes and</p> <p>21  their posture while we're talking. We</p> <p>22  also can have these questionnaires or do</p> <p>23  psychological tests as a more objective</p> <p>24  appraisal.</p> <p>25       For example, when I do a</p>

<p style="text-align: right;">Page 314</p> <p>1       STEPHEN B. LEVINE, M.D.  2 forensic report for somebody who's  3 committed or is accused of a crime, I  4 always provide psychological testing to  5 verify my impressions or to see what I've  6 missed, so to speak. So there are things  7 that are objective and we gather  8 information that is patient narrative.  9 But, again, we also -- we're also being  10 paid what some of my patients call big  11 bucks, we get the big bucks for making  12 judgments about what the person says and  13 thinks and feels, and we sometimes  14 provide an alternate view of -- and then  15 we watch -- sometimes this is called an  16 interpretation -- and we watch the  17 patient's response to our alternate view,  18 and then we see that patient over time  19 and we see how our alternate view may  20 land on fertile ground and help a person  21 shift their subjectivity.  22       I mean, a lot of people say --  23 I don't mean to sound too proud about  24 this -- but a lot of people say, it was  25 so very helpful talking to you, Dr.</p>	<p style="text-align: right;">Page 316</p> <p>1       STEPHEN B. LEVINE, M.D.  2 paradoxes in psychiatry. We live with  3 paradoxes and contradictions.  4       It is -- you know, the APA  5 declared in 2010 that there is no such  6 thing as an abnormal gender identity, and  7 the policy from the DSM-IV was  8 inconsistent with that.  9       Now, the DSM-V has said, well,  10 gender identity, per se, is not an  11 abnormality, but if people are distressed  12 then they have a psychiatric diagnosis.  13       You see, if you are going to  14 ask me if I have issues with the DSM-V  15 diagnosis of gender dysphoria, you really  16 need to ask me if I have issues about  17 psychiatric diagnosis, in general, and  18 then we would have to talk about that at  19 great length. And you don't want me to  20 spend an hour talking about that. And  21 then we could get to the specifics about  22 gender dysphoria as a diagnosis and why  23 the DSM -- why the ICD-11 has went out of  24 its way to not make it a psychiatric  25 diagnosis, and how they think that that's</p>
<p style="text-align: right;">Page 315</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Levine, you've really helped me today, I  3 feel much better leaving after 50 minutes  4 than I did when I walked in here. That's  5 why I get paid the big bucks, so to  6 speak, you know.  7       So I don't know if you want to  8 call this objective. I'm comfortable with  9 the subjectivity, the patient's  10 subjectivity and my subjectivity and the  11 relationship between the two of those  12 subjectivities.  13       Q.   Do you take issue with the DSM  14 diagnosis of gender dysphoria?  15       MR. CANTRELL: Object to form,  16 vague.  17       A.   What issue would you be  18 referring to?  19       Q.   Do you think that gender  20 dysphoria is appropriately considered a  21 psychiatric condition?  22       A.   Oh. Well, in the DSM-V there  23 is a psychiatric condition. In the  24 ICD-11 it is a condition that affects  25 sexual health. This is one of the great</p>	<p style="text-align: right;">Page 317</p> <p>1       STEPHEN B. LEVINE, M.D.  2 a major step forward, and which I think  3 it helps everyone deny the importance of  4 self-harm and suicidality and depression  5 and anxiety. Because that's something  6 separate from gender identity, you see.  7 It's a comorbidity. As though a person  8 can have six different diagnoses. I  9 laugh when I sometimes get patients who  10 come from others who gave six psychiatric  11 diagnoses, it's one person and they have  12 six different problems. And you see,  13 this is the diagnostic problem, this is  14 the diagnostic foolishness I think that  15 we have in separating things out. It's  16 just one person struggling with life, you  17 see.  18       Q.   Do you think that gender  19 dysphoria is diagnosed only based on  20 patient's self-report?  21       MR. CANTRELL: Object to form.  22       A.   By whom?  23       Q.   By the -- by you, by whoever  24 is doing --  25       A.   If you are asking about me</p>

<p style="text-align: right;">Page 318</p> <p>1       STEPHEN B. LEVINE, M.D.  2 versus -- you didn't ask about me. You  3 asked about, do I think gender dysphoria  4 is diagnosed by a patient's self-report?  5 Well, of course, it begins with patient's  6 self-report and it also requires a sense,  7 the doctor's sense of what is gender  8 dysphoria and where does it come from and  9 how long has it existed and who is this  10 person, you see, and is this person  11 mentally ill, apart from the gender  12 dysphoria problem, you see.  13       So you know, one can be  14 psychotic and have gender dysphoria or  15 one can be a little anxious and have  16 gender dysphoria, and those are different  17 kettles of fish.  18       Q.   And I think we talked about  19 this earlier, do you look to information  20 from the parents when diagnosing a minor  21 with gender dysphoria?  22       A.   Why, of course.  23       Q.   Is the reliance on self-report  24 from patients and information from family  25 members unique to the diagnosis of gender</p>	<p style="text-align: right;">Page 320</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is, is that -- is the reliance on  3 patient's self-report and report from  4 family members unique in the psychiatric  5 field to the diagnosis of gender  6 dysphoria?  7       MR. CANTRELL: Object to form.  8       A.   Oh, I see. I see where you've  9 been going here.  10       Self-report is a very  11 important component in the diagnosis of  12 any psychiatric condition.  13       In the field of gender  14 dysphoria, in the beginning of the  15 history of the gender dysphoria we  16 recognized in the '70s and '80s that many  17 people lied to us because they read the  18 textbook description and they wanted  19 hormones, for example, and they gave us  20 textbook descriptions of their gender  21 dysphoria. So we trying to distinguish  22 in the '70s and '80s in adults between  23 people who had -- looking at men, for  24 example, men who evolved into trans  25 identities from transvestitic fetishism</p>
<p style="text-align: right;">Page 319</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria?  3       MR. CANTRELL: Object to form.  4       A.   No.  5       Q.   Is that true of other  6 psychiatric conditions?  7       A.   Yes. For example, if somebody  8 is having cognitive troubles, and say,  9 oh, I'm not having any troubles, I just  10 got lost on the way home last night, I'd  11 be happy to talk to their spouse or their  12 son or their daughter or their other  13 doctor, whatever.  14       Of course, I mean, this is --  15 you know, this is standard medical stuff.  16 It doesn't require just being a  17 psychiatrist. The internist does the  18 same thing, the pediatrician does the  19 same thing, even the neurosurgeon does  20 the same thing.  21       Q.   Well, I'm asking because there  22 have been critiques by others that the  23 diagnosis of gender dysphoria is not  24 valid because it is only based on  25 patient's self-report. And my question</p>	<p style="text-align: right;">Page 321</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or cross-married, heterosexual  3 cross-dressers from people who had what  4 we thought back then was true gender  5 dysphoria. We didn't call it gender  6 dysphoria in those days, true  7 transsexualism.  8       It turns out now that  9 children, teenagers spend so much time on  10 social media and so much time on trans  11 social media, and that there are people  12 telling teenagers what to tell the  13 doctor, that now we have the problem of;  14 do we believe the patient's subjective  15 report? Is there -- is the patient  16 telling us the truth as they experience  17 themselves or are they telling us what we  18 think we need to hear in order to  19 recommend affirmative care? And this is  20 one of the reasons why we need to have a  21 conservative, slow report to figure out  22 the truth because people lie to doctors  23 when they want something, and transgender  24 people are no exceptions to the human  25 potential to lie to doctors to achieve</p>


<p style="text-align: right;">Page 322</p> <p>1       STEPHEN B. LEVINE, M.D.  2 some goal that they have in mind. And so  3 doctors can't treat people like they're  4 liars, but they have to understand that  5 it may not be the whole truth.  6       So that when someone says it's  7 not valid because it's only self-report,  8 I think the substance of that claim is  9 that it may not always be true, just  10 self-report and, therefore, it's  11 important to get multiple sources of  12 information sometimes and it's important,  13 Levine would say it's important to know  14 that person over time because stories  15 change.  16    Q.   Are there other mental health  17 conditions that you can diagnose only  18 based on self-report and report from  19 others who know the patient?  20    A.   I think that's how it works.  21    Q.   That's how psychiatry works?  22    A.   Yes. I think the answer to  23 your question; are there other  24 conditions, the answer is simply yes. But  25 I'm so long-winded here.</p>	<p style="text-align: right;">Page 324</p> <p>1       STEPHEN B. LEVINE, M.D.  2 So I don't know -- he made mention of  3 several different issues he wanted to  4 talk to me about.  5       So I don't know -- I can just  6 report to you some somebody called me  7 about -- he called me a weak ago Friday,  8 tomorrow would be a week, last Friday he  9 called but I've been -- I was on my way  10 to the APA meeting.  11    Q.   What issues did he say he  12 wanted to talk about?  13    A.   He didn't say, but I presumed  14 it was something about trans world.  15 People don't ask me to be expert  16 witnesses about schizophrenia.  17    Q.   Do you think parents of a  18 minor on hormone therapy should be deemed  19 child abusers?  20       MR. CANTRELL: Object to form.  21    A.   That's sort of a -- let me see  22 if I got that question. Do I think the  23 parents who support a child being on  24 hormones should be accused of child  25 abuse?</p>
<p style="text-align: right;">Page 323</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Are you familiar with the  3 decision in Texas to investigate families  4 of children who are -- actually, not  5 children. I'll start that again.  6       Are you aware of a decision in  7 Texas to deem gender-affirming medical  8 care for minors to be child abuse?  9    A.   I read the papers.  10   Q.   So you are aware of that from  11 the news; is that right?  12   A.   The dear Governor of Texas.  13   Q.   You are aware; is that  14 correct?  15   A.   I read the papers. I'm aware.  16 I don't know if I'm as aware as you are  17 but I'm aware somewhat of this idea.  18   Q.   Have you been asked to provide  19 expert testimony in litigation in Texas  20 over that policy?  21   A.   Actually, last week somebody  22 from the Attorney General's Office called  23 me and I said there is no possibility I  24 could talk to you until -- for another  25 couple of weeks because I'm so damn busy.</p>	<p style="text-align: right;">Page 325</p> <p>1       STEPHEN B. LEVINE, M.D.  2   Q.   Yes.  3   A.   Is that your question?  4   Q.   Yes.  5   A.   I would say that's sort of a  6 laughable idea.  7   Q.   Why do you say that?  8   A.   Because I've spent almost  9 seven hours to you explaining the answer  10 to that question.  11   Q.   Yeah, tell me how I missed it.  12       So it's a laughable idea  13 because you don't consider parents who  14 access gender-affirming medical care for  15 their minor children to be engaged in an  16 act of child abuse?  17   A.   I don't think they're  18 knowingly abusing their child. I think  19 they often are misinformed because of the  20 principles I outlined in our article. I  21 don't think they've been informed and I  22 don't think we should punish parents by  23 taking their child away. And I've, by  24 the way, seen that where social agencies  25 take children away, custody of children</p>

<p style="text-align: right;">Page 326</p> <p>1 STEPHEN B. LEVINE, M.D.  2 away from 14-year-old kids who object to,  3 you know, the use of affirmative care on  4 their 14-year-old.  5 The culture is somewhat  6 hyperbolic about this subject, you see,  7 and people need to calm down about this.  8 The Governor needs to calm down about  9 this, I mean the Governor of Texas. And  10 you know, these principles have something  11 to do with the election cycle. And I'm  12 talking about science here. And I'm not  13 an expert on election cycles, but I am a  14 citizen, you know, I do vote, I do make  15 up my mind about what happens in the  16 political sphere. But I really want you  17 to talk to me about what I know about  18 science.  19 If you're asking me about my  20 opinions about various political things,  21 I'll be happy to tell you, but I don't  22 think, you know, that's what you got me  23 here for. But maybe I don't understand  24 why you have me here.  25 Q. Do I take it from your answer</p>	<p style="text-align: right;">Page 328</p> <p>1 STEPHEN B. LEVINE, M.D.  2 law there and they said, well, thank you  3 very much, Dr. Levine, we'll get back to  4 you. So I haven't heard since that time  5 from them.  6 Q. What concerns did you explain  7 to them?  8 A. I don't remember the details  9 of the Alabama law, only that it made me  10 uncomfortable. I particularly -- I think  11 there was something like revocation of  12 licenses or ten years in prison,  13 something that I thought was Draconian. I  14 think there was -- I think they were  15 threatening to send doctors to prison.  16 And I'm aware that there are many  17 controversies in medicine. And it's only  18 in this area -- or in the abortion area  19 and this area that we have such passion  20 as a nation. And when we think about  21 taking a cultural resource like  22 physicians that communities depend upon  23 for their physical and mental health and  24 putting them in prison because they have  25 a different view some medical issue, I</p>
<p style="text-align: right;">Page 327</p> <p>1 STEPHEN B. LEVINE, M.D.  2 that if you were asked to serve as an  3 expert witness on behalf of the State of  4 Texas to help them defend their policy of  5 investigating parents for child abuse for  6 providing gender-affirming hormone  7 therapy that you would decline that?  8 MR. CANTRELL: Object to form.  9 A. Oh, yes.  10 Q. Was that an "oh, yes", did I  11 hear that right?  12 A. Yes. At this moment I would  13 decline that, if that's how they phrased  14 it, yeah.  15 Q. I can't remember if I asked  16 you this already. Have you been asked to  17 offer expert testimony in the case  18 involving the felony ban on  19 gender-affirming medical care in Alabama?  20 A. I was in discussions with the  21 Attorney General, one of the Assistant  22 Attorney Generals of Alabama, about a  23 month ago and I had a conference call and  24 I explained some of my concerns about  25 that, about what I understood to be the</p>	<p style="text-align: right;">Page 329</p> <p>1 STEPHEN B. LEVINE, M.D.  2 just think that's over the top.  3 Q. Are you aware that the  4 Arkansas law provides that doctors who  5 provide gender-affirming medical care to  6 minors would be deemed to be acting in  7 violation of medical ethics and could  8 have their licenses taken away by the  9 State Medical Board?  10 MR. CANTRELL: Object to form.  11 A. That is not -- that is not my  12 reading of the law. I do know that there  13 is a kind of threat of reporting to the  14 State Medical Board, but I don't really  15 think that law mandates the removal of  16 their medical license.  17 Q. A consequence of the law, if  18 that is what the law means, would that be  19 a concern of yours?  20 MR. CANTRELL: Object to form.  21 And Dr. Levine is not an attorney  22 so he, of course, can't answer  23 legal -- can't give a legal  24 opinion.  25 MS. COOPER: Of course.</p>

<p style="text-align: right;">Page 330</p> <p>1 STEPHEN B. LEVINE, M.D.  2 Q. I'm not asking for your legal  3 opinion. I'm asking if the state law does  4 actually mean that some doctors could  5 have their licenses taken away if they  6 provide gender-affirming medical care to  7 minors, would that cause you concern?  8 A. So, listen, you may not know  9 this but the State Medical Board of Ohio  10 has used me as an evaluator of doctors  11 who have gotten into trouble over many  12 years. They've used me since I would say  13 1990, and they have me -- when people  14 renew their licenses, they have to listen  15 to a 20-minute talk by me. And that's in  16 the last year, not for 30 years. They've  17 used me for consultations for errant  18 doctors.  19 I've been witnessing for 30  20 years how state medical boards operate,  21 our state medical -- the Ohio State  22 Medical Board operates. And so when  23 doctors are accused of things they get a  24 very careful evaluation.  25 So just because the Arizona</p>	<p style="text-align: right;">Page 332</p> <p>1 STEPHEN B. LEVINE, M.D.  2 support a policy that would discipline  3 doctors who provide this care by taking  4 away their medical licenses?  5 MR. CANTRELL: Object to form.  6 A. I'm actually not here to  7 support policy, but to let science lead  8 policy.  9 Q. You mentioned that there are  10 others in your medical practice who  11 provide care for minors with gender  12 dysphoria.  13 Are they aware of your  14 participation in this case and other  15 cases involving issues related to this  16 treatment?  17 A. I'm sorry. Which group of  18 people are you asking me about?  19 Q. The doctors in your -- the  20 providers in your practices.  21 A. Yes. Yes. I think they may not  22 be aware of Arkansas, per se, but they're  23 aware that I do function as an expert  24 witness in some states, sometimes.  25 Q. And is it your experience that</p>
<p style="text-align: right;">Page 331</p> <p>1 STEPHEN B. LEVINE, M.D.  2 law says something, words something that  3 is vaguely threatening, it really doesn't  4 mean that, practically speaking, that  5 they will lose their license.  6 I don't think the law remands  7 or demands that the Arkansas State  8 Medical Board removes their license. I  9 think, if I remember reading it  10 correctly, they could report them to the  11 State Medical Board.  12 Q. I'm not asking your analysis  13 of the statute. I am asking if doctors  14 were to lose their licenses because they  15 provided gender-affirming medical therapy  16 to minors, would that be a concern to  17 you?  18 MR. CANTRELL: Object to form.  19 A. If we leave it as simply as  20 you just said, it would be a concern to  21 me. But I think what I was trying to tell  22 you is it's more complicated, the  23 process. The devil is in the details and  24 not in the statement that you made.  25 Q. And fair to say you would not</p>	<p style="text-align: right;">Page 333</p> <p>1 STEPHEN B. LEVINE, M.D.  2 they agree with the opinions you have  3 offered in these cases?  4 A. I don't think they know the  5 opinions that I offer in these cases. I  6 don't think any one of them have read any  7 expert opinion report I ever wrote. I  8 mean, if you look at the length of this  9 report you got to be a lawyer to read  10 this. No one else in their right mind  11 would read these reports or maybe a  12 parent would read this report.  13 Q. Would you agree there is  14 disagreement among doctors and other  15 healthcare providers about the  16 appropriate way to treat adolescents with  17 gender dysphoria?  18 MR. CANTRELL: Object to form.  19 A. I think I must be getting  20 tired because I'm having a hard time  21 grasping what you're asking me. Would I  22 agree to what?  23 Q. That there is -- I'll ask it  24 again because maybe you didn't hear all  25 of it.</p>

<p style="text-align: right;">Page 334</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Would you agree that among</p> <p>3 doctors and other healthcare providers</p> <p>4 there are diverse views about the</p> <p>5 appropriate treatment for gender</p> <p>6 dysphoria in adolescents?</p> <p>7       A.   Yes. I would agree to that.</p> <p>8       Q.   Some oppose the use of</p> <p>9 hormonal interventions to treat gender</p> <p>10 dysphoria and some support it; is that a</p> <p>11 fair statement?</p> <p>12      A.   Oh, I'm aware that, you know,</p> <p>13 your Plaintiffs' experts support it and</p> <p>14 they represent many people in those</p> <p>15 50-some units across America who are</p> <p>16 actively providing hormone treatment for</p> <p>17 teenagers. Yes, I'm aware.</p> <p>18      Q.   Are there other psychiatric</p> <p>19 conditions about which there is</p> <p>20 substantial disagreement in the field</p> <p>21 about the appropriate course of</p> <p>22 treatment?</p> <p>23      A.   Of course.</p> <p>24      Q.   Can you give me an example or</p> <p>25 two?</p>	<p style="text-align: right;">Page 336</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 hearts and revascularize the</p> <p>3 atherosclerotic blood vessels and there</p> <p>4 was a controversy and people couldn't</p> <p>5 decide. So people did a study and found</p> <p>6 out if you treat this medically you don't</p> <p>7 need to have open heart surgery. And</p> <p>8 then we further then had controversies</p> <p>9 about should we put a stent in rather</p> <p>10 than using medication.</p> <p>11       So medicine advances because</p> <p>12 there are disagreements. There are</p> <p>13 disagreements in psychiatry. There are</p> <p>14 disagreements in every field. You see,</p> <p>15 trans care is the only -- is the most</p> <p>16 controversial, most passionate thing. The</p> <p>17 passion comes from patients who want it</p> <p>18 and the passion comes from doctors who</p> <p>19 believe compassionately, wholeheartedly</p> <p>20 that this is helping them, and they don't</p> <p>21 want to know that the suicide rates after</p> <p>22 all they do, after all this treatment</p> <p>23 have not improved, you see.</p> <p>24       So controversy -- I want to</p> <p>25 teach people that controversy is how we</p>
<p style="text-align: right;">Page 335</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2      A.   Well, some people think that</p> <p>3 high-dose antipsychotic drugs are the</p> <p>4 treatment, lots of people disagree about</p> <p>5 which drugs to use. I wrote a book in</p> <p>6 2020 called Psychotherapeutic Approaches</p> <p>7 to Sexual Problems. And on the 10th and</p> <p>8 final chapter of the book I urged the</p> <p>9 readers to not run away from controversy</p> <p>10 but to embrace controversy and understand</p> <p>11 what the controversy is about and to</p> <p>12 recognize that the reason there is a</p> <p>13 controversy is that we don't have enough</p> <p>14 science to answer the question, and that</p> <p>15 would help us pay attention to subsequent</p> <p>16 studies to move us in the direction.</p> <p>17       You see, what's happened in</p> <p>18 this field is people got polarized and</p> <p>19 they try to cancel the opposing views out</p> <p>20 all the time. I say, embrace the</p> <p>21 controversy. Of course, there are</p> <p>22 controversies. That's how science</p> <p>23 advances, you see.</p> <p>24       There used to be controversies</p> <p>25 about whether you should open up the</p>	<p style="text-align: right;">Page 337</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 advance knowledge and we -- we don't have</p> <p>3 to -- we have to acknowledge the</p> <p>4 controversy and we have to be balanced</p> <p>5 enough to understand the opposing points</p> <p>6 of view and then conceptualize how in the</p> <p>7 world -- or some of us have to</p> <p>8 conceptualize how in the world are we</p> <p>9 going to advance and get the answer to</p> <p>10 the contentious issue. But defining the</p> <p>11 contentious issue is the first step to</p> <p>12 progress.</p> <p>13       MS. COOPER: With that I can</p> <p>14 pass the witness.</p> <p>15       MR. CANTRELL: Okay. Let's</p> <p>16 take a short break.</p> <p>17       VIDEOGRAPHER: Going off the</p> <p>18 record. The time is 6:09.</p> <p>19       (Recess is taken.)</p> <p>20       VIDEOGRAPHER: Back on the</p> <p>21 record. The time is 6:21.</p> <p>22 CROSS-EXAMINATION BY MR. CANTRELL:</p> <p>23      Q.   Just one question, Dr. Levine.</p> <p>24       You discussed earlier a social</p> <p>25 worker in your clinic named Anna Novak.</p>

<p style="text-align: right;">Page 338</p> <p>1       STEPHEN B. LEVINE, M.D.  2       My only question is, what  3 capacity, what ability does she have to  4 approve minors for hormone therapy?  5       A. As a standalone person I don't  6 think she has any authority or legitimacy  7 or credentials to approve surgery or  8 hormones. She's a social worker. She's a  9 very competent person and she's very  10 experienced in this area and we depend  11 very much on Anna Novak to evaluate  12 families and parents and the life history  13 of children with this problem and to  14 enter into a substantial, ongoing  15 relationship. And if, in doing what we  16 have earlier said today is the process of  17 informed consent and having a growing  18 understanding of what the dynamics in the  19 family are, if the parents decide, having  20 recognized the various forms of treatment  21 options that are available, if the  22 parents decide that they would like to go  23 ahead with, say, cross-sex hormones then  24 Anna will write a letter to the -- she  25 will present it to me or to the group and</p>	<p style="text-align: right;">Page 340</p> <p>1       STEPHEN B. LEVINE, M.D.  2 child. And so we say, go ahead and give  3 them hormones and hopefully you'll follow  4 the patient and we'll follow the patient.  5       So I don't really like the  6 word that we recommended or Anna Novak  7 recommended or Anna Novak approved it.  8       What we're really saying is  9 that we've done what we can, to the best  10 of our ability with this family and they  11 have autonomy in decisionmaking about  12 this.  13       I think that's a lot different  14 than happens in many clinics, when you  15 hear about someone, and maybe this isn't  16 the modal experience, but it is certainly  17 a common enough experience that people  18 get -- I want testosterone and by the end  19 of the first visit they have a  20 prescription. Is that an answer?  21       MR. CANTRELL: That's an  22 answer, Dr. Levine. And with that,  23 we'll pass the witness. But we  24 will review and sign.  25       MS. COOPER: No more</p>
<p style="text-align: right;">Page 339</p> <p>1       STEPHEN B. LEVINE, M.D.  2 if there is a consensus agreement about  3 this, considering what we all know about  4 the situation, and we have no -- we have  5 no reason to believe that this is going  6 to be a disaster, even though we have no  7 reason to believe that there is going to  8 have a favorable outcome, we will write a  9 letter to the endocrinologist about our  10 understanding of this case and that we --  11 we give our permission for the -- not the  12 urologist, but the endocrinologist to  13 provide those hormones.  14       In that sense I think people  15 might say, well, don't you approve it?  16 But Anna Novak doesn't prove it. If  17 anyone approves it, it's my signature  18 with the MD degree that legitimizes the  19 -- it gives the endocrinologist not only  20 a great deal of information about the  21 patient and the family, it gives them the  22 idea that we have concerns, of course,  23 the parents are aware of our concerns,  24 and they have decided that this is in the  25 best interests of their family and their</p>	<p style="text-align: right;">Page 341</p> <p>1       STEPHEN B. LEVINE, M.D.  2 questions.  3       VIDEOGRAPHER: This concludes  4 the video deposition. The time is  5 6:25. Going off the record.  6       (The proceedings were  7 adjourned at 6:25 p.m.)  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25</p>

<p style="text-align: right;">Page 342</p> <p>1 CERTIFICATE</p> <p>2 I, MAUREEN M. RATTO, a</p> <p>3 Registered Professional Reporter, do</p> <p>4 hereby certify that prior to the</p> <p>5 commencement of the examination,</p> <p>6 STEPHEN B. LEVINE, M.D. was sworn by me</p> <p>7 to testify the truth, the whole truth</p> <p>8 and nothing but the truth.</p> <p>9 I DO FURTHER CERTIFY that the</p> <p>10 foregoing is a true and accurate</p> <p>11 transcript of the proceedings as taken</p> <p>12 stenographically by and before me at</p> <p>13 the time, place and on the date</p> <p>14 hereinbefore set forth.</p> <p>15 I DO FURTHER CERTIFY that I am</p> <p>16 neither a relative nor employee nor</p> <p>17 attorney nor counsel of any of the</p> <p>18 parties to this action, and that I am</p> <p>19 neither a relative nor employee of such</p> <p>20 attorney or counsel, and that I am not</p> <p>21 financially interested in this action.</p> <p>22</p> <p>23 </p> <p>24 MAUREEN M. RATTO, RPR</p> <p>25 License No. 817125</p>	<p style="text-align: right;">Page 344</p> <p>1 Stephen B. Levine, M.D. Monday,</p> <p>2 December 21, 2020 re: Juli</p> <p>3 Claire v. Florida Department of</p> <p>4 Management Services</p> <p>5 Exhibit Levine 6, Declaration of 234</p> <p>6 Dr. Stephen B. Levine, dated</p> <p>7 July 2021</p> <p>8 Exhibit Levine 7, Declaration of 239</p> <p>9 Stephen B. Levine, MD dated</p> <p>10 December 9, 2021</p> <p>11 Exhibit Levine 8, Canadian 272</p> <p>12 Gender Report, dated October 1,</p> <p>13 2019</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 343</p> <p>1 INDEX</p> <p>2 WITNESS: STEPHEN B. LEVINE, M.D. 6</p> <p>3 DIRECT EXAMINATION BY MS. COOPER 6</p> <p>4 CROSS-EXAMINATION BY 337</p> <p>5 MR. CANTRELL</p> <p>6</p> <p>7 EXHIBITS</p> <p>8 Exhibit Levine 1, Declaration of 64</p> <p>9 Stephen B. Levine, MD, dated</p> <p>10 February 23, 2022</p> <p>11 Exhibit Levine 2, excerpt of the 70</p> <p>12 deposition of Stephen B. Levine,</p> <p>13 MD re: Reiny Keohane v. Julie</p> <p>14 Jones</p> <p>15 Exhibit Levine 3, article re: 86</p> <p>16 Reconsidering Informed Consent</p> <p>17 written by Stephen B. Levine,</p> <p>18 MD, in the Journal of Sex &amp;</p> <p>19 Marital Therapy</p> <p>20 Exhibit Levine 4, transcript re: 181</p> <p>21 Presentation on Healthcare</p> <p>22 Models For Transgender</p> <p>23 Adolescents, dated March 12,</p> <p>24 2020</p> <p>25 Exhibit Levine 5, transcript of 190</p>	<p style="text-align: right;">Page 345</p> <p>1 MICHAEL CANTRELL, ESQ.</p> <p>2 michael.cantrell@arkansasag.gov</p> <p>3 June 8, 2022</p> <p>4 RE: BRANDT, et al. vs. RUTLEDGE, et al.</p> <p>5 5/26/2022, Stephen B. Levine (#5163591)</p> <p>6 The above-referenced transcript is available for</p> <p>7 review.</p> <p>8 Within the applicable timeframe, the witness should</p> <p>9 read the testimony to verify its accuracy. If there are</p> <p>10 any changes, the witness should note those with the</p> <p>11 reason, on the attached Errata Sheet.</p> <p>12 The witness should sign the Acknowledgment of</p> <p>13 Deponent and Errata and return to the deposing attorney.</p> <p>14 Copies should be sent to all counsel, and to Veritext at</p> <p>15 erratas-cs@veritext.com.</p> <p>16</p> <p>17 Return completed errata within 30 days from</p> <p>18 receipt of testimony.</p> <p>19 If the witness fails to do so within the time</p> <p>20 allotted, the transcript may be used as if signed.</p> <p>21</p> <p>22 Yours,</p> <p>23 Veritext Legal Solutions</p> <p>24</p> <p>25</p>

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1 BRANDT, et al. vs. RUTLEDGE, et al.  
 2 5/26/2022 - Stephen B. Levine (#5163591)  
 3 E R R A T A S H E E T  
 4 PAGE\_\_\_\_ LINE\_\_\_\_ CHANGE\_\_\_\_  
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 24 Stephen B. Levine Date  
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1 BRANDT, et al. vs. RUTLEDGE, et al.  
 2 5/26/2022 - Stephen B. Levine (#5163591)  
 3 ACKNOWLEDGEMENT OF DEPONENT  
 4 I, Stephen B. Levine, 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 Stephen B. Levine Date  
 13 \*If notary is required  
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS  
 15 \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.  
 16 \_\_\_\_\_  
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[draconian - emotional]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, 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.

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# Exhibit 7

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

(313) 414-4460. Lawrence\_Przybysz@mied.uscourts.gov

Proceedings recorded by mechanical stenography.  
Transcript produced by computer-aided transcription.

APRIL DEBOER, ET AL.,  
Plaintiffs,  
v.  
RICHARD SNYDER, ET AL.,  
Defendants.

HONORABLE BERNARD A. FRIEDMAN  
No. 12-10285

\_\_\_\_\_ /

**BENCH TRIAL**

**Monday, March 3, 2014**

**Appearances:**

FOR THE PLAINTIFFS: LESLIE COOPER, ESQ.  
CAROLE M. STANYAR, ESQ.  
DANA M. NESSEL, ESQ.  
KENNETH MOGILL, ESQ.  
ROBERT SEDLER, ESQ.

FOR THE DEFENDANTS: TONYA C. JETER, ESQ.  
KRISTIN M. HEYSE, ESQ.  
JOSEPH E. POTCHEN, ESQ.  
MICHELLE BRYA, ESQ.  
BETH M. RIVERS, ESQ.  
ANDREA J. JOHNSON, ESQ.  
MICHAEL L. PITT, ESQ.

- - -

To obtain a certified transcript, contact:  
Lawrence R. Przybysz, MA, CSR, RPR, RMR, CRR  
Official Federal Court Reporter  
Theodore Levin United States Courthouse  
231 West Lafayette Boulevard, Room 718  
Detroit, Michigan 48226

Bench Trial  
Monday, March 3, 2014

Bench Trial  
Monday, March 3, 2014

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**I N D E X**

- - -

<u>Defendant's Case in Chief</u>	<u>Page</u>	<u>Vol.</u>
<b>Mark Regnerus, Ph. D.</b>		
Direct Examination By Ms. Heyse:	6	1
Certification of Reporter .....	118	

1 Detroit, Michigan

2 Monday, March 3, 2014

3 1:00 p.m.

4 - - -

5 **THE COURT:** Thank you. You may be seated,

6 who is the next witness?

7 **MR. POTCHEN:** Before we begin, I would like

8 to apologize I didn't bring this up before the break. Mr.

9 Girgis was on the stand and he authenticated the book,

10 What is Marriage? And we would like to move to admit this

11 book. I mean, he's still in the courtroom if you would

12 like to ask any questions about that. But to the extent

13 that this Court ruled regarding his qualifications for an

14 expert, we understand that, but --

15 **THE COURT:** I will admit it for the sole

16 purpose -- is that he testified that this was his book and

17 that this is a copy of that book. It was part of the voir

18 dire to see whether or not he could testify.

19 **MR. POTCHEN:** Thank you, your Honor. And

20 that's Defendant's Exhibit Number Four.

21 **THE COURT:** Very well. Okay.

22 **MS. HEYSE:** He is just right in the hall.

23 **THE COURT:** No worries. As I said, both

24 side -- collegiality in terms of timing.

25 **MS. HEYSE:** Thank you, your Honor.

**THE COURT:** Be kind enough to raise your hand.

- - -

**MARK REGNERUS, PH. D.,**  
being first duly sworn by the Court to tell the truth, was examined and testified upon their oath as follows:

**THE COURT:** Come in and have a seat. Get comfortable. when you have had an opportunity to be seated, give us your full name and spell the last name, please.

**THE WITNESS:** My name is Mark Regnerus. Last name spelling, R-e-g-n-e-r-u-s.

**THE COURT:** Thank you, very much. You may proceed.

- - -

#### DIRECT EXAMINATION

**BY MS. HEYSE:**

**Q.** Good afternoon, Doctor Regnerus.

**A.** Good afternoon.

**Q.** Doctor Regnerus, where are you employed?

**A.** I'm employed at the University of Texas at Austin.

**Q.** And what do you do there?

**A.** I am an Associate Professor in sociology In the Sociology Department.

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**Q.** Do you hold any other titles at the University of Texas at Austin?

**A.** I am a research associate in the Population Research Center.

**Q.** And are you tenured?

**A.** I'm tenured.

**Q.** And when were you tenured?

**A.** I was tenured in 2007.

**Q.** And what are your duties with respect to the positions that you hold at the University of Texas?

**A.** I am responsible for up to four courses per year, administrative duties. In terms of committees, chairs and sitting on the committees, like admissions and things like that.

**THE COURT:** Like admissions? That is the most important one, you would think.

**THE WITNESS:** Right. And I expected to have an ongoing research agenda.

**BY MS. HEYSE:**

**Q.** You mentioned you teach some courses at the university?

**THE COURT:** I didn't hear the question.

**BY MS. HEYSE:**

**Q.** You mentioned that you teach --

**THE COURT:** Pull the microphone closer.

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Probably the base so you don't have to worry about moving it. Perfect.

**BY MS. HEYSE:**

**Q.** You mentioned, Doctor, that you teach some courses at the university. Can you tell us little bit about those.

**A.** My primary course is the Introduction To Sociology for undergraduates. It's a large course. Basically it covers the fundamentals of the discipline. And then I will teach as my secondary course sometimes I will teach a graduate course in how to write for the social sciences. And sometimes I will teach a sociology and religion course. I came in teaching because I'm interested in sociology and religion, back in 2002. So I still teach classes on it occasionally. But intro is my primary.

**Q.** And you mentioned you have some administrative responsibilities. Can you explain that a little bit more?

**A.** Right. This semester I am on the, this year I'm on the Admissions Committee Team. We review people who apply for the graduate program in sociology, offer admission to some of them. And the Executive Committee which is sort of, we give counsel to the Chair of the Department on certain matters that come before their attention. So, this is the kind of committee work we are talking about.

**Q.** Okay. Thank you. Can you tell us little bit about

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your educational background --

**A.** My Master's and Ph.D. is from the University of North Carolina, Chapel Hill, in sociology.

**THE COURT:** Where? Blue?

**THE WITNESS:** North Carolina. Sky blue. Not dark blue.

**THE COURT:** That's right. I was just there last week on the campus.

**A.** Nice. Prior to that time I had my undergraduate degree at Trinity Christian College, a small liberal arts school outside Chicago, also in sociology.

**Q.** What does the study of sociology entail?

**A.** Sociology is about sort of the influence of social forces on human behavior and then also how people, how they operate in sort of social groups and things like that and sort of the influence of sort of how social structures change or don't change. And but then within that there are, you know, dozens of sort of subdisciplines where people focus their attention one, say, for example, religion or family or the economy and like that.

**Q.** And where do you tend to focus your attention, Doctor Regnerus?

**A.** In my research?

**Q.** Yes?

**A.** As I said, I started at University of Texas

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1 interested in sociology of religion, mapping religious  
2 influences on human behavior with an emphasis on teenagers  
3 because I was interested in the data from the National  
4 Longitudinal Study of Adolescent Health based at the  
5 University of North Carolina where I went to school. But  
6 I drifted away from that over the last few years. I wrote  
7 on religious influences on adolescent sexual behavior. At  
8 that point I became interested in sort of the study of  
9 sexual relationships and relationship formation. And so  
10 that's what I have done since then.

11 Q. Can you give the Court an overview of your  
12 employment history before coming to the University of  
13 Texas?

14 A. Right. After I finished my Ph.D. in 2000 I was  
15 employed for a year as a research associate at the  
16 University of North Carolina. And then I went to Calvin  
17 College in Grand Rapids for a year. I was the director of  
18 the center for social research. And then from there I  
19 went to Texas in 2002.

20 Q. You mentioned you teach an introduction to sociology  
21 course at the University of Texas. What are some of the  
22 topics that are covered in that particular course?

23 A. We give, I should say I gave introduction to the  
24 basic research methods for sociologists, what sociologists  
25 do. But then we go through some of the kinds of the key

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1 aspects of sociology -- the socialization, how people  
2 learn things, culture, what it is, how it changes, social  
3 structure and how things change very slowly and often not  
4 at all. And then we get a little bit later in the  
5 semester we hit on things like family, population change,  
6 some of the sort of more focused areas within sociology.

7 Q. Does that course touch on the issues of same sex  
8 marriage or parenting?

9 A. It does. Not extensively so, but it does.

10 Q. Have you published any peer review articles?

11 A. Yes. About 30 to 32, somewhere in there. 31.

12 Q. Do any of them deal with issues that are relevant to  
13 this trial?

14 A. Yes. A few.

15 Q. And how are they relevant?

16 A. One is on the New Family Structure Study which is --  
17 that was something I published in 2012 which I'm sure we  
18 will talk about. And the follow up which was not peer  
19 reviewed but it was a response to critics of the original  
20 study. So those are the two primary.

21 Q. Aside from those that specifically address  
22 children's outcomes, what we are going to talk about  
23 today, do you have -- to any of those address more general  
24 topics of say, parent/child relationships?

25 A. Uh-huh.

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1 Q. And how many those touch on that topic?

2 A. I think there are roughly six, six or seven that  
3 talk about the relationship between parent and children  
4 and especially the quality of interaction between parent  
5 and child.

6 Q. Do any of the peer reviewed articles address the  
7 topic of social science research methods?

8 A. Right. Probably five or six would be characterized  
9 as being about methods or methodological novelties, ways  
10 of asking certain questions in different ways, yeah.

11 Q. Have you published any books, Doctor Regnerus?

12 A. I published two books.

13 Q. What are the topics of those books?

14 A. The first one which I briefly mentioned earlier was  
15 on -- it's called Forbidden Fruit: Religion In The Lives,  
16 Religion Sexual Behavior In The Lives Of American  
17 Teenagers. That was 2007 from Oxford. The second one was  
18 called Pre-Marital sex in America: How young Americans  
19 meet, mate and think about marrying. That was 2011 from  
20 Oxford.

21 Q. And were your books well received by your peers?

22 A. Generally speak, yeah. I had multiple reviews in  
23 journals about those books. I think the last book had  
24 one, you know, mediocre review but it had four or five  
25 positive reviews.

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1 Q. Have you ever been asked to review other peers'  
2 work?

3 A. Yes.

4 Q. And how many times have you done that?

5 A. For journal article peer review I have done at least  
6 three times as many as I have published. So, somewhere  
7 between 90 and 120 I would say over the last 12 years.

8 Q. Just out of curiosity have you done any peer review  
9 work since the release of the NFSS study?

10 A. Yes.

11 Q. Have any -- has any of your peer review work covered  
12 the issues of marriage or same sex marriage?

13 A. Same sex relationships, yes.

14 Q. Have you given any presentations, Doctor Regnerus?

15 A. I have.

16 Q. How many have you given?

17 A. Probably somewhere between 50 and 60, I would say.

18 Q. And what topics?

19 A. Oh, all manner of topics. As I said earlier my  
20 research interests have changed somewhat. Most of the  
21 articles that I have published are those 30, I had  
22 presented in conference format at least at some point or  
23 another, so --

24 Q. Have you received any awards or recognition for your  
25 work?

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1 A. Yes.  
2 Q. Okay. And what type of awards or recognition have  
3 you received?  
4 A. It's listed in the CV in detail. But 2001 there was  
5 ASA Section, the American Sociological Association section  
6 on religion through a paper award for the year. I think I  
7 won the ASA sections, Religion Section Student Award at  
8 one time and I think was runner up a couple times in the  
9 crime law and deviance section of the ASA student paper.  
10 Q. And that's the American Sociological Association?  
11 A. That is.  
12 Q. ASA?  
13 A. Yes.  
14 Q. How many studies or data collection efforts have you  
15 collected?  
16 A. I have been a part of probably five or six data  
17 collection efforts. National Longitudinal Study of  
18 Adolescent Health and National Study for Family Growth.  
19 They each asked me to play a minor role in different  
20 points in consulting on their survey questionnaire in one  
21 particular section of that. The National Study Of Youth  
22 And Religion I was more of a key part in that. Then the  
23 New Family Structure Study one I was principal  
24 investigator of. So I would say at least five in general  
25

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1 that I have been part of either in a minor way or an  
2 extensive way. A project on religion and H.I.V. AIDS in  
3 Africa. That was several years ago. That was -- I was  
4 the co-investigator of that.  
5 Q. You touched on this a little bit, but how many of  
6 these studies were you the principal investigator?  
7 A. Either principal or co of two, I would say.  
8 Q. Are you affiliated with the Austin Institute for the  
9 Study Of The Family And Culture?  
10 A. I am.  
11 Q. And how are you affiliated?  
12 A. I am a senior fellow.  
13 Q. And what does the Austin Institute do?  
14 A. We conduct research, social science research on  
15 matters related to family, marriage, sexual behavior, that  
16 general orbit of things.  
17 Q. When did you become a senior fellow?  
18 A. I think it was late summer, early fall of 2013.  
19 Q. Okay. And how did you get that position?  
20 A. I was part of the founding of that institute and so  
21 in discussion with other people who helped found it, it  
22 just made more sense for me to have a senior fellow  
23 status, not in the sort of the running of the day-to-day  
24 of it.  
25 Q. What does being a senior fellow entail?

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1 A. I give ideas to the staff about things that they  
2 should consider studying. There is a research associate  
3 or research assistant, I guess, that we co-author pieces  
4 with and he crunches numbers and I give him ideas about  
5 what he should consider doing. So it's ideation mainly, I  
6 would say.  
7 Q. Can you give an example of the type of work that you  
8 do at the Austin Institute?  
9 A. Well, we have -- one of the things we are interested  
10 in doing is sort of getting information out in creative  
11 ways speaking not just sort of the standard journal format  
12 but based on my suggestion and encouragement they created  
13 an animated video of about nine minutes that focuses on  
14 the dynamics of the mating market.  
15 THE COURT: What kind of market?  
16 THE WITNESS: The mating market. How people  
17 meet and fall in love and some marry or some don't. So  
18 that went up live in February and it's already got about  
19 300,000 views. So, things like that. But also sort of  
20 regular academic papers. We call them research shorts  
21 where the research assistant will crunch some numbers and  
22 write a brief kind of on-line abstract of certain ideas.  
23 Q. And just for the record, where is that available?  
24 A. These things are on the web, the Austin students'  
25 website.

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1 Q. Okay. Have you spoken to any legislature or  
2 legislative officials?  
3 A. I think it was back in November. I am not totally  
4 sure about the date of 2013, some Hawaiian legislators, I  
5 went out and talked to. I think there were four of them  
6 in advance of their, I think they had the same sex  
7 marriage bill going through both their house and Senate.  
8 Q. What was the purpose of your speaking with them?  
9 A. They wanted to ask me questions about the New Family  
10 Structure Study and my awareness of other population based  
11 projects going on in the area about that.  
12 Q. And have you written or signed any Amicus briefs  
13 regarding --  
14 A. I have.  
15 Q. -- regarding same sex marriage?  
16 A. I have.  
17 Q. At this time, if you will look at that very large  
18 binder next to you and open it up to the tab for Exhibit  
19 Five?  
20 A. My CV?  
21 Q. Yes. Can you identify that for me, Doctor Regnerus?  
22 A. Yes. That's my Curriculum Vitae.  
23 Q. I'm sorry?  
24 A. My Curriculum Vitae.  
25 Q. Does that appear to be a true and accurate copy of

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1 your Curriculum Vitae?  
2 **A.** Yes.  
3 **MS. HEYSE:** Your Honor, I move for admission  
4 of State Defendant's Exhibit Number Five.  
5 **THE COURT:** Any objection?  
6 **MS. COOPER:** No objection.  
7 **THE COURT:** Received.  
8 **BY MS. HEYSE:**  
9 **Q.** Doctor Regnerus, can you explain the areas of  
10 expertise you will be testifying about today?  
11 **A.** I will be testifying about sociology in general,  
12 survey research methods and measurement of sexual  
13 relationships and I presume the New Family Structure Study  
14 and its articles.  
15 **Q.** Thank you. And more specifically within those areas  
16 of the expertise, have you been asked to provide your  
17 expert opinion regarding outcomes for children being  
18 raised in same sex households, correct?  
19 **A.** Yes. That's correct.  
20 **Q.** And did you, in fact, conduct a study called The New  
21 Family Structure Study the acronym NFSS?  
22 **A.** I did.  
23 **Q.** Did that study look at adult outcomes among children  
24 whose parents reported having a same sex relationships?  
25 **A.** I looked at adult children who reported their  
  
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1 small of samples to actually detect differences between  
2 groups which tended to be a problem certainly when you  
3 think about studies that compare 18 kids. And, I mean,  
4 you are just not going to have enough cases to detect real  
5 differences that maybe exist in the population.  
6 Statistically you can't do that. So we want to collect a  
7 large population data set because there is not many of  
8 them on this broader topic.  
9 **Q.** And what were your general findings?  
10 **A.** Our general findings were that.  
11 **MS. COOPER:** Objection. The witness has not  
12 been qualified as an expert yet.  
13 **THE COURT:** Yes. The objection is sustained.  
14 He has gotten a little bit further.  
15 **MS. HEYSE:** Thank you, your Honor. Two  
16 things, your Honor. I forget at the outset to provide you  
17 with a copy.  
18 **THE COURT:** That's great. Just hand it to  
19 me.  
20 **MS. HEYSE:** I apologize.  
21 **THE COURT:** Nothing to worry about. Thank  
22 you.  
23 **MS. HEYSE:** And, second, then at this time,  
24 your Honor, I move to qualify Doctor Regnerus as an expert  
25 in the area of sociology, and, more specifically, the  
  
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1 parents have had same sex relationships, yes.  
2 **Q.** And the outcomes for those individuals?  
3 **A.** Yes. But it was not the parent who reported the  
4 relationship. It was the child.  
5 **Q.** Thank you for clarifying.  
6 **A.** Adult child.  
7 **Q.** Can you tell the Court what methods you followed  
8 with regard to the NFSS? What type study was that?  
9 **A.** Right. This was a large survey. We screened 15,058  
10 people, asked them a series of questions. The key focus  
11 here was the question whether their mother or father,  
12 while they were growing up, whether the mother or father  
13 ever had a romantic relationship with a member of the same  
14 sex. And we then interviewed extensively across a lot of  
15 different domains, 2,988 people, including everyone who  
16 said yes to that particular question. And then I analyzed  
17 that data.  
18 **Q.** And why did you follow those methods? Is this a  
19 typical or standard --  
20 **A.** Right. I don't think it was typical or standard.  
21 In this domain of study there are not very many very large  
22 population based samples out there because we are talking  
23 about a fairly small population to begin with. So, the  
24 interest was in sort of collecting a large enough number  
25 of cases so that you didn't encounter a problem with too  
  
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1 sociology of sexual behaviors.  
2 **THE COURT:** Okay. Counsel, do you have any  
3 objection or voir dire?  
4 **MS. COOPER:** No objection.  
5 **THE COURT:** You may proceed.  
6 **MS. HEYSE:** Thank you, your Honor.  
7 **BY MS. STANYAR:**  
8 **Q.** Doctor Regnerus, I want to start out talking about  
9 sampling and general research methods terminology. Okay?  
10 What is population based data?  
11 **A.** Population based data is about the sampling that is  
12 involved in this. There two broad different types of  
13 sampling strategies when you want to talk -- to get  
14 information about a group of people. There is probability  
15 based sampling and there is non-probability based  
16 sampling.  
17 So, for example, if I wanted to get a population  
18 based sample of the City of Detroit, you would want  
19 everyone in Detroit to have an equal chance of being in  
20 it, in your sample. So that's a probability based study  
21 of a particular population. So you note underlying  
22 population and then you can generate meaningful estimates  
23 and statistics because the underlying population you are  
24 trying to map is known. That's different than  
25 non-probability based studies which might want to get at a  
  
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1 population but the methods they use don't allow them to  
2 generalize to a larger population.

3 Q. Would an example of a population based probability  
4 study be one that's nationally representative?

5 A. A nationally representative study would be, its  
6 population that speaks to, you know, the nation, right?  
7 So, there are a variety of these kinds of studies out  
8 there, sure.

9 Q. That would be one type?

10 A. Uh-huh.

11 Q. And you touched a little bit on a non-probability  
12 sample. Would an example of a non-probability sample be a  
13 convenient sample?

14 A. Yes, correct.

15 Q. Okay.

16 A. Convenient samples are a type of non-probability  
17 sample where you pick, I mean, you use variety of means to  
18 sort of collect the people that are going to be in your  
19 study. It could be, you know, like you go in a coffee  
20 shop and you can pull off a tab. Would you like to be in  
21 this study? Or you see a billboard. We would like you  
22 for this study. That is a convenient sample. People opt  
23 into that. And since it's not really known what is the  
24 underlying probability that they would be picked randomly,  
25 it's difficult to generalize that to the broader

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1 32 year olds. What I can say is I have learned something  
2 about the lives of these people. What I can't know from  
3 it is how similar they are or how different they are from  
4 all 24 that 32 year olds. From that kind of thing and  
5 hopefully in the same book, I lean on probability,  
6 nationally representative samples, survey data. So, it's  
7 more, for me, that provides color commentary. You can go  
8 in-depth in people's lives and things like that but you  
9 don't get a sense of what is going on among the large  
10 group that way.

11 Q. So, in your opinion, should these convenient samples  
12 be used to render opinions in social science?

13 A. Not exclusively. I mean, they can inform us about  
14 aspects of people's lives and relationships but I don't  
15 think you should make major decisions without getting a  
16 sense of the underlying population and especially leaning  
17 on national representative data.

18 Q. So there a better method for rendering opinions in  
19 social science?

20 A. I think it's unwise to make major decisions without  
21 leaning on large population based nationally  
22 representative studies especially if you have something  
23 that is -- has more of a broad or national scope to it.  
24 Sure.

25 Q. So is there such thing as an ideal study?

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1 population that you might be after.

2 So there is convenient samples, too, that are --

3 we call them snowball samples where if I said I want to  
4 talk to -- I want to survey Red Wings fans, you talk to  
5 one, you say, do you know any other ones? My brother.  
6 You talk to the brother. It's a snowball. You pick up  
7 cases along the way. So, you know, that's not a  
8 probability sample because not everybody has an equal  
9 chance of being in it. They are opting in based and on  
10 their own self selection and observation about it. So  
11 it's not able to tell us about the real population that  
12 you are after like a probability study can.

13 Q. Okay. If these convenient sample studies are not  
14 able to tell you about the population as a whole, why are  
15 they used?

16 A. Well, there are different things you can learn from  
17 convenient samples and I have used them in my own research  
18 in the past. I mean, depends on what you purported to do  
19 with them, right? So the book I am slowly working on, we  
20 talked to a hundred different 24 to 32 year olds. We  
21 wanted 50 men, 50 women. So we call that a quota sample.  
22 Right? And we didn't use some sort of random method to  
23 get them in. We just want different people of different  
24 kinds of jobs. And so it was a quota sample. But I can't  
25 generalize from that to knowing something about all 24 to

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1 A. Depends on what the purpose -- what you are trying  
2 to accomplish. But ideal studies of this sort would be  
3 large. I mean, you say how large? Large enough so that  
4 you could analyze, you can create sub-samples that are not  
5 ten or fifteen people large. You know, hundreds and  
6 hundreds of cases drawn from a sampling strategy where  
7 everybody in the underlying population you are trying to  
8 get at has an equal chance of getting in, equal chance of  
9 weighing in. I think that's the fairest way.

10 Q. Would an ideal study be a random sampling?

11 A. Yes.

12 Q. Okay. Why is that important?

13 A. Random is just sort of, do the people who make up  
14 this population have a equal shot at being part of it? I  
15 think that's what random is about. And I think it's a  
16 good thing, otherwise people, if people just opt in you  
17 don't hear the average person. You hear the people who  
18 are most interested in signing up for the study.

19 Q. And in the ideal study, it would be representative?

20 A. It would be representative of the underlying  
21 population that you are trying to --

22 Q. Would it be longitudinal?

23 A. Ideally, yes. I mean, the benefits of measuring  
24 people over time and revisiting them is a helpful thing.  
25 You can see how they changed. And you can see how, you

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can see how people change or how trends emerge or fade over time if you talk to the same people or you give the same questions over ideally many years. I mean, one of the better studies that we hear about regularly is the general social survey. They ask the same questions, some of which get out of date. They asked the same questions since 1972. So you can kind of map how --

**THE COURT:** Who is they? Who does that study?

**THE WITNESS:** The National Opinion Research Center at University of Chicago.

**A.** So quite often when you see in the newspaper some sort of social survey, some change in American views on this, that or the next thing, it will be from the general social survey. It's not asking the same people but it's asking a different group of people the same question over, every two years for since 1972.

**BY MS. HEYSE:**

**Q.** Would your ideal study also be replicable?

**A.** Ideally, yes. You know, when I have created survey questions I will often sort of lean on other people who have asked them so that if they have a national representative survey and I have one, we can ask the same question and you can compare them over time. So, replicability is ideal.

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what you can know from convenient samples.

**Q.** So would it be fair to say can you learn a lot about individuals that are being studied?

**A.** Is it fair to say -- I'm sorry?

**Q.** You can learn a lot about the individuals being studied?

**A.** Sure.

**Q.** But not necessarily about the population or the nation as a whole?

**A.** Correct.

**Q.** Okay. In social science research is it important to have a clearly defined comparison group before you draw a conclusion regarding differences between those two groups?

**A.** Right. It's ideal. And people will disagree on the construction of the comparison groups, but what you want to be as clear about who is in this and who is not in this so that when other scientists come along and read your data they can sort of say, I see how you made that group and I agree or disagree or I think we should do it a different way.

**Q.** What are controls in social science research?

**A.** Controls. Okay. So, when we talk about regression models, when we predict an outcome based on a set of independent variables or a set of effects, usually we have in mind like the thing we are most interested in, like

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**Q.** Why is that important?

**A.** So that you can sort of assess changes or trends, surveys questions. You first want them to be valid, good, that they measure what they purport to measure. But seconding you want them to be comparable which is what is replicability is about.

**Q.** And why is this ideal study that you described better than the convenient sample studies?

**A.** I'm sorry. Could you say that again?

**Q.** Why is the ideal study that we just talked about random, representative, longitudinal, replicable? Why is that better than these convenient sample studies?

**A.** Because you actually know something about the underlying population you purport to talk about. So, what happens often is, and in a lot of convenient samples they don't claim to do this, but people still tend to interpret their data in that way because you see a study and you automatically kind of mentally accord it, this is a study of all such and such. Even if they don't, even if the creators of the study are not claiming that. But a convenient sample is like we learn something about who is in the sample. Since we don't know their likelihood of inclusion because it's not a probability sample, we don't know if what they are like is what the underlying population is like. So, there are some limitations to

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what is the effect of X and Y? Net of other things, right? When you say net of other things you are talking about a set of controls. Usually sometimes they are standard. Sometimes they are just things that you think may influence an outcome but that are not critically important to what you are interested in. So that what we call controls. And most regression models employ some sort of series of controls when they are doing that.

**Q.** And why are they used?

**A.** In part because you want to sort of test sort of the influence of X on Y and you might be hypothesizing it exists independently of this set of controls. So, but it's usually sort of a standard set of demographic things you will often see. Other things that might affect the outcome but that are not of interest to you or different -- there is no sort of established protocol about what must be a controlled variable in models. I mean, some -- there are disputes in sociology, like should you have 20 control variables? Some people call it everything but the kitchen sink. Other people say, no, we don't have all of those. Focus on just a handful. So there is no protocol, but it's a common practice.

**Q.** What are some the standard or common controls that you mentioned?

**A.** Age, like as people age, they tend to do different

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1 things or think different things. So, gender or sex,  
2 male, female, race and ethnicity and that's the sort of  
3 the -- in sociology we often do mother's education as a  
4 proxy for social class of the family. Income, if you know  
5 it, although a lot of people don't like to report their  
6 income. So sometimes that can be a little tricky. But  
7 there is a standard -- those are standard controls.  
8 Q. Okay. Let's turn now to the American Psychological  
9 Association's position with regard to outcomes for  
10 children. Are you familiar with their No Differences  
11 Claim?  
12 A. In general, yes.  
13 Q. Do you have an opinion on that No Difference Claim?  
14 A. I think it's premature. In the social science of  
15 family which I have monitored off and on since I have been  
16 in graduate school I have not been actively into it until  
17 the last several years. But things historically did not  
18 change very quickly in the study of families and parents  
19 and things like that. But they seem to have changed  
20 rapidly in the last ten or fifteen years. And such that  
21 it seems premature to say that something that involves a  
22 reduced kinship, meaning somebody is not a biological  
23 parent to the child, to claim there are no differences.  
24 And it's important to clarify what the No Differences is  
25 against.

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1 criticize the psychologists here, but I think it's wise if  
2 you are going make a statement on No Differences that you  
3 would want a variety of probability sample studies to be  
4 weighed in that. So there are more non-probability  
5 convenient samples studies than I would want to lean on in  
6 making that claim.  
7 Q. Okay. And do these non-probability convenience  
8 sample studies tend to be small in size?  
9 A. Not all of them. But most them, typically well  
10 under a hundred. Sometimes 78 or 44. Yeah. Typically  
11 under a hundred.  
12 Q. Okay. And what is the problem with the small sample  
13 size?  
14 A. The small sample size issue is, do you have, they  
15 call it statistical power, do you have the power to detect  
16 real differences that might exist in the population but --  
17 and the smaller the sample size, the more difficult it  
18 becomes to detect real differences. So you could, if you  
19 had 20 cases of something versus 20 other cases, you could  
20 say we don't detect any statistical difference between  
21 this group of 20 and this group of 20. You could look at  
22 face value, you can look at the numbers and they could  
23 look dramatically different but they are not statistically  
24 different because they are, it's called type two error,  
25 the ability to detect statistically what might exist in

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1 But it suggests there is no differences between  
2 a parenting unit that, at least in one case, it lacks a  
3 genetic link to a child compared to parent units where  
4 there is a mother and a father and they are both the  
5 parents of that child and they stay in that relationship  
6 together. That had long been considered. I mean, in 1994  
7 I think it was McLanahan and Sandefur in Wisconsin. And  
8 this was not a study of same sex parents, but it was about  
9 single parent families. And they said, if we were going  
10 to design the ideal family, I mean, we would pick this  
11 sort of two parent ideal where there is two genetic  
12 connections to the child, two sources of -- resources for  
13 the child and security and things like that.  
14 So just to watch the social science discourse  
15 change so rapidly on this subject struck me as  
16 unscientific, premature, and worth -- I mean, scientists  
17 are nothing if not tending to be a little skeptical when  
18 people purport rapid change in a paradigm. So it just  
19 strikes me as premature.  
20 Q. What type of studies does the APA rely onto support  
21 this No Differences Claim?  
22 A. There are probably other people who could speak to  
23 that a little more clearly. But my read on it is when it  
24 was issued, there was primarily non-probability samples.  
25 More psychology than sociology. And I'm not trying to

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1 reality. So the smaller the sample size, the higher the  
2 risk of making that kind of error is. So, the known  
3 hypothesis, when you look at groups, you say there is no  
4 differences, but you can make a mistake in saying I see no  
5 differences when there actually exists -- your sample size  
6 is too small to detect them.  
7 Q. Would it be fair to say that bigger is better for  
8 purposes of statistical power?  
9 A. Generally bigger is better.  
10 Q. Do the studies that the APA relies on, what type  
11 comparison groups do they use?  
12 A. That also varies widely. Some of the No Differences  
13 Claims have been about -- one I can remember is a matched  
14 sample of comparable sort of social demographics, but that  
15 was one of the Patterson pieces that exactly used the 44  
16 cases in the Ad Health Study which is a probability study.  
17 But the comparison group was some matched sample  
18 out the same study, but they didn't tell us what they were  
19 like. Right? I mean, were these kids from single parents  
20 or kids from step-parents? Have they had household  
21 transitions in their lives? They didn't say. So some of  
22 them are more clear about their comparison category being  
23 heterosexual single mothers or heterosexual step-parents  
24 arrangements. But in those studies there has been wide  
25 variety of comparison groups used. Not -- I mean there is

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1 not one stable reliable comparison group.

2 Q. You mentioned this earlier, and I wanted to make

3 sure it's clear for the record, you referred to something

4 called reduced kinship. Can you explain what that is?

5 A. Right. Reduced kinship is sort of the basic idea

6 that when a biological mother and father are not raising a

7 child together in the same household, some guys go off to

8 the military, so, I mean, there is still an intact family

9 even though dad or whoever is gone. But where the family

10 has been broken up, the mother, biological mother, and

11 father are not actively in, you know, raising the child

12 together at the same time.

13 Q. Do you have any opinion with regard to children

14 being exposed to reduced kinship?

15 A. I think it's not the ideal. Now, we certainly

16 didn't necessarily forbid diminished kinship

17 relationships, obviously. But states typically consider

18 them as concessions to, ideally -- I think about foster

19 care. There is always that impulse to get foster children

20 back in the household with their mother and father. And

21 so far as that is possible, states wish to do that.

22 That's sort of this longstanding interest in kinship

23 structure.

24 Q. So just to be clear, are you saying that either

25 step-parenting or adoption are bad things?

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1 of these same sex parents relationships, there is reduced

2 kinship, I mean, almost by definition there, right? So

3 there is an impulse to compare them to something

4 comparable. At the same time, one runs the risk in this

5 declaring there is no difference in forgetting to compare

6 them to sort of kinship structures that are in tact and

7 original, biological. So I think we run the risk of not

8 remembering the structure that has been historically best

9 for children. So then when you get claims like No

10 Differences, I think they, you know, people hear this and

11 think they are just like anybody else. Well, anybody else

12 perhaps of diminished kinship structure which is not

13 ideal.

14 Q. Are there also issues with source bias in these

15 small convenient samples relied on by the APA?

16 A. Yes. Source bias is who is doing the reporting on

17 the child in the study? Some of the times you are talking

18 about children who are young, too young to report for

19 themselves so the parents will report. But parents, you

20 when parents are talking about their kids and their

21 well-being, you know, I know about my kids. I am more apt

22 to paint them publicly as better than they, right? I say

23 my kids are good, right? But there is an impulse in

24 reporting about one's children to feel social desirability

25 bias, the impulse to say things about them that may not be

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1 A. I am not saying they are bad things. I am saying

2 they are typically recognized as concessions, sometimes

3 necessary, but sort of not the ideal what people want for

4 a child typically.

5 Q. What is the ideal.

6 A. Married, mother and father, stably residing with the

7 child.

8 Q. And why is that better than a reduced kinship

9 relationship?

10 A. Well, better largely in the data historically but

11 also back to that McLanahan and Sandefur comment, they

12 talk about biological parents are less likely to abuse or

13 harm a child. It doesn't mean they never do, but on

14 average, they are less likely than a step-parent

15 relationship. More likely to sacrifice for that child.

16 And just, in general, children flourish better in

17 households where mom and dad are together and married.

18 Q. Turning back now to the studies that the APA relied

19 on. Did some of those studies use a comparison group with

20 reduced kinship?

21 A. Yes. I mean, many of them did. There was no

22 consistent -- there is not a consistent category that was

23 used as a comparison.

24 Q. Do you see this as a problem or --

25 A. I understand the impulse because there is, in a lot

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1 completely a hundred percent accurate.

2 So, that improves if you talk to say, teenagers,

3 about themselves. Right? Teachers, teachers often can

4 give what I call a little more objective perspective

5 although teachers have their own biases, but it's probably

6 ideal to wait until, I think to wait. That's why we did

7 to wait until they are out house so they can reflect on

8 their own lives and speak for themselves.

9 Q. So, Doctor Regnerus, are you saying there is no

10 benefit to the type of studies that the APA relied on?

11 A. I am not saying there is no benefits. Different

12 studies seek to do different things. Some studies kind of

13 are social psychological aspects of parent/child

14 relationships or parenting processes. So you can learn a

15 lot from the dynamics of different families from

16 convenient sample studies. What you cannot know is how

17 much they reflect an underlying population. So, if you

18 had ten same sex couples in a convenient sample you can

19 know a lot about those ten, but can you know how similar

20 those ten are to same sex couples s everywhere? I would

21 said the answer is no, not from a non-probability study.

22 Q. So given that critique, in your opinion, what type

23 of study is needed to definitively conclude there is no

24 difference?

25 A. What kind of study is needed?

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1 Q. Yes.

2 A. A study as far as I am aware has not been done yet.

3 The science in this domain as I said is new. People have

4 been studying this for a while but just in the last year

5 several years we have kind of started getting questions on

6 it and to national representative studies. I have a

7 longitudinal study, something that tracks kids from, I was

8 going to say from birth, but really you want people from

9 before, when parents meet or get together, and track them

10 through the birth of children into ideally into their

11 adulthood and interview every few years.

12 So, and a large -- that would be a large study,

13 a national representative study. I mean, it reminds me

14 of, you know, day care was -- the affects of day care and

15 kids is people have all sorts of opinions about that, but

16 several years ago there was finally this Omnibus study of

17 day care that had come to fruition, meaning they had done

18 several different waves of this talking to parents,

19 watching children, etc. So, it kind of clarified the story

20 about day care and people's lives, kids' lives, that I

21 think would be ideal and necessary really to get a sense

22 of whether the No Differences line is true or with respect

23 to what kind of kinship structure are we talking about No

24 Differences.

25 THE COURT: What did the study say about day

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1 those, 2000 some odd other people from different kinds of

2 household experiences, and asked them 80, 100 plus

3 different questions about their life in the past, their

4 relationship with their parents, mother, father, how their

5 life is going now, questions about their employment

6 status, any interaction with the Criminal Justice System,

7 education. I think I had a question or two on religion.

8 A series of questions on sexual behavior. Just kind of

9 across the spectrum set of questions.

10 Q. Okay.

11 A. What was your original question? Did I answer it?

12 Q. Yes, you did. That's fine. What were your general

13 findings with regard to that study?

14 A. My general findings with regard to the study is, I

15 called into the question the No Differences Claim with

16 respect to the in tact biological family which is not

17 often used as the comparison category in a lot of these

18 convenient samples, when mom and dad are married, were

19 married and are married, even when the child is an adult,

20 compared to kids for whom their mother or their father had

21 had a same sex relationship. And out of 40 different

22 outcomes we evaluated including things that they reflected

23 on their childhood and things that are current today. 25,

24 I might get the details mixed up, but 25 of the 40

25 different outcomes, there was a simple statistical

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1 care?

2 THE WITNESS: You know, I don't actually

3 recall the punch lines because my kids were really small

4 and in day care. But I was thinking it was a mixed bag

5 and it was not sort of -- they are not demonstrable. I

6 think the mother/child connections were a little weakened

7 but the kids didn't seem any worse for wear academically

8 for it. And socially, they were a little bit more

9 advanced. I think that was the punch line. But I just

10 remember it being an Omnibus study of day care that people

11 have been waiting for a long time.

12 BY MS. HEYSE:

13 Q. I want to talk about the New Family Structure Study

14 and I am going refer to it at the NFSS. Again, you were

15 the principal investigator for that study, correct?

16 A. I was.

17 Q. And is this a large population based study?

18 A. It is. I mean, as large as we could make it. We

19 screened 15,000 people between the ages of 18 and 39.

20 15,058. Asked them a series of questions, one of which

21 was, you know, there are about adoption and things like

22 that. But one of which was, have your mother or father,

23 did the mother or father have a romantic relationship with

24 a member of the same sex while you were growing up with

25 another woman or another man? And we interviewed all

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1 difference and always in the favor of the in tact

2 biological family. I think 24 of those held up after,

3 meaning they were still significant with a series of

4 controlled variables. The controlled variables were age,

5 race, ethnicity, mother's education, gender, their

6 perception about their family income while they were

7 growing up, a measure of whether they had been bullied as

8 a child or during their growing up years, and a measure of

9 the gay friendliness of the state in which they were

10 residing now, measures of the different states. There was

11 scale I think the Los Angeles Times put out, one to five.

12 I used this as a control variable.

13 So even after those controls there was 24

14 differences between the kids who grew up in an in tact

15 biological family and kids for whom the mother had a same

16 sex relationship. There were fewer statistical

17 differences between kids whose father had a gay

18 relationship. Partly that is a function of the sample

19 size. We had 73 of those cases compared to 175 for the

20 mother, where the mother had a same sex relationship.

21 So when you get to smaller ends, you, of course,

22 you lose statistical power. So even if there were

23 differences, you would be less apt to detect that many of

24 them. There are fewer among the men. And they were less

25 likely to have lived with their father as well. So, then

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1 they were with their mother.  
2 And then I also compared them with kids who grew  
3 up in step-families or kids who had single parents. Now,  
4 what we did is had a household roster where we asked who  
5 did you live with at each year while you were growing up?  
6 Who was in the household? And, I mean, there is a lot of  
7 messy households out there. So even the step-parenting  
8 thing, we said, the step-parents might have come in at age  
9 16, might have come in at age two, right? Single parents  
10 where the mom never really, typically the mother, they  
11 lived with her and she didn't remarry. But we also  
12 compared kids who said their mom had a same sex  
13 relationship or the dad with kids that largely grew up in  
14 a single parent household or step-parenting household and  
15 adopted before age two. --  
16 **THE COURT:** Define same sex relationship.  
17 **THE WITNESS:** I mean, just from that screener  
18 question where we said, while you were growing up did your  
19 mother ever have a romantic relationship with another  
20 woman, I think, or it might have been phrased a member of  
21 the same sex. Did your father ever have a romantic  
22 relationship with a member of the same sex?  
23 **THE COURT:** While you were growing up?  
24 **THE WITNESS:** During your growing up years.  
25 **THE COURT:** So they may not have even been in

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1 **THE COURT:** Okay. I was just curious. Thank  
2 you. You may continue.  
3 **MS. HEYSE:** Thank you.  
4 **BY MS. HEYSE:**  
5 **Q.** I'm going to back you up a little bit, Doctor  
6 Regnerus, and talk about how the NFSS came about. When  
7 did you first begin working on the NFSS?  
8 **A.** I think it was envisioned in 2010 at some point. I  
9 want to say in the fall, but it might have been kicking  
10 around in the summer.  
11 **Q.** Go ahead.  
12 **A.** It was not my brain child, but it came out of the  
13 series of conversations that were involving me and  
14 eventually the funding agency, Witherspoon Institute,  
15 Princeton, New Jersey. And kind of the recognition that,  
16 wow, the social science here doesn't have a lot of  
17 probability based large samples, albeit, of a smallish  
18 population. There was a sense of a lot of social science  
19 here based on small samples, the non-probability samples.  
20 There should be more on large samples, probability  
21 samples.  
22 So, I was finishing my second book at that time  
23 and this was, you know, an idea that struck me as curious.  
24 So I agreed to think more about it. And then there was a  
25 meeting of several social scientists to talk about what

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1 that same household.  
2 **THE WITNESS:** They may not have been in same  
3 household.  
4 **THE COURT:** If there's divorce or separation.  
5 **THE WITNESS:** There was a great deal of  
6 separation, yes.  
7 **THE COURT:** Just curious.  
8 **A.** Just to follow up on that. The screener question  
9 was designed to be able to capture people for whom that  
10 may have been true as well as people for whom, you know,  
11 no, I was -- my mother had me by assisted reproductive  
12 technology. We didn't ask whether that was true. They  
13 could have stayed with their mother and partner during  
14 their entire growing years.  
15 So that was the product of the decision we  
16 hammered out at the beginning like how do we -- we know  
17 that like ART is not going to be common as a form of how  
18 these kids came into being, but how can we make sure that  
19 gets included even though we don't expect it to be the  
20 normative experience of kids. So that question was meant  
21 to be big enough to get in the fold everybody for whom,  
22 you know, their parents had had a same sex relationship,  
23 some of which lasted, some of which they started with, a  
24 majority of which they did not start with. They started  
25 with a heterosexual union.

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1 would social science in this domain of family look like?  
2 And out of that emerged, I mean, I proposed a project that  
3 eventually turned into the NFSS, although basically it was  
4 just this idea of we should do a big study, a big random  
5 population based study in this area. But it didn't take  
6 real shape until January of 2011 when I had gotten several  
7 consultants on board who met in Austin in January to talk  
8 about sampling strategy which was kind of a big deal  
9 because I had said, you know, the way that studies had  
10 been done before, this was non-probability samples, etc.  
11 How should we be distinctive? So the assumption in the  
12 room was, we have to have a probability sample, nationally  
13 representative.  
14 And we talked about what should be on the  
15 survey? But the primary thing was hammering out how are  
16 we going to go about getting a nationally representative  
17 sample? So I had a representative of the data collection  
18 firm that I had already figured we should go with because  
19 they are the largest in the country, present to tell us  
20 what he thought their data, I mean, the people in their  
21 sample, how many people could -- what the sample sizes  
22 would look like. So, that was January 2011.  
23 And then at spring, we wrote the survey for it  
24 and got it started in July. Most of the cases came in  
25 early because -- they can collect data rather quickly on,

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1 you know, cases that are easy to find, but we really sort  
2 of emphasized to them we want to find as many adopted kids  
3 and children who said their mother and father had a same  
4 sex relationship. So we left it in the field for quite a  
5 while. I mean, months and months until, I don't know,  
6 early 2012. Yes. Does that answer the question?

7 Q. Uh-huh. You mentioned that Witherspoon Institute  
8 funded the NFSS. Were there any -- was there any other  
9 funding for the study?

10 A. I don't know. Like half way along Witherspoon had  
11 reached out to the Bradley Foundation to see if they would  
12 help. They are in Milwaukee. Also, a socially  
13 conservative foundation. But, they said, sure, we will  
14 help. I think they paid \$90,000 for it.

15 Q. You mentioned also conservative?

16 A. Witherspoon, they are -- I think they originally  
17 started as kind of a Gradebooks Institute located next to  
18 Princeton. But they are generally socially and  
19 politically conservative. And they hadn't funded social  
20 science research but they were interested in it and  
21 excited about the study possibility and agreed to fund it.  
22 I agreed. I floated the idea and agreed to lead it if  
23 they didn't tell me how to do it, nor would they have a  
24 clue how to do, you know, a probability based survey  
25 study.

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1 my mind, a primary deliverable. And that just -- I had  
2 set deadlines for myself about when that report should get  
3 written. And I had one of my colleagues at the University  
4 of Texas had agreed to, you know, co-author that report  
5 with me. And we were going to discuss all sorts of the  
6 statistics and comment back and forth about what we saw in  
7 the data.

8 Q. Were you provided any directive from the Witherspoon  
9 Institute or anyone else for that matter about the results  
10 of the study?

11 A. No. I had told Witherspoon, well, they wouldn't  
12 have attempted to do that, but I told them I am going to  
13 tell you whatever the data says. And, frankly, I had no  
14 idea what the study would reveal.

15 Q. Doctor Regnerus, was the purpose of the NFSS to  
16 inform the debate on same sex marriage?

17 A. Not to my -- in my estimation, it was not. I say in  
18 the articles I have written about it, that it doesn't  
19 primarily address, it's not intended to address political  
20 and legal questions. I'm here addressing a legal  
21 question. But that's not its intention. It's not its  
22 primary strength I would say.

23 That said, it can be -- I mean, politicians and  
24 legislators can, you know, they should have good  
25 information and I think I wanted to provide quality

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1 Q. Were any deadlines placed on you by the Witherspoon  
2 Institute?

3 A. You know, in all the e-mail that came out about this  
4 study, there was one where Louise Tellez, who is the  
5 President of Witherspoon, had said it would be nice to  
6 have this by the time the Supreme Court case is on. I  
7 think that was back in 2010. I was oblivious of the  
8 Supreme Court cases.

9 Q. I want to stop you there. What Supreme Court cases  
10 are you referring to?

11 A. He just said Supreme Court cases.

12 Q. Okay.

13 A. Or something like that. I had never considered that  
14 a deadline or a mandate of any sort, keeping in mind that  
15 was 2010, well before anything came to the Supreme Court.  
16 But he said, you know, the emphasis is just on doing a  
17 good job. I always saw my goal as doing a good job. The  
18 only deadline I worked with was internal because I had  
19 finished one book and was interested in starting another  
20 book on 24 to 32 year old relationship behaviors.

21 And I didn't want this to take forever. So, I  
22 kept, you know, I think a lot, a lot of researchers say I  
23 would like to be done by such and such a time so I can get  
24 on with another project. I told them I would write them a  
25 report at the end of the project and that report was, in

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1 information on people's household experiences and child  
2 outcomes that they might find useful. But that was not  
3 its intention.

4 Q. I think you mentioned earlier that you had some  
5 assistance or you were consulted with regard to drafting  
6 the survey?

7 A. Uh-huh.

8 Q. Is that correct?

9 A. Yes.

10 Q. Were there any individuals -- actually, can you tell  
11 me who assisted with that survey?

12 A. Cynthia Osborne at the LBJ school in UT was the kind  
13 of the co-investigator of sorts. She helped me with the  
14 survey questionnaire and was more interested in it than  
15 the average consultant. Back in January of 2011 we met in  
16 Austin with several people who offered advice on the  
17 design and broadly on the survey. Most of them, their  
18 roles started and finished roughly then. I kept them  
19 aware of what was going on at different points in time.  
20 In the spring of 2012, I offered the data to them. Only a  
21 couple of them wanted it at the time. So, does that help?

22 Q. Did you ask Doctor Gary Gates to consult on your  
23 study?

24 A. I did ask him to consult. I asked Brandt (ph)  
25 Powell of Indiana University to consult. I asked my

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1 Michael Rosenfeld to consult. He gave me some good  
2 information but elected not to consult. Abbey Goldberg,  
3 Susan Brown at Bowling Green. And it might be one or two  
4 others. Tim Bidlar (ph), Southern Cal.  
5 Q. Did Doctor gates decline your invitation?  
6 A. He did.  
7 Q. How many outcomes were you evaluating in the survey  
8 itself?  
9 A. We had no fixed idea. Just we had, wanted to have a  
10 big survey of a lot of present and past stuff. And if I  
11 had to tally them up there is probably 80, 100 different  
12 distinctive outcomes. Some of them we pooled into  
13 indexes. You could use them separately if you wanted to,  
14 but --  
15 Q. How many did you ultimately settle on when you  
16 analyzed the data?  
17 A. I settled on 40 for the published article.  
18 Q. And how were those outcomes chosen?  
19 A. To be a broad representation of their growing up  
20 years, their current life, and different kinds of domains,  
21 a little bit of, you know, experience with the Criminal  
22 Justice System. I think we had, you know, smoking,  
23 drinking behavior, how to get -- how do you get along with  
24 your mother, parent/child. There is an index of sort of  
25 the security of your -- as you reflect upon your life

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1 A. We had 248 total out of the 15,048 who said, yes, my  
2 mother or my father had a romantic relationship with  
3 someone of the same sex. 157 said that was true of their  
4 mother. 73 said it was true their father.  
5 Q. So you observed more children reporting their mom  
6 had a same sex relationship, correct?  
7 A. That's correct.  
8 Q. Were you able to -- if I can have the next slide,  
9 please -- were you able to tell who those children lived  
10 with and how were you able to tell?  
11 A. Yes. I mean, this slide is of, well -- there is not  
12 175. Not quite 175 filled out all of the household  
13 calendar data. But of those that did, we were able to map  
14 who grew up with who, when. Those are four of the most  
15 common living arrangements. And you can tell that modal  
16 means by which kids came into the world was with a  
17 biological mother and father. And that union failed and  
18 at some point after that they had -- that's when the  
19 relationship, same sex relationship they are speaking of  
20 occurred.  
21 Another -- it looks like roughly 30 to 35  
22 percent said at the time of their birth or age one they  
23 were only with their biological mother. So, most of those  
24 same sex relationships did not occur, the vast majority  
25 did not occur at birth.

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1 growing up, how secure did your family feel? Do you feel  
2 you have any negative experience that you are still  
3 working out with respect to the family? Your family of  
4 origin, sexual partnerships, experience of sexual  
5 violence, just a bunch different domains. 40 total  
6 questions or 40 total variables.  
7 Q. Who did your data collection, Doctor Regnerus?  
8 A. It's a research firm called Knowledge Networks. I  
9 think they're in Paolo Alto, in Washington. As far as I  
10 can tell, they do the best on-line population based  
11 nationally representative survey firm. They keep an  
12 active data base of over 50,000 people that you can, you  
13 pay to sample those people. So, it's the best on-line  
14 source of nationally representative data that's out there.  
15 They get a lot of federal contracts, a lot of university  
16 contracts.  
17 Q. Did Professor Michael Rosenfeld also use that  
18 particular data collection?  
19 A. Yes, for how his How Couples Stay Together Project,  
20 which is a two year, three wave study. He might still be  
21 doing that study in different waves. But he used  
22 Knowledge Networks for that.  
23 Q. So you were able to analyze the data, Doctor  
24 Regnerus. How many individuals reported growing up with a  
25 parent that had a same sex relationship?

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1 Q. I just want to back up for a minute because I'm not  
2 sure we touched on it. What is the household calendar?  
3 What was purpose of it?  
4 A. The household calendar is envisioned like an Excel  
5 file where you -- they had told us who had lived with them  
6 at some point in their childhood and we automatically map  
7 onto this screen those names, those roles. If they said  
8 the mother had a same sex partner, so that row comes in,  
9 and each year while they were growing up. And we asked  
10 them to tell, who did you live with at the different years  
11 of your life until you left the household or turned 18?  
12 And so they would click on like when -- they  
13 could click saying I lived with my mother the entire time  
14 and it all goes in. But if they had lived with different  
15 people or if mom had had a spouse that came, a husband  
16 came, they would, if they left their mom to live with  
17 their dad, we could X out until that age and then X in  
18 they lived with their father. So that is how the  
19 household calendar worked.  
20 Q. And if I understand you correctly, the majority of  
21 the respondents in the NFSS were the product of a failed  
22 heterosexual union?  
23 A. Yes. And you can see from the slide that that is  
24 the case.  
25 Q. For the folks that are not familiar with this graph,

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1 can you just explain what this represents?  
 2 **A.** So, if you look at the pyramid, the triangle at the  
 3 bottom that starts -- this is the percentage of  
 4 arrangements, the household arrangements, and on the  
 5 bottom is the age and years of the child, the respondent  
 6 who is now an adult. So you can see that over half said  
 7 when I was age one I was with my biological mother and  
 8 biological father. That is the darkest part of the bottom  
 9 group. Another share that gray area, said I lived with my  
 10 biological mother only from. So that is almost all the  
 11 way up to 90 percent of the kids.

12 Then next to top haphazard row, those who said  
 13 they lived with their biological mother or mother's  
 14 partner, very few were born into that arrangement but the  
 15 share of them that experienced it grew over time  
 16 especially, I mean, the modal age is 14. That is when the  
 17 most people who said their mom had a same sex  
 18 relationship, lived with mom and her partner, and that  
 19 goes to 18. It diminished a little bit. But teenage  
 20 years were when that maternal same sex relationship was  
 21 most likely to be residential for the kid.

22 **Q.** What is the final category?

23 **A.** The top, the biological mother, biological father,  
 24 which is typically, so far as we can tell, probably a  
 25 joint custody kind of relationship. You spend time, but,

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1 yeah, the joint custody kind of relationship, so far as I  
 2 can tell. They could say, if they had joint custody, I  
 3 lived with my mother and I lived with my father, but they  
 4 were not in the same place.

5 **Q.** Thank you. Did you use the acronyms LM and GF in  
 6 your results?

7 **A.** I did in the initial, the July 2012 article, and I  
 8 regret that. And I said that as much in the November  
 9 followup because it seemed to conflate sexual orientation,  
 10 using it as adjective rather than a reflection of the  
 11 relationship.

12 In the original article in July 2012 I said,  
 13 right when I described these acronyms I said, we shouldn't  
 14 assume this means that the parent is lesbian by their own  
 15 self-reported orientation because we didn't talk to the  
 16 parents and I didn't want to presume that the child -- I  
 17 didn't want the child feeling like they had to out their  
 18 parent if their parent was not out. So I stated pretty  
 19 clearly in the article, one should not read this as a  
 20 description of orientation of their parents.

21 But I regret doing that. And the origin was  
 22 that when I first got the data back, the first round of  
 23 the data back, I was like, I need some acronyms to start  
 24 working through this and when I was coding the data. So  
 25 that is what I did. And I never really let it go. So I

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1 clarified in the November article, I shouldn't be  
 2 conflating this in the popular imagination even if I had  
 3 been clear in the article. So at that point I said let's  
 4 talk about these as mothers who have had lesbian  
 5 relationships or fathers who had a gay relationship.

6 **Q.** And just so the record is clear, the LM  
 7 represents --

8 **A.** It stands for lesbian mother.

9 **Q.** And then the GF?

10 **A.** Gay father.

11 **Q.** Thank you. Did you control for family transitions  
 12 or instability in the NFSS?

13 **A.** I did not control for that in either the July or the  
 14 November follow up. And that's been a source of some  
 15 contention about this. Not about the data set, because  
 16 the data set is able to evaluate this. But it became  
 17 obvious to me in analyzing the data that, and you can see  
 18 a little bit in the slide, that sort of the household  
 19 transitions were notable and most of the children who  
 20 experienced mother who had a same sex relationship or the  
 21 father who had a same sex relationship experienced  
 22 household instability. And there was only handful of  
 23 cases where there was a nonstop presence of mom and her  
 24 partner in the household the entire childhood of the  
 25 respondent.

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1 So what does one do with instability? Some  
 2 people do control for it. And but my intention in the  
 3 July 2012 article was -- so this is a mapping of a new  
 4 data set and a description of a data set and I  
 5 characterized it that way in print. So I didn't think it  
 6 was helpful to control for instability which in some ways,  
 7 you know, I mean, there is a debate about this. Does it  
 8 hide something or does it reveal something? I wanted to  
 9 map something.

10 One of the things I think sociology is best at  
 11 is its ability to describe social reality. And in the  
 12 literature on same sex parenting, one could say that  
 13 rapidly moving to control for instability when instability  
 14 is endemic, writes it off like it's a control variable.  
 15 It's like we are not concerned about it. It doesn't  
 16 matter. And I thought that is not -- that doesn't really  
 17 do a service to trying to help people understand the lives  
 18 and households that we are describing. So I didn't elect  
 19 to do it in this study. It can be done. And the way I  
 20 framed it is that I made public and in November of 2012,  
 21 like five, four months, three months after this, the  
 22 article came out and saying there are different ways  
 23 people can evaluate this data and they are welcome to do  
 24 that.

25 **THE COURT:** So, is this the place to take an

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1 afternoon recess?  
2 **MS. HEYSE:** Sure.  
3 **THE COURT:** You can segue-way in?  
4 **MS. HEYSE:** I will make it work, your Honor.  
5 No problem.  
6 **THE COURT:** I am not in a hurry. We will  
7 take a 15 minute recess and reconvene at quarter to.  
8 Thank you.  
9 **MS. HEYSE:** Thank you, your Honor.  
10 (Recess from 2:15 p.m. until 2:30 p.m.)  
11 **THE COURT:** Thank you. You may be seated.  
12 Doctor, first of all, I never know, do the pros like to  
13 be called doctor or professor?  
14 **THE WITNESS:** I prefer my first name.  
15 **THE COURT:** No, I can't do that. But I  
16 understand. I am just curious.  
17 **THE WITNESS:** Doctor is fine.  
18 **THE COURT:** I'm going ask you to straighten  
19 out your chair and kind of talk to counsel and right into  
20 the microphone. And I will tell you why. Usually I like  
21 to have face contact with you. But the people -- you  
22 maybe seated, I'm sorry -- the people that are here are  
23 having a difficult time hearing you. And also being able  
24 to see you and so forth. So just talk to counsel and move  
25 your chair a little bit more. There you go. And those

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1 make it clear, what does this graph actually represent?  
2 **A.** Right. It shows the sort of diversity of household  
3 occupants for children who said their mother had a same  
4 sex relationship. Clearly from that bottom piece you see  
5 is that from the left side, age one, 55 percent of kids  
6 said they lived with biological mother and father when  
7 they were age one and that diminishes all the way down to  
8 just a handful of cases well under 10 percent that was the  
9 case at age 18.  
10 A lot of them lived with just their biological  
11 mother only. And that's not necessarily the same people  
12 in the big gray block, but the same share roughly as at  
13 age one lives with only their mother at age 18. And that  
14 share above it, this is the kind of thing where you are  
15 thinking about, when a child lives with his mom and her  
16 same sex partner. Very few of them were born into that,  
17 right? It looks like we have -- there's only two cases so  
18 far as I can tell in the data where it's the case. And  
19 along the way that number increases because either the  
20 mother begins to partner with somebody or a relationship  
21 fails and she begins to partner with somebody and that  
22 peaks at age 14 where I think I want to say there was like  
23 20 cases. I can't exactly recall where they are with  
24 their mother and the partner in the same household. It  
25 fluctuates over time.

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1 that can't hear, raise your hand this time. Don't wait  
2 until we get to a break. Okay. You may proceed.  
3 **THE WITNESS:** Would you like me to address  
4 you?  
5 **THE COURT:** No. Just look at counsel and then  
6 your voice will be directed to her and to those that are  
7 here and I can still hear. No problem. They are having a  
8 hard time, and I understand why. These microphones are  
9 such. Talk to counsel. They will be able to hear and see  
10 you. For those that are hear, when you can't hear, don't  
11 wait for a break. Raise your hand.  
12 **MS. HEYSE:** Thank you, your Honor. I  
13 understand they were having trouble hearing me, too.  
14 **THE COURT:** Oh, good.  
15 **MS. HEYSE:** I will try to pay attention.  
16 **THE COURT:** Again, I'm sorry we had to wait  
17 to long.  
18 **MS. HEYSE:** Hopefully I will be closer.  
19 **THE COURT:** I will, too, now. I just  
20 realized I am not talking in the microphone.  
21 **MS. HEYSE:** Thank you.  
22 **BY MS. HEYSE:**  
23 **Q.** I just want to backtrack for a moment, Doctor  
24 Regnerus. Before the break we were actually taking a look  
25 at this graph and I want to just make it clear or have you

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1 This also gives you an indication of sort of the  
2 difficulty in tracking stability because it fluctuates  
3 over time in that mother and mother's partner unit. So  
4 the share of people who lived with their mom and her  
5 partner for I think it was for over five years is like, I  
6 think it was like 30 cases or so. It diminishes. Over  
7 ten years it's less than that and down to the entire  
8 childhood is two cases, right? And people got upset about  
9 that, saying, you know, this is not a comparison of kids  
10 who lived their entire life.  
11 I said, that's correct. But this is a  
12 population based study. This is what is going on in the  
13 population of kids who are 18 to 39 years old now telling  
14 us who they lived with when. It doesn't purport to be a  
15 study of something that is not the case in the broader  
16 population.  
17 So, it looks quite different than some of the  
18 non-probability studies that begin with a proposed sample  
19 of people who are with their mom and partner at birth.  
20 That's just uncommon in the population in this era. How  
21 common it is today, I don't know. I don't think it's been  
22 established.  
23 **Q.** Sure. Does this graph tell you anything about the  
24 number of respondents of the NFSS that were the product of  
25 a failed heterosexual union?

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1 A. On the left, you know, most at age one is when  
2 biological mother and father are together. Now, this does  
3 not reflect their union status. Some of them were  
4 married. Some of them were not married. But this slide  
5 doesn't distinguish between that.

6 Q. And does it also indicate that a large majority of  
7 respondents from the NFSS were being raised at least  
8 living with the single mom?

9 A. Yes. A lot. Right? I mean, of this population,  
10 right? Which is already a smallish minority. I mean, as  
11 I said earlier, that becomes the modal household unit  
12 where at probably at by age 10 or 11 the bio mom and dad  
13 category has receded enough that the single mom, bio  
14 mother only is pronounced then. So, the case where you  
15 live with mom and her partner is higher obviously then  
16 at -- in the teenage years but it's never the modal  
17 household circumstance.

18 Q. So this indicates that for whatever reason the  
19 children started out living with both bio mom and dad for  
20 a period of time and then ultimately?

21 A. That is the modal, the most common experience.

22 Q. And ultimately, the biological father left the home  
23 and mom was left to raise the kids?

24 A. Who knows who left the home? It was mom and the  
25 child, and then some share -- that's when you sort of,

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1 the NFSS that had been exposed to a same sex relationship,  
2 the outcomes were poorer from them when you compare them  
3 to the stably in tact opposite sex union?

4 A. Correct.

5 Q. Was there a particular comparison group that had  
6 outcomes most similar to the children who lived for some  
7 duration with their mother or father and same sex partner?

8 A. Yeah. I got at this a little bit more firmly in the  
9 November followup in social science research where you  
10 split out more types of categories. Instead of 8, there  
11 was 15. They compared most favorably, the ones where mom  
12 lived, the respondent lived with the mom and partner for  
13 some period of time, they compared most favorably to  
14 single parents who did not have subsequent relationships  
15 over the course -- before the child left the household.  
16 They compare also fairly favorably to the child who said  
17 their father had a gay relationship. And not that far  
18 different, I mean, I think there was four differences, I  
19 could look it up if you like, with step-parenting  
20 arrangements, although I would have to look that up to  
21 confirm that.

22 Q. Okay. What were some of the outcomes if you recall  
23 where children of parents who had a same sex relationship,  
24 those outcomes were poorer than those of the children that  
25 were raised?

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1 they start. The mother's partner moves into the household  
2 at some point. But that is never a large share of the  
3 population.

4 Q. Okay. Thank you.

5 A. The focus though is to get a portion of what is  
6 really going on out there, regardless of what we thought  
7 might be going on.

8 Q. Okay. Thank you for explaining that. So what  
9 comparison did you -- first comparison group did you  
10 actually use for purposes of your results of the reporting  
11 your reports of the NFSS?

12 A. I used the in tact biological family where the mom  
13 and dad were together when the child was born and they are  
14 still together today.

15 Q. Okay. Why did you use that particular comparison  
16 group?

17 A. Because historically in the sociology of family it  
18 had been documented that a stable in tact mom and dad  
19 household has been the best context for children to  
20 flourish in. So, I thought, well, why not? Why would you  
21 want to compare it against something less than what has  
22 been -- had long been considered the ideal, right?

23 Q. And I think you mentioned earlier in your testimony  
24 that in doing that comparison in 24 of the 40 outcomes  
25 when you had controlled the children, the respondents in

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1 A. Repeat that.

2 Q. I'm sorry. It's a longer question so I am happy to  
3 do that. What were some of the outcomes, some of the  
4 categories of outcomes where the children that were -- the  
5 parents had had a same sex relationship, were poorer than  
6 those of children who were raised by the stably in tact  
7 biological?

8 A. Right. I can look it up and rattle them off or  
9 rattle some of them off from memory.

10 Q. Which are you more comfortable with?

11 A. I would rather look it up. Do you want that from  
12 the original or the followup where I have more categories  
13 including when the respondent lived with the mother and a  
14 partner?

15 Q. I am looking for some examples. I don't need an  
16 exhaustive list.

17 A. Sure.

18 THE COURT: And tell us what you are looking  
19 at, Doctor.

20 A. Sure. This is page 1372 of the November followup  
21 where I compared -- they said the mother had a  
22 relationship with another woman and they lived with their  
23 partner. This is from Table One. After the set of  
24 controls they are more likely to have received welfare  
25 while growing up. They were more likely to be currently

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1 on public assistance, currently less likely to be  
2 currently employed full-time, more likely to be currently  
3 unemployed, more likely to say they had an affair while  
4 they were married or cohabiting, more likely to have had a  
5 sexually transmitted infection.

6 Table Two has less educational attainment, less  
7 safety or security if their family of origin that they are  
8 reflecting on, more negative impact from their family of  
9 origin.

10 The Table Three has greater marijuana use,  
11 greater frequency of smoking, frequency of having been  
12 arrested or pled guilty to a non-minor offense. More  
13 female sex partners among women. More male sex partners  
14 among men.

15 Q. Can you just identify for the record what exhibit  
16 number that is, Doctor Regnerus?

17 A. The tab number you mean?

18 Q. Correct.

19 A. That's seven.

20 Q. So State's Proposed Exhibit Seven. And can you  
21 identify for the record what that document is, Doctor  
22 Regnerus?

23 A. The title of it? Parental Same Sex Relationships.  
24 Family stability And Subsequent Life Outcomes For Adult  
25 Children. Answering Critics of the New Family Structure

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1 Study.

2 Parental Sexual Relationships, Family  
3 Instability, and Subsequent Life Outcomes For Adult  
4 Children, answering critics of the New Family Structure  
5 Study with additional analysis.

6 Q. And is that your article, doctor Regnerus?

7 A. That's the November followup.

8 Q. Correct. Did you -- is that your original writing?

9 A. Correct.

10 Q. And does that appear to be a true and accurate copy?

11 A. Yes.

12 MS. HEYSE: At this time, I move for  
13 admission of the State Defendant's Exhibit Number Seven,  
14 your Honor.

15 THE COURT: Any objection?

16 MS. COOPER: No objection.

17 THE COURT: Number 17 is received.

18 BY MS. HEYSE:

19 Q. I guess while you have that book in front of you,  
20 Doctor Regnerus, if you can open it to Exhibit Tab Six?

21 A. Okay.

22 Q. Can you identify that document for me?

23 A. By title?

24 Q. First identify what it is.

25 A. It's the original NFSS based summary article that I

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1 wrote which appeared in Social Sciences in July 2012.

2 Q. And very slowly, can you give us the title?

3 A. How Different Are The Adult Children Of Parents Who  
4 Have Same Sex Relationships: Findings From The New Family  
5 Structure's Study.

6 Q. Okay. And does this appear to be a true and  
7 accurate copy of your article?

8 A. Yes.

9 MS. HEYSE: I move at this time for the  
10 admission of State Defendant's Exhibit Number Six.

11 THE COURT: Any objections to six, you mean?  
12 17 was already received.

13 MS. HEYSE: Yes. We went backwards.

14 MS. COOPER: No objection.

15 THE COURT: Very well. Received.

16 BY MS. HEYSE:

17 Q. Doctor Regnerus, were there any limitations to the  
18 NFSS?

19 A. Yes. As in all studies have their limitations, this  
20 is not a longitudinal study. It's cross-sectional. So  
21 you get a snapshot at one point in time. So it's not able  
22 to answer causal sort of claims about this causes this is  
23 to happen. And I stated that clearly in the article.

24 It is not a study of parental same sex  
25 orientation or sexual orientation. And I stated that

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1 pretty emphatically as well. I don't make claims about  
2 the influence of sexual orientation, strong claims on any  
3 sort of outcome. It's more a focus on relationships.  
4 Partly it's a function of, you know, I don't think there  
5 is any standard way that social scientists have decided to  
6 document the orientation of parents in the literature as  
7 far as I can tell. Certainly not in the census it does  
8 not ask about orientation at all. So that's -- I'm losing  
9 track of the original question.

10 Q. I was asking if there were any limitations to the  
11 NFSS?

12 A. Right. It was not about -- not intended to be about  
13 the orientation of parents. So it really is like snapshot  
14 data, is able to answer certain things about what is going  
15 on now without being able to say where it all came from.

16 Q. Okay. Were there any limitations with regard to the  
17 age of the respondents?

18 A. To some extent. I mean, they are 18 to 39. So  
19 these are young adults. So some, I mean, they all at some  
20 level are removed from the household of origin. Most of  
21 them, I assume. If they had gone to like age 13 that  
22 would have involved a lot more invasive human subjects  
23 review, I suspect. So we didn't.

24 But also that's a different kind -- there I  
25 don't have the method of variance of asking kids who are

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1 now out of the house. You have to blend it with kids who  
2 are in the house. But, so that's, I mean, one could say  
3 it's a limitation. I think it's a source of strength to  
4 talk to people after they are done with their childhood,  
5 so to say.

6 Q. We took a look at the graph but were you actually  
7 able to come up with a percentage of NFSS respondents that  
8 were a product of the failed heterosexual union?

9 A. I think I said 55 percent is what that looks like at  
10 age one.

11 Q. And were you able to determine a percentage of  
12 respondents who were the product of assisted reproductive  
13 technology or ART?

14 A. We didn't ask about their origins. So I took an  
15 educated guess based on like whether the child was ever in  
16 the household with a father. So I thought that's unlikely  
17 to be the case. Or so I think in the original article my  
18 hunch is, I think I said 18 to 25 percent that is the  
19 maximum that was of a planned origin. Even though I still  
20 think that's unlikely to all be assisted reproductive  
21 technology. I don't think very many is the bottom line.

22 Q. What else would it be if it's not -- if they don't  
23 fall within the ART category?

24 A. Surrogacy if it was among fathers. Yeah. So I  
25 don't think -- I think the number is fairly small. It's

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1 a social science or natural science, if people share their  
2 data and can, you know, everybody can have an open look at  
3 the data. And, you know, it long aggravated me that there  
4 had been data sets dealing with not just this subject but  
5 subject matters I am interested in that have not been made  
6 public because they were funded privately. So nobody got  
7 to know what their data says, right? So I was under no  
8 obligation to release it because it was not federally  
9 funded data. But it's the right thing to do.

10 Q. Not all researchers do that?

11 A. No. One of the primary data collection projects  
12 that has contributed to the literature around this subject  
13 is the National Longitudinal Lesbian Family Study.  
14 Privately funded so far as I can tell. And never been  
15 released publicly. I don't know what wave it's on now but  
16 now it's 20 some years old I think. And, you know, I  
17 think it's now 21 published studies. So, I mean, it's  
18 fair to say, yeah, there is a literature that says, that  
19 often says no differences. But when you're talking about  
20 21 studies based on a small end sample of 78 people and a  
21 data set that's never been made public so nobody else can  
22 evaluate it, I mean, it's -- I don't think that is a  
23 scientific value.

24 Q. Thank you. Doctor Regnerus, is researching the same  
25 sex community challenging?

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1 hard to decipher like the bio mother only category. Like  
2 did she -- was she in the union with a man for this?  
3 Likely, I would say, but we don't know for sure.

4 Q. And were you able to determine the percentage of  
5 respondents who were the product of an adoption?

6 A. Yes. There were statistics around adoption, either  
7 by strangers or family members before age two or after age  
8 two, by one person or two persons, yes.

9 Q. Okay. Was there any potential for source bias in  
10 the NFSS?

11 A. In so far as you are not talking to the parents of  
12 these children, I suppose. You are not getting reports  
13 from their employer and things like that. But you are  
14 getting a report from an adult about their own life. So I  
15 think less source bias than you might have with studies of  
16 younger children.

17 Q. And you made the NFSS data available to the public?

18 A. I did.

19 Q. And when did you do that?

20 A. I think it was November 1st, 2012 or right around  
21 that, give or take a few days.

22 Q. Why did you do that?

23 A. It might have been October 1st. October 1st or  
24 November 1st. Because I had said I would. Because it's a  
25 scientific value to -- science moved forward, whether it's

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1 A. It is. I mean, it's numerically a small population  
2 at face value. There are different estimates about  
3 basically, how we are going to map this? Is this about  
4 sexual identity? Is it about attraction? Is it about  
5 same sex behavior? There are different ways you might  
6 want to map this. I elected to map it by relationship  
7 behavior, parental relationship behavior. Fairly  
8 objective in some ways.

9 You ask somebody to say, tell when your mother  
10 or father, have they had a romantic relationship? So I  
11 consider that a fairly objective measure. Obviously, it's  
12 coming from somebody who is offering that information.  
13 But it's not like saying, do you think your father is gay  
14 or do you think your mother is a lesbian, which the child  
15 may or may not think that. The parent may or may not  
16 self-identify as that.

17 So I wanted to stick to relationship behavior.  
18 And so I think we found 1.7 percent of the population had  
19 a mother or father who said they had a mother or father  
20 who had had a same sex romantic relationship.  
21 1.7 percent. So you know you are looking for a small  
22 population to begin with and it's a share -- it's a  
23 percentage of the population who would consider themselves  
24 gay or lesbian, right? Not all of them have children. And  
25 in this era, from 18 to 39 year olds, I didn't want to

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1 make assumptions about how their parents or the kids would  
2 describe their parents' identity. So that's why we stuck  
3 with relationship behavior. That's long been my general  
4 interest in the study of relationships is behavior, not  
5 identity.

6 Q. Okay. Is the same sex community as a whole very  
7 diverse?

8 A. It seems to me to be, yes. In both in the census  
9 and in the NFSS, and I think Mike Rosenfeld's census based  
10 study, I think he said 43 -- something like 43 percent or  
11 39 percent of the population was of same sex couples in  
12 his case, were African-American or Hispanic. I think mine  
13 was 43 percent African-American or Hispanic.  
14 Disproportionate compared to their shares in the  
15 population as a whole. But they also, African-American  
16 and Latino same sex couples, according to the National  
17 Study Of Family Growth, another population study, are more  
18 apt to have children and want to have children. So the  
19 more you think about it, compared to the NLFSS which has,  
20 I think is 12 percent of the national lesbian family  
21 study. I think 12 percent is non-white. 94 percent of  
22 them have a college education. That's just not -- that's  
23 not reflective the underlying population, which is why we  
24 wanted to go to population based studies.

25 Q. Let me back you up just a little bit. I think you

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1 it comes from how do they collect -- how do they gather  
2 their sample? It was essentially a convenience sample. I  
3 think it included snowball aspects to it by putting up  
4 advertisements in lesbian book stores in Washington,  
5 Boston and San Francisco. So they are apt to pick up  
6 people who frequent those book stores. Right? So, and  
7 those three towns you would be more likely to be college  
8 educated. So, I mean, you get where the  
9 disproportionality comes from. But it's still like, that  
10 is not an accurate reflection of the underlying population  
11 of same sex parents.

12 Q. So in your opinion, diversity is reflected at these  
13 large population based studies?

14 A. Yes, almost by definition since they are probability  
15 samples. That is a more accurate picture of what is going  
16 on out there as a whole.

17 Q. Did the NFSS tell you anything about the stability  
18 of same sex couples?

19 A. Yes, it did. You look at sort of how many kids  
20 lived with their mother and father for different -- or  
21 their mother and her same sex partner for how long. I  
22 think there was a total of 85 who lived with mom and her  
23 partner for at least some segment of one year. Right? I  
24 think it was 31 of those 85 lived for only up to one year  
25 with mom and a partner together before either the

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1 mentioned in mine, you saw diversity. Are you referring  
2 to in the NFSS you were able to tell about diversity?

3 A. Right. In the appendix I compared the general  
4 percentages of a lot of different things to the current  
5 population study. I think I saw the University of  
6 Michigan, the National Study Of The Family Growth,  
7 National Study Of Youth And Religion, Ad Health, all of  
8 them. So that's how you kind of show people that your  
9 data looks like other nationally representative population  
10 based samples.

11 Q. Again, what was the percentage for minorities in the  
12 NFSS?

13 A. In the NFSS, I think 43 percent. I think that was  
14 it, that were African-American or Latino.

15 Q. You mentioned the NLFSS. So that is a study that is  
16 relied on by the APA for purposes of the No Differences  
17 Claim.

18 A. A couple times.

19 Q. Okay. And so it's your opinion that the type of  
20 diversity that you found in the NFSS and other studies is  
21 not reflected in those small convenient samples?

22 A. It is not.

23 Q. That are relied on by the APA?

24 A. 94 percent. I think 30 percent of the US has a  
25 college education, I think. And this is 94 percent. But

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1 relationship ended or, I mean, the person left the  
2 household, the partner left the household or they turned  
3 18. Another 20 cases, that was for two years duration.  
4 And then that number keeps shrinking all the way to like  
5 only two cases where they spent the entire growing up  
6 years together. Yes.

7 So, I mean, the instability was notable. And  
8 for the fathers who had a gay relationship, it's even, you  
9 know, very few of them lived with dad and his partner for  
10 a share of a year.

11 Q. So, so I understand you correctly, the NFSS showed  
12 that there was instability within?

13 A. Within the household, right, in terms of comings and  
14 goings. We are not exactly able to measure how often  
15 these happened. It's possible the partner moved out but  
16 they were still in a relationship with them. Probably  
17 not. But we didn't measure when the relationship ended.  
18 We measured who entered the household and how long did  
19 they stay.

20 Q. Why did you measure that?

21 A. It was actually upon the advice of one of our  
22 consultants, I believe. And this is emerging family  
23 studies. This is getting a household roster. Right?  
24 Because there is a growing awareness of the complex  
25 families that people have. So, and if you take a look

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1 sort of saying I grew up in a step-parent family, when did  
2 that start? Right? Obviously, if you are a step-parent  
3 you are no longer with your biological father or mother.  
4 When did your biological father or mother either leave or  
5 one of the parents died?

6 I mean, so when did that start? Did it start at  
7 age two or age ten? Are you on your second step-dad or  
8 third step-mother? So the household roster was meant to  
9 capture some of that complexity. And I think it did. I  
10 mean, I don't lean very heavily on the household roster in  
11 the first article because it's very complex. The first  
12 article is intended to be an overview of what we learned.  
13 But a household roster data was there and for people to  
14 analyze, make the data public and people can analyze it.

15 Q. I want to follow up on a question or a point that  
16 the Judge made earlier. Did you include respondents --  
17 include in your results respondents that never lived with  
18 their parents, same sex romantic partner?

19 A. Yes. And then the November followup I distinguished  
20 the moms who did from the moms who did not, the kids whose  
21 mothers lived in the same household as a partner from the  
22 mothers who didn't. But I did in the July article, yes.  
23 It was about split roughly fifty fifty. I think 90 said  
24 they had not lived with their mother's partner. 85 did.

25 Q. Why did you include those people?

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1 A. For a couple reasons. One is that I have to be  
2 sensitive to sample size. I was -- having looked at the  
3 household rosters, we were aware that stability was not  
4 profound. So, I mean, unless I wanted to create ten  
5 categories of a group that is only 175 large to begin  
6 with, and then your statistical power goes down to very  
7 little and then you are in the same boat that everybody  
8 else had been in except for the census. Right? And the  
9 census didn't ask about orientation or behavior.

10 So it was a judgment call with respect to sort  
11 of both sample size and the reflection of how long a lot  
12 of those relationships had lasted or so far as we could  
13 tell in terms of household. Not very many years. So they  
14 had a lot in common that those whose -- the mother had  
15 been in a relationship with another woman weren't  
16 reporting extensive household experience with that person.

17 Q. Were there any respondents of the NFSS that lived  
18 with their parent and the parent's same sex partner  
19 through age 18?

20 A. Who? From the beginning?

21 Q. Uh-huh.

22 A. Yes. Two. There were some people for whom the  
23 relationship started later and was still ongoing at age  
24 18.

25 Q. I mean, any respondents that lived with their parent

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1 and same sex partner from birth to through age 18?

2 A. Yes. Two.

3 Q. Two. Okay. And what were the outcomes like for  
4 those two children?

5 A. Right. On average they looked pretty good.

6 Q. Are you aware of any other research regarding the  
7 stability of same sex couples?

8 A. Yes, I mean, Michael Rosenfeld attempted to tackle  
9 it in the census. And that's where Professor Allen and  
10 Professor Pakaluk and Professor Price sort of contest how  
11 he deals with residential stability in the census. And he  
12 lops it off at sort of as to the last five years. And I  
13 think Professor Allen and company say, why do you do that?  
14 You are then giving a false sense of the instability. I  
15 mean, so there is a debate going on among them about that.

16 I mean, I also know in the Early Childhood  
17 Longitudinal Study, The Kindergarten Cohort, which Daniel  
18 Potter published articles in the Journal of the Emerging  
19 Family, July of 2012. Controlling for instability, he  
20 doesn't find any differences. I think it's some sort of  
21 academic progress outcome.

22 But if you dig deeper into those cases, and  
23 that's public data, you find that there were no cases  
24 where the gay couple stayed together for eight years, I  
25 think through kindergarten through eighth grade and

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1 70 percent of the lesbian couples had broken up by eighth  
2 grade. So it was extensive instability in that data set.  
3 Right? But once you control for it there is no  
4 differences. Right?

5 So a lot of this debate and a lot of the  
6 criticism around this revolves around what you do you do  
7 with instability, right? If you control for it, are you  
8 saying, oh, well, we realize that it matters but our focus  
9 is on this other variable. But it's a live question. Is  
10 there, you know, something -- is there something, you  
11 know, systematically unstable about that kind of  
12 arrangement? So, and one could say if you control for it  
13 you are not shedding light on it. You are just sort of  
14 pushing that out of sight. So I had I assessed that as  
15 being an overview portrait of what is going on,  
16 instability and all. Right? So --

17 Q. You mentioned that NFSS shows evidence of  
18 instability within same sex couples. And you mentioned  
19 the ECLS. Are you aware of the study by Anderson?

20 A. The Norwegian Sweden study, right.

21 Q. Did that inform your decision or your opinion with  
22 regard to the stability of same sex couples?

23 A. Right. And I think Norway and Sweden might have  
24 slightly different definitions of union and marriage. But  
25 in their study, that was, I think it was in Demography,

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1 and they actually mapped sort of predictions for estimates  
2 for what they would expect in subsequent years. I think  
3 they said we should expect lesbians, lesbian couples,  
4 lesbian marriage -- I'm not sure if they are marriages or  
5 unions -- to break up at a rate of 30 percent over six  
6 years. Gay couples, 20 percent over six years. And  
7 heterosexual couples, I want to say 12 percent over six  
8 years. So 30, 20, 12.

9 Q. Thank you.

10 A. That was -- I think that was Norwegian data.

11 Q. Did you also --

12 A. I think that might have been the Swedish data.

13 Sorry.

14 Q. Did Rosenfeld also have some research with regard to  
15 the stability of same sex couples?

16 A. In the How Couples Meet And Stay Together project  
17 which also used Knowledge Networks, and he presented that  
18 at the Denver American Psychological Meeting in 2012. And  
19 he documented, I mean, he called it a lesbian effect on  
20 instability in relationships. So after a variety of  
21 controls, he still found lesbian unions were more apt to  
22 break apart.

23 Q. And what about the NLFSS?

24 A. NLFSS, National Longitudinal Lesbian And Family  
25 Study. It's not a national study so I did not focus as

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1 finish the question -- outcomes for children of same sex  
2 parent as a whole?

3 A. Right. I mean, two comes from 175, right? Or some  
4 share of those did not fill out the household calendars.  
5 But most of them did. So, it's just long odds, right? I  
6 mean, to get, to be those two kids who turned up fine, on  
7 average, it's just sort of the odds were against them  
8 compared to the odds against -- I think, 40 percent of the  
9 sample was -- said their mothers and father were married  
10 and still married today. Right? So, much taller odds to  
11 succeed and to witness that kind of stable union.

12 Q. So, in the NFSS, there were, if I understand you  
13 correctly, there were two respondents that came from a  
14 stably coupled same sex household?

15 A. Correct. From the household roster that is what we  
16 mapped.

17 Q. Did your screening protocol somehow prevent these  
18 stably coupled same sex households from appearing in the  
19 NFSS?

20 A. Not that I recall. No. If it had, there wouldn't  
21 be two, right? And I remember after the first criticism  
22 starting rolling in, I went right back to the screener  
23 questionnaire and I tried to map out all of the  
24 permutations possible and I didn't see any problem.

25 Q. So you were surprised by the fact that there were

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1 much on that. That's interesting to look at. So it's  
2 94 percent college educated, overwhelmingly white, and in  
3 Boston, Washington and San Francisco, it's like you would  
4 say it's a privileged sample. Right? In terms of  
5 opportunities. And yet by wave five when the kids were on  
6 average 17 years old, 40 of the 71 couples they had  
7 tracked since the birth of the child had broken up. So  
8 it's 56 percent I think it is. Which struck me as higher  
9 than I would have expected in a sample of sort of  
10 privileged folks. Right? So, 56 percent by the time the  
11 kid was 17.

12 Q. I want to go back for a minute to --

13 THE COURT: Why are they privileged? I don't  
14 get it.

15 THE WITNESS: Overwhelmingly college  
16 educated. Eighty-seven were white, etc.

17 MS. HEYSE: Thank you.

18 BY MS. HEYSE:

19 Q. I want to go back to your response to my question  
20 about how many of the children, the respondents from the  
21 NFSS had lived with their parents and same sex partner  
22 from birth to age 18. So the two that actually --

23 A. Right.

24 Q. In your opinion, Doctor Regnerus, are two children  
25 enough to make any judgment on outcomes for -- let me

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1 only --

2 A. I was.

3 Q. -- two?

4 A. I didn't know what it expect really. But you would  
5 think there would be more than two.

6 Q. All right. I'm going it a turn here now and talk to  
7 you a little bit about some of the criticisms that  
8 plaintiff's experts had lodged against the NFSS. We have  
9 mentioned names a couple times. I just want to make it  
10 clear for the record. Are you familiar with plaintiff's  
11 expert witness, Doctor Michael Rosenfeld?

12 A. Yes.

13 Q. Are you familiar with his work?

14 A. Over the last several years, yes. I mean, with  
15 respect to this area, yes.

16 Q. Doctor Rosenfeld has criticized the NFSS because you  
17 did not control for instability. Do you have a reaction  
18 to that criticism?

19 A. He criticized the data or my article?

20 Q. The results.

21 A. Okay. So the article?

22 Q. Correct.

23 A. Yes, I mean, I understand his complaint. I don't  
24 think that was the purpose of that original overview  
25 article which was to map, rather than explain away some

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1 things. And it intended to bring up the subject of why  
2 such instability, right? So, as I point out, I already  
3 had seen like the instability was endemic in the sample on  
4 average and not just the instability of the same sex  
5 relationships, but the households in which the mother had  
6 had a same sex relationship. There was -- most of them  
7 had come from a heterosexual group, right?

8 So there was relationship instability of all  
9 sort, not just same sex. And I think it's an active  
10 social scientific debate about what to think about that  
11 and what to do about that, right? But in the -- for this  
12 case, Michigan is thinking about what it out to esteem in  
13 the household of its average children. So, I think, it's  
14 helpful to see how children fare when mom and dad stay  
15 together. I stated I think it was in the followup article  
16 or in my report, there may be a gold standard, same sex  
17 household of stably coupled mothers or fathers, but no  
18 population based data that I have seen is yet able to  
19 widely consistently confirm evidence of it, right? It may  
20 exist. Just maybe we have not collected large enough data  
21 or over time data or -- so, it might exist but we are not  
22 seeing it consistently in the population based data that  
23 we have and that's been collected in the last several  
24 years.

25 And, you know, you bump from mine up to like --

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1 A. Absolutely. You think about all of the data  
2 collection projects that ought to be done before one  
3 settles a scientific question like this. I mean, you can  
4 go back 20 to 30 years ago when people starting dabbling  
5 in this area. Most of it was convenient samples. The  
6 probability based sample discussions have been, I am  
7 thinking, the last three years, four years, maybe at the  
8 most. Right?

9 And then to say we settled this No Differences  
10 question back in 2005 or 2006 when the APA thing came out,  
11 we weren't even working with probability based large  
12 samples at that time really. I mean, Ad Health Study had  
13 44 cases, I guess, right? Of same sex couples. But 44 is  
14 not that large of a number, right? Of the statistical  
15 power to detect genuine difference that might exist in the  
16 population is limited.

17 So, it is very new. So it's intellectually  
18 usually it was frustrating to see social science close off  
19 a debate by claiming that it doesn't -- your screen has  
20 changed -- closing off a debate by saying this is settled  
21 when we haven't even corrected the ideal kind of data yet,  
22 right? And assess its limitations, census limitations.  
23 Let's get some more before making wide scale changes of an  
24 institution that has been around for time immemorial.

25 Q. Those experts have also criticized the NFSS as not

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1 you have to go up to the Census to start talking about --  
2 it doesn't get much bigger than that, right? I mean,  
3 talking about -- to document more stable relationships.  
4 But the Census does not ask about orientation or behavior.  
5 So they do their own estimation. I think they do a good  
6 job. But you can't figure out like how long mom and her  
7 partner have been together.

8 Q. When you are referring to, they do a good job, are  
9 you referring to --

10 A. People who use the census to analyze relationships.

11 Q. Any, in particular, you are referring to --

12 A. I mean, both Gary Gates and Mike Rosenfeld used the  
13 census and Joe Price used the census and Doug Allen has  
14 used the Census. They have a lively debate about this  
15 subject. And it all seems to hinge around household  
16 instability and what to make of it. To control for it  
17 makes it disappear and go out your mind and say, it  
18 doesn't matter. I mean, or are you giving the impression  
19 it doesn't matter. It matters profoundly. And I think we  
20 to people and to the public to sort of describe social  
21 reality any all its complexity.

22 Q. So given these questions surrounding stability and  
23 the limitations with regard to studying same sex couples  
24 that you mentioned earlier, do you think it's just too new  
25 to make definitive conclusions?

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1 being a study of children actually raised by same sex  
2 couples.

3 A. Right.

4 Q. Do have you a reaction to that criticism?

5 A. Sure. I am aware of the tension around this. To  
6 say one is raised, does that mean you have spent your  
7 entire household, your growing up years in the same  
8 household with the same person? Increasingly American  
9 family lives are complicated. So you have got more people  
10 coming and going. More people experiencing step-parents.  
11 More people experiencing single parenthood and things like  
12 that.

13 Who is doing the raising in all these? If you  
14 primarily live with your mother but see your father on the  
15 weekend, is your father not raising you? I mean, I assume  
16 the father is raising you to some extent. So, raising, we  
17 have got this mentality that it's consistent, stable  
18 presence, right? And that's optimal, I'm sure, as the  
19 data suggests. That may be different than influence,  
20 right? And whereas all sorts of parents can be influencing  
21 children. Parental relationships can be influencing  
22 children.

23 I mean, one of the things we noticed in the  
24 data, we didn't make a whole lot about it, is one of the  
25 next best parenting structures to when mom and dad are

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1 married and stayed married, are that if mom divorces and  
2 never recouples, right? Never recouples until the kid is  
3 out of the house. I mean, because the child only  
4 experienced this one transition, right? Which is better  
5 than experiencing -- can often be better than experiencing  
6 a second or third transition. Subsequent marriages fail  
7 at rates greater than first marriages. So instability  
8 snowballs, really. So I maybe I'm getting away from your  
9 original question.

10 Q. You're fine. Previous expert have also criticized  
11 your use of stably in tact biological parents as a  
12 comparison group saying you're comparing apples to  
13 oranges. Do you have a reaction to that?

14 A. Right. Really, it's -- everything except in stably  
15 intact parents would be -- it's a kinship reduction, to  
16 some extent. So, I mean, even as I said earlier, like  
17 figuring out, so what counts as a step-family? How long do  
18 they have to live with their step-dad before he counts?  
19 As raising, I mean -- so there is a lot of subjective  
20 judgment calls in this stuff where you want to be clean  
21 and clear about it. And we have eight categories. But  
22 even in those comparison categories there is a lot -- it's  
23 not just that the category of mom and her partner is  
24 complex. It is. I mean, a mother and her stepfather is  
25 complex. Stepfather, dad and a stepmother, is when did it

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1 right. For that you kind of, the NLFSS gives information  
2 even though it's not a probability sample. You really --  
3 to map sort of how the children who grew up who were donor  
4 inseminated, their origin, you want that, and you want  
5 that in a big survey. You want it to get a national  
6 portrait of what that looks like and that doesn't exist.  
7 Right? A lot of things in this domain do not exist yet.

8 Q. Previous experts have testified that essentially  
9 putting together a group, a collection of these small  
10 convenient sample studies over time is just as good as one  
11 large population based study. Do you have an opinion on  
12 that?

13 A. They can be illuminating about certain dynamics.  
14 They not telling of what one should expect across the  
15 population. I mean, it's a strange calculation to say,  
16 you know, ten baseballs make a football. They are  
17 different kinds of studies.

18 So, when we are dealing with questions of wide  
19 import, I will always think we should privilege these  
20 nationally representative studies of which they exist.  
21 They are not cheap to do, but I think there is pressing  
22 interests in it so they ought to be conducted.

23 So I don't usually say that or think about like  
24 five of one thing equaling one or another. They are just  
25 very different. They have their own strength and

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1 occur? Did they break up again? So, the apples and oranges  
2 suggests there is -- it's kind of dualist or binary when  
3 the household rosters are complicated and people's lives  
4 are complicated. And with respect to the mothers who have  
5 had relationships with men of the same sex, the rosters  
6 are all over the place. There is a lot of household  
7 movement.

8 Q. Plaintiff's experts also criticized the NFSS as not  
9 revealing anything about the well-being of children being  
10 raised in families created by gays and lesbians. So in  
11 other words, ART or by donor insemination. Do you have a  
12 response to that?

13 A. Well, the point was of that was to map social  
14 reality in the United States population based sample,  
15 right? And that era -- there were clearly was probably not  
16 too many people who had children by artificial means, or  
17 Assisted Reproductive Technology or insemination.

18 What we don't know is how many, as of today,  
19 everybody assumes it's a lot more. We know that Assisted  
20 Reproductive Technology accounts for one and a half  
21 percent of all births today. And so, donor insemination  
22 or artificial technology, to say lesbian couples, what  
23 share of that 1.5 percent are theirs? I mean, it's  
24 certainly not half because they are not that numerous in  
25 the population. It's some small share of 1.5 percent, so,

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1 weaknesses. But in the case of something like some  
2 significant policy things at stake, I think you ought to  
3 error on the side of large data collection efforts  
4 underlying representative samples.

5 Q. Thank you.

6 A. We do this when elections come up, right? CNN poll,  
7 plus or minus 2 percent, who is voting for this or that  
8 candidate? You want that to be representative of a state  
9 or a country. You don't want to say CNN poll of the  
10 people working in our office. That is not going to tell  
11 us anything about what to expect in terms of what is  
12 probable among the collective.

13 Q. When was your article published in Social Science  
14 Research, the NFSS results?

15 A. July 2012. And followup was in November 2012.

16 Q. And what was the time line for publication of that  
17 article?

18 A. Tag line. I'm not sure what you're saying.

19 Q. Do you recall when the Social Science Research  
20 actually received that article?

21 A. When I submitted it to them?

22 Q. Correct.

23 A. Okay. Late January, early February.

24 Q. Okay. And do you recall when it was accepted by the  
25 journal?

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1 A. I would say sometime in the middle of March. Prompt.  
 2 Q. And would you agree that that time frame is  
 3 unusually fast?  
 4 A. It was unusually fast.  
 5 Q. Do you know why that happened?  
 6 A. I can only speculate. But the part that I  
 7 contributed to was that I was prompt in once I got reviews  
 8 back, I was prompt in returning, you know, the edited  
 9 manuscript or a revised manuscript to the Journal. So I  
 10 didn't keep it with me for very long. I could have kept  
 11 it for months. I mean, one of my mantras that I learned  
 12 in graduate school, when you revise and submit a decision,  
 13 you hurry up and you clear your desk and that's what you  
 14 focus on because that's your job is publishing. So, that  
 15 was my part.  
 16 When I first contacted the editor of the journal  
 17 to -- I knew this was a sensitive subject. Wanted to know  
 18 if he would consider it. And I had asked for a speedy  
 19 review under the logic that I was still writing this  
 20 report, this larger report. I was going to try to get an  
 21 overview study in. Maybe we could squeeze it in before  
 22 the large report that is due. And it's only due in my  
 23 head, right? Like March. And I pushed it back to May and  
 24 I pushed it back to -- it was going to be September of  
 25 2012. So I asked him for a speedy review of which an

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1 this study when they left all sorts of methodological  
 2 challenges go in previous studies. So, I know a lot of  
 3 people were unhappy with it or unhappy with what it  
 4 implied or something.  
 5 Q. Sure. You said that it was severe and swift. What  
 6 do you mean by that? What happened?  
 7 A. Well it came out in June 12, a few weeks early.  
 8 That's why the on-line version. And, man, within a day I  
 9 was, you know, receiving complaints and there was stuff on  
 10 the web trying to take down this, the analyses, and we  
 11 learned nothing from this article, etc. You learned  
 12 nothing from this article? Seems unlikely.  
 13 Q. Was there an effort to get your article retracted?  
 14 A. Yes. Probably at a couple different times.  
 15 Q. And do you know who led that effort?  
 16 A. Well, there was a blogosphere effort to do so, but I  
 17 know Gary Gates, I think, it was Gary Gates had got 200  
 18 people, a little over 200 people signed the letter. Only  
 19 a handful of them were family demographers. I went and  
 20 looked and read their list and who that was. I mean,  
 21 family demographers, I think know better what this kind of  
 22 data collection challenge is.  
 23 Somebody once said creation is difficult.  
 24 Destruction is easy. There is a list, a letter of 200  
 25 people complaining to the editor. I don't recall if they

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1 editor is not under any obligation to do.  
 2 Q. You mentioned that you had asked him to do that  
 3 because you knew this was going to be sensitive. What do  
 4 you mean by that?  
 5 A. I asked him if he would consider it because some,  
 6 you know, quite often when I will submit an article I will  
 7 check in first with the editor like, would you even accept  
 8 a submission on this topic? Sometimes they don't take  
 9 literature reviews. I have written one or two of those  
 10 before, or studies -- if you are wondering, you just write  
 11 the editor and say, are you accepting stuff like this?  
 12 But social science research typically, historically has  
 13 been known for publishing things that involve some sort of  
 14 novel methodology or novel approach to a research  
 15 question. So, that's why I thought of them. Right? And  
 16 I had been a reviewer for them at various points in the  
 17 past and I found them easy to work with.  
 18 Q. What was the reaction to your article?  
 19 A. It was severe and swift. Surprised me. I knew it  
 20 would stir the pot and some people would be upset. But it  
 21 was clear that draft copies of the article had been  
 22 circulating for quite some time, from whatever source. I  
 23 don't know. And so people had developed extensive  
 24 critiques. One of the weird things, it felt like all a  
 25 sudden everybody turned into a methodological purist with

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1 asked for outright retraction. Retraction is only in the  
 2 case of outright fabrication. So that is not -- has not  
 3 happened. But they complained about different aspects of  
 4 the study including the time line, including the use of  
 5 the acronyms for which I definitely wanted to make that  
 6 right in the November followup. So, some legitimate  
 7 criticisms of which there always are in studies, some that  
 8 I thought were a little over the top.  
 9 Q. Was there an audit conducted?  
 10 A. There was, which is a very strange experience, very  
 11 unusual experience with respect to a social science study.  
 12 I never heard of such a thing. I don't know why the  
 13 editor agreed to do that. He was getting a lot of flack  
 14 from what I could tell and that he did not expect. And  
 15 decided, okay, I think it was an editorial board member of  
 16 his who had -- who did not like me and has not liked me  
 17 for years, for whatever reason. I'm not really sure. Had  
 18 agreed, who basically volunteered to do an audit and the  
 19 editor seemed to say, well, you can't -- we can't -- we  
 20 can't --  
 21 MS. COOPER: Objection. Hearsay.  
 22 THE COURT: It's not for the truth of the  
 23 matter. It's for the state of mind.  
 24 THE WITNESS: I should continue?  
 25 THE COURT: Do it from your perspective.

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**THE WITNESS:**

A. Sure. Can't be construed as being friendly. I mean, and he wasn't friendly, nor was he neutral. This is a person who has ranted in blogs for years about me and some other people, some other friends of mine, and gave the audit job to him which, you know, that doesn't seem to compute.

So, he and the editor turned over, so far as I can tell, the correspondence around the article. And he solicited University of Texas for all my grant expenditures on it and audited the process and concluded that he didn't think the article should be published. He thought it was deeply flawed, etc. And I'm not sure if it's just because I didn't control for instability or not. But, deeply flawed, etc. But concluded -- he could foresee why the editor would have made the decision. He had three reviews in hand that all said, publish. So, he seemed to exonerate the editor and then took off on a rant on the article itself which did not seem to be part of the audit. The audit is to review process, not to review the article. So that was done, I don't know, late summer of 2012. All very prompt. I mean, cooler heads would say let science work this out another time, right?. And I was still intending to release my data which I did in November, October.

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sort of thing. They looked through my e-mail, and then I have to go in front of a little tribunal of four or five department chairs and the scientific misconduct officer reading the eight charges of a blogger from New York who is not an academic. Strange stuff.

Q. What was the ultimate result of that scientific misconduct?

A. There are two processes to this. Misconduct review, and if they find ample evidence, they ask for a scientific misconduct investigation. The whole thing is supposed to operate in where both parties are going to be quiet. The blogger was not quiet. Right? So, but the end result is I appeared before this little tribunal and told them my side of the story. They evaluated it and recommended it to the Provost to dismiss the case and not open the scientific misconduct investigation. And the Provost accepted their decision.

Q. It was dismissed at that first stage of the process?

A. It was.

Q. Did all of this controversy surrounding the release of your article, did that leave you to ultimately write that followup article.

A. That was -- not inherently, but that was a request from the editor of the social science research. He said, Mark, you know, you're getting a lot of criticism. I

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Q. Who conducted that audit?

A. Darren Sheraat (ph), Professor of Sociology at Southern Illinois.

Q. In your opinion, that was not an objective audit?

A. I think that is an understatement.

Q. Was your article every retracted?

A. It was not.

Q. Did all -- well, strike that. Baking up a little bit. Was there also some allegation of misconduct that resulted from the publication of the article?

A. Let's see. June 12 had come out. By July 5th, University of Texas Research Integrity Officer said, Mark, we are opening a scientific misconduct review of your case. And I'm like, you're kidding me.

**THE COURT CLERK:** Can you speak into the mike a little bit?

A. By early July, the scientific integrity officer at the University of Texas said, Mark, we have to open a scientific misconduct review of you which stunned me. And it was a lie. We have had these allegations brought by someone who is claiming scientific misconduct. We are bound to do them. This was from a blogger in New York who had made outlandish accusations of me. Successfully got the university to put me under misconduct review, took all of my lap tops, hard drive, my computer, all records, that

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think I better open up some space in the November issue or whatever issue he had in mind for critics and for you to respond to your critics. So that is what he did.

Q. And was it November that that follow up was published?

A. It was.

Q. And what did that followup say?

A. I went back to the data and I looked at -- I sliced the pie some different ways. I had added seven different categories that makes it more complex in some ways, but one of the key things I did was sort of split the children whose mother had a same sex relationship into these two groups. Ones who lived with mom and her partner and ones who did not. That makes sense. On average they look quite similar over the outcomes. But it has more clarity in our mind about what the child -- what kind of situation they are in.

But even once where mom lived with the partner, as I said, their relationship durations were not lengthy on average. I think it's 22 percent is the statistic for -- of whom the mom's relationship was ongoing when they left the household at age 18. Otherwise they had, their household relationship had started, then stopped. 78 percent.

Q. You started touching on this earlier?

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1 A. I'm sorry. There is more to that question. You  
2 asked about the response. So there was that split. Then  
3 there is also addressing the apples and oranges thing  
4 which I had done a few minutes ago, talking about foster  
5 care because some critics said same sex couples are more  
6 likely to adopt from foster care. Went back to the data,  
7 to the household rosters, because we had foster care as an  
8 option. And so far as I could tell, there was only seven  
9 out of 21 cases where the child either left foster care to  
10 go with mother's partner and mother or else they went into  
11 foster care from that. I mean, otherwise foster care  
12 looked like randomly distributed across experiences in the  
13 household. So I didn't think the foster care story was  
14 what we were after. If you let me look, and I can briefly  
15 summarize the other criticisms I addressed.

16 Q. Sure, if that helps you recall.

17 A. In number seven. So I addressed the LM and GF thing  
18 where I said I shouldn't have done that. Classification.  
19 Addressed the apples and oranges thing where it's like not  
20 as easy as you might think. They are complex household  
21 structures. I addressed instability. Is it a controlled  
22 variable or a pathway of analysis, right?

23 Other people would suggest a path analysis  
24 approach which I did not do. One could do it with the  
25 data, so forth. This maternal same sex relationship, does

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1 it predict instability which then predicts poorer outcomes  
2 rather than mapping a direct influence from a maternal  
3 same sex relationship? I addressed the subject of what do  
4 you do with controlling for this thing?

5 I mean, and then the issue of instability, is it  
6 a thing of the past or what do we know about it? And  
7 that's where he talked about the Swedish data and  
8 Norwegian data. I mentioned Bidlars (ph) and Stacey in  
9 2010 when they did the literature review said they noted  
10 mostly this was from the convenience studies that lesbian  
11 parents face a, quote, somewhat greater risk of splitting  
12 up due in part to their, quote, high standards of  
13 equality.

14 I addressed that subject and people had said the  
15 emphasis it is not a representative sample. This is -- we  
16 should pay attention to Rosenfeld and the census, etc.  
17 This is garbage. And I said, it's not garbage. And it  
18 looks quite a bit like census estimates, NSFG  
19 characteristics, etc.

20 And the subject of mixed orientation marriages,  
21 which I don't know -- I don't always know, was this a  
22 marriage that ended. In the graph I showed and that is  
23 from the November followup, what people were basically  
24 born in and what happened after that. But mixed  
25 orientation marriages. Some are, yeah. Plenty are. I

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1 didn't ask whether -- I just asked if the parents, the  
2 biological parents were divorced. Anyways, bisexuality  
3 was the subject -- I'm sure of these women are bisexual.  
4 Right? But one thing I did say in here, most of the time  
5 when in the cases of when the respondent lived with mom or  
6 partner, she had exited an opposite sex union, entered a  
7 same sex union, either exited that -- or basically saying  
8 they didn't know, man, woman, man. So it looked more like  
9 a former heterosexual union, now a same sex union.

10 I addressed the subject but said it would be  
11 impossible to tell. Those are the things that I sought to  
12 address in that.

13 Q. Thank you. So, again, turning now, you touched on  
14 this earlier and I want to circle back to it, in talking  
15 about the topic of this area being a new area of social  
16 science.

17 In your opinion, Doctor Regnerus, what has the  
18 social science of same sex parents based on convenient  
19 samples taught us to date?

20 A. I think it taught us about the dynamics going on  
21 within same sex households. It's also shown us it's  
22 possible to be stably raised in lesbian couple households.  
23 And if it's possible, it doesn't show it's probable. I  
24 mean, these convenience samples are not -- you can get  
25 what is possible from them. I think Paul Amato (ph)

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1 brings this up in his response in the July article, you  
2 know. He said if it would have been terribly destructive  
3 we should have seen it by now, these convenience studies.  
4 We see it's possible. We don't get a sense of what the  
5 most likely outcome is. And you don't get that unless you  
6 use probability based studies.

7 Q. Are you aware of other probability based studies  
8 that have found sub-optimal outcomes for children raised  
9 in same sex homes?

10 A. I mean, in Rosenfeld's assessment of the census, he  
11 disputes this with Price, Allen, Pakaluk. But you look at  
12 the raw numbers, the children who grow up in heterosexual  
13 stably coupled heterosexual households fare better. It's  
14 comparable. Nothing statistically significantly  
15 different. That's one outcome. Academic progress in  
16 school. Potter's longitudinal studies, that is also an  
17 academic progress thing. This was 40 outcomes. So that  
18 was lot to chew on. But the science really is young here.  
19 Think about this. This is the study that has come out  
20 with the most outcomes, right? Don't you think we should  
21 have more of these kinds of things?

22 One of the kind of mantras of responses to  
23 critics didn't come from me, but from some people, said if  
24 you don't like the study, go field your own population  
25 based national representative study and ask the questions

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1 you like. I really think it's too early to tell a lot of  
2 these things. And until we have more data I think it's  
3 rational and prudent of states to be very careful and to  
4 privilege what we already know to be true about the stably  
5 coupled married opposite sex households and tread very  
6 carefully what we don't know to be true.

7 Q. Would Doug Allen's study of the Canadian census be  
8 another probability study that showed sub-optimal  
9 outcomes?

10 A. It is. I read it and I wrote a brief thing about  
11 it. It's not -- that kind of thing other people can  
12 analyze because you had to apply to the Canadian  
13 Government to look at it and he no longer has access to it  
14 himself. But he found less optimal outcomes. So people  
15 pushing back and forth on that study too.

16 Q. And just to make it clear for the record, when you  
17 are talking about this debate between Doctor Rosenfeld and  
18 Doctors Price, Allen, Pakaluk, we are talking about the  
19 study of the United States census data regarding  
20 children's progress in school, correct?

21 A. Correct.

22 Q. Okay. And do you have an opinion regarding that  
23 debate?

24 A. A modest opinion, you know, back to this sort of,  
25 what are you going to do about instability? Is it

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1 relevant? Is it a controlled variable or is it something  
2 to wrestle with? And I have some doubt on the side that  
3 it's something to be open about and wrestle with rather  
4 than to control for and mask probably because I'm not  
5 making a claim that same sex orientation causes something,  
6 right?

7 But to say, you know, the experience of parental  
8 same sexual relationship was associated with, correlated  
9 with greater household instability. And when you control  
10 for it and say there is no differences, you know, people  
11 do that, but I don't think it has -- that certainly has  
12 not shed light on the social reality of the children in  
13 those circumstances.

14 Q. You used the terminology, privilege, several times?

15 A. Privilege samples? That sort of thing?

16 Q. You just mentioned we should privilege what we have  
17 known.

18 A. Right.

19 Q. I want to make sure it's clear what you mean that we  
20 should privilege something?

21 A. I mean, in this case, you know, I think the State of  
22 Michigan should tread carefully and privilege the  
23 definition of marriage as between a man and woman because  
24 historically, and still in this data set, you see that  
25 it's the optimal child development environment for kids

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1 into adulthood even. Right? Not just in their growing up  
2 years. So I think we should privilege what we can learn  
3 from especially -- from these large data collection  
4 projects in our decision making about what is prudent and  
5 what is best to do.

6 Q. Doctor Regnerus, do you believe that this issue is  
7 settled? So, in other words, there are no difference in  
8 outcomes between --

9 A. No.

10 Q. -- children of same sex couples and children of  
11 opposite sex couples?

12 A. Nothing -- it's not that nothing can ever be  
13 settled, but we are definitely sort you in the novel  
14 period of social science on relationships. I highly  
15 recommend more data collection efforts, prudence going  
16 forward with respect to large scale social changes. But  
17 we have not settled anything. I think is what we have  
18 learned is that it's possible to grow up in a same sex  
19 household and the children be fine. You will only learn  
20 if it's probable until you really track kids over time  
21 with a lot of cases, far more cases than we have seen to  
22 this point.

23 Q. Doctor Regnerus, are you affiliated with any  
24 particular religion?

25 A. I am Roman Catholic.

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1 Q. So that's a yes?

2 A. Yes.

3 Q. Does that affiliation affect your research in any  
4 way?

5 A. I would say people think it does in this stuff but I  
6 don't see it, frankly. I mean, there is no Catholic way  
7 of doing statistics or sampling strategy. I think, if  
8 anything, it shapes research questions I am interested in.  
9 But I'm not afraid of what data has to say. So I think it  
10 shapes the kinds of things I study but not like the  
11 process of studying them.

12 Q. Do you have a belief about marriage, what it is or  
13 what it means?

14 A. I do.

15 Q. What is that?

16 A. I think that marriage is essentially a union between  
17 a man and a woman. It's intended to be permanent.

18 Q. Are there specific norms of that relationship or  
19 requirements of that relationship that you believe in?

20 A. I mentioned permanence. On average, marriage is,  
21 among younger people, is to expect to welcome children. I  
22 think partners expect sexual fidelity. I don't think  
23 people who marry want to or expect to cheat or leave. So  
24 I think it's built into the fabric of marriage, this sort  
25 of permanent you and me, and baby makes three kind of

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1 mentality. And I think it's been true for a long time.  
2 Q. So that I am clear, so, three, for lack of a better  
3 term, requirements of marriage in your opinion are  
4 permanence, fidelity or exclusivity --  
5 A. Requirements?  
6 Q. Components. Is that a better term?  
7 A. Components. Historically, generally speaking,  
8 stable components. I mean, we can error on polygamy. But  
9 I think we moved away from that era. And I don't think  
10 people on the average wish for that.  
11 Q. I apologize for the terminology. So, again, three  
12 main components in your estimation are permanence,  
13 exclusivity and an expectation of producing children?  
14 A. Right. That's not always the case with people but  
15 that's historically been part of the arrangement. And,  
16 you know, you see in the data, I didn't create that in my  
17 mind, but when you see permanence, I don't have a measure  
18 of fidelity among the in tact biological families.  
19 Permanence and, you know, children, I mean, the children  
20 flourish in that environment.  
21 Q. What is your basis for that opinion or definition of  
22 marriage?  
23 A. I don't know. It's a pretty historically stable  
24 basis. I don't think -- I mean, the Catholic Church likes  
25 that argument. But I don't think it's uniquely religious

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1 actually be used, correct?  
2 A. Not used in general, but used -- in this particular  
3 case, to settle an intellectual dispute about No  
4 Differences, I think it's unwise to lean on so many of  
5 those or at least not exclusively. And the case in  
6 general, I think you can learn about stability in same sex  
7 couples households, but you don't want -- so I think you  
8 should privilege larger non-probability samples to get  
9 information about what is going on in the public and the  
10 underlying population of both opposite sex and same sex  
11 couples as a whole.  
12 Q. So let me ask you this. If there were population  
13 based studies that showed equivalent outcomes for children  
14 raised by same sex couples and opposite sex biological  
15 parents, would you reconsider your position with regard to  
16 same second marriage?  
17 A. Can you say that again?  
18 Q. Sure. If there were population based studies that  
19 show equivalent outcomes for children raised by same sex  
20 couples and opposite sex biological parents, would you  
21 consider your position about same sex marriage?  
22 A. I mean, there are probability based studies that do  
23 this. And even the NFSS in all fairness, 25 out of 40  
24 outcomes where there are differences, it's not 40 out of  
25 40. It's -- and even on the outcomes are there kids that

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1 in origin. It's fairly stable over time. It's  
2 cross-religion, cross-culture.  
3 MS. COOPER: Objection. It's beyond the  
4 scope.  
5 THE COURT: Sustained.  
6 BY MS. HEYSE:  
7 Q. Do you have an opinion about redefining marriage to  
8 include same sex couples?  
9 A. I don't think it's a good idea.  
10 Q. And did that opinion affect your research in any  
11 way?  
12 A. No. Not in how I conducted the research. I mean,  
13 it was -- the research question is a curiosity about how  
14 children fare in same sex households but it didn't affect  
15 the conduct of it. I mean, if it did, then I wouldn't  
16 have gathered together a group of diverse consultants and  
17 have different people weigh in on how we are going to do  
18 this. So, which I did those things.  
19 Q. Doctor Regnerus, your testimony and your work places  
20 a lot of emphasis on population based or probability  
21 studies. Would that be accurate?  
22 A. Yes. I have done other things, but I always like  
23 doing things with large probability based studies.  
24 Q. And you've been critical at least in your testimony  
25 today to the extent that non-probability studies can

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1 fare just fine and kids of opposite sex couples that are  
2 not faring fine. So it's a likelihood of occurrence. I  
3 would want to see, certainly want to see more cases or  
4 more studies. I think what is most likely to be changed  
5 is my opinion about the No Differences thing, I mean, that  
6 until we get a lot more evidence from probability based  
7 studies I think we should be skeptical about that.  
8 Q. So kind of up to wrap up your testimony from today,  
9 Doctor Regnerus, based on the NFSS and your knowledge of  
10 the research in this area, have you formed any opinions  
11 relative to this case?  
12 A. Right. I mean, I think the NFSS data together with  
13 the disputes that go on around instability in the census  
14 data and things like that suggest that it's prudent to --  
15 for the state to retain its definition of marriage which  
16 was the will of the people as between one man and one  
17 woman. I think there is a wisdom in the people's  
18 assessments here. And it's wisdom borne out in the data.  
19 As I mentioned earlier, it's possible that there is a  
20 stably coupled lesbian, you know, household type that just  
21 doesn't show up in sufficient number of cases in  
22 probability based data to make claims, and certainly not  
23 to make major changes on it, right?  
24 I mean, two kids, and those two kids are okay.  
25 Well over a hundred. The odds are against it, right? And

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1 nothing is preventing people from having unions and having  
2 children. But the state has to consider the entire  
3 population of people, not just one group or not just sort  
4 of the most stable of a group. I mean, they have to  
5 consider the children as a whole and what is good for  
6 them. And that's why I think with respect to the  
7 population based data that is available, some of it  
8 highlighted here, the most prudent thing to do is wait and  
9 evaluate some of these changes over time before making any  
10 radical moves around marriage. Marriage has been around a  
11 long time. We are in the process of overhauling it very  
12 rapidly on modest information.

13 Q. And is that opinion -- let me back up. I want to  
14 make clear the opinions that you are expressing here  
15 today. Okay? In your opinion, Doctor Regnerus, what is  
16 the ideal environment for raising children?

17 A. When you are born into your married mother and  
18 father's life and they stay together, ideally, and into  
19 adulthood, right? I mean, that's the zero transitions,  
20 right? And kids fare best when they experience zero  
21 transition. Some transition can't be helped. Some  
22 transitions, the parent gets violent. Things like that.

23 But the states usually recognize it's a  
24 concession when we take a kid out of the household or a  
25 parent decides to leave a household or the parent dies.

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1 right? But APA, they wrote this years before we started  
2 really focusing on some of these population based broad  
3 nationally representative studies. And I think you should  
4 privilege those kind of studies because they tell you what  
5 is going on among the people, not just one small group.

6 Q. In light of that fact, that you don't believe there  
7 is research and data to definitively answer that question  
8 about child outcomes, do you have any opinion as to the  
9 wisdom of making decisions on these questions without that  
10 critical information?

11 A. I think in any business, they don't make critical  
12 decisions based on lack of information. I think nor  
13 should governments. We have started adding to a new  
14 science. I mean, a new field, so to speak. Some  
15 interesting information. Didn't know what I would find.  
16 I think it's prudent to collect more data before one makes  
17 any major conclusions on this. That doesn't seem to be  
18 the movement of what is going on in the country. I mean,  
19 people are asking for change prior to ample information.  
20 I think it would be prudent and wise to be patient and map  
21 this out. Map it out in multiple data over time before  
22 you jump in.

23 Q. So is it your opinion until we have that research  
24 and data, it's prudent for the State of Michigan to define  
25 marriage as between a man and a woman in order promote

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1 That's not optimal. Right? So, I think the idea of  
2 esteeming a kinship structure that by its very definition  
3 reduced in terms of a biological connection between child  
4 mother and father, I don't see why states would do that.  
5 I mean, it's not the optimal context for flourishing for  
6 children. It's a concession. I think states are prudent  
7 when they say, this is what is best. This is what we want  
8 for our children.

9 Q. In your opinion, Doctor Regnerus, can same sex  
10 couples raise children?

11 A. Sure.

12 Q. In your opinion, is there any conclusive evidence  
13 that shows that there are no differences in outcomes for  
14 children growing up in households with same sex  
15 relationships?

16 A. Say that again.

17 Q. Is there any conclusive evidence that there are no  
18 differences in outcomes for children growing up in a  
19 household with same sex relationships?

20 A. I don't think there is too many conclusive, too much  
21 conclusive evidence that there are no differences. I  
22 think there are some outcomes or some measures,  
23 relationship with the mother. But on average, I don't  
24 think we are anywhere near saying there is conclusive  
25 evidence that there is no difference. APA disagrees,

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1 what you believe is the ideal environment for raising  
2 children?

3 A. I do, yes.

4 MS. HEYSE: I have no further questions.

5 THE COURT: Thank you, very much. I think we  
6 will start Cross-Examination tomorrow. Tell me, what  
7 witness do you have, the state has lined up?

8 MS. HEYSE: We have Doctor Joseph Price  
9 coming tomorrow.

10 THE COURT: Tell me what is his science.

11 MS. HEYSE: He is -- economics, yes.

12 THE COURT: Okay. And good. So in terms of  
13 timing, we will do Cross-Examination and then you will  
14 call Doctor Price?

15 MS. HEYSE: Correct.

16 THE COURT: Okay. Any questions?

17 MS. NESSEL: I have a question regarding

18 Doctor Price. I was told by counsel there is a power  
19 point presentation to accompany his testimony. We have  
20 not received it and I was wondering if we could get a time  
21 line.

22 THE COURT: Soon to have that.

23 MS. HEYSE: Sure. I am happy to do that. We  
24 had some similar incidents with plaintiff's counsel. We  
25 are happy to provide it to them. We are just doing some

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1 finalization.

2 **THE COURT:** As soon as you get it, e-mail it  
3 to them.

4 **MS. HEYSE:** I got Ms. Nessel's e-mail address  
5 to make sure I can get that to her.

6 **THE COURT:** Perfect. See you in the morning.

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1 **C E R T I F I C A T I O N**

2 I, Lawrence R. Przybysz, official court reporter  
3 for the United States District Court, Eastern District of  
4 Michigan, Southern Division, appointed pursuant to the  
5 provisions of Title 28, United States Code, Section 753,  
6 do hereby certify that the foregoing is a correct  
7 transcript of the proceedings in the above-entitled cause  
8 on the date hereinbefore set forth.

9 I do further certify that the foregoing  
10 transcript has been prepared by me or under my direction.

11  
12 s/Lawrence R. Przybysz  
13 Official Court Reporter

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# Exhibit 8

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2

UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

I N D E X

APRIL DEBOER, ET. AL.,

Plaintiffs,

-v-

Case Number: 12-10285

RICHARD SNYDER, ET. AL.,

Defendants.

/ VOLUME 6 - AM SESSION

BENCH TRIAL  
BEFORE THE HONORABLE BERNARD A. FRIEDMAN  
UNITED STATES DISTRICT JUDGE  
100 U. S. Courthouse & Federal Building  
231 West Lafayette Boulevard West  
Detroit, Michigan 48226  
TUESDAY, MARCH 4<sup>TH</sup>, 2014

APPEARANCES:

For the Plaintiffs:

Vickie L. Henry, Esq.  
Leslie Cooper, Esq.  
Carole M. Stanyar, Esq.  
Dana M. Nessel, Esq.  
Kenneth Mogill, Esq.  
Robert Sedler, Esq.

For the Defendants:

Richard Snyder,  
Bill Schuette,

Tonya C. Jeter, Esq.  
Kristin M. Heyse, Esq.  
Joseph E. Potchen, Esq.

Lisa Brown

Beth M. Rivers, Esq.  
Andrea J. Johnson, Esq.  
Michael L. Pitt, Esq.

To Obtain Certified Transcript, Contact:  
JOAN L. MORGAN, OFFICIAL COURT REPORTER  
734 812-2672

3

I N D E X

STATE DEFENDANTS' CASE

Preliminary Matters

4

WITNESS:

PAGE:

MARK REGNERUS, Ph.D.

Cross-Examination by Ms. Cooper

10

E X H I B I T S

RECEIVED:

None.

BENCH TRIAL - VOLUME 6 - PART A  
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1 Detroit, Michigan  
2 Tuesday, March 4<sup>th</sup>, 2014  
3 (At or about 9:00 a.m.)  
4 -- --- --  
5 THE COURT: You may be seated.  
6 Just before our morning break, we'll talk a  
7 little bit about scheduling so we have some idea.  
8 Doctor -- is he here?  
9 MS. HEYSE: Plaintiffs have some preliminary  
10 matters, your Honor.  
11 What do you have?  
12 MS. NESSEL: Good morning your Honor.  
13 When we recessed yesterday I brought to the  
14 Court's attention the fact that Ms. Heyse had indicated to  
15 me that she intended to present a power point presentation  
16 for Joseph Price who is scheduled to be the witness after  
17 Dr. Regnerus today.  
18 THE COURT: Right.  
19 MS. NESSEL: I had asked for the presentation as  
20 quickly as possible. Despite the fact that we sent a couple  
21 emails requesting it following court, I did not receive an  
22 email with the presentation until like 10:28 last night.  
23 The presentation involves many complex charts and  
24 graphs that I've never seen before. And the content of this  
25 just from my quick review of it, it appears to include some

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content that was never in Dr. Prices' expert report. So I am requesting of the Court one of a number of remedies: Either that the Court strike the power point and not permit that to be used or that Dr. Price instead of testifying after Dr. Regnerus which I think everybody assumes will be today that he not testify until tomorrow which would give me an opportunity to review all this matter. Or in the alternative give an extensive, a lengthy, lengthy recess following Dr. Regnerus' testimony so that I have an opportunity to review all this because this is a lot of material and I've never seen it before. Obviously at 10:30 at night, you know, I was going to bed.

THE COURT: Going to bed. This is an important case.

MS. NESSEL: I know.

THE COURT: Wait a minute.

MS. NESSEL: I haven't had an opportunity to --

THE COURT: Ten thirty, you're suppose to take your No-Doze.

MS. NESSEL: I know. If it was over the counter, then, yes.

So those are my requests to the Court, your Honor.

THE COURT: What does the State have to say?

MS. HEYSE: Good morning, your Honor.

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I'm happy to address this but before I do I just want to take a brief moment.

Your Honor had asked me to introduce members of our staff.

THE COURT: I did.

MS. HEYSE: They were able to come to court.

THE COURT: Please do.

MS. HEYSE: I do want to point out that one of our newest Assistant Attorney General is Scott Shimkus who is in the courtroom here today.

THE COURT: Nice to see you.

MS. HEYSE: He has been a tremendous help to the team in preparing for the case so I did want to acknowledge him.

THE COURT: Good to have you. We're trying to get everybody acknowledged.

MS. HEYSE: Thank you, so much for that opportunity, your Honor.

And, again, I'm happy to address Ms. Nessel's requests. She is absolutely right that we were unable to get her the power point until later in the evening yesterday. I don't dispute that. The fact of the matter is that we left here, we went to meet with our witness who came in from out of state, was able to go over the power point with him, and finalize it so we could get them the

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final version.

Just to represent to your Honor, it certainly wasn't anything that was purposeful on our part. We got to it as I represented yesterday, got it to her as soon as we possibly could.

I would point out just a few things, your Honor, with regard to this matter. It is demonstrative evidence. Everything that is in that power point and I won't dispute the fact that there are quite a few slides. Everything that is in that power point is either contained in Dr. Price's report or his article that is going to be admitted. Again, it's demonstrative so we're not moving for admission, it's just something he's going to be discussing during his testimony.

I also point out for your Honor that, you know, we've had similar experiences with plaintiffs in this matter as well. We had some last minute changes from them with regard to two power points that we just bring to the Court's attention because quite frankly these things just happen in trial. So, you know, we would ask that we be allowed to use the power point. We certainly don't have any objection if Ms. Nessel needs additional time to prepare. We have no objection to that, your Honor, but we would ask that we be allowed to present the power point.

THE COURT: Okay. I think -- demonstrative

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evidence is just that, it demonstrates or helps the witness demonstrate to the Court in an easier fashion. We had a policy that each side would exchange it as soon as they had it. Each side in this case has gotten along, the civility is great. I have no reason to believe that the State didn't get it to them -- to the plaintiffs as soon they could. So what we're going to do, we'll proceed. It's demonstrative, it's not anything else.

Ms. Nessel, if there comes a time when it becomes necessary to have more time, we'll certainly talk about. I have no problems with that. But I think -- let's see what it's all about. As I say, we've seen demonstrative evidence before. And, again, it's only to demonstrate and to help the Court and those are here understand the testimony.

It is limited, however, of course, to the report. If it exceeds the report then there would be I suspect an objection indicating that -- not so much demonstrative evidence but the testimony itself because the demonstrative evidence is not evidence.

So we'll proceed and take it one step at a time.

MS. NESSEL: May I just briefly, your Honor?

THE COURT: Yes.

MS. NESSEL: My only issue, your Honor, is that I won't know that until I see it presented since I haven't had an opportunity to review it. So that's why I'm asking

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1 to have some kind of lengthier recess so that I can at  
2 least review the slides to know whether they were in the  
3 report or not. It's very difficult as you can imagine the  
4 second that it appears for me then to know, you know, was  
5 it in the report --

6 THE COURT: But you know -- okay. I'm going to  
7 give you some time. But you know, it's in the report. It's  
8 not what's on the screen that counts, it's what the expert  
9 testifies to. If he's testifying to something to whether it  
10 be on the screen or based upon his testimony, and it's not  
11 in his report then I would suspect that you're going to  
12 make an objection. You already know the report I'm sure  
13 backwards and forwards. So you will be able to make that  
14 objection. It has no bearing whatsoever to the  
15 demonstrative evidence. It has to do with his sworn  
16 testimony.

17 MS. NESSEL: I would only bring to the Court's  
18 attention, there's some very complex charts and graphs with  
19 many, many numbers so I have to be able to go through the  
20 numbers to --

21 THE COURT: Let's take it one at a time. Let's  
22 move on.

23 MS. NESSEL: All right.

24 THE COURT: We'll see. We may get a break and it  
25 may be right at the right time for lunch, and we may take a

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1 little longer lunch. Let's take a look. We're not going to  
2 jam either side. I think each side throughout this whole  
3 trial their intent wasn't to do anything to the other side.

4 Let's move on. Anything else?

5 MS. STANYAR: No, your Honor.

6 THE COURT: Okay. Where's our witness?

7 We're not going to re-swear you, you're still  
8 under oath.

9 Counsel, you may proceed.

10 MS. COOPER: Thank you.

11 THE COURT: I don't know if the witness has met  
12 you.

13 M A R K R E G N E R U S, P H.D.,  
14 HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

15 CROSS-EXAMINATION

16 BY MS. COOPER:

17 Q Leslie Cooper.

18 Good to see you live in person.

19 Good morning.

20 A Good morning.

21 Doctor Regnerus, you mentioned on Direct Exam  
22 yesterday that you asked two of the plaintiffs' expert  
23 witnesses, Michael Rosenfeld and Gary Gates to serve as  
24 consultants on your NFSS Study; is that right?

25 A Yes.

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1 Q And you consider Michael Rosenfeld to be well-regarded  
2 professionally; is that right?

3 A Yes.

4 Q And you consider Gary Gates to be well-regarded in  
5 lesbian and gay demography; correct?

6 A Yes.

7 Q Now, turning your opinions, it's not your opinion, is  
8 it, that children raised by same sex parents necessarily  
9 have poor outcomes; is that right?

10 A Would you restate that?

11 Q Sure. It's not your opinion is it that children raised  
12 by same sex parents necessarily have poor outcomes; is that  
13 right?

14 A Poorer outcomes.

15 Q Poorer outcomes.

16 A That is not my opinion.

17 Q And you agree that the social science of gay parenting  
18 based on non-probability samples have taught us that it is  
19 possible for children raised in same sex households to  
20 develop normally; is that right?

21 A Yes.

22 Q In fact, you wrote in your -- in one of your NFSS  
23 articles that most of the respondents in your own NFSS  
24 Study report ample success and largely avoid problematic  
25 physical and emotional difficulties regardless of their

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1 parents' experiences; is that right?

2 A It depends on the different outcomes. You know, some  
3 outcomes that's certainly true.

4 THE COURT: Speak a little bit slower.

5 BY MS. COOPER:

6 Q And you have written that,

7 "It's possible that there may be genuinely be two  
8 gold standards of family stability and context for children  
9 flourishing, a stably couple heterosexual household and a  
10 stably couple homosexual household but no population base  
11 sample analyses have yet been able to consistently confirm  
12 wide evidence of the latter"; is that right?

13 A Yes, presuming you're directly quoting from --

14 Q Your report.

15 A The report, yes.

16 Q Okay. You have recognized that studies using non-  
17 population base samples suggest that children in planned  
18 gay, lesbian, bisexual families seem to fair comparatively  
19 well; is that right?

20 A Could you repeat that once more?

21 Q Sure.

22 MS. HEYSE: Your Honor, I would ask that if we're  
23 going to have lengthy quotes that Dr. Regnerus be able to  
24 see a copy of what she's quoting from?

25 THE COURT: I think he has the report.

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1 MS. COOPER: This was from the study itself.  
2 BY MS. COOPER:  
3 Q Do you have a copy of your NFSS Study?  
4 A From the study itself?  
5 Q The study itself?  
6 THE COURT: Do you remember what exhibit --  
7 MS. HEYSE: Exhibit 6 from your original article.  
8 THE COURT: Counsel, you can continue to ask him  
9 questions, but just kind of refer him to the page.  
10 BY MS. COOPER:  
11 Q Looking at page 766, the conclusion section.  
12 A Yes.  
13 Q Bottom of the first paragraph, if you'll read with me.  
14 You reference that,  
15 "While previous studies suggest that children in  
16 planned GLB families seem to fare comparatively well": is  
17 that right?  
18 A Yes.  
19 Q Okay. Now you also believe that we should privilege  
20 the collection of probability base data over other data; is  
21 that right?  
22 A Yes.  
23 Q In your view, the hallmark of a rigorous study is a  
24 large representative pool of participants drawn from a  
25 population base random sample; is that right?

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1 A That's correct.  
2 Q But you recognize that this is not necessarily true  
3 within the field of psychology; is that right?  
4 A I know psychologists don't privilege those kind of  
5 samples in the way that sociologists or certainly  
6 demographers do.  
7 Q And your understanding is that most research in  
8 psychology uses smaller non-representative samples; right?  
9 A I wouldn't speak for all of psychology, but there are  
10 plenty that privilege smaller samples for sure.  
11 Q Okay. You had your deposition taken in January; is  
12 that right?  
13 A Yes.  
14 Q And you have a copy of your transcript there? I have  
15 one for you.  
16 If you turn with me to page 19. Line 19,  
17 beginning there,  
18 "Question: And is it true that most research in  
19 psychology uses smaller non-representative samples?  
20 "Answer: That is my understanding."  
21 Did I read that correctly?  
22 A Yes.  
23 Q Thank you. Now, yesterday on Direct testimony you  
24 talked about your criticism of the research on gay parent  
25 families that was discussed in a report by the American

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1 Psychological Association. Now that report was issued in  
2 2005; is that correct?  
3 A Right.  
4 Q And you're aware that research on children of same sex  
5 parents did not stop in 2005?  
6 A Correct.  
7 Q That there has been research conducted since then?  
8 A Yes.  
9 Q Now, yesterday you testified that it's premature I  
10 think is the word you used to allow same sex marriage until  
11 we have large scale population base longitudinal studies on  
12 outcomes for children of same sex couples; is that right?  
13 A Yeah, and I think the reference -- I could be mistaken  
14 but the reference is to premature to settle the signs  
15 around this stuff.  
16 Q Okay. You, yourself, did a large scale study of over  
17 15,000 individuals in the NFSS; is that right?  
18 A We screened 15,000. Interviewed fully just under  
19 3,000.  
20 Q You would call that a large scale study.  
21 A Yes.  
22 Q And after screening over 15,000 people you found only  
23 two who were raised from birth in a same sex parent family;  
24 is that right?  
25 A That's correct.

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1 Q That sample wasn't big enough to give you statistical  
2 power to evaluate children raised from the beginning in  
3 same sex families; right?  
4 A That is correct.  
5 Q You need a bigger group to do that.  
6 A Definitely.  
7 Q How many people do you think you would need to survey,  
8 to screen rather, to get a large enough group to study?  
9 A It depends a little bit on the outcome that you're  
10 evaluating. If on average the outcomes at face value differ  
11 markedly, for example, the sample -- in adults whose  
12 mothers have same sex relationship, mothers -- adult  
13 children whose mothers had a same sex relationship they  
14 tend to report experiencing poverty or being on community  
15 assistance at notably greater rates. It's like 70 percent  
16 or something compared to closer to 10 to 20 percent for  
17 intact biological families. When you have a profound  
18 difference one does not need lots of cases because there's  
19 already a notable difference in the effect. But when you're  
20 detecting smaller effects then you need a larger number of  
21 cases.  
22 So like my reference yesterday to the CNN poll  
23 where if two candidates are running neck and neck you need  
24 a larger sample size to distinguish whether there's a  
25 statistically significant difference between those two. But

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1 if one is being -- in the other 70 to 30 you don't need  
2 that many cases. But certainly more than two, certainly  
3 more than -- ideally well over -- more than 50 or a 100.  
4 Q Okay. So if they need more than 50 or 100 let's say --  
5 A Ideally. It depends on the outcome and how different  
6 those outcomes are.  
7 Q So by my math to get 50 if your 15,000 people yielded  
8 only two to get 50 -- you can check my math -- you would  
9 have to have 375,000 people screened?  
10 A I don't have to check your math, but it's -- it's a  
11 lot more than 15,000 to screen which indicates that we're  
12 not only dealing with a small population among whom  
13 stability was comparatively rare in that era, but we're  
14 also -- I mean, it calls for more data analysis. So this is  
15 why people are interested in the census and what it has to  
16 say on this, or the versions of the census, The American  
17 Community Survey. But it raises an interest in new data  
18 collection.  
19 Q Because the census data doesn't actually provide  
20 information on child outcomes; right?  
21 A Not many.  
22 Q School progress is one.  
23 A Right.  
24 Q Okay. How much did it cost you to do the project  
25 surveying or screening 15,000 people?

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1 A You're saying how much did it cost?  
2 Q How much did it cost to do that survey?  
3 A I think total about \$415,000.  
4 Q So to screen -- your survey was not longitudinal,  
5 right it was just one assessment.  
6 A Yes.  
7 Q So if it was -- you say 400 --  
8 A Four hundred fifteen is my recollection.  
9 Q So in order to screen say 375,000 people on multiple  
10 assessments can you even estimate the cost of that? Is it  
11 in the tens of millions of dollars to fund that?  
12 A I can't offhand estimate, but it's not something that  
13 the federal grant system can't handle if it wishes to study  
14 this.  
15 Q Is it common for researches to get grants in the tens  
16 and millions of dollars?  
17 A Well, I know that the Ad Health Project is now on it  
18 way four or five, that was in the eight figures I know in  
19 terms of the grant. I mean, it's unusual but it's not  
20 unheard of for those large federally funded grants.  
21 Q And do you expect anyone would fund a tens of millions  
22 of dollars study to assess whether children raised by same  
23 sex parents fair any differently than children raised by  
24 heterosexual couples when the professional groups in the  
25 fields of psychology, sociology and pediatrics have already

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1 said we have sufficient research to answer this question  
2 and we know the answer?  
3 A One of the things I think it ought to be added to is  
4 either an existing or an upcoming large federal grant and  
5 there's a handful of them out there at any given time. I'm  
6 not aware of what's out there right now. It could be tacked  
7 onto an existing children's study. So it's not -- for all I  
8 know it could be in the works, but I'm unaware of it.  
9 Q So in your opinion -- or is it your opinion that if  
10 the type of study you describe, a nationally representative  
11 large scale, longitudinal study if that type of study is  
12 never done because its cost prohibitive is it your view  
13 that we should just never allow same sex couples to marry?  
14 MS. HEYSE: Objection, your Honor. Calls for  
15 speculation.  
16 THE COURT: He's an expert. He can testify.  
17 A Well, there are other aspects to consider including  
18 scientific aspects. I mentioned in a deposition and I think  
19 I mentioned yesterday that marriage historically is about  
20 expectation of permanence, fidelity, and generally openness  
21 and welcoming of children. Scientifically and studies that  
22 we talked about yesterday permanence is -- permanence is  
23 less common especially in households of two women.  
24 Expectations of fidelity are less common in households of  
25 two men scientifically. And then you look at the welcoming

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1 of children and that's when we get into talking about  
2 expectations -- assisted reproductive technology which is  
3 very expensive and less expected among people of lower  
4 means. So it's not just about science around child  
5 outcomes. It's also a science around common expectations  
6 and marriage.  
7 Q So either if we had the type of study you would  
8 require that still wouldn't be -- that wouldn't answer the  
9 question and allow you to support same sex marriage.  
10 A There are more aspects to it than just a large child  
11 outcome study for sure.  
12 Q Now, I want to go back to your statement that there  
13 may be two gold standards of family stability and context  
14 for children flourishing, a stably coupled heterosexual  
15 household and a stably coupled homosexual household but no  
16 population base sample analyses have yet been able to  
17 consistently confirm wide evidence of the latter. That was  
18 your statement in your report; right?  
19 A Yes.  
20 Q Now, are there population base studies that  
21 consistently confirm that children of low income couples  
22 develop as well as children of higher income parents?  
23 A I'm going to ask you to repeat that one.  
24 Q Sure. Are there population base studies that  
25 consistently confirm that children of low income couples

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BENCH TRIAL - VOLUME 6 - PART A  
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1 develop as well as children of higher income couples?

2 MS. HEYSE: Objection, your Honor. That's outside  
3 the scope of his report.

4 THE COURT: Again, he's an expert and it's cross-  
5 examination. If he knows.

6 A Insofar as I know, yes.

7 BY MS. COOPER:

8 Q Confirming the equally good outcomes of children of  
9 low income and high income parents?

10 A Confirming that, no. I mean -- typically  
11 distinguishing that there are differences.

12 Q Right. So, in fact, studies show the opposite. It  
13 doesn't confirm that they are doing equally well, it  
14 confirms that children raised by low income parents don't  
15 on average develop as well.

16 A That's what I'm agreeing with.

17 Q Okay. Are there population base studies that  
18 consistently confirm that children of non-college educated  
19 parents develop as well as children of college educated  
20 parents?

21 A I know less about that, but on average I would expect  
22 there to be differences.

23 Q Right. Studies actually show the opposite that kids of  
24 non-college educated parents don't develop as well as  
25 children of college educated parents.

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1 A Typically insofar as it's associated with social class  
2 and life chances for children.

3 Q But you don't favor excluding low educated couples  
4 from marriage; is that right?

5 MS. HEYSE: Objection, your Honor. That's not  
6 relevant to these proceedings.

7 THE COURT: Overruled. Again, it's cross-  
8 examination.

9 A I do not.

10 BY MS. COOPER:

11 Q And you don't favor excluding low income people from  
12 marriage; is that right?

13 A I do not.

14 Q So it is not your view that marriage should be limited  
15 to those groups whose children are statistically most  
16 likely to have positive child development outcomes.

17 A Can you say that again?

18 Q It is not your view, is it, that marriage should be  
19 limited to those groups whose children are statistically  
20 most likely to have positive outcomes?

21 A Correct, it's not.

22 Q And it is not your opinion that groups that are known  
23 from the scientific research to raise children who fair  
24 more poorly should be excluded from marriage.

25 A Right.

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1 Q But in your view because there are, quote, outstanding  
2 questions about whether children develop as well in same  
3 sex households compared to opposite households that same  
4 sex couples should not be allowed to marry?

5 A It's my view that the science here is very new whereas  
6 the science around these other questions you've asked is  
7 notably older. So there's an intellectual debate going on  
8 though people would like to close it quickly, I think it  
9 should still be open and it should be further investigated  
10 about the no differences debate. But as I mentioned just a  
11 little bit earlier it doesn't tackle the question of the  
12 hallmarks, the historic hallmarks of marriage.

13 Q And that's a separate issue. We'll got to that.

14 MS. HEYSE: I'm going to object, your Honor. He  
15 should be able to finish his response.

16 THE COURT: He may complete his answer.

17 A I mean, it's not just about the science around child  
18 outcomes. It's also the science around long-standing  
19 expectations around marriage.

20 BY MS. COOPER:

21 Q So given -- you mentioned that the research on low  
22 income and low educated couples is more longstanding, that  
23 research actually confirms poor outcomes but you don't  
24 favor excluding those groups.

25 A Right.

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1 Q Okay.

2 A It's a function of sort -- they're more in line with  
3 the longstanding criteria around marriage especially to the  
4 idea that marriage unites man and woman and the  
5 expectations around children because I think still today  
6 half of all children that are born are unplanned. And  
7 marriage for a very long time has served to unite the  
8 parents, the biological parents of children in a union that  
9 will be protective of that child whereas -- I mean --

10 MS. COOPER: Your Honor, it's non-responsive to  
11 the question.

12 THE COURT: There's no question.

13 MS. COOPER: Thank you.

14 BY MS. COOPER:

15 Q Now, in your opinion and I think this was your  
16 ultimate opinion in your expert report and I'm happy to  
17 pull that out if you need but it's a sentence so you tell  
18 me.

19 In your opinion,

20 "It remains prudent for government to continue to  
21 recognize marriage as a union of a man and a woman thereby  
22 promoting what is known to be an ideal environment for  
23 children"; is that right?

24 A Yes.

25 Q Okay. Now, you recognize that same sex couples have

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1 children either through adoption or assisted reproduction  
2 including in states like Michigan where they can't marry.  
3 A Right.  
4 Q And you recognize that excluding same sex couples from  
5 marriage does not prevent them from having children in  
6 these ways.  
7 A That is true.  
8 Q And you're not aware of any data showing that allowing  
9 same sex couples to marry reduces the number of children  
10 who are raised in heterosexual biological parent families;  
11 is that right?  
12 A I'm unaware of that.  
13 Q So, in fact, you acknowledged, did you not that you  
14 don't actually know whether the exclusion of same sex  
15 couples from marriage actually does anything to promote  
16 what you consider to be the ideal environment for children.  
17 A Right, we don't know except that it's an open  
18 question. Moving forward there's more data to collect here.  
19 Q But you don't know.  
20 A I don't know.  
21 Q Okay. Now I want to ask you some questions about your  
22 NFSS Study. You noted yesterday that to be included in your  
23 "lesbian mother," or "gay father" groups the respondent had  
24 to affirmatively answer the following question:  
25 "From when you were born until age 18 or until

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1 you left home did either of your parents ever have a  
2 romantic relationship with someone of the same sex"; is  
3 that right?  
4 A Yes.  
5 Q And just for the record if I use "lesbian mother" or  
6 "gay father" terms I'm not using that to suggest anything  
7 about the sexual orientation of the individuals but those  
8 are the terms used in the study so I may use that in  
9 shorthand.  
10 For example, if a respondent reports that her  
11 mother had a relationship with another woman for, say, six  
12 months but otherwise only had relationships with men that  
13 individual would be put in the "lesbian mother" group;  
14 right?  
15 A Right, and in a followup I said it would be better to  
16 talk about this category as mothers who've had lesbian  
17 relationships or fathers who had gay relationships.  
18 Q But this individual would still be in that category.  
19 A Right, because the relationship was a same sex one.  
20 Q Okay. And over half of the respondents you deemed to  
21 fall into the "lesbian mother" category never actually  
22 lived in a same sex household; right?  
23 A Well, they didn't live in the household but their  
24 mother and her partner --  
25 Q So that's yes.

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1 A I don't purport to know how long the partnership  
2 lasted.  
3 Q But they never lived in an household where there was  
4 a same sex couple living.  
5 A Not according to them, yes, correct.  
6 Q Okay. And very few of the respondents that you deemed  
7 to be children of a "gay father" ever lived in a same sex  
8 couple household.  
9 A In that era that was particularly uncommon.  
10 Q So that's correct?  
11 A Did you say none of them ever --  
12 Q No, no, very few.  
13 A Few. I want to say 23 percent lived for some share of  
14 a year with their dad and his partner.  
15 Q And you have noted that a majority of the respondents  
16 you deemed to fall into the "lesbian mother" or "gay  
17 father" group were the product of a failed heterosexual  
18 union; correct?  
19 A I said a majority, did you say?  
20 Q Yes.  
21 A Yes.  
22 Q Now, your primary heterosexual parent comparison group  
23 or any of your heterosexual parent comparison groups were  
24 not defined by asking the question did your parent ever  
25 have a heterosexual relationship; right? That's not how you

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1 established groups.  
2 A That is correct.  
3 Q Your primary comparison group was a group of  
4 individuals who lived from birth to age 18 in an intact --  
5 two biological parent family; is that right?  
6 A According to them, yes.  
7 Q Well, all of this is according to them.  
8 A Yes.  
9 Q And this group which is called in shorthand IBF,  
10 intact biological family, excluded all divorced, a single  
11 parent, heterosexual families; right?  
12 A Excluded who?  
13 Q Divorced people?  
14 A Right. I mean, they may have had a divorce before the  
15 child came along. But the child experienced it as an intact  
16 biological family for the duration of their childhood.  
17 Q Okay. So any child who had experienced divorce was not  
18 in that group.  
19 A That is correct.  
20 Q And similarly any child who experienced single parent  
21 family life, that was stripped away, not in that group.  
22 A Correct.  
23 Q Okay. So the idea of intact biological family group  
24 was defined by the stability of the families.  
25 A Yes. I did that intentionally because stability has

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1 long been seen as a resource. And in a lot of the  
2 literature in this area the exact stability of the  
3 comparison group was often unclear sometimes entirely.  
4 Historically, stability is a good thing, I wanted  
5 to make sure that we understood the comparison category was  
6 fairly clear.  
7 Q So that's a yes it was defined by it being a stable  
8 family group.  
9 A Yes.  
10 Q Okay.  
11 A By the way, we don't know how happy this group was. I  
12 didn't make that -- are they together.  
13 Q So on the one hand you compared the two groups -- two  
14 of the groups in which a majority of the individuals had  
15 been through a family breakup. That would be the "lesbian  
16 mother" and "gay father" group. You compared them to a  
17 group that was defined by its stability, the intact  
18 biological parent -- sorry, intact biological family group.  
19 A Could you repeat the first part of that?  
20 Q Sure. You compared two groups in which the majority of  
21 the respondents had been through a family breakup. That  
22 would be the "lesbian mother" and "gay father" group. You  
23 compared them to a group that was defined by the stability  
24 of the group, the intact biological family group.  
25 A Yes.

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1 Q Okay.  
2 A That was not the criteria by which -- the criteria by  
3 which I sorted them whether they had a same sex -- the  
4 parents had a same sex relationship.  
5 Q But that was the comparison.  
6 A Yes.  
7 Q Now, the two respondents in the "lesbian mother" group  
8 who like the individuals in the "IBF" group lived from  
9 birth to age 18 in an intact stable family appeared well  
10 adjusted.  
11 A On average. I don't recall them being notably either  
12 way.  
13 Q Yesterday you testified they made --  
14 A Yes.  
15 Q And you recognize that I think you just said a few  
16 moments ago that stability is associated with better  
17 outcomes for children.  
18 A Right.  
19 Q And divorce is generally associated with poorer  
20 outcomes for children; is that right?  
21 A Yes.  
22 Q Now, yesterday you said you had no idea what the study  
23 would reveal before the data came in. Are you saying you  
24 really had no idea that a sample in which most of the  
25 subjects experienced a family breakup would fair worse than

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1 a comparison group where not a single one of the subjects  
2 had experienced the family breakup because it was defined  
3 to exclude those individuals?  
4 A What I mean by the statement is I had no idea what the  
5 -- when the data was in the field how it would return in  
6 terms of the number of people who had said their parents  
7 had same sex relationship or what their household calendars  
8 would look like. That's what I mean by I had no idea.  
9 Q But you recognize that in the era in which these  
10 individuals grew up planned same sex parent families was  
11 quite uncommon.  
12 A It was, and I mention that in the study.  
13 Q Okay. Now, you said yesterday I think that individuals  
14 in the "lesbian mother" group had outcomes that were very  
15 comparable to the individuals in the step family group; is  
16 that right?  
17 A If that's what I had said yesterday, I think -- step  
18 family, yeah.  
19 Q Okay.  
20 A I think what I said was in the followup study where I  
21 split the pies a little bit more narrow the fewest  
22 differences between cases where adult children had a mom or  
23 same sex relationship and they lived with their partner and  
24 single parents who did not have subsequent partners. I  
25 think that was the most close equation that I mentioned

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1 yesterday.  
2 Q But I think you also mentioned the comparison to step  
3 families were very comparable?  
4 A Slightly less but comparable.  
5 Q Okay. Now that actually wouldn't be surprising, would  
6 it, given that in almost every case in the "lesbian mother"  
7 group the mother's same sex partner was not an original  
8 member of the household. It was a later formed  
9 relationship.  
10 A Sure.  
11 Q Okay. Now, you made clear yesterday that you were not  
12 making any claims about causation regarding child outcome  
13 in the NFSS Study; is that right?  
14 A Right.  
15 Q Okay. In fact, you agree that the sub-optimal outcomes  
16 that you found in the "lesbian mother" and "gay father"  
17 groups may not be due to the sexual orientation of the  
18 parent; is that right?  
19 A Since I did not measure it, I cannot make a claim  
20 about it.  
21 Q Okay. Now, switching gears a little bit. I want to  
22 talk about the pool. So the respondents in the NFSS were  
23 ages 18 to 39; right?  
24 A Yes.  
25 Q So the data was collected in 2011 and 2012; right?

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1 A Yes.  
2 Q So that means they were born from 1972, to 1993; that  
3 window?  
4 A Yes.  
5 Q At the time the individuals in the NFSS were being  
6 raised, you agree that stigma was more pronounced and  
7 social support for lesbian and gay parents was far more  
8 modest than it is today; is that right?  
9 A I would suspect so. I did not measure that. I mean, I  
10 measured how often they were bullied, things like that, but  
11 one can presume so.  
12 Q Now, in your article on the NFSS you noted that it is  
13 often the case and it certainly is true of the NFSS that a  
14 gay or lesbian parent first formed a heterosexual union  
15 prior to coming out of the closet; right?  
16 A Right.  
17 Q And you also wrote that the NFSS may best capture what  
18 might be called "an earlier generation" of children of same  
19 sex parents and includes among them many who witnessed a  
20 failed heterosexual union."  
21 MS. HEYSE: Again, your Honor, I would just ask if  
22 we're going to be reading from specific --  
23 THE COURT: I agree, and a little bit slower.  
24 MS. COOPER: Sure, sure.  
25 BY MS. COOPER:

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1 Q You've got your NFSS article with you?  
2 A Yes.  
3 Q If you would turn to page 756, and if you look with me  
4 at the bottom paragraph on that page, second sentence.  
5 "Today's children of gay men and lesbian women  
6 are more apt to be 'planned' (that is, by using adoption,  
7 IVF, or surrogacy) than as little as 15-20 years ago, when  
8 such children were more typically the products of  
9 heterosexual unions."  
10 You wrote that?  
11 A Yes.  
12 Q Okay. Let's stay on page 756. Skip that.  
13 On page 765, if you go to the third paragraph  
14 from the bottom, last sentence,  
15 "Child outcomes in stable 'planned' GLB families  
16 and those that are the product of previous heterosexual  
17 unions are quite likely distinctive as previous studies  
18 conclusions would suggest."  
19 You wrote that?  
20 A Yes.  
21 Q Okay.  
22 A And I followed it up with sort of -- we don't know how  
23 many of those actually are.  
24 Q You don't believe that you can draw conclusions from  
25 your NFSS Study about outcomes for children in planned

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1 lesbian couple families; is that right?  
2 A If by "planned" you mean assisted reproductive  
3 technology things like that, yeah.  
4 Q Okay. Now, that's families like the plaintiffs --  
5 well, actually families like many couples seeking to marry  
6 and form families together; is that right?  
7 A I don't purport to know what share of that is true.  
8 Q Okay. I think you emphasized this yesterday but I want  
9 to make sure we understand that the NFSS Study documented  
10 differences statistically significant differences between  
11 groups. In other words, in the groups in the so-called  
12 lesbian mother group and those in the intact biological  
13 family group, but it did not concern itself with the  
14 magnitude of those differences.  
15 A Correct, and I stated in the article that was not my  
16 purpose.  
17 Q Now, you talked yesterday about the audit of the NFSS  
18 Study conducted by the Journal Social Science Research that  
19 -- the journal that published the study.  
20 A It was authorized by the journal. It was not conducted  
21 by the journal.  
22 Q Authorized by the journal, okay. And you expressed  
23 some views about the motives of the individual who wrote  
24 the audit, but one question about this that I just don't  
25 think was answered yesterday was -- it was the journal that

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1 published that audit; isn't that right?  
2 A I believe so.  
3 Q Now, are you familiar with a sociologist named Paul  
4 Amato?  
5 A Yes.  
6 Q He's a professor of sociology at Penn State?  
7 A Yes.  
8 Q And you consider Paul Amato to be a well-regarded  
9 scholar in family structure studies?  
10 A I do.  
11 Q You consider him to be a level and level-headed  
12 scholar?  
13 A Generally speaking.  
14 Q And you consider him to be a scholar who's right down  
15 the middle politically neither liberal, nor conservative?  
16 A He had struck me at one point. I have no idea if that  
17 is entirely accurate, but he strikes me as a moderate.  
18 Q And, in fact, you asked Paul Amato to be one of the  
19 consultants on your study.  
20 A I did.  
21 Q And he agreed?  
22 A He did.  
23 Q So he served as a consultant?  
24 A Yes.  
25 MS. COOPER: I like to mark a document as an

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1 exhibit for identification. It's Exhibit 54.  
2 MS. HEYSE: Your Honor, I would just ask that we  
3 be provided a copy. We have not seen it.  
4 THE COURT: I think counsel as a bunch of copies.  
5 MS. HEYSE: If we could have a few minutes to  
6 review?  
7 THE COURT: Sure. Show it to the witness so he can  
8 review it also.  
9 MS. HEYSE: Your Honor, I would just note for the  
10 record that we did agree to exchange exhibits in advance of  
11 the trial and this was not provided to us.  
12 THE COURT: Why was it not provided?  
13 MS. COOPER: This is being used for identification  
14 to ask questions, and it was an exhibit that was used at  
15 the deposition, they have it.  
16 THE COURT: Do you intend to introduce it?  
17 MS. COOPER: No.  
18 THE COURT: Okay.  
19 MS. HEYSE: Oh, I'm sorry.  
20 THE COURT: It's only for purposes of use, but not  
21 for --  
22 MS. COOPER: Not to admit.  
23 THE COURT: Okay.  
24 BY MS. COOPER:  
25 Q So, Dr. Regnerus, this is a statement Paul Amato wrote

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1 about your NFSS Study; is that right?  
2 A The source is a blog. I'm not sure what all of it is  
3 verbatim, Paul Amato's words, and what is --  
4 Q Well, I'll direct your attention. Thank you for  
5 clarifying.  
6 A This is not Paul Amato's blog.  
7 Q Understood. If you'll read with me. It says here --  
8 THE COURT: Tell him where you're reading.  
9 MS. COOPER: I just want to find the right  
10 passage.  
11 BY MS. COOPER:  
12 Q If you look at the second paragraph from the top.  
13 A First page?  
14 Q Yes. Second sentence,  
15 "I regret that before writing that post" --  
16 A Who wrote that?  
17 Q I'll clarify. The first three paragraphs in Italics  
18 are statements from somebody who wrote the blog, not  
19 attributable to Paul Amato.  
20 MS. HEYSE: I'm going to object, your Honor, to  
21 the extent this is hearsay.  
22 THE COURT: I'm not sure where she's going at.  
23 The first three were not written by --  
24 MS. COOPER: I'm trying to direct Professor  
25 Regnerus to the statement that this blogger says,

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1 "There is a statement sent to me by Paul Amato  
2 which I agree to post" and then he posts the statement  
3 below.  
4 A And who is he?  
5 THE COURT: Who is the blogger, is that your  
6 question?  
7 THE WITNESS: Yes.  
8 MS. COOPER: The blogger's name is Phil Cohen, I  
9 believe. This is something we looked at your deposition.  
10 BY MS. COOPER:  
11 Q Do you not recall identifying it?  
12 A I do, yeah. I just don't know -- I can't identify on  
13 this who wrote this top part.  
14 Q Okay. But the part I want to flag your attention to is  
15 in the second paragraph it says -- this is not Paul Amato,  
16 this is the blogger,  
17 "I regret that before" --  
18 MS. HEYSE: Your Honor, I'm going to object to the  
19 extent of reading something into the record --  
20 THE COURT: Sustained.  
21 The blogger said something and now what's your  
22 question?  
23 MS. COOPER: I don't really care what the blogger  
24 said, I just wanted to direct Professor Regnerus so the  
25 statement from Paul Amato that is posted here.

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1 THE COURT: Good.  
2 BY MS. COOPER:  
3 Q That begins,  
4 "Thoughts on the Mark Regnerus 2012 Study by Paul  
5 Amato."  
6 Do you see that heading in bold?  
7 A Yes.  
8 Q So that's the beginning of the statement.  
9 So I'd like you to turn to page 3 of this  
10 statement.  
11 A Are there's 12 pages to this? I'm only seeing four.  
12 Q This is the first four. I didn't print the comments to  
13 the blog because -- I think, in fact, that may have been  
14 something that counsel for defendants did not want to  
15 include in the exhibit. But either way I did not consider  
16 that.  
17 THE COURT: The exhibit is just to ask him  
18 questions.  
19 MS. COOPER: It's just to feature the statement.  
20 BY MS. COOPER:  
21 Q So if you can go to page 3 with me.  
22 A Okay. If you would look at the second paragraph from  
23 the bottom, okay, beginning with the second sentence, and  
24 read along with me,  
25 "Many" --

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MS. HEYSE: Your Honor, it's hearsay and she can't read it into the record.

MS. COOPER: It's not for the truth. I want to ask him if he agrees with statements made by one of his own consultants about his study.

THE COURT: For that purpose, you may.

BY MS. COOPER:

Q "Many conservative observers have cited the Regnerus study as if it provided evidence that being raised by gay or lesbian parents is harmful to children. This claim is disingenuous because the study found no such thing. A noteworthy example came from Regnerus himself who signed an amicus brief to the Supreme Court citing his study as evidence against same sex marriage. This is curious because on page 766 in his 2012 article, Regnerus stated that his study was not intended to either affirm or undermine the legal right to same sex marriage."

And on page 768 of his response to the commentaries in the same issue, he stated,

"That his data should not be used to press any political program. Given these cautious early statements it is exasperating to see Regnerus later cite his own study as evidence against same sex marriage."

So, first question about this: Is Professor Amato who is a consultant on your study correct to say that it is

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disingenuous to claim that the NFSS Study provides evidence that being raised by gay or lesbian parents is harmful to children?

A The question hinges around sort of what does it mean to be raised by, right? And I think we mentioned this a little bit yesterday and it says gay or lesbian parents. My mistake and acronyms notwithstanding I talk about parents who have same sex relationship with no assumptions about their orientation. So when he talks about being raised by which implies some degree of time I assume and household presence I assume. But then he goes and uses gay or lesbian as an adjective which I don't think -- I mean, I don't have data on the orientation, it's harmful to children. I think the jury is out on this, figuratively speaking. What we need is -- the absence raises significant questions about children who grow up in families where a parent has a same sex relationship.

What it doesn't answer his question about orientation, and it didn't come design to answer political questions. It came design to address an intellectual question.

Q Okay. So he is correct in your view that -- sorry. He is correct that you said the study was not intended to either affirm or undermine the legal rights of same sex marriage?

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A That's what I wrote in the original study, yes.

Q Okay. Okay. Great.

Now, are you aware that yesterday the Chair of the Sociology Department at the University of Texas, your department, issued a statement posted on its website stating the following:

"Like all faculty" --

MS. HEYSE: Objection, your Honor. Hearsay.

MS. COOPER: I'm happy to provide a copy if you like. I'm not seeking to admit it again -- happy to show a copy if you don't have it.

MS. HEYSE: I don't have a copy.

THE COURT: And, again, it's only for purposes of cross-examination.

MS. HEYSE: Thank you.

MS. COOPER: So I've marked this for identification as Exhibit 55.

BY MS. COOPER:

Q So, if you'll read along with me, the statement says, "Like all faculty Dr. Regnerus has the right to pursue his areas of research and express his point of view. However, Dr. Regnerus' opinions are his own. They do not reflect the views of the sociology department of the University of Texas at Austin. Nor do they reflect the views of the American Sociological Association which takes

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the position that the conclusions he draws from his study of gay parenting are fundamentally flawed on conceptual and methodological grounds and that findings from Dr. Regnerus' work have been cited inappropriately in efforts to diminish the civil rights and legitimacy of LGBTQ, partners and their families. We encourage society as a whole to evaluate his claims."

There's additional material but I just wanted to call your attention to that paragraph.

Were you aware of this statement?

A I saw it yesterday.

Q Okay. And what is your reaction to that?

A It's regrettable. I think the University has characterized my academic freedom. I guess they have been getting negative press probably about my appearance here, and decided to make a statement which they had not made before even though I had conducted the research -- the process a few years ago. The article came out a year and a half ago. I think they just wanted to distance themselves from me which is sad. And I heard from some of my colleagues that this was an inappropriate thing for the department to do.

Q And you are aware that The American Sociological Association did submit a brief, an amicus brief in the U.S. Supreme Court in the Windsor and Perry cases stating that

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1 your study doesn't allow for conclusions about being raised  
2 by -- the impact of being raised by same sex parents; is  
3 that right?  
4 A I'm aware of that.  
5 Q Okay. And I want to switch gears away from NFSS now  
6 and your research and ask about another study.  
7 You're familiar with a study done by Douglas  
8 Allen based on the Canadian Census that looks at high  
9 school graduation rates?  
10 A I've read and I wrote a little summary piece about it  
11 but I'm not intimately familiar with that data. It cannot  
12 be replicated so far as I can tell because it was  
13 proprietary to the Canadian Census.  
14 Q Okay. You mentioned that you wrote a little blog piece  
15 or a little article about that.  
16 A Yes.  
17 Q In that article you said that a limitation of this --  
18 actually, let me show it to you so we don't have any  
19 confusion here.  
20 The document I've marked for identification as  
21 Exhibit 56 called "A Married Mom and Dad Really Do Matter:  
22 New Evidence from Canada" that's the blog piece you wrote  
23 about the Allen study?  
24 A Yes.  
25 Q Okay. If you could turn with me to the second page.

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1 If you look at the third paragraph from the bottom, and  
2 read along. It says,  
3 "Every study has its limitations and this one  
4 does, too. It is unable to track the household history of  
5 children nor is it able to establish the circumstances of  
6 the birth of the children whose education is evaluated,  
7 that is, were they the product of a heterosexual union,  
8 adopted, or born via surrogate or assisted reproductive  
9 technology."  
10 You wrote that?  
11 A I did.  
12 Q Okay. And you have said that you would bet that given  
13 the time period in which these 17 to 22 year olds in  
14 Allen's study were born that many of the individuals who  
15 were in the same sex family group were the product of  
16 former heterosexual unions; right?  
17 A Did I say that? I don't think I said that.  
18 Q Well, let's take a look at your deposition.  
19 A I may have said it. If you could point to the page?  
20 Q Would you agree with that now?  
21 A If you would repeat the question.  
22 Q Sure. You would bet that given the time period in  
23 which the 17 to 22 year olds in Allen's study were born  
24 many of the individuals who were in the same sex family  
25 group were the product of a former heterosexual union.

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1 A It's likely given the timing.  
2 Q Sure.  
3 A Again, we don't really have good data on sort of ART  
4 in the past. We really don't have good data on it at the  
5 present.  
6 Q Okay. But you think it's likely.  
7 A It's likely.  
8 Q And you've said you suspect that planned same sex  
9 couple families were not what the Allen study evaluated on  
10 average.  
11 A I don't think he could, yeah. I mean --  
12 Q Okay. Now, there's been a lot of discussion about  
13 couple stability. So I want to ask you some questions about  
14 that.  
15 First of all, can you tell us generally what the  
16 divorce rate for heterosexuals is in this country?  
17 A What do you mean by divorce rate? Rate per year, I  
18 think it's two percent per year.  
19 Q Isn't the data over sort of a ten-year period?  
20 MS. HEYSE: Your Honor, I'm going to object.  
21 THE COURT: Let him answer.  
22 MS. COOPER: I'm sorry. I thought he was finished.  
23 My apologies. Go ahead.  
24 A My recollection is the divorce rate is, you know, it's  
25 24,000 married women per year.

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1 BY MS. COOPER:  
2 Q Okay. And is there data showing the divorce rate over,  
3 say, you know, percentages of marriages that fail at, say,  
4 five years or ten years?  
5 A The National Study of Family and Growth is able to do  
6 it. I've crunched it once. I don't recall offhand the  
7 numbers. But it varies by, you know, age at marriage and  
8 things like that.  
9 Q But as a population as a whole looking at all  
10 marriages you don't have a sense of what the divorce rate  
11 is over --  
12 A Over ten years, it would be guess work. Around 20 to  
13 30 percent -- over five years? No, it be over ten or 15  
14 years. It would really be guess work and it would be  
15 inappropriate for me to do that.  
16 Q Okay. Now, you talked a lot about the issues of  
17 instability in the NFSS Study and the "lesbian mother" and  
18 "gay father" groups. But there are two concepts that I  
19 think got potentially blurred yesterday and I want to see  
20 if we can clarify. The concepts of household instability on  
21 the one hand, and couple instability on the other. So I  
22 have a couple of questions to help get at that.  
23 So, I think your testimony made clear that  
24 individuals in the "lesbian mother" and "gay father" groups  
25 experienced significant household instability, you'd agreed

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1 with that; right?  
2 A Right.  
3 Q For example, you noted that a majority of the  
4 individuals in this group had started out life in a  
5 heterosexual mother father family that broke up; right?  
6 That's household instability, that's not about couple  
7 instability.  
8 A None of these are choices that children make, right?  
9 Q Of course. But is that correct?  
10 A That's who we are interviewing is the adult children.  
11 They're telling us who came and went.  
12 Q Understood. So, again, that example, that in the  
13 majority of the families, you know, the individuals in  
14 "lesbian mother" and "gay father" group, the fact that they  
15 came from a prior heterosexual union that broke up that's  
16 an example of household instability but not an example of  
17 same sex couple instability; is that right?  
18 A Correct. If, in fact, those -- what broke was the  
19 opposite sex relationship.  
20 Q Which was a majority of the household --  
21 A That was the majority of the circumstances around  
22 there origins.  
23 Q Okay. Now, so, for example, in the NFSS the fact that  
24 a subject only spent say two years living in a same sex  
25 household that doesn't necessarily mean that the couple

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1 relationship lasted two years; is that right?  
2 A That is true, although I'm not sure why, you know, a  
3 live-in relationship would suddenly, you know, end and the  
4 partner would not be the household. They may have moved,  
5 but I would presume most of them that when a partner leaves  
6 the household of the mother and her child that the  
7 relationship has probably ceased, but I don't know that for  
8 sure.  
9 Q Now, in some of the cases that you only count two  
10 years of living with the same sex partner because it was a  
11 change of custody, right, the kid went, say, to live from  
12 mom's house to dad's house. So in that particular case the  
13 couple may be together, may not be together; is that right?  
14 A True. That would require one to go into the actual  
15 individual household rosters and look at what happened in  
16 different kids.  
17 Q But is it correct that the fact that a particular  
18 individual reports living two years with the same sex  
19 couple and in some cases that has no bearing on the length  
20 of time of the couple, it may be that the child left;  
21 right?  
22 A It could be, although it's uncommon and general for a  
23 mother to lose -- you know, cede custody of her child some  
24 --  
25 Q So none of the children in the NFSS Study --

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1 A Oh, I'm sure some of them did, but I don't know how  
2 many.  
3 Q Let me start that again. Are you saying that none of  
4 the individuals in the "lesbian mother" group experienced a  
5 change of custody from mom's custody to dad's?  
6 A I didn't say that, no. I'm just saying it's less  
7 common for a mother to lose custody in general. You can't  
8 really tell lose custody. You just know that a child lived  
9 with mom or didn't live with mom. The child would report as  
10 an adult who he lived with at different years.  
11 Q So did any of the individuals in the "lesbian mother"  
12 group from the NSFF report a change from living with mom to  
13 living with dad?  
14 A I believe there are some cases. I don't recall how  
15 many.  
16 Q Okay. And also in some cases, you know, you stopped  
17 counting when the child was 18, right, so you -- the fact  
18 that an individual reports that mom's partner moved in when  
19 they were 16 and then at 18 you're done counting; right?  
20 A Right.  
21 Q Okay. Now, the individuals in the NSFF were all raised  
22 prior to marriage being an option for same sex couples  
23 anywhere in the United States; is that right?  
24 A If we do the math I guess the youngest people in the  
25 NFSS were 18 in 2011. So they should have been cases -- I

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1 don't think -- I don't know the state where they lived. But  
2 there should have been cases where they lived in states  
3 where their mothers could married, right?  
4 Q Let me classify because I think I can be more precise  
5 in the question.  
6 None of the individuals in the NSFF were born  
7 into families where couples, same sex couples could have  
8 been married; is that correct?  
9 A That is correct.  
10 Q Okay. And you agree that marriage helps promotes  
11 stability among heterosexual couples.  
12 A In general I think it reflects stability. People who  
13 wish to make their union secure seek marriage. And marriage  
14 generally speaking entails -- reflects some security and it  
15 entails some security and puts up some barriers to break  
16 up.  
17 Q So it does help stabilize couples.  
18 A Conceptually, yes.  
19 Q Conceptually.  
20 A Yes.  
21 Q In reality do you know?  
22 A There's something called self-selectivity like the  
23 kinds of people who marry are the kind of people who are  
24 more apt to stay together anyway. But generally speaking  
25 it's understood that marriage both reflects and fosters

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1 security.  
2 Q Okay. So it reflects -- selects for stable couples and  
3 also fosters stability in those couples; is that right?  
4 A Yes.  
5 Q Okay. And you have said you would expect greater  
6 stability among married gay and lesbian couples than those  
7 even in civil unions; is that right?  
8 A Can you point to where I said that?  
9 Q Sure. Do you have your report?  
10 A The report? I don't think I have the report.  
11 Q I will mark this as 57. Again for identification only.  
12 If you'll turn with me to paragraph 49 of your  
13 report. It's on page 13.  
14 A Okay.  
15 Q Now, just to give the context the previous paragraph  
16 you'll see is referencing a work by Michael Rosenfeld, a  
17 study by Rosenfeld. In 49 you say,  
18 "In that study the highest stability rates appear  
19 among heterosexual married couples while notably better  
20 stability is located among married, gay and lesbian couples  
21 than among those in civil unions as would be expected."  
22 You wrote that?  
23 A Yes.  
24 Q Okay.  
25 A Which is a reflection of people who wish to have

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1 relational stability tended to track towards, you know,  
2 greater legal stability.  
3 Q But for heterosexuals you recognize that it's not just  
4 the matter of selecting the most stable, marriage also  
5 helps foster stability.  
6 A On average, yes.  
7 Q Okay. Now, you mentioned yesterday that in the NFSS  
8 the household rosters, those are the calendars that you  
9 talked about, right, they are complicated not just among  
10 the individuals in the "lesbian mother" and "gay father"  
11 group but also in other groups like the step family group  
12 and single parent family group; is that right?  
13 A Yes.  
14 Q So there was instability for those individuals as  
15 well?  
16 A Yes.  
17 Q So there was instability in all the groups in the  
18 study except for the one that was defined by the stability  
19 that would be the intact biological family group.  
20 A Right.  
21 Q Okay. Now, you talked yesterday about your decision  
22 not to control for family instability, that you didn't  
23 think it was appropriate to do that, but you did  
24 effectively control for stability among the exclusively  
25 heterosexual parent groups by creating the intact

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1 biological family group; right? You separated out all the  
2 stable ones.  
3 A I didn't control for it. It is reflected in the  
4 category.  
5 Q Okay. Still talking about the topic of couples  
6 stability yesterday you cited some data from the UK where  
7 you said I think there were higher dissolution rates of  
8 civil partnerships of lesbians compared to gay men --  
9 A Yesterday, I don't saying anything about the UK  
10 yesterday.  
11 Q Oh, okay. I thought you did. My notes may be bad.  
12 You also talked yesterday about Michael  
13 Rosenfeld's study on school progress using the US Census;  
14 right?  
15 A Yes.  
16 Q And you identified this study as relevant to couples'  
17 stability I think the language you used, you said the study  
18 controlled the way instability.  
19 A Controlled for, yes.  
20 Q But just to clarify what he controlled for was whether  
21 the child actually lived in the particular family structure  
22 at issue during the past five years; right?  
23 A Right.  
24 Q He didn't actually control for couple breakups.  
25 A Right.

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1 Q I mean, the Census data doesn't provide that  
2 information; does it?  
3 A So far as I know.  
4 Q Okay. Now, you raised the issue of stability in same  
5 sex couple relationships but I think you started to touch  
6 on it before that there's a variety among groups in the  
7 United States about divorce rates when I asked you a  
8 question about the divorce rate.  
9 A Yes.  
10 Q So, for example, there are differences in divorce  
11 rates associated with race?  
12 A Generally speaking, yes.  
13 Q Different racial groups have different rates of  
14 divorce.  
15 A Right.  
16 Q So is it correct that African-Americans have a higher  
17 rate of divorce than other racial groups?  
18 A On average.  
19 Q And it is correct that interracial couples have higher  
20 risk of divorce than same race couples?  
21 A On average although I'm not entirely -- I mean, I'm  
22 less clear with that.  
23 Q Okay. And I think you mentioned yesterday that  
24 remarriages by what -- I understood it means second  
25 marriages?

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1 A Yes.  
2 Q That remarriages fail at a higher rate than first  
3 marriages.  
4 A Correct.  
5 Q Do you favor excluding African-Americans from marriage  
6 based on the elevated rate of divorce in that group?  
7 A I don't.  
8 Q In fact, if there were population base data showing  
9 that African-Americans had a breakup rate that was higher  
10 than that of same sex couples you would not favor excluding  
11 African-Americans from marriage.  
12 MS. HEYSE: Objection, your Honor. Calls for  
13 speculation.  
14 THE COURT: He's an expert. He can answer if he  
15 has an opinion.  
16 A I don't.  
17 BY MS. COOPER:  
18 Q Okay. And do you favor excluding people who have  
19 previously already been married and divorced from  
20 remarrying given the elevated rate of divorce for  
21 remarriages?  
22 A I have no strong opinion on that. I tend to wish  
23 people would try to work it out. It's not always possible I  
24 understand that, their original marriages. But I don't hold  
25 a strong opinion on that.

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1 Q So you don't have an opinion about whether prior  
2 divorce people should be allowed to get married?  
3 A I mean it exists. I don't think much about it. I don't  
4 have a strong opinion about that.  
5 Q So if Michigan were to pass a law barring marriage by  
6 people who had been divorced you wouldn't have an opinion  
7 about that?  
8 MS. HEYSE: Objection, your Honor. It calls for  
9 speculation and he's answered the question.  
10 THE COURT: Sustained.  
11 BY MS. COOPER:  
12 Q Okay. It's not view then is it that groups -- the fact  
13 that a group has an elevated divorce rate is a reason to  
14 exclude the group from marriage.  
15 A Correct.  
16 Q Switching gears and focusing on issues of biological  
17 relatedness what I think you called diminished kinship  
18 yesterday. Just to make sure I'm clear with your terms when  
19 you talk about diminished kinship you mean the lack of a  
20 biological relationship between parent and child; is that  
21 right?  
22 A Between mother, father and child, yes.  
23 Q Between each parent and the child.  
24 A Right.  
25 Q Okay. And you assert that diminished kinship poses

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1 risks to children; is that right?  
2 A On average.  
3 Q On average. Okay. An example that you've given of  
4 diminished kinship would include couples who have children  
5 through donor sperm or donor ova; right?  
6 A It depends on -- I mean -- if it's a donation from  
7 outside the couple, that would be a diminished kinship.  
8 Q Right. Somebody goes to a sperm bank or an egg donor  
9 --  
10 A Some form of assisted reproductive technology are  
11 within the biological parents.  
12 Q That would be an example of diminished kinship?  
13 A Not if it's within the biological parents.  
14 Q Right, but if it's outside of.  
15 A Correct.  
16 Q And that includes both for heterosexual couples and  
17 same sex couples who have children in this way; is that  
18 right?  
19 A Yes.  
20 Q And you said the majority of children born through  
21 assisted reproductive technology are raised by heterosexual  
22 parents; is that right?  
23 A By the numbers that should be the case, yes. Only one  
24 to one and a half percent of all children born today are  
25 born via assisted reproductive technology. I don't know

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1 that we have data about whether that's outside the  
2 biological couple or not. We're talking about pretty small  
3 numbers though.  
4 Q But the majority are heterosexual couples not same sex  
5 couples.  
6 A Yes.  
7 Q And you don't have an opinion on whether the use of  
8 donor sperm, again, donor from outside the family whether  
9 the use of donor sperm or ova should be prohibited.  
10 A From outside the family?  
11 Q Meaning from a sperm bank let's say.  
12 A I'm not a fan of that. I don't have a strong opinion.  
13 I've never weighed in on the subject.  
14 Q Okay. You don't have an opinion about whether it  
15 should be prohibited?  
16 A I'm not of fan of it, I'll tell you that. I don't have  
17 a strong sense about the legal permission around it. I  
18 think it diminishes kinship so we should privilege that  
19 which enhances kinship between a mother, father and child.  
20 Q Now, in support of the proposition that the lack of  
21 biological relationship between parents and child poses a  
22 risk to children you testified yesterday about comparative  
23 rates of abuse by step parents compared to biological  
24 parents; right?  
25 A Can you say that one more time?

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1 Q Sure. That you -- in support of your proposition that  
2 lack of biological relationship between parents and child  
3 poses a risk to children in support of that proposition you  
4 testified about comparative rates of abuse by step parents  
5 and biological parents; right?  
6 A Yes.  
7 Q Now, you testified there's an elevated risk of abuse  
8 by step parents, right, compared to biological parents?  
9 A Right, and --  
10 Q But you don't favor prohibiting marriage by people who  
11 already have children, right? In other words, people who  
12 are going to create step families despite the heightened  
13 risk to children in step families?  
14 A Step families come from different kinds of places. I  
15 mean, sometimes a parent dies and somebody remarries so  
16 they remarry into a step family, but through divorce, but  
17 through death. So step families are complicated as well.  
18 Q So is it your understanding then that step families  
19 that form, you know, after a parent is widowed versus  
20 divorce that they don't have the same kind of risks?  
21 A I don't know if there's a difference in how those  
22 outcomes work. I do know that, you know, it can be more  
23 difficult to -- on a child to navigate step families and  
24 different custody arrangements which is not the case  
25 typically when the parent dies and the surviving parent

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1 remarries.  
2 Q Okay.  
3 A And in the -- the group of people for whom the child  
4 outcomes looked next best where kids for whom their mothers  
5 and fathers were married until one of them passed away.  
6 Q Okay. So, again, you identified data showing elevated  
7 risk of abuse in step families compared to biological  
8 families --  
9 A Outside the study. Not the NFSS.  
10 Q Understood.  
11 So you cited data showing elevated risk abuse in  
12 step families compared to biological parent families, but  
13 you don't favor excluding people who are going to create  
14 step families, in other words, people who already have  
15 children from remarrying.  
16 A What do you mean by people who are going to create  
17 step families?  
18 Q People who have children --  
19 A Right.  
20 Q -- and want to marry someone.  
21 A Right. Generally not, although, you know -- it is more  
22 sympathetic when people have -- when a parent has died than  
23 -- as I said earlier it's nice when people try to work out  
24 their arrangements and not get a divorce in the first place  
25 because that creates hostile instability for children. But,

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1 in general, no.  
2 Q So even a parent who has divorced, have children,  
3 divorced, they'd like to remarry a new person, you don't  
4 think that should be barred.  
5 MS. HEYSE: Objection, your Honor. I believe  
6 that's been asked and answered.  
7 THE COURT: I'm not sure. He may answer.  
8 A I have no, you know, strong opinion on the legality of  
9 that. I mean, it's been around for time and memorial. So I  
10 don't have a strong opinion about it.  
11 Q Okay. Now, I'd like to turn to your report, paragraph  
12 28. Let me get you the page. It's at the bottom of page  
13 7, it begins. Paragraph 28. You got it?  
14 A Yes.  
15 Q You say,  
16 "Yet, every child born to a couple via ART" and  
17 let me pause, by that you mean if it's a reproductive  
18 technology?  
19 A Yes.  
20 Q Okay. So, I'll start again.  
21 "Yet, every child born to a couple via ART  
22 ('planned' gay or lesbian family) retains at least one non-  
23 biological 'step' parent suggesting the more favorable  
24 comparison group would not be the biologically intact  
25 mother-father household, but heterosexual step families."

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1 Did I read that right?  
2 A Right.  
3 Q Okay. Now, you agree that most heterosexual step  
4 families are blended families; is that right?  
5 A Meaning children come from both the marrying woman and  
6 the marrying father?  
7 Q Well, by "blended" -- we can look at your deposition  
8 if you'd like, but let me ask you this way, by "blended" do  
9 you understand that term to mean the creation of a  
10 household out of previous failed households, or failed  
11 union?  
12 A Some of them fail. Some of them, you know, one person  
13 was never married, and they marry somebody who had been  
14 married before, and they're blending something. They're not  
15 always blending completely, you know, new families.  
16 Sometimes one partner has children, sometimes they both  
17 have children.  
18 Q Understood.  
19 A Sometimes blended marriages with no children.  
20 Q But it's blending two prior families whether they had  
21 children --  
22 A One of them might have been single.  
23 Q And in heterosexual step families you're generally  
24 talking about a new person coming in to somebody -- an  
25 existing family.

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1 A If there are children -- yeah.  
2 Q Okay. Now, you wouldn't use the term "step family" if  
3 you had two single people who got married and neither had  
4 children; right? Step families --  
5 A Two single parents who --  
6 Q Two single people with no children.  
7 A Two people.  
8 Q You have to have children, excuse me, to have a step  
9 family; right?  
10 A Correct.  
11 Q Okay. So step family among heterosexuals are, you  
12 know, a new person coming into an existing family with  
13 children.  
14 A Right.  
15 Q Okay. And in planned same sex parent families you  
16 don't have that circumstance; correct?  
17 A "Planned" as in assisted reproductive technology.  
18 Q Correct.  
19 A Right.  
20 Q Okay. Now --  
21 A But you still do have -- you know, somebody's not a  
22 biological parent of the child.  
23 Q That's the analogy, right, that's one is non-  
24 biologically related but --  
25 A So there's still diminished kinship.

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1 Q You have diminished kinship but you don't have the  
2 circumstances of the disruption of an existing family unit.  
3 A It's a little bit different, right.  
4 Q Okay. Now, you -- I believe in your deposition you  
5 were not aware of research that looks at the well-being of  
6 children conceived through assisted reproduction using  
7 donor sperm or ova; is that right?  
8 A Population base data.  
9 Q Right. You're not aware of studies on that?  
10 A Assisted reproductive technology, large population  
11 basis, no, I'm not.  
12 Q What about other studies? Non-probability.  
13 A Non-probability ones, you know, where they're kind of  
14 snowballed samples or something --  
15 Q You're aware --  
16 A Right. NLFS is like that as far as I can tell.  
17 Q Have you reviewed the research, the non-population  
18 base research that body of research on assisted  
19 reproduction whether it's heterosexual or same sex couples?  
20 A By "review" you mean --  
21 Q Read.  
22 A Some of the NLFS studies I've read, not all of them.  
23 There's a bunch of them.  
24 Q Outside of the NLFS have you read the research that  
25 looks at -- compares children raised by donor -- let me ask

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1 it this way.  
2 Studies looking at a class of donor conceived  
3 children and naturally conceived children, heterosexual  
4 families? Have you read that body of research?  
5 A Can you cite a particular author?  
6 Q I'm just asking if you've read a body of research?  
7 A I've read some examples I think out of England.  
8 Q And are you aware of research showing then that  
9 children conceived by donor insemination whether  
10 heterosexual parents or same sex parents fair no  
11 differently than naturally conceived children in those  
12 studies?  
13 A I don't recall comparison categories. I wouldn't want  
14 to speak about any particular study unless I was looking at  
15 it in front of me and looking at the sample sizes, and  
16 looking at how the comparison categories were constructed.  
17 Sometimes you can detect no differences in some of these  
18 small non-probability samples. And it's a function of  
19 diminished ability to detect real differences that exists.  
20 I often will look at the raw scores, right, and at least  
21 see how the differences are in the simple difference level  
22 even if they're not detecting any statistically significant  
23 difference because they may not have the statistical power  
24 to do so. But I don't want to claim I know about a  
25 particular study unless I'm looking at it in front of me.

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1 Q Can we turn to your deposition? If you will look at  
2 page 43, please? If you would go to line 10 and I'll read  
3 with the question, beginning,  
4 "Question: Are you familiar with the research on  
5 children conceived through ART using donor egg or sperm  
6 with a heterosexual or gay parent family?  
7 "Answer: I don't believe there's any population  
8 base data doing that.  
9 "Question: Are you aware of any research looking  
10 at such families?  
11 "Answer: I'm not. It may exist."  
12 A Right. I think I was referring to that, the population  
13 base data. I was not aware of anything. I have looked at  
14 some non-population base data.  
15 Q Okay.  
16 A Referring to the population base aspect of it.  
17 Q If you'll turn to page 44, line 2,  
18 "Question: Sure. Do you know whether the non-  
19 biological parent" -- I'm sorry. Withdrawn.  
20 Moving away from assisted reproduction, focusing  
21 on adoption. You are aware of research showing that in  
22 adoptive families where the parents lack, both parents lack  
23 a biological relationship with the children, that there's  
24 research showing that adoptive parents invest more time in  
25 their children than two biological parent families.

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1 A There's some research that suggest that, yes. I don't  
2 know if the research would all conclude that.  
3 Q Okay. Now, you cite uncertainty about outcomes for  
4 children of same sex parents as a basis to limit marriage  
5 to heterosexual couples, but you have no opinion do you  
6 whether lesbian and gay couples should be allowed to be  
7 adopt children?  
8 A Can you state that again?  
9 Q You cite uncertainty about the outcomes for children  
10 of same sex parents as a basis to limit marriage to  
11 heterosexual couples, but you have no opinion on whether  
12 lesbian and gay couples should be allowed to adopt  
13 children.  
14 A The uncertainty about -- I'm still trying to find the  
15 first part of that clause.  
16 Q I can ask it differently. I can streamline this  
17 question for you.  
18 A Okay.  
19 Q Do you have an opinion on whether lesbian and gay  
20 couples be allowed to adopt children?  
21 A I don't have a strong opinion that, no.  
22 Q Do you have any opinion?  
23 A The State looks to place children with families as a  
24 means helping kids who are, you know, orphans -- looking --  
25 it's a concession. The State looks to do that. I don't have

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1 a strong opinion on -- I've thought very hard about it, who  
2 should they go to, to one parent, two parents, single, I  
3 mean --  
4 Q So, do you have an opinion -- you said you don't have  
5 a strong opinion, do you have any opinion about whether  
6 lesbian and gay couples ought to be allowed to adopt  
7 children?  
8 A I just haven't fashioned one.  
9 Q You don't have one; is that right?  
10 A Yes.  
11 Q Okay. So you have no opinion about whether a child  
12 would be better off staying in the foster care system  
13 rather than being adopted by two parents of the same sex?  
14 A When you think about the State's interest in  
15 sheltering children, most people think it's better to be  
16 out of the foster care system than in the foster care  
17 system. Otherwise -- some kids fair okay in the foster  
18 system, but it's not the ideal.  
19 Q So you do have an opinion about whether children would  
20 better off staying in foster care than being adopted by two  
21 parents of the same sex?  
22 A I think you asked me that at the deposition, I don't  
23 recall what I said. I think I probably had no strong  
24 opinion on it.  
25 Q Do you have any opinion?

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1 A No, I don't think so.  
2 Q Okay. Now, in cases like the situation for plaintiffs  
3 in this case where you have a child who is adopted into a  
4 family headed by a same sex couple is that right that you  
5 have no opinion about whether it's better for the child to  
6 be adopted by just one of the adults or both?  
7 A Given that it's a concession in the first place and  
8 not an ideal -- not ideal for the child to be apart from  
9 its biological parents, but sometimes it's a necessary  
10 concession, I don't believe I made a statement about the --  
11 whether it's one or two. Is that what you're asking?  
12 Q I'm just asking do you have an opinion about in such  
13 situations is it better for the child to be adopted by just  
14 one of the two adults raising him or her --  
15 A Well, sometimes it's the biological child of one of  
16 the two adults.  
17 Q Okay. So a child who is adopted out of the foster care  
18 system not related to either partner --  
19 A Right.  
20 Q -- adopted into a family headed by a same sex couple  
21 do you have an opinion whether it's better for that child  
22 to have -- to be adopted by just one of those adults or  
23 both of those adults?  
24 A I think I said at the deposition I didn't have an  
25 opinion on that.

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1 Q Okay. And is that correct, you don't have an opinion  
2 on it?  
3 A Yeah, I haven't thought through all the permutations  
4 and combinations so I don't.  
5 Q So you don't have an opinion.  
6 A Right.  
7 Q Okay. And similarly in situations where a child is  
8 conceived into a lesbian couple family through assisted  
9 reproduction you have no opinion about whether it's better  
10 for the child to be able to adopted by the non-biological  
11 parent to have a legal tie with both parents in the family?  
12 A I think you asked me again at the deposition I don't  
13 have a strong formulated opinion on that.  
14 Q I'm sorry, I didn't hear you.  
15 A I don't think I have a strong formulated opinion on  
16 who should have legal connections and -- when kinship is  
17 diminished.  
18 Q Do you have any opinion?  
19 A I don't believe I listed one last time.  
20 Q Do you have one now?  
21 A No.  
22 Q Okay. Now, in situations where a heterosexual couple  
23 conceives using, say, donor sperm from a sperm bank, is it  
24 right you have no opinion about whether it's beneficial to  
25 the child to have a legal parent-child relationship with

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1 both parents in that family?  
2 A I don't know the legalities of these things in terms  
3 of whose accorded legal status when the mother and father  
4 are already married and they go get assisted reproductive  
5 technology, a donor insemination, I don't purport to know  
6 at all about how the legal parental rights work in that  
7 case. I mean, as I said before, I think it's less optimal  
8 to get donor inseminated because then you are giving --  
9 taking in a diminished kinship, right, you're taking on  
10 that rather than working with parents to -- even by ART to  
11 retain the genetic connection between mother, father and  
12 child. That's optimal.  
13 Q So going back to the question for heterosexual couples  
14 who are infertile and the way they have a child is to get  
15 sperm from a sperm bank do you have an opinion about  
16 whether the non-biological father in that family should be  
17 recognized as the legal father to the child born?  
18 A I've never fashioned an opinion on that. I presume  
19 they are recognized, but I don't -- I'm not an expert in  
20 ART or adoption law.  
21 Q So you have no opinion.  
22 A Generally speaking, no.  
23 Q Okay. Now --  
24 A My only opinion is that states have interest in  
25 reducing diminished kinship, and seeking to heighten the

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1 link mom, dad and child biologically as well as socially.  
2 Q But you understand that there are families where's  
3 that's not the case.  
4 A I understand that.  
5 Q And you have no opinion about whether legal ties  
6 should be established with both parents --  
7 MS. HEYSE: Objection, your Honor. This has been  
8 asked several times.  
9 THE COURT: I'll sustain the objection.  
10 BY MS. COOPER:  
11 Q Moving on, switching gears, your position in favor of  
12 limiting marriage to heterosexual couples is not based  
13 solely on the scientific research related to child outcomes  
14 or couple stability; is it?  
15 A Correct.  
16 Q You've never been a fan of same sex marriage; isn't  
17 that right?  
18 A Correct.  
19 Q And you were not a fan of same sex marriage before you  
20 even started your work on the NFSS; is that right?  
21 A Correct.  
22 Q And that's because in your view marriage in much of  
23 human history has privileged expectation of permanency,  
24 fidelity, and generally the anticipation of children and  
25 you believe that doesn't comport with same sex marriage; is

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1 that right?  
2 A Yes.  
3 Q And you also agree as a matter of religious  
4 affiliation that sexual relationship outside of marriage  
5 between a man and a woman are wrong; is that right?  
6 A Can you state that last part again?  
7 Q Sure. That you also agree as a matter of our religious  
8 affiliation that sexual relationships outside of a marriage  
9 between a man and a woman are wrong?  
10 A Yes.  
11 Q Okay.  
12 A That doesn't really shape how I go about doing my  
13 social science, but I do hold that to be true.  
14 MS. COOPER: Non-responsive, your Honor.  
15 THE COURT: Okay.  
16 BY MS. COOPER:  
17 Q This is marked for identification -- I believe we're  
18 at Exhibit 59, another document.  
19 Professor Regnerus, this document marked for  
20 identification as Exhibit 59, is that an alumni profile  
21 from your alma mater?  
22 A It is.  
23 Q An alumni profile about you.  
24 A It is.  
25 Do you know when that was published?

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1 Q I can't answer that, but you recognize this an alumni  
2 profile.  
3 A Yes, it's not recent.  
4 Q Okay. I want to read some quotes attributable you in  
5 this profile.  
6 A Sure.  
7 Q And you'll scroll down to -- six paragraphs down and  
8 read along with me.  
9 "As Christians our lives should reflect our  
10 relationship with God and our desire to glorify him."  
11 Regnerus says,  
12 "I've noticed that some Christian professors see  
13 a disconnect between their faith and their profession. I  
14 believe that if your faith matters it should inform what  
15 you teach and what you research."  
16 First of all, did I read that correctly?  
17 A Yes.  
18 Q Okay. If you go onto the next paragraph, it says,  
19 "I've had students here tell me that I'm the only  
20 Christian professor they've had. I'm not approved to share  
21 the Gospel, but I don't necessarily hide my beliefs either.  
22 When I teach, I don't seek to break down or build any  
23 particular faith, but my world view colors what I do in the  
24 classroom."  
25 I want to skip down to a quote, again, in the

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1 last paragraph of the page,

2 "That's what I want my students to recognize the  
3 connection between my faith and my work."

4 If we could stop there and I just want to ask  
5 you, is it right that your faith shapes your interest in  
6 researching sexual decision-making family and  
7 relationships?

8 A Yeah, it's a source of interest, although, the genesis  
9 of my interest in sexual behavior came from a chapter in a  
10 book I was writing when the chapter got really long and  
11 very interesting. Prior to that I hadn't been all that  
12 interested in studying sexual decision-making.

13 Q But you have said that your faith shapes your interest  
14 in those topics?

15 A Yeah, a lot of people when they get interested in  
16 research topics it has some sort of personal connection to  
17 them.

18 Q I want to --

19 A This is fairly an old document though. It doesn't  
20 really -- I've changed a little bit over ten plus years.  
21 I'm probably not as -- I'm not as open about my faith as I  
22 might have once been.

23 Q Okay. Now, the idea for the NFSS Study emerged from a  
24 series of conversations you had with various people about  
25 what research projects could be done. I think you touched

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1 on that yesterday; is that right?

2 A Right.

3 Q Those people included Luis Tellez?

4 A Yes.

5 Q He was the President of the Witherspoon Institute?

6 A Yes.

7 Q And you presume that the Witherspoon Institute is  
8 against marriage for same sex couples?

9 A I presume so.

10 Q Tellez is also involved with the National Organization  
11 for Marriage?

12 A I have heard that. I have never -- I'm not familiar  
13 with all the connections, but he has an affiliation of some  
14 sort, yeah.

15 Q Now, that's an organization that advocates for  
16 limiting marriage to opposite sex couples?

17 A They do.

18 Q One of the people involved in these conversations that  
19 you refer to about research possibilities was Maggie  
20 Gallagher; is that right?

21 A Correct.

22 Q Maggie Gallagher is a prominent advocate against  
23 marriage for same sex couples; is that right?

24 A Correct.

25 Q Now you attended a meeting in Washington, D.C., a grop

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1 of people including Luis Tellez from Witherspoon and Maggie  
2 Gallagher among others; is that right?

3 A Right.

4 Q And the purpose of that meeting was to discuss or to  
5 think about study possibilities in the area of marriage and  
6 relationships?

7 A Generally speaking what kind of research questions are  
8 -- are good to be asked and answered in the broader domain.  
9 I think that was -- do you have a date on that?

10 Q If you remember --

11 A I think in the deposition we said in the fall of 2009,  
12 I think.

13 Q By the way was that the Heritage Foundation, that  
14 meeting?

15 A I don't think it was.

16 Q Where was it?

17 A Some hotel.

18 Q Hotel, okay.

19 Now, the Witherspoon Institute paid the expenses  
20 of the meeting attendees of that D.C. meeting that you  
21 attended?

22 A I believe so.

23 Q Ultimately you submitted a proposal to Witherspoon to  
24 fund the NFSS Study.

25 A Right.

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1 Q Okay. They accepted it?

2 A They did.

3 Q And they funded the study.

4 A They did.

5 Q Okay. I'd like to mark again for identification  
6 Exhibit 60.

7 Have you had a change to take a look?

8 A Could you give me a minute?

9 Q Sure.

10 MS. HEYSE: Your Honor, I just want to make clear  
11 you're not moving to admit?

12 MS. COOPER: No.

13 MS. HEYSE: Okay. Thank you.

14 A Okay.

15 BY MS. COOPER:

16 Q So this document that's been marked as Exhibit 60 for  
17 identification is this an email in which Brad Wilcox is  
18 responding to some questions you wrote him on September  
19 21s, 2010 about the NFSS Study?

20 A Right. So this would be roughly -- yeah. Several  
21 months before we fashioned the first meeting of people in  
22 Austin.

23 Q And just to be clear, Wilcox he's the person who  
24 introduced you to Luis Tellez of Witherspoon; is that  
25 right?

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1 A Right, roughly a year before that or something.  
2 Q Okay. I think you need to speak up just a bit.  
3 A I'm sorry.  
4 Q I saw people leaning.  
5 A Some share of time before that, roughly a year.  
6 Q Okay. I want to call your attention to the bottom  
7 paragraph. And, again, just before I read it, this is an  
8 email you wrote to Brad Wilcox, right, September 21<sup>ST</sup>,  
9 2010?  
10 A Yes.  
11 Q Okay. Bottom paragraph says,  
12 "I would like at some point to get more feedback  
13 from Luis and Maggie about the 'boundaries' around this  
14 project, not just costs but also their optimal time lines  
15 (for the coalition meeting, the data collection, et.) And  
16 their hopes for what emerges from this project including  
17 the early report we discussed in D.C. Feel free to forward  
18 this to them."  
19 Did I read that right?  
20 A Yes.  
21 Q Now the Luis that refers to Luis Tellez of  
22 Witherspoon?  
23 A Right.  
24 Q And Maggie is Maggie Gallagher, the advocate against  
25 same sex marriage?

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1 A I presume so.  
2 Q Okay.  
3 A I don't believe I ever -- I don't believe I ever got  
4 feedback after that.  
5 Q I'm just asking whether you wrote this.  
6 A Yes.  
7 Q Okay. And these are the same individuals, Luis Tellez  
8 and Maggie Gallagher who were among others at the meeting  
9 in Washington, D.C. you mentioned where you talked about  
10 ideas for studies?  
11 A Right.  
12 Q Okay. So you wanted to know what hopes Luis Tellez and  
13 Maggie Gallagher had for your research project?  
14 A I wanted to know what they -- when they anticipated  
15 the results from this, and what it -- what they thought it  
16 would like because we hadn't even met yet in January of  
17 2011, to start hammering out how are we going to sample  
18 people, etc.  
19 I was aware of, you know, what Witherspoon  
20 thought about same sex marriage, but I was a skeptic at any  
21 data analysis project we took on could tackle what they  
22 might expect. So I wanted to know like if they had false  
23 expectations for what this is capable is doing. It was  
24 really intended to be a -- it's an intellectual question we  
25 were answering. I think they would be surprised if -- I

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1 didn't know if they would expect that it could answer a lot  
2 more questions than I had a feeling it could.  
3 Q At this point had Witherspoon already agreed to fund  
4 your study?  
5 A I don't honestly know. I'm -- I think the formal  
6 funding came later. I don't recall.  
7 Q Will it help you refresh your recollection if you  
8 looked to what's numbered as point one, towards the top of  
9 the mail?  
10 A I think they probably had given me a voice go ahead,  
11 but we hadn't gotten cost estimates yet or anything like  
12 that. I mention it at the bottom that, you know, costs. I  
13 didn't know how much it was going to cost and how much they  
14 thought they were capable of funding.  
15 Q In point one, you're asking we want to run this  
16 project through UT's PRC. I'm presuming 10 percent overhead  
17 is acceptable to Witherspoon. You're asking about details  
18 of costs and funding; right?  
19 A Right.  
20 Q Okay. Now in the paragraph at the bottom we were  
21 looking at a moment ago, you reference the coalition  
22 meeting. What coalition meeting were you referring to?  
23 A The only coalition meeting I can recall is -- was in  
24 the fall of 2009, the one I mentioned at the hotel. But I  
25 don't know about -- I'm not sure what coalition meeting

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1 this referring to. I honestly don't.  
2 Q You don't know what you meant when you wrote that?  
3 A I don't. Unless it means -- it's probably a reference  
4 to the pooling together of consultants and getting together  
5 which we did in January of 2011. That's my best guess.  
6 Q Consultants --  
7 A I don't know what coalition meant to me at the time  
8 here. We did meet, a body of consultants in January of 2011  
9 to hammer out like how we're going to do this study.  
10 Q And you might --  
11 A It might have been that, I'm not sure.  
12 Q You would have called the consultants on your study a  
13 coalition?  
14 A A coalition of consultants, yeah, I don't know.  
15 Q Okay.  
16 A That would have made sense.  
17 Q There's not a question pending.  
18 A Okay.  
19 Q I'm going to mark for identification Exhibit 61.  
20 So what's been marked as Exhibit 61 is this an  
21 email you received from Luis Tellez of the Witherspoon  
22 Institute?  
23 A On the bottom  
24 Q I'm sorry, yes. Below the line there are two emails on  
25 this page. Thanks for clarifying. The bottom email.

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1 A Yes, I believe so.  
2 Q And it's dated September -- sorry. September 22<sup>nd</sup>,  
3 2010?  
4 A Right.  
5 Q Okay. Now, in the body of it, are you talking about  
6 the NFSS Study they were funding?  
7 A Yeah. I mean, it didn't have a name yet. I don't think  
8 it had a name. It was an idea at the time. The project that  
9 was going to get rolling starting in January of 2011.  
10 Q Okay. Now -- let's see. If you look he says,  
11 "Move on it. Don't dilly dally etc. It would be  
12 great to have this before a major decision of the Supreme  
13 Court"; is that right?  
14 A Right, and before that he said don't get hung up with  
15 deadlines. Do it as right and best and think how you would  
16 want it done which is always what I did.  
17 Q I think you mentioned yesterday that you approached  
18 Jim Wright at The Journal Social Science Research and asked  
19 him if he would consider reviewing your manuscript of the  
20 NFSS Study and if he be speedy about it?  
21 A Right, in part because I had a report that I intended  
22 to write. I had my own internal deadlines around it. It  
23 just kept getting shifted in the future and I wanted to get  
24 back to my other research projects.  
25 Q So you were so eager to have this published speedy

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1 that you submitted the manuscript to the Journal before the  
2 data collection was completed; isn't that right?  
3 A Ninety-eight percent completed basically and the  
4 findings were fairly robust. I mentioned when -- I sent  
5 Paul Amato a copy of the manuscript after I submitted it,  
6 and said, I didn't think it was a big deal, put it in the  
7 cue at the social science research. We were waiting on data  
8 trickling in from Knowledge Networks, just a handful of  
9 cases. If Social Science Research was going to reject it  
10 then I wanted to know that sooner rather than later.  
11 Q Because you had an internal deadline in your head;  
12 right?  
13 A Right, because I inserted this study -- before our  
14 report I was intending to write which I never did write.  
15 Q Okay. So the study is published in July, 2012, and  
16 online in June of that year; is that right?  
17 A June 12 I think or 11.  
18 Q So this was before the Windsor and Perry cases were  
19 heard in the U.S. Supreme Court?  
20 A I don't know the time tables of all that stuff.  
21 Q But you were able cite to the study --  
22 A Right.  
23 Q -- in the amicus brief that you wrote --  
24 A I don't remember --  
25 Q Let me finish the question.

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1 THE COURT: Let her finish the question.  
2 MS. COOPER: It's confusing for the reporter.  
3 BY MS. COOPER:  
4 Q Okay. So you were able to cite and discuss the study  
5 in the amicus brief that you wrote to the Supreme Court in  
6 Windsor and Perry in opposition to same sex marriage; is  
7 that right?  
8 A True. It was a component of the amicus brief.  
9 There were more components to it than just this.  
10 Q A day or two before the NFSS Study was to be published  
11 by the Journal, you gave a presentation at the Heritage  
12 Foundation about the findings of that study; is that right?  
13 A Yes, maybe a day before that or something like that.  
14 Q Heritage Foundation is a conservative think tank in  
15 Washington?  
16 A Right.  
17 Q By the way, were they part of -- does that help  
18 refresh your recollection about the coalition you  
19 referenced earlier?  
20 A I don't believe that was the coalition I referring to.  
21 That was -- I gave a talk I think Luis probably invited me  
22 to do. I don't know for sure, I don't recall. But that  
23 would not have been on my radar back in 2010. That was not  
24 the coalition meeting. It was here's a study coming out,  
25 would you like to give a talk at Heritage about it and I

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1 said fine.  
2 Q So you gave that talk a day or so, a day or two before  
3 the study was published, and Heritage gave you immediate  
4 training document suggesting talking points for you to use  
5 when talking about the study?  
6 A They gave it to me or sent it to me and I largely  
7 ignored it.  
8 Q I've marked for identification Exhibit 62.  
9 MS. HEYSE: Your Honor, I'm going to object on a  
10 line of questions. Doctor Regnerus just -- if that's what  
11 she intends to do, Dr. Regnerus just testified that he  
12 largely ignored this document.  
13 THE COURT: You may renew your objection. I  
14 haven't her question yet so it's hard for me to rule at  
15 this point.  
16 MS. COOPER: I will just clarify, he largely  
17 ignored it, doesn't seem to take it off the table.  
18 BY MS. COOPER:  
19 Q I want to just first ask you is this the -- this  
20 document has a few pages, four pages, and I want to focus  
21 on the first two pages of the document. Is that the media  
22 training document provided to you by Heritage?  
23 A I presume so, but as I said I don't believe I used it.  
24 It was recovered in some Freedom of Information Act request  
25 out of some computer file of mine, but it was filed away

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1 and -- it's their words, not mine.  
2 Q If you look down on paragraph -- six paragraphs down  
3 one of the key points to make that they provided for you  
4 is,  
5 "For many years" --  
6 MS. HEYSE: Objection, your Honor.  
7 THE COURT: Sustained.  
8 MS. HEYSE: Thank you.  
9 THE COURT: You can't read from it. I think you  
10 need a little more foundation in terms of the document.  
11 BY MS. COOPER:  
12 Q I understood, Professor Regnerus, you say you largely  
13 ignored it. I didn't understand you to be saying you did  
14 not read it, you did not consider it at all.  
15 A Came over email because that's where it was had. I  
16 filed it in some folder that eventually got discovered and  
17 -- I mean, it's their words, not mine.  
18 Q So you're saying you never read it?  
19 A I have no recollection if I read it or not.  
20 Q Okay.  
21 A It's almost two years ago, a year and a half ago.  
22 Q Now, apart from your interactions with Luis Tellez of  
23 Witherspoon regarding the meeting in D.C. that you  
24 discussed and the funding of your NFSS Study, you mentioned  
25 yesterday that you also worked with him to create an

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1 organization called the Austin Institute; is that right?  
2 A Yes.  
3 THE COURT: Excuse, I'm sure you have some more to  
4 go. We have to switch court reporters. That's why we take a  
5 break at 11:00. That's how they have their thing. Is that  
6 okay?  
7 MS. COOPER: Of course.  
8 THE COURT: I mean, do you want to finish real  
9 quick? I don't know how much you have.  
10 MS. COOPER: If you need to take a break, let's  
11 take a break.  
12 THE COURT: We don't need to, but I think it's a  
13 good time.  
14 Okay. We'll take 15 minutes, and we'll reconvene  
15 at a quarter after.  
16 (Court recessed, 11:00 a.m.)  
17 -- -- --  
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# CERTIFICATE

1  
2  
3 I, JOAN L. MORGAN, Official Court Reporter for the  
4 United States District Court for the Eastern District of  
5 Michigan, appointed pursuant to the provisions of Title 28,  
6 United States Code, Section 753, do hereby certify that the  
7 foregoing proceedings were had in the within entitled and  
8 number cause of the date hereinbefore set forth, and I do  
9 hereby certify that the foregoing transcript has been  
10 prepared by me or under my direction.

11  
12 S:/ JOAN L. MORGAN, CSR  
13 Official Court Reporter  
14 Detroit, Michigan 48226  
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March 4<sup>th</sup>, 2014

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