EXHIBIT B

1 UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
2
TALLAHASSEE DIVISION
3
4 AUGUST DEKKER, et al.,
5 Plaintiffs,
6 vs.
7 JASON WEIDA, et al.,
8 Defendants.
______________________________/
9
10 REMOTE VIDEOCONFERENCE DEPOSITION
OF
11 SOPHIE SCOTT, Ph.D.
12 Taken on behalf of the Plaintiffs
13
DATE TAKEN: Monday, March 20, 2023
14
TIME: 11:00 A.M. - 3:00 P.M.
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LOCATION: Zoom Videoconference
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20 VERITEXT LEGAL SOLUTIONS
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1 I N D E X

2 SOPHIE SCOTT, Ph.D. PAGE NO.

3 Direct by Mr. Shaw: 4

Cross by Mr. Beato: 174

4

CERTIFICATE OF OATH 176

5 CERTIFICATE OF REPORTER 177

NOTIFICATION LETTER 178

6 CERTIFICATE OF WITNESS 179

ERRATA SHEET 180

7

8

9 PLAINTIFFS' EXHIBITS MARKED

10 Exhibit 1 Sophie Scott's Report 45

Exhibit 2 Lewis Child Textbook 137

11 Exhibit 3 Scarcella Tweet 160

Exhibit 4 "Jack, Not Jackie" Tweet 162

12 Exhibit 5 Bozenka Tweet 165

13
14
15
16
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22
23
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1 BY MR. SHAW:
2 Q Professor Scott, do you understand what
3 this case is about?
4 A I understand some of the background in
5 terms of laws that have been changed in the U.S.
6 generally, and this is specifically a case in
7 Florida about the removal of healthcare to people
8 who are transgender.
9 Q Is that all of your understanding?
10 A It's the most general sense, yeah. I'm
11 sure there's many, many aspects and details I don't
12 know about.
13 Q So you understand that we're going to
14 discuss a rule issued by one of the State -- an
15 agency with the State of Florida, correct?
16 A Uh-huh.
17 Q And that agency is the Agency for
18 Healthcare Administration or AHCA. Do you
19 understand that?
20 A I do. Thank you.
21 Q And you understand that this rule bans all
22 services for treatment of gender dysphoria,
23 including puberty blockers, hormones, sex
24 reassignment surgeries, and any other procedures
25 that alter the primary or secondary sexual

1 characteristics?
2 MR. BEATO: Object to form. But you can
3 answer that, Dr. Scott.
4 A Yes. Yes, I understand that.
5 BY MR. SHAW:
6 Q Do you understand that you're giving an
7 opinion in support of that rule?
8 A I do.
9 Q Do you support that rule?
10 A I put this in my report. I think it's
11 entirely possible that there are people, young
12 people who this is an entirely appropriate course of
13 treatment potentially. The problem at the moment is
14 we don't know who those young people are. And
15 probably more importantly, we don't understand and
16 there is no good evidence, and we need to look at
17 more good evidence, on what the influences
18 specifically of puberty blockers are on brain
19 development as well as body development. But I work
20 on the brain.
21 So I have a complex position in respect to
22 this. I don't think it's a good idea to ban
23 treatment in a blanket way. But I also think that
24 people who are transsexual deserve both the best
25 healthcare and also deserve the best information

1 about that healthcare and the implications of that
2 healthcare. And at the moment, I don't think that's
3 happening.
4 Q What do you mean by transsexual?
5 A So transsexual, transgender. I'm sorry.
6 Error of language. What would have once been called
7 transsexual is now more commonly called transgender.
8 But people who experience gender dysphoria.
9 Q Okay. I'm going to pause for one moment
10 and just play with my microphone. I'm having a
11 little bit of a hard time hearing you.
12 (Off the record.)
13 BY MR. SHAW:
14 Q I want to ask my question again, because I
15 don't believe I got a clear answer.
16 A Uh-huh.
17 Q Do you support the rule issued by Florida
18 Medicaid?
19 A I don't have a clear answer to give you.
20 I think that it is a mistake to have blanket bans on
21 medical issues generally. I think it should be
22 something that's worked out in terms of a scientific
23 and a medical approach. I also don't think it's a
24 good idea the way that we're currently approaching
25 trans healthcare in that we are not doing the

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1 mean about being able to give people information
2 about what could happen to them when they embark on
3 this kind of treatment course. There is very little
4 evidence and it's not much of it of a very high
5 quality. And there's almost nothing that we know
6 about humans.
7 So I think at the moment, you could say
8 that they are making a decision based on the
9 evidence. But it's a lack of evidence and that's
10 not a good position for anybody.
11 Q So if you had to vote yes or no on this
12 ban, would you vote yes or no?
13 A I don't think I can give you a good answer
14 to that. I don't -- I can understand why -- the
15 aspect of why the ban has been put in place. I
16 don't think it's a good way of approaching
17 healthcare. I would probably abstain like a coward.
18 Q You expressed concern with this rule just
19 now. Is that fair to say? Concern.
20 A I think that it's -- there are going to be
21 people out there who would benefit from therapy
22 around these issues. I mean this in the broadest
23 sense. But I don't think necessarily the way that
24 we're approaching it at the moment, which is often
25 to seeing that there has to be a medicalized ruse is

1 a particularly good idea. This is what I mean about
2 I think the healthcare options for people who are
3 trans at the moment are not good. They're not
4 evidence-based.
5 Q Do you think all the treatments that are
6 mentioned in this rule are as you say "not good"?
7 A Well, I think in that they're all highly
8 medicalized, I think this is a situation where we
9 need a lot more evidence before we blithely put
10 teenagers on a route that might take them to
11 somewhere that might not be something that's
12 consistent with how they feel in a few years' time,
13 and we know that that can happen. Not for
14 everybody. It will help some people, but at the
15 moment we don't know who.
16 Q Does your opinion change if these
17 decisions are made by not only the patients, but
18 their family and their medical team?
19 A At the moment, no, it doesn't. There
20 isn't -- there's not high quality evidence about the
21 benefits of this or who would benefit from it. We
22 do know that there is some evidence in favor of
23 watchful waiting. But generally there is just a
24 horrible dearth of good data in this whole area,
25 which means that the clinicians are operating

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1 This is science in humans.
2 Q Is your concern -- we talked about your
3 concern with these treatments. Is that limited to
4 adolescence?
5 A I mean, I think so. The situation with
6 the adolescent brain, it's such a continuing age of
7 importance in terms of brain development that it
8 really should be taken seriously both in what the
9 possible implications of specifically delaying
10 puberty could have on that. We don't have good
11 evidence about this. And I'm -- what evidence we do
12 have suggests that there are effects on the brain of
13 delaying puberty. And we don't know what that might
14 mean further down the line. We just don't know.
15 There aren't follow-up studies. Even the studies
16 that have looked at this in animals haven't then
17 look at the life-long profile for those animals.
18 So it is a particular area of concern for
19 me, because I'm a brain scientist. I mean, I'm sure
20 people could have legitimate questions about the
21 whole rest of the body. But I care about brains and
22 brains are still developing at that age. I think
23 once somebody's an adult, their body is their own.
24 They should absolutely have autonomy to do whatever
25 they want.

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1 focused around techniques like functional magnetic
2 resonance imaging and magnetic encephalogram. So
3 looking at electrical distributions in the brain.
4 And we involve both clinical researchers and basic
5 scientists.
6 Q Has anyone at the Institute ever conducted
7 any clinical studies related to gender dysphoria?
8 A No, not that I'm aware of. There was up
9 until three years ago, four years ago, there was
10 Sara-Jayne Blakemore was at the ICN. She's now in
11 Cambridge. And she was one of the people who was
12 really investigating the teenage brain in a more
13 general sense, but that's the closest.
14 Q She was investigating the teenage brain in
15 a gender dysphoria context or just generally?
16 A In a general sense she was looking at
17 brain development in the teenage years. Yes.
18 Q So you've never conducted any clinical
19 studies yourself related to gender dysphoria?
20 A No.
21 Q What about the affects of gender affirming
22 care?
23 A Nope. And as I say, I'm not aware of many
24 people actually doing studies on this.
25 Q Has the Institute ever studied the affects

1 of puberty blockers?
2 A No.
3 Q And just to be clear, you understand what
4 I mean by puberty blockers?
5 A Yeah.
6 Q Yeah.
7 A Suppression of hormones. Yes.
8 Q You said -- you mentioned Ms. Blakemore
9 was studying the teenage brain.
10 A Yeah.
11 Q Does anyone else study teenage brain
12 development at the Institute?
13 A The only people that are still -- Sara
14 still has some staff working there finishing up
15 grants, that's it.
16 Q Have you ever studied teenage brain
17 development?
18 A Yes. I did a study a couple -- probably
19 more than a couple of years, but five years ago with
20 Essi Viding and Eamon McCrory where we were looking
21 at teenage boys, and we were looking at teenage boys
22 at risk for psychopathy. And we were comparing
23 across teenage boys at risk for psychopathy and
24 teenage boys who were neurotypical, and looking at
25 their perception of emotional vocalizations and

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1 somebody. And we had another group of boys who had
2 conduct disorders, but were low in callous and
3 unemotional traits. And that's an important
4 contrast, because they're not well behaved these
5 boys, but they feel bad if they do something wrong.
6 And it's the boys with this two-fold profile, their
7 conduct disorders and high in callous and
8 unemotional traits, they're the ones at risk of
9 psychopathy. And psychopathy in adulthood is
10 associated with unpleasant and uncaring behavior
11 towards other people.
12 Q Did any part of that study inform the
13 opinion you gave today?
14 A Only in the most general sense that the
15 teenage brain is changing. I mean, even in that
16 study, we couldn't conclude if the differences we
17 saw were because of something innately different
18 about boys at risk for psychopathy or because of the
19 experiences they had had as they were growing up.
20 And that's -- and that's a problem you keep coming
21 back to in this literature. You may -- even if you
22 find a difference, how you interpret that
23 difference, what's driven that difference can be
24 very hard to determine. So only very generally.
25 Q Do you treat patients?

1 A No. I'm not a medical doctor.
2 Q Any medical training?
3 A No. I've worked a lot with patients, but
4 that's been just in basic studies.
5 Q Are you a psychologist?
6 A Yes. My training is in biology and
7 psychology, and my Ph.D. is in cognitive science.
8 Q So are you sort of certified as a
9 psychologist?
10 A We don't really have that system in the
11 U.K.. If you want to practice, you can join the
12 Healthcare Professionals Association. But I'm
13 not -- I'm not a clinical psychologist. I'm not
14 clinically qualified. I'm a basic scientist. So
15 I'm not affiliated with any professional
16 organization other than the British Psychological
17 Society, which is just most to belong to.
18 Q Have you ever had a clinical practice in
19 any way?
20 A No. So I've worked with patients,
21 normally patients with strokes. Some work with
22 psychopathy and dyslexia in children and teenagers.
23 But really all of that, all of it was just basic
24 science. It wasn't -- it wasn't in a clinical
25 study. It wasn't a study of treatment. It

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1 neurologist?
2 A Neurologist is somebody who's medically
3 qualified, and then they specialize in diseases of
4 the brain and the nervous system. And they see
5 patients. They work clinically. They prescribe
6 drugs. A neuroscientist is somebody who studies
7 brains. He would probably work with neurologists.
8 But he's studying it in a purely basic science
9 position. They're not treating people. They're not
10 prescribing things.
11 Q Are neuroscientists qualified to advise on
12 gender affirming care?
13 A I think in terms of their understanding of
14 how the brain develops, yes. I think we are not at
15 a stage where there's good cognitive neuroscience on
16 the brains of people who are transgender. There are
17 some studies, but it's not -- what they are -- I
18 didn't put this in my report, and I'm answering it
19 because you asked me about it.
20 What those studies are showing is that
21 what you start to pick up is a difference in the
22 brain that's associated with the dysphoria. I think
23 there was a belief that somehow people with trans --
24 who are transgender would have the brain of the
25 opposite gender and that's not what you find. So

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1 MR. BEATO: Object to form. Dr. Scott,
2 you can answer.
3 A I don't think so yet. Because as I say,
4 the brain scans, that seems to be telling us
5 something about who -- a difference in the brain if
6 somebody is experiencing dysphoria from a
7 neurotypical individual. That's still we're looking
8 at two patterns of activation, but we're not saying
9 two different populations and we could categorize
10 people one way or the other. So it's not telling
11 you about categories and it's also not telling you
12 anything about how that profile might change. If
13 other things were affecting the gender dysphoria,
14 would that resolve in a different way. So it's not
15 going to be good evidence across for predicting for
16 what I suspect.
17 Q So just sort of to recap a little bit on
18 you. You're the director of -- you're the Director
19 of the Institute on Cognitive Neuroscience. You are
20 a neuroscientist, correct?
21 A Yeah.
22 Q You do not treat patients?
23 A Nope.
24 Q You have no medical training?
25 A Nope.

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1 Q I just skipped a bunch of pages. Do you
2 recognize what's on the screen?
3 A Yeah.
4 Q What is this?
5 A They are some of my refereed articles.
6 Q I'm going to scroll down. Are these all
7 the articles that you list on your CV?
8 A Yeah.
9 Q I looked -- why is six missing?
10 A I've got no idea. I think probably
11 because I've copied and pasted.
12 Q Okay. Just a typo. Is there --
13 A Almost certainly what I've done is I've
14 copied and pasted the text in from PubMed or
15 something like that to get the reference, and that
16 normally puts in a few extra returns. And they need
17 to be deleted to get the numbers to go right, and
18 I've done that incorrectly. Sorry.
19 Q Do you recall any publications that you
20 wrote that are missing from this list, publications
21 that you wrote around this time?
22 A Well, it's difficult to say without having
23 another CV in front of me. But I can't -- I can't
24 see anything obviously. No.
25 Q Okay. All of these publications are about

1 speech, laughter and sound. Isn't that right?
2 A There are a few other things. But yeah,
3 that's the majority. That is my main area of
4 research.
5 Q Are any of them about gender affirming
6 care?
7 A No.
8 Q Are any of these publications specific to
9 gender dysphoria?
10 A No.
11 Q Any about puberty blockers?
12 A No.
13 Q Any publications on how pharmaceutical
14 drugs interact with the brain?
15 A If you go back -- I'm trying to remember.
16 We did do some work with methamphetamine and people
17 who had strokes. I'm trying to remember if there
18 was a study on that. If there was, it was a while
19 ago.
20 Q How long are you -- how long ago? Sorry.
21 A Twenty years ago. And I now can't
22 remember if there was a published paper from it,
23 so...
24 Q All right.
25 A Let me think if there's anything else.

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1 Q And what did Mr. Conrathe say?
2 A He contacted me and some of the other
3 people who -- like I said before, there's a case in
4 Florida, would you be interested in making a similar
5 kind of report to them writing about the same sort
6 of issues.
7 Q Why did you think that you had an opinion
8 to give in this case?
9 A Because I provided an opinion before for
10 the Keira Bell case. And I discussed that a lot
11 with Paul Conrathe at the time for all the reasons
12 you said. I'm not a clinician. I haven't worked in
13 this area. And all the people that have -- do work
14 in that area were not prepared to make a comment
15 about issues around consent and issues about puberty
16 blockers. And I did some reading into the
17 literature, and I was concerned enough that I
18 thought somebody needs to, so I did.
19 Q You mentioned the Keira Bell case.
20 A Yeah.
21 Q What was your role in that case?
22 A I provided very similar testimony about
23 the particular issues of consent for Keira Bell,
24 because that was her particular claim at the
25 judicial review. But also in the course of writing

1 that, it became very clear to me that, you know, the
2 potential role for gender affirming drugs, puberty
3 blockers or cross-sex hormones during adolescence
4 could really be significant, and that informed my
5 comment.
6 Q So you formed your opinion about puberty
7 blockers in adolescents while you were working on
8 the Bell case?
9 A Yeah.
10 Q Did you submit a written report in that
11 case?
12 A Yes.
13 Q Do you recall the date?
14 A No. I don't recall the date. It would
15 have been -- it was probably over the summer or
16 towards the end of the summer in 2020.
17 Q Would you be willing to provide us a copy
18 of --
19 A I'm not certain if I can. Can I chat with
20 Paul Conrathe?
21 Q Sure. Why would he --
22 MR. BEATO: I think there may be some
23 confidentiality issues with that in that case,
24 Dr. Scott.
25 A Yeah. I would need -- the last time

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1 brain development. But that's not necessarily
2 normalizing anything. That could simply be changing
3 the brain in a way that might be negative.
4 Q But that's not necessarily harming
5 anything?
6 MR. BEATO: Object to form. You can
7 answer, Dr. Scott.
8 A But it's not very good evidence that it's
9 safe, particularly if -- and I remind you of this.
10 The original claim for puberty blockers is that they
11 are just pressing pause, and they're clearly not
12 just pressing pause. They are changing brain
13 structure and they're changing behavior.
14 Q But you can't say here --
15 A Sorry. Go on.
16 Q But you can't say here that these puberty
17 blockers have any harmful effects on the brain?
18 MR. BEATO: Object to form. But you can
19 answer, Dr. Scott.
20 A But we know that they change the brain and
21 we don't know that that's not harmful. And
22 that's -- I think that's the critical point. We
23 know that in the -- again, this came up in one of
24 the rebuttals. A different person said, well,
25 wouldn't -- if delayed puberty is problematic for

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1 blockers are not doing anything bad for the brain,
2 even if you said that, you have to accept that the
3 puberty blockers are going to be changing the
4 effects of testosterone and estrogen in the brain,
5 which at a bare minimum affect the parts of the
6 brain that show sexual differentiation in males and
7 females.
8 And the evidence and the literature that
9 we have from these papers that I've reviewed more
10 recently indicates that that's already happening
11 before puberty. Even prior to puberty if you give a
12 puberty blocker, something that's cutting off all
13 production of estrogen and testosterone to a female
14 monkey, that will already start to affect her brain
15 structure.
16 So they're suggesting as they do in the
17 paper there's an effect of estrogen on the whole
18 brain, the whole brain volume before puberty starts.
19 MR. BEATO: Counsel, I apologize. I just
20 have a quick question. We've been going for
21 about an hour and 30 minutes. Do you think we
22 can work in a five-minute break, or if you have
23 some follow-up questions that relate to what
24 Dr. Scott is saying. We can take a five-minute
25 break a little bit later on.

[PAGE BREAK]

1 the amount of time they've been on the drugs with
2 the things to see if there's an effect of that. But
3 in terms of long-term, I am not certain about that.
4 Q Is there a study --
5 A -- looking at cognitive things.
6 Q So this study does not determine whether
7 there are any long-term effects of puberty blockers
8 for precocious puberty?
9 A No. Because it's still -- you know, the
10 girls are still young when they're being tested.
11 Q And yet we still prescribe puberty
12 blockers to treat precocious puberty?
13 A Yes, as far as I'm aware. Although, in
14 this paper they say it's not completely clear that
15 it's totally not affecting girls, if you see what I
16 mean. Most of the girls are very similar, but there
17 were some points in which they looked different.
18 Q Why should we be concerned about
19 prescribing puberty blockers to treat gender
20 dysphoria based on a lack of knowledge when we had
21 the same lack of knowledge for precocious puberty?
22 A I don't think that's necessarily a reason
23 to do it in precocious puberty. I think that the --
24 I have some concerns about the data in precocious
25 puberty. I don't think that's trouble free. So the

1 girls -- the normally developing girls, there was a
2 seven point difference in IQ between them and the
3 girls with precocious puberty, which means that some
4 of the girls in precocious puberty had even lower
5 IQs. And that's -- this is not my words. Somebody
6 else wrote a commentary on this saying that's not
7 nothing. There's a small group. It's enough to
8 make you slightly worried.
9 So I think probably the argument that the
10 medics would make with precocious puberty is that if
11 you're just going to do this for a short amount of
12 time, get them across the right age, you know, a
13 year or two for Tanner Stage 2 to be okay, and then
14 off you go. But I don't think it necessarily means
15 that it is safe.
16 Q Are your --
17 A The cognitive function, the data is not
18 100 percent clear that it doesn't have an effect.
19 Q Are your concerns with puberty blockers
20 for precocious puberty shared by the medical
21 community?
22 A I don't know. They are certainly shared
23 by Dr. Hay who wrote that commentary that I cited.
24 But that's, you know -- I suspect that precocious
25 puberty, because their sights on things like height

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1 aspect of human behavior that is determined by just
2 one factor. That's why things like advertising
3 exists, the marketing, you know, because humans are
4 complicated. You can't just simply manipulate them
5 into doing what you want them to do or find what
6 they like simply. So that's just a general truth
7 about doing psychology. It's always a -- you always
8 end up with complex patterns of things that
9 influence behavior.
10 Q So you're saying every brain is different?
11 A Yes. Because the thing that brains change
12 hugely in development over your lifespan, but they
13 also change massively based on your experience. And
14 that means that, you know, if I was to clone you
15 tomorrow, I would still have somebody who even if
16 they had the exact same brain as you would grow up
17 to be different, because they would grow up in a
18 different world. They would grow up in a different
19 environment and their brain would not be exactly the
20 same as yours.
21 So you got this kind of fascinating, but
22 sort of extremely complex continual interaction
23 between the brain that you have. And remember,
24 you're born with 86 billion braincells. And you
25 have those braincells all your life. You don't grow

[PAGE BREAK]

1 BY MR. SHAW:
2 Q I'm going to go back to your report. I
3 want to talk about starting at paragraph nine.
4 A Yeah.
5 Q Paragraphs 9 through 14. I can show you
6 all of them if you want. You talk about how the
7 brain develops.
8 A Yeah.
9 Q Is it a fair characterization of your
10 report to say that you believe teenager's brains are
11 prone to more risky behavior during that time?
12 A Yes. There's a recent review. It came
13 out too recently for my report, I think, but in the
14 nature of neuroscience, which described risk-taking
15 behavior in adolescents is a defining feature of the
16 decision-making.
17 Q Is that common for all adolescents?
18 A Well, I mean adolescence is very variable
19 like all humans. We're talking about population
20 level here. So yes, there's a reason why in law we
21 try and protect adolescents from the things that
22 could have livelong consequences for them, like what
23 age they get married and what age they have tattoos
24 and what age they get in a car. So that's kind
25 of -- you know, all human cultures recognize to some

1 degree this difference. And we don't always deal
2 with it well, but it's definitely a brain that's
3 still in development.
4 Q Would you say that you're an expert in
5 adolescent behavior?
6 A I'm only somebody that works in brains. I
7 don't -- I have been involved in some studies on
8 this and it's literature I know about. I do not --
9 this is not in any way my main area of research.
10 But as I say, it's a mistake to assume that because
11 somebody doesn't research something, they don't
12 therefore understand it. As I said, I did write a
13 book on this last year, brains in general.
14 Q Is it fair to assume -- is it fair to say
15 that -- let me rephrase.
16 Is it fair to say that because someone
17 does not investigate this area specifically, that
18 they're not an expert in the area?
19 A Some area of specific expertise. But I
20 think anybody that can -- I can read and understand
21 and interpret and draw across the papers. So my
22 expertise in neuroscience is what I'm speaking to
23 here more generally.
24 Q Can a nonexpert review the papers?
25 A I'm absolutely certain they can do.

1 Q Can they understand them?
2 A I think some of it gets -- not necessarily
3 understanding is going to be the problem, but
4 interpreting what that could mean and what the
5 bigger implications are might just be easier for
6 somebody who's more familiar with the wider field.
7 Q Do you need to be an expert in
8 neuroscience to understand that teenagers on the
9 whole engage in risky behavior?
10 A No. Like I said in my report, it's
11 something that all cultures recognize. It's
12 interesting how long it took science to start asking
13 questions about it. For a long time, developmental
14 psychology meant sort of not to tend. But actually
15 now people think about, as I said, the human brain
16 is a work in progress. I've studied developing
17 brain. I've studied aging brains. Your brain is
18 always changing.
19 So it's definitely something that's become
20 of more interest. But it's always been I think, you
21 know, as long as can you find history for humans,
22 you find humans complaining about teenagers.
23 Q How is this increased level of riskiness
24 relevant to your other opinions?
25 Let me back up. Excuse me. If I may.

[PAGE BREAK]

1 could come back to have implications for you that is
2 more likely for teenagers to engage with. So the
3 hot/cold is important, but it's not capturing all
4 aspects of risk.
5 Q But we're not talking about teenagers
6 deciding about gender affirming care themselves in
7 this case, right?
8 A No. I understand that this would be
9 something where the consent is not with the
10 teenager.
11 Q Say that again. Consent is --
12 A Consent is being made by somebody else.
13 The informed consent is being made by somebody else.
14 I think one would assume that they're still part of
15 the discussion, and that this isn't being visited on
16 them in an unwilling way. And I think that the
17 point still stands about being able to fully
18 comprehend the implications of factors that
19 could have big influences further down the line.
20 Q Do you think adults can help teenagers
21 understand fully the implications of gender
22 affirming care?
23 A I think if those adults had really good
24 information about what the implications are, then
25 yes, I think they could do. But we're back to the

[PAGE BREAK]

1 sometimes larger brain areas. What that translates
2 into we don't know. But smaller brain areas are
3 rarely good.
4 Q So would you say that your opinion --
5 would you agree with me that your concern is
6 limited -- let me rephrase.
7 Would you say that your concern is limited
8 to puberty blockers or all forms of gender affirming
9 care?
10 A I think the immediate proximal concern has
11 to be puberty blockers given these effects in the
12 published literature. From the brains eye view,
13 this is not a pause button and that concerns me. I
14 have other thoughts about -- that's not true.
15 Anything else I said would be much more of an
16 opinion, and it's harder -- it's not impossible, but
17 because puberty blockers -- no, that's not true.
18 No. I think it's probably fair to say that. I
19 think it's fair to say that my primary concern is
20 about puberty blockers and giving them in
21 adolescents and the risk associated with that.
22 Q So you're not giving an opinion about
23 adults?
24 A No.
25 Q You would agree that a complete

[PAGE BREAK]

1 at the bottom of the screen?
2 A It's very small. Could you make it
3 bigger, please?
4 Q Sure can.
5 A Thanks. Yeah.
6 Q You said, "The book says that girls who
7 like bugs and wear super hero" -- I think you meant
8 capes there, "and who don't like pink dresses are in
9 fact boys. I think that's your cheap shot right
10 there."
11 A Yeah.
12 Q What was your problem with the book?
13 A Because I was a little girl who dressed
14 like a super hero and collected water beetles, and I
15 was never a boy. So I think it seems reductive to
16 assume that a girl who likes boyish things can't in
17 fact be a girl.
18 Q Is that really what the book says?
19 A It's the story of the book, isn't it? She
20 doesn't like girlish things. She wants to be called
21 a boy's name. And then at the end, hooray, she's a
22 boy.
23 Q Well, the book starts with the premise
24 that it's a trans boy.
25 A Yes.

1 Q Right?
2 A What's a trans boy if that's not a girl?
3 Q So that it's not about her liking bugs and
4 capes.
5 A Yeah.
6 Q It's that she's a trans -- or that he's a
7 trans boy.
8 A So a girl who likes bugs and capes has to
9 be a trans boy?
10 Q No. Anyone can like bugs and capes.
11 A Yeah.
12 Q The book is about addressing that issue
13 with your family. You didn't read the book?
14 A Well, that was -- I've just quoted off the
15 bits I saw. This is -- you've asked me why I said
16 it and that's why I said it.
17 Q Is a trans boy a girl?
18 A A trans boy is a natal female. If they
19 weren't a natal female, they would just be a boy.
20 Q That person cannot consider themselves to
21 be a boy?
22 A Yeah. Absolutely they can consider
23 themselves to be a boy. Totally.
24 Q So they're a boy, right?
25 A They're a trans boy. Yeah. Yeah.

[PAGE BREAK]

1 seeing this, what's on the screen?
2 A What year was this?
3 Q This is -- I'll bring up your tweet. The
4 reason I'm doing this like this is because the
5 pictures don't show up on the tweet.
6 A Right.
7 Q So this is where that picture was.
8 A Okay.
9 Q And you tweeted, "Oh, God."
10 A Yeah.
11 Q What did you mean by "oh, God"?
12 A Because I'm guessing -- this is six years
13 ago. There was a shift in people going from asking
14 if you're male or female and for protecting
15 characteristics like male and female being used as
16 terminology to what you identify as. And that is
17 something that has continued and has got no better.
18 And my concern at that time was that if you move
19 something from being specifically for females and
20 make it for anybody who identifies as a female,
21 there is the possibility for -- well, first of all,
22 you're making this less available to do the things
23 you're supposed to do, which is increase
24 applications from females. And also you are at
25 least opening up the possibility for somebody to

1 self-identify in a way that is trying to take
2 advantage of the situation. I think if you want to
3 make things better and more inclusive for trans
4 people, what you do is you do specific stuff for
5 trans people. That's why I've said that.
6 Q Doesn't that section them off from
7 everyone?
8 A Yes. But that's the nature of doing
9 positive discrimination, isn't it? You do specific
10 things for specific groups of people.
11 Q So you don't think that trans women should
12 be allowed to apply for the same scholarships as cis
13 women?
14 A If by cis women you mean natal females,
15 then it would depend on what it's for and what
16 they're trying to correct by having the -- if you're
17 in a situation where there aren't enough natal
18 females and you're trying to boost it with
19 scholarships, then probably no. You probably should
20 keep it for natal females. If it's a situation
21 where you are worried about trans representation,
22 you would be entirely appropriate, and certainly the
23 equality is lower in the U.K., would let you have a
24 much more specific group for trans people and to
25 specifically benefit them.

[PAGE BREAK]

1 C E R T I F I C A T E

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH)

5

6 I, the undersigned authority, certify that

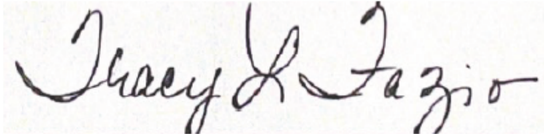
7 SOPHIE SCOTT, Ph.D. appeared before me and was duly

8 sworn.

9 WITNESS my hand and official seal this 23rd day

10 of March, 2023.

11



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13 Tracy Lyn Fazio, FPR

Notary Public - State of Florida

14 Commission No. HH 089243

Expires: 02/25/2025

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