UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION
CASE NO. 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,
Plaintiffs,
VS.

JASON WEIDA, et al.,

Defendants.
_____/

Remote via Zoom
March 20, 2023
10:10 a.m. - 4:04 p.m.

DEPOSITION OF KRISTOPHER KALIEBE, M.D.
Taken before Lilly Villaverde, RPR and Notary Public in and for the State of Florida at Large, pursuant to Notice of Taking Deposition filed in the above-mentioned cause.

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I N D E X

E X A M I N A T I O N S

E X H I B I T S

came out with a report regarding their assessment of how to move forward with gender care and it was a Yahoo News report, which led me to this organization which is -- seems like a quasi-governmental or public organization, but I can -- I could find the name of that, but that was the news report that I found.

Q. Okay. By any chance, is it the Society For Evidence-Based Gender Medicine?

A. No, I had some -- but, no, this was a Yahoo News report.

Q. Okay. When you talked to counsel, was anybody else present in that call besides counsel?

A. No.

Q. Have you discussed the deposition with anyone else besides counsel?

A. Have I discussed the details of my report, no. Some people are aware that I'm testifying, but I have not discussed the details of the testimony, except for occasionally I've asked my wife a few questions. So I have asked my wife some questions.

Q. Sorry, you've asked your wife what?

A. I have asked my wife to -- some questions regarding the case.

Q. What questions have you discussed with your wife regarding the case?

A. I asked my wife some questions about endocrine-disrupting chemicals and their possible effects on the developing brain.

I asked my wife about the effects of hormone blockers and exogenous hormones on individuals being treated for a number of conditions, including treatment with regards to gender-affirming care.

Q. What's your wife's background or professional background?

A. She's an endocrinologist, board-certified endocrinologist.

Q. What did your wife say with regard to the effects of puberty blockers on hormones?

A. She opined that the effects are unknown and that she would have concerns regarding bone density, especially as people age, teenage years, or when lay down much of their bone and there can be significant bone loss related to puberty blockers.

She gave me her assessment that providing exogenous hormones could be -- could later cause a number of cancers and that there -- in her opinion, there's not really anything known about what cancers could be brought forth by exogenous hormones.

She indicated also there could be cardiovascular risks related to exogenous hormones. She

by listening to presentations at the conferences.

Q. So like lectures, some of these may be CME?

A. Yeah, I mean, all this stuff from the conferences is CME, yes.

Q. Yeah. Okay. Let me ask you this, you have not published any literature regarding gender dysphoria; is that right?

A. That is correct.

Q. You have not published any literature regarding transgender people; is that right?

A. That's correct.

Q. You have not published any literature regarding gender identity; is that right?

A. That's correct.

Q. All right. Let me talk a little bit about your clinical experience and I think it might be helpful to sort of separate a little bit the years at LSU with the last seven years at -- at USF. How many patients would you see on a weekly basis?

A. My clinical job changed frequently, but I know that when I had my clinic at St. Charles Community Health Center, which I did for 11 straight years, which is a federally-qualified health center. I'm not sure if you know what that is, but it's a community health center that also provides mental health services.

clinics and we would have three or four residents per day. I don't schedule my own patients during that time. I'm there to -- I'm the, you know, physician of record. So I have to see all the new people and I have to supervise all the cases. We discuss them. So I don't know the numbers of how many, you know, we see in an afternoon, but that had a one-day-a-week Silver clinic throughout my time at USF. I think -- if you want to stick on that, so that has been my main outpatient child psychiatry setting.

Q. Okay. And then I imagine you see or consult with regards to the three juvenile facilities for which you --

A. Correct, yes.

Q. How many patients have you diagnosed and treated with gender dysphoria while at USF?

A. I would approximate a dozen.

Q. So in your last seven years you have diagnosed and treated a dozen patients with gender dysphoria?

A. Correct, and it's an estimate. I can look.

Q. Okay. Where did you diagnose and treat these patients as part of your clinical affiliations?

A. I have -- I have both within the Silver Child Development Center and also within the juvenile correctional system.

Q. What's the treatment you provide for these patients with gender dysphoria?

A. With patients that I see at the Silver Child Development Center, since I'm working with the residents, I do the initial assessment with the resident and then they usually are seeing the person. Although, each year, when the new residents turnover, then I stay with the patient usually and then they get a new resident to work with the patient and we try to work in a multidisciplinary way. So they may be also getting care at other parts of the university, which could include a gender clinic, but also, more frequently, would include psychotherapy either outside of USF or by a therapy provider within our -- within our system.

Q. Okay. So just to be clear, some of these patients have been getting gender -- medical treatment for gender dysphoria within the USF system?

A. I don't -- yes and no. Some of the patients are -- some of the patients that I had have gone on, I believe, to get gender treatment, because sometimes they leave and don't come back and you don't really know, but they were on a path towards getting medicalized treatment. I can't say for sure once they leave the clinic, but that could -- that seemed to be the plan, at least some of the cases.

still be the physician of record on.

Q. So the ones -- of the 12 -- and I'm just trying to get the numbers more or less.

A. Sure.

Q. So of the 12, there's one that presented as prepubertal child, didn't continue care with you in particular, so we don't know outcome or course of treatment for that person. There's five or so -- and I guess that these are not hard numbers. Five or so of the 12 that have continued on to care with somebody else. And then there are at least two to three that have continued on where you have supervised and/or are providing the treatment; is that right?

A. Correct.

Q. Okay. So of the two or three, those are the ones that have not gone on to medicalized care; is that right?

A. Correct.

Q. So we don't know really the outcome for the other nine, as to medicalized care; is that right?

A. Correct.

Q. And you said that you provide -- they're not necessarily interested in medical care and/or you are treating other comorbidities, if you will, on these patients. What's the treatment that you provide for the

dysphoria?

A. The treatment that is provided for the dysphoria at that Silver Clinic would be in combination with the residents that are marking this and we come up with a plan of how we were going to help this patient in the best way that we can.

So what we prefer is for them to be in psychotherapy and to also have a consistent psychotherapist that's seeing them. So that would be my preferred mode of treatment, that they would have an individual therapist and that we would be providing medications and also our opinion, you know, whatever else we can sort of add to the case.

In terms of gender dysphoria, obviously you don't treat it directly with medicines, nor are we involved with providing hormones or those type of things. We provide supportive therapy, basically, is what -- psychosocial support, that's what I would frame our general approach as.

Q. Yeah. No, no. Thank you. I appreciate that. I'm not trying to be difficult. I'm really trying to understand your practice, if you will. I guess what type of psychotherapy is being provided, right, and I think you can agree with me that there are different modes of thinking of what the psychotherapy should be or

could be. And so I'm curious as to what is the psychotherapy that is being provided with regards to the gender dysphoria or if I'm understanding you correctly, you are not providing the psychotherapy, you recommend that they see another therapist to provide the psychotherapy?

A. Yes. I mean, I also -- I worked in many settings where you have more than one provider and usually they help each other and support. So we wouldn't -- we don't mind if someone is getting psychotherapy from, let's say, a social worker and that's consistent, but when we see the patient we are also providing some therapy of sorts of supportive.

I mean, mostly from -- in that clinic, it would be just supportive therapy and I don't know that we would say we were giving therapy for gender dysphoria, if you understand what I'm saying.

Q. Okay. So you wouldn't be providing treatment for the dysphoria at Silver Clinic?

A. I think we would not be directly addressing gender dysphoria in psychotherapy. We would be doing maybe some exploratory work with patients about what's going on with their life and these patients all have comorbidities, so they have depression or anxiety or trauma or personality disorders or whatever. So we are

trying to provide them skills and sort of basic coping mechanisms, self-regulation, all the standard things you provide to someone who has emotional dysregulation or behavioral problems or, you know, emotional problems, standard care.

Q. Understood. Thank you. Let me ask you this, you mentioned that some of these patients may present with comorbidities. Let me just go at a basic level. Would you agree with me that gender dysphoria is a very real condition?

A. Yes.

Q. Okay. So it wasn't a trick question. I was just -- you would be surprised. I have other people that say no, right.

So okay. So with that basic understanding, then I guess my question is, the fact that somebody has comorbidities doesn't necessarily mean or -- a person with gender dysphoria doesn't necessarily flow from those comorbidities, right?

A. Could you explain -- please rephrase or --

Q. Sure.

A. Let me listen --

Q. Yeah. So a patient may have more than one condition, so they may have comorbid conditions, but the conditions may be independent of each other, if you

will.

A. Yes, that is possible.

Q. Okay. So they're not necessarily related, is what I am trying to get at?

A. It's possible, yes.

Q. And of course that -- it takes the work of, sort of, assess, right, if that's the case in a particular patient or not; is that right?

A. Correct.

Q. So providing treatment for comorbidities doesn't necessarily mean -- and I don't understand that you were saying this, but just want to make sure that we are on the same page. Providing treatment for comorbidities doesn't necessarily address a patient's gender dysphoria; would you agree with me on that?

A. Doesn't necessarily, correct, I would agree.

Q. All right. I did have a clarifying question and I'm not -- this is not a gotcha. I'm just trying to understand. Maybe this happened while you were at USF, but it sort of, you know, came from the past. On paragraph 11 of your report, you state that you have been consulted to provide a second opinion and coordinate care regarding a patient with gender dysphoria in the Louisiana juvenile correction system.

A. Correct.

are not fully -- family --

A. I guess.

Q. In the context of the therapy that you provide, understanding you are not doing the psychotherapy directly would these patients, but just overseeing some of their pharmacological care. Do you use the pronouns that they -- that are consistent with their identity?

A. Yes. Although, I would also say I often, in the correctional system, usually use the last name, which is very common in those systems. So I don't use -- I would use either the pronouns that they suggest that they would like or I would use the last name. I lean towards avoiding pronouns in direct conversation with someone, but, yeah, yes, recommended pronoun.

Q. Let me just finish a particular line of questioning here and then we can take a quick break.

You have not done any original scientific research into gender dysphoria, gender identity disorder or transsexualism; is that right?

A. Correct.

Q. You have not done any original scientific research with regards to transgender people?

A. Correct.

Q. And you have not done any original scientific research with regard to gender identity?

A. Correct.
Q. And you are not an endocrinologist; is that right?
A. Correct.
Q. Okay. Nor are you certified in pediatrics?
A. Correct.
Q. Or adolescent medicine?
A. Correct.
Q. Understanding that you have a child and adolescent psychiatry certification, which is a different one, but specific -- okay.
Let me ask you a little bit about the scope of your testimony. Is the scope of your report limited about the propriety of care to minors or is it -- does it encompass also adults?
A. I definitely have more expertise and more experience in child psychiatry. That has been more of my professional home and I think the questions are more grave related to child psychiatry and adolescent psychiatry, yet I was asked to review and opine generally. So I did my best to try to catch up on adult literature and know more about adult issues, but I am -- I am, admittedly, more comfortable with child and adolescent and young adult, which a lot of -- in child psychiatry, you end up treating a lot of young adults.

So that would be more where I'm comfortable.

Q. All right. So I -- we'll get to some of the specifics then, because I'm just -- I will be honest, I wasn't clear if you were opining at large about medical treatment for adolescent and adults or just adolescents in certain parts of your report so?

A. Okay.

Q. We'll get to that.

All right. Let's take a quick five-minute break. Come back at 11:25.

A. Okay.

MR. PRATT: Sounds good.

MR. GONZALEZ-PAGAN: We can go off the record.

(Off the record.)

BY MR. GONZALEZ-PAGAN:

Q. Welcome back, Mr. Kaliebe. All right. So you prepared an original report, which we've been discussing a little bit, as well as a rebuttal report. Your original report, does that contain the totality of the opinions you are going to provide in this case affirmatively?

A. Can you repeat the question?

Q. Sure. Your original report, does that contain the totality of your opinions that you are providing affirmatively?

about -- overall, to some degree or visibility, if you will, about transgender people in this day and age, then there was ten years ago, 20 years ago; is that right?

A. Correct.

Q. Okay. So the fact that more people have been showing up at clinics could be explained by the fact that, A, the care is more available; and, B, more people feel comfortable seeking the care?

A. Could be explained by that, but I don't believe that's consistent with the evidence.

Q. Okay. And why don't you believe that that's the case?

A. Well, very welcoming countries, such as Sweden and Norway, have had the same explosive rise in gender dysphoria presentations among youth. And they for many, many years had very welcoming and open society, yet had the same massive rise in people presenting for gender dysphoria. So that -- so that, for one, belies that -- since it's been a worldwide phenomenon, that it would be related to a more welcoming.

Plus the change to the presentation of these youth that have so many comorbidities now. So the -- you know, we're especially seeing youth with significant mental health problems presenting and identifying. And once again, so that makes it seem like disproportionally

hundred thousand is in the 2013 DSM, that seems to be more like the historical base rate and now we are talking -- especially in the young generation, you can even look in different generations, see the different amounts.

Q. That also was citing to evidence before there was a depathologization of identity within the DSM; is that right?

A. That's one way to look at it. There's other ways to look at it.

Q. But that is correct, though?

A. The DSM --

Q. The DSM depathologized identity and moved to the gender dysphoria as the diagnosis, focused on the stress as opposed to the identity?

A. It is correct that the DSM changed their nomenclature and rates went up, yes.

Q. It wasn't just the nomenclature, though, right? They changed the diagnostic criteria as well?

A. Well, it's a different entity now they're calling it. So, yeah -- I mean, yes. The different entity was -- uses different criteria, yes.

Q. Okay. On paragraph 30, you state, "Multiple lines of evidence going to direct social influences and online and social media contagions as a major

contributors to this increase in gender dysphoria."

What are the lines of evidence to which you refer?

A. They would be cited further down in my paper with all the explosion of social contagion of different types occurred within the last two decades, as youth gravitated towards social media.

Q. But none of those have to do with gender dysphoria; is that right? With the exception of the Littman article, which we will discuss.

A. They do not. Yes, it's very hard to get those -- that type of data published regarding gender dysphoria.

Q. You say it's hard to publish, but has anybody studied it?

A. I think due to the current political atmosphere, no one is like really allowed to study things like that.

Q. We'll get to the political atmosphere in a little bit, but I think it goes both ways, but I guess my question is, you point to multiple lines of evidence, but yet you point to studies that don't have to do with gender dysphoria. So my question would be, at best, you are hypothesizing, you are not citing to any studies documenting that?

A. We are all hypothesizing, obviously. We've never had a major social change like this go on. We are not going to have any clear one source.

I would remind you that a poll at the American Academy of Child and Adolescent Psychiatry when they asked child psychiatrists at the conference how many of them believe that social media is influenced gender identity, it was 82 percent said often or very often.

So my opinion seems consistent with other child psychiatrists who have seen the same thing and in talking to youth, they often identify and I've had patients identify that part of this occurred after they search things online. So I said -- I have the direct experience with someone told me that.

Q. A single patient?

A. Correct.

Q. Since you mentioned the polls -- outlines are the best things laid out and then you have to move around.

Okay. Here we go. You state that -- on paragraph 41, you state, "Psychiatrists also believe social media has significantly contributed to the rise in gender dysphoria."

A. Sure.

Q. You don't cite to any literature. So I'm

wondering is the evidence for that these two polls that you cited?

A. Well, the French National Academy of Medicine press release also raises similar concerns and all the data about social contagions of other types and there are a bunch of articles from child psychiatrists that mention the influence. They are not studies, but there is -- I didn't cite them all, but there are plenty of articles of people in child psychiatry discussing contagion issues and relating them to gender identity.

Q. What are those articles? Do you know them?

A. I could -- not off the top of my head. I can provide them.

Q. Okay. And these are not studies, these are just what, case reports?

A. Correct, or opinions.

Q. So opinion pieces, okay. Let me -- and then you go on to say, "Yet most child and adolescent psychiatrists admit to me they will not speak publicly on this subject due to how sensitive the topic is and also fears of hostilities from activists, along with condemnation and retribution from others within their universities or organization."

What's the basis for that statement?

A. The basis for that statement is that multiple

child psychiatrists have told me they will not speak in public regarding gender dysphoria because of the things that I listed, that people are quite hostile to you if you voice any -- except, depending on what situation or what university you are in, people are afraid to even bring up the subject.

Plus, if -- we are in a profession where you are trying to serve your patients and you don't want to have negative interactions with them. And you have patients who have all sorts of different opinions, some of them -- on either side of an issue like this and when you have to speak publicly on it, you are now potentially polluting the relationship that you would have.

So it is wise for any psychiatrist, if they can, to try to stay out of these debates, it's because you don't know what patient you are going to face and what opinion they are going to have and it may be the -- express skepticism or positive feelings about this, you can create a negative relationship.

I would also add that patients have -- child psychiatrists have specifically said to me that they are afraid of people in their university, you know, giving them, you know -- affecting their job, affecting what their ability would be to get promoted, if they voiced

said, No, I don't feel comfortable. I would never voice my real opinion because of fears of retribution and --

Q. And all of your residents share your opinion?

A. No, certainly not.

Q. And you say "residents," I guess I'm wondering -- let me show you Exhibit 4 briefly.

(Plaintiffs' Exhibit 4 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

Q. Do you see this document?

A. Yes.

Q. Okay. This is a printout of the page "What is Psychiatry" from the American Psychiatric Association from today. And if we go down to the third page -- no, I lied, fourth page, right here it says, "There are about 45,000 psychiatrists in the United States," right? Do you dispute that number?

A. No.

Q. So I guess my question is, how do you get from a few anecdotal conversations who most child and adolescent psychiatrists -- to talk about this?

A. I was asked to provide my opinion. I have spoken with a wide range of psychiatrists, I've pulled whatever sources I can from, let's say, the polls and other -- and asked other people's opinions about what

they think. So that's based on my experience --

Q. Well --

A. -- and based on my conversations, that's my opinion.

Q. Okay. But there's a difference between the majority of the folks that you have spoken to most adolescents -- child and adolescents psychiatrists, right? Your conversations are not a representative sample of all childhood adolescent psychiatrists; would you agree with that?

A. Correct.

Q. Okay. And going back to these polls that you cited, let's talk about the first one on paragraph 42. When was the presentation at issue in that paragraph?

A. This was the Social Media Institute at the American Academy of Childhood and Adolescents annual conference.

Q. So the presentation or workshop, it was called the Social Media Institute?

A. Correct. Institutes are high profile, one day long special presentations that the -- at the Child Psychiatry conference.

Q. Okay. Are there presentations within the institute?

A. Yes, so because of COVID, we -- this time did

Childhood Adolescent Psychiatry can give you the information. The vast majority are child psychiatrists, but it would include pediatricians occasionally, family practice, other people who deal with child psychiatry issues, but it was not super well attended by other specialties.

Q. And you would agree that a poll like this at a presentation during a conference is not a scientific study of any kind, right?

A. I think it's just -- I mean, it's very similar to a lot of the science, as you cited, in this case, where people do online polls. In fact, I think it's a lot better than a lot of what I've seen cited in this case.

Q. Did you do any regression analysis? Did you do any statistical significance? I mean, it's not the same as --

A. The data speaks for itself. But, no, you don't -- I did not.

Q. Okay. And you would agree it's not a representative sample?

A. Perhaps, and it was people who are attending an academic conference --

Q. People that --

A. -- representative.

Q. Well, it's -- all the survey tell us and that poll tells us is the views of the attendees of that particular seminar?

A. Okay. Yes, it does.

Q. Would you agree with that?

A. Yes.

Q. Okay. The same with the one on paragraph 43; is that right?

A. Yes, that one we can say for sure those are all psychiatrists.

Q. They were all psychiatrists --

A. Excuse me, child psychiatrists.

Q. Okay. So those are all child psychiatrists, but all that tells us is the views of those that attended that particular --

A. Right.

Q. -- session?

And isn't it equally -- the survey just asks how often do you see teens who seem to be influenced by social media in regards to their sexual and/or gender identity. Isn't it part, as to these two polls, non-scientific polls, if you will, that it is not shocking that teens find like-minded teens online and they speak to each other about their similar experiences?

A. No, it's not. Correct.
Q. And would you agree with me that, in particular, small populations that tend to be isolated and/or discrete tend to turn to social media actually as a way to connect and find one another?
A. Yes, I concur.
Q. And earlier you cited the -- made reference to the press release from the French academies; do you recall that?
A. Yes.
Q. Okay. A press release is not peer-reviewed or scientific literature; is that right?
A. Correct.
Q. Okay. You conclude in your report, specifically on paragraph -- on page 16, at the end of paragraph 40, you conclude, "The French National Academy of Medicine has concluded that the epidemic-like rise in gender dysphoria is tied to social media," but the release which you quote in that same paragraph, what it says is, Whatever the mechanism involved in the adolescent, hyphen, overuse of social networks, greater social acceptability or example in the entourage, dot, dot, dot.
That doesn't seem, to me, to attribute any conclusion as to social media, it just says that it's a

interventions for adolescents?

A. Correct.

Q. Okay. The corrections actually had to do with the fact that clarifying the study, unlike the original version, wasn't pointing out to some phenomenon that was observed in adolescents. It was pointing out to observations collected from parents.

A. I believe it was clear in the original study that it was from parents, but, yes, that was the area of contention that led to the review.

Q. And the study doesn't incorporate, address or speak to the actual experiences of the adolescents in question; is that right?

A. Correct.

Q. And so the study actually doesn't reach any conclusions as to social contagions, at best, from the study, it actually raises hypothesis?

A. Okay. Yes, correct.

Q. And the corrected study states, quote, Limitations of parental report include information that parents may not be aware of and parental biases, close quote; did you read that when you were reviewing this?

A. Yes, that's correct.

Q. So you were aware of all of these critiques, right, about the Littman article when you were

into a discussion of what's the evidence base and for what care for what person. So I'm not --

Q. Yeah. I'm focused on adult.

A. -- care --

Q. I'm focused on adults in my question.

A. And what care --

Q. We --

A. Are you speaking of surgeries? Are you speaking of hormone?

Q. Hormones and surgery, right. The care for adults. We have longitudinal studies going back 40 years for adults in the United States, longitudinal studies in the United States.

A. Yeah, there are --

MR. PRATT: Object to form.

THE WITNESS: Yeah, what -- I guess since -- what is your question?

BY MR. GONZALEZ-PAGAN:

Q. Well, I guess my question is what is the basis for you to say that there's no studies or showing it's safe or effective?

A. Well, I never claimed that there's no studies. I do think the quality in adults, which, you know, has -- as I've been reviewing this case and the literature, I have mostly focused on children, adolescents and young

adults. And I will admit that I know less about and am less up to date everything about adult transgender care. What I have reviewed, you know, still is equivocal, in terms of the strength of the evidence. And so, therefore, you know, I think that is a debate about what's the right care or what type of care is appropriate for that group.

Q. All right. 12:34, let's take a -- let's take a ten-minute break. Come back at 12:45, if that's all right.

A. Yeah, fine with me.

Q. Actually, let me ask this, would you prefer to do lunch now? We can do another hour where we come back and then lunch after, let me ask that -- actually, let's go off the record.

(Off the record.)

BY MR. GONZALEZ-PAGAN:

Q. Welcome back, Mr. Kaliebe. Thank you so much.

Mr. Kaliebe, we left off discussing a little bit the evidence base, if you will, in some of the studies regarding care. On paragraph 45 you state, "My review of the research concludes that the evidence base for gender dysphoria treatment is mixed and generally low quality."

I guess, I know that you looked at reviews

published by governmental agencies in Sweden and Finland and the Cass review in the UK and you cite to the Brignardello assessment attached -- commissioned by Florida Medicaid and attached to the GAPMS report, and by GAPMS I mean G-A-P-M-S, generally accepted professional medical standards. None of those are published, peer-reviewed literature; is that right?

A. Correct.

Q. Okay. Did you actually review the studies in question?

A. Yes, I think that the low quality was -- it's right in the Endocrine Society's own practice guidelines that the evidence is all -- or treatment, it's all low quality or very low, all in the --

Q. No, no. But I'm asking if you reviewed the actual studies?

A. I reviewed many studies, which -- you would have to say which study.

Q. Yeah. I'm sorry, I'm not -- just to be clear, right, like there are many published literature, some of them are review of literature, some of them are opinion pieces, some of them are letter to the editor, but there are actual designed, original scientific research studies, right, that look at either from an observational, cross-sectional or longitudinal follow-up

basis the care, medical care for gender dysphoria.

And so my question is, how many of those studies did you look at?

MR. PRATT: Objection, form.

THE WITNESS: I would estimate, I don't know, dozens. I mean, at least a couple -- I looked through many actual original studies, in addition to reading reviews.

BY MR. GONZALEZ-PAGAN:

Q. Okay. Because I went through your bibliography and there's only four studies that are cited. Those being the Dhejne, the Branstrom, the Kaltiala and the Chen study.

So none of them have to do with puberty blockers. Two have to do with hormones in adolescents, and two have to do with surgery in adults. So I guess I'm curious as to which study did you look at to come to your conclusion?

A. Well, my conclusion about low quality reviews were the best guide for me to use that exact word, because that's what I said, even the Endocrine Society review uses low quality. So I'm using their words, so.

Q. How do you get to mixed?

A. Mixed would mean that there are positive studies and there are negative studies and, therefore, I

Q. You state, With regards to the assessment authored by Dr. Brignardello-Peterson and Dr. Wiercioch, that the conclusions fit the data and are logically sound. You are not an expert on systematic reviews; is that right?

A. Correct.

Q. And you are not an expert on grading of evidence; is that right?

A. I am just as capable as other physicians of grading evidence.

Q. Sure. Let me rephrase. By grading of evidence, I mean the actual grade system.

A. I am familiar with it.

Q. Have you conducted a grade evaluation of any particular studies before?

A. No.

Q. We already established that the Brignardello/Wiercioch paper attached to the GAPMS report has not been published or been subject to peer review; is that right?

A. Correct.

Q. And neither have been the reports from Sweden, Finland or the Cass review in the United Kingdom; is that correct?

A. Yes.

Q. And the latter three, in fact, all of them that we've been discussing, they're focus on assessments of the evidence pertaining to youth, not adults; is that right?

A. That's correct.

Q. And the rule at issue here prohibits coverage for medical care for adults as well; isn't that right?

A. Correct.

Q. So these assessments don't really -- would you agree with me that these assessments do not speak to the question of care for adults?

A. Well, I think they provide some evidence regarding care for adults, but they are not -- I would agree that they are not specifically tailored for -- certainly the international reviews are not tailored towards adults.

Q. Okay. And with regards to these countries, none of them have provided -- have stopped providing this care for adolescents?

A. You are saying completely stopped, it's my understanding that that would be correct.

Q. And in fact, all of these countries, which have nationalized health care systems, provide coverage for medical treatment for gender dysphoria in adolescence in certain circumstances, which they have tied it; is that

correct?

A. Yes.

Q. All right. You are not an expert on the development of clinical practice guidelines; is that right?

A. Just like other physicians, I am very familiar with how they're used, but I'm not sure what you mean by an expert.

Q. Well, in the development of them.

A. Correct.

Q. On paragraph -- starting on paragraph 61 to 66, you discuss SOC-8 and by SOC-8, I refer to the Standards of Care For the Health of Transgender and Gender Diverse People, Version 8, published by the World Professional Association For Transgender Health; is that right?

A. Correct.

Q. And you seem to apply that the SOC-8 was not based on a systematic review of the literature and the grading of evidence. Did I understand your report correctly?

A. Well, they used a quasi-process where they obviously have some elements of a proper review, but then didn't follow it all the way through its full conclusion.

Q. You say that SOC -- that, "Despite the

Q. And just so -- for clarity of record, I think I get what you mean by body affirmation. I just wanted to clarify as to that, but what you mean by "body affirmation" is to -- for somebody to be comfortable with what could be termed their sex assigned at birth or their natal sex or whatever that may be; is that right?

A. Well, you are more speaking of their gender identity, where I am more speaking of their body. So I don't think you need to challenge someone's gender identity to help them come to peace with or learn to love and accept their body more, because they're really, at the end of the day, you know, if you are comparing something, you know, we can help with that. Plus body affirmation can help with comorbidities, right. So --

I apologize, my dog is barking.

Sort of general therapy approaches are often helpful for depression, anxiety, self-harm, suicidality, all that kind of stuff.

So, yes, I think we need more studies to see how we can help people cope best with whatever reality they are facing and it can include targeting any of those things, but I do think people learning to accept and live in their body that they have could be an important therapy approach that I did not see, really, anyone explore, nor have I really seen much exploratory

on any other therapy.

Q. I'm not trying to be dense here. This is why I asked the clarify question. I haven't heard of the body affirmation paradigm that's being suggested here before. So I'm trying to see if it's, you know, something by another name or if it's something new that we're discussing.

And so if I'm understanding you correctly, and please correct if I'm wrong, what you are referring to as "body affirmation" doesn't deal with that person's gender identity. It is purely about them being comfortable with their body. So it could be somebody that identifies as female, but being completely comfortable with their stereotypically male body, notwithstanding that they identify as female; is that what you are saying?

A. It could be, yes. I mean, these are all sort of ideas that people have floated around about how -- what approaches might typically work, you know, and as we all know, we don't really know what approaches may or may not work. And so, yeah, I don't think directly challenging someone's gender identity is wise or indicated. Then again, if we could resolve someone's gender dysphoria or their gender identity, you know, depending on how you see it, normalizes or returns to

their cis body or their born body, I mean, wouldn't that be a great outcome, right.

So are there ways and are there sub segments, since we have lots of different populations, you know, especially now with all the developmental disorders and trauma population, you have personality disorder, you have depression and anxiety, you know, among those, perhaps, there are certain therapy approaches that are going to be quite helpful.

We know that in trauma therapies, when we do trauma specific therapy, the comorbidities get better. So we know that you can just treat the trauma and the depression and anxiety and other things, you know, that the patient has, often go away. Sometimes go away completely, once they've done a whole course of trauma-focused therapy.

So, you know, are there -- we don't really -- like I said, we haven't explored. There's all sorts of possibility.

Q. Let me ask you this, and I'm exploring the possibility with you here in conversation, right. So let me ask you this follow-up, how does getting somebody to be comfortable with their body not challenging their identity? How does that resolve the dysphoria? Because isn't part -- and so let me ask this first question

before I ask that one, which isn't part of somebody's gender dysphoria the distress associated with that incongruence due in part to how they are perceived by others in the world?

A. I think, yes, it can be, and my answer to the question is we -- if we could help people become more comfortable in the body that they are in, you know, perhaps, that would mean that they could be somewhat more comfortable and maybe the gender dysphoria never goes away, but we might be able to help them with their depression or anxiety or self-harm or other things. We don't really know, until we explore some of these things, what is more amendable to treatment and what is less amendable to treatment and which approaches maybe work with --

Q. But in the gender-affirming care model, isn't it true that it is recommended that other mental health cursors be managed and addressed, including comorbidities? Like the fact that somebody is getting medical care, that addresses the dysphoria, that doesn't address other mental health concerns. And so it is recommended that they get therapy for other mental health concerns to the extent that they are present.

A. Well, it is recommended, but, once again, we don't really have data on these populations about what

But, no, I have not participated. I see a lot of their work product in the presentations and stuff, but I have not participated.

Q. Again, you state at paragraph 77, "Most physicians are weary of the very concept that it can be beneficial to give cross-sex hormones to still developing minors."

Where do you get "most physicians" from? Is this based on anecdotal evidence as we discussed before?

A. Yes, that is my impression anecdotally.

Q. You mention on paragraph 81 a communication with the other of the Journal For American Academy For Psychiatry and the Law; do you recall that?

A. Yes.

Q. What was the context of that e-mail?

A. I had written a letter to the editor regarding a -- an article and I was aware that I had written a pretty strong letter to the editor that made a lot of important points that I thought the readership should be able to hear and the letter to the editor -- the editor chose not to publish. So since I was aware that I had written a quite strong letter and they weren't going to publish it, I wanted to ask why. So I sent an e-mail asking how come you did not --

Q. Can I ask a quick clarify -- I apologize I

I thought was very, you know, poorly reasoned and inappropriate. So, and that article was a -- was an article towards research related to gender issues that include gender dysphoria, but it was -- I don't think it included perspectives on transgender care and how we should address research based on the perspective of and it was interviews with non-binary individuals at a clinic, I believe. So it was curated by some professionals, but included the view points of --

Q. And it was a commentary piece, the article --

A. Correct. It was commentary, yes.

Q. Okay. Did you seek to have your paper or response published elsewhere?

A. No.

Q. In paragraph 82 you say, "I have not found a single skeptical or even ideologically balanced article in any of these journals. Have you reviewed all the literature pertaining to gender dysphoria or transgender people?

A. I really tried to catch up on it within those journals. I have reviewed a lot of articles from all those journals, yeah. I don't know if I've caught every article.

Q. Are you aware that the Endocrine Society has published critical letters, including to their own

guidelines authored by Dr. Laidlaw and Dr. Kearns?

A. Correct, they did.

Q. Okay. So that's an example of a skeptical or contrary article being published by one of these journals; isn't that right?

A. It is one example, correct.

Q. There's actually two letters that they've published, at least, right?

A. Yes, I think -- and I think there was another article -- another letter to the editor -- no, it's not in one of those journals, sorry.

So the Endocrine Society did publish a critical letter to the editor.

Q. Okay. So I -- it would be fair to say that your sentence, I have not found a single skeptical or ideologically balanced article in any of these journals, to be a little bit inaccurate --

A. In my defense, I had not come across that Laidlaw article at that time. So I just recently saw that.

Q. Okay. Then you say on paragraph 89, "Thankfully, journals outside of medicine have not allied themselves to one view point and are willing to embrace open scholarly dialogue." And you cite to two articles as an example, those being Abbruzzesse 2023 and

primary concern is not assessing and accumulating more evidence.

Q. Okay. All right. Let's go to paragraph 105. You state at the beginning of that paragraph, "While I have little direct experience with the Endocrine Society, my assessment that many endocrinologists, and perhaps most, also believe their professional organization is also too strongly influenced by activist physicians."

What is the basis for your statement?

A. Well, my wife is an endocrinologist and I actually go sometimes to their meetings and I interact socially with a number of endocrinologist and I see the dynamics that have occurred within endocrinology, which I've seen, on my smaller scale view point, that mirror a lot of the dynamics that have happened also in psychiatry and child psychiatry. So I am making the assumption that many of the things are similar in endocrinology to what I've seen in psychiatry.

Q. Okay. You also state that the Endocrine Society statement mischaracterizes puberty delaying medication as a safe reversible conservative approach.

A. Correct.

Q. You do not provide medical treatment for gender dysphoria; is that right?

A. Medicines, correct.
Q. Yeah. And we established earlier that you are not an endocrinologist?
A. Correct.
Q. You actually consulted with your wife as to the side effects of some of these medications; is that right?
A. Correct.
Q. So you really don't have any firsthand knowledge as to whether puberty delaying medication is safe, reversible or conservative approach?
A. Well, I wouldn't need firsthand knowledge, because I have reviewed the literature. So the literature would be what determines whether something is a safe, reversible and conservative approach.
Q. How is it not reversible?
A. How are puberty blockers not reversible?
Q. Correct.
A. Because any time that you provide someone a medicine that stops a process in the human body, you have multiple effects that go on and even when you stop that medicine, things will start, but you will have missed a period of time when you are not -- don't have the hormones you would have had and that can't -- you can't change it. You can't go back in time.

even if they don't really agree, they assume that other people agree, whether or not that's true or not. So a leadership or people making, you know, strong claims can induce -- can stop dialogue and induce many of the people in the middle, who is really people we like to hear more from, to be silent.

So there is a literature on that. I can't remember how much of that is in the Peters article I cited.

Q. Okay. In paragraph 123, you cite -- you say, "Thus we are in the curious situation where in private, but not in public, most psychiatrists will acknowledge there are doubts regarding gender-affirming care."

Just for completeness of record, is this based on the anecdotal evidence we have talked about earlier?

A. Correct.

Q. You then state, "Most child and adolescent psychiatrists consider automatic affirmation inappropriate, even though many are willing to use affirmative approached selectively. Most psychiatrist are willing to admit we don't have enough research to really know how to proceed."

Again, is this based primarily on your anecdotal evidence?

A. Correct.

A. I didn't cite any evidence base, but my understanding is that that's pretty well established, that sexual orientation seems to be a relatively fixed -- fixed relatively early on.

Q. I'm going to show you what's been marked as Exhibit 8.

(Plaintiffs' Exhibit 8 was marked for identification.)

BY MR. GONZALEZ-PAGAN:

Q. Do you see this?

A. Yes.

Q. Okay. This is an article published in the Journal of Neuroendocrinology. It titled, "Neurobiology of Gender Identity and Sexual Orientation." It was published in 2018. Have you encountered this article in your research?

A. I've seen it cited. I do not believe I've read it. Yeah. So, no.

Q. Okay. Just going to go to page 4. Here speaking specifically -- and obviously this is the review of existing research. It's not an original article or original research, if you will.

Just going to zoom in a little bit.

The last sentence of the first paragraph states, "Several extensive reviews by Dick and Swaab and

of an individual's sexual identity and sexual orientation"; did I read that correctly?

A. You did, yes.

Q. Okay. Let's go to paragraph 136 of your report. There you speak of CBT or cognitive behavioral therapy; is that right?

Are you suggesting that CBT could be an effective treatment for gender dysphoria?

A. Well, CBT could be an effective -- I don't know that it's been studied. I know CBT could be effective for the depression, anxiety, suicidality and other comorbidities that are seen, but those have been shown to.

Q. Okay. So you are state -- as I understand it, part of what you are stating is that CBT has been shown to be effective in treating some of the comorbidities associated with gender dysphoria, including anxiety and depression; is that right?

A. Correct.

Q. Okay. But you are not saying that CBT has been shown to be effective to treat gender dysphoria?

A. It's not been studied, as far as I know.

Q. Next paragraph you discuss gender exploratory therapy as a mode of treatment; is that right?

A. Correct.

Q. I know the answer to this question, but I'm going to ask it anyway. There any evidence that gender exploratory therapy is safe or effective?

A. No.

Q. In gender exploratory therapy, they consider self-identification as transgender to be more suspect or deserving of exploration than self-identification as cisgender?

A. Once again, I know that I speak for those who perform exploratory therapy, because it's a proposed thing that I don't know how it's being operationalized.

My understanding is that if someone's gender dysphoria can resolve, that that's a good thing. And so we would want people's gender dysphoria to resolve. If transgender status resolves, that's perfectly good. If it doesn't resolve, I think that's perfectly good also.

Q. Okay. Let me ask you this, what do you make of the distress of adolescent or youth who are truly trans who will experience ongoing distress during the exploratory therapy, do they have to engage in this process, even though it's actually exacerbating their distress?

A. Are you saying that the therapy would exacerbate stress?

Q. Well, the thoughts that the therapy would cause

generally disagree.

Q. Let me ask you this, I just -- the part that I get a little bit confused by is where does -- I'm truly curious as to your position or view on this, but -- let me ask it this way, would you agree that there are some people who are helped by gender-affirming medical treatment?

A. Well, I think everything in life is trade-offs and cost versus benefits. I think that some people -- we don't know what would have happened with an alternative. So it's hard to say how people's life would have gone would they have not -- we've never really done controlled studies on this. So we can't say for sure in the long run how -- affect people's lives.

I would say, yes, it's consistent with the literature that a lot of people are very happy with gender-affirming care, especially in the first, you know, part of it. And so I think we're definitely seeing trade-offs and that there are lots of people who identify as having a positive response from it.

Q. Thank you. Paragraph 142 of your report, you conclude, this is page 59, "Yoga and other somatic therapies should be studied as a component of comprehensive treatment for gender dysphoria."

I believe you mentioned it at least once

earlier today during our conversation. What's the basis for your statement?

A. Well, yoga has lots of, you know, studies. Once again, it's not that well studied, not a lot of money in studying yoga, but it has -- to the degree it has been studied, it's very good for mood. It helps with anxiety. It includes a number of components of well-established, proven mental health techniques, like mindfulness, breathing exercises.

It is physically, because you twist and turn your body. A lot of stress and trauma gets stored in the body and it seems that this is a way for people's bodies to feel good and to release. And a lot of people, especially people who are traumatized don't want to feel their body anymore. So if you don't want to feel your body, you block what's going on in your body and it seems that yoga has the ability to get people to tune into their bodies better and feel more comfortable in their body.

So I have no idea what the strength of the intervention would be, but it seems to me that that -- the type of -- rather than just talking therapy, because many of the experts in trauma actually really like these mind-body therapies that are not talking therapies, they're experiential. And so it seems to me that this

would be -- make a good part of any treatment and it increases physical health. Your body is stronger, healthier you feel better. So I would say that this is a really interesting thing to study in this context.

Q. Let me just ask you, you noted some of the positive attributes, effects possibly attributable to yoga and other somatic therapies. Has yoga been shown to effectively resolve any mental health conditions?

A. Well, as I mentioned, there are not studies on yoga. But, no, there's not a lot of studies directly targeting mental health.

Q. Okay. Paragraph 152, you state, I believe it's the second sentence, "The burden of proof is on those who propose hormones and surgery on minors to conduct long-term studies and show these practices to be safe and effective."

I think we discussed a little bit, but I'm curious -- I think we discussed this to some extent, but I'm curious, assuming for purposes of just the question that these studies do not exist, how can you conduct them if the care is prohibited?

A. Well, obviously they would have to be -- the care would have to be available in order to study.

Q. Okay. And are you aware -- we discussed some of these before, but you are aware that there are some

and correct me, but I take your criticism then to be not specific to the promulgation of guidelines within the context of gender dysphoria. It is also somewhat more generic about how guidelines are promulgated generally within the medical profession?

A. Correct. I feel like some of the weaknesses of how we create guidelines has -- which has been problems for other guidelines we are seeing in these guidelines. So it is not -- I have criticisms of other guidelines, especially, once again, in the context of multi-morbidity. So there's a guideline for your depression, for your high blood pressure and there's a guideline for your high cholesterol and there's a guideline for your sedentary behavior and there's a guideline and, you know, you end up -- especially when you have someone who has mutli-morbidity, which are the guidelines you follow and how you integrate them, it's a complex problem.

Q. Yeah. And let me ask you this, the Standards of Care 8 were posted for public comment on December 2021. Did you submit public comment?

A. I was not aware of the Standards of Care 8 were coming out at that time and so, no, I didn't know they had come out until they were already.

Q. And just for clarity of record, you know, we