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

DYLAN BRANDT, et al.,

Plaintiffs,

v. No. 4:21CV00450 JM

November 28, 2022
Little Rock, Arkansas
8:57 AM

LESLIE RUTLEDGE, et al.,

Defendants.

TRANSCRIPT OF BENCH TRIAL - VOLUME 5
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
UNITED STATES DISTRICT JUDGE

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Appearances continuing...

Pl. Trial Ex. 080

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Proceedings reported by machine stenography. Transcript prepared utilizing computer-aided transcription.

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(Proceedings continuing in open court at 8:57 AM.)

THE COURT: Are y'all ready?

MR. JACOBS: Your Honor, Defendants are ready to call, I guess, our next witness, not our first witness. One thing I wanted to check in on. So Dr. Regnerus is prepared to testify remotely tomorrow, and I wanted to ask at what time the Court could begin tomorrow with the hope that it could begin I guess as early as we can make it happen. Because Dr. Regnerus is testifying late in the evening from where he's located, so just to avoid him having to run into testifying in the wee hours of the early morning, if we could start as early as we can. I recognize that --

THE COURT: I expect this will likely make everybody cringe, but courthouse opens at 7:30.

MR. JACOBS: Could we -- I think he'd be available to start at like 8:00.

THE COURT: That's fine. That would give everybody time to get in the building and get settled and we could make sure stuff is up.

MR. JACOBS: Okay. That's all the preliminary matters that we have.

THE COURT: So with an asterisk, you've got my entire week. What are your thoughts on how long you're going to take?

MR. JACOBS: Our witnesses will be done Thursday and

we'll rest on Thursday.

THE COURT: I've got two sentencings, one at 1:00 and one at 2:00 on Wednesday. Those usually last 30 minutes, so we're probably going to work a little later into lunch on Wednesday.

MR. JACOBS: That won't be a problem, Your Honor.

THE COURT: And then it looks like I've got a lunch hearing on the 1st. Okay. That's what is on my schedule other than you guys. So are we ready to jump back in?

MR. JACOBS: We're ready, Your Honor. Defendants will call Dr. Stephen Levine.

THE COURT: Sir, if you could come on the far side of that silver rail. Good morning.

STEPHEN LEVINE, DEFENDANTS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MR. CANTRELL:

Q Good morning, Dr. Levine.

A Good morning.

Q Can you state your name and spell it for the record.

A Stephen, S-t-e-p-h-e-n, Barrett, B-a-r-r-e-t-t, Levine, L-e-v-i-n-e.

Q Thank you. Dr. Levine, can you tell us what academic and clinical positions that you currently hold?

A I am clinical professor of psychiatry at Case Western Reserve University. I'm a staff psychiatrist in a group

dictating a trans identity. As many people have come to realize that teenagers and now especially during COVID when teenagers were at home have spent a great deal of time on the internet and we believe that the internet has many opportunities to learn about trans life, and we think this has been an influence on the rising incidence of transgender identities.

But I can say that while I could go on and speculate about why there has been this increase, I don't really think that science can tell you why. We can speculate and various people have various speculations. Some people think it's a social contagion from the internet, other people think it's a social contagion from friends, close relationships, especially among girls who have a friend who's trans. Some people think that it's a retreat from adverse life experiences and family disruptions and inability to like both parents or love both parents, but these are all speculations, and I doubt since there are so many people involved with this that we would find one explanation that would explain everything.

We need to understand that in mental health work and trying to grasp what happens to people who become who they become and why, that we can't ever find one explanation for things. Things are multifactorial, so I think this phenomenon must be multifactorial as well, but it is a dramatic worldwide change in how young people are identifying. And they're not

A. Yes.
Q. Have you reviewed any transcripts of the first week of trial?
A. No.
Q. Has anyone spoken to you about the testimony that was given during the first week of trial?
A. No.
Q. You've been a psychiatrist seeing patients, I believe you said, since 1973. Is that correct?
A. I started my residency three years before and I saw patients then, so officially as credentialed psychiatrist, yes, 1973.
Q. And the overwhelming majority of your patients have been adults.
A. Over the years, yes.
Q. Is that right, that the overwhelming majority have been adults?
A. Yes.
Q. Is that a yes?
And you've estimated that you've seen about 50 minors, patients under 18, in your nearly 50-year career. Is that correct?
A. Yeah. In a previous testimony, give can you give me that number?
Q. I can show you.

THE COURT: Let's short cut. Is that true?

THE WITNESS: It's approximately true.

MS. COOPER: Thank you, Your Honor.

BY MS. COOPER:

Q. And you've testified that you've seen about six prepubertal children in your career over 50-plus years.

A. Yes. That's probably approximately true, personally seen.

THE COURT: What was the last part? I couldn't hear you?

THE WITNESS: I'm sorry?

THE COURT: I didn't hear the last couple of words. Did you say something --

THE WITNESS: That I personally have been involved.

THE COURT: Thank you. You faded off. I couldn't hear.

BY MS. COOPER:

Q. I believe you testified on direct that there are about 70 gender clinics in the United States. Is that right?

A. Yes.

Q. And you don't know how different practitioners or clinics provide care, correct?

A. There are many, many practitioners. How would I

possibly know how they all provide care? I've been aware of some instances of care, yes.

Q. So there are many practitioners and clinics about which you don't know protocols --

A. Many.

Q. And you don't know how common it is for clinicians to provide hormone therapy to minors without a careful assessment of the child and their comorbidities. Is that correct?

A. Well, I've been in touch with many parents from all over the country who have indicated that to me. But in a numerical sense with a denominator, I'm not aware. I certainly have had many experience where I heard complaints of -- about that.

Q. You don't know if it's a small minority, a majority, or something in between?

A. I don't know that 38 percent do and 42 percent don't or -- I don't have that kind of information.

Q. You wouldn't say whether it's a majority or a minority.

A. Couldn't say.

Q. You don't have any knowledge about how gender affirming medical care is provided to minors in Arkansas. Is that correct?

A. That's correct.

of rapid onset gender dysphoria versus lifelong gender dysphoria, the parents -- the parents' view is vital, you see.

But, you know, today most of the onset of the gender dysphoria presents itself at first in adolescence, not at age four. In that sense, you and I are talking past each other.

Q. All right. If we can look at -- just to wrap this question up for clarity, on page 41 -- can you see the screen in front of you --

A. Yes.

Q. -- beginning on line 22. Question: Does your -- you mentioned that you meet with the parents too. Does that contribute to your assessment whether someone meets the criteria for gender dysphoria, what's reported by the parents.

Answer: Of course.

That was your testimony?

A. I thought I just explained what I meant by that.

Q. When you diagnosis patients for other conditions like depression or bipolar disorder, do you rely on self-report of patients?

A. And reports from the parents.

Q. Reliance on self-report from the patients and information from parents is not unique to the diagnosis of

gender dysphoria, is it?
A. That's right. It's not unique.
Q. Diagnosing patients based on self-report and information from families who know the -- people who know the patient, that's how psychiatry works, isn't it?
A. Ideally.
Q. You were deposed this past March in a case called BPJ in West Virginia. Do you remember that case involving athletics?
A. Yes.
Q. I'd like to show you a passage from -- well, a passage from your deposition in that case. Can we look at paragraph 6, please?
Do you see that in front of you in paragraph 6? It says, if you'll read along with me: In the course of my five decades of practice treating patients -- I'm sorry. This is not your deposition. Let me back up. I misspoke.
You remember giving a report in the BPJ case. Is that right?
A. I vaguely remember.
Q. And is this your expert report?
A. I don't know. You just --
Q. Can we scroll through this front page just to show?
A. It's my signature, yes.
Q. So if we can turn back to paragraph 6. And I would

like you to read along with me. In the course of my five decades of practice treating patients who suffer from gender dysphoria, I have at one time or another recommended or prescribed or supported social transition, cross-sex hormones, and surgery for particular patients, but only after extensive diagnostic and psychotherapeutic work.

So you wrote this passage, correct?

A. Yes.

Q. And you have supported patients' social transition. Is that correct?

A. This -- this paragraph or sentence doesn't give an age group.

Q. Understood. But I'm just asking generally, you have supported --

A. Many four-year-olds.

Q. Yes. Okay. You have counseled some parents to support the transgender identification of their child, haven't you?

A. I'm not sure that's true. Depending on what you mean by child. Child -- a could be 25. That is a child of a parent can be 25.

Q. You've counseled some parents to support their minor child's social transition, haven't you?

A. I have on rare occasion, yes.

Q. And switching back to adults, you've written letters of authorization for adults seeking gender-affirming surgeries. Is that correct?
A. I have.
Q. And you've done that as recently as the past two years.
A. I have.
Q. And you've also written letters authorizing hormone therapy for adult patients with gender dysphoria.
A. I have.
Q. And these are letters they can take to the endocrinologist. Is that right?
A. Yes.
Q. And you have written such letters approving hormone therapy for minors under 18 in a few cases within the past five years, haven't you?
A. I don't think in the past five years.
Q. Okay. Can we turn to Dr. Levine's deposition, page 78?

I would like you to read along with me starting on line 3. So between you and Mrs. Novak, there have been a handful of cases in the past, say, five years where you have approved hormone therapy for minor. Is that right?

These are particularly fraught difficult circumstances, yes.

A. Yes.
Q. Mrs. Novak is someone who works in your medical practice -- or your psychiatry practice?
A. She's a younger colleague of mine.
Q. That was your testimony.
A. I'm sorry?
Q. That was your testimony that I read correctly.
A. Yes. I'm just not sure today whether it's five years or six years now. And in generally, there have been a few very fraught cases where we felt that this is a very reasonable thing given the severity, the complexity of the case, and that we would -- we, along with parents, would hold our breath that this would be of help.
Q. And you have cosigned letters for hormone therapy for minors written by Mrs. Novak, again, approving some minors for hormone therapy. Is that right?
A. Yes, but this has not occurred very recently, Ms. Cooper.
Q. You would not write a letter supporting hormone therapy for a minor if you did not believe the patient had gender dysphoria, correct?
A. Correct.
Q. And you would not write a letter approving a minor for hormone therapy without first determining that they had a longstanding, stable gender identity. Is that

much more cautious. We will give adolescents hormones, but not as quickly as the Standards of Care would like.

That was your testimony in Keohane.

A. I have to say yes.

Q. And just to clarify, the Standards of Care you're referring to in the 7th Edition, is that the WPATH's Standards of Care 7th Edition?

A. Yes.

Q. When you were deposed in May of this year in this case, the Brandt case, you testified, did you not, that going forward you have not made a decision to no longer write letters approving hormone therapy for patients under 18 years of age.

A. Indulge me a minute. In the previous thing you put up, my deposition of adolescents was not the definition I gave to the Judge earlier this morning. It was my definition of an adolescent is somebody 19 years of age. And so if you reread that, it would include 18-year-olds and 19-year-olds.

So would you repeat the last question you asked me?

Q. Sure. When you were deposed this past May in this case in Arkansas, you testified that, going forward, you have not made a decision to categorically not write letters approving hormone therapy for patients under 18, correct?

A. I don't remember saying that, but if you have that, I trust you.

Q. Yeah. I think we want to put that in the record.

Can we look at deposition page 227?

And if you go to line 3, part way through beginning with the words, "Have you made a decision." Are you with me? It's highlight.

Have you made a decision to no longer consider hormone therapy for anybody who has not reached their 18th birthday since you provided those letters?

Answer: I've made a decision to be very cautious and to put a period of time in therapy between me and the letter.

You go on to say more, which you're welcome to read if you would like, but I want to continue on to another passage that picks up rather than taking the Court's time reading a lot of discussion in between.

If we could turn to page 228, line 3. Let me know if you want to review there.

MR. CANTRELL: Your Honor, I would like to just, if we could, take a look at the intervening testimony, glance at that.

MS. COOPER: Sure. We can post that. Absolutely.

THE COURT: I thought you were in the

deposition, Mr. Cantrell, but go ahead.

BY MS. COOPER:

Q. Do you have that in front of you now, Doctor? If you look at line 3 and read along with me.

So I'm not sure if that answers my question. Have you made a decision to no longer provide letters?

Answer: Oh, I'm sorry. No, I haven't made that decision.

Question: So would it be a case-by-case basis if there were a patient that you felt it was appropriate for you -- appropriate for, you would consider doing it, say, a 17-year-old or a 16-year-old?

Mr. Cantrell: Object to form.

Answer: I don't have a -- yes. The answer to your question is yes.

I'm not going to ask you if that was your testimony again --

A. Thank you.

Q. -- since I see how you love those questions.

Now, today you testified that you would not recommend hormone therapy for patients under 18. Do you mean you would not generally recommend hormone therapy as a general matter?

A. Yes.

Q. So there may be exceptional cases where you would

still consider it appropriate.

A. Yes. These are very fraught circumstances. I think all of us all over the world recognize that we are under very difficult circumstances sometimes. We don't know what to do and we eventually go along with the patient's sincere desire to try hormones.

Q. Now, you talked on direct about an article you wrote called, *Reconsidering Informed Consent for Trans-identified Children, Adolescents, and Young Adults.*

And I just want to ask you a couple of questions about that article.

In this article, you recommend informed content process that you think providers should undertake before authorizing medical or surgical transition for minors, correct?

A. Yes.

Q. I'd like to pull up a passage from that article to show you. If we can look at page 2. And I have some material highlighted. Actually, I would like you to skip to -- sorry. I wasn't in front of the mic. I would like to skip to the second highlighted paragraph.

A. I know what you're you talking about.

Q. We over highlighted. If you'll read along with me in the second paragraph there.

Social transition, hormonal interventions, and

that is immutable, that it cures suicidal ideation, and that it makes everyone live happily ever after, you see.

So in order to understand that last -- the second-last sentence there, it does not preclude transition. It presumes that the doctor is knowledgeable. And what it I have been saying is that all the doctors are not equally knowledgeable about the state of science.

Q. But you're not saying that no doctors are knowledgeable.

A. Of course I'm not saying that, Ms. Cooper.

Q. In that article that we're looking at here, you don't say that gender-affirming medical care, specifically hormone therapy or blockers or surgeries, should be categorically prohibited for minors, do you?

A. No, I don't. This is -- that was not the topic of this article.

Q. You testified that you would like to see an international committee -- this was today. You testified that you'd like to see an international committee developed standards for informed consent to provide gender-affirming medical care to adolescents. Is that right?

A. Yes.

Q. So, you're not seeking to prohibit care, but to ensure that patients have been thoroughly provided

information and take the time and patience to understand it before making this monumental decision.

A. Ms. Cooper, when you say "patients," you need to ask -- for me to agree to that, you have to add parents and patients.

Q. Thank you. Let me ask it differently.

So you're not looking to prohibit care, but to ensure that patients, and particularly their parents when they're minors, have thorough information in order to be able to adequately make that decision. Is that correct?

A. I am not motivated to prohibit care. I am motivated to clarify the scientific basis upon which the care is provided, and if the basis is inadequate, to let doctors be cautious about this.

Q. And to inform families of this information as well.

A. And to inform -- to use their own ethical unease about the wisdom of this in their informing patients and parents about the state of science here and what is not known, the uncertainties, and the risks of harms.

Q. And your view is that, if families are -- by "families," I'm specifically focusing on parents -- are fully informed about the risks and the state of the science, the decision about whether to pursue hormone therapy for adolescents -- minor adolescents should be made by the parents, patient, and doctors. Is that

Q. I'm sorry. Yes?
A. Yes.
Q. You believe that for youth who are currently receiving hormone therapy, requiring them to discontinue treatment could create a psychological -- could create psychological and physiological problems, correct?
A. Most certainly, I think it would be a psychological challenge for those folks, whether physiologically or cause a significant problem is not clear because, depending on their age and depending on the original maturation of their ovaries and testes, stopping estrogen or stopping testosterone abruptly may cause brief periods of thermo-regulatory -- what we call hot flashes.

But I think if a person's just had hormones, say, starting at age 15 or 16, their gonads had matured enough, that they would begin the secretion of progesterone and estrogen for biologic girls and testosterone for boys. But I think psychologically, it would be a shocking and devastating thing for them.

There are lots of negative things that happen to all of us in life that are shocking and devastating, and we learn to cope with it. And what I said at the deposition is that doctors are compassionate people generally and they would find a way to be of help. And my concern with the law as ti was originally written is that it seems to

(Proceedings continuing at 3:00 p.m.)
BY MS. COOPER:
Q. Dr. Levine, you submitted a report in opposition to our plaintiffs' motion for preliminary injunction. Do you remember doing that in this case?
A. In this case?
Q. In this case, yeah.
A. That's too legalese for me.
Q. Okay. Let's show you -- if you can put up the report or the rebuttal.
If you can look at the document on the screen dated July 9th, '21, or filed. On the top, it says, "July 9th, '21, declaration of Stephen Levine." Is this a report that you prepared in this case?
A. That was my original report.
Q. Okay. If you can look at page -- excuse me -- paragraph 35, and read along, the highlighted material.
"To my knowledge, there is no credible scientific evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents and women."
That's what you said in your report?
A. That's what I did say, yes.
Q. Okay. Now, you talked on direct about your clinical

experience, and you mentioned that most of your patients were adult patients. It's correct that you've had only two patients who have detransitioned after medically transitioning. Is that correct?

A. That I'm aware of at the moment, yeah.

Q. Okay. And in your report in this case, you cited a paper by Exposito-Campos about detransition. Correct?

A. Yes.

Q. And you noted that the Exposito-Campos review of detransitioning claimed to have identified 16,000 entries in a search of proliferating websites devoted to this topic. Is that correct?

A. Detransitioning, yes.

Q. And, to be clear, this did not represent 16,000 detransitioners. Right?

A. It's not possible to know what percentage of them are individual people who have detransitioned.

Q. That was a reference of the number of people participating in these online groups. Is that right?

A. Right.

Q. Uh-huh. Okay. Now, you talked some during direct testimony about detransition and studies looking at rates of detransition. I just had a couple of questions about that. You mentioned that there was a study that said that there was a rate of about 30 percent of patients detransitioned.

A. Yes.
Q. Right? How was detransition defined in that study?
A. I think as stopping hormones.
Q. People may stop hormones without going back to reverting to their biological sex. Correct?
A. Yeah. The study is about the rate, you see. It's not about the details, right?
Q. Okay. And I would like to pull up a passage in your rebuttal report in this case. Do you have that, paragraph 17? If you can look at page 1, is this your rebuttal?
Oh, is this the same document? I'm sorry. It is the same document.
This is your report you wrote in this case?
A. I trust you.
Q. It has your name on it. Right? Did you look at it? I want to make sure we're on the same page.
A. A rebuttal declaration of Dr. Stephen Levine, M.D.
Q. Let's look at paragraph 17, please. I would like to have you go down sort of towards the bottom, second-to-last line in that paragraph, beginning with the word "according." And read along with me.
It says, "According to a recent study from a UK adult gender clinic, 6.9 percent of those treated with gender-affirmative interventions detransitioned within 16 months of starting treatment, and 3.4 percent had a pattern of care

detransition occurs in various forms to various degrees should not be denied any longer. The incidence of using this 1 or 2 percent of regret for the whole phenomenon of maybe a mistake has been made somewhere along the line no longer is acceptable. What we need to think is that with the rising number of people getting hormones and the rising number of people saying they are transgender and then the rising number of people getting access to hormones, we should expect that some of those people, given the ordinary ambivalence of the human soul, will change their mind as they get older and detransition to various degrees. These studies are just the first early reports.

Q. Understood. But my question has to do with the 30 percent figure you gave. These studies don't show that 30 percent of patients who were on treatment detransitioned. Isn't that right?

A. I think -- yes, that's right. They are showing that 30 percent dropped out of treatment or were lost to the original treatment plan.

Q. So, to be clear, they showed that 6.9 percent, what you described here, 6.9 percent detransitioned, and another 3.4 percent had a pattern of care suggestive of detransition. But separately, to get to the remainder, to get to that 30 percent are 21.7 percent who are just people who dropped out of the program. Right?

A. And that's study No. 1. That's Hall.

Q. Just to clarify, we don't know if 21 percent of those people detransitioned.
A. No. They may have gotten their care at a different country.
Q. In fact, your own description says some of them reengaged in the clinics in those 21 percent.
A. That was a quote.
Q. That was a quote. Okay. Tell me, so there's another study that showed 30 percent detransitioned? Which one is that?
A. If you look down further to No. 9, reference No. 9 to Boyd, that's a study of older people detransitioning.
Q. Okay.
A. My point, Ms. Cooper, is that people detransition. And we shouldn't be surprised, and we shouldn't sell the public that once a trans always a trans.
Q. I want to switch gears for now and ask you about a presentation you gave at the American Psychiatric Association this past May. Correct?
A. Correct.
Q. Yeah. You presented at an annual conference of the American Psychiatric Association in a symposium on reexamining the best practices for transgender youth. Is that correct?
A. That is very correct.
Q. And among your co-presenters were Ken Zucker. Correct?
A. Yes.

Q. And others were Lisa Marchiano and Sasha Ayad? Correct?
A. Yes.
THE COURT: Ms. Cooper, can you spell that last name?
MS. COOPER: I can. Ayad is A-y-a-d.
BY MS. COOPER:
Q. And all four of you who were on that panel are people who have dissenting views from APA policies on trans healthcare. Correct?
A. That's right.
Q. Okay. And the APA was aware that the four of you were presenting ideas that were not in keeping with official policies of the APA. Correct?
A. Yes. They made an announcement of that before we were allowed to present. And they sent a special person to moderate it. They didn't allow me, the chairman, to moderate it, but they didn't tell me they were going to do that. They just showed up three minutes before the symposium, yes.
Q. And while you were talking, the group in the audience was polite, and no one interrupted. Is that correct?
A. While I --
Q. While you were presenting on the panel.
A. Yes. They were very polite until the presentation was -- the presentations were finished.
Q. Excuse me? Until the presentations were --
A. Finished.

THE COURT: Dr. Levine, as a psychiatrist, how did that make you feel? No. I'm kidding.

THE WITNESS: I can answer that, Your Honor.

THE COURT: You don't have to answer it. I'm just trying to shake things up a bit. Keep going.

THE WITNESS: You succeeded.

BY MS. COOPER:

Q. No one interrupted. Correct?

A. I'm sorry?

Q. No one interrupted the presentations. Correct?

A. The only interruption in the presentation was when I began to speak to introduce the symposium, this woman appeared and told me to wait a minute, she was going to make the first comment.

Q. But there wasn't a disruption of the content of the presentations?

A. That's right.

Q. We just mentioned Ken Zucker, who was on the panel with you. Is it correct that he is called -- excuse me -- he is a proponent of what some call watchful waiting for prepubertal children?

A. That's not what he presented about.

Q. But your understanding is he's a proponent. I'm sorry if that wasn't clear. Putting aside his presentation at the panel, he is a person who supports watchful waiting for prepubertal

for off-label use."

That was your testimony. Correct?

A. Oh, yes, yes. That was my testimony.

Q. Okay. Off-label drug use is very common in probably every field of medicine. Correct?

A. Yes.

Q. Uh-huh. And the fact that a drug is being used off label does not make the use experimental. Correct?

A. In some sense it is experimental. It's not approved. There hasn't been evidence other than in a clinical fashion to do it. It's not experimental in the same serious way we're talking about using the various drugs for gender dysphoria off label and perhaps experimental.

Q. You would agree, though, that the fact that a drug is being used off label does not alone mean that it's experimental. Correct?

A. I would agree with that.

Q. People in your field know the difference between articles that are peer reviewed in a scientific journal and different kinds of publications. Right?

A. Yes.

Q. Speaking generally about psychiatric conditions, you would agree that because of the complexity of the human psyche and the difficulty of running controlled experiments in this area, substantial disagreements among professionals about the causes

WPATH's principles.
Q. But, again, you don't know how most practitioners around the country, how credentialed they are and how they provide care.
A. Who in the world knows?
Q. But you don't.
A. I don't and you don't.
Q. Okay. Now, I want to switch gears and talk about some of the European reports that you talked about. Let's start with Finland. You talked about a report from Finland. Do you remember talking about that? Okay. And you mentioned that a committee of, I believe you said, blue ribbon experts put together these international reports. Which were the experts who were the blue ribbon experts who put together the Finnish report?
A. Their names?
Q. Anything about them.
A. I don't know their names.
Q. Do you know anything about them?
A. Well, I know the head of this national program. I know her, but I don't know her colleagues.
Q. And do you know what organization put that report out?
A. Well, it's called COHERE. Please don't ask me what the COHERE stands for.
Q. How many experts were on that blue ribbon committee that

THE COURT: Is that true, Doctor?
THE WITNESS: It is true.
BY MS. COOPER:
Q. Okay. Now, the French report, the French document that you talk about, that's not a review of the literature. Right?
A. I'm sorry. Which one?
Q. The French application.
A. The French, I don't think -- I don't want to testify it's based on a review.
Q. So you don't know if that was done by a blue ribbon committee of experts?
A. I don't know who did it, just there was a national body in France.
Q. Okay. Thank you. That helped clarify that. I want to go back to some of these individual reports and just a few questions. The Finnish report did not recommend banning gender-affirming medical care for minors, did it?
A. I think in special cases they thought it could be continued.
Q. In fact, it allowed puberty blockers on a case-by-case basis after careful consideration. Isn't that what it says?
A. I think so.
Q. And it says in the Finnish report that hormone therapy could be provided to minors based on a thorough case-by-case consideration if it can be ascertained that the identity as the

other sex is of a permanent nature and causes severe dysphoria. Is that correct?
A. Yes.
Q. Now --
A. Ms. Cooper, then how could a bunch of doctors know that a nine year-old's gender identity is permanent? It only could be based on the fact it has existed for three years.
Q. Is anybody providing hormone therapy -- cross-sex hormone therapy to nine year-olds?
A. Yes, yes, yes.
Q. Cross-sex hormone therapy?
A. No, no.
Q. That's what we're talking about.
A. Puberty blocking hormones.
Q. This was about cross-sex hormone therapy.
A. Oh, I'm sorry.
Q. Yeah.
A. Even so, if somebody has consistent cross-gender identification from 12 to 16, there's no guarantee that that person will be cross-gender identified at 25.
Q. But that's what the Finnish report said, what I described.
A. Right. You see the limitations inherent even in policy.
Q. So, turning to the French report, just to be clear, they did not recommend prohibiting gender-affirming medical care for minors, did they?

A. I don't know.
Q. You don't know?
A. At this moment.
Q. Uh-huh. So you don't know if in France minors can receive gender-affirming medical care to treat gender dysphoria?
A. I think this was a general recommendation rather than a prohibition. And the recommendation was psychotherapy and psychiatric evaluation first.
Q. Okay.
A. I think what we have in common here in all of these countries we're talking about is the recommendation, the prudent recommendation that psychiatric evaluation and attention to associate a psychopathology and worry about both detransition and the rapid rise in the number of people calling themselves transgender calls for a different approach, not the preclusion of individual cases getting a particular treatment, but, in general, doctors of our country think psychotherapy first, not hormones first, not transition first. That's what these things have in common, whether I remember one phrase or another from the report.
Q. And your assumption is in the U.S. doctors are doing medical transition before psychotherapy?
A. Oh, yes.
Q. But you don't actually know how many doctors do that. Right?

get these drugs.
Q. And you mentioned a report from Canada. Hormone therapy and puberty blockers are not prohibited for minors in Canada, are they?
A. No. This was done for the State of Florida. It was not done by the Canadian National Service. But what it did was reiterate the low quality of evidence for puberty blockers being beneficial and for cross-gender hormones being beneficial or them in sequence being beneficial. Based on international standards, blue ribbon people, sophisticated people, every review says that the scientific objective review of the evidence supporting these treatments is of very low quality.
Q. I'm not asking about the quality of evidence. I'm asking about the recommendations in the reports. That's what my questions were focused on. And going back to the Canadian report, do I understand from what you said earlier that that's a report that was prepared to be used in litigation to support a ban on treatment in Florida?
A. I don't know exactly why it was done. What I was trying to help you not make a mistake in thinking, that it was part of Canadian national policy. It was an academic center. That place does reviews, does all kind of reviews. And somebody I think from the State of Florida commissioned and paid for the review. And the review said, and it was objectively done, the same thing that the other reviews have said, low quality and

taking that into consideration in comorbidities, but in Europe they are focusing on that. But when I pointed out that the standards of care here actually require that, you said, well, they don't really follow the standards.

A. Ms. Cooper, what I was trying to say to you, you can read these wonderful words in the standards of care, but it turns out the devil is in the details. The devil is how it's translated, who is doing the psychiatric assessments, what mindset do they have, what knowledge do they have, and how long do they have to do it. Every clinic can say we do comprehensive care. Every clinic will say we do these evaluations. But from the parents' point of view or the educated parents' point of view, that is not what is happening to their child frequently.

Q. For some families you've talked to.

A. Frequently.

Q. For some families you've talked to. Correct?

A. I'm sorry?

Q. For some families you've talked to.

A. Almost for all the families I've talked to.

Q. Which is a tiny amount, representing a very tiny amount of the clinics around the country. Correct?

A. And I don't know what percentage of the clinics, but they are from many states.

Q. I just have a few more questions. I want to go back to the second study on detransition that you mentioned showing the

30 percent detransition rate.
A. The Boyd study?
Q. That was the one by Boyd. Thank you. We're going to put that up so we can get clarity on that. Looking at a study called "Care of Transgender Patients: A General Practice Quality Improvement Approach" by Isabel Boyd, et al., that's the study you are talking about?
A. That was I think a primary care study.
Q. Okay. You have the highlighted portion in front of you?
A. Yes.
Q. "3.2.4. Undesired Treatment Outcomes (stopping hormones, abnormal blood test results, side effects and complications)." It says here, "Nine patients had stopped hormone therapy, one related to practice policy because they had not attended any GIC follow-up (the patient has restarted since the audit). Thus, eight patients had stopped hormones voluntarily (20 percent stopping rate; six trans men, two trans women). These patients had been on treatment for a mean of five years (range 17 months to 10 years). Four trans men had comments in the record that related to a change in gender identity or detransitioning (4 out of 41, 9.8 percent) quote: Would like to gradually detransition. No longer wish to live your life as a male. Has decided to detransition. Feels comfortable having decided to dress and appear more feminine. Feels it was a mistake identifying as non-binary now, close quotes.

None of these patients had undergone any gender-related surgery. They had presented at a mean of 18 years of age, taken testosterone for a mean of 18 months and currently presented as female (three) or non-binary (one). The other four patients who had stopped hormones continued to present as trans (two women, two men): One, who had experienced orchidectomy, had a record of regret (no hormonal treatment currently, regrets gender reassignment); one had a medical reason noted for stopping, quote, problems with PV bleeding despite androgen; two had no specific reason for stopping in their record, but it was documented that they had stopped."

So I see a 20 percent stopping rate, but I don't see a 30 percent detransition rate anywhere in there. Is this the study you are talking about?

A. Yes. But, you know, I haven't read this study since it came out. And you've picked out one paragraph. And perhaps we could sit down and read it together and figure out whether I'm right or wrong. And if I'm wrong, I'm wrong by 10 percent. The point is, Ms. Cooper, the detransition for various reasons happens. If it happens in this clinic, we should assume it happens in Arkansas and in Missouri and everywhere else. And the idea that people think it's a mistake is one of the things I've tried to talk about this morning. We can't be sure that a 14 or 15 or 17 year-old knows what his or her future is going to be. And if they cannot be prudent, we have to be prudent. And

if the medical profession isn't prudent about this, isn't careful, isn't aware of the limitations, I guess legislatures make a decision.

So I'm just asking the medical profession to be prudent and to know about the evolution of gender identity. Even after it's been solid during adolescence for three years or four years, it doesn't mean that when you are 23 you don't think differently. We must be prudent, and we must protect people sometimes against things that we have reason to believe that a majority of people may come to regret. Now, you see the real question here is not the Boyd study.

Q. Well, I do want to stay on the Boyd study for a minute. I understand your point that detransition happens. And that is not the question I want to -- I'm not arguing about that.

A. Good.

Q. I'm asking about this 30 percent number that you testified. I understand now you may be not standing by that 30 percent figure?

A. Yeah. Maybe I'm going back to 20 percent.

Q. Then, even the 20 percent you would agree is not a representation of detransition, but it represents the number of people who stop medical transition for various reasons, some medical reasons and unknown reasons. Correct?

A. I don't think you are going to make compelling points in my view by picking out one paragraph and not looking at the whole

thing.
Q. You used the number 30 percent, and this appears to be where it came from, so I need to pick it apart.
A. I do not represent myself as infallible. And my statements, I can't imagine every statement is verifiable that I ever make in my life. I'm doing the best I can with my memory.
Q. Fair enough. It's not a memory test. Looking at it here now, though, you would agree that this study does not even say 20 percent detransitioned. It says 20 percent stopped the medical transition for various reasons.
A. Well, can you tell what the denominator here is?
Q. Well, 20 percent. Twenty is a percentage.
A. That requires a denominator. What number of people are we talking about?
THE COURT: Twenty out of a hundred.
THE WITNESS: That's not --
BY MS. COOPER:
Q. 41 is the N. If you want to know the number, it's 41 I think it says. Four out of 41 were the ones who --
A. Is 41 the denominator?
Q. 4 out of 41 detransitioned.
A. So nine of 41 people stopped their hormones. Is that what you are saying? So we do that math. 9 of 41.
Q. Twenty percent stopped.
A. It's over 20 percent.

Q. Stopped hormones?
A. Yeah.
Q. I just want to be clear, though, that doesn't represent detransition. It represents stopping hormones for a variety of different reasons.
A. And I want to be clear. I want to be clear that you don't know it doesn't represent detransition. It means stopping hormones. Why does a person stop hormones?
Q. Well, it says right here problems with bleeding despite androgen, and two had no specific reasons. You don't understand people stopping hormones besides detransition?
A. What are you quizzically asking?
Q. Do you think the only reason somebody who is on hormone therapy for gender dysphoria would stop treatment, that the only reason would be because they detransitioned?
A. No. Some stop because they get hypertension. Some stop because they get obese. Some stop because they get blood clots. Some stop because their hemoglobin levels go way up and they are threatened with stroke.
Q. But they may still maintain their trans identity. Correct?
A. And, of course, if that would happen to a person, that would make them rethink everything.
Q. I think we can put this study aside, and just a couple of questions. Prior to this case, you had never heard of Mark Regnerus. Correct?

Q. I understand you are speculating about the connection there. But the national review board of Sweden did not ban blockers. Correct? We talked about that before.
A. If Karolinska blocked blockers and if Karolinska is the primary site for the Swedish people to get gender-affirming care --
Q. Is it your understanding that's the only place you could get gender-affirming medical care if you are a minor in Sweden?
A. I'm not sure. Sweden is a small country compared to the United States. Those countries tend to create clinics like the Portman Clinic in the UK that funnel these patients to the centers of excellence, the centers of study.
Q. But you don't know how it's done in Sweden?
A. I don't know for sure how it's done in Sweden. I do know Sweden, we're very concerned about the suicide rates of their transgender population. The last report I had, it was 3.5 percent higher than the general population.
Q. I lied. I have a second question, if that's okay, related to the same topic. I would like to put up another document, the Swedish national report that we have discussed. This is, for reference, DX17. This is the Swedish report you were discussing earlier. Correct?
A. The translation of it?
Q. The English translation. If we can scroll, if you can look at the first highlighted paragraph with me. "To minimize the

risk that a young person with gender incongruence later will regret a gender-affirming treatment, the NBHW deems that the criteria for offering GnRH analog and gender-affirming hormones should link more closely to those used in the Dutch protocol, where the duration of gender incongruence over time is emphasized. Accordingly, an early childhood onset of gender incongruence, persistence of gender incongruence until puberty and a marked psychological strain in response to a pubertal development is among the recommended criteria."

I'm sorry. I'm reading the wrong paragraph.

Apologies. I'm going to read the highlighted second paragraph. "To ensure that new knowledge is gathered, the NBHW further deems that treatment with GnRH analogs and sex hormones for young people should be provided within a research context, which does not necessarily imply the use of randomized controlled trials, RCTs. As in other healthcare areas where it is difficult to conduct RCTs while retaining sufficient internal validity, it is also important that other prospective study designs are considered for ethical review and that register studies are made possible. Until a research study is in place, the NBHW deems that treatment with GnRH analogs and sex hormones may be given in exceptional cases, in accordance with the updated recommendations and criteria described in the guidelines." This is the requirement or provision in the Swedish national report. Correct?

eight o'clock tomorrow.

MR. JACOBS: Yes, Your Honor.

(Overnight recess at 4:19 p.m.)

REPORTER'S CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/Elaine Hinson, RMR, CRR, CCR Date: December 4, 2022.
United States Court Reporter