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(Via Video Conference)

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**ALSO PRESENT:** Zoom Moderator, Joel Scherer  
 Bailey Steinhauer, Andrew Shaw  
 Charles Ferguson

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1 KRISTOPHER KALIEBE, M.D.  
 2 the witness herein, having been first duly sworn to  
 3 tell the truth, the whole truth, and nothing but the  
 4 truth, was examined and testified as follows:  
 5 EXAMINATION,  
 6 QUESTIONS BY MR. SELDIN:  
 7 Q Dr. Kaliebe, good morning.  
 8 A Good morning.  
 9 Q My name is Harper Seldin. I'm an attorney with  
 10 the ACLU for the plaintiffs on this matter.  
 11 Joining me is Stevie Pactor, along with Gavin  
 12 Rose, along with some interns as well as an intern  
 13 from the national office.  
 14 How are you this morning?  
 15 A I'm good.  
 16 Q So just to do a little bit of table setting and  
 17 some housekeeping and then we will get right to  
 18 it.  
 19 MR. SELDIN: Mr. Patterson, I don't know  
 20 if you want to enter an appearance for the  
 21 record?  
 22 MR. PATTERSON: I'm appearing on behalf of  
 23 the defendants and to defend this deposition.  
 24 Q Dr. Kaliebe, have you had your deposition taken  
 25 before?

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1 A Yes.  
 2 Q About how many times?  
 3 A Fifteen.  
 4 Q Okay. So this will all be familiar to you, but I  
 5 will say it again.  
 6 A Yes.  
 7 Q I'm sure fourteen times you have heard lawyers say  
 8 you know this, but we will go over it anyway.  
 9 First, are you on any medications today that  
 10 would prevent you from hearing and understanding  
 11 me and providing truthful responses?  
 12 A No.  
 13 Q Any other reason today that you could not testify  
 14 truthfully or understand what I'm asking you?  
 15 A No.  
 16 Q Great. So today we will be having a discussion.  
 17 I just ask that with the Zoom lag that we let each  
 18 other finish. Please let me finish my question  
 19 even if you think you know where I'm going. I  
 20 will endeavor to let you finish your answer.  
 21 If you answer my question I will assume that  
 22 means you understood it. Is that fair?  
 23 A Yes.  
 24 Q Great. And your responses need to be verbal.  
 25 Uh-huh and huh-uh look pretty much the same on the

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1 record. We ask that you verbalize your response.  
2 If at any time you need a break, let me know. I  
3 will try to break us around the hour mark. I ask  
4 if there is a question pending that you answer the  
5 question before you take a break.  
6 Does that sound like a good plan?  
7 A Yes.  
8 Q Great. Then, Doctor, do you have any notes with  
9 you today or anything on your desk?  
10 A I only have a blank piece of paper and a pen, so,  
11 no, I have no notes or anything like that.  
12 Q Okay. Great. So the first thing that I would  
13 like to show you is an exhibit that has been  
14 marked Exhibit 1.  
15 I think Joel will pull that up for us.  
16 A Okay.  
17 Q My question when we see Exhibit 1 is just going to  
18 be do you recognize this document?  
19 A Yes, I recognize that document.  
20 Q And is this the declaration that you submitted in  
21 this case?  
22 A It does appear to be so.  
23 Q Does this contain all of the opinions that you  
24 intend to offer in this case?  
25 A Yes. Unless I'm asked about other matters.

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1 Q As of this moment it contains all of the opinions  
2 that you intend to offer?  
3 A Yes.  
4 MR. SELDIN: Joel, could you scroll us  
5 down toward the end.  
6 Q Dr. Kaliebe, I don't believe there was a C.V.  
7 attached to this declaration. I just want to go  
8 to the end. I believe it just includes a list of  
9 publications. I just want you to confirm that  
10 that is the case.  
11 A Correct.  
12 Q Okay.  
13 MR. SELDIN: Joel, can you pull up  
14 Exhibit 3 for us.  
15 Q My question, Dr. Kaliebe, is just going to be do  
16 you recognize this document?  
17 A Yes.  
18 Q What is this?  
19 A This is another report, expert report for the  
20 state of Alabama.  
21 Q And I believe there was a C.V. attached to the end  
22 of this.  
23 MR. SELDIN: Joel, if you can scroll down  
24 for us, please. I believe it starts at about  
25 Page 87 of the PDF.

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1 Q Is this a copy of your C.V?  
2 A It does appear to be so.  
3 Q Were there any changes from when you submitted  
4 this report and when you submitted the declaration  
5 in this case?  
6 A Nothing major. I'm not sure the C.V. has my  
7 promotion to full professor on it. That occurred  
8 as of a couple months ago.  
9 Q Other than your promotion to full professor,  
10 congratulations, would there be any material  
11 changes?  
12 A If they are, they are quite minor.  
13 Q Dr. Kaliebe, do you still hold the opinions that  
14 you provided in the report that you submitted in  
15 Boe v. Marshall?  
16 A Yes.  
17 Q Were you aware that the state of Indiana provided  
18 this report to plaintiffs as an example of a  
19 report that you might offer in this case?  
20 A Yes.  
21 MR. SELDIN: Joel, if you can pull up  
22 Exhibit 4 for us.  
23 Q Dr. Kaliebe, do you recognize this document?  
24 A Yes.  
25 Q What is it?

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1 A It's a report for the state of Florida.  
2 Q The case caption is Decker v. Weida, is that  
3 correct?  
4 A Yes.  
5 Q Do you still hold the opinions contained in this  
6 report?  
7 A Yes, I think perhaps some minor opinions have  
8 evolved somewhat. But I would say for the most  
9 part, yes.  
10 Q How would they have evolved?  
11 A You have to be specific. I have continued to --  
12 the report was filed, you know, months ago.  
13 Q Looking at the date at the top of this -- you were  
14 fading out.  
15 A No. I just continue to read. I continue to amass  
16 more information. So, you know, opinions that I  
17 had a couple months ago may be more nuanced if I  
18 have additional data to substantiate or slightly  
19 alter opinions.  
20 I don't have any direct, I don't have any  
21 particular things that I know of in the report  
22 that I feel differently on. Although, I'm  
23 guessing there are probably some things that have  
24 slightly changed.  
25 Q Just to make sure I understand, the report in

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1 Decker was filed on April 7, correct?  
2 A Correct. Yes.  
3 Q So it's your belief that in less than the two  
4 months that have elapsed between this report and  
5 today your opinions may have been refined or  
6 evolved, but are materially the same?  
7 A Correct.  
8 MR. SELDIN: Joel, can you pull up  
9 Exhibit 5?  
10 Q Dr. Kaliebe, I'm showing you what we marked as  
11 Exhibit 5.  
12 Do you recall being deposed in the Decker  
13 matter we were just discussing?  
14 A Yes, I do.  
15 Q Does this appear to be a copy of your deposition  
16 in that case?  
17 A Yes, it is.  
18 Q Were you truthful in that deposition?  
19 A Yes. Although, as I read the deposition  
20 transcript, I feel like there are a couple times  
21 where the answer that I gave, as I read it, seemed  
22 to be somewhat -- the question asked seemed to be  
23 somewhat different than as I understood it at the  
24 time.  
25 So I was truthful, however, now that I look

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1 at some of the answers I might have answered them  
2 with some different nuance.  
3 Q Is there a particular question you have in mind  
4 when you are explaining that to me?  
5 A Well, yes. There were some questions about  
6 treatment of gender dysphoria that were framed in  
7 a manner that seemed to me as I read them that  
8 were sort of, that indicated that it must be  
9 treated. Where I believe at the time the  
10 questioner was, you know, is this a valid thing to  
11 treat? Would this be a good thing to treat? You  
12 know, just a slight nuance there.  
13 I also noted that the questioner asked, they  
14 had a comment that I had to ask my wife, who is an  
15 endocrinologist, about the endocrinological  
16 patients. I didn't note it at the time that that  
17 was how the questioner framed it.  
18 Of course, I know plenty about those things  
19 and have done my own research. I just thought it  
20 was nice to add on top of that, you know, she is a  
21 board certified endocrinologist.  
22 As I read it, there are some minor things  
23 like that that I think were in the moment I didn't  
24 hear the question the way reflected as I read it.  
25 I would refine my answer.

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1 Q Did you have an opportunity to review your  
2 deposition transcript in Decker to submit an  
3 errata?  
4 A Yes.  
5 Q Did you submit any errata?  
6 A Yes.  
7 Q Did your errata address your different  
8 understanding of those questions or --  
9 A My errata contained what I thought were misquotes  
10 of myself. I didn't see the errata as a time to  
11 change my answer on things. I just saw it as a  
12 time to correct any errors in the transcript. So  
13 that is what is in the errata.  
14 Q When did it become apparent to you that perhaps  
15 you would have changed some of your answers in  
16 this deposition if you had understood the question  
17 differently?  
18 A When I read the transcript.  
19 Q Okay. So is it fair to say -- so you read the  
20 transcript for errata. You changed what you  
21 believed were misquotes, but you did not seek to  
22 address to change your answers when you had a new  
23 understanding of the questions?  
24 A Correct.  
25 Q Okay. So for purposes of this deposition let's

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1 just make sure that you understand my questions  
2 and so if there is any ambiguity we sort that out.  
3 How about that?  
4 A Yes.  
5 Q Okay.  
6 MR. SELDIN: Joel, could you pull up  
7 Exhibit 7.  
8 Q Dr. Kaliebe, in the Decker matter do you recall  
9 testifying at trial?  
10 A Yes.  
11 Q That was very recently, is that right?  
12 A May 18.  
13 Q And is this, you will see this is a transcript of  
14 the fifth day of the trial in Decker.  
15 MR. SELDIN: Joel, can you take us to  
16 Page 1058.  
17 MR. PATTERSON: It looks like it is  
18 Page 95 if I'm doing that math correctly.  
19 MR. SELDIN: Mr. Patterson is much braver  
20 than I to do math in the middle of a deposition.  
21 MR. PATTERSON: I was off by one page.  
22 Q Dr. Kaliebe, you will see on Page 1058 --  
23 MR. SELDIN: Joel, if you can scroll down  
24 one more.  
25 Q It starts afternoon session. I might have the

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1 wrong page on this one. Give me a second.  
2 A I was the second witness in the afternoon.  
3 Q Let me find the right page. I apologize.  
4 MR. SELDIN: Joel, I think it's 1095 or  
5 try Page 133.  
6 Q Dr. Kaliebe, do you see where it says Direct  
7 Examination and then --  
8 A Yes.  
9 Q Is this a copy of your trial testimony in Decker?  
10 A Yes.  
11 Q Were you truthful during that testimony?  
12 A Yes.  
13 Q Did you do your best to answer honestly?  
14 A Yes.  
15 Q Was that true when the state of Florida was asking  
16 you questions?  
17 A Yes.  
18 Q Was that also true when plaintiffs in that case  
19 were asking you questions?  
20 A Yes.  
21 Q I believe that the court in that case also asked  
22 you some questions while you were on the stand.  
23 Do you recall that?  
24 A Yes.  
25 Q Did you do your best to be truthful when answering

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1 the judge in that case?  
2 A Yes.  
3 MR. SELDIN: Joel, can you pull up  
4 Exhibit 6 for us.  
5 Q Dr. Kaliebe, have you ever seen this document  
6 before?  
7 A Yes.  
8 Q What is this document?  
9 A It's a Plaintiff's Memorandum of Law in Support of  
10 Motion to Exclude Expert Testimony of  
11 Dr. Kristopher Kaliebe.  
12 Q Is it your understanding then that the plaintiffs  
13 in Decker tried to exclude your testimony in that  
14 case?  
15 A Yeah. I just found that out the other day.  
16 Q I'm sorry. You said --  
17 A Yes. I guess so. I just found out.  
18 Q Do you know whether the court has resolved this  
19 motion yet?  
20 A No.  
21 Q Were you aware prior to testifying for Decker that  
22 this motion had been filed?  
23 A No.  
24 Q Thank you so much.  
25 MR. SELDIN: Joel, we can take that down

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1 for now. Thank you.  
2 Q Dr. Kaliebe, I will ask you some questions about  
3 how you prepared for today's deposition.  
4 Just to head trouble off at the pass, I'm not  
5 asking you what you talked about with your  
6 lawyers. I'm asking you questions about the where  
7 and who, but not the what.  
8 I'm sure Mr. Patterson will cut you off if  
9 you try. I just want to be clear about that ahead  
10 of time.  
11 So my question is just going to be how did  
12 you prepare for today's deposition?  
13 A Well, I did have a meeting, I think it was Sunday,  
14 with the lawyer for about forty-five minutes. So  
15 I had one meeting with the lawyer. The other prep  
16 was I read my report. I read the deposition that  
17 I gave. I read my trial testimony.  
18 Q When you say you read the deposition that you  
19 gave, are you referring to the deposition in  
20 Decker that we were just talking about?  
21 A Yes.  
22 Q When you say your trial testimony, are you  
23 referring to the trial testimony in Decker that we  
24 were just discussing?  
25 A Correct.

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1 Q Do you recall which lawyer you met with for about  
2 forty-five minutes this past Sunday?  
3 A Yeah. I hate to -- I do not remember Brian's last  
4 name. There has been a lot of switching of the  
5 lawyers.  
6 Q Any part of their name will do.  
7 A Brian.  
8 Q Did you say Brian?  
9 A Yes.  
10 Q Is that Brian Barnes with Cooper and Kirk?  
11 A I believe it is.  
12 Q Any other attorneys that you spoke with?  
13 A No.  
14 Q Okay. Any other meetings other than that  
15 forty-five minute meeting?  
16 A No.  
17 Q Did you speak with anyone else at all in  
18 preparation for today's deposition?  
19 A No.  
20 Q Okay. Other than your report or your declaration  
21 in this case, your deposition testimony in Decker,  
22 and your trial testimony in Decker, did you review  
23 any other documents to prepare for today's  
24 deposition?  
25 A Well, I continually am educating myself and

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1 reading more reports, articles, and such. None of  
 2 them were in preparation for this deposition  
 3 though.  
 4 Q Did you review the expert declarations from  
 5 Dr. Shumer, Dr. Karasic, or Dr. Turban?  
 6 A I did.  
 7 Q Did you review the transcription of their  
 8 depositions?  
 9 A I did.  
 10 Q Did you review any of the declarations submitted  
 11 by Indiana's other experts?  
 12 A No, I did not.  
 13 Q I'm sorry?  
 14 A No. I don't believe so. Just those three.  
 15 Q In the process of preparing for today's  
 16 deposition, did you review any of the medical  
 17 records of the plaintiffs in this case?  
 18 A I reviewed medical records, but not regarding, you  
 19 know, it was a while back. It was not regarding  
 20 this deposition.  
 21 Q So did you review the plaintiffs' medical records  
 22 in your declaration?  
 23 A I did review them. But I decided, it was decided  
 24 to not, you know, include anything regarding those  
 25 records in my report.

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1 So if that answers your question, I reviewed  
 2 the records. I did not, you know, formulate  
 3 opinions or, you know, add anything into my report  
 4 related to that. So I did review them, but I  
 5 didn't comment on them.  
 6 Q Have you spoken to Diana Kenny, who is one of the  
 7 experts in this case that Indiana has proffered?  
 8 A No.  
 9 Q Have you spoken with Daniel Weiss, who is another  
 10 of the Indiana experts in this case?  
 11 A No.  
 12 Q Have you spoken with Paul Hruz?  
 13 A No.  
 14 Q Have you spoken with James Cantor?  
 15 A No.  
 16 Q When we were talking earlier about your deposition  
 17 in Decker you referred to part of the transcript  
 18 where you discussed speaking with your wife,  
 19 Dr. Olga Kaliebe, who is a board certified  
 20 endocrinologist, is that correct?  
 21 A Yes.  
 22 Q Have you spoken with your wife, Dr. Kaliebe, about  
 23 this case?  
 24 A No.  
 25 Q Did she assist in any way in your declaration in

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1 this case?  
 2 A No.  
 3 Q Thank you, Dr. Kaliebe.  
 4 Anything else that you did to prepare for  
 5 today's deposition that we have not covered?  
 6 A No.  
 7 Q Then Dr. Kaliebe, I want to talk a little about  
 8 your background. You are board certified in  
 9 psychiatry, is that correct?  
 10 A Yes.  
 11 Q You are also board certified in child and  
 12 adolescent psychiatry, is that correct?  
 13 A Yes.  
 14 Q And forensic psychiatry as well?  
 15 A Correct.  
 16 Q Do you have any other board certifications?  
 17 A No.  
 18 Q Do you have any formal training in sociology?  
 19 A Well, I believe during medical school and  
 20 residency, yeah, training in the broad range of  
 21 the field, which sociology is somewhat included  
 22 within psychiatry. So psychiatry has some  
 23 sociology included.  
 24 Q Was there a specific course in sociology that you  
 25 took as part of your medical training?

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1 A Well, since psychiatry deals with biopsychosocial  
 2 phenomenon in people, sociology is a component of  
 3 how you are trained. So the social part is quite  
 4 important.  
 5 As I said, what people think about how you  
 6 approach the patient is biopsychosocial. So  
 7 social is a major component. In psychiatry we  
 8 frame our approach to patients as biopsychosocial.  
 9 So social matters are essential and a large part  
 10 of psychiatry. So there's a lot of psychiatric  
 11 training and medical school training.  
 12 So, yes, it is quite important to be up on  
 13 social matters and understand social interactions.  
 14 That is a large component of our training.  
 15 Q And how are you defining sociology?  
 16 A Well, how am I defining sociology? In psychiatry  
 17 social matters are very important. Social  
 18 interactions are the basis of sociology is my  
 19 understanding. So that is how I was applying  
 20 them.  
 21 Q Fair to say that in psychiatry you are treating  
 22 individual patients, correct?  
 23 A Well, you do. You treat families. You treat them  
 24 within a context. You are also asked for input  
 25 regarding matters that are more broad. So, you

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1 know, it depends. Yes. Typically our model is  
2 individual patients or families.  
3 COURT REPORTER: Doctor, I'm sorry. you  
4 are cutting out and I am having a hard time  
5 hearing you.  
6 MR. SELDIN: Let's go off the record.  
7 (OFF RECORD AT 10:00 A.M.)  
8 (AT THIS TIME A SHORT RECESS WAS HELD OFF  
9 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS  
10 WERE HAD:)  
11 (ON RECORD AT 10:01 A.M.)  
12 BY MR. SELDIN:  
13 Q Thank you, Dr. Kaliebe. Do you treat families in  
14 your psychiatry practice currently?  
15 A When you practice child psychiatry you typically  
16 do see the family. Right? You have to see the  
17 family. So you are doing family work.  
18 Q I'm not asking typically. I'm asking do you  
19 specifically treat families currently in your  
20 psychiatry practice?  
21 A Yes. I mean, when you work in child psychiatry  
22 you work with the family, yes.  
23 Q And when you say you work with the family, you  
24 mean providing psychiatric treatment to the family  
25 and consulting with the family about the child?

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1 A Well, neither of those is the right way to frame  
2 it. You work with a child and family together.  
3 The child may be the assigned patient, but you are  
4 working with the entire family.  
5 Q Do you prescribe medication as part of your  
6 psychiatry practice?  
7 A Yes.  
8 Q Are you prescribing medication to any of the  
9 parents or the family members of your child  
10 patients as part of your practice?  
11 A No.  
12 Q Do you provide psychotherapy as part of your  
13 psychiatric practice?  
14 A You would provide parent training. So, yes, you  
15 are providing -- it's not, it's family work so you  
16 do some family therapy. Even when you are in a  
17 room with a parent and the child together that is  
18 a therapeutic interaction with both members.  
19 Q Then other than the training in sociology that you  
20 talked about as part of your medical training, do  
21 you have any other training in group dynamics or  
22 organizational dynamics?  
23 A We receive some of that training as, you know, in  
24 medical school and during your residency and  
25 because I was the program director and was

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1 involved in training when I was at LSU you do  
2 learn about a lot of organizational stuff because  
3 you do the trainings that the universities do to  
4 help understand how to run a residency and work  
5 with trainees.  
6 There is some organizational work, some  
7 organizational training that I received as part of  
8 that. Each medical school has a medical education  
9 department. They do trainings about other work  
10 systems.  
11 Q Anything other than that?  
12 A Not that I recall.  
13 Q And then in your declaration you said that gender  
14 dysphoria and its treatment were part of your  
15 professional training.  
16 Do you recall that part of your declaration?  
17 A Yes.  
18 Q Okay. And what professional training did you  
19 receive on gender dysphoria or its treatment?  
20 A Well, at the time it would have been called gender  
21 identity disorder. I use the modern term. But  
22 when you are doing a general psychiatry residency  
23 your section of the training in medical school  
24 includes a section of training or learning that  
25 includes those disorders.

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1 In child psychiatry residency, you have  
2 training that includes those disorders. So at  
3 every level of training you get some education  
4 regarding, you know, at that point it was gender  
5 identity disorder, but now it's called gender  
6 dysphoria.  
7 Q Did you take any specialized or targeted classes  
8 that dealt with gender identity disorder or  
9 gender dysphoria as part of your medical school  
10 training?  
11 A No.  
12 Q Okay. Have you done any continuing education on  
13 gender identity disorder or as it was previously  
14 called or gender dysphoria?  
15 A Yes.  
16 Q What continuing education have you done?  
17 A Okay. So I attend meetings at the American  
18 Academy of Child and Adolescent Psychiatry, they  
19 have CME meetings at every annual meeting. And I  
20 attended in the last four years, five years, I  
21 would guess about half a dozen, maybe more, of the  
22 presentations, or I bought the, you know, you get  
23 the audio package later.  
24 With COVID it kind of got messed up so it was  
25 not the usual conference. We were doing online

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1 not real time so you could watch later. Because  
 2 of that I would not say that all of the ones I  
 3 watched every single minute of, you know, during  
 4 that online period.  
 5 When you are in person you know that you sit  
 6 there through the whole presentation. So I would  
 7 estimate at least six presentations which are CME  
 8 presentations from the American Academy of Child  
 9 and Adolescent through the annual meeting.  
 10 Most of them were at the time of the annual  
 11 meeting, but some of them were later because I get  
 12 the package where you can watch them later so if  
 13 you miss something you can go back and watch.  
 14 I was at the American Psychiatric Association  
 15 meeting last year and attended a CME meeting  
 16 related to gender dysphoria and adolescents. And  
 17 I downloaded, or I also participated in one of the  
 18 American Psychiatric Association trainings related  
 19 to gender dysphoria this year.  
 20 Q So it sounds like those first six CME credits that  
 21 you were talking about, were those all related to  
 22 gender dysphoria or its treatment?  
 23 A Yes.  
 24 Q Okay. So the past four or five years about how  
 25 many hours of CME training do you think you have

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1 had on gender dysphoria or its treatment?  
 2 A About ten.  
 3 Q Okay. And so six years ago and later about how  
 4 many hours of CME credit do you think you had  
 5 related specifically to gender dysphoria or gender  
 6 identity disorder?  
 7 A Only to the degree it was included in larger  
 8 programs. So at that point I had not sought out  
 9 any. So one answer to that question is none.  
 10 Or only as it was included in course reviews  
 11 or other classes. Because when you do, when you  
 12 go to the annual conference there's a performance  
 13 and practice feedback that you do, which is asking  
 14 and answering questions about different topics in  
 15 child psychiatry. That includes topics related to  
 16 gender dysphoria.  
 17 Then also when you do board review there are  
 18 sections of board review that are also related to  
 19 gender dysphoria and gender dysphoria treatments.  
 20 That is a general review of all topics, but it  
 21 includes those.  
 22 So I did retake my boards, I'm guessing in  
 23 2005. Then in 2015 would have been my redo for my  
 24 child psychiatry boards. So I would have to  
 25 study. But you do get CME for taking the board.

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1 That is considered continued medical education,  
 2 taking the board review.  
 3 Q Doctors have a better deal than lawyers when it  
 4 comes to CLEs.  
 5 A It's expensive.  
 6 Q Other than the ten hours we talked about and the  
 7 education that you would have gotten in the  
 8 ordinary course as part of your board  
 9 certifications and continuing training, anything  
 10 else since 2005?  
 11 A I do not believe anything else that was CME.  
 12 Q Okay. How did you come to be an expert in this  
 13 case?  
 14 MR. PATTERSON: I will object to the  
 15 extent it calls for attorney/client privilege  
 16 communication.  
 17 Q Let me break it down a little more in smaller  
 18 chunks to see if we can avoid the problem. This  
 19 is a yes or no question.  
 20 Did the state of Indiana reach out to you  
 21 about becoming an expert in this case?  
 22 A Yes.  
 23 Q So you did not affirmatively reach out to them, is  
 24 that correct?  
 25 A Correct.

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1 Q When was the first case -- excuse me.  
 2 Prior to Decker, were you an expert in any  
 3 case involving gender dysphoria or its treatment?  
 4 A No.  
 5 Q Other than Decker and Boe v. Marshall, have you  
 6 been involved in any case involving gender  
 7 dysphoria or its treatment?  
 8 A No.  
 9 Q In your C.V. and in Boe and in your declaration  
 10 you listed your prior expert engagements.  
 11 Fair to say other than Decker, Boe, and this  
 12 matter, none of the rest would pertain to gender  
 13 dysphoria or its treatment?  
 14 A Correct.  
 15 Q In which case did you become an expert first,  
 16 Decker or Boe?  
 17 A Decker.  
 18 Q Okay. In the Decker matter in Florida, did the  
 19 state of Florida reach out to you about becoming  
 20 an expert?  
 21 A Yes.  
 22 Q Were any third parties involved in making that  
 23 connection between you and the state of Florida?  
 24 A I actually don't know.  
 25 Q Prior to Decker had you ever held yourself out as



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1 an expert in gender dysphoria or its treatment?

2 A No.

3 Q Have you ever lobbied before a state legislature?

4 A No.

5 Q Have you ever testified before a state

6 legislature?

7 A No.

8 Q The same question at the federal level, have you

9 ever lobbied for federal legislature?

10 A No.

11 Q Have you ever testified before Congress?

12 A No.

13 Q You are aware this case involves Senate Enrolled

14 Act 480 in Indiana, correct?

15 A Correct.

16 Q Have you made any public statements for or against

17 Senate Enrolled Act 480?

18 A No.

19 Q Have you ever made any public statements for or

20 against any other laws pertaining to the treatment

21 of gender dysphoria in minors in other states?

22 A No.

23 Q No op eds or letters to the editor? Nothing like

24 that?

25 A Correct.

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1 Q Dr. Kaliebe, I will ask you some questions about

2 your background. They come from the portions of

3 your declaration and when we talk about it if you

4 would like to refer to those, let me know and we

5 will pull up Exhibit 1.

6 My questions will be what were the

7 circumstances of starting or stopping various

8 jobs. I'm not trying to trick you. If you want

9 to refer to that for dates, just let me know.

10 According to your declaration you stopped

11 being the assistant professor at LSU Health

12 Science Center in 2016, is that correct?

13 A Yes.

14 Q What prompted the end of your employment there?

15 A I moved to Tampa, Florida. It did not totally end

16 my employment with LSU. I'm not exactly sure how

17 long I remained with some contracts in Louisiana.

18 I retained my medical license in Louisiana and

19 still had an LSU collaborative care contract when

20 I moved to Florida. I can't exactly say that it

21 ended.

22 I mostly became a University of South Florida

23 employee and had moved to Tampa. I had a

24 collaborative care contract, I believe it was for

25 one more year at LSU, you know, doing psychiatry

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1 and collaborative care back to Louisiana. But I

2 mostly moved from Louisiana to Florida, thereby

3 changing my work from mostly LSU to mostly the

4 University of South Florida.

5 Q Did your role at LSU involve clinical treatment?

6 A Yes.

7 Q Did it involve clinical supervision?

8 A Yes.

9 Q Did you teach?

10 A Yes.

11 Q Did you perform research?

12 A Yes.

13 Q Okay. Did you have any administrative

14 responsibilities?

15 A Yes.

16 Q Here is the tough question, what percentage of

17 your job do you think was clinical treatment

18 versus the other things we just talked about?

19 A So when I was at LSU my job involved, it changed

20 over time. That is not a question that I can

21 answer easily because there were different times

22 with different roles.

23 Mostly I would do clinical work. So, you

24 know, I was mostly a clinician. But I would say I

25 was heavily a clinician educator. So I was always

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1 very involved with the training programs and

2 teaching. So I always had a large teaching role.

3 In my clinical sites I would have students or

4 residents come with me where I was working a lot

5 of the time and people would, you know, sit in

6 with me. So I had a clinical role, which included

7 some resident supervision. Then if you want me to

8 breakdown the numbers --

9 Q I think that is a good answer. Thank you.

10 A Okay.

11 Q In your current role at USF do you have roughly

12 the same mix of responsibilities in terms of being

13 a clinician and teaching?

14 A Well, yes and no. When I moved to Florida I was

15 offered a number of contracts in corrections which

16 was actually a little bit more time in juvenile

17 corrections than I was spending in Louisiana. So

18 I do more correctional work in Florida than I was

19 doing in Louisiana hours-wise.

20 Recently I'm doing more forensic cases so I'm

21 doing more forensic work. My clinical role in

22 Florida was significantly decreased in terms of,

23 like, having an individual patient clinic. Right?

24 So I have two resident clinics right now.

25 But that is, you know, a lot less sort of

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1 direct patient care and, you know, very little  
2 independent patient care compared to what I was  
3 doing in Louisiana.  
4 Q Dr. Kaliebe, how long have you been practicing  
5 psychiatry?  
6 A Well, I finished my first residency in, which  
7 would be the general psychiatry residency as I  
8 transferred into child psychiatry, that would be  
9 in 2004.  
10 At that point, because I was already  
11 moonlighting, which was an independent practice,  
12 you know, I would say my first independent  
13 practice was 2001 or 2002. So during your  
14 residency sometimes you are also independent  
15 practicing. So I would have to say 2001 would  
16 probably be my first year of independent practice.  
17 I graduated medical school in 1999.  
18 I know during your first year of residency no  
19 one does any independent practice. That is one  
20 way to answer the question.  
21 Another way to answer is when I finished all  
22 my fellowships and residencies, that would be  
23 July 2005 because I did general psychiatry. Then  
24 I did child and adolescent psychiatry.  
25 So general for three years. Child psychiatry

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1 for three years. Forensic psychiatry for one  
2 year. And finished in July of 2005.  
3 Q Fair to say then you have seen patients in some  
4 capacity for about twenty-two years?  
5 A Correct. You could say my residency started on  
6 July 1 of 1999.  
7 Q Round numbers, is it fair to say you have treated  
8 thousands of patients in that twenty plus year  
9 period?  
10 A Correct.  
11 Q Of those thousands of patients how many of them  
12 have you treated that have had gender dysphoria or  
13 gender identity disorder?  
14 A As you have probably seen in my deposition, there  
15 is a -- it is probably around sixteen or seventeen  
16 patients right now.  
17 Q I believe you had a colloquy with the court in  
18 Decker that led you to that number about sixteen  
19 or seventeen.  
20 Do you recall that part of your testimony?  
21 A Yes.  
22 Q Okay. Of those sixteen or seventeen patients with  
23 gender identity disorder or gender dysphoria, how  
24 many of them were under eighteen?  
25 A I would guess twelve or thirteen of them.

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1 Q So twelve to thirteen were under eighteen? Then  
2 we will call it --  
3 A I'm not sure how you count the people that you saw  
4 and they were below eighteen and now they are over  
5 eighteen in that question.  
6 Q When you started seeing those people under  
7 eighteen, if we use that definition, does the  
8 twelve to thirteen still stand?  
9 A We will make it thirteen if it's when I started to  
10 see them. You know, that is my, I'm, that is the  
11 best estimate that I can give you.  
12 Q I will spot you the one. We will call it  
13 thirteen.  
14 Of those thirteen did you diagnose any of  
15 them with gender dysphoria?  
16 A Yes.  
17 Q How many of them did you diagnose with gender  
18 dysphoria?  
19 A There are different ways to answer that question.  
20 All of them are diagnosed with gender dysphoria  
21 and had come to me with that diagnosis or some  
22 question regarding that diagnosis.  
23 Now, are you asking am I the first person to  
24 diagnose gender dysphoria for that patient? Or  
25 are you asking me did I continue a diagnosis of

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1 gender dysphoria?  
2 Q We will break it down into small chunks to get  
3 exactly at that question. Of those thirteen  
4 patients how many of them when they arrived in  
5 your office already had a diagnosis of gender  
6 dysphoria?  
7 A I would guess maybe ten.  
8 Q Okay. Of those ten who arrived in your office  
9 already with a diagnosis of gender dysphoria, how  
10 many of those did you also diagnose with gender  
11 dysphoria?  
12 A I'm trying to think back if there was any. I  
13 believe there was a continuation of a diagnosis in  
14 all patients.  
15 Q So of those ten who showed up with a diagnosis of  
16 gender dysphoria, in none of them you said, I  
17 don't think that is correct. You don't have  
18 gender dysphoria.  
19 A Well, you are asking me questions about when they  
20 present for treatment. You know, you see people  
21 over time. So it may be a different answer at the  
22 end of the day did they always leave the practice  
23 also with a gender dysphoria diagnosis, you know,  
24 that is a slightly different question.  
25 I believe there was continuation of the

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1 incoming diagnosis in all ten.  
2 Q When the ten, when those ten who showed up with a  
3 diagnosis of gender dysphoria at least at the  
4 beginning you thought all ten of these have, I  
5 agree with that diagnosis of gender dysphoria. Is  
6 that fair to say then?  
7 A Yes.  
8 Q At the end of treatment for those ten, were there  
9 any of them where you did not continue the  
10 diagnosis of gender dysphoria?  
11 A I would say no. That is a difficult question  
12 sometimes because you get people for, you know, at  
13 the clinics for a certain amount of time. Then  
14 they roll off of your clinic or they leave and you  
15 often don't know what happens next with them.  
16 But I don't remember taking away that  
17 diagnosis in any particular patient.  
18 Q We talked about the ten of the thirteen who showed  
19 up with a diagnosis of gender dysphoria.  
20 Of the three additional folks who were minors  
21 when you began seeing them, did you diagnosis all  
22 three of those people with gender dysphoria?  
23 A Yes.  
24 Q Were you using the DSM-5-TR criteria to make that  
25 diagnosis?

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1 A Yes.  
2 Q I believe that leaves four adults who you have  
3 seen or treated who had gender dysphoria.  
4 The same set of questions. When they showed  
5 up in your office did all of those four adults  
6 already have a diagnosis of gender dysphoria?  
7 A Yes.  
8 Q Did you continue the diagnosis for all four  
9 adults?  
10 A Yes.  
11 Q I'm sort of zooming out to the sixteen or  
12 seventeen people who you have seen with gender  
13 dysphoria.  
14 Did any of them have a gender identity  
15 disorder diagnosis, or were they all post DSM-5?  
16 A Post DSM-5, correct.  
17 Q Did you recommend or prescribe any treatment for  
18 the gender dysphoria that you diagnosed in these  
19 individuals?  
20 A Yes.  
21 Q What treatment did you prescribe?  
22 A Well, I recommend when a child presents with  
23 gender dysphoria that they enter psychotherapy.  
24 Q Anything other than psychotherapy?  
25 A No. I mean, if you are talking about treating --

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1 people come in with co-morbidities. So there's  
2 treatment for matters other than gender dysphoria,  
3 which could include medications or other  
4 therapies.  
5 Let me qualify, also, that I have a practice  
6 of always recommending certain things for patients  
7 when they show up in my clinic. It includes a  
8 number of matters that all patients get. So I  
9 would recommend these things also for a patient  
10 who presents with gender dysphoria. So I don't  
11 just recommend people for psychotherapy and leave  
12 it at that.  
13 Would you like me to tell you about what I  
14 recommend for all of the patients that I interact  
15 with?  
16 Q Well, so I want to ask a clarifying question. Of  
17 the general suite of things that you recommend to  
18 all of your patients, is that fair to say that is  
19 part of general wellness? It is not specific to  
20 any diagnosis?  
21 A I don't think wellness is the correct word. I am  
22 talking about things that do promote wellness, but  
23 they also have an impact on mental health.  
24 So, you know, when I am, when I have someone  
25 present to me with a mental health condition, the

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1 fact that I want them to get involved with  
2 physical activity, exercise, you know, perhaps  
3 sports. Perhaps, you know, yoga. Perhaps, you  
4 know, time in nature. Perhaps taking walks. I  
5 mean, all that physical activity and movement  
6 stuff has very good evidence base and is  
7 important. I emphasize it with all my patients.  
8 So it is true with a patient with gender  
9 dysphoria.  
10 I would talk about changing how people eat,  
11 food related issues. Once again, that is pretty  
12 strong evidence base, great risk and benefit  
13 profile. It does treat and help with mental  
14 disorders.  
15 Then the other component is managing what I  
16 call honoring silence. That is a general frame  
17 for having some mediative or calming practice that  
18 you do all of the time.  
19 And then, also, mindfully managing your  
20 exposure, especially for children these days, to  
21 electronics. When I say honor silence, that  
22 includes, you know, turning, coming to some  
23 conclusion as a family about, you know, what is  
24 the relationship that this person is going to have  
25 with electronics? Where do they go? How much

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1 time do they spend on the different devices? What  
2 other activities, you know, might be better than  
3 the extra time online? Are there any things that  
4 are good or positive they are doing online? Those  
5 could be increased or the important part of it.  
6 But that is advice that I do think is  
7 pertinent and I give to all patients. So that  
8 would include, you know, that would include  
9 patients with gender dysphoria. They would get  
10 the advice to, you know, basically eat food to  
11 improve their diet. Move their body, physical  
12 activity. Mixed in with mindfulness. Hopefully a  
13 mindful practice of moving their body and properly  
14 managing, because today's kids are so heavily  
15 involved in electronics and it's so much of their  
16 social world. So managing those things.  
17 That is not everything that I tell people,  
18 but that is a standard, you know, speech that I  
19 give or discussion that I have with every single  
20 patient. It would be applicable in this case in  
21 addition to my referral for, you know,  
22 psychotherapy.  
23 Q And is it fair to say that you didn't say to any  
24 of those patients that I think if you do more yoga  
25 or are more mindful you will no longer have gender

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1 dysphoria?  
2 It was just part of your general suite of all  
3 your patients you see, you think that is a good  
4 plan for everyone to do yoga and limit screen  
5 time and be --  
6 A No. I would not say it like that. I would say  
7 there is a significant possibility that people can  
8 help with their distress about their body through  
9 the practices that I'm recommending and by  
10 managing, you know, what is coming into their  
11 brain through, you know, media.  
12 So, yes, I do think particularly in these  
13 cases this would be a part of the treatment plan.  
14 I think it is something that is important to  
15 communicate to the patients.  
16 Q Are there any randomized controlled trials,  
17 studies, regarding yoga as a treatment for gender  
18 dysphoria?  
19 A No.  
20 Q In your declaration you said that you were  
21 consulted about providing a second opinion and  
22 coordinating care regarding a patient with gender  
23 dysphoria in the Louisiana Juvenile Correctional  
24 System.  
25 Do you recall that part of your declaration?

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1 A Correct.  
2 Q Is that patient included in your sixteen or  
3 seventeen, or is that a separate person?  
4 A Actually it was not included.  
5 Q Who asked you for a second opinion?  
6 A Well, at the time when I moved to Florida I still  
7 had a relationship with the clinic with the  
8 correctional system in Louisiana. If you remember  
9 what I said, I moved here. I kept the Louisiana  
10 license. I was still doing work in Louisiana.  
11 As the most senior clinician within the  
12 company that has all of the contracts for the  
13 juvenile justice in Louisiana, whenever they have  
14 challenging cases I was likely to get consulted.  
15 That was a patient who was moving facilities  
16 and so they asked my opinion. They asked, you  
17 know, basically what approach should they have.  
18 So that was actually working for the company at  
19 that time and they consulted me.  
20 Q I take it that was because it was a juvenile  
21 correctional system that that person was under  
22 eighteen?  
23 A That person -- well, I don't want to speak too  
24 much about individual patients because, you know,  
25 especially when we get into specifics about where

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1 they are and how they move.  
2 Q Well, we can designate this portion of your  
3 deposition transcript as confidential.  
4 A Can we?  
5 Q Yes.  
6 MR. SELDIN: Mr. Patterson, I don't know  
7 if you are aware of the confidentiality order that  
8 we have in this case. We have been using that to  
9 designate portions in other expert testimony  
10 pertaining to the plaintiffs.  
11 If it's appropriate here, we can designate  
12 this portion as confidential so I can inquire into  
13 his expertise.  
14 MR. PATTERSON: Yes. We can designate it  
15 confidential, but I would say to the extent he is  
16 under any obligations not to disclose any  
17 information even in a confidential setting he has  
18 to abide by those. I'm okay with this being made  
19 confidential.  
20 MR. SELDIN: Great.  
21 Q The particular individual about whom you provided  
22 a second opinion, was that person a minor?  
23 A They, since this is not -- I mean, I don't believe  
24 that in this context that this would be too, that  
25 I'm revealing too much. I do want to not speak

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1 too specifically because, obviously, we are, when  
 2 you talk about individual patients, any of this  
 3 could be trackable. I do not want to say anything  
 4 that would reveal anything about any patient that  
 5 I'm treating. Right?  
 6 So I'm trying to keep it as general as  
 7 possible. Redacted  
 8 Redacted  
 9 Q Redacted  
 10 Redacted  
 11 Redacted  
 12 Redacted  
 13 A Redacted  
 14 Redacted  
 15 Redacted  
 16 Redacted  
 17 Redacted  
 18 Redacted  
 19 Redacted  
 20 Q Redacted  
 21 Redacted  
 22 Redacted  
 23 Redacted  
 24 A Redacted  
 25 Redacted

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1 Redacted  
 2 Redacted  
 3 Q Redacted  
 4 Redacted  
 5 Redacted  
 6 A Redacted  
 7 Redacted  
 8 Redacted  
 9 Redacted  
 10 Redacted  
 11 Q Also, in your declaration you said that you  
 12 provided an opinion about whether a pediatric  
 13 patient was competent to assent to the  
 14 administration of puberty blockers.  
 15 Doctor, do you recall that part of your  
 16 declaration?  
 17 A Yes.  
 18 Q In what capacity were you consulted on that? I  
 19 guess which contract was that a part of?  
 20 A It was within the USF, you know, child psychiatry  
 21 realm.  
 22 Q Okay. When you provided that opinion, was that to  
 23 someone you were supervising or a lateral  
 24 colleague?  
 25 A Lateral colleague.

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1 Q What was your opinion on their competence to  
 2 assent?  
 3 A Well, my opinion was that at the age they were  
 4 that it seems unlikely that they would have full  
 5 knowledge or capacity to fully assent, you know,  
 6 or if you want to say consent to the procedure.  
 7 It seemed -- the particular wording of the  
 8 question was not can they assent or not. It was  
 9 more do they have the, you know, capacity to fully  
 10 understand what they are agreeing to.  
 11 Q Do you recall how old that person was?  
 12 A I don't, I don't remember for sure. But I do  
 13 think it was twelve or thirteen.  
 14 Q And were you asked to provide an opinion on that  
 15 child's parents' ability to consent to the  
 16 treatment?  
 17 A No.  
 18 Q Did you have any concerns based on what you heard  
 19 in that consultation about the parents' ability to  
 20 consent?  
 21 A No.  
 22 Q You also said that you have been consulted  
 23 regarding psychotherapeutic approaches to young  
 24 adult patients who detransition.  
 25 Do you recall that part of your declaration?

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1 A Correct.  
 2 Q When you say young adult, I take it you mean those  
 3 people were over eighteen?  
 4 A Correct.  
 5 Q You also said you collaborate in the care of  
 6 patients with gender dysphoria as part of your  
 7 work with the Florida Medicaid psychiatric  
 8 hotline.  
 9 Do you recall that part?  
 10 A Yes.  
 11 Q And about how many patients have you collaborated  
 12 in the care with for those hotline calls?  
 13 A That also had gender dysphoria?  
 14 Q Yes.  
 15 A I'm trying to think if it was two or one. Only  
 16 one that I remember. So one time.  
 17 Q Did your involvement in that care go beyond that  
 18 phone call?  
 19 A No.  
 20 Q How many patients have you consulted about in  
 21 connection with your work on the Florida Medicaid  
 22 psychiatric hotline?  
 23 A Good question. Twenty. Thirty.  
 24 Q Dr. Kaliebe, have you conducted any research about  
 25 gender dysphoria?

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1 A No.  
 2 Q Any research on gender identity generally?  
 3 A No.  
 4 Q Any research focusing on the treatment of  
 5 transgender people?  
 6 A No.  
 7 Q Have you published any papers on those topics?  
 8 A No.  
 9 Q Have you supervised any research on those  
 10 topics?  
 11 A No.  
 12 Q Have you ever had to retract a research paper?  
 13 A No.  
 14 Q Or issue a correction to a research paper?  
 15 A No.  
 16 Q Have you ever been sued for medical malpractice?  
 17 A No.  
 18 Q Have you ever been the subject of professional  
 19 discipline?  
 20 A No.  
 21 Q Have you ever been sanctioned by a licensing  
 22 board?  
 23 A No.  
 24 Q Have you ever had a professional complaint filed  
 25 against you?

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1 A No.  
 2 Q Have you ever been the subject of a Title Nine  
 3 complaint?  
 4 A Not that I know of.  
 5 Q Have you ever been arrested or charged with a  
 6 crime?  
 7 A No.  
 8 Q Are you on social media?  
 9 A Yes.  
 10 Q What social media do you use?  
 11 A Use would probably be a strong word because I'm on  
 12 social media, but I do not use social media  
 13 generally. I have a Facebook account. I believe  
 14 I have an Instagram account that links to my  
 15 Facebook. I never actually go on Instagram. So  
 16 it's very rare that I'm on Facebook. That would  
 17 be the only social media that I'm on.  
 18 I will, I occasionally have gone on Twitter.  
 19 I don't make it a practice to go on Twitter. But  
 20 I have gone on Twitter. I don't have a presence.  
 21 I don't post. I don't do any of those things.  
 22 Sometimes to access things I'm occasionally linked  
 23 to Twitter. I would not say I really have a  
 24 Twitter account, but I've gone on Twitter.  
 25 Q I think the youth call people like us lurkers.

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1 That is the technical term. I don't know if you  
 2 have encountered that in the practice with your  
 3 youth?  
 4 A Yes, I have used that term.  
 5 Q Fair to say you fall more on that side of the  
 6 continuum?  
 7 A That is fair to say, yes.  
 8 Q Have you given any interviews in either  
 9 traditional media or elsewhere on the topic of  
 10 gender dysphoria?  
 11 A Given any interviews? Yes.  
 12 Q What interviews have you given on the topic of  
 13 gender dysphoria?  
 14 A Well, I haven't, I was contacted by someone to do  
 15 an interview. I talked briefly with the person.  
 16 I don't have their name in front of me. This was  
 17 quite recently. So I was contacted by someone to  
 18 do an interview regarding some of the stuff I  
 19 guess that has gone on, you know, in this case or  
 20 with professional organizations.  
 21 Q Do you recall the name of who --  
 22 A I don't. I don't.  
 23 Q Do you recall what publication they were with?  
 24 A I don't.  
 25 Q Do you recall --

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1 A I can tell you it was not a publication or place  
 2 that I had heard of. So, hence, maybe that is  
 3 part of why I don't remember actually who they  
 4 are. Yeah.  
 5 Q I take it you said no?  
 6 A We briefly spoke. I said yes.  
 7 Q I'm sorry. What did you speak about?  
 8 A Well, they asked about things that are going on  
 9 with the professional organizations that I have  
 10 written about in my report.  
 11 So they asked for details regarding those  
 12 things and what is going on and I said that I  
 13 would talk a little bit about it, but not, you  
 14 know, not at length.  
 15 I said that it is accurate what I wrote in my  
 16 reports that we have attempted to submit proposals  
 17 that seem to have been squashed based on  
 18 ideological grounds. I said that that is, you  
 19 know, accurate. And basically, you know, I left  
 20 it at that.  
 21 I was, I had mixed emotions, of course, about  
 22 getting myself involved. I've not previously and  
 23 I'm trying to not be involved with press related  
 24 stuff. So I didn't want to talk at length. Yeah.  
 25 Q Was this on background with this person, or do you

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1 anticipate there will be an article?  
2 A I don't know if there will be an article or not.  
3 I asked to, you know, to not be named or, you  
4 know, so, yeah.  
5 Q When you said your reports, were you talking about  
6 your reports in Decker and Boe?  
7 A Yes. You know, I guess those are public. I don't  
8 know what is publicly available and what is not.  
9 I have already made statements in these cases  
10 regarding my opinion regarding what is going on  
11 within the academia and our professional  
12 organizations.  
13 Q Fair to say, did you speak specifically about this  
14 case in that interview?  
15 A No.  
16 Q How did that person get in touch with you?  
17 A I got an email.  
18 Q Did you keep that email?  
19 A Yes.  
20 Q Why do you try not to get involved with press  
21 around this?  
22 A Well, I guess there are a number of things. For  
23 one, it seems like if you are an honest broker of  
24 information and try to work for more cautious care  
25 and for people to be careful about transitioning

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1 minors, then you get painted as a right wing  
2 extremist and hateful and transphobic. I would  
3 prefer myself and my family not to go through  
4 that.  
5 So I'm trying to, you know, be honest with  
6 the courts. I was asked for an opinion so I feel  
7 like I have to give my honest opinion. I feel  
8 like the safeguarding of children is very  
9 important. I feel like I have a duty to my  
10 patients to testify.  
11 Yet, you know, as I wrote in my report, there  
12 are a lot of thought levels and tribalism in our  
13 society. People are using this issue to attack  
14 other people. And I don't want to be involved  
15 with attacking other people.  
16 I also would prefer for, I would prefer to  
17 remain within respectful academic-type dialogue.  
18 That is hard to get to happen in these things, as  
19 I've written in my report. But I feel like the  
20 dialogue of ideas would go best through medical  
21 either journals and professional organizations and  
22 that is a, you know, the more ideal way to work  
23 these things out rather than going through, you  
24 know, the media.  
25 Although, I do think that, you know, once

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1 again, considering the stakes that I'm getting  
2 asked, I mean, it's a tough discussion. But, yes,  
3 those are some of the factors that I thought  
4 about.  
5 Q In your answer you said you thought you had a duty  
6 to your patients in this regard.  
7 Were you referring to the sixteen or  
8 seventeen patients with gender dysphoria that you  
9 have treated?  
10 A Yes. And to all patients, yes.  
11 Q And of the sixteen or seventeen patients with  
12 gender dysphoria, you believed as a psychiatrist  
13 that they all, in fact, had gender dysphoria,  
14 correct?  
15 A Yes, that they had that diagnosis. Correct.  
16 Q You said you thought there, that you wanted to  
17 participate in more academic dialogue about this  
18 topic.  
19 Do you believe that Senate Enrolled Act 480  
20 furthers academic dialogue on this topic?  
21 A I think just, like anything else in life, there  
22 are trade offs. So it might. It might not. I  
23 guess we would have to see what the results of it  
24 are.  
25 Q You said trade offs. Do you believe that the

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1 trade off of banning medical treatment for gender  
2 dysphoria in minors in Indiana is an acceptable  
3 trade off to possibly further academic dialogue on  
4 this topic?  
5 MR. PATTERSON: Object. This is outside  
6 of the scope of his testimony.  
7 You can answer.  
8 A Well, I don't think, I think that is only one of  
9 the implications of the law. So, no, that is not  
10 the primary implication of the law. It is an  
11 implication of it.  
12 Q I'm sorry. What is not a primary implication of  
13 the law?  
14 A The law's effect on the academic or scholarly or  
15 public dialogue is a secondary effect and not a  
16 primary effect.  
17 Q Do you agree with the primary -- I take it then  
18 that you are supportive, however, of the primary  
19 effect of Senate Enrolled Act 480, which is to  
20 prohibit gender-affirming care for minors in the  
21 state of Indiana?  
22 MR. PATTERSON: Object. The law speaks  
23 for itself.  
24 You can answer the question if you  
25 understand it.

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1 A I will answer in that I was asked to give my  
 2 opinion about matters related to the treatment of  
 3 gender dysphoria, what is going on in professional  
 4 organizations, what is going on in the academia.  
 5 That is where my realm, you know, is that I'm  
 6 providing expertise.  
 7 So the effects of the laws, both good and  
 8 bad, is not something that I've given, that is  
 9 sort of a secondary effect.  
 10 But, yes, I'm, I do believe that in all it's  
 11 better to stop these gender-affirming treatments  
 12 which in total I believe cause more harm than they  
 13 ameliorate.  
 14 Q When you say in total cause more harm than they  
 15 ameliorate, do you mean at the individual level or  
 16 population level?  
 17 A Both.  
 18 Q Do you believe there are any individual patients  
 19 for whom gender-affirming care as a minor is a net  
 20 positive?  
 21 A I'm not sure.  
 22 Q Of the thirteen patients who you have seen with  
 23 gender dysphoria, were any of them receiving care  
 24 that would otherwise be banned by the state of  
 25 Indiana?

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1 A If we are going to ask me about my patients I  
 2 would like to go off the record again.  
 3 MR. PATTERSON: You mean confidential?  
 4 A Confidential, yes.  
 5 Q I think the way we have been doing this is that  
 6 when we remember during the deposition we say it  
 7 and then when we get the transcripts we mark it.  
 8 A Okay. So you would like me to answer? As long as  
 9 its confidential then I will answer. <sup>Redacted</sup>  
 10 Q Redacted  
 11 Redacted  
 12 Redacted  
 13 A <sup>Redacted</sup>  
 14 Q Redacted  
 15 A Redacted  
 16 Redacted  
 17 Redacted  
 18 Q Redacted  
 19 Redacted  
 20 Redacted  
 21 A Redacted  
 22 Q Of the thirteen, how many of those patients were  
 23 receiving care that would otherwise be banned by  
 24 the state of Indiana?  
 25 A Well, I mean, one at one time would have been.

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1 Q Redacted  
 2 Redacted  
 3 A Redacted  
 4 Q Redacted  
 5 Redacted  
 6 A Redacted  
 7 Redacted  
 8 Redacted  
 9 Redacted  
 10 Redacted  
 11 Q Redacted  
 12 Redacted  
 13 A Redacted  
 14 Redacted  
 15 Redacted  
 16 Redacted  
 17 Redacted  
 18 Redacted  
 19 Q Dr. Kaliebe, you are testifying on behalf of the  
 20 state of Indiana, right?  
 21 A Yes.  
 22 Q They are defending a law that bans  
 23 gender-affirming care for minors.  
 24 Part of your expertise is predicated in your  
 25 representation to the court that you have treated

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1 some number of patients with gender dysphoria.  
 2 A Correct.  
 3 Q You told me that you believe that at the  
 4 individual level the provision of the kind of care  
 5 that is banned by Indiana now for minors is more  
 6 harmful than it is beneficial.  
 7 So I'm trying to ask so the court, when it  
 8 sees the transcript, can assess what is it that  
 9 you have observed as a clinician that makes you  
 10 think this care is more harmful than it is  
 11 beneficial?  
 12 So it would be helpful then to know -- let me  
 13 ask you small questions to see how far we get.  
 14 Were these long-term risks you were concerned  
 15 about or short-term?  
 16 A Once, again, I would prefer not to talk about  
 17 individual patients.  
 18 Q Let's talk generally. What are the general risks  
 19 you believe outweigh the benefits for this kind of  
 20 treatment?  
 21 A Well, so first off, there are risks related to  
 22 mental health that are, especially long-term  
 23 mental health, that seem apparent based on  
 24 long-term data. And especially would be apparent  
 25 in someone who has not gone through a proper



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1 process of actually developing as an individual  
2 before they moved on to consider such things.  
3 And in such cases, they should have a period  
4 of time where they are able to interact with  
5 mental health professionals and explore their  
6 identity, explore how they got to the place where  
7 they are, explore what possibly might be other  
8 things that could be involved that would lead  
9 them, you know, to have this gender dysphoria.  
10 So that should all be worked up prior to  
11 initiation of these treatments. And as someone  
12 who is a growing, developing adolescent, they  
13 should finish their development or very close to  
14 finishing it before they make permanent changes in  
15 their bodies. Those are some of the  
16 psychological.  
17 The physical risks is risk of surgery,  
18 hormones, cancers. Any kind of medical problems  
19 that could come.  
20 Q Do you believe that there are any patients at the  
21 end of this process that you propose, that the  
22 provision of gender-affirming care, the benefits  
23 will outweigh the risks?  
24 A Yes. Could I qualify since we have not gone on  
25 yet? I think you are asking me to opine on an

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1 unknown that I would not say that I have a -- I'm  
2 saying yes based on that I think those who have  
3 gone through, you know, a proper process and are  
4 adults, you know, I think that that is a, that  
5 it's unknown, it's unknown still overall about the  
6 risks and benefits of these transitions. I think  
7 we do need more evidence on it. But that is my  
8 qualified answer. Go ahead.  
9 Q Would you support a ban on this kind of care for  
10 adults?  
11 A You would have to tell me what you mean by ban.  
12 Q Well, you are familiar with Senate Enrolled Act  
13 480, which we are talking about in this case as  
14 pertains to minors.  
15 A Yes.  
16 Q Would you support a law like Senate Enrolled Act  
17 480 if it applied to adults?  
18 A You are saying starting at what age?  
19 Q Let's start with for anybody of any age, would you  
20 support a ban on this kind of care?  
21 A I mean, I think you can reasonably say there must  
22 be some, there could be an age limit. There could  
23 be a process that people have to go through.  
24 Yes. I mean, it may be in the current  
25 climate that you need some legislative safeguards

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1 in order to ensure that there is a proper process.  
2 Q I am asking two questions then.  
3 The first question is so you believe that  
4 after some kind of proper evaluation process the  
5 provision of this care may be appropriate in  
6 adults, correct?  
7 A Correct.  
8 Q Setting aside what that process is, do you believe  
9 that there is any age limit that should exist for  
10 folks who are even eligible to go through that  
11 process to then receive this kind of care?  
12 A Well, I don't have a formulated opinion on what  
13 would be the pluses and minuses of a particular  
14 age limit.  
15 But I do think, in general, we understand  
16 that people are growing and developing and, you  
17 know, in other circumstances people are often, oh,  
18 the brain develops until twenty-five or until  
19 twenty-one.  
20 You know, there is an active debate about the  
21 age where someone sort of becomes, you know, a  
22 fully developed complete person and, you know,  
23 when their identity of any type, you know, would  
24 have solidified.  
25 I think you can have -- I don't think we have

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1 had enough quality discussion and debate in the  
2 literature regarding those things to give me a  
3 sense of what would be a, you know, how to  
4 approach that.  
5 Q In the interim while this debate is continuing or  
6 not, do you believe that there should be a ban on  
7 this kind of care for folks who are over  
8 eighteen?  
9 A A blanket ban for over eighteen? Well, as I was  
10 saying, I just think my belief would be with some  
11 process and with some age bar which might be more  
12 than eighteen could be appropriate.  
13 Q Okay. Well, I guess, earlier when we were talking  
14 about how you think that there is not sufficient  
15 research or there has not been sufficient debate  
16 with respect to folks under eighteen so you  
17 support a ban in the interim.  
18 I am asking the same question for over  
19 eighteen. Do you think there should be an age ban  
20 above eighteen in the interim?  
21 A I have not given it -- I think that it could be  
22 reasonable to have an age ban over eighteen,  
23 correct.  
24 I don't know what exactly, I've not given it  
25 a lot of thought, nor have I seen in the

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1 literature what would be a proper way to approach  
2 this. What process would people have to go  
3 through. I mean, whenever you make an age limit  
4 like sixteen for driving, or twenty-one for  
5 drinking, there are always problems with those  
6 strict age limits. There are those trade offs.  
7 There is a lot of complex calculation that would  
8 go into any such trade off.  
9 And so I've not really seen any analysis of  
10 exactly what would be the best trade off in these  
11 situations.  
12 MR. SELDIN: We have been going for a  
13 little bit at this point. How would a five minute  
14 break sound?  
15 (OFF RECORD AT 11:09 A.M.)  
16 (AT THIS TIME A SHORT RECESS WAS HELD OFF  
17 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS  
18 WERE HAD:)  
19 (ON RECORD AT 11:15 A.M.)  
20 BY MR. SELDIN:  
21 Q Dr. Kaliebe, welcome back.  
22 MR. SELDIN: Joel, will you pull up  
23 Exhibit 1 for us?  
24 Q Dr. Kaliebe, I would like to talk a little about  
25 your declaration.

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1 A Okay.  
2 Q Dr. Kaliebe, in your declaration in Paragraph 25  
3 you say, "Current discussions regarding  
4 transgender care take place in the context of an  
5 unexplained and remarkable rise in minor patients  
6 reporting gender dysphoria."  
7 Do you see where you wrote that?  
8 A Yes.  
9 Q Would you agree that gender dysphoria is a real  
10 condition that requires treatment?  
11 A Well, that is one of the things I was talking  
12 about before in my preamble about things I was  
13 asked before.  
14 So is it a real disorder? Correct. But  
15 the "requires treatment" part is a complicated  
16 matter. So I would say, no. Even though before I  
17 sort of automatically said yes, that sounds  
18 reasonable. Lots of times in our business there  
19 are problems people have that they mostly work  
20 through on their own and do not get treatment for.  
21 So that is the standard, you know, mental  
22 health, most of the things that people have that  
23 might meet criteria for a disorder or a problem do  
24 not usually get solved by therapy or the medical  
25 community.

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1 So, no. I would not say that I would agree  
2 with that statement in that it does not, it seems  
3 to reflect a it must be treated part. So I can't  
4 agree with that.  
5 MR. SELDIN: Joel, will you pull up  
6 Exhibit 7? We will be at Page 157 of the PDF.  
7 Q Dr. Kaliebe, earlier I showed you Exhibit 7, which  
8 was your testimony at trial in Decker.  
9 Do you recall us talking about that?  
10 A Yes.  
11 Q Okay. You will see on this Page 1119 of the  
12 transcript starting at Line 11 you are asked  
13 questions.  
14 "Q. Dr. Kaliebe, you would agree that gender  
15 dysphoria is a real condition that requires  
16 treatment?  
17 A. Correct."  
18 Do you see that?  
19 A Yes, I do.  
20 Q Was the testimony that you provided at trial in  
21 Decker that I just read truthful?  
22 A Yes. In that I -- if you remember at the  
23 beginning when you asked about did I make any  
24 changes, as I looked at it and saw the wording of  
25 this in both my previous, you know, as I was

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1 questioned, this is exactly what I was talking  
2 about that now that I see how that was worded,  
3 that I, in some ways, misunderstood about  
4 "requires treatment" because you can talk about  
5 that in different ways.  
6 Is it, do we normally -- would we like to  
7 treatment something? Is it good if something is  
8 treated? Sometimes that is what you mean by  
9 requires treatment.  
10 I just want to clarify there are lots of  
11 disorders and problems that do not require  
12 treatment that for most people most of the time  
13 they solve their problems without medical or  
14 psychiatric treatment.  
15 Now that I have had time to think about it  
16 and looked at it in print, that is what I was  
17 mentioning that I think I was, you know, I believe  
18 that "requires" is a word that I was misreading.  
19 And now I can see that if that is the, if  
20 that is how you are asking it, "must be treated",  
21 no, I don't, I want to add some nuance to that  
22 question.  
23 Q So, Dr. Kaliebe, earlier you were talking about  
24 your deposition in Decker, which was like this,  
25 just lawyers, no court.

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1 We talked about how you reviewed your  
2 transcript for errata. In that case you pointed  
3 out misquotes, but not sot of substantive changes  
4 that you were thinking about after reflecting upon  
5 the testimony.  
6 What we just read was testimony that you  
7 provided live in court from Decker a few weeks  
8 ago. Are you saying the testimony I just read  
9 that you provided to the court in Florida is, in  
10 fact, not true?  
11 A I'm saying that I would add nuance to it because  
12 the word "requires" can be seen in different ways.  
13 I don't want to be boxed into a corner of saying  
14 something that I didn't.  
15 Now that I read it, as I said about the  
16 deposition, I am now reflecting an opinion that  
17 the word "requires" can mean different things in  
18 different contexts. So I'm just clarifying.  
19 Q Do you feel like given what you have just told me  
20 you will need to correct your testimony in Decker?  
21 A I don't know what you mean by correct my  
22 testimony.  
23 Q Well, in Decker you said in court in front of a  
24 judge, just like the judge that we have in our  
25 case in Indiana, you were asked "You would agree

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1 that gender dysphoria is a real condition that  
2 requires treatment?"  
3 You said, "Correct."  
4 Then you moved on being questioned. So the  
5 judge in that case heard you say that it's  
6 correct.  
7 Do you think that judge needs to know that,  
8 in fact, you want to add nuance to that because  
9 it's not the answer that you wanted to give?  
10 MR. PATTERSON: Objection.  
11 You can answer.  
12 A I think the judge is plenty intelligent to siphon  
13 out these things himself. He saw the rest of my  
14 testimony. I'm pretty sure that he was capable of  
15 coming to conclusions about what I felt and how I  
16 approached treatment.  
17 So I think, I don't think it's necessary for  
18 me to go and, you know, try to have something  
19 amended. I don't see it as a matter that would  
20 reach that level of importance.  
21 But, once again, since I noticed it and I  
22 have evolved or became more mindful of exactly how  
23 the words are asked to me to, you know, and could  
24 be perhaps used to twist or change what my opinion  
25 is, I wanted to make sure here I'm on the record

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1 accurately with what my opinion is.  
2 Q So you believe that your views have evolved since  
3 May 18 when you provided this testimony?  
4 MR. PATTERSON: Objection.  
5 Mischaracterizes his testimony.  
6 You can answer.  
7 A I don't think, I think, you know, my views have  
8 not changed on it. I just, the word "requires" is  
9 an overly strong word that now I'm realizing I had  
10 agreed to and now would be, I would add nuance. I  
11 should have at that time added the nuance to my  
12 answer.  
13 Q All right. Further down on this page, you know,  
14 right after this question I will read you part of  
15 this testimony.  
16 On Line 14 you were asked the question, "You  
17 provided some testimony just earlier about the  
18 number of people presenting for care. Do you  
19 recall that?"  
20 You said, "Correct."  
21 Then you were asked, "You previously  
22 testified that the fact that more people have been  
23 showing up in clinics could be, could be explained  
24 by, (a), that the care is more available; and,  
25 (b), that more people feel comfortable seeking

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1 care; is that correct?"  
2 And you said, "Yes."  
3 A Correct.  
4 Q Do you have any nuance that you want to add to  
5 that testimony?  
6 A Well, I would assume if you have specific  
7 questions, you could ask me. So I think that that  
8 speaks for itself.  
9 Q So when I asked you correct -- when we were  
10 talking earlier you said you had some nuance to  
11 add to your answer in Line 16 of "Correct."  
12 So I'm asking the same question here, which  
13 is, did you understand the question then and  
14 answer truthfully, I guess? Then, is there  
15 anything that you need to change now to make that  
16 the case?  
17 A No. I mean, I think that those are factors which  
18 are involved. So I still would believe -- I  
19 believed at the time and I still believe the --  
20 no, that's -- I will stick with that.  
21 Q In your report or your declaration you talk about  
22 how you had not seen any patients for gender  
23 dysphoria between 2005 and 2016.  
24 Do you recall that?  
25 A Yes.

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1 Q Okay. And you are aware that there was at least  
2 one clinic in the United States as early as 2007,  
3 correct?  
4 A Yes.  
5 Q Is there a particular reason you didn't include  
6 that fact in this declaration?  
7 A I don't understand the question.  
8 Q Okay.  
9 MR. SELDIN: Joel, will you pull up  
10 Exhibit 4?  
11 Q Look at Paragraph 102. We were earlier talking  
12 about the report that you provided in Decker.  
13 This was filed with the court on April 7.  
14 In Paragraph 102 if you read maybe two-thirds  
15 of the way down the paragraph you said, "The first  
16 gender clinic in the United States just opened in  
17 2007."  
18 Do you see that?  
19 A Correct.  
20 Q So is there a particular reason that you did not  
21 include that fact in your declaration in this  
22 matter?  
23 A No.  
24 Q Earlier we talked about how Decker was the first  
25 case you had been an expert in that involved

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1 gender dysphoria, correct?  
2 A Yes.  
3 Q You said you had not held yourself out as having  
4 any particular expertise in gender dysphoria prior  
5 thereto, correct?  
6 A Well, other than I have obviously testified on, in  
7 many cases being a forensic psychiatrist. I have  
8 repeatedly held myself out as an expert in  
9 psychiatry and in child psychiatry.  
10 So my expertise is as a psychiatrist and as a  
11 child psychiatrist.  
12 Q But you did not specifically hold yourself out as  
13 having an expertise in gender dysphoria, is that  
14 correct?  
15 A Correct.  
16 Q Okay. So turning back to Exhibit 1, Paragraph 26,  
17 you will see in Paragraph 26 that you talk about  
18 how from 2005 to 2016, that eleven year period,  
19 none of the medical students or residents you  
20 supervised presented you with cases involving  
21 gender dysphoria.  
22 Do you see where you wrote that?  
23 A Yes.  
24 Q It would not be surprising if no one came to  
25 specifically ask you about gender dysphoria if you

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1 were not holding yourself out as having a  
2 particular expertise on that topic, right?  
3 A No. Because I work with residents and medical  
4 students and primary care doctors on all sorts of  
5 patients. So if we were seeing those patients  
6 they would have brought them to me because I was  
7 working with them as a supervisor under many  
8 circumstances.  
9 So, no, it would not have to be that I was an  
10 expert. I was the expert as the attending  
11 clinician or the person who ran the clinic or the  
12 person doing the consultative service.  
13 So I would disagree with that  
14 characterization.  
15 Q You would agree then that from 2005 to 2016 just  
16 because you were not encountering patients with  
17 gender dysphoria, that does not mean that no one  
18 was encountering patients with gender dysphoria,  
19 right?  
20 A Well, I think I was very clear that it was just  
21 nobody in my sphere that I worked in at all and my  
22 personal interaction.  
23 So I didn't ever claim that no one anywhere  
24 ever saw a patient with gender dysphoria.  
25 Q Okay.

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1 MR. SELDIN: Then, Joel, take to us  
2 Paragraph 30, please.  
3 Q You wrote, "Never before have there been large  
4 cohorts of individuals seeking medical services to  
5 alter their secondary sex characteristics."  
6 Do you see that?  
7 A Yes.  
8 Q What do you base that statement on?  
9 A Well, we are looking right at a graph of the  
10 increases. I know that is Sweden. We could make  
11 a similar graph in other places.  
12 You know, as I mentioned in my report also,  
13 you know, the base rate of gender dysphoria was  
14 seen as very low even by the DSM-5, which I  
15 believe is a pretty reputable source, two to  
16 fourteen per 100,000.  
17 So, you know, clearly there was not large  
18 amounts of patients seeking services until  
19 recently.  
20 Q The question that I have is in that sentence you  
21 say just seeking medical services to alter  
22 secondary sex characteristics.  
23 You are referring to a chart about gender  
24 dysphoria children, adolescents in Sweden. I  
25 guess what I'm asking is when you make that broad

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1 statement, are you considering the history of  
2 cosmetic surgery and plastic surgery globally  
3 which does often, in fact, alter secondary sex  
4 characteristics?  
5 A Okay. Yeah. I mean, I think point taken. People  
6 do have voluntary surgeries for those things and  
7 that has existed for a while. Yes.  
8 Q So would it be fair to say that there have been  
9 large cohorts of individuals seeking medical  
10 services to alter their secondary sex  
11 characteristics.  
12 They just may not have had gender dysphoria  
13 for that, correct?  
14 A Well, you know, this report is related to gender  
15 dysphoria. So I assume, you know, and these  
16 charts are related to children.  
17 So I would assume that it was understood that  
18 we were talking about children presenting to  
19 change their secondary sex characteristics to the  
20 other gender, which is accurate.  
21 You are correctly pointing out that there are  
22 other circumstances where people have sought out  
23 surgeries to change their sex characteristics.  
24 Q In Paragraph 28 you talk about referrals to  
25 certain gender clinics in England and elsewhere.

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1 Do you see that?  
2 A Yes.  
3 Q Would you agree that there is a difference between  
4 having gender dysphoria and being referred to a  
5 gender clinic?  
6 A Yes.  
7 Q Okay. So it's -- the base rate of gender  
8 dysphoria and referrals to clinics is not apples  
9 to apples, right?  
10 A Well, you know, very likely they are related.  
11 Q Very likely, but you were not certain?  
12 A No.  
13 MR. SELDIN: Joel, would you take us to  
14 Paragraph 33.  
15 Q In your third line of Paragraph 33 you say, "Yet  
16 multiple lines of evidence point to direct social  
17 influences and online and social media contagion  
18 as major contributors to the remarkable rise in  
19 gender dysphoria in adolescents."  
20 Do you see where you wrote that?  
21 A Yes.  
22 Q What multiple lines of evidence are you referring  
23 to here?  
24 A Well, I go on in the report to talk about the  
25 increase in presentations to child psychiatrists

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1 of other disorders or problems that are seemingly  
2 acquired online or contributed to online which we  
3 have, it has been shown that there is a  
4 relationship between online viewing and  
5 suicidality, self-harm, multiple personality  
6 disorder, tic disorders.  
7 So we have a significant literature that does  
8 show the influence of online habits and  
9 presentations to child psychiatrists for problems.  
10 That whole idea of culture and disorders and how  
11 the medical system's theories and naming of  
12 disorders and treatments influence patient  
13 presentations has gone back a long time.  
14 I referenced the Shorter book which goes back  
15 to the Victorian era. So we have known for a long  
16 time that the way the medical establishment or  
17 clinics see problems can bleed out into the  
18 community and affect it.  
19 In addition, there are currents in our  
20 society that are, you know, reflect viewpoints or  
21 ideologies that often are flowing through the  
22 media. And those seem to, you know, have  
23 influence on how people see themselves. That  
24 could be any number of ways. And I don't think  
25 that gender identity or gender dysphoria would be

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1 immune to any of those influences.  
2 Q So the multiple lines of evidence you are  
3 referring to then is by inference or analogy that  
4 you would think that also applies to gender  
5 dysphoria?  
6 A Well, it would be a pretty incredible coincidence  
7 that right at the same time that social media came  
8 on the scene and became widely adopted by children  
9 and adolescents and that the popularity of  
10 influencer and ideology related to transgender and  
11 gender dysphoria sort of came on the scene, that  
12 that was right at the same time that we had this  
13 large rise in presentations to gender clinics.  
14 So it seems that there is very likely an  
15 interaction between the two. Certainly we should  
16 be skeptical and cautious when, you know, there is  
17 such a change so quickly.  
18 Q You would agree that is correlation and not  
19 causation at this point?  
20 A Correct.  
21 Q When you say influencers, who were you referring  
22 to.  
23 A Well, I don't have specific names of people  
24 online. Although over time we have heard many  
25 names. There are TV shows. There are people that

Page 82

1 are online. There's a number of individuals who  
2 are transgender who are well-known personalities.  
3 There are also subgroups. You know,  
4 influencers might be a strong word for this, but  
5 there are a lot of people who are active on the  
6 online communities, Reddit, and these type of  
7 places where adolescents and children can be  
8 influenced by what they encounter online.  
9 Q Do you believe that a celebrity who is on social  
10 media merely existing as openly transgender is a  
11 source of social contagion?  
12 A Well, they may be or may be not. I don't, I would  
13 not say merely existing. Definitely it would  
14 depend on how they present themselves and how they  
15 are talking about themselves.  
16 It could be -- no, not by merely existing.  
17 Q When you say it would depend on what they said and  
18 how they are presenting, what do you mean?  
19 A Well, I think that we would have to be cautious  
20 about the presentation of individuals who may have  
21 a large influence over children and adolescents  
22 who may take celebratory views regarding  
23 transition.  
24 That may have a large influence on minors.  
25 And so I think that there's a potential for those

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1 who are celebratory to have an influence in a way  
2 that, you know, can especially for minors who  
3 already have mental health problems or are very  
4 easily influenced, could lead them to believe or  
5 develop a belief that transition is a solution to  
6 the problems that they have, or that their gender  
7 dysphoria, the solution to that would help them,  
8 could contribute to the development of gender  
9 dysphoria or contribute to the belief that a  
10 transition would be, you know, a good source for  
11 them.  
12 Q Do you believe that to be the case even if there  
13 is no mention by that particular celebrity about  
14 any other co-morbid conditions?  
15 You said celebratory. If someone really  
16 celebrates the fact that they have medically  
17 transitioned, do you believe that that is  
18 sufficient to cause social contagion in youth such  
19 that they will then believe that they also have  
20 gender dysphoria?  
21 A Well, I don't know that is sufficient. It could  
22 be a contributor.  
23 Q Is it possible that a celebrity who is celebratory  
24 about their medical transition really creates a  
25 more welcoming environment for people who already

Page 84

1 have gender dysphoria to be more open about it?  
2 A Yes, it's possible.  
3 MR. SELDIN: Joel, please take us to  
4 Paragraph 52.  
5 Q You wrote, "Yet most child and adolescent  
6 psychiatrists I speak with admit to me that they  
7 will not speak publicly on this subject due to how  
8 sensitive the topic is, expressing fears of  
9 hostilities from activists along with condemnation  
10 and retributions from others with their  
11 universities and organizations."  
12 Do you see that?  
13 A Yes.  
14 Q Can you tell me which child and adolescent  
15 psychiatrists have said this to you?  
16 A Are you asking me to out the people who said they  
17 do not want to speak publicly?  
18 Q You represented to the court here that most of the  
19 people you talk with have said this to you. I  
20 would like to know who said this to you.  
21 MR. PATTERSON: I object. There could be  
22 First Amendment issues here.  
23 At a minimum, we should go confidential on  
24 this part of the transcript.  
25 MR. SELDIN: I think it is presumptively

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1 confidential for two days so we can work it out.  
2 Q Dr. Kaliebe, who said this to you?  
3 A So this is confidential? Is that what you are  
4 saying?  
5 Q Yes. We can designate this portion as  
6 confidential.  
7 MR. PATTERSON: You will not object to  
8 maintaining confidentiality of this portion,  
9 correct?  
10 MR. SELDIN: No, I won't.  
11 Q Redacted  
12 A Redacted  
13 Redacted  
14 Redacted  
15 Redacted  
16 Redacted  
17 Redacted  
18 Redacted  
19 Redacted  
20 Redacted  
21 Redacted  
22 Redacted  
23 Redacted  
24 Redacted  
25 Redacted

Page 86

1 Redacted  
2 Redacted  
3 Redacted  
4 Redacted  
5 Redacted  
6 Q Let's start with the folks you just named. You  
7 first named, I think, you counted five or six  
8 people.  
9 Is that most of the psychiatrists that you  
10 have talked to? I'm trying to understand how you  
11 are coming to this conclusion of "most"?  
12 A I talk to many more. I talk to many, many more  
13 psychiatrists. When I go to the child psychiatry  
14 meetings I'm trying to talk to people about these  
15 issues so that we can come up with more.  
16 I just have not prepared a list to provide to  
17 out people who do not want to be outed during my  
18 deposition due to their fears of recrimination and  
19 hostility.  
20 That was not something I thought I would be  
21 asked to reveal. If you want me to make a list  
22 and give it to you later, you know, but like I  
23 said, as I am representing in my report, that it's  
24 many people.  
25 Q You were talking just a minute ago about a talk

Page 87

1 you gave in Puerto Rico. When was that?  
2 A May 2 or May 3 I would guess.  
3 Q What was the conference you were presenting at?  
4 A It was the Oasis Child Psychiatry Conference.  
5 Q What is the Oasis Child Psychiatry Conference?  
6 A A continuing medical education conference that is  
7 presented in different places. Basically people  
8 pay a fee and they travel to wherever it is. This  
9 one was in Puerto Rico.  
10 People like me who are experts provide talks  
11 on different things. I gave three talks at the  
12 Child Psychiatry Conference.  
13 You didn't ask me about presenting CMEs. I  
14 did present this CME talk on child, on gender  
15 dysphoria. So if you want to add that to my  
16 expertise, you can. But this was at the Oasis  
17 Child Psychiatry Conference.  
18 Q Who organizes that conference?  
19 A It's a larger, it's under the umbrella of a large  
20 organization that does many different, they have a  
21 psychiatry conference. They have a child  
22 psychiatry conference.  
23 They have many other things. I don't  
24 remember the name of the company. I don't  
25 remember the company of that organization.

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1 Q So it's, are they affiliated with a medical  
2 institution or association, or is this like a CME  
3 company?  
4 A It's like a board review CME company.  
5 Q Right. Was the topic of the conference you  
6 presented at specific to gender dysphoria?  
7 A No. The topic of the conference was specific to  
8 child psychiatry. I presented three topics.  
9 Gender dysphoria was one of the three topics.  
10 Q What were the other two?  
11 A Traumatic brain injury and social media.  
12 Q Had you presented any version of this presentation  
13 on gender dysphoria before?  
14 A No.  
15 Q Have you presented it again since May 2 or 3?  
16 A No.  
17 Q Have you presented other CMEs on gender dysphoria  
18 prior to May 2 or May 3?  
19 A No.  
20 Q Okay.  
21 A The date might be a little off. I'm not sure. It  
22 was May. It was early May.  
23 Q Okay. How many people attended your session on  
24 gender dysphoria?  
25 A There were probably sixty to eighty in the room.

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1 Q Okay. And about how many people attended the  
2 conference?  
3 A I would assume somewhere around that same number.  
4 It's also online.  
5 Q The entire conference you think was under one  
6 hundred practitioners?  
7 A Yeah. On site I would guess so. Yeah. I'm  
8 not -- it's a guess.  
9 Q Did you reach out to Oasis about this presentation  
10 or did they reach out to you?  
11 A I have spoken for them before. This was the third  
12 time that I have spoken for them. I spoke some at  
13 the adult psychiatry one contiguous with it.  
14 I have done it twice before for them for  
15 child. They have an adult and then a child  
16 conference. I spoke a little at the adult and  
17 then also the child conference this time. They  
18 request me as a speaker. They reached out to me.  
19 Q Did you discuss your involvement as an expert  
20 during your presentation?  
21 A No.  
22 Q I would assume when you say most of the  
23 psychiatrists that you speak with, and this may  
24 seem like a silly question, but you don't speak  
25 with most psychiatrists in the U.S. I take it,

Page 90

1 right?

2 A Correct.

3 Q You have stated you believe that it is

4 controversial to take the position that you take

5 regarding gender dysphoria, correct?

6 A Not controversial among psychiatrists or

7 physicians, yet controversial in the public

8 sphere. Yes.

9 Q So would it surprise you then that once you

10 express some receptiveness to this view of gender

11 dysphoria, would it surprise you then that what

12 appears to be an unusually large number of folks

13 would come to you expressing the same one?

14 A Well, mostly these are regular private

15 conversations from people that I know. It's not

16 like I was approached by the names that I gave you

17 or the people that I'm speaking about when I say

18 that child psychiatrists are afraid to talk about

19 this, but feel supportive of my approach.

20 Q Dr. Weiss, let's go to Paragraph 53 of your

21 declaration. We will scroll down a little bit.

22 MR. PATTERSON: Did you say Dr. Weiss?

23 Q Sorry. My mind is still in last week.

24 Dr. Kaliebe, you will see in this paragraph

25 you talk about social media as an influence

Page 91

1 regarding teenagers.

2 Do you think that heterosexuality is a sexual

3 identity?

4 A Could you repeat the question?

5 Q Is heterosexuality a sexual identity?

6 A Yes.

7 Q Do you believe that social media has an influence

8 in how teenagers who are heterosexual express

9 their identity?

10 A Identity, no.

11 Q You believe that teenagers who use social media

12 who are heterosexual or straight, the way they

13 express being straight is not influenced by social

14 media?

15 A It could be. It could be.

16 Q Are you familiar with the movie genre of the teen

17 rom com?

18 A Is that romantic comedy?

19 Q Right. You are generally familiar with the fact

20 that a decent amount of media television or movies

21 revolve around teenagers in high school who date.

22 Is that a fair description of a certain part

23 of American media?

24 A Yes.

25 Q Do you think that those movies and TV shows when

Page 92

1 they show straight teenagers dating, do you think

2 that that has an influence on how American

3 teenagers date or their expectations of dating as

4 straight teenagers?

5 A It could, yes.

6 Q All right. For teenagers who are not straight,

7 who have a different sexual identity, do you think

8 that media influences their expression more or

9 less than heterosexual teenagers?

10 A I would not have an opinion more or less. I'm not

11 sure.

12 Q Okay. And then do you think everyone has a gender

13 identity?

14 A I think that is an open scientific question. I'm

15 not, I would not say that that is a settled

16 question. That has been an assumption that most

17 people are going on.

18 That seems to be a common assumption. I'm

19 not sure that it is a settled scientific question.

20 Q Do you think that most people have an internal

21 sense of whether they are male or female or

22 something else?

23 A I think we are getting into nuance about internal,

24 what you mean by internal sense. Most people can

25 identify themselves as either male or female. So

Page 93

1 I would say that is correct because that does

2 exist in their brain. Yes.

3 Q When you say sense of themselves you mean as male

4 or female? We will start there.

5 A Correct.

6 Q Okay. Do you think that -- okay. In Paragraph 54

7 of your declaration you talk about the -- I'm

8 sorry. I lost my place here.

9 Yes. In Paragraph 53 you talk about

10 Dr. Weigle's publication in the Psychiatric

11 Times.

12 Do you see that about three lines up from the

13 end of Paragraph 53?

14 A Yes.

15 Q Is the Psychiatric Times a peer reviewed journal?

16 A No.

17 Q Dr. Kaliebe, in Paragraph 54 you say -- in

18 Paragraph 55 you say in my opinion --

19 MR. SELDIN: Joel, can you scroll down to

20 Paragraph 55, please.

21 Q You say, "In my opinion, technological,

22 ideological, and social factors underlie much of

23 the recent increase in gender dysphoria in

24 adolescents."

25 Do you see that?



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1 A Yes.

2 Q We will take a look at your report in Decker.

3 MR. SELDIN: Joel, will you pull that up?

4 That is Exhibit 4, Paragraph 44. You say there,

5 "It is plausible and probable that ideological and

6 social factors underlie the increase in gender

7 dysphoria."

8 Do you see that?

9 A Yes.

10 Q My question is in this earlier report in Decker

11 you said it's plausible and probable that

12 ideological and social factors underlie the

13 increase.

14 Then in your declaration here you say, "In my

15 opinion technological, ideological, and social

16 factors underlie much of the recent increase in

17 gender dysphoria in adolescents."

18 My question is, is this two ways of saying

19 the same thing? Or are you holding this opinion

20 to a different degree of certainty from April to

21 now?

22 A I guess it was just the -- it seems to me that I'm

23 pretty much saying the same thing on both

24 occasions. I'm just perhaps fine tuning it. I

25 don't know that it really adds more or less

Page 95

1 certainty, the change.

2 Q All right. In the Decker report you said it is

3 plausible and probable that ideological and social

4 factors underlie the increase in gender dysphoria.

5 Is it fair to say then that you are not sure,

6 but this could be true?

7 A Well, I'm saying it is probable. So, yeah, I

8 mean, I think in either case, you know, if it's my

9 opinion, I think the -- I mentioned it is

10 plausible because of it's so, you have had such

11 panic in the academic community when there has

12 been talk of social contagion that it's, you know,

13 it has been really remarkable how people have

14 fought against the idea that there possibly are

15 social or online influences driving these things

16 or having a large influence.

17 That is why I put in the word plausible there

18 because there are academics who are saying that

19 it's not plausible. But I think it is an

20 extraneous word, so I did not use it in the next

21 report.

22 Q As a general matter, would you expect teens who

23 had something in common to find each other online?

24 A Yeah, they could. Yes.

25 Q And would you generally expect that small

Page 96

1 populations that tend to otherwise be isolated

2 would find each other online?

3 A Yes.

4 MR. SELDIN: Joel, will you take us to

5 Paragraph 57, please.

6 I'm sorry. Can you take us back to

7 Exhibit 1 and then go to that Paragraph 57. I

8 apologize.

9 Q Dr. Kaliebe, in Paragraph 57 you provide what you

10 call, "A prescription for open exchange and

11 deliberate consideration regarding gender

12 dysphoria treatments..."

13 Do you see that?

14 A Yes.

15 Q Where does that prescription come from?

16 A Well, I don't know exactly where it comes from. I

17 feel like it's an amalgam of thoughts that come

18 from John Haidt, who I cited just below. He is a

19 public intellectual who has commented about group

20 think, the squashing of opinions within academia.

21 He is a social scientist. That is in part from

22 him.

23 It is in part from Jonathan Rauch, who

24 wrought a book called The Constitution of Ideas,

25 which is a quite thoughtful recent book that lays

Page 97

1 out, I think, even a list of something similar.

2 This could come from Jonathan Rauch.

3 Steven Pinker has written extensively on this same

4 topic and the importance of rationality and the

5 importance of a dialogue of ideas.

6 You could take this as far back as

7 John Stuart Mill, who was originally one of the

8 originals who sort of brought forth a lot of our

9 ideas that underpin what some people call liberal

10 science or scientific exchange today.

11 So this list is a time tested list and it's

12 reflecting of much of the underpinning of how we

13 have achieved, you know, science and moved

14 knowledge forward.

15 As Jonathan Rauch talked about in his book,

16 there is no one person who has a monopoly on the

17 truth. We get to the truth by exchange, which is

18 conflict, and we need that in order to understand

19 both our opinions better and the opinions of

20 others. And each of us, hopefully, with this

21 conflict will help us all get closer to the

22 truth.

23 So I know that was a long answer for where

24 that list comes from. I'm pretty sure if I looked

25 in those sources I could find a list that is

Page 98

1 similar. I don't know exactly where it comes  
 2 from.  
 3 Q Have you evaluated any other areas of medicine  
 4 that you believe have a credible evidence base to  
 5 assess whether this prescription was followed?  
 6 A Well, I believe in a lot of medicine these things  
 7 are broadly followed. So, yes, I believe in many  
 8 places we have a rigorous scientific exchange on  
 9 multiple matters within medicine. Yes.  
 10 Q I guess, have you personally examined any  
 11 particular treatment in the field of medicine to  
 12 say I wonder if they follow this prescription and  
 13 have done this analysis?  
 14 A Yes. I think that the best example -- there are  
 15 many examples, but I think the scholarly exchange  
 16 regarding antidepressant medications is really a  
 17 prime example of how we have a robust exchange of  
 18 ideas.  
 19 Q At the end of that robust exchange of ideas that  
 20 you believe took place with antidepressants, did  
 21 any state ban the use of antidepressants in  
 22 minors?  
 23 A No.  
 24 Q Okay. Do you think they should have?  
 25 A No.

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1 Q Is that an area with what we know now about  
 2 antidepressants where you think individual  
 3 clinicians have sufficient guidance to make  
 4 decisions about their particular patients?  
 5 A I think that we still are affected by some  
 6 distortions of that scholarly dialogue in the  
 7 past.  
 8 It's in my report regarding undue influence  
 9 of pharmaceutical companies which have swayed  
 10 people in a different direction. Thankfully,  
 11 there was enough rigor and enough people took  
 12 interest, although, it took outside pressure  
 13 because it was the lawsuit asking for a release of  
 14 full information that helped lead to that.  
 15 But, yes, at this point those who are looking  
 16 can find a rigorous dialogue of ideas and make  
 17 decisions for themselves.  
 18 Q Do you think that that evolution would have  
 19 benefited from a ban on the use of antidepressants  
 20 in any population while it took place?  
 21 A No.  
 22 Q In Paragraph 58 you say, referring to this  
 23 prescription, "This framework would depersonalize  
 24 the search for truth and esteemed empirical  
 25 dialogue, which has been in short supply on

Page 100

1 numerous topics within academia."  
 2 Do you see that?  
 3 A Yes.  
 4 Q What are the other numerous topics you are  
 5 referring to here?  
 6 A I think in general many of our academic  
 7 institutions and professional organizations  
 8 included have gotten behind ideas of social  
 9 justice.  
 10 I think social justice ideas at some point,  
 11 you know, may or may not reflect the truth. So if  
 12 your goal is social justice, it can bump up  
 13 against rigorous science.  
 14 So I would say that in general that would be  
 15 the one good example.  
 16 Q Which social justice topics do you think are  
 17 bumping up against empirical science?  
 18 A Well, it could be any number of them. I think  
 19 this is a case in point. So I think this is part  
 20 of why it's in my report.  
 21 Rather than being seen as a dialogue related  
 22 to what is the science and ensuring a rigorous  
 23 scientific dialogue, it has been treated as if  
 24 it's a social justice issue rather than an issue  
 25 of what is good medical practice.

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1 But I think, you know, the issues related to  
 2 hot button topics, race would be one.  
 3 Q In what way?  
 4 A Well, I think that when -- I think that after  
 5 George Floyd's murder and other events that there  
 6 has been, but that in particular, there was a call  
 7 for a special influence on matters of race. Which  
 8 is a great thing for people to be more attune to  
 9 and to have scholarly dialogue.  
 10 But they asked for a certain viewpoint. I  
 11 think a good example is Ibram Kendi's, you know,  
 12 antiracism sort of viewpoint on it to be put  
 13 forward as the way that we are supposed to handle  
 14 it.  
 15 So a lot of our journals, in fact, the Child  
 16 Psychiatry Journal, they declared itself an  
 17 antiracist journal, which is joining an ideology  
 18 on how to approach race, rather than calling for  
 19 more open and rigorous dialogue about race, which  
 20 would have been the more appropriate viewpoint for  
 21 a medical journal.  
 22 Q I think you just described antiracism as a  
 23 particular ideology about race.  
 24 What are the other ideologies about race that  
 25 you believe exist?

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1 A Well, like I said, I don't have a countervailing  
2 ideology of it. Like I said, the journal in our,  
3 in child psychiatry declared itself to be an  
4 antiracist journal, which is an affiliation with  
5 that ideology.  
6 I'm actually against affiliations with  
7 ideology. I don't know that there is a  
8 counter-ideology. We prefer it to just be a  
9 rigorous scientific dialogue about important  
10 issues. That is what we would be aiming for if  
11 you follow the prescription that I've laid out  
12 here.  
13 Q Are there any particular principles in antiracism  
14 as an ideology that you think are antithetical to  
15 the search for the truth or scholarly dialogue  
16 that you think that journal should have  
17 undertaken?  
18 A Well, I didn't, you know, I'm not prepared to go  
19 into a, you know, in depth into that. I would say  
20 there's a, there are some broad narratives about  
21 the world included in that, which is that certain  
22 groups are oppressors and other groups are  
23 oppressed.  
24 That would be a primary narrative that is,  
25 can be accurate. But yet we would have to be

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1 nuanced about how we approached those things and  
2 that we should be very careful to make  
3 generalizations especially in the realm of  
4 science.  
5 The more broad your generalization, the more  
6 likely that you are over inclusive and  
7 overgeneralizing. And so that would be the  
8 oppressor versus oppressed narrative, that would  
9 be a good example.  
10 Another example of that would be the whole  
11 idea of race being codified into a more important  
12 marker of people's identity. Whereas, it's not  
13 actually a very scientific idea. It is a really  
14 complex idea.  
15 People come from different backgrounds and  
16 origins. You know, where do you draw the line?  
17 How do we sort of determine this? And what do you  
18 do about mixed race couples? What do you do about  
19 people who look like they are one race, but they  
20 are the other? I mean, it's very complex.  
21 So the broader narratives embraced are  
22 problematic when you come to, when you come to  
23 science. Then, also, it's a call for, I mean,  
24 when editors call for a certain viewpoint, once  
25 again, I just think that that is not what any job

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1 of an editor or a journal would be.  
2 They can call for more viewpoints and  
3 discussions which would be great, but not to call  
4 out or prefer a certain viewpoint.  
5 Q Do you think there are any viewpoints about race  
6 that journals should not seek to include?  
7 A Well, I think that there, I think that certainly  
8 you are not going to, you know, considering where  
9 the dialogue is and who would be writing to  
10 psychiatry journals, you are only going to have  
11 thoughtful academics writing in and trying to talk  
12 about a nuance.  
13 So not within the, not that I, not that a  
14 psychiatrist would write into a journal. I find  
15 it would be highly unusual that there would be any  
16 idea written in or someone who would submit for an  
17 article that would be outside of the bounds of  
18 what would be acceptable dialogue.  
19 I would say maybe, you know, in theory there  
20 could be. In practice, there is not.  
21 Q Do you believe that there is, as a normative  
22 matter, a view on race that a psychiatrist could  
23 seek to present to a journal that without  
24 hampering the search for truth the journal could  
25 say that is actually outside of the bounds of

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1 discussion?  
2 A Well, if they were overgeneralizing, which is  
3 exactly what I'm talking about. Yes, so. I'm  
4 against people overgeneralizing.  
5 So a journal editor should knock down any  
6 article that overgeneralizes.  
7 Q Dr. Kaliebe, in the middle of Paragraph 62 in your  
8 declaration you say, "Supporters of  
9 gender-affirming treatment want to believe they  
10 have found an ethical and evidence based  
11 solution."  
12 Do you see where you wrote that?  
13 A Yes.  
14 Q What do you think is unethical about  
15 gender-affirming treatment?  
16 A Well, gender-affirming treatment as an actual  
17 clinical treatment can do harm. So I think it is  
18 unethical to do harm.  
19 Q What harm do you think it does?  
20 A Well, when you are asked to evaluate a child or an  
21 adolescent, they need to be seen in the context of  
22 a total individual and their total environment.  
23 You would have a biopsychosocial formulation.  
24 They are in the process of identity development.  
25 So to see someone through just the lens of

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1 affirming can be harmful and can turn the  
2 discussion just towards gender identity or gender  
3 dysphoria rather than away from the traditional  
4 way that you would approach a patient.  
5 So it's trying to, it is, I believe it's poor  
6 medical care to move to affirming automatically  
7 patients who present with gender identity issues  
8 or gender dysphoria.  
9 Q So is the harm from the diagnosis of gender  
10 dysphoria, or from the possibility that the  
11 evaluation process does not discover other  
12 co-morbid conditions?  
13 A There is not a problem with the diagnosis of the  
14 gender dysphoria. But there is a problem with an  
15 overemphasis on one component of people's identity  
16 and a turning away from the typical therapeutic  
17 approach which we have always used which does not  
18 jump towards affirmation, but lets a person  
19 develop in their own way and would be broadly  
20 based and notice what is the context, what other  
21 disorders, what else is going on, what traumas  
22 have occurred, you know. What other family issues  
23 are going on?  
24 So, yes, I feel like that when this is  
25 proposed as a way to approach these patients, that

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1 it distorts care away from what would be a proper  
2 and traditional psychiatric approach.  
3 Q Do you think that the care can be ethical if all  
4 of the traditional psychiatric or  
5 psychotherapeutic approaches that you are  
6 referencing had already happened or are happening  
7 concurrently?  
8 Could then treatment that is gender-affirming  
9 be ethical?  
10 A Well, if you are -- yes, it could be. It could be  
11 if they have had a proper workup and have, you  
12 know, that that is the approach that the clinician  
13 has decided after working with the patient for a  
14 long period of time.  
15 But I'm talking about a psychotherapy  
16 approach. I assume that is what you are talking  
17 about, too. When you say gender-affirming care  
18 that can include medicalized care.  
19 I want to be clear. I'm not talking about  
20 medicalized care. I think we are talking about  
21 therapy and therapeutic approaches.  
22 Q I think we will talk about both. For  
23 psychotherapeutic approaches you believe it is  
24 possible to provide gender-affirming  
25 psychotherapeutic approaches to minors who are

Page 108

1 experiencing gender dysphoria, is that fair?  
2 A Well, you could get to it after providing  
3 appropriate care, you know. Would there be a  
4 place down the road where you could decide that,  
5 you know, and I'm not quite sure what exactly you  
6 are meaning by affirmative care, but I assume you  
7 mean for, like, going along with the patient's  
8 conceptualization of what is going on, which would  
9 not be what we usually do in mental health.  
10 We usually remain neutral about what is going  
11 on rather than joining a patient's  
12 conceptualization.  
13 If at the end of the day, you know, would  
14 that mean is it okay for a clinician to use the  
15 pronouns that are requested by a patient, then I'm  
16 saying, yes. You know, that is perfectly  
17 reasonable and under certain circumstances, you  
18 know, yes.  
19 But is it appropriate to ever completely go  
20 along with the patients' narratives or views of  
21 the world so that is, you know, a clinical  
22 decision that maybe you could get to.  
23 MR. SELDIN: We have been going for  
24 another hour. I think most of the folks here are  
25 on East Coast time.

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1 Do we want to take a short break now and  
2 then go for an hour and then do lunch? How are  
3 folks feeling?  
4 Dr. Kaliebe, will you be okay with a five  
5 minute break and then another hour?  
6 A I will do whatever the group wants.  
7 MR. SELDIN: Let's do that. We will come  
8 back at 12:27 Eastern.  
9 (OFF RECORD AT 12:21 P.M.)  
10 (AT THIS TIME A SHORT RECESS WAS HELD OFF  
11 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS  
12 WERE HAD:)  
13 (ON RECORD AT 12:27 P.M.)  
14 BY MR. SELDIN:  
15 Q Dr. Kaliebe, welcome back after that short break.  
16 In Paragraph 65 you describe a dynamic, "In  
17 fact, sophisticated language skills enable  
18 virtuosity in creating and promoting false  
19 narratives."  
20 Then you go on to say, "These dynamics have  
21 arisen before in medicine, and it is my assessment  
22 this has occurred again with regards to medical  
23 interventions to treat gender dysphoria in  
24 minors."  
25 Do you see that?

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1 A Yes.  
 2 Q What is your methodology for assessing that that  
 3 has happened here?  
 4 A Well, I think if you look at a lot of the journal  
 5 articles, the press releases from national  
 6 organizations, the sort of what I would call  
 7 cheerleading for affirmative care, that it seems  
 8 to be that it's like a, more of a tribal dynamic  
 9 than an actual usual discussion, a very complex  
 10 nuanced evidence based and a new treatment  
 11 population.  
 12 Within that environment clearly there is some  
 13 who are, I believe, very caught up in a group  
 14 think regarding these issues. So I can give you  
 15 more details. But basically, the things that I  
 16 put in my report sort of speak for themselves.  
 17 The way the professional organizations are  
 18 framing their arguments, the way the people write  
 19 the guidelines all speak to a moralized type of  
 20 environment rather than the usual dialogue  
 21 regarding medical evidence.  
 22 Q Is your primary concern the consensus or the  
 23 enthusiasm?  
 24 A Well, the false consensus is definitely a problem  
 25 because they are, without really undergoing the

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1 standard academic debate, they are sort of  
 2 pretending like there is a consensus and this is  
 3 all settled science.  
 4 Then the level of enthusiasm is also very  
 5 problematic because the level of enthusiasm should  
 6 be proportional to your confidence in your  
 7 argument and the safety of your argument.  
 8 So when people are coming out very  
 9 enthusiastic for something that, you know, is not  
 10 settled and unclear clinically, that then,  
 11 those -- so I would believe those are both  
 12 problems.  
 13 Q Then you say that these dynamics have arisen  
 14 before in medicine.  
 15 When have they arisen before?  
 16 A Well, when for a time lobotomies were popular and  
 17 were sort of celebrated as curing a very difficult  
 18 patient population with serious problems.  
 19 The person, you know, won the Nobel Prize for  
 20 lobotomy. In retrospect it sounds horrible, but  
 21 that is an example.  
 22 I think your, I mean, I think whenever you  
 23 have intermixing of moralized environments -- on  
 24 the flip side you could also say, like,  
 25 pronunciations against, you know, making

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1 heterosexuality a disorder in the DSM would rise  
 2 from moralized environments where people took what  
 3 should be a scientific or medical issue and turned  
 4 it into a disorder based on social or cultural  
 5 elements.  
 6 Q So with your homosexuality example, do you think  
 7 the moralizing environment led to its inclusion in  
 8 the DSM or its removal from the DSM?  
 9 A Inclusion in the DSM.  
 10 Q Do you agree with its removal from the DSM?  
 11 A Yes.  
 12 Q Okay. In Paragraph 66 you talk about emotional  
 13 reasoning. In the last sentence you say that it  
 14 "helps explain opinion cascades, partisanship, and  
 15 group think."  
 16 Do you see that?  
 17 A Yes.  
 18 Q Those are terms that come from sociology, is that  
 19 correct?  
 20 A I mean, there's a, they -- I'm not sure exactly.  
 21 They jump from field to field. So you can get  
 22 those terms in a number of different fields.  
 23 Behavioral economics is a field that uses  
 24 those terms. You know, we do talk about them some  
 25 in medicine, too. Yes, I believe sociology and

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1 behavioral economics would be the, would be where  
 2 I found them.  
 3 Q Is it fair to say these are not conditions that  
 4 you diagnose as a psychiatrist?  
 5 A Behavioral economics was sort of founded by a  
 6 psychologist. The only psychologist who won the  
 7 Noble Prize, Daniel Kahneman, so it's within the  
 8 realm of people who are experts in how the mind  
 9 works and how we make decisions.  
 10 Is it directly psychiatric? I think it's  
 11 important for you to size up the person in front  
 12 of you and where they get their information and if  
 13 they have cognitive distortions related to groups,  
 14 you know, and the information that comes to them  
 15 in groups they affiliate with.  
 16 I think modern psychiatrists should  
 17 understand and know these things.  
 18 Q Do you think you have expertise beyond that of a  
 19 well-trained psychiatrist to assess whether  
 20 opinion cascades, partisanship, and group think  
 21 are occurring?  
 22 A Well, I think I was mentioning that I would hope  
 23 that all psychiatrists should understand these  
 24 phenomenon and be able to see when they may apply.  
 25 Q Do you, yourself, believe above that level that

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1 any psychiatrist should have, do you believe you  
2 have particular expertise in identifying when  
3 these things are happening?  
4 A Well, I put in a lot of work. As I mentioned in  
5 my report, I did present on misinformation at the  
6 child psychiatry conference. If you look at some  
7 of my articles, like my article on child obesity,  
8 I bring in a lot of the ideas related to  
9 behavioral economics and how to approach the world  
10 and how we, how human beings tend to fool  
11 themselves.  
12 Yes, I probably put in more work than other  
13 psychiatrists on these matters.  
14 Q Okay.  
15 A I will say I read a lot. So, you know, I probably  
16 read a lot more than almost any psychiatrist that  
17 you will talk to.  
18 So, yes. I do pull from lots of different  
19 things, but I think that what I'm pulling from  
20 here is important and most psychiatrists  
21 understand these dynamics.  
22 Q Doctor, look at Paragraph 79. Dr. Kaliebe, in  
23 this paragraph you are talking about the opioid  
24 epidemic.  
25 On the bottom of Page 27 there is a sentence

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1 that starts, "While a small number of patients may  
2 have achieved better pain control as a result, it  
3 came at the cost of creating legions of addicts."  
4 Do you see where you wrote that?  
5 A Yes.  
6 Q And so is it fair to say that you have identified  
7 opioid prescription as an area in which providers  
8 were practicing either outside of the guidelines  
9 or recklessly?  
10 A Well, what I was saying was, in fact, the  
11 guidelines were pushing them towards, they were  
12 exerting pressures on them to prescribe  
13 inappropriately.  
14 So, no, you know, this was my whole point.  
15 You get, you get ideas that come from, you know, a  
16 small group, yet then can get taken up and become  
17 popular. Especially when you have the idea of you  
18 are being more compassionate so this is the right  
19 thing to do. You are a bad person to ignore  
20 someone's pain without realizing at the end of the  
21 day these are complex matters and you can do harm  
22 by opioid prescribing.  
23 I believe that was pretty clear in what I  
24 wrote.  
25 Q Do you believe that the treatment of gender

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1 dysphoria like the treatment of pain is a complex  
2 area?  
3 A Yes.  
4 Q Okay. And in response to the opioid epidemic, the  
5 states have implemented greater controls, is that  
6 fair to say?  
7 A Yes.  
8 Q But they have not banned them entirely?  
9 A Correct.  
10 Q Dr. Kaliebe, before the break we sort of talked  
11 about, we touched on this and I want to dig a  
12 little deeper.  
13 So you say in Paragraph 83, you talk about  
14 "affirmative treatment." You put that in quotes.  
15 What is affirmative treatment?  
16 A Well, I believe it has two major components. I  
17 mean, one would be the idea that when someone  
18 presents with -- well, specifically we are talking  
19 children and adolescents here.  
20 If a child presents and declares a gender  
21 identity that the clinician should agree with that  
22 identity. That is one component.  
23 And then the other part of affirmative  
24 treatment is medicalized treatment such as puberty  
25 blockers, hormones, and surgeries.

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1 Q Where do you get that definition from?  
2 A Of affirmative treatment?  
3 Q Yes.  
4 A I mean, I have seen much more complex descriptions  
5 of affirmative treatment. I think that is what it  
6 boils down to.  
7 Q You say in Paragraph 83 there is a push for  
8 affirmative treatment.  
9 How do you think the groups that you list in  
10 this paragraph are pushing the treatment?  
11 A Well, if you look at the guidelines from WPATH, I  
12 think those are clear. The Endocrine Society and  
13 the American Academy of Pediatrics came out with  
14 guidelines that specifically advocate for them.  
15 American Psychiatric Association has, I  
16 believe, they didn't come out with treatment  
17 guidelines, but they have come out in support of  
18 it in multiple ways, press releases, stuff on the  
19 website, publicity things and in their journals.  
20 So there's, you know, the way that they  
21 selected articles and the articles that they  
22 publish all, they all seem to reflect an idea that  
23 those are the, that this is the approach that they  
24 favor as institutions.  
25 Q When you say push for affirmative treatment, do

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1 you mean just the organizational support around  
2 the existing guidelines?  
3 Or do you mean push for affirmative treatment  
4 at the individual level?  
5 A Well, it seems clear to me that they want us to  
6 adopt this as treatment.  
7 Q And what is your basis for saying that this kind  
8 of care is politicized?  
9 A Well, I think, for one, if you look at a survey,  
10 opinions about these matters tend to clump in  
11 lines that go along political affiliation.  
12 So for one, it's just a fact that is based on  
13 the surveys. There has been a number of surveys.  
14 It tends to be that people who are in, you know,  
15 in one political party have certain feelings about  
16 this and people in another political party have  
17 certain feelings about this.  
18 So I cited a Regenerist article that did  
19 questions after people came out of polls. That  
20 was sort of a direct peer view published line of  
21 that evidence. There have also been a number of  
22 opinions polls.  
23 The political parties, you know, have, I  
24 don't know that the, I don't know if the, to what  
25 degree the Republican party has come out, you

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1 know, with strong statements or push for these  
2 things. But if my memory serves me correctly,  
3 their administrative, I mean, political parties,  
4 whoever is in political power has some control  
5 over administrative issues.  
6 So, I mean, I think that some aspects of the  
7 general idea or rights for transgender individuals  
8 is a politicized idea. So I think that that is  
9 where I say that. I would also say that if you  
10 look at the organizations -- I put some data in  
11 there.  
12 These organizations, particularly the  
13 psychiatric ones, and the American Academy of  
14 Pediatrics, I could say that for sure, too, tend  
15 to be a left-leaning organization. They tend to  
16 support politics that are, you know, to the left  
17 of the center.  
18 And also it's true if you will look at just  
19 even polls of who in what medical specialty aligns  
20 with what political party. One of the polls I saw  
21 had psychiatry was second to the most left-leaning  
22 of all of the specialties with only public health  
23 being more left-leaned.  
24 So not surprising that the professional  
25 organizations follow the politics of the members

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1 that tend to lean in one direction. That is -- I  
2 put examples in my report.  
3 Q Based on that definition of certain kinds of care  
4 being politicized, do you think that as a  
5 clinician that is a reason to provide or not  
6 provide certain kinds of care?  
7 A Well, I think that it is not a reason you should  
8 be providing care based on what is good care. But  
9 it could make you more skeptical of these  
10 professional organizations' support for certain  
11 care because you know that they come out and  
12 support things that happen to lean in their  
13 political or within their, you know, thought  
14 level. They are very accepting of things that  
15 are, in that case, left-leaning.  
16 Therefore, they are susceptible to  
17 confirmation bias, group think, group dynamics  
18 that would lead them to move away from a  
19 scientific, more clinical approach towards an  
20 ideological approach.  
21 Unfortunately, I put in my report that is  
22 what I feel has occurred.  
23 Q Are there other areas of psychiatry where you  
24 think the political alignment of psychiatrists or  
25 their organizing groups has negatively influenced

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1 care?  
2 A Yes and no. I mean, there are different  
3 priorities that the organizations have. I mean,  
4 my priority and what I was trying to push for  
5 within the American Academy of Child and  
6 Adolescent Psychiatry and the American Psychiatric  
7 Association with some of the articles that I wrote  
8 and, you know, supporting in meetings, was a  
9 collaborative care, particularly working in  
10 federally qualified health centers.  
11 So what I would love to see is for them to  
12 put an emphasis on getting primary care support to  
13 deal with mental health issues. Getting an  
14 emphasis on us growing more federally qualified  
15 health centers which are primary care clinics that  
16 provide like WIC and dental and, you know, mental  
17 health care to communities. You can only open an  
18 FQHC if you are an underserved or disadvantaged  
19 community.  
20 So that is what I was pushing for us to do.  
21 We do do that some as an organization, push for  
22 that. I just feel like that would be a much  
23 better priority for an organization. So  
24 unfortunately, you know, they seem to be more at  
25 times interested in other things rather than what

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1 I think would be the most helpful approach.  
 2 It seems that sometimes the other things that  
 3 they are interested in are things that are hot  
 4 button political items rather than the actual, a  
 5 great thing you can do like supporting primary  
 6 care in disadvantaged neighborhoods.  
 7 Q So relative ranking of priorities aside, is there  
 8 any individual kind of care in psychiatry that you  
 9 think is being provided and should not be because  
 10 of the political alignment of psychiatrists or the  
 11 organized medical groups?  
 12 A No. I think gender medicine has been the first  
 13 time that this type of ideological care has  
 14 actually come in and affected, you know, patient  
 15 care on a wide level. Yeah. I have never seen  
 16 that before.  
 17 Q In Paragraph 84 you say in the third sentence, "I  
 18 have directly observed over the last decade, but  
 19 particularly the last 5 years, that these  
 20 organizations have prioritized a politicized,  
 21 narrow vision of social justice advocacy."  
 22 Do you see where you wrote that?  
 23 A It is kind of cut off at the bottom. Yes. I  
 24 remember writing it.  
 25 Q Other than what you just called gender medicine,

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1 what else have you directly observed in the last  
 2 five years that falls into this category?  
 3 A Well, I think we talked about race, so I think  
 4 that is an issue that, you know, while an  
 5 important issue and I'm glad that they want to  
 6 emphasize it, the way that they have emphasized  
 7 that has also has been very, it has been  
 8 politicized. And the sort of policing of, or the  
 9 curation of what goes in the journal, at least of  
 10 the psychiatric organizations, does seem to be  
 11 very narrow.  
 12 But that would be the other main thing that I  
 13 can think of. There are probably more. That is  
 14 what I can think of right now.  
 15 Q When you referenced just now narrow curation, are  
 16 you talking about articles regarding the treatment  
 17 of gender dysphoria or something else?  
 18 A Something else. I'm saying I do believe they do  
 19 that. But since I was asked about what else is  
 20 sort of politicized and the social justice, we  
 21 spoke before about how they have come out with  
 22 becoming antiracist journals rather than just  
 23 saying we would like to focus more on race. Race  
 24 is a really important topic. It is an important  
 25 component of what goes on in society.

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1 Q Let's look at Paragraph 85 and 86 together.  
 2 Dr. Kaliebe, you talk about your time  
 3 co-chairing -- is AACAP the way you say that?  
 4 A Yes. People say AACAP.  
 5 Q When you co-chaired AACAP's media committee, it  
 6 seemed like in Paragraph 86 you characterize that  
 7 as a committee of content experts, is that fair?  
 8 A Yes. Yes.  
 9 Q And then in Paragraph 85 you are talking on the  
 10 second line about special interest groups. You  
 11 put that in quotes.  
 12 Do you see where you wrote that?  
 13 A Correct.  
 14 Q Is there a difference between special interest  
 15 groups and content committee and content?  
 16 A Well, I was trying to differentiate that there are  
 17 groups of people that do, that are attracted  
 18 towards certain approaches. And so they could be  
 19 a group of people that are not officially a  
 20 committee.  
 21 So you could self-select in more ways than  
 22 one. The committees are vehicles within the  
 23 professional organizations.  
 24 Q What I'm trying to get at, your concerns about  
 25 group think and opinion cascades, do you think

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1 that was in affect when you were co-chairing the  
 2 AACAP committee on media?  
 3 A Yes and no. I think in the media committee we  
 4 were always mindful to bring in diverse opinions  
 5 of people. So we didn't want -- there are a lot  
 6 of people who are generally negative about the  
 7 media. They would want to present or talk about  
 8 media in negative ways.  
 9 We were very conscious that humans seem to  
 10 have a negativity bias and negative stuff gets  
 11 noticed more. There are also positives with  
 12 media. We are trying to cultivate in our  
 13 presentations and in our output a balanced look.  
 14 So, you know, I don't think by any estimation  
 15 anyone would think that our committee became  
 16 one-sided or too, you know, too negative. But  
 17 once again, you deal with clinical issues. So  
 18 there is always some bias towards negative. That  
 19 is something that we were cognizant about.  
 20 Q Are there other committees in AACAP that you feel  
 21 didn't do as good a job providing that kind of  
 22 balanced view other than the ones dealing with the  
 23 treatment of gender dysphoria?  
 24 A Well, I think I had mentioned previously that at  
 25 one point those who wrote -- or had in my



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1 report -- that those who wrote the pharmacology  
2 guidelines were overly enthusiastic, influenced,  
3 or excited or however you want to say it,  
4 regarding psychopharm.  
5 So I think at times any of these committees  
6 can be somewhat overconfident or have opinions  
7 that lean towards interventionalism towards  
8 whatever intervention that the committee is about.  
9 So I think that, yes, you know, the  
10 psychopharmacology committee would tend to be too  
11 much focused on psychopharmacology from the  
12 perspective of a regular psychiatric practitioner  
13 that has to take the different patients and use  
14 all sorts of different modalities and not just  
15 pharmacology.  
16 The group dynamics have some affect on the  
17 other committees. I mean, I would probably guess  
18 that, or it is possible that there is some other  
19 committees that they also may interact with. I  
20 have not been to the, I think it's, like, I will  
21 probably mess up the name. I think there is,  
22 like, a race and diversity committee.  
23 Is it possible that they would be, you know,  
24 could that committee be overly politicized? It is  
25 possible.

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1 Other than the gender committee I have never  
2 seen it affect clinical care in this way.  
3 Q Dr. Kaliebe, at the end of Paragraph 87 you  
4 characterize the group that works in the area of  
5 gender dysphoria as "a well-intentioned but  
6 homogenous group of supporters."  
7 What do you mean by homogenous?  
8 A I am talking about at the beginning of the  
9 paragraph, they have self-selected into providing  
10 this type of care and are enthusiastic about it.  
11 And so when you have a group of like-minded  
12 individuals that support it without really a --  
13 more skeptical people end up not being on that  
14 committee. So that is my impression.  
15 Q Just to describe a similar dynamic, the  
16 psychopharmacology committee, that they would have  
17 bias toward intervention using certain kinds of  
18 medication, is that also what you mean by -- would  
19 homogenous be a way to describe that as well?  
20 A Yes.  
21 Q Okay. Would you generally agree that a group of  
22 people that have a special interest in a topic  
23 is -- I guess, what I'm trying to ask you is when  
24 you were the chair of AACAP's media committee, did  
25 that committee benefit from the fact that its

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1 members had a special interest in media issues?  
2 MR. PATTERSON: Objection. Assumes facts  
3 not in evidence.  
4 You can answer.  
5 A Yes.  
6 Q Generally speaking, in your evaluation of group  
7 dynamics, if you have a small committee you would  
8 prefer folks who were interested in the topics  
9 rather than disinterested, correct?  
10 A Well, no. I would give some nuance to that. I  
11 mean, I would really love to see -- I actually  
12 thought that it probably would be really quite  
13 helpful for -- let's go back to the  
14 psychopharmacology committee -- for there to be  
15 some, like, regular bread and butter practitioners  
16 on that committee so that the committee would be  
17 mindful of what is happening in the real world and  
18 how, you know, their proclamations on, you know,  
19 medications play out.  
20 You know, especially as I've served in  
21 disadvantaged and underserved communities, you  
22 know, the idea that there is a medication solution  
23 for people's problems, you know, the guidelines  
24 were very heavy into pharmacologic, you know,  
25 solutions. And it just is not, it's just

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1 unrealistic on a massive level.  
2 No, I think it would be best if there was a  
3 way to make sure that there is broad inclusion of  
4 people. But in reality, that is not how  
5 committees are formed. It is people that tend to  
6 be enthusiasts.  
7 So I think there is some advantage to people  
8 being enthusiasts, but I think there are  
9 disadvantages, too. You know, as I mentioned the  
10 psychopharmacology example, you know, it would be  
11 nice for there to be a counterbalance of people in  
12 the field who are not so enthusiastic.  
13 Q Do you think that is true for every field?  
14 A Yes.  
15 Q Dr. Kaliebe, in Paragraph 89 you talk about  
16 watchful waiting.  
17 What do you -- is watchful waiting the  
18 approach that you prefer for treating minors with  
19 gender dysphoria?  
20 A Well, I think a component of the approach,  
21 regarding certainly medicalization-wise I would  
22 say yes. I think that would make the most sense  
23 to let people grow up and then once they, you  
24 know, are adults to make decisions about hormones  
25 and surgeries when they are fully developed

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1 humans.

2 So medicalization-wise, yes. But I think as

3 I mentioned before, I believe that it is ideal for

4 people to get other types of, you know, to have a

5 well-rounded approach to life which would include

6 a number of things and potentially psychotherapy.

7 Q And so you, in this paragraph you say that the

8 policy statement at issue from the AAP contained

9 citation errors, overstatements, and

10 mischaracterizations of the -- sorry -- you say it

11 mischaracterized the long-standing and

12 well-regarding clinical approach of watchful

13 waiting.

14 How do you think they mischaracterized it?

15 A Well, they say it right there. "Watchful waiting

16 is based on binary notions of gender."

17 I mean, to translate, that sounds like saying

18 well, those people who do watchful waiting, they

19 are just those old rubes who don't know any

20 better.

21 We're the sophisticated new people that want

22 to do this intervention. We are going to get rid

23 of that approach is what we want to do because we

24 know better now.

25 And I think that that right there kind of

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1 shows that they are failing to appreciate the

2 nuance and difficult realities of when you have a

3 developing situation and you don't know where it's

4 going to go, it's often better to not intervene

5 than to intervene and potentially do harm.

6 Q Do you agree that there are instances where not

7 intervening can actually also cause harm?

8 A Are we talking about with gender dysphoria or just

9 in general?

10 Q First, we will start in general. Do you agree

11 there are situations where the choice not to

12 intervene can also cause harm?

13 A Correct. Yes.

14 Q Do you think that there are instances in the

15 treatment of gender dysphoria in minors where

16 declining to intervene can cause harm?

17 A I would not frame it as causing harm. So I would

18 not use those words.

19 Q What words would you use?

20 A Well, I would say that the not intervening would

21 allow a patient to grow and develop. And then

22 once they have a sort of fully developed self,

23 then they can make decisions about medicalization

24 of their body.

25 So I don't, I just, I think you have got --

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1 that would be a better way to say it.

2 Q So are you aware that some of the original

3 proponents of the watchful waiting approach were

4 the Dutch and Ken Zucker in Toronto?

5 A I mean, I would step back and just say, you know,

6 watchful waiting is a term that we use in medicine

7 all of the time. It was used for decades before

8 it was adopted by gender medicine.

9 So I would say this is an old term that has

10 lots of uses in medicines. So, yes, I would, I am

11 aware that both Ken Zucker and those in the

12 Netherlands have used that approach.

13 Q Both the Amsterdam Clinic and Zucker's Toronto

14 clinic both treated adolescents with blockers

15 and hormones once they reached puberty, is that

16 right?

17 A Yeah. I mean, I don't have data about Zucker's

18 treatment protocol or what was going on there. I

19 can't speak to what treatment they were getting in

20 the clinic. The Dutch clinic has published a lot

21 of articles so we are familiar with that.

22 Q So in that respect, watchful waiting would apply

23 to prepuberty at those clinics?

24 A Correct.

25 Q And so even those proponents of watchful waiting,

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1 they still recommended medical interventions when

2 the incongruence of distress persisted into

3 puberty?

4 A Yes, I know the Dutch did. I don't know that

5 Zucker's protocol, I have not seen exactly how it

6 was treated or what his approach was.

7 Q Do you oppose social transition for minors with

8 gender dysphoria?

9 A Well, I think it's a complex subject. I think,

10 yes, in that children with gender dysphoria it

11 seems would be wise for them to be thought of as

12 children with gender dysphoria, not transgender

13 children.

14 We don't know what their, in the end

15 development is going to be, so why not, I think

16 it's most wise to keep them developing within

17 their biological sex, be honest that they are a

18 person with gender identity issues with gender

19 dysphoria.

20 They may grow up to be a transgender

21 individual as an adult. They may also grow up to

22 be not transgender as an adult. Since we don't

23 really know, why don't we more conservatively

24 approach this and not socially transition them

25 when they are young. That would be my

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1 recommendation.  
2 That being said, you know, families can  
3 decide to do whatever they want to do and, you  
4 know, I don't know that there could not be some  
5 exceptions to that recommendation. But that would  
6 be my recommendation.  
7 Q It sounds like you would agree that individual  
8 families might decide that for their particular  
9 child the appropriate way to address their gender  
10 dysphoria would be to allow them to socially  
11 transition?  
12 A Well, they do decide that. Yes. I mean, like I  
13 said, I don't think that is a wise decision. But  
14 once again, that is a family decision. Whatever a  
15 psychiatrist says cannot change what a family  
16 does.  
17 Q Would you support a ban on social transition among  
18 minors?  
19 A Well, I do think that the society has always used  
20 biological sex as the main marker of what a minor,  
21 you know, how a minor is classified.  
22 So I don't see a compelling reason to stop  
23 using biological sex as the marker which we --  
24 especially considering these are children with  
25 gender dysphoria. They are not transgender

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1 children. Right? We don't know what the end of  
2 their trajectory will be so why are we going  
3 through this at this point?  
4 Like I said, through human history the marker  
5 of biological sex has some, it has trade offs, but  
6 it has generally worked well for us. I would say  
7 that is the most sensible approach right now.  
8 Q So my question was, I guess, do you think that  
9 there should be a ban on parents taking the  
10 approach of allowing their children to socially  
11 transition prepuberty?  
12 A I don't know that I have an answer to that  
13 question because I've not thought about a ban. I  
14 have a clinical impression or what I would  
15 recommend. But I've not gone through the  
16 implications of that.  
17 Q You said that some of the children who have gender  
18 dysphoria you believe may grow up to be  
19 transgender and some may not be transgender, is  
20 that right?  
21 A Correct.  
22 Q For the children who do grow up and are  
23 transgender, do you think they will have been  
24 harmed by not being allowed to socially transition  
25 while they were children?

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1 A My guess is that we, since we never know about  
2 what will happen with any one child we can't  
3 really say if any individual would have been  
4 better or would have been worse.  
5 I would not frame it in terms of harm.  
6 Children have been growing up all through human  
7 history. We have generally not been socially  
8 transitioning them and it has not been a major, I  
9 think in general societies they have decided that  
10 not transitioning is the better trade off.  
11 So continuing with that approach seems wise  
12 until we know better.  
13 Q What do you base that statement on, that  
14 assessment of the trade off?  
15 A Well, for one, through all of human history we  
16 have used biological sex as a main marker where  
17 we, how we divide children.  
18 Children with gender dysphoria do have a  
19 harder time and are going to have significant  
20 problems. I think it's one of those issues of,  
21 like we often have in medicine where there is  
22 only difficult choices. There is no easy choice  
23 and no, like, clear that this is going to lead to  
24 some great solution.  
25 However, since we know so many of these kids

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1 will grow up to be -- like I said, I consider them  
2 children with gender dysphoria. I do not consider  
3 their identity to be fixed. I would like everyone  
4 to have the opportunity to grow up and then become  
5 an adult and then decide about what their identity  
6 is.  
7 Q What do you base that statement on that most of  
8 the children with gender dysphoria do not grow up  
9 to be transgender?  
10 A That has been traditionally the data, that most  
11 childhood onset gender dysphoria children grow up  
12 and are typically, more likely the adult outcome  
13 is being a same sex attracted adult.  
14 Q Is that a particular study you are thinking of  
15 when you say that?  
16 A I have seen it referenced many times.  
17 MR. SELDIN: Joel, will you take to us  
18 Paragraph 91.  
19 Q Dr. Kaliebe, in this paragraph you talk about  
20 political activisms around laws pertaining to  
21 gender-affirming care.  
22 Do you see that?  
23 A Yes.  
24 Q You characterize it as political activisms.  
25 Do you think it's political advocacy for

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1 endocrinologists who treat diabetes to take a  
 2 position on the affordability of insulin?  
 3 A No.  
 4 Q Why not?  
 5 A Well, that is not an issue that aligns with any  
 6 particular politics. I have not seen any data  
 7 that makes me think that Republican  
 8 endocrinologists and Democrat endocrinologists see  
 9 that differently. So, once again, it would not be  
 10 a political issue because that seems to be a  
 11 general medical care issue.  
 12 Q And so when you say political, do you mean  
 13 measurable difference in opinion by a political  
 14 party?  
 15 A Yes. Well, I don't -- I'm saying political saying  
 16 these organizations seem very willing to get  
 17 involved with political activism from a certain  
 18 viewpoint. There could be any number of things  
 19 where they -- you would think at least once maybe  
 20 they would get, have some issue that is not from  
 21 that same viewpoint, but it does not seem very --  
 22 they seem very willing to make things more  
 23 political than they really are.  
 24 I believe that questions about  
 25 gender-affirming care are clinical questions. And

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1 so I don't think that these organizations should  
 2 be condemning people who see the evidence  
 3 differently or want to be cautious.  
 4 But it seems like that is in the press  
 5 releases where they would want to approach it. So  
 6 I can't think it's anything other than political  
 7 because they usually, let's say, the American  
 8 Academy of Pediatrics would be respectful of  
 9 people who want a cautious approach or parents  
 10 that do not agree with this approach.  
 11 So, yes, I believe the way that they are  
 12 approaching seems that it must be political.  
 13 Q Earlier you were talking about how you wish some  
 14 medical organizations prioritized things like  
 15 access to primary care through federally funded  
 16 health centers.  
 17 Do you remember when we were talking about  
 18 that?  
 19 A Yes.  
 20 Q Do you believe that that is a political issue?  
 21 A Not so much because it has bipartisan support. So  
 22 I believe that would be an issue that would not be  
 23 politicized because I think individuals on both,  
 24 on both on the left and the right could get behind  
 25 those things. So it's a less politicized issue.

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1 Q Do you think an endocrinologist who testifies  
 2 before a legislative body about a particular bill  
 3 is engaged in political advocacy?  
 4 For example, if there were a bill to make  
 5 insulin free and an endocrinologist testified in  
 6 favor of that bill, do you think that  
 7 endocrinologist is engaging in political advocacy?  
 8 A It would depend on how they testified and in what  
 9 way and exactly what the bill was. I could not  
 10 say. I would not make a blanket statement that it  
 11 was or wasn't.  
 12 Q So you think that the content of the opinion  
 13 determines whether it is political advocacy or  
 14 not?  
 15 A That is one component of how I would decide, yes.  
 16 Q What other components would help you decide  
 17 whether that was political advocacy?  
 18 A Well, depending on the issue. Right? The issue  
 19 at hand here is an issue that does have clumpings  
 20 of political support in different parties and  
 21 different sides.  
 22 So clearly, whenever you are talking about an  
 23 issue that does have clear political implications,  
 24 then that would make you at least be skeptical or  
 25 consider that there is something political going

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1 on.  
 2 Q Do you think clinicians who provide legislative  
 3 testimony about bills like Senate Enrolled Act 480  
 4 are engaged in political advocacy?  
 5 A It would depend on the testimony they are giving.  
 6 So possibly or possibly not.  
 7 Q What would make their testimony political  
 8 advocacy?  
 9 A Well, I don't know if you are asking me about are  
 10 they providing, you know, references to studies?  
 11 Are they talking about -- you know, I'm not sure  
 12 what they are bringing up.  
 13 If they are trying to portray evidence as  
 14 more than it really is or kind of, you know, if  
 15 they use political language. I mean there are any  
 16 number of ways that someone can reveal that they  
 17 are more interested in advocating for a certain,  
 18 you know, tribal political viewpoint than an  
 19 actual sober discussion of what is the situation  
 20 at hand.  
 21 I think most clinicians who would get up and  
 22 testify should be able to remain respectful about  
 23 the other side of the opinion and realize the  
 24 trade offs and difficulties and nuances.  
 25 So if that is what they are doing and getting

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1 up and admitting all those things, then I would,  
 2 you know, lean towards it not being so political.  
 3 If that is not what they are doing, then I'm  
 4 leaning in towards it being more political.  
 5 Q In Paragraph 91 you are talking about this press  
 6 release. You say, "Yet the press release frames  
 7 these limits as discrimination based on gender  
 8 identity, a moralized characterization of  
 9 restrictions on care."  
 10 Why do you think that is a moralizing  
 11 statement?  
 12 A Well, if I accuse you of discriminating I think  
 13 that is a morale accusation. Right?  
 14 Whereas, normally when you are talking about  
 15 medical care you would be talking about what is  
 16 the evidence base for this medical care. Or let  
 17 me show you this study that strongly supports my  
 18 opinion.  
 19 That is what I would think that a medical  
 20 organization would be doing, rather than claiming  
 21 that this is discrimination.  
 22 Q So back to my example of an endocrinologist and  
 23 insulin. If I am an endocrinologist and I testify  
 24 before a legislative body, I treat a lot of people  
 25 with diabetes. They need insulin. The cost of

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1 insulin means some of them don't get it. That is  
 2 a negative outcome. I think this bill should pass  
 3 because it will make insulin free.  
 4 Do you think any of that is political and  
 5 moralizing?  
 6 A No. Because they are talking about a clear-cut  
 7 medical, you know, situation that seems  
 8 apolitical.  
 9 Q What if they then say, And I think it's  
 10 discrimination against people with diabetes not to  
 11 make insulin free? What then?  
 12 A I mean, they could say that. I think that that  
 13 would be a, I mean, they would be trying to  
 14 moralize the argument. I don't think it would be  
 15 a compelling argument.  
 16 I'm guessing that people who are deciding  
 17 about what could be paid for and not paid for are  
 18 mostly working on economic arguments and not on  
 19 discrimination arguments.  
 20 MR. SELDIN: Joel, in Paragraph 92 about  
 21 two-thirds of the way down, if you could show us  
 22 Paragraph 92. Thank you.  
 23 Q You are critical of the American Academy of  
 24 Pediatrics. You say, "As such, a more appropriate  
 25 perspective from a medical organization would be a

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1 call for reasoned dialogue to evaluate the moral  
 2 claims on each side and examine the logic and data  
 3 behind these moral frameworks and treatments."  
 4 Do you see where you wrote that?  
 5 A Yes.  
 6 Q Is your issue that, I guess, do you think the  
 7 competing moral frameworks in this particular  
 8 instance are equally worth debating?  
 9 A Well, I think there are multiple moral frameworks  
 10 so you would have autonomy of patients. You would  
 11 have parental decision rights. You would have  
 12 whether an analysis of an evidence base is a moral  
 13 one or a discriminatory one.  
 14 So there's multiple moral issues at play.  
 15 There would be the moral issue of can someone  
 16 consent or not consent? Is it moral to allow  
 17 those things?  
 18 So there are just a number of ethical and  
 19 moral issues that could be wrapped into any  
 20 discussion.  
 21 Q So in the realm of pediatrics generally you have  
 22 issues of assent and consent, is that fair to say?  
 23 A Yes.  
 24 Q So in that respect, every decision about pediatric  
 25 medicine involves the moral issue of assent and

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1 consent, right?  
 2 A Yeah. I mean, you know, I would not quite -- I  
 3 would say there's almost no moral issue for many  
 4 or most regular pediatric treatment issues.  
 5 Whether to get an antibiotic or whether to brace  
 6 an arm after it's broken, you know, this is what  
 7 most medical decisions are.  
 8 Most of them do not have difficult competing  
 9 moral frameworks like permanent treatments to  
 10 minors with gender dysphoria. That is a lot more  
 11 complex.  
 12 Q Let's talk about some other medical interventions  
 13 in pediatrics.  
 14 Are you familiar with Cochlear implants?  
 15 A Somewhat.  
 16 Q Do you think that there is any moral valiance to a  
 17 decision about whether to provide those to a  
 18 child?  
 19 A Well, not being my area of expertise, I don't know  
 20 what the statistics are and how successful they  
 21 are and how established they are.  
 22 There may or may not be on different  
 23 treatments depending on all those things. If it's  
 24 a well established treatment and they have a great  
 25 evidence base on, then the amount of the moral

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1 dilemma is small.  
2 When you have unknowns in a treatment or it's  
3 an experimental treatment, that is much more of a  
4 moral dilemma. I don't know Cochlear implants  
5 enough to tell you where I fall on that.  
6 Q Do you believe then that the level of moral  
7 dilemma is inverse to the evidence base?  
8 A Well, the less evidence base and the more  
9 potential harm would raise the moral implications.  
10 Yes.  
11 Q Okay. So then in any area of medicine where there  
12 is an uncertainty about the evidence base or  
13 outcomes you believe there is a moral issue?  
14 A Well, specifically, I mean, yes. Especially when  
15 we are talking about lifelong changing of  
16 characteristics of a developing adolescent.  
17 So, yes. I mean, yes. But there is, you  
18 know, we are talking about something quite  
19 significant.  
20 Q Well, are you familiar with ear pinning as a  
21 medical intervention in children?  
22 A I mean, not very.  
23 Q Well, I will represent to you that for children  
24 whose ears stick out there is a surgical  
25 intervention where you can pin their ears back so

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1 they stick out less.  
2 Are you familiar with that?  
3 A Okay. Yes.  
4 Q Okay. Have you heard of such a thing?  
5 A I have heard of it. Yes.  
6 Q Okay. Do you think that that has moral  
7 implications?  
8 A Not -- I don't know. But it sounds like that is a  
9 low risk surgery. So to me, I'm guessing that  
10 it's a low risk procedure which, you know, seems  
11 to be well received or work out the way that  
12 individuals who have gotten in the past want. I  
13 don't know how long it has been around for.  
14 So it could be a significant moral issue if  
15 it's the first patient that it's ever been done on  
16 and there are some potential downfield negative  
17 effects that could be serious.  
18 If it's a standard procedure that is done all  
19 of the time without much problem, then that makes  
20 it less of a moral issue.  
21 Q Even though it permanently alters the appearance  
22 of the child you don't believe that that by itself  
23 raises a moral issue?  
24 A Well, is the outcome -- you know, if this is an  
25 established procedure that has a known good

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1 outcome, then it reduces the moral or ethical  
2 dilemma.  
3 Q You don't believe that all interventions that  
4 alter the bodies of minors involve moral dilemmas?  
5 A I just said there are degrees. There would be a  
6 degree.  
7 Q In terms of what should inform moral  
8 considerations around the provision of treatment  
9 to minors, we have talked about evidence based.  
10 We have talked about assent and consent.  
11 Are there any other things that you think  
12 should factor into that moral calculus?  
13 A Evidence base. Assent and consent. Family and  
14 parental viewpoints. There are any number of  
15 possible other inputs.  
16 Q What do you mean by family?  
17 A I think if a family -- in a family there may or  
18 may not be agreement with procedures. I think  
19 that is something to take into account.  
20 Q Would that fall under assent and consent?  
21 A I guess it could. Yeah.  
22 Q In Paragraph 93 --  
23 A I could say there is some -- you are asking about  
24 what moral dilemmas possibly you would have. I  
25 think, you know, we talked about the evidence

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1 base. But, also, you know, we don't really have  
2 an evidence base about a, you know, human  
3 developing identity, which is also something that  
4 we are treating. I just want to throw that out  
5 there. We are sort of fiddling with something  
6 which that is important and fundamental in human  
7 beings.  
8 I just think that also raises caution beyond  
9 what a typical discussion of evidence base would  
10 be.  
11 Q Are you offering an opinion in this case about the  
12 evidence base?  
13 A Regarding gender-affirming care?  
14 Q Yes.  
15 A Well, I mean, yes. I've put, I did not  
16 concentrate on that in my report, but I think I  
17 make it clear in my report my assessment of the  
18 evidence base.  
19 MR. SELDIN: Joel, can you pull up  
20 Exhibit 4. Take us to Paragraph 4, please. I'm  
21 sorry. Can you scroll up to the first page so we  
22 can see the caption.  
23 Q Dr. Kaliebe, this was your report in the Decker  
24 case that we were talking about.  
25 Do you see the case caption?

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1 A Yes.

2 Q Then Paragraph 4 (b) and (c), Dr. Kaliebe, in your

3 Decker report you offered the opinion at 4 (b),

4 "There is no consensus in the field regarding the

5 treatment of gender dysphoria, nor is there an

6 evidence base sufficient to lead to any confident

7 recommendations."

8 Do you see where you wrote that in your

9 Decker report?

10 A I don't. Okay. Yes. Yes, I do.

11 Q Then in 4 (c) you said, "Multiple reviews of the

12 evidence base regarding treatment of gender

13 dysphoria indicate that the evidence for

14 affirmative treatment is low quality."

15 Do you see where you wrote that in the Decker

16 report?

17 A Correct. Yes.

18 Q There do not appear to be corresponding opinions

19 of this nature in your declaration in this case.

20 That is why I'm asking, are you offering

21 these opinions in this case here?

22 A Well, yeah. I'm not sure how to answer that in

23 that I believe there are other experts in this

24 case that are reviewing the evidence base.

25 Those are my opinions. But my -- in terms of

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1 this case, I wrote in my report the things that I

2 was emphasizing.

3 Q So is it fair to say that you, Dr. Kaliebe, the

4 individual, hold these views, but you,

5 Dr. Kaliebe, Indiana's expert in this case, are

6 not offering yourself as an expert on these two

7 points?

8 A I would not commit to that. Since I have put this

9 in my report even though it's not exactly these

10 same statements, I have mentioned the low quality

11 evidence base.

12 Since I have mentioned that in my report and

13 I am already speaking as an expert and I've gone

14 on the record, I think I am affirming that this is

15 my opinion and this opinion is in my report.

16 MR. SELDIN: I wonder if now is a good

17 time to take a little longer break for lunch.

18 Dr. Kaliebe, Mr. Patterson, would that work

19 for you?

20 MR. PATTERSON: Fine with me.

21 A Fine with me.

22 (OFF RECORD AT 1:31 P.M.)

23 (AT THIS TIME A SHORT RECESS WAS HELD OFF THE

24 RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE

25 HAD:)

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1 (ON RECORD AT 2:15 P.M.)

2 BY MR. SELDIN:

3 Q Dr. Kaliebe, welcome back.

4 MR. SELDIN: Joel, could you pull

5 Exhibit 1 back up for us.

6 Q This is your declaration that we have been talking

7 about in this case.

8 MR. SELDIN: Joel, can you take us to

9 Paragraph 121.

10 Q Dr. Kaliebe, in Paragraph 121 of your declaration

11 you have some criticisms of SOC-8. I take it that

12 is WPATH's Standards of Care 8?

13 A Correct.

14 Q And in Subsection A you say, "SOC-8 makes no

15 analysis for why it prioritizes affirmation of

16 gender identity over affirmation and acceptance of

17 the physical sexed body."

18 Do you see where you said that?

19 A Yes.

20 Q What is affirmation and acceptance of the physical

21 sex body?

22 A Well, it would be the concept that it is important

23 for people to come to accept and work with the

24 body that they have, which is a time tested

25 approach, you know, in individuals who have

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1 challenges and disorders, distress related to

2 their body.

3 Q When you say time tested, what do you mean?

4 A Well, I mean in many other psychiatric disorders

5 we have patients that are uncomfortable or

6 distressed by the body that they have.

7 Someone with anorexia will starve themselves

8 in order to, you know, not go into development or

9 because they don't want to, because they have a

10 distorted view of themselves, a body dysmorphic

11 disorder.

12 During development, of course, many people

13 are uncomfortable or distressed by the body that

14 they have.

15 Q In prior declarations you refer to this as body

16 affirmation.

17 Is affirmation acceptance of the physical sex

18 body the same as body affirmation?

19 A Yeah. I mean, I think they are part of the same

20 concept, yes.

21 Q Did you come up with this distinction between body

22 affirmation and gender affirmation?

23 A Did I come up with it? Well, I think that this is

24 a noticeable discrepancy by the way that we are

25 asked to approach gender dysphoria compared to

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1 other disorders like I was, like I was mentioning  
2 previously.  
3 So, yes. I don't have a clear source from  
4 where that comes from. It's just that I've noted  
5 that this is a very different approach to affirm  
6 and emphasize, you know, a psychological concept  
7 about self over the physical body.  
8 Q Is there any literature where researchers  
9 discussed this distinction between gender  
10 affirmation and body affirmation?  
11 A There probably is. You know, since we are in such  
12 a new field right now, you know, I don't think  
13 that there has been much on this regarding  
14 particularly this issue.  
15 But I think there is significant literature  
16 in other disorders regarding patients, healthy  
17 patients, learning to come to peace with or love  
18 the body that they have or reducing their distress  
19 about the body that they have.  
20 Q So it sounds like you are not aware of any studies  
21 on body affirmation versus gender affirmation as  
22 it pertains to gender dysphoria, is that correct?  
23 A Correct.  
24 Q In Paragraph 121, Subsection (d) another one of  
25 your criticisms is that, "SOC-8 downplays concerns

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1 related to detransitioning."  
2 Do you see where you wrote that?  
3 A Correct.  
4 MR. SELDIN: Joel, can you please pull up  
5 Exhibit 14.  
6 Q Dr. Kaliebe, have you seen this document before?  
7 A Yes. It's the Standards of Care for the Health of  
8 Transgender and Gender Diverse People, Version 8.  
9 I was referring to that in my report as the  
10 SOC-8.  
11 MR. SELDIN: Joel, can you take us to  
12 Page 43 of the PDF, please.  
13 Q Dr. Kaliebe, do you see where it says  
14 Statement 5.7?  
15 A Yes.  
16 Q Do you see, "We recommend health care  
17 professionals assessing adults who wish to  
18 detransition and seek general-related hormone  
19 intervention, surgical intervention, or both,  
20 utilize a comprehensive multidisciplinary  
21 assessment that will include additional viewpoints  
22 from experienced health care professionals in  
23 transgender health and that considers, together  
24 with the individual, the role of social transition  
25 as part of the assessment process."

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1 Do you see that?  
2 A Yes.  
3 Q There is a whole section of SOC-8 that talks about  
4 detransition, correct?  
5 A Correct. I think if you look at the amount of  
6 pages devoted to it, and I do see 260 pages on the  
7 document, that is why I was saying underemphasized  
8 the component.  
9 Q What would be an appropriate emphasis in the SOC-8  
10 for detransition?  
11 A Well, I think a more realistic approach in  
12 regarding the new patient population, which has  
13 recently emerged. And we do not know what the  
14 rates of detransition will be in this new  
15 different patient population.  
16 And so I think while it generally downplays  
17 it, reporting it to be rare, which I think, you  
18 know, once again, we are not totally clear on, the  
19 data is not so clear on how rare it really is.  
20 But, secondly, it's especially pertinent  
21 considering the large rise in these treatments  
22 among minors and minors that are very different  
23 than the minors that were in the Dutch protocol or  
24 other early interventions.  
25 MR. SELDIN: Can you take us back to

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1 Exhibit 1, please.  
2 Q In Paragraph 122, Doctor, in Paragraph 122 you  
3 say, "There have been several other episodes I  
4 have learned about that have caused me to conclude  
5 that I do not feel comfortable relying on WPATH or  
6 its U.S. affiliate, USPATH, to guide my care of  
7 gender dysphoric patients."  
8 A Yes.  
9 Q What do you rely on to treat your gender dysphoria  
10 patients?  
11 A My experience as a child psychiatrist. And I  
12 think patients are all human beings. They all  
13 share a lot of qualities. We have a wealth of  
14 clinical and other research data, which gives us a  
15 general approach on how to approach patients.  
16 And so when a new population and a new  
17 treatment model comes in and asks you to do  
18 something a different way and you see that it has  
19 flaws and it's not, it has not, it does not have  
20 the evidence base that it claims to have, then you  
21 have to use your, you have to use what you know  
22 about other treatments, which are, of course, you  
23 know, which are generalizable in order to approach  
24 that patient population.  
25 Q Earlier we talked about how in total you have



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1 treated maybe sixteen or seventeen patients with  
2 gender dysphoria.  
3 How many of those are you currently treating?  
4 A I would guess half that number.  
5 Q Are they aware you are not using USPATH or WPATH  
6 standards of care in their treatment?  
7 A I don't know that patients are ever aware of what  
8 guidelines or treatments or what approaches that  
9 you use as a clinician.  
10 That would be no regarding any of my patients  
11 with any of my approaches.  
12 Q Do you think a patient would want to know if you  
13 were intentionally not using consensus guidelines  
14 to treat their condition?  
15 A Well, I don't believe these to really be consensus  
16 guidelines. So, you know, there is no reason to  
17 inform patients exactly where you are getting your  
18 clinical approach from.  
19 You take it from all sorts of places. So I'm  
20 not -- no, I don't think it's necessary. I never  
21 inform my patients in other circumstances what  
22 guidelines I use or don't use. I don't think  
23 these patients are really any different.  
24 Q Are any of the patients you are currently treating  
25 for gender dysphoria minors?

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1 A Yes.  
2 Q Do you think their parents would want to know that  
3 you were not using WPATH and USPATH guidelines to  
4 treat them?  
5 A Once again, parents have never ever in the past  
6 asked me about what guidelines I use for my  
7 treatment. So I think that it would be a  
8 discussion to have perhaps if there is a  
9 discussion about medicalization. So in those  
10 situations I'm more than happy to tell them what  
11 my perspective is.  
12 But, once again, you know, you really don't  
13 usually go into treatment guidelines when you are  
14 discussing matters with parents or with patients.  
15 Q Are you treating these particular patients with  
16 what you call body affirmation?  
17 A Well, as I mentioned before, I think whenever you  
18 are referring people for things like physical  
19 activity, exercise, mindfulness approaches, those  
20 all have some elements of coming to peace with and  
21 using the body, appreciating the body that you  
22 have.  
23 I think that approach is known because those  
24 are things that I talk about. I think it would  
25 be, I don't think I talk about my philosophy of

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1 treatment with any of my patients. I just provide  
2 recommendations and treatment.  
3 Q Is it fair -- have you ever had a conversation  
4 with these patients or their parents in which you  
5 have explained what you explain here, that there  
6 is gender affirmation and there is body  
7 affirmation and you are going to prioritize body  
8 affirmation?  
9 A I have, in a manner, yes. I think that as I have  
10 spoken with parents they have -- I have  
11 communicated to them what my approach is. I don't  
12 use those words. I will tell parents what I  
13 emphasize and don't emphasize in my treatment.  
14 Once again, these are not the conversations,  
15 I mean, this is not usual -- you know, out in the  
16 community as a treater or in the clinics that I  
17 work in, I mean, this is not the level of  
18 conversation that you are typically having.  
19 So I am not usually talking about which  
20 guidelines I use or what approach I use with  
21 patients. This is quite unusual.  
22 Q Doctor, you have not told them there is no  
23 research about body affirmation versus gender  
24 affirmation?  
25 A Well, hold on. Because you are claiming that

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1 there is some research, which is not accurate.  
2 There is research in all sorts of things. You are  
3 just saying in the exact specific condition of  
4 gender dysphoria, which we have almost no research  
5 on anything in regard to any kind of therapy with  
6 gender dysphoria.  
7 It's such a new condition with this  
8 population with this large amount that we only now  
9 are starting to be able to roll out studies.  
10 Once again, you are mischaracterizing what is  
11 going on. But, yeah. So, no, I don't have  
12 exactly that conversation because that is not an  
13 appropriate framing of it.  
14 Q Well, have you had the conversation with parents  
15 or patients where you have said there is not any  
16 specific research on the use of body affirmation  
17 to treat your condition, gender dysphoria, but  
18 there is research for other conditions?  
19 So what I will recommend in the absence of  
20 that research on your specific condition is that  
21 we use body affirmation instead of gender  
22 affirmation.  
23 Have you had any kind of conversation like  
24 that with your patients?  
25 A Well, you know, once again, I think we are talking

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1 about these large, you know, concepts rather than  
2 talking about specifics.  
3 I mean, you know, you could still be  
4 affirmative, meaning use the pronouns the person  
5 was working with, and be affirmative in that you  
6 are supporting them. But, also, want to work with  
7 them in coming to peace with the body that they  
8 have.  
9 Q Is that your general practice with your minor  
10 patients that have gender dysphoria, to use the  
11 pronouns that they want to be known by?  
12 A Yes.  
13 Q Earlier you were talking about how you treat  
14 patients given your desire not to use WPATH or  
15 USPATH guidelines.  
16 Is it fair to say then that you consider your  
17 clinical practice sufficient to sort of establish  
18 guidelines for yourself?  
19 A Well, I think when you are a child psychiatrist  
20 and you treat all of the different conditions that  
21 could come in, people come in with autism. People  
22 come in with psychosis. People come in with  
23 bipolar disorder. They come in with PTSD. They  
24 come in with all number of different problems.  
25 And then they have problems in development.

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1 They have problems of identity that are not  
2 related to gender. They have problems  
3 academically. They have neurocognitive problems.  
4 They have problems related to school. They have  
5 problems relating to getting into fights. They  
6 have family conflict.  
7 So when you approach a patient clinically,  
8 you are putting together a treatment plan and an  
9 assessment that speaks to them specifically. So  
10 I'm using what, you know, is the, I would say,  
11 mainstream psychiatric approach with all these  
12 patients, including the patients with gender  
13 dysphoria.  
14 Q So your description then of your clinical  
15 experience, that is sufficient you think to  
16 establish good clinical practices?  
17 A I don't think that patients with gender dysphoria  
18 are that different than other patients that I  
19 should throw out all my training for everything  
20 else I do and do something that WPATH has  
21 determined to be the right approach even though my  
22 assessment of the evidence is that it's not the  
23 right approach. So, correct.  
24 MR. SELDIN: Joel, will you take us to  
25 Paragraph 129, please.

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1 Q Dr. Kaliebe, in Paragraph 129 you are discussing  
2 Dr. Shumer.  
3 Do you recall writing this paragraph?  
4 A Yes.  
5 Q In this paragraph at the very end you say, "This  
6 virtuous sense of self must at least raise  
7 concerns as to whether Dr. Shumer and other  
8 advocates engage in sober reviews of the  
9 evidence."  
10 Do you see where you wrote that?  
11 A Yes.  
12 Q Would you generally agree that patients should  
13 receive competent and compassionate care, medical  
14 care?  
15 A Yes.  
16 Q Do you generally agree that transgender people are  
17 emerging and demanding specific kinds of care?  
18 A Emerging and demanding specific types of care?  
19 Yeah. I mean, this is, I think some of the  
20 questions that we have is a child, you know, a  
21 transgender person, or are they a child with  
22 gender dysphoria? Or is this a teenager with  
23 gender dysphoria or a transgender person?  
24 So I think, you know, as your identity is  
25 still developing I think it's important for us to

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1 step back and look that we are not necessarily  
2 dealing with someone who at the end of the day  
3 should be best conceptualized as a certain person.  
4 And that the fact that someone, that there  
5 are some demands for care, once again, is detailed  
6 elsewhere in my report. Yes, people should be  
7 compassionate and we should be competent.  
8 But often the type of care that patients  
9 request is often not the best type of care for  
10 them. So, you know, I am somewhat agreeing with  
11 your characterization. But I think there is some  
12 nuance there.  
13 Q We talked about this a little bit earlier. I  
14 wanted to clarify.  
15 You said you prefer to treat, to consider  
16 children with gender dysphoria as children with  
17 gender dysphoria and not as what you called  
18 transgender children, is that accurate?  
19 A Correct.  
20 Q You would agree, though, that some, that at least  
21 some children with gender dysphoria are, in fact,  
22 transgender, right?  
23 A No. Because we don't know what their identity  
24 really is or what it will be at the end. I don't  
25 think we are, I mean, putting a label on a child

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1 that is still developing, I mean, that's not, I  
 2 don't think it's a wise practice.  
 3 So I would not call them transgender as I  
 4 have stated. I would call them a child with  
 5 gender dysphoria.  
 6 Q And would you agree that some children with  
 7 gender dysphoria come to identify as transgender  
 8 adults?  
 9 A Yes.  
 10 Q Earlier we were talking about your concerns about  
 11 some of the moralizing language that you think  
 12 exists in discussions about the treatment of  
 13 gender dysphoria.  
 14 Do you remember us talking about that earlier  
 15 today?  
 16 A Correct.  
 17 Q And it seems like based on Paragraph 129 that you  
 18 have some concerns about folks who use what you  
 19 term, folks who use what you characterize as  
 20 moralizing language that they can't soberly review  
 21 the evidence.  
 22 Is that fair to say?  
 23 A Well, they may or may not be able to. It would  
 24 raise, it would raise a level of skepticism.  
 25 MR. SELDIN: Joel, will you pull up

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1 Exhibit 11.  
 2 Q Dr. Kaliebe, this is a printout of a website for  
 3 an organization called Do No Harm.  
 4 Have you heard of Do No Harm before?  
 5 A I have heard the name. I'm not familiar with it,  
 6 no.  
 7 Q You will see in the "About Us" section it says,  
 8 "We are a diverse group of physicians, health care  
 9 professionals, medical students, patients, and  
 10 policymakers united by a moral mission: Protect  
 11 health care from a radical, divisive, and  
 12 discriminatory ideology."  
 13 Do you see where I read that?  
 14 A Yes.  
 15 Q Do you consider this the kind of moralizing  
 16 language that gives you pause about an ability to  
 17 soberly review the evidence?  
 18 A Well, I think they are using language similar to  
 19 Turban and Karasic and Shumer. Yeah. I would  
 20 think that those who look at any sort of group  
 21 that has a mission, you know, you would have to  
 22 be, you have to be skeptical and understand that  
 23 they are potentially a part of a group.  
 24 MR. SELDIN: Joel, scroll down, please, to  
 25 Page 6 of the PDF.

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1 Q Dr. Kaliebe, you will see at the bottom there is a  
 2 photo of Dr. Daniel Weiss, Senior Fellow.  
 3 Do you see that?  
 4 A Yes.  
 5 Q And I think we were talking earlier today, are you  
 6 aware that Dr. Weiss is one of Indiana's experts  
 7 in this case?  
 8 A I am now that you are asking me that question.  
 9 Q Would his membership in this group give you some  
 10 pause about his ability to soberly review the  
 11 evidence?  
 12 A No. I mean, I think that your, you know, the fact  
 13 that someone has joined a group which is calling  
 14 for cautious care under the circumstances would  
 15 not necessarily, you know, give me pause.  
 16 So, no, I think, I mean, yes, is it possible  
 17 that this could also have some group think or  
 18 group identity issues, you know, distorting their  
 19 viewpoint, it's possible.  
 20 I, you know, as I said before, it just means  
 21 that you should look at what the person says and  
 22 examine the evidence and the idea about ideas  
 23 competing with each other.  
 24 Rather than personally attacking the person,  
 25 you should identify the idea and evaluate the

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1 quality of the evidence or the idea.  
 2 Q And so for clinicians like Dr. Shumer, do you  
 3 think the same applies, that rather than simply  
 4 judging him by his participation or any kind of  
 5 group or gender clinic you should look at his  
 6 ideas and evaluate them on the merits?  
 7 A Correct.  
 8 Q Okay.  
 9 MR. SELDIN: Joel, will you take us back  
 10 to Exhibit 1, please.  
 11 Q Look at Paragraph 130. Dr. Kaliebe, in  
 12 Paragraph 130 you talk about what you perceive to  
 13 be a chilling effect on scholarly dialogue.  
 14 Do you see where you wrote that?  
 15 A In 130? I don't use those words there.  
 16 Q Sorry.  
 17 A It's not in Paragraph 130.  
 18 MR. SELDIN: Joel, are you on Exhibit 1?  
 19 JOEL SCHERER: Yes, this is Exhibit 1.  
 20 MR. SELDIN: Okay. I have something wrong  
 21 with my pagination.  
 22 Q You do recall that there is some scholarly  
 23 dialogue missing, right?  
 24 A Yes.  
 25 Q What specific articles do you think should have

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1 been published that have not been?  
2 A Well, I think I say in the report there are many  
3 articles that should be published and many issues  
4 to be explored. We are in the infancy of medical  
5 and hormonal treatments for young people and we  
6 don't really have good long-term outcome data. We  
7 don't have any control data.  
8 So, you know, we should be still debating  
9 what is the right approach considering the actual  
10 level of the evidence. We should be careful about  
11 promoting one type of care or the other and,  
12 obviously, be talking about what evidence base  
13 supports it.  
14 I think specifically in the, in the arena of  
15 gender-affirming care what we should talk about,  
16 we should have articles in major medical journals  
17 about informed consent in relation to that. We  
18 should have articles regarding psychotherapy. We  
19 should have articles regarding special populations  
20 like traumatized individuals, personality  
21 disorders, autism.  
22 I mean, we have so much to explore. There is  
23 so much more we don't know than what we do know.  
24 To, you know, to only sort of allow one type of an  
25 article or one perspective on this seems quite

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1 misguided.  
2 Q Just to make sure we are talking about the same  
3 thing, in your declaration you list some specific  
4 instances of some specific articles that you  
5 believe should have been published that were not.  
6 Just in your answer now you are talking more  
7 broadly about kinds of papers you wish you had  
8 seen.  
9 Were you referring to anything specific?  
10 A I don't know exactly what has been submitted that  
11 has not been published. So it is impossible for  
12 us to know what articles were rejected. I'm not  
13 quite understanding the question.  
14 Q Well, fair to say you don't know if these, you are  
15 not sure if maybe these articles don't exist at  
16 all or they are being submitted and just not being  
17 published?  
18 A Correct. Other than my letters to the editor  
19 which I know were rejected.  
20 Q Do you know the rejection rate for letters to the  
21 editor?  
22 A No.  
23 MR. SELDIN: Joel, can you take us to  
24 Paragraph 142, please.  
25 Q Dr. Kaliebe, in Paragraph 142 you talk about, "A

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1 colleague told me about a difficult experience  
2 with editors of the American Academy of Psychiatry  
3 and the Law Newsletter."  
4 Do you see that?  
5 A Correct.  
6 Q Who is the colleague that --  
7 A Josh Sanderson.  
8 Q Okay. Do you know if he tried to get this article  
9 published anywhere else?  
10 A It got published. He just, they just asked him to  
11 remove the actual behavior of the transgender  
12 individuals on the inpatient unit.  
13 So the whole, you know, part of the article  
14 was to communicate that these are difficult  
15 situations that we are having on the inpatient  
16 unit with individuals who identify as transgender.  
17 They forced him to take out the part about  
18 what was actually happening on the inpatient unit,  
19 thereby, stopping clinical exchange of information  
20 related to caring for individuals on inpatient  
21 units.  
22 Q Did this colleague try to get his unedited article  
23 published somewhere else?  
24 A I'm not aware.  
25 Q In Paragraph 144 at the end you say, "Former sex

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1 researchers have left the field due to the  
2 harassment and intellectual bullying they  
3 received."  
4 Do you see where you wrote that?  
5 A Yes.  
6 Q Who has left the field?  
7 A I gave the one example of Debra Soh. I don't  
8 have a list in front of me. She is not the only  
9 one.  
10 Q Who else do you think has left the field?  
11 A I don't have that in front of me. I think you  
12 could read Debra Soh's book and it would provide a  
13 lot of detail about the harassment and  
14 anti-scientific atmosphere in which she endured.  
15 Q Other than Soh, there is no one you can  
16 specifically remember?  
17 A There are examples in her book. And if I could  
18 add on, I mean, it's not just about leaving the  
19 field. It's about staying away from areas of  
20 scholarly exploration, which there are plenty of  
21 examples. Right?  
22 So, for one, it's difficult to get grants or  
23 to then be able to study things that are  
24 controversial in universities, especially  
25 controversial and related to gender dysphoria or

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1 transgender care.  
2 So, unfortunately, that is, you know, we are  
3 reducing the amount of information flow due to  
4 these things.  
5 MR. SELDIN: Joel, will you take us to  
6 Paragraph 145, please.  
7 Q Dr. Kaliebe, in Paragraph 145 you talk about your  
8 personal interactions with psychiatrists.  
9 Do you recall writing this paragraph?  
10 A Yes.  
11 Q Would you agree that your personal interactions  
12 with psychiatrists is a form of anecdotal  
13 evidence, right?  
14 A Correct.  
15 Q In Paragraph 145 you use the term automatic  
16 affirmation.  
17 A Yes.  
18 Q What is automatic affirmation?  
19 A As I mentioned earlier, when a patient comes to  
20 you and has a certain perspective on something, it  
21 is not typical within mental health for you to  
22 automatically agree with their perspective.  
23 So that is not what we do in any other  
24 situation, but for whatever reason with gender  
25 dysphoria we have been asked to, or there seems to

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1 be pressures that if someone says that they have a  
2 certain gender identity that we are obligated to  
3 agree with that. That is just a departure from  
4 typical mental health care.  
5 Q Where does the term automatic affirmation come  
6 from?  
7 A Well, that seems to be the approach which is being  
8 pushed. I don't know that term, I'm  
9 characterizing the affirmative approach as  
10 automatic or some component of it. I'm sure that  
11 there are people who consider themselves  
12 affirmative who do not automatically affirm or do  
13 not consider their affirmation automatic, yet it  
14 seems that there is some pressure to automatically  
15 affirm. So that is why I put that in there.  
16 It seems very unusual that you would  
17 necessarily agree with a patient when in mental  
18 health care we don't affirm or agree with patients  
19 in general.  
20 Q So automatic is your descriptive modifier based on  
21 your experience --  
22 A Well, yes. It is one of the fundamental problems  
23 with gender-affirming care. So it's an  
24 underlying, you know, unstable base that  
25 gender-affirming care has in my assessment.

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1 Q Earlier in one of your answers you said clinicians  
2 were obliged to accept gender identity.  
3 What did you mean by obliged?  
4 A Well, as I have said before, we typically in  
5 mental health -- let's say you are working with an  
6 adult client and they come in and say I want to  
7 have a divorce.  
8 You know, you are usually not going to be, I  
9 mean, any reputable therapist would be, like,  
10 let's sit down. Let's talk about it. Let's see  
11 what is going on. Let's understand your history  
12 and your current situation. Let's, I mean, let me  
13 hear more about this.  
14 You don't, you know, a mental health provider  
15 would not be yes, you should get a divorce, or no,  
16 you should not. Right? I mean, that would be  
17 inappropriate. Certainly we would not offer  
18 anything like suggestions in matters of, you know,  
19 major life choices like a divorce.  
20 At some point by getting to know a person you  
21 may get a sense of whether that would be a wise  
22 course for them or not. I'm just bringing that up  
23 as an example of what normally, how normally you  
24 would approach a patient in mental health when  
25 they say I have this situation.

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1 So you don't, you would not necessarily say  
2 yes, do something, or no, don't do something.  
3 Q Are you aware of any clinicians who are not asking  
4 follow-up questions when patients present  
5 themselves saying I think I have gender dysphoria  
6 or I might be transgender?  
7 A Yeah. If you look at the Hannah Barnes book, Time  
8 To Think, or you look at the whistleblower  
9 report, you can see that there is sufficient,  
10 significant evidence that within gender clinics  
11 there are a lot of pressures to automatically, and  
12 there are people in the community who say the  
13 first thing that you should do is immediately  
14 affirm. You have to go with it. This can never  
15 be challenged.  
16 So, yes, I feel that clinicians, therapists,  
17 have a lot of pressure, especially if they are,  
18 if, especially probably in places like gender  
19 clinics to automatically affirm.  
20 Q Based on your secondhand review of the literature  
21 you believe this is happening?  
22 A Well, based on what I read in WPATH guidelines,  
23 and based on what I have read in Hannah Barnes'  
24 book, and based on my experience talking with  
25 other psychiatrists, and based on my experience

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1 going to meetings and listening to child  
 2 psychiatrists who are presenting on gender  
 3 dysphoria, yes, I believe this is what is  
 4 happening.  
 5 Q If a patient presents themselves and says, you  
 6 know, I think I have gender dysphoria or I think  
 7 I'm transgender and I want you to use male  
 8 pronouns for me, do you think it is automatic  
 9 affirmation to begin using male pronouns for that  
 10 person?  
 11 A It may or may not be. It depends on the  
 12 circumstance.  
 13 Q In what circumstance would it not be automatic  
 14 affirmation?  
 15 A Well, if you are, if their request to use male  
 16 pronouns is in a situation where you, you know,  
 17 there has been a long history of gender dysphoria  
 18 or issues related to it and this is a well thought  
 19 out process that emerges in therapy, or someone  
 20 has already done a bunch of therapy work, if they  
 21 are older, I mean, there are all sorts of factors  
 22 that you may consider whether to go with that.  
 23 Or the next question might be why do you feel  
 24 that way? What's going on? Tell me about that.  
 25 Usually in therapy you are asking questions

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1 regarding what is the experience of the patient  
 2 and why they feel a certain way.  
 3 Q Would you agree that it's possible to do both? To  
 4 say great, thank you, I will use male pronouns.  
 5 Can you tell me a little more about that?  
 6 A That would be one choice, yes.  
 7 Q Would you consider that automatic affirmation?  
 8 A It could be. Yeah. If you are going to go with  
 9 it, right, at the first request of a patient I  
 10 would consider that automatic affirmation.  
 11 Q What do you think you should do instead?  
 12 A Once again, it depends on the clinical situation.  
 13 I mean, I have written that in the report.  
 14 Someone, you know, if someone comes up and they  
 15 were just sexually assaulted and now they say, I  
 16 want to, I want to use male pronouns. I'm going  
 17 to change to this male name.  
 18 I would be, like, hold on. What's going on?  
 19 You know, let me hear more about this. Let me  
 20 hear what's behind your decision.  
 21 Yes, we want to talk about it because we want  
 22 to know, and I would want to explore what exactly  
 23 is happening.  
 24 Q That example that you just referred to about a  
 25 patient recently being sexually assaulted, is that

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1 based on a specific patient or a hypothetical?  
 2 A Well, that is, that particular vignette would be a  
 3 hypothetical.  
 4 Q So you are aware of that happening. That is an  
 5 example that you came up with --  
 6 A There is evidence there is increased gender  
 7 dysphoria after sexual assault. That is in my  
 8 report. This is part of the concern that after a  
 9 sexual assault there is evidence that there is  
 10 more likely to be gender dysphoria.  
 11 Q That is a vignette that you came up with based on  
 12 your reading of data, not a specific patient?  
 13 A Correct.  
 14 Q Okay. In Paragraph 145 you talk about some  
 15 psychiatrists who are, many psychiatrists are  
 16 "willing to use affirmative approaches  
 17 selectively."  
 18 Do you see where you wrote that?  
 19 A Yes.  
 20 Q Is that what we talked about just now where you  
 21 said depending on the therapeutic history it might  
 22 be warranted to affirm someone by using their  
 23 pronouns?  
 24 A Yes.  
 25 Q Do you think in a patient that had that kind of

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1 long therapeutic history it would be warranted to  
 2 provide them with gender-affirming care, medical  
 3 care in the form of puberty blocks or hormones?  
 4 A I think that we have already discussed this. I  
 5 mean, if they are fully grown into adulthood that  
 6 that would be worth considering.  
 7 Yes, if they are done developing and they are  
 8 still not in a process of identity development  
 9 that could make sense.  
 10 Q Do you think there are seventeen year olds who are  
 11 sufficiently developed in their identity and have  
 12 a long enough history that gender-affirming care  
 13 in the form of hormones would be appropriate?  
 14 A I don't think that we have enough data about if  
 15 seventeen year olds will maintain their identity  
 16 that they have in order to justify that.  
 17 Q Can you imagine any circumstance in which it would  
 18 be appropriate to provide hormones to a seventeen  
 19 year old?  
 20 A I don't think it is a good clinical decision. So,  
 21 no, I don't. In my opinion, it would not be wise.  
 22 MR. SELDIN: Joel, will you take us to  
 23 Page 53, please. Can you scroll down a little  
 24 bit. Go to Page 53. Thank you.  
 25 Q Paragraph 131 appears out of order. It is on the

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1 bottom of Page 53.  
2 Do you see where you are discussing here  
3 Levine's list of assumptions misrepresented as  
4 facts.  
5 Do you see that?  
6 A Yes.  
7 Q Then the third bullet down says, "All gender  
8 identity variations are biologically determined  
9 and inherently healthy."  
10 Do you see that?  
11 A Yes.  
12 Q Do you believe that there are some gender identity  
13 variations that are inherently unhealthy?  
14 A Do I believe there are some -- well, yeah. I  
15 mean, I think we have an open scientific question  
16 if some patient's gender identities are unhealthy  
17 for them, correct.  
18 Q What do you mean by unhealthy for them?  
19 A Well, we could go back to the data related to  
20 trauma and increased gender dysphoria. I mean, is  
21 the, you know, is this really an avoidance  
22 strategy to shield someone, you know,  
23 psychologically from the trauma that they had.  
24 Right?  
25 So if someone develops a transgender identity

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1 or gender dysphoria after a sexual assault, it  
2 could be an unhealthy response to that. And that  
3 could end up being a, you know, you know,  
4 nonproductive, nonfunctional way for them to cope  
5 or react to that.  
6 Q Do you think having a transgender gender identity  
7 is inherently unhealthy?  
8 A No, not across the board. So I think that, you  
9 know, in an adult with an established transgender  
10 identity, the -- you would have a, a transgender  
11 identity -- everything in life is -- you know, so  
12 first of all, there are people that seem to just  
13 feel this very strongly. And it comes, and it has  
14 come from not a place of another disorder or  
15 trauma and it has been persistent for a long  
16 period of time.  
17 So I think that is the group of patients  
18 where we are saying that that does not seem so  
19 much like this is an unhealthy or problematic  
20 identity.  
21 Q So you would agree then that there are at least  
22 some transgender adults for whom there is no  
23 traumatic etiology for their transgender  
24 identities? It is just the way they are, correct?  
25 A Correct.

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1 Q Do you feel that way about any minors?  
2 A What I would prefer to conceptualize this as is  
3 that a minor is a developing individual with  
4 gender dysphoria. So I don't think clinically it  
5 is the right approach to consider them a fixed  
6 transgender individual.  
7 And only time will tell if they end up being  
8 an adult who, you know, does have that fixed  
9 identity of a stable transgender identity. So,  
10 you know, for any one individual teenager or  
11 child, I mean, we don't know what their life will  
12 bring them or how they will develop.  
13 Q If you could predict with a hundred percent  
14 certainty which children with gender dysphoria  
15 would grow up to become transgender adults, would  
16 you have the same objections to provision of  
17 gender-affirming care, medical care to minors?  
18 A If you could predict with a hundred percent  
19 certainty?  
20 Well, I guess I would have a number of  
21 caveats with that. We are saying someone without  
22 co-morbidities or other problems that possibly  
23 could be a contributing factor to developing it.  
24 So I think, yes, I think you are -- then we  
25 would, you know, everyone would feel much more

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1 comfortable if we knew for sure or we knew what  
2 the person's individual development trajectory  
3 would be.  
4 So, you know, I have never thought of that  
5 question before exactly like that. But, yeah,  
6 perhaps if we knew, if we knew a hundred percent.  
7 Q Is there any other medical condition for which you  
8 think we should have a hundred percent certainty  
9 as to outcome before we provide it?  
10 A You know, well, not that I know of. I do think  
11 this is an exceptional case because of the  
12 permanent changing of a person's, you know,  
13 trajectory with a, you know, low quality evidence  
14 base.  
15 So that is the challenge here, is that we  
16 don't really know who is going to have what type  
17 of identity as an adult. We don't know the  
18 long-term outcomes. Yes, other situations where  
19 we were talking about things that do not have this  
20 risk level, sure, we don't demand such a high  
21 certainty.  
22 I'm not saying that I'm demanding a hundred  
23 percent certainty. I'm saying I am demanding a  
24 lot more certainty than we have with the current  
25 patient population that we have.

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1 Q Would you support studies that would bring us  
2 closer to certainty about the, about what you  
3 believe would be --  
4 A Yes. Yes.  
5 Q You are aware that Senate Enrolled Act 480 does  
6 not include any carve outs for research?  
7 A Yes.  
8 Q Do you think that that is a mistake?  
9 A I don't know all of the factors that go into  
10 making the bill. I would say, in general, I wish  
11 we would be studying things more. Especially if  
12 we were studying one pool of patients with  
13 psychotherapy and psychosocial treatments.  
14 As long as we are actually studying  
15 alternatives, then I think studies are great. If  
16 all you are going to study is medicalized  
17 treatments, then we are going to be in the same  
18 boat down the road because we are not going to  
19 really know what treatments are better.  
20 Q If I understand, you have opinions about study  
21 design.  
22 Generally speaking, you would support  
23 studies?  
24 A Correct.  
25 Q Okay.

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1 MR. SELDIN: Joel, will you take us to  
2 Page 55, please.  
3 Q Dr. Kaliebe, you will see in Paragraph 151 you  
4 talk about in the third sentence, "Psychotherapy  
5 involves getting patients to recognize their own  
6 thought patterns, disturbed emotions, and, when  
7 appropriate, includes challenging irrational,  
8 self-defeating, and harmful beliefs."  
9 Do you see that?  
10 A Yes.  
11 Q Do you think gender dysphoria is an irrational,  
12 self-defeating or harmful belief?  
13 A I believe that what I have seen in many patients  
14 with gender dysphoria is that it includes those  
15 types of beliefs, yes.  
16 So when you have a patient who is saying, you  
17 know, who is so fearful of puberty, and they are  
18 saying this will be the worst thing. This will be  
19 so horrible. They are predicting a future that  
20 they don't know. They are assuming the worst.  
21 Right?  
22 That is a classic assuming the worst  
23 cognitive distortion. Right? They don't know  
24 what will happen, but they feel it's bad. They  
25 have thoughts related to that.

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1 A lot of patterns in gender dysphoria are  
2 classic patterns that you have in all psychiatric  
3 disorders. If they seem quite amenable to  
4 treatment and if you can get patients to engage in  
5 such treatment, then they could be less disturbed.  
6 Yes.  
7 Q So you were talking about the dreaded puberty as a  
8 potentially irrational self-defeating or harmful  
9 belief?  
10 A Yes.  
11 Q But you believe there are some children with  
12 gender dysphoria who do grow up to be transgender  
13 adults, right?  
14 A Correct.  
15 Q So for those youth, their fear of puberty is not  
16 irrational, right?  
17 A Well, it may be irrational because it may be out  
18 of proportion. So just because a possible outcome  
19 is that puberty will be bad, I mean, you know,  
20 puberty may be good.  
21 That person does not know until they  
22 experience it. So they are assuming the worst and  
23 making themselves suffer more. This is a lot of  
24 what you do in therapy, is help people to have  
25 realistic and flexible thought patterns and accept

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1 what they have to accept and not making things  
2 worse for themselves.  
3 You don't want people catastrophizing the  
4 worst and focusing on negatives. That is amenable  
5 to therapy. I think those could be quite helpful  
6 in patients with gender dysphoria.  
7 Q You might disagree with the amplitude of their  
8 distress, but it would not be irrational to be  
9 worried about going through puberty that didn't  
10 match your gender identity, right?  
11 A It is not all about rational. That is one  
12 component of it. An overfocus on negative things  
13 makes people more upset and causes them to do  
14 worse.  
15 So there are many different components of how  
16 your thought patterns contribute to suffering. So  
17 we want to minimize suffering from people having  
18 flexible thoughts, alternative seeking, remaining  
19 realistic.  
20 And so just the overfocus itself, even if it  
21 is rational, can be a harmful approach.  
22 Q You talk about minimizing suffering as a generally  
23 good goal. We talked about, you know, children  
24 with gender dysphoria, minors with gender  
25 dysphoria who grow up to be transgender adults.



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1 Would you agree that it's good to minimize  
2 their suffering of going through puberty that does  
3 not match their identity?  
4 A I don't know that we know enough right now to say  
5 whether that is -- even for the ones who end up  
6 being adults, I don't know that we know that it's  
7 not a better path, even if it's difficult, to go  
8 through puberty, become an adult, have a  
9 solidified identity and then make a choice to  
10 transition when you have gone through that even if  
11 it was painful or difficult or there was suffering  
12 involved.  
13 So while, yes, we want to minimize suffering,  
14 I don't know that in your hypothetical that we  
15 would be. I think that is one of the many  
16 unknowns.  
17 MR. SELDIN: Joel, will you take us to  
18 Paragraph 154 on the next page, please.  
19 Q Five lines down you say, "Yet, the false binary of  
20 affirmative psychotherapy versus conversion for  
21 gender dysphoria is being used to push therapists  
22 away from consideration that acceptance of one's  
23 biological sex or resolution of gender dysphoria  
24 is a positive event."  
25 Do you see where you wrote that?

Page 191

1 A Yes.  
2 Q This false binary, what do you base that on?  
3 A Well, a lot, there have been many attempts to call  
4 different types of therapy for gender dysphoria or  
5 approaches to people who are transgender as  
6 conversion therapy.  
7 Conversion therapy usually was thought of as  
8 attempts to force changes in sexual orientation.  
9 Those are not any -- I mean, in the distant past  
10 those occurred. They were rejected by the mental  
11 health community a long time ago. They may exist  
12 in certain religious sects or in other parts of  
13 society.  
14 But to then associate regular, you know,  
15 psychotherapy with conversion I think has done a  
16 lot of damage in that people don't want to engage  
17 in deep regular therapy with patients because for  
18 fear of this.  
19 And because patients hear that therapy is not  
20 the solution to their problems. That they really  
21 just need to be affirmed and get medical  
22 treatments. So that can also interfere with the  
23 patient's willingness to do therapy when therapies  
24 are called conversion therapy.  
25 Q So I'm trying to understand the distinction

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1 between this regular psychotherapy that you are  
2 talking about and affirmative therapy.  
3 Earlier you said it would not necessarily be  
4 affirming for a therapist or psychiatrist to say,  
5 Great, I'll use those pronouns. Can you tell me  
6 more about that?  
7 I mean, what is the difference between  
8 regular psychotherapy and affirmative therapy in  
9 that instance?  
10 A Well, that would be fine. It's fine to choose  
11 that approach. But as long as we are getting to  
12 the, Can you tell me more about that, and we are  
13 really truly going down that road it seems like  
14 many proponents of medicalized transitions for  
15 youth are not emphasizing how important it is for  
16 there to be a true process of actual exploration  
17 and a completion of identity development before  
18 medicalized treatment.  
19 And I just think that, you know, the, calling  
20 therapies for gender identity or addressing  
21 elements of gender identity conversion therapy is  
22 an inappropriate attempt to, it's, it makes  
23 therapy a pejorative and it argues against therapy  
24 for kids who really could benefit from therapy.  
25 MR. SELDIN: Joel, will you take us to

Page 193

1 Paragraph 168.  
2 Q Dr. Kaliebe, in Paragraph 168 you say in the  
3 second sentence, "Beyond standard psychotherapies,  
4 more specific and nuanced approaches for gender  
5 dysphoria exist, such as Exploratory Therapy."  
6 Then you include the URL for  
7 [genderexploratory.com](http://genderexploratory.com).  
8 Do you see that?  
9 A Yes.  
10 Q Have you studied Gender Exploratory Therapy?  
11 A I don't know what you mean by "studied." But I've  
12 looked at the site and the approach, yes.  
13 Q What is the evidence base for this approach?  
14 A Well, it's based on long-standing principles of  
15 psychotherapy. And as I note in other parts of my  
16 report, the evidence base in general for  
17 psychotherapy is quite good.  
18 So since we are using lots of the techniques  
19 from standard therapy, my guess is that it would  
20 generalize and be quite good. Just like  
21 everything else, there are very few studies as we  
22 have a very new patient population.  
23 Q You have a hypothesis that can work, but there is  
24 not an evidence base specifically for gender  
25 dysphoria?

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1 A There is a huge evidence base for psychotherapy.  
 2 I don't see any reason that patients with gender  
 3 dysphoria would be so different from all of the  
 4 other patients. So we can look at the massive  
 5 evidence base that there is for psychotherapy and  
 6 assume that all human beings with struggles and  
 7 problems and distress could benefit from talking.  
 8 People have been fine tuning and honing  
 9 therapy for quite a while and there are lots of  
 10 really well proven techniques. I have cited  
 11 cognitive therapy in my report.  
 12 I mean, there is a really strong substantial  
 13 base for this being a very effective tool. So I  
 14 don't see any reason why it would not work in  
 15 gender dysphoria.  
 16 Q You think you have a really good hypothesis, but  
 17 there is not a study showing that --  
 18 A Yes. Yes. There is no study showing it does not  
 19 work, right. There are a lot of studies that show  
 20 it works for everything else. But, no, we do not  
 21 have a specific study in this.  
 22 Q Right. Would you agree that gender dysphoria is  
 23 distress based on the existence of psychological  
 24 characteristics that don't align with their gender  
 25 identity?

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1 A That is a complex question. I'm not sure that  
 2 that is the primary driver for most of or --  
 3 Q Doctor, I don't mean to cut you off. I think  
 4 maybe you misunderstood my question. I'm not  
 5 talking about etiology. I'm just talking about  
 6 what it describes.  
 7 As a descriptive matter, gender dysphoria as  
 8 a distress because of having psychological  
 9 characteristics that don't align with your gender  
 10 identity, is that fair to say that is a  
 11 descriptive matter?  
 12 A I'm not sure. I mean, I think those are elements  
 13 of what is going on. But, in totality, we are not  
 14 really sure what the children and teens, what  
 15 factors are causing them to have the, you know,  
 16 thoughts and feelings that they have.  
 17 But, yes, I mean, I would agree to that, you  
 18 know, that part of the criteria is that there is  
 19 distress about their physical characteristics.  
 20 So I think that there are some qualifications  
 21 and that we really sort of have not fully  
 22 developed theories and knowledge about what is  
 23 driving gender dysphoria.  
 24 But, yes, I would agree that just by the  
 25 criteria, you are talking about someone who has

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1 distress related to their secondary sex  
 2 characteristics and physiology.  
 3 Q And even though you have talked about evidence for  
 4 things like cognitive behavioral therapy as a  
 5 treatment for other conditions, you are not aware  
 6 of any studies regarding the effectiveness of CBT  
 7 for the treatment of gender dysphoria, is that  
 8 correct?  
 9 A Yeah. I'm not aware of any studies that don't say  
 10 it treats it. But I'm not aware of any studies  
 11 that say it does treat it.  
 12 There are lots of studies that say it works  
 13 for a lot of things. It just has not been  
 14 studied, correct.  
 15 MR. SELDIN: Joel, will you take us back  
 16 to Page 56, please.  
 17 Q Dr. Kaliebe, in Paragraph 154 you say, "It is  
 18 surely reasonable and compassionate for a  
 19 psychotherapist to prefer a patient no longer to  
 20 suffer with gender dysphoria."  
 21 Do you see where you wrote that?  
 22 A Yes.  
 23 Q It's your belief that gender dysphoria can  
 24 resolve? Or it's your belief that gender  
 25 dysphoria can possibly be resolved by a person

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1 accepting their biological sex, is that fair?  
 2 A I believe that a component of resolution of gender  
 3 dysphoria could be in many cases, and maybe in all  
 4 cases, that acceptance. So yes, that could be one  
 5 component of it.  
 6 Q Would you agree that gender dysphoria can also be  
 7 resolved by treatments that bring a person's body  
 8 in line with their gender identity?  
 9 A I'm not so -- I think when you talk about the  
 10 patient population of adolescents that we are  
 11 treating, I'm not, I don't think that the evidence  
 12 is overwhelming that that does resolve their  
 13 gender dysphoria.  
 14 There's mixed evidence on that. So I would  
 15 not say that that is a uniform response to gender  
 16 affirming treatment. I would agree it does seem  
 17 there is evidence in some cases it resolves gender  
 18 dysphoria.  
 19 Q So I guess my question is if it's -- and we can  
 20 disagree about the frequency. But if it's  
 21 sometimes resolution through accepting their  
 22 biological sex, or through changing physical  
 23 characteristics to match gender identity, is it  
 24 ethical to totally ban one of those two?  
 25 A Well, I would add there is a third that sometimes

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1 these would just resolve on their own.  
 2 So, yes, I think that we also have to  
 3 understand and consider that gender dysphoria  
 4 could just resolve without treatment. So we don't  
 5 necessarily have to do a medicalized treatment for  
 6 all individuals with gender dysphoria.  
 7 So would it appropriate? Well, I think in  
 8 the case of developing minors, I think it is  
 9 proper to argue that they should wait until  
 10 complete development, and then have sufficient  
 11 psychotherapy and other supports that would help  
 12 them get to a place as an adult and with enough  
 13 time that they have stayed gender dysphoric before  
 14 moving on to medicalized treatments.  
 15 MR. SELDIN: Joel, will you pull up  
 16 Exhibit 7. Take us to Page 1130, which is  
 17 Page 168 of the PDF.  
 18 Q And so, Dr. Kaliebe, we were talking earlier about  
 19 your testimony in the Decker trial that took place  
 20 recently.  
 21 Do you remember we were talking about that?  
 22 A Yes.  
 23 Q This is going to be a long portion of me reading.  
 24 My question at the end will be did I read that  
 25 correctly.

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1 A Okay.  
 2 Q So you know where we are going. So on Page 1130  
 3 of this transcript at Line 11 the Court said -- or  
 4 rather we will start at Line 9.  
 5 "THE WITNESS: Yes, I do not believe that we  
 6 should be doing hormones and surgeries for  
 7 developing adolescents."  
 8 "THE COURT: My question was therapy. And I  
 9 think I take it from your answers that you don't  
 10 think therapy that would make an adolescent  
 11 comfortable with gender identity different from  
 12 the sex assigned at birth is ever appropriate.  
 13 Did I misunderstood it?"  
 14 "THE WITNESS: I would say a little bit. I  
 15 think that we wouldn't have a goal of trying to  
 16 change someone's gender identity in therapy. I'm  
 17 not trying to get to one particular result. It's  
 18 more you want to -- so if that's the end result  
 19 that they have a, you know, a gender identity  
 20 opposite from their natal sex, I am fine with  
 21 that. I'm not opposed to that.  
 22 "I do think that you would have a leaning  
 23 towards or it is sort of a better outcome for most  
 24 kids most of the times, considering the  
 25 co-morbidities and everything going on, that they

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1 come to peace with their natal sex because then  
 2 they don't have all the problems that come from  
 3 not having that, and the distress from not having  
 4 that. But I'm okay with -- obviously, there are  
 5 going to be people that are going to go on and be  
 6 transgender and not be comfortable with their  
 7 natal sex, so you could support that."  
 8 Did I read that correctly?  
 9 A Yes.  
 10 Q Do you still agree with that testimony that you  
 11 provided in Decker?  
 12 A Yes, I think that was very similar to the  
 13 conversation that we just had.  
 14 Q Earlier we talked about a situation in which you  
 15 were comfortable with the certainty of the  
 16 prediction.  
 17 For those children, for minors with gender  
 18 dysphoria who go on to be transgender adults there  
 19 may be a role for medical gender-affirming care  
 20 for those people, would you agree?  
 21 MR. PATTERSON: Objection. It has been  
 22 asked and answered several times.  
 23 You can answer again.  
 24 A You are saying as adults?  
 25 Q Yes. We will start with as adults.

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1 A Repeat the question then before I answer it.  
 2 Q So we talked about before those minors with gender  
 3 dysphoria who go on to be transgender adults.  
 4 Do you believe that there is a role for  
 5 gender-affirming medical care in the form of  
 6 hormones for those individuals?  
 7 A Yes.  
 8 Q Is it your belief it is ever appropriate to  
 9 provide that kind of medical care to someone who  
 10 is under eighteen?  
 11 MR. PATTERSON: Objection. Objection  
 12 asked and answered.  
 13 You can answer.  
 14 A My belief is that there is no evidence base to  
 15 support that practice.  
 16 MR. SELDIN: Joel, will you take us back  
 17 to Exhibit 1.  
 18 Q Dr. Kaliebe, we were talking earlier and you were  
 19 talking about conversion therapy in the context of  
 20 sexual orientation.  
 21 Do you remember that?  
 22 A Yes.  
 23 Q You said it was rare. Do you recall saying that?  
 24 A Yes. I qualified that conversion therapy was, if  
 25 it is carried out these days, it's typically

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1 carried out within parts of our society that are  
2 not related to mental health care or medical care.  
3 Q What do you base that statement on?  
4 A That in all of my experience I've not encountered  
5 medical or mental health professionals who would  
6 attempt to change anyone's sexual orientation.  
7 Nor have I ever seen any compelling evidence of it  
8 in any of our medical journals.  
9 Q Any evidence of it happening, you mean?  
10 A Correct. Within the medical community or mental  
11 health community, correct.  
12 Q We will look at Page 59.  
13 Dr. Kaliebe, earlier you had mentioned that  
14 you thought trauma might have a role in gender  
15 dysphoria in some minors.  
16 A Correct.  
17 Q For minors who have no history of trauma this  
18 hypothesis would not be applicable, right?  
19 A Correct.  
20 Q And would you agree, or rather, do you think that  
21 there are people who have gender dysphoria who  
22 separate and unrelated have had some kind of  
23 trauma in their life?  
24 A Correct. You can see if something occurred before  
25 the development of the gender dysphoria or at the

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1 same time as the development of the gender  
2 dysphoria.  
3 We would call that a co-occurring disorder if  
4 it occurred at the same time or around the same  
5 time, but after the trauma.  
6 Q Would you agree then that -- once someone's trauma  
7 has been adequately addressed it is possible that  
8 that person could still have gender dysphoria?  
9 A Yes.  
10 Q Okay.  
11 MR. SELDIN: We have been going a little  
12 over an hour. Is now a good time for a five  
13 minute break for folks? Let's come back at 3:37  
14 Eastern.  
15 (OFF RECORD AT 3:31 P.M.)  
16 (AT THIS TIME A SHORT RECESS WAS HELD OFF  
17 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS  
18 WERE HAD:)  
19 (ON RECORD AT 3:37 P.M.)  
20 BY MR. SELDIN:  
21 Q Let's look at paragraph -- sorry.  
22 MR. SELDIN: Joel, will you bring up  
23 Exhibit 15. Click us through to that link.  
24 Q You recall earlier you mentioned this conference  
25 you spoke about. Oasis.

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1 A Yes.  
2 MR. SELDIN: Joel, will you scroll down.  
3 Keep going.  
4 Q I believe this is -- does this look like the  
5 agenda from the conference that you were talking  
6 about?  
7 A Okay. Hold on. This is the adult conference.  
8 Q Okay. The adult conference. Okay. There was a  
9 separate child conference?  
10 A Correct.  
11 Q Well, let's stay here for a moment. So,  
12 Dr. Kaliebe, you said that you provided three  
13 different CME lectures at this weekend in  
14 Puerto Rico, is that right?  
15 A Of the child. Two for adult and three for child.  
16 Q Okay. So are these the two for the adult that you  
17 were talking about?  
18 A Correct. Yes.  
19 Q So the agenda would be listed separately for the  
20 child conference?  
21 A Yes.  
22 Q I'm asking because I only saw two of the three. I  
23 was not sure where the third had gone. We will  
24 take a look at that in a second.  
25 MR. SELDIN: Joel, will you pull up

Page 205

1 Exhibit 16.  
2 Q Earlier you said you had a Twitter account. Is  
3 that your handle?  
4 A It must be ancient. Maybe I just joined to read  
5 some things. I don't know that I have a handle.  
6 I don't ever tweet anything. Maybe when I logged  
7 in it connected to me through Google or some other  
8 way. Like I said, I have gone on to read things.  
9 Q Is that photo there --  
10 A That is me in the photo.  
11 Q Is that a New Orleans Saints jersey?  
12 A It is a Saint's jersey, yes.  
13 Q So that is you. The bio says "psychiatrist and  
14 septic."  
15 Does that sound like something you would  
16 write?  
17 A It is. I don't remember -- anyway. Yeah. I  
18 would write that. I don't remember.  
19 Q Okay. You don't have any reason to believe this  
20 is a different Kristopher --  
21 A That is me.  
22 Q Okay. All right. And then we will scroll down.  
23 You said you used Twitter to read some things.  
24 It looks like that this profile liked this  
25 tweet by Dr. Jordan B. Peterson that says, "Why

Page 206

1 can't we tell the truth about Lia Thomas?"

2 It links to an article on spiked-online.com.

3 Do you see that?

4 A Yes.

5 Q Do you recall liking this tweet?

6 A I believe that is accurate that I probably did.

7 Q Do you recall reading this article?

8 A I don't know that I ever read the article, no.

9 Q Okay.

10 A I may have. I may not have.

11 MR. SELDIN: Joel, scroll down.

12 Q You liked another tweet on March 28, 2022. This

13 was posted by komunik8e to Jordan Peterson. It

14 says, "The Party told you to reject the evidence

15 of your eyes and ears. It was their final, most

16 essential command."

17 That is a George Orwell quote from 1984

18 superimposed on a photo of Lia Thomas.

19 Do you recall liking this tweet?

20 A No. I don't doubt that I did if it showed up in

21 my profile.

22 Q What do you think this graphic means?

23 A What does the graphic mean? Well, I think there

24 is, the graphic means that there seems to be a

25 problem with inclusion of biological males in

Page 207

1 women's sports and that we, you know, that this is

2 an issue that seems, I think, important and that

3 we should have an honest proper discussion about

4 it.

5 And my opinion is that it's important to keep

6 women's sports to those who are biologically

7 female with whatever, you know, definition that

8 you have. Yes, I would agree that is the main

9 part.

10 The bigger part, though, is the, you know,

11 there is an Orwell quote. As I was mentioning

12 regarding, regarding, you know, silencing of

13 debate, it seems like that we have not had any

14 sort of proper dialogue, especially in the medical

15 journals and within medical societies about how we

16 are going to handle these complex issues.

17 So, you know, therefore, the George Orwell

18 quote I think is, you know, part of why I tweeted

19 it. Or why I liked it. I have never tweeted

20 anything as far as I know.

21 MR. SELDIN: Joel, scroll down to the last

22 page.

23 Q You will see you liked a tweet from Andre MCato on

24 March 28, 2022. The tweet that you are liking

25 says, "Who has the courage to interview Thomas and

Page 208

1 ask him how he justifies winning among women? In

2 a free society, that interview would have already

3 happened."

4 Do you see that?

5 A Okay. Yes.

6 Q Do you recall why you liked that tweet?

7 A No. I think it speaks for itself.

8 Q What do you mean?

9 A Well, I think that we should have a close look at

10 what is going on. And, you know, to me this is a

11 problematic issue when someone swims as a

12 biological male for three years in college and

13 then transitions and then swims as a female.

14 So, once again, this is something that I

15 think is challenging, but there is a clear answer

16 that most people would support. And I support

17 that biological sex when it comes to sports is

18 very important.

19 It is quite unfair for female participants if

20 someone who is a biological male and gone through

21 biological puberty is then allowed to compete with

22 biological females.

23 Q You would agree that Senate Enrolled Act 480 has

24 nothing to do with sports?

25 A Correct.

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1 Q Okay. And you will see that this tweet uses male

2 pronouns to refer to Lia Thomas.

3 Do you think that is appropriate?

4 A You know, once again, I don't think it's a big

5 deal. I don't know that I noticed whether it used

6 male pronouns or not. I mostly was liking things

7 that brought up this issue of fairness and, you

8 know, basically allowing women to compete fairly

9 in women's sports, which I think is an important

10 issue.

11 MR. SELDIN: Joel, I'm dropping into the

12 chat a link which I will call Exhibit 17 for

13 purposes of this exercise. If you can take us

14 there.

15 Q Is Exhibit 17 the agenda for the child portion of

16 the Oasis conference?

17 A Yes. You would have to scroll down to see the

18 rest.

19 Q You will see -- Dr. Kaliebe, do you see there are

20 two CMEs listed with your name next to them?

21 A Yes.

22 Q "Social Media and Cyberbullying: Prevention."

23 A Yes.

24 Q The second one is, "Cannabinoid: New Forms and

25 New Problems."

Page 210

1 A Yes.

2 Q I guess my question is earlier you talked about

3 presenting on gender dysphoria specifically at the

4 child portion of this conference.

5 I'm just wondering why it's not listed here?

6 A Yeah. Well, that's a good question. I've not

7 accessed this before. This is also garbled

8 because the presenters do not match up. I did not

9 represent on cannabinoids. I did present on the

10 social media. Some of this is messed up.

11 Q Okay. Did you present one or two CMEs?

12 A Three. I presented three.

13 Q Are the three that you did listed here?

14 A No. So only one is listed here. I presented the

15 social media one. I'm not sure if the other ones

16 are wrong or what is wrong on this. I presented

17 on the three. It was Social Media and Cyber

18 Bullying. It was Traumatic Brain Injury and

19 Gender Dysphoria. What is listed there is

20 incorrect.

21 Q Do you recall what the title of that CME would

22 have been on gender dysphoria?

23 A I know gender dysphoria. It was Reviewing the

24 Evidence or something like that.

25 MR. SELDIN: Joel, will you please bring

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1 up Exhibit 3.

2 Q Earlier today we talked about this as the C.V.

3 that you attached to your report in Boe v.

4 Marshall.

5 A Yes.

6 Q Look at Page 107 of this PDF. You will see,

7 Dr. Kaliebe, on Page 21 it says at the top that

8 you were a member of Zero To Three from 2017 to

9 2021.

10 Do you see that?

11 A Yes.

12 Q What is Zero To Three?

13 A Zero to Three is an organization devoted to young

14 children. So this is, there's a field, sometimes

15 people call it infant psychiatry or infant mental

16 health.

17 The first few years of life are incredibly

18 important. This is an organization devoted

19 towards supporting children, infants, young babies

20 and also their caregivers, especially their

21 mothers.

22 So Zero To Three is a professional

23 organization of those devoted to trying to promote

24 support for moms and babies.

25 Q Why did you stop being a member after 2021?

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1 A I had presented a couple times at their

2 conference. I do a lot of different things. So

3 that was not totally, or, you know, I didn't feel

4 like it was -- I just do so many things. I had to

5 give some things up. It's a great organization.

6 I would be happy to join or contribute again in

7 the future.

8 Q And then we will look at Exhibit 8 next. This is

9 an article on the Zero To Three website dated

10 December 15, 2021.

11 It says, "Embracing Diversity: Developing a

12 Gender Identity."

13 Do you see this article?

14 A Yes.

15 Q Have you seen this article before?

16 A No.

17 MR. SELDIN: Joel, scroll down to

18 "Supporting Healthy Development."

19 Q I will read something. My question will be did I

20 read that correctly.

21 Under Supporting Healthy Development it says,

22 "Make sure your child knows they have your

23 support. Gender identity is a central part of a

24 child's identity and well-being. Parents don't

25 make their children cisgender or transgender.

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1 This is also not a choice children make - it is

2 simply who they are. To grow up healthy, every

3 child needs to know that they are fully accepted,

4 loved, and supported."

5 Did I read that correctly?

6 A Yes.

7 Q Do you agree with that?

8 A Yeah.

9 Q Dr. Kaliebe it says, "Read stories that feature

10 all kinds of families, as well as stories that

11 include transgender, non-binary, and gender

12 expansive characters. Shared reading is a

13 powerful way for all families to nurture an

14 inclusive worldview and challenge stereotypes from

15 the start."

16 Then it links to some suggested titles.

17 Did I read that correctly?

18 A Yes.

19 Q Do you generally agree with that advice?

20 A You know, I don't, I'm not sure that if we are

21 talking about Zero To Three, you know, which is

22 really like, you know, very, very young children.

23 I think, you know, it's debatable what positive

24 influence you would have in a very, very young

25 child introducing these different characters.

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1 I don't think, you know, I'm not necessarily  
2 opposed to it. But I'm also not thinking that  
3 this is a, you know, that this is necessarily  
4 important.  
5 I mean, yeah, I mean, once again, I think I  
6 would honestly, I personally would have a somewhat  
7 different emphasis. I don't think there is  
8 anything wrong with reading stories that include  
9 transgender or nonbinary, or gender expansive  
10 characters.  
11 Q Dr. Kaliebe, further down there is a section that  
12 says, "Build an inclusive community."  
13 It says, "This is important for all kids, and  
14 it's especially important for kids who may later  
15 identify as LGBTQ. In the past, one of the  
16 toughest things for kids discovering that their  
17 sexual orientation or gender identity was  
18 different than those around them was a feeling of  
19 being alone. Actors, politicians, teachers,  
20 sports stars, family, and friends who are upfront  
21 about their identities help make the world more  
22 comfortable for questioning kids. Make it clear  
23 that all people are welcome in your community and  
24 in your household. Living your values in this way  
25 shows your child that they will be loved however

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1 they show up and whoever they become."  
2 Did I read that correctly?  
3 A Yes.  
4 Q Do you agree with that?  
5 A Yes. It is important for us to have broad roles,  
6 or a broad range of how what, of how children can  
7 act. I do think it is important that we accept  
8 boyish girls and girlish boys and don't try to  
9 pigeonhole kids into my particular gender  
10 expression.  
11 So I would definitely agree that allowing a  
12 wide range of gender expression is important.  
13 Q Do you think that extends to people who are  
14 transgender?  
15 A Well, I think we have had this conversation  
16 already. Children with gender dysphoria I would  
17 not categorize as transgender. I would say they  
18 are a child with gender dysphoria because I don't  
19 think it is appropriate to place an identity on a  
20 child.  
21 So within their life we should make room for  
22 children to express themselves in any way,  
23 including gender nonconforming ways.  
24 So, yes, we are in agreement that we need to  
25 make space for all children, including gender

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1 nonconforming children. And that it is important  
2 for society to create space for gender  
3 nonconforming children.  
4 Where I think we are not on the same page or  
5 there is some difference of viewpoint is that I  
6 think it's important to emphasize that what we are  
7 talking about in, you know, we are saying gender  
8 nonconforming could be fine and not gender  
9 dysphoria.  
10 But if we are talking about a gender  
11 dysphoria child, I'm not for labeling that child a  
12 transgender child. I think that we can label them  
13 a child with gender dysphoria.  
14 Q In the middle of this paragraph it says, "Actors,  
15 politicians, teachers, sports stars, family, and  
16 friends who are upfront about their identities  
17 help make the world more comfortable for  
18 questioning kids."  
19 Do you see that?  
20 A Yes.  
21 Q Earlier today we were talking about whether  
22 celebrities who are openly transgender are a  
23 source of social contagion. You thought they  
24 might be.  
25 Do you remember us talking about that?

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1 A Yes.  
2 Q Do you think these two, this sentence and that  
3 belief are in tension with each other?  
4 A Well, I think there's a lot of nuance. As I said,  
5 I think we have to be careful about anything that  
6 may encourage children to want to change their  
7 body prior to them fully developing as  
8 individuals.  
9 So I think that there is a challenge there in  
10 wanting to accept a child as they are whether that  
11 is gender nonconforming or not. So making space  
12 for all children, but not having children feel  
13 pressured that they would need to change their  
14 body prior to them fully developing.  
15 Q But per this paragraph just about people being  
16 upfront about their identities, do you think just  
17 being upfront about identity as a transgender  
18 adult, that that is a source of social contagion?  
19 A No, that is fine.  
20 MR. SELDIN: Dr. Kaliebe, Mr. Patterson,  
21 it may be that I'm able to wrap up soon. I think  
22 another break might help me determine that.  
23 Would you be opposed to a longer break,  
24 about ten minutes until 4:13?  
25 MR. PATTERSON: Fine.

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1 (OFF RECORD AT 4:02 P.M.)  
 2 (AT THIS TIME A SHORT RECESS WAS HELD OFF  
 3 THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS  
 4 WERE HAD:)  
 5 (ON RECORD AT 4:09 P.M.)  
 6 MR. SELDIN: Dr. Kaliebe, thank you for  
 7 the conversation today. Unless Mr. Patterson has  
 8 questions that I want to follow up, I think we are  
 9 at an end.  
 10 MR. PATTERSON: I don't have any  
 11 questions. I think we are done.  
 12  
 13  
 14 AND FURTHER DEPONENT SAITH NOT  
 15  
 16  
 17 \_\_\_\_\_  
 18 KRISTOPHER KALIEBE, M.D.  
 19  
 20  
 21  
 22  
 23  
 24  
 25

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1 STATE OF INDIANA )  
 2 ) SS:  
 3 COUNTY OF BOONE )  
 4  
 5 I, Wendi Kramer Sulkoske, Notary Public in and  
 6 for said county and state, do hereby certify that  
 7 KRISTOPHER KALIEBE, M.D., the deponent herein was  
 8 by me first duly sworn to tell the truth in the  
 9 aforementioned matter;  
 10 That the foregoing deposition was taken on  
 11 behalf of the Plaintiffs at the time and place  
 12 heretofore mentioned with counsel present as  
 13 noted.  
 14 That the deposition was taken down in  
 15 Stenograph notes, reduced to typewriting under  
 16 my direction, is a true record of the testimony  
 17 given by said deponent, and was thereafter  
 18 presented to the deponent for signature.  
 19 That this certificate does not purport to  
 20 acknowledge or verify the signature hereto of  
 21 the deponent.  
 22 I do further certify that I am a  
 23 disinterested person in this cause of action;  
 24 that I am not a relative or attorney of any of  
 25 the parties or otherwise interested in the event  
 of this action, and am not in the employ of the

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1 attorneys for the respective parties.  
 2 IN WITNESS WHEREOF, I have hereunto set my  
 3 hand and affixed my notarial seal this \_\_\_\_\_  
 4 day of \_\_\_\_\_ 2023.  
 5  
 6 *Wendi K. Sulkoske*  
 7  
 8 \_\_\_\_\_  
 9 Wendi Kramer Sulkoske, Notary Public  
 10  
 11 Commission Number NP0661030  
 12 My commission expires December 1, 2030.  
 13 My County of residence is Boone.  
 14  
 15  
 16  
 17  
 18  
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 24  
 25

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NOTICE OF FILING

UNITED STATES DISTRICT COURT  
 SOUTHERN DISTRICT OF INDIANA  
 INDIANAPOLIS DIVISION

K.C., et al, )  
 Plaintiffs, ) Case No.  
 ) 1:23-cv-00595-JPH-KMB  
 -vs- )  
 THE INDIVIDUAL MEMBERS OF THE )  
 MEDICAL LICENSING BOARD OF )  
 INDIANA, in their official )  
 capacities, et al., )  
 Defendants. )

In compliance with the Indiana Rules of  
 Procedure, Rules of the Industrial Board or Federal  
 Rules of Procedure, pursuant to Indiana Supreme Court  
 Order dated 10/1/86, you are notified that the signed  
 original deposition of KRISTOPHER KALIEBE, M.D.,  
 taken on behalf of the Plaintiffs on June 1, 2023 has  
 been sealed and submitted to the originating party,  
 along with the attached Errata Sheet(s), if  
 applicable.

(Date Received by Circle City Reporting)

CIRCLE CITY REPORTING  
 135 North Pennsylvania, Suite 1720  
 Indianapolis, Indiana 46204



<b>A</b>	102:25;161:1; 165:18;206:6	9:18;38:20;155:21	141:17	30:16,20;50:25; 95:14;100:13,17; 102:6;105:4;111:25; 143:10;192:23
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<b>AACAP (4)</b>	72:1	12:7,22;134:9	80:18;125:1; 126:16;127:2	48:3;63:18,19,22; 64:9,14,21;65:11,19, 22;66:3,6
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<b>AAP (1)</b>	142:12	192:20	113:15;157:6	204:5,19;209:15
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<b>academically (1)</b>	64:20;82:5	26:16;77:24;79:19; 81:9;82:7,21;93:24; 94:17;116:19; 132:14;197:10;199:7	28:23	7:20
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