UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

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

DEPOSITION OF KRISTOPHER KALIEBE, M.D.

The deposition upon oral examination of KRISTOPHER KALIEBE, M.D., a witness produced and sworn before Wendi Kramer Sulkoske, Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiff via videoconference in Tampa, Hillsborough County, Florida on June 1, 2023, pursuant to the Federal Rules of Civil Procedure.

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(Via Video Conference)

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Bailey Steinhauer, Andrew Shaw
Charles Ferguson

EXAMINATION INDEX

EXHIBIT INDEX

KRISTOPHER KALIEBE, M.D.
the witness herein, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:
EXAMINATION,
QUESTIONS BY MR. SELDIN:

Q Dr. Kaliebe, good morning.
A Good morning.
Q My name is Harper Seldin. I'm an attorney with the ACLU for the plaintiffs on this matter. Joining me is Stevie Pactor, along with Gavin Rose, along with some interns as well as an intern from the national office.
How are you this morning?
A I'm good.
Q So just to do a little bit of table setting and some housekeeping and then we will get right to it.
MR. SELDIN: Mr. Patterson, I don't know if you want to enter an appearance for the record?
MR. PATTERSON: I'm appearing on behalf of the defendants and to defend this deposition.
Q Dr. Kaliebe, have you had your deposition taken before?

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

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

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Q As of this moment it contains all of the opinions that you intend to offer?
A Yes.
MR. SELDIN: Joel, could you scroll us down toward the end.
Q Dr. Kaliebe, I don't believe there was a C.V. attached to this declaration. I just want to go to the end. I believe it just includes a list of publications. I just want you to confirm that that is the case.
A Correct.
Q Okay.
MR. SELDIN: Joel, can you pull up Exhibit 3 for us.
Q My question, Dr. Kaliebe, is just going to be do you recognize this document?
A Yes.
Q What is this?
A This is another report, expert report for the state of Alabama.
Q And I believe there was a C.V. attached to the end of this.
MR. SELDIN: Joel, if you can scroll down for us, please. I believe it starts at about Page 87 of the PDF.

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

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

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

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

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Q Did you have an opportunity to review your deposition transcript in Decker to submit an errata?
A Yes.
Q Did you submit any errata?
A Yes.
Q Did your errata address your different understanding of those questions or --
A My errata contained what I thought were misquotes of myself. I didn't see the errata as a time to change my answer on things. I just saw it as a time to correct any errors in the transcript. So that is what is in the errata.
Q When did it become apparent to you that perhaps you would have changed some of your answers in this deposition if you had understood the question differently?
A When I read the transcript.
Q Okay. So is it fair to say -- so you read the transcript for errata. You changed what you believed were misquotes, but you did not seek to address to change your answers when you had a new understanding of the questions?
A Correct.
Q Okay. So for purposes of this deposition let's

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

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wrong page on this one. Give me a second.
A I was the second witness in the afternoon.
Q Let me find the right page. I apologize.
MR. SELDIN: Joel, I think it's 1095 or try Page 133.
Q Dr. Kaliebe, do you see where it says Direct Examination and then --
A Yes.
Q Is this a copy of your trial testimony in Decker?
A Yes.
Q Were you truthful during that testimony?
A Yes.
Q Did you do your best to answer honestly?
A Yes.
Q Was that true when the state of Florida was asking you questions?
A Yes.
Q Was that also true when plaintiffs in that case were asking you questions?
A Yes.
Q I believe that the court in that case also asked you some questions while you were on the stand. Do you recall that?
A Yes.
Q Did you do your best to be truthful when answering

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the judge in that case?
A Yes.
MR. SELDIN: Joel, can you pull up Exhibit 6 for us.
Q Dr. Kaliebe, have you ever seen this document before?
A Yes.
Q What is this document?
A It's a Plaintiff's Memorandum of Law in Support of Motion to Exclude Expert Testimony of Dr. Kristopher Kaliebe.
Q Is it your understanding then that the plaintiffs in Decker tried to exclude your testimony in that case?
A Yeah. I just found that out the other day.
Q I'm sorry. You said --
A Yes. I guess so. I just found out.
Q Do you know whether the court has resolved this motion yet?
A No.
Q Were you aware prior to testifying for Decker that this motion had been filed?
A No.
Q Thank you so much.
MR. SELDIN: Joel, we can take that down

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for now. Thank you.
Q Dr. Kaliebe, I will ask you some questions about how you prepared for today's deposition.
Just to head trouble off at the pass, I'm not asking you what you talked about with your lawyers. I'm asking you questions about the where and who, but not the what.
I'm sure Mr. Patterson will cut you off if you try. I just want to be clear about that ahead of time.
So my question is just going to be how did you prepare for today's deposition?
A Well, I did have a meeting, I think it was Sunday, with the lawyer for about forty-five minutes. So I had one meeting with the lawyer. The other prep was I read my report. I read the deposition that I gave. I read my trial testimony.
Q When you say you read the deposition that you gave, are you referring to the deposition in Decker that we were just talking about?
A Yes.
Q When you say your trial testimony, are you referring to the trial testimony in Decker that we were just discussing?
A Correct.

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Q Do you recall which lawyer you met with for about forty-five minutes this past Sunday?
A Yeah. I hate to -- I do not remember Brian's last name. There has been a lot of switching of the lawyers.
Q Any part of their name will do.
A Brian.
Q Did you say Brian?
A Yes.
Q Is that Brian Barnes with Cooper and Kirk?
A I believe it is.
Q Any other attorneys that you spoke with?
A No.
Q Okay. Any other meetings other than that forty-five minute meeting?
A No.
Q Did you speak with anyone else at all in preparation for today's deposition?
A No.
Q Okay. Other than your report or your declaration in this case, your deposition testimony in Decker, and your trial testimony in Decker, did you review any other documents to prepare for today's deposition?
A Well, I continually am educating myself and

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reading more reports, articles, and such. None of them were in preparation for this deposition though.
Q Did you review the expert declarations from Dr. Shumer, Dr. Karasic, or Dr. Turban?
A I did.
Q Did you review the transcription of their depositions?
A I did.
Q Did you review any of the declarations submitted by Indiana's other experts?
A No, I did not.
Q I'm sorry?
A No. I don't believe so. Just those three.
Q In the process of preparing for today's deposition, did you review any of the medical records of the plaintiffs in this case?
A I reviewed medical records, but not regarding, you know, it was a while back. It was not regarding this deposition.
Q So did you review the plaintiffs' medical records in your declaration?
A I did review them. But I decided, it was decided to not, you know, include anything regarding those records in my report.

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So if that answers your question, I reviewed the records. I did not, you know, formulate opinions or, you know, add anything into my report related to that. So I did review them, but I didn't comment on them.
Q Have you spoken to Diana Kenny, who is one of the experts in this case that Indiana has proffered?
A No.
Q Have you spoken with Daniel Weiss, who is another of the Indiana experts in this case?
A No.
Q Have you spoken with Paul Hruz?
A No.
Q Have you spoken with James Cantor?
A No.
Q When we were talking earlier about your deposition in Decker you referred to part of the transcript where you discussed speaking with your wife, Dr. Olga Kaliebe, who is a board certified endocrinologist, is that correct?
A Yes.
Q Have you spoken with your wife, Dr. Kaliebe, about this case?
A No.
Q Did she assist in any way in your declaration in this case?
A No.
Q Thank you, Dr. Kaliebe.
Anything else that you did to prepare for today's deposition that we have not covered?
A No.
Q Then Dr. Kaliebe, I want to talk a little about your background. You are board certified in psychiatry, is that correct?
A Yes.
Q You are also board certified in child and adolescent psychiatry, is that correct?
A Yes.
Q And forensic psychiatry as well?
A Correct.
Q Do you have any other board certifications?
A No.
Q Do you have any formal training in sociology?
A Well, I believe during medical school and residency, yeah, training in the broad range of the field, which sociology is somewhat included within psychiatry. So psychiatry has some sociology included.
Q Was there a specific course in sociology that you took as part of your medical training?

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A Well, since psychiatry deals with biopsychosocial phenomenon in people, sociology is a component of how you are trained. So the social part is quite important.
As I said, what people think about how you approach the patient is biopsychosocial. So social is a major component. In psychiatry we frame our approach to patients as biopsychosocial. So social matters are essential and a large part of psychiatry. So there's a lot of psychiatric training and medical school training.
So, yes, it is quite important to be up on social matters and understand social interactions. That is a large component of our training.
Q And how are you defining sociology?
A Well, how am I defining sociology? In psychiatry social matters are very important. Social interactions are the basis of sociology is my understanding. So that is how I was applying them.
Q Fair to say that in psychiatry you are treating individual patients, correct?
A Well, you do. You treat families. You treat them within a context. You are also asked for input regarding matters that are more broad. So, you

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know, it depends. Yes. Typically our model is individual patients or families.

COURT REPORTER: Doctor, I'm sorry. you are cutting out and I am having a hard time hearing you.

MR. SELDIN: Let's go off the record.

(OFF RECORD AT 10:00 A.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 10:01 A.M.)

BY MR. SELDIN:

Q Thank you, Dr. Kaliebe. Do you treat families in your psychiatry practice currently?

A When you practice child psychiatry you typically do see the family. Right? You have to see the family. So you are doing family work.

Q I'm not asking typically. I'm asking do you specifically treat families currently in your psychiatry practice?

A Yes. I mean, when you work in child psychiatry you work with the family, yes.

Q And when you say you work with the family, you mean providing psychiatric treatment to the family and consulting with the family about the child?

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A Well, neither of those is the right way to frame it. You work with a child and family together. The child may be the assigned patient, but you are working with the entire family.

Q Do you prescribe medication as part of your psychiatry practice?

A Yes.

Q Are you prescribing medication to any of the parents or the family members of your child patients as part of your practice?

A No.

Q Do you provide psychotherapy as part of your psychiatric practice?

A You would provide parent training. So, yes, you are providing -- it's not, it's family work so you do some family therapy. Even when you are in a room with a parent and the child together that is a therapeutic interaction with both members.

Q Then other than the training in sociology that you talked about as part of your medical training, do you have any other training in group dynamics or organizational dynamics?

A We receive some of that training as, you know, in medical school and during your residency and because I was the program director and was

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involved in training when I was at LSU you do learn about a lot of organizational stuff because you do the trainings that the universities do to help understand how to run a residency and work with trainees.

There is some organizational work, some organizational training that I received as part of that. Each medical school has a medical education department. They do trainings about other work systems.

Q Anything other than that?

A Not that I recall.

Q And then in your declaration you said that gender dysphoria and its treatment were part of your professional training.

Do you recall that part of your declaration?

A Yes.

Q Okay. And what professional training did you receive on gender dysphoria or its treatment?

A Well, at the time it would have been called gender identity disorder. I use the modern term. But when you are doing a general psychiatry residency your section of the training in medical school includes a section of training or learning that includes those disorders.

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In child psychiatry residency, you have training that includes those disorders. So at every level of training you get some education regarding, you know, at that point it was gender identity disorder, but now it's called gender dysphoria.

Q Did you take any specialized or targeted classes that dealt with gender identity disorder or gender dysphoria as part of your medical school training?

A No.

Q Okay. Have you done any continuing education on gender identity disorder or as it was previously called or gender dysphoria?

A Yes.

Q What continuing education have you done?

A Okay. So I attend meetings at the American Academy of Child and Adolescent Psychiatry, they have CME meetings at every annual meeting. And I attended in the last four years, five years, I would guess about half a dozen, maybe more, of the presentations, or I bought the, you know, you get the audio package later.

With COVID it kind of got messed up so it was not the usual conference. We were doing online

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not real time so you could watch later. Because of that I would not say that all of the ones I watched every single minute of, you know, during that online period.

When you are in person you know that you sit there through the whole presentation. So I would estimate at least six presentations which are CME presentations from the American Academy of Child and Adolescent through the annual meeting.

Most of them were at the time of the annual meeting, but some of them were later because I get the package where you can watch them later so if you miss something you can go back and watch.

I was at the American Psychiatric Association meeting last year and attended a CME meeting related to gender dysphoria and adolescents. And I downloaded, or I also participated in one of the American Psychiatric Association trainings related to gender dysphoria this year.

Q So it sounds like those first six CME credits that you were talking about, were those all related to gender dysphoria or its treatment?

A Yes.

Q Okay. So the past four or five years about how many hours of CME training do you think you have

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had on gender dysphoria or its treatment?

A About ten.

Q Okay. And so six years ago and later about how many hours of CME credit do you think you had related specifically to gender dysphoria or gender identity disorder?

A Only to the degree it was included in larger programs. So at that point I had not sought out any. So one answer to that question is none.

Or only as it was included in course reviews or other classes. Because when you do, when you go to the annual conference there's a performance and practice feedback that you do, which is asking and answering questions about different topics in child psychiatry. That includes topics related to gender dysphoria.

Then also when you do board review there are sections of board review that are also related to gender dysphoria and gender dysphoria treatments. That is a general review of all topics, but it includes those.

So I did retake my boards, I'm guessing in 2005. Then in 2015 would have been my redo for my child psychiatry boards. So I would have to study. But you do get CME for taking the board.

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That is considered continued medical education, taking the board review.

Q Doctors have a better deal than lawyers when it comes to CLEs.

A It's expensive.

Q Other than the ten hours we talked about and the education that you would have gotten in the ordinary course as part of your board certifications and continuing training, anything else since 2005?

A I do not believe anything else that was CME.

Q Okay. How did you come to be an expert in this case?

MR. PATTERSON: I will object to the extent it calls for attorney/client privilege communication.

Q Let me break it down a little more in smaller chunks to see if we can avoid the problem. This is a yes or no question.

Did the state of Indiana reach out to you about becoming an expert in this case?

A Yes.

Q So you did not affirmatively reach out to them, is that correct?

A Correct.

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Q When was the first case -- excuse me.

Prior to Decker, were you an expert in any case involving gender dysphoria or its treatment?

A No.

Q Other than Decker and Boe v. Marshall, have you been involved in any case involving gender dysphoria or its treatment?

A No.

Q In your C.V. and in Boe and in your declaration you listed your prior expert engagements.

Fair to say other than Decker, Boe, and this matter, none of the rest would pertain to gender dysphoria or its treatment?

A Correct.

Q In which case did you become an expert first, Decker or Boe?

A Decker.

Q Okay. In the Decker matter in Florida, did the state of Florida reach out to you about becoming an expert?

A Yes.

Q Were any third parties involved in making that connection between you and the state of Florida?

A I actually don't know.

Q Prior to Decker had you ever held yourself out as

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an expert in gender dysphoria or its treatment?
A No.
Q Have you ever lobbied before a state legislature?
A No.
Q Have you ever testified before a state legislature?
A No.
Q The same question at the federal level, have you ever lobbied for federal legislature?
A No.
Q Have you ever testified before Congress?
A No.
Q You are aware this case involves Senate Enrolled Act 480 in Indiana, correct?
A Correct.
Q Have you made any public statements for or against Senate Enrolled Act 480?
A No.
Q Have you ever made any public statements for or against any other laws pertaining to the treatment of gender dysphoria in minors in other states?
A No.
Q No op eds or letters to the editor? Nothing like that?
A Correct.

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Q Dr. Kaliebe, I will ask you some questions about your background. They come from the portions of your declaration and when we talk about it if you would like to refer to those, let me know and we will pull up Exhibit 1.
My questions will be what were the circumstances of starting or stopping various jobs. I'm not trying to trick you. If you want to refer to that for dates, just let me know.
According to your declaration you stopped being the assistant professor at LSU Health Science Center in 2016, is that correct?
A Yes.
Q What prompted the end of your employment there?
A I moved to Tampa, Florida. It did not totally end my employment with LSU. I'm not exactly sure how long I remained with some contracts in Louisiana. I retained my medical license in Louisiana and still had an LSU collaborative care contract when I moved to Florida. I can't exactly say that it ended.
I mostly became a University of South Florida employee and had moved to Tampa. I had a collaborative care contract, I believe it was for one more year at LSU, you know, doing psychiatry

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and collaborative care back to Louisiana. But I mostly moved from Louisiana to Florida, thereby changing my work from mostly LSU to mostly the University of South Florida.
Q Did your role at LSU involve clinical treatment?
A Yes.
Q Did it involve clinical supervision?
A Yes.
Q Did you teach?
A Yes.
Q Did you perform research?
A Yes.
Q Okay. Did you have any administrative responsibilities?
A Yes.
Q Here is the tough question, what percentage of your job do you think was clinical treatment versus the other things we just talked about?
A So when I was at LSU my job involved, it changed over time. That is not a question that I can answer easily because there were different times with different roles.
Mostly I would do clinical work. So, you know, I was mostly a clinician. But I would say I was heavily a clinician educator. So I was always

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very involved with the training programs and teaching. So I always had a large teaching role.
In my clinical sites I would have students or residents come with me where I was working a lot of the time and people would, you know, sit in with me. So I had a clinical role, which included some resident supervision. Then if you want me to breakdown the numbers --
Q I think that is a good answer. Thank you.
A Okay.
Q In your current role at USF do you have roughly the same mix of responsibilities in terms of being a clinician and teaching?
A Well, yes and no. When I moved to Florida I was offered a number of contracts in corrections which was actually a little bit more time in juvenile corrections than I was spending in Louisiana. So I do more correctional work in Florida than I was doing in Louisiana hours-wise.
Recently I'm doing more forensic cases so I'm doing more forensic work. My clinical role in Florida was significantly decreased in terms of, like, having an individual patient clinic. Right? So I have two resident clinics right now.
But that is, you know, a lot less sort of

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direct patient care and, you know, very little independent patient care compared to what I was doing in Louisiana.
Q Dr. Kaliebe, how long have you been practicing psychiatry?
A Well, I finished my first residency in, which would be the general psychiatry residency as I transferred into child psychiatry, that would be in 2004.
At that point, because I was already moonlighting, which was an independent practice, you know, I would say my first independent practice was 2001 or 2002. So during your residency sometimes you are also independent practicing. So I would have to say 2001 would probably be my first year of independent practice. I graduated medical school in 1999.
I know during your first year of residency no one does any independent practice. That is one way to answer the question.
Another way to answer is when I finished all my fellowships and residencies, that would be July 2005 because I did general psychiatry. Then I did child and adolescent psychiatry.
So general for three years. Child psychiatry

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for three years. Forensic psychiatry for one year. And finished in July of 2005.
Q Fair to say then you have seen patients in some capacity for about twenty-two years?
A Correct. You could say my residency started on July 1 of 1999.
Q Round numbers, is it fair to say you have treated thousands of patients in that twenty plus year period?
A Correct.
Q Of those thousands of patients how many of them have you treated that have had gender dysphoria or gender identity disorder?
A As you have probably seen in my deposition, there is a -- it is probably around sixteen or seventeen patients right now.
Q I believe you had a colloquy with the court in Decker that led you to that number about sixteen or seventeen.
Do you recall that part of your testimony?
A Yes.
Q Okay. Of those sixteen or seventeen patients with gender identity disorder or gender dysphoria, how many of them were under eighteen?
A I would guess twelve or thirteen of them.

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Q So twelve to thirteen were under eighteen? Then we will call it --
A I'm not sure how you count the people that you saw and they were below eighteen and now they are over eighteen in that question.
Q When you started seeing those people under eighteen, if we use that definition, does the twelve to thirteen still stand?
A We will make it thirteen if it's when I started to see them. You know, that is my, I'm, that is the best estimate that I can give you.
Q I will spot you the one. We will call it thirteen.
Of those thirteen did you diagnose any of them with gender dysphoria?
A Yes.
Q How many of them did you diagnose with gender dysphoria?
A There are different ways to answer that question. All of them are diagnosed with gender dysphoria and had come to me with that diagnosis or some question regarding that diagnosis.
Now, are you asking am I the first person to diagnose gender dysphoria for that patient? Or are you asking me did I continue a diagnosis of

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gender dysphoria?
Q We will break it down into small chunks to get exactly at that question. Of those thirteen patients how many of them when they arrived in your office already had a diagnosis of gender dysphoria?
A I would guess maybe ten.
Q Okay. Of those ten who arrived in your office already with a diagnosis of gender dysphoria, how many of those did you also diagnose with gender dysphoria?
A I'm trying to think back if there was any. I believe there was a continuation of a diagnosis in all patients.
Q So of those ten who showed up with a diagnosis of gender dysphoria, in none of them you said, I don't think that is correct. You don't have gender dysphoria.
A Well, you are asking me questions about when they present for treatment. You know, you see people over time. So it may be a different answer at the end of the day did they always leave the practice also with a gender dysphoria diagnosis, you know, that is a slightly different question.
I believe there was continuation of the

Page 38

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

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A Yes.
Q I believe that leaves four adults who you have seen or treated who had gender dysphoria.
The same set of questions. When they showed up in your office did all of those four adults already have a diagnosis of gender dysphoria?
A Yes.
Q Did you continue the diagnosis for all four adults?
A Yes.
Q I'm sort of zooming out to the sixteen or seventeen people who you have seen with gender dysphoria.
Did any of them have a gender identity disorder diagnosis, or were they all post DSM-5?
A Post DSM-5, correct.
Q Did you recommend or prescribe any treatment for the gender dysphoria that you diagnosed in these individuals?
A Yes.
Q What treatment did you prescribe?
A Well, I recommend when a child presents with gender dysphoria that they enter psychotherapy.
Q Anything other than psychotherapy?
A No. I mean, if you are talking about treating --

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

Page 41

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

Page 42

time do they spend on the different devices? What other activities, you know, might be better than the extra time online? Are there any things that are good or positive they are doing online? Those could be increased or the important part of it.

But that is advice that I do think is pertinent and I give to all patients. So that would include, you know, that would include patients with gender dysphoria. They would get the advice to, you know, basically eat food to improve their diet. Move their body, physical activity. Mixed in with mindfulness. Hopefully a mindful practice of moving their body and properly managing, because today's kids are so heavily involved in electronics and it's so much of their social world. So managing those things.

That is not everything that I tell people, but that is a standard, you know, speech that I give or discussion that I have with every single patient. It would be applicable in this case in addition to my referral for, you know, psychotherapy.

Q And is it fair to say that you didn't say to any of those patients that I think if you do more yoga or are more mindful you will no longer have gender

Page 43

dysphoria?

It was just part of your general suite of all your patients you see, you think that is a good plan for everyone to do yoga and limit screen time and be --

A No. I would not say it like that. I would say there is a significant possibility that people can help with their distress about their body through the practices that I'm recommending and by managing, you know, what is coming into their brain through, you know, media.

So, yes, I do think particularly in these cases this would be a part of the treatment plan. I think it is something that is important to communicate to the patients.

Q Are there any randomized controlled trials, studies, regarding yoga as a treatment for gender dysphoria?

A No.

Q In your declaration you said that you were consulted about providing a second opinion and coordinating care regarding a patient with gender dysphoria in the Louisiana Juvenile Correctional System.

Do you recall that part of your declaration?

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A Correct.

Q Is that patient included in your sixteen or seventeen, or is that a separate person?

A Actually it was not included.

Q Who asked you for a second opinion?

A Well, at the time when I moved to Florida I still had a relationship with the clinic with the correctional system in Louisiana. If you remember what I said, I moved here. I kept the Louisiana license. I was still doing work in Louisiana.

As the most senior clinician within the company that has all of the contracts for the juvenile justice in Louisiana, whenever they have challenging cases I was likely to get consulted.

That was a patient who was moving facilities and so they asked my opinion. They asked, you know, basically what approach should they have. So that was actually working for the company at that time and they consulted me.

Q I take it that was because it was a juvenile correctional system that that person was under eighteen?

A That person -- well, I don't want to speak too much about individual patients because, you know, especially when we get into specifics about where

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they are and how they move.

Q Well, we can designate this portion of your deposition transcript as confidential.

A Can we?

Q Yes.

MR. SELDIN: Mr. Patterson, I don't know if you are aware of the confidentiality order that we have in this case. We have been using that to designate portions in other expert testimony pertaining to the plaintiffs.

If it's appropriate here, we can designate this portion as confidential so I can inquire into his expertise.

MR. PATTERSON: Yes. We can designate it confidential, but I would say to the extent he is under any obligations not to disclose any information even in a confidential setting he has to abide by those. I'm okay with this being made confidential.

MR. SELDIN: Great.

Q The particular individual about whom you provided a second opinion, was that person a minor?

A They, since this is not -- I mean, I don't believe that in this context that this would be too, that I'm revealing too much. I do want to not speak

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too specifically because, obviously, we are, when you talk about individual patients, any of this could be trackable. I do not want to say anything that would reveal anything about any patient that I'm treating. Right?

So I'm trying to keep it as general as possible. Redacted

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Q Redacted

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A Redacted

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Q Redacted

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Page 47

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Q Redacted

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Q Also, in your declaration you said that you provided an opinion about whether a pediatric patient was competent to assent to the administration of puberty blockers.

Doctor, do you recall that part of your declaration?

A Yes.

Q In what capacity were you consulted on that? I guess which contract was that a part of?

A It was within the USF, you know, child psychiatry realm.

Q Okay. When you provided that opinion, was that to someone you were supervising or a lateral colleague?

A Lateral colleague.

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Q What was your opinion on their competence to assent?

A Well, my opinion was that at the age they were that it seems unlikely that they would have full knowledge or capacity to fully assent, you know, or if you want to say consent to the procedure.

It seemed -- the particular wording of the question was not can they assent or not. It was more do they have the, you know, capacity to fully understand what they are agreeing to.

Q Do you recall how old that person was?

A I don't, I don't remember for sure. But I do think it was twelve or thirteen.

Q And were you asked to provide an opinion on that child's parents' ability to consent to the treatment?

A No.

Q Did you have any concerns based on what you heard in that consultation about the parents' ability to consent?

A No.

Q You also said that you have been consulted regarding psychotherapeutic approaches to young adult patients who detransition.

Do you recall that part of your declaration?

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A Correct.

Q When you say young adult, I take it you mean those people were over eighteen?

A Correct.

Q You also said you collaborate in the care of patients with gender dysphoria as part of your work with the Florida Medicaid psychiatric hotline.

Do you recall that part?

A Yes.

Q And about how many patients have you collaborated in the care with for those hotline calls?

A That also had gender dysphoria?

Q Yes.

A I'm trying to think if it was two or one. Only one that I remember. So one time.

Q Did your involvement in that care go beyond that phone call?

A No.

Q How many patients have you consulted about in connection with your work on the Florida Medicaid psychiatric hotline?

A Good question. Twenty. Thirty.

Q Dr. Kaliebe, have you conducted any research about gender dysphoria?

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A No.
Q Any research on gender identity generally?
A No.
Q Any research focusing on the treatment of transgender people?
A No.
Q Have you published any papers on those topics?
A No.
Q Have you supervised any research on those topics?
A No.
Q Have you ever had to retract a research paper?
A No.
Q Or issue a correction to a research paper?
A No.
Q Have you ever been sued for medical malpractice?
A No.
Q Have you ever been the subject of professional discipline?
A No.
Q Have you ever been sanctioned by a licensing board?
A No.
Q Have you ever had a professional complaint filed against you?

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A No.
Q Have you ever been the subject of a Title Nine complaint?
A Not that I know of.
Q Have you ever been arrested or charged with a crime?
A No.
Q Are you on social media?
A Yes.
Q What social media do you use?
A Use would probably be a strong word because I'm on social media, but I do not use social media generally. I have a Facebook account. I believe I have an Instagram account that links to my Facebook. I never actually go on Instagram. So it's very rare that I'm on Facebook. That would be the only social media that I'm on.
I will, I occasionally have gone on Twitter. I don't make it a practice to go on Twitter. But I have gone on Twitter. I don't have a presence. I don't post. I don't do any of those things. Sometimes to access things I'm occasionally linked to Twitter. I would not say I really have a Twitter account, but I've gone on Twitter.
Q I think the youth call people like us lurkers.

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That is the technical term. I don't know if you have encountered that in the practice with your youth?
A Yes, I have used that term.
Q Fair to say you fall more on that side of the continuum?
A That is fair to say, yes.
Q Have you given any interviews in either traditional media or elsewhere on the topic of gender dysphoria?
A Given any interviews? Yes.
Q What interviews have you given on the topic of gender dysphoria?
A Well, I haven't, I was contacted by someone to do an interview. I talked briefly with the person. I don't have their name in front of me. This was quite recently. So I was contacted by someone to do an interview regarding some of the stuff I guess that has gone on, you know, in this case or with professional organizations.
Q Do you recall the name of who --
A I don't. I don't.
Q Do you recall what publication they were with?
A I don't.
Q Do you recall --

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

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

Page 55

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

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again, considering the stakes that I'm getting asked, I mean, it's a tough discussion. But, yes, those are some of the factors that I thought about.
Q In your answer you said you thought you had a duty to your patients in this regard.
Were you referring to the sixteen or seventeen patients with gender dysphoria that you have treated?
A Yes. And to all patients, yes.
Q And of the sixteen or seventeen patients with gender dysphoria, you believed as a psychiatrist that they all, in fact, had gender dysphoria, correct?
A Yes, that they had that diagnosis. Correct.
Q You said you thought there, that you wanted to participate in more academic dialogue about this topic.
Do you believe that Senate Enrolled Act 480 furthers academic dialogue on this topic?
A I think just, like anything else in life, there are trade offs. So it might. It might not. I guess we would have to see what the results of it are.
Q You said trade offs. Do you believe that the

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trade off of banning medical treatment for gender dysphoria in minors in Indiana is an acceptable trade off to possibly further academic dialogue on this topic?
MR. PATTERSON: Object. This is outside of the scope of his testimony.
You can answer.
A Well, I don't think, I think that is only one of the implications of the law. So, no, that is not the primary implication of the law. It is an implication of it.
Q I'm sorry. What is not a primary implication of the law?
A The law's effect on the academic or scholarly or public dialogue is a secondary effect and not a primary effect.
Q Do you agree with the primary -- I take it then that you are supportive, however, of the primary effect of Senate Enrolled Act 480, which is to prohibit gender-affirming care for minors in the state of Indiana?
MR. PATTERSON: Object. The law speaks for itself.
You can answer the question if you understand it.

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

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A If we are going to ask me about my patients I would like to go off the record again.
MR. PATTERSON: You mean confidential?
A Confidential, yes.
Q I think the way we have been doing this is that when we remember during the deposition we say it and then when we get the transcripts we mark it.
A Okay. So you would like me to answer? As long as its confidential then I will answer.
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A Redacted
Q Redacted
A Redacted
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Q Redacted
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A Redacted
Q Of the thirteen, how many of those patients were receiving care that would otherwise be banned by the state of Indiana?
A Well, I mean, one at one time would have been.

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Q Redacted
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A Redacted
Q Redacted
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Q Redacted
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Q Dr. Kaliebe, you are testifying on behalf of the state of Indiana, right?
A Yes.
Q They are defending a law that bans gender-affirming care for minors.
Part of your expertise is predicated in your representation to the court that you have treated

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

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process of actually developing as an individual before they moved on to consider such things. And in such cases, they should have a period of time where they are able to interact with mental health professionals and explore their identity, explore how they got to the place where they are, explore what possibly might be other things that could be involved that would lead them, you know, to have this gender dysphoria. So that should all be worked up prior to initiation of these treatments. And as someone who is a growing, developing adolescent, they should finish their development or very close to finishing it before they make permanent changes in their bodies. Those are some of the psychological. The physical risks is risk of surgery, hormones, cancers. Any kind of medical problems that could come.

Q Do you believe that there are any patients at the end of this process that you propose, that the provision of gender-affirming care, the benefits will outweigh the risks?

A Yes. Could I qualify since we have not gone on yet? I think you are asking me to opine on an

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unknown that I would not say that I have a -- I'm saying yes based on that I think those who have gone through, you know, a proper process and are adults, you know, I think that that is a, that it's unknown, it's unknown still overall about the risks and benefits of these transitions. I think we do need more evidence on it. But that is my qualified answer. Go ahead.

Q Would you support a ban on this kind of care for adults?

A You would have to tell me what you mean by ban.

Q Well, you are familiar with Senate Enrolled Act 480, which we are talking about in this case as pertains to minors.

A Yes.

Q Would you support a law like Senate Enrolled Act 480 if it applied to adults?

A You are saying starting at what age?

Q Let's start with for anybody of any age, would you support a ban on this kind of care?

A I mean, I think you can reasonably say there must be some, there could be an age limit. There could be a process that people have to go through. Yes. I mean, it may be in the current climate that you need some legislative safeguards

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in order to ensure that there is a proper process.

Q I am asking two questions then. The first question is so you believe that after some kind of proper evaluation process the provision of this care may be appropriate in adults, correct?

A Correct.

Q Setting aside what that process is, do you believe that there is any age limit that should exist for folks who are even eligible to go through that process to then receive this kind of care?

A Well, I don't have a formulated opinion on what would be the pluses and minuses of a particular age limit. But I do think, in general, we understand that people are growing and developing and, you know, in other circumstances people are often, oh, the brain develops until twenty-five or until twenty-one. You know, there is an active debate about the age where someone sort of becomes, you know, a fully developed complete person and, you know, when their identity of any type, you know, would have solidified. I think you can have -- I don't think we have

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had enough quality discussion and debate in the literature regarding those things to give me a sense of what would be a, you know, how to approach that.

Q In the interim while this debate is continuing or not, do you believe that there should be a ban on this kind of care for folks who are over eighteen?

A A blanket ban for over eighteen? Well, as I was saying, I just think my belief would be with some process and with some age bar which might be more than eighteen could be appropriate.

Q Okay. Well, I guess, earlier when we were talking about how you think that there is not sufficient research or there has not been sufficient debate with respect to folks under eighteen so you support a ban in the interim. I am asking the same question for over eighteen. Do you think there should be an age ban above eighteen in the interim?

A I have not given it -- I think that it could be reasonable to have an age ban over eighteen, correct. I don't know what exactly, I've not given it a lot of thought, nor have I seen in the

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literature what would be a proper way to approach this. What process would people have to go through. I mean, whenever you make an age limit like sixteen for driving, or twenty-one for drinking, there are always problems with those strict age limits. There are those trade offs. There is a lot of complex calculation that would go into any such trade off.

And so I've not really seen any analysis of exactly what would be the best trade off in these situations.

MR. SELDIN: We have been going for a little bit at this point. How would a five minute break sound?

(OFF RECORD AT 11:09 A.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 11:15 A.M.)

BY MR. SELDIN:

Q Dr. Kaliebe, welcome back.

MR. SELDIN: Joel, will you pull up Exhibit 1 for us?

Q Dr. Kaliebe, I would like to talk a little about your declaration.

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A Okay.

Q Dr. Kaliebe, in your declaration in Paragraph 25 you say, "Current discussions regarding transgender care take place in the context of an unexplained and remarkable rise in minor patients reporting gender dysphoria."

Do you see where you wrote that?

A Yes.

Q Would you agree that gender dysphoria is a real condition that requires treatment?

A Well, that is one of the things I was talking about before in my preamble about things I was asked before.

So is it is a real disorder? Correct. But the "requires treatment" part is a complicated matter. So I would say, no. Even though before I sort of automatically said yes, that sounds reasonable. Lots of times in our business there are problems people have that they mostly work through on their own and do not get treatment for.

So that is the standard, you know, mental health, most of the things that people have that might meet criteria for a disorder or a problem do not usually get solved by therapy or the medical community.

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So, no. I would not say that I would agree with that statement in that it does not, it seems to reflect a it must be treated part. So I can't agree with that.

MR. SELDIN: Joel, will you pull up Exhibit 7? We will be at Page 157 of the PDF.

Q Dr. Kaliebe, earlier I showed you Exhibit 7, which was your testimony at trial in Decker.

Do you recall us talking about that?

A Yes.

Q Okay. You will see on this Page 1119 of the transcript starting at Line 11 you are asked questions.

"Q. Dr. Kaliebe, you would agree that gender dysphoria is a real condition that requires treatment?

A. Correct."

Do you see that?

A Yes, I do.

Q Was the testimony that you provided at trial in Decker that I just read truthful?

A Yes. In that I -- if you remember at the beginning when you asked about did I make any changes, as I looked at it and saw the wording of this in both my previous, you know, as I was

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questioned, this is exactly what I was talking about that now that I see how that was worded, that I, in some ways, misunderstood about "requires treatment" because you can talk about that in different ways.

Is it, do we normally -- would we like to treatment something? Is it good if something is treated? Sometimes that is what you mean by requires treatment.

I just want to clarify there are lots of disorders and problems that do not require treatment that for most people most of the time they solve their problems without medical or psychiatric treatment.

Now that I have had time to think about it and looked at it in print, that is what I was mentioning that I think I was, you know, I believe that "requires" is a word that I was misreading.

And now I can see that if that is the, if that is how you are asking it, "must be treated", no, I don't, I want to add some nuance to that question.

Q So, Dr. Kaliebe, earlier you were talking about your deposition in Decker, which was like this, just lawyers, no court.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

confidential for two days so we can work it out.
Q Dr. Kaliebe, who said this to you?
A So this is confidential? Is that what you are saying?
Q Yes. We can designate this portion as confidential.
MR. PATTERSON: You will not object to maintaining confidentiality of this portion, correct?
MR. SELDIN: No, I won't.
Q Redacted
A Redacted
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Q Let's start with the folks you just named. You first named, I think, you counted five or six people.

Is that most of the psychiatrists that you have talked to? I'm trying to understand how you are coming to this conclusion of "most"?

A I talk to many more. I talk to many, many more psychiatrists. When I go to the child psychiatry meetings I'm trying to talk to people about these issues so that we can come up with more.

I just have not prepared a list to provide to out people who do not want to be outed during my deposition due to their fears of recrimination and hostility.

That was not something I thought I would be asked to reveal. If you want me to make a list and give it to you later, you know, but like I said, as I am representing in my report, that it's many people.

Q You were talking just a minute ago about a talk you gave in Puerto Rico. When was that?

A May 2 or May 3 I would guess.

Q What was the conference you were presenting at?

A It was the Oasis Child Psychiatry Conference.

Q What is the Oasis Child Psychiatry Conference?

A A continuing medical education conference that is presented in different places. Basically people pay a fee and they travel to wherever it is. This one was in Puerto Rico.

People like me who are experts provide talks on different things. I gave three talks at the Child Psychiatry Conference.

You didn't ask me about presenting CMEs. I did present this CME talk on child, on gender dysphoria. So if you want to add that to my expertise, you can. But this was at the Oasis Child Psychiatry Conference.

Q Who organizes that conference?

A It's a larger, it's under the umbrella of a large organization that does many different, they have a psychiatry conference. They have a child psychiatry conference.

They have many other things. I don't remember the name of the company. I don't remember the company of that organization.

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Q So it's, are they affiliated with a medical institution or association, or is this like a CME company?

A It's like a board review CME company.

Q Right. Was the topic of the conference you presented at specific to gender dysphoria?

A No. The topic of the conference was specific to child psychiatry. I presented three topics. Gender dysphoria was one of the three topics.

Q What were the other two?

A Traumatic brain injury and social media.

Q Had you presented any version of this presentation on gender dysphoria before?

A No.

Q Have you presented it again since May 2 or 3?

A No.

Q Have you presented other CMEs on gender dysphoria prior to May 2 or May 3?

A No.

Q Okay.

A The date might be a little off. I'm not sure. It was May. It was early May.

Q Okay. How many people attended your session on gender dysphoria?

A There were probably sixty to eighty in the room.

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Q Okay. And about how many people attended the conference?

A I would assume somewhere around that same number. It's also online.

Q The entire conference you think was under one hundred practitioners?

A Yeah. On site I would guess so. Yeah. I'm not -- it's a guess.

Q Did you reach out to Oasis about this presentation or did they reach out to you?

A I have spoken for them before. This was the third time that I have spoken for them. I spoke some at the adult psychiatry one contiguous with it.

I have done it twice before for them for child. They have an adult and then a child conference. I spoke a little at the adult and then also the child conference this time. They request me as a speaker. They reached out to me.

Q Did you discuss your involvement as an expert during your presentation?

A No.

Q I would assume when you say most of the psychiatrists that you speak with, and this may seem like a silly question, but you don't speak with most psychiatrists in the U.S. I take it,

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right?
A Correct.
Q You have stated you believe that it is controversial to take the position that you take regarding gender dysphoria, correct?
A Not controversial among psychiatrists or physicians, yet controversial in the public sphere. Yes.
Q So would it surprise you then that once you express some receptiveness to this view of gender dysphoria, would it surprise you then that what appears to be an unusually large number of folks would come to you expressing the same one?
A Well, mostly these are regular private conversations from people that I know. It's not like I was approached by the names that I gave you or the people that I'm speaking about when I say that child psychiatrists are afraid to talk about this, but feel supportive of my approach.
Q Dr. Weiss, let's go to Paragraph 53 of your declaration. We will scroll down a little bit.
MR. PATTERSON: Did you say Dr. Weiss?
Q Sorry. My mind is still in last week.
Dr. Kaliebe, you will see in this paragraph you talk about social media as an influence

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regarding teenagers.
Do you think that heterosexuality is a sexual identity?
A Could you repeat the question?
Q Is heterosexuality a sexual identity?
A Yes.
Q Do you believe that social media has an influence in how teenagers who are heterosexual express their identity?
A Identity, no.
Q You believe that teenagers who use social media who are heterosexual or straight, the way they express being straight is not influenced by social media?
A It could be. It could be.
Q Are you familiar with the movie genre of the teen rom com?
A Is that romantic comedy?
Q Right. You are generally familiar with the fact that a decent amount of media television or movies revolve around teenagers in high school who date.
Is that a fair description of a certain part of American media?
A Yes.
Q Do you think that those movies and TV shows when

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they show straight teenagers dating, do you think that that has an influence on how American teenagers date or their expectations of dating as straight teenagers?
A It could, yes.
Q All right. For teenagers who are not straight, who have a different sexual identity, do you think that media influences their expression more or less than heterosexual teenagers?
A I would not have an opinion more or less. I'm not sure.
Q Okay. And then do you think everyone has a gender identity?
A I think that is an open scientific question. I'm not, I would not say that that is a settled question. That has been an assumption that most people are going on.
That seems to be a common assumption. I'm not sure that it is a settled scientific question.
Q Do you think that most people have an internal sense of whether they are male or female or something else?
A I think we are getting into nuance about internal, what you mean by internal sense. Most people can identify themselves as either male or female. So

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I would say that is correct because that does exist in their brain. Yes.
Q When you say sense of themselves you mean as male or female? We will start there.
A Correct.
Q Okay. Do you think that -- okay. In Paragraph 54 of your declaration you talk about the -- I'm sorry. I lost my place here.
Yes. In Paragraph 53 you talk about Dr. Weigle's publication in the Psychiatric Times.
Do you see that about three lines up from the end of Paragraph 53?
A Yes.
Q Is the Psychiatric Times a peer reviewed journal?
A No.
Q Dr. Kaliebe, in Paragraph 54 you say -- in Paragraph 55 you say in my opinion --
MR. SELDIN: Joel, can you scroll down to Paragraph 55, please.
Q You say, "In my opinion, technological, ideological, and social factors underlie much of the recent increase in gender dysphoria in adolescents."
Do you see that?

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A Yes.
Q We will take a look at your report in Decker.
MR. SELDIN: Joel, will you pull that up? That is Exhibit 4, Paragraph 44. You say there, "It is plausible and probable that ideological and social factors underlie the increase in gender dysphoria."
Do you see that?
A Yes.
Q My question is in this earlier report in Decker you said it's plausible and probable that ideological and social factors underlie the increase.
Then in your declaration here you say, "In my opinion technological, ideological, and social factors underlie much of the recent increase in gender dysphoria in adolescents."
My question is, is this two ways of saying the same thing? Or are you holding this opinion to a different degree of certainty from April to now?
A I guess it was just the -- it seems to me that I'm pretty much saying the same thing on both occasions. I'm just perhaps fine tuning it. I don't know that it really adds more or less

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certainty, the change.
Q All right. In the Decker report you said it is plausible and probable that ideological and social factors underlie the increase in gender dysphoria.
Is it fair to say then that you are not sure, but this could be true?
A Well, I'm saying it is probable. So, yeah, I mean, I think in either case, you know, if it's my opinion, I think the -- I mentioned it is plausible because of it's so, you have had such panic in the academic community when there has been talk of social contagion that it's, you know, it has been really remarkable how people have fought against the idea that there possibly are social or online influences driving these things or having a large influence.
That is why I put in the word plausible there because there are academics who are saying that it's not plausible. But I think it is an extraneous word, so I did not use it in the next report.
Q As a general matter, would you expect teens who had something in common to find each other online?
A Yeah, they could. Yes.
Q And would you generally expect that small

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populations that tend to otherwise be isolated would find each other online?
A Yes.
MR. SELDIN: Joel, will you take us to Paragraph 57, please.
I'm sorry. Can you take us back to Exhibit 1 and then go to that Paragraph 57. I apologize.
Q Dr. Kaliebe, in Paragraph 57 you provide what you call, "A prescription for open exchange and deliberate consideration regarding gender dysphoria treatments..."
Do you see that?
A Yes.
Q Where does that prescription come from?
A Well, I don't know exactly where it comes from. I feel like it's an amalgam of thoughts that come from John Haidt, who I cited just below. He is a public intellectual who has commented about group think, the squashing of opinions within academia. He is a social scientist. That is in part from him.
It is in part from Jonathan Rauch, who wrought a book called The Constitution of Ideas, which is a quite thoughtful recent book that lays

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out, I think, even a list of something similar. This could come from Jonathan Rauch. Steven Pinker has written extensively on this same topic and the importance of rationality and the importance of a dialogue of ideas.
You could take this as far back as John Stuart Mill, who was originally one of the originals who sort of brought forth a lot of our ideas that underpin what some people call liberal science or scientific exchange today.
So this list is a time tested list and it's reflecting of much of the underpinning of how we have achieved, you know, science and moved knowledge forward.
As Jonathan Rauch talked about in his book, there is no one person who has a monopoly on the truth. We get to the truth by exchange, which is conflict, and we need that in order to understand both our opinions better and the opinions of others. And each of us, hopefully, with this conflict will help us all get closer to the truth.
So I know that was a long answer for where that list comes from. I'm pretty sure if I looked in those sources I could find a list that is

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

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

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

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

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A Well, like I said, I don't have a countervailing ideology of it. Like I said, the journal in our, in child psychiatry declared itself to be an antiracist journal, which is an affiliation with that ideology.

I'm actually against affiliations with ideology. I don't know that there is a counter-ideology. We prefer it to just be a rigorous scientific dialogue about important issues. That is what we would be aiming for if you follow the prescription that I've laid out here.

Q Are there any particular principles in antiracism as an ideology that you think are antithetical to the search for the truth or scholarly dialogue that you think that journal should have undertaken?

A Well, I didn't, you know, I'm not prepared to go into a, you know, in depth into that. I would say there's a, there are some broad narratives about the world included in that, which is that certain groups are oppressors and other groups are oppressed.

That would be a primary narrative that is, can be accurate. But yet we would have to be

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nuanced about how we approached those things and that we should be very careful to make generalizations especially in the realm of science.

The more broad your generalization, the more likely that you are over inclusive and overgeneralizing. And so that would be the oppressor versus oppressed narrative, that would be a good example.

Another example of that would be the whole idea of race being codified into a more important marker of people's identity. Whereas, it's not actually a very scientific idea. It is a really complex idea.

People come from different backgrounds and origins. You know, where do you draw the line? How do we sort of determine this? And what do you do about mixed race couples? What do you do about people who look like they are one race, but they are the other? I mean, it's very complex.

So the broader narratives embraced are problematic when you come to, when you come to science. Then, also, it's a call for, I mean, when editors call for a certain viewpoint, once again, I just think that that is not what any job

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of an editor or a journal would be.

They can call for more viewpoints and discussions which would be great, but not to call out or prefer a certain viewpoint.

Q Do you think there are any viewpoints about race that journals should not seek to include?

A Well, I think that there, I think that certainly you are not going to, you know, considering where the dialogue is and who would be writing to psychiatry journals, you are only going to have thoughtful academics writing in and trying to talk about a nuance.

So not within the, not that I, not that a psychiatrist would write into a journal. I find it would be highly unusual that there would be any idea written in or someone who would submit for an article that would be outside of the bounds of what would be acceptable dialogue.

I would say maybe, you know, in theory there could be. In practice, there is not.

Q Do you believe that there is, as a normative matter, a view on race that a psychiatrist could seek to present to a journal that without hampering the search for truth the journal could say that is actually outside of the bounds of

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discussion?

A Well, if they were overgeneralizing, which is exactly what I'm talking about. Yes, so. I'm against people overgeneralizing.

So a journal editor should knock down any article that overgeneralizes.

Q Dr. Kaliebe, in the middle of Paragraph 62 in your declaration you say, "Supporters of gender-affirming treatment want to believe they have found an ethical and evidence based solution."

Do you see where you wrote that?

A Yes.

Q What do you think is unethical about gender-affirming treatment?

A Well, gender-affirming treatment as an actual clinical treatment can do harm. So I think it is unethical to do harm.

Q What harm do you think it does?

A Well, when you are asked to evaluate a child or an adolescent, they need to be seen in the context of a total individual and their total environment.

You would have a biopsychosocial formulation. They are in the process of identity development. So to see someone through just the lens of

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affirming can be harmful and can turn the discussion just towards gender identity or gender dysphoria rather than away from the traditional way that you would approach a patient.

So it's trying to, it is, I believe it's poor medical care to move to affirming automatically patients who present with gender identity issues or gender dysphoria.

Q So is the harm from the diagnosis of gender dysphoria, or from the possibility that the evaluation process does not discover other co-morbid conditions?

A There is not a problem with the diagnosis of the gender dysphoria. But there is a problem with an overemphasis on one component of people's identity and a turning away from the typical therapeutic approach which we have always used which does not jump towards affirmation, but lets a person develop in their own way and would be broadly based and notice what is the context, what other disorders, what else is going on, what traumas have occurred, you know. What other family issues are going on?

So, yes, I feel like that when this is proposed as a way to approach these patients, that

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it distorts care away from what would be a proper and traditional psychiatric approach.

Q Do you think that the care can be ethical if all of the traditional psychiatric or psychotherapeutic approaches that you are referencing had already happened or are happening concurrently?

Could then treatment that is gender-affirming be ethical?

A Well, if you are -- yes, it could be. It could be if they have had a proper workup and have, you know, that that is the approach that the clinician has decided after working with the patient for a long period of time.

But I'm talking about a psychotherapy approach. I assume that is what you are talking about, too. When you say gender-affirming care that can include medicalized care.

I want to be clear. I'm not talking about medicalized care. I think we are talking about therapy and therapeutic approaches.

Q I think we will talk about both. For psychotherapeutic approaches you believe it is possible to provide gender-affirming psychotherapeutic approaches to minors who are

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experiencing gender dysphoria, is that fair?

A Well, you could get to it after providing appropriate care, you know. Would there be a place down the road where you could decide that, you know, and I'm not quite sure what exactly you are meaning by affirmative care, but I assume you mean for, like, going along with the patient's conceptualization of what is going on, which would not be what we usually do in mental health.

We usually remain neutral about what is going on rather than joining a patient's conceptualization.

If at the end of the day, you know, would that mean is it okay for a clinician to use the pronouns that are requested by a patient, then I'm saying, yes. You know, that is perfectly reasonable and under certain circumstances, you know, yes.

But is it appropriate to ever completely go along with the patients' narratives or views of the world so that is, you know, a clinical decision that maybe you could get to.

MR. SELDIN: We have been going for another hour. I think most of the folks here are on East Coast time.

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Do we want to take a short break now and then go for an hour and then do lunch? How are folks feeling?

Dr. Kaliebe, will you be okay with a five minute break and then another hour?

A I will do whatever the group wants.

MR. SELDIN: Let's do that. We will come back at 12:27 Eastern.

(OFF RECORD AT 12:21 P.M.)

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 12:27 P.M.)

BY MR. SELDIN:

Q Dr. Kaliebe, welcome back after that short break.

In Paragraph 65 you describe a dynamic, "In fact, sophisticated language skills enable virtuosity in creating and promoting false narratives."

Then you go on to say, "These dynamics have arisen before in medicine, and it is my assessment this has occurred again with regards to medical interventions to treat gender dysphoria in minors."

Do you see that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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report -- that those who wrote the pharmacology guidelines were overly enthusiastic, influenced, or excited or however you want to say it, regarding psychopharm.

So I think at times any of these committees can be somewhat overconfident or have opinions that lean towards interventionalism towards whatever intervention that the committee is about.

So I think that, yes, you know, the psychopharmacology committee would tend to be too much focused on psychopharmacology from the perspective of a regular psychiatric practitioner that has to take the different patients and use all sorts of different modalities and not just pharmacology.

The group dynamics have some affect on the other committees. I mean, I would probably guess that, or it is possible that there is some other committees that they also may interact with. I have not been to the, I think it's, like, I will probably mess up the name. I think there is, like, a race and diversity committee.

Is it possible that they would be, you know, could that committee be overly politicized? It is possible.

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Other than the gender committee I have never seen it affect clinical care in this way.

Q Dr. Kaliebe, at the end of Paragraph 87 you characterize the group that works in the area of gender dysphoria as "a well-intentioned but homogenous group of supporters."

What do you mean by homogenous?

A I am talking about at the beginning of the paragraph, they have self-selected into providing this type of care and are enthusiastic about it.

And so when you have a group of like-minded individuals that support it without really a -- more skeptical people end up not being on that committee. So that is my impression.

Q Just to describe a similar dynamic, the psychopharmacology committee, that they would have bias toward intervention using certain kinds of medication, is that also what you mean by -- would homogenous be a way to describe that as well?

A Yes.

Q Okay. Would you generally agree that a group of people that have a special interest in a topic is -- I guess, what I'm trying to ask you is when you were the chair of AACAP's media committee, did that committee benefit from the fact that its

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members had a special interest in media issues?

MR. PATTERSON: Objection. Assumes facts not in evidence.

You can answer.

A Yes.

Q Generally speaking, in your evaluation of group dynamics, if you have a small committee you would prefer folks who were interested in the topics rather than disinterested, correct?

A Well, no. I would give some nuance to that. I mean, I would really love to see -- I actually thought that it probably would be really quite helpful for -- let's go back to the psychopharmacology committee -- for there to be some, like, regular bread and butter practitioners on that committee so that the committee would be mindful of what is happening in the real world and how, you know, their proclamations on, you know, medications play out.

You know, especially as I've served in disadvantaged and underserved communities, you know, the idea that there is a medication solution for people's problems, you know, the guidelines were very heavy into pharmacologic, you know, solutions. And it just is not, it's just

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unrealistic on a massive level.

No, I think it would be best if there was a way to make sure that there is broad inclusion of people. But in reality, that is not how committees are formed. It is people that tend to be enthusiasts.

So I think there is some advantage to people being enthusiasts, but I think there are disadvantages, too. You know, as I mentioned the psychopharmacology example, you know, it would be nice for there to be a counterbalance of people in the field who are not so enthusiastic.

Q Do you think that is true for every field?

A Yes.

Q Dr. Kaliebe, in Paragraph 89 you talk about watchful waiting.

What do you -- is watchful waiting the approach that you prefer for treating minors with gender dysphoria?

A Well, I think a component of the approach, regarding certainly medicalization-wise I would say yes. I think that would make the most sense to let people grow up and then once they, you know, are adults to make decisions about hormones and surgeries when they are fully developed

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humans.
So medicalization-wise, yes. But I think as I mentioned before, I believe that it is ideal for people to get other types of, you know, to have a well-rounded approach to life which would include a number of things and potentially psychotherapy.
Q And so you, in this paragraph you say that the policy statement at issue from the AAP contained citation errors, overstatements, and mischaracterizations of the -- sorry -- you say it mischaracterized the long-standing and well-regarding clinical approach of watchful waiting.
How do you think they mischaracterized it?
A Well, they say it right there. "Watchful waiting is based on binary notions of gender."
I mean, to translate, that sounds like saying well, those people who do watchful waiting, they are just those old rubes who don't know any better.
We're the sophisticated new people that want to do this intervention. We are going to get rid of that approach is what we want to do because we know better now.
And I think that that right there kind of

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shows that they are failing to appreciate the nuance and difficult realities of when you have a developing situation and you don't know where it's going to go, it's often better to not intervene than to intervene and potentially do harm.
Q Do you agree that there are instances where not intervening can actually also cause harm?
A Are we talking about with gender dysphoria or just in general?
Q First, we will start in general. Do you agree there are situations where the choice not to intervene can also cause harm?
A Correct. Yes.
Q Do you think that there are instances in the treatment of gender dysphoria in minors where declining to intervene can cause harm?
A I would not frame it as causing harm. So I would not use those words.
Q What words would you use?
A Well, I would say that the not intervening would allow a patient to grow and develop. And then once they have a sort of fully developed self, then they can make decisions about medicalization of their body.
So I don't, I just, I think you have got --

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that would be a better way to say it.
Q So are you aware that some of the original proponents of the watchful waiting approach were the Dutch and Ken Zucker in Toronto?
A I mean, I would step back and just say, you know, watchful waiting is a term that we use in medicine all of the time. It was used for decades before it was adopted by gender medicine.
So I would say this is an old term that has lots of uses in medicines. So, yes, I would, I am aware that both Ken Zucker and those in the Netherlands have used that approach.
Q Both the Amsterdam Clinic and Zucker's Toronto clinic both treated adolescents with blockers and hormones once they reached puberty, is that right?
A Yeah. I mean, I don't have data about Zucker's treatment protocol or what was going on there. I can't speak to what treatment they were getting in the clinic. The Dutch clinic has published a lot of articles so we are familiar with that.
Q So in that respect, watchful waiting would apply to prepuberty at those clinics?
A Correct.
Q And so even those proponents of watchful waiting,

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they still recommended medical interventions when the incongruence of distress persisted into puberty?
A Yes, I know the Dutch did. I don't know that Zucker's protocol, I have not seen exactly how it was treated or what his approach was.
Q Do you oppose social transition for minors with gender dysphoria?
A Well, I think it's a complex subject. I think, yes, in that children with gender dysphoria it seems would be wise for them to be thought of as children with gender dysphoria, not transgender children.
We don't know what their, in the end development is going to be, so why not, I think it's most wise to keep them developing within their biological sex, be honest that they are a person with gender identity issues with gender dysphoria.
They may grow up to be a transgender individual as an adult. They may also grow up to be not transgender as an adult. Since we don't really know, why don't we more conservatively approach this and not socially transition them when they are young. That would be my

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

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

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

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

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

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

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

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

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up and admitting all those things, then I would, you know, lean towards it not being so political.

If that is not what they are doing, then I'm leaning in towards it being more political.

Q In Paragraph 91 you are talking about this press release. You say, "Yet the press release frames these limits as discrimination based on gender identity, a moralized characterization of restrictions on care."

Why do you think that is a moralizing statement?

A Well, if I accuse you of discriminating I think that is a morale accusation. Right?

Whereas, normally when you are talking about medical care you would be talking about what is the evidence base for this medical care. Or let me show you this study that strongly supports my opinion.

That is what I would think that a medical organization would be doing, rather than claiming that this is discrimination.

Q So back to my example of an endocrinologist and insulin. If I am an endocrinologist and I testify before a legislative body, I treat a lot of people with diabetes. They need insulin. The cost of

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insulin means some of them don't get it. That is a negative outcome. I think this bill should pass because it will make insulin free.

Do you think any of that is political and moralizing?

A No. Because they are talking about a clear-cut medical, you know, situation that seems apolitical.

Q What if they then say, And I think it's discrimination against people with diabetes not to make insulin free? What then?

A I mean, they could say that. I think that that would be a, I mean, they would be trying to moralize the argument. I don't think it would be a compelling argument.

I'm guessing that people who are deciding about what could be paid for and not paid for are mostly working on economic arguments and not on discrimination arguments.

MR. SELDIN: Joel, in Paragraph 92 about two-thirds of the way down, if you could show us Paragraph 92. Thank you.

Q You are critical of the American Academy of Pediatrics. You say, "As such, a more appropriate perspective from a medical organization would be a

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call for reasoned dialogue to evaluate the moral claims on each side and examine the logic and data behind these moral frameworks and treatments."

Do you see where you wrote that?

A Yes.

Q Is your issue that, I guess, do you think the competing moral frameworks in this particular instance are equally worth debating?

A Well, I think there are multiple moral frameworks so you would have autonomy of patients. You would have parental decision rights. You would have whether an analysis of an evidence base is a moral one or a discriminatory one.

So there's multiple moral issues at play. There would be the moral issue of can someone consent or not consent? Is it moral to allow those things?

So there are just a number of ethical and moral issues that could be wrapped into any discussion.

Q So in the realm of pediatrics generally you have issues of assent and consent, is that fair to say?

A Yes.

Q So in that respect, every decision about pediatric medicine involves the moral issue of assent and

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consent, right?

A Yeah. I mean, you know, I would not quite -- I would say there's almost no moral issue for many or most regular pediatric treatment issues. Whether to get an antibiotic or whether to brace an arm after it's broken, you know, this is what most medical decisions are.

Most of them do not have difficult competing moral frameworks like permanent treatments to minors with gender dysphoria. That is a lot more complex.

Q Let's talk about some other medical interventions in pediatrics.

Are you familiar with Cochlear implants?

A Somewhat.

Q Do you think that there is any moral valiance to a decision about whether to provide those to a child?

A Well, not being my area of expertise, I don't know what the statistics are and how successful they are and how established they are.

There may or may not be on different treatments depending on all those things. If it's a well established treatment and they have a great evidence base on, then the amount of the moral

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

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

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

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

A Yes.
Q Then Paragraph 4 (b) and (c), Dr. Kaliebe, in your Decker report you offered the opinion at 4 (b), "There is no consensus in the field regarding the treatment of gender dysphoria, nor is there an evidence base sufficient to lead to any confident recommendations."
Do you see where you wrote that in your Decker report?
A I don't. Okay. Yes. Yes, I do.
Q Then in 4 (c) you said, "Multiple reviews of the evidence base regarding treatment of gender dysphoria indicate that the evidence for affirmative treatment is low quality."
Do you see where you wrote that in the Decker report?
A Correct. Yes.
Q There do not appear to be corresponding opinions of this nature in your declaration in this case.
That is why I'm asking, are you offering these opinions in this case here?
A Well, yeah. I'm not sure how to answer that in that I believe there are other experts in this case that are reviewing the evidence base.
Those are my opinions. But my -- in terms of

this case, I wrote in my report the things that I was emphasizing.
Q So is it fair to say that you, Dr. Kaliebe, the individual, hold these views, but you, Dr. Kaliebe, Indiana's expert in this case, are not offering yourself as an expert on these two points?
A I would not commit to that. Since I have put this in my report even though it's not exactly these same statements, I have mentioned the low quality evidence base.
Since I have mentioned that in my report and I am already speaking as an expert and I've gone on the record, I think I am affirming that this is my opinion and this opinion is in my report.
MR. SELDIN: I wonder if now is a good time to take a little longer break for lunch.
Dr. Kaliebe, Mr. Patterson, would that work for you?
MR. PATTERSON: Fine with me.
A Fine with me.
(OFF RECORD AT 1:31 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)

(ON RECORD AT 2:15 P.M.)
BY MR. SELDIN:
Q Dr. Kaliebe, welcome back.
MR. SELDIN: Joel, could you pull Exhibit 1 back up for us.
Q This is your declaration that we have been talking about in this case.
MR. SELDIN: Joel, can you take us to Paragraph 121.
Q Dr. Kaliebe, in Paragraph 121 of your declaration you have some criticisms of SOC-8. I take it that is WPATH's Standards of Care 8?
A Correct.
Q And in Subsection A you say, "SOC-8 makes no analysis for why it prioritizes affirmation of gender identity over affirmation and acceptance of the physical sexed body."
Do you see where you said that?
A Yes.
Q What is affirmation and acceptance of the physical sex body?
A Well, it would be the concept that it is important for people to come to accept and work with the body that they have, which is a time tested approach, you know, in individuals who have

challenges and disorders, distress related to their body.
Q When you say time tested, what do you mean?
A Well, I mean in many other psychiatric disorders we have patients that are uncomfortable or distressed by the body that they have.
Someone with anorexia will starve themselves in order to, you know, not go into development or because they don't want to, because they have a distorted view of themselves, a body dysmorphic disorder.
During development, of course, many people are uncomfortable or distressed by the body that they have.
Q In prior declarations you refer to this as body affirmation.
Is affirmation acceptance of the physical sex body the same as body affirmation?
A Yeah. I mean, I think they are part of the same concept, yes.
Q Did you come up with this distinction between body affirmation and gender affirmation?
A Did I come up with it? Well, I think that this is a noticeable discrepancy by the way that we are asked to approach gender dysphoria compared to

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other disorders like I was, like I was mentioning previously.

So, yes. I don't have a clear source from where that comes from. It's just that I've noted that this is a very different approach to affirm and emphasize, you know, a psychological concept about self over the physical body.

Q Is there any literature where researchers discussed this distinction between gender affirmation and body affirmation?

A There probably is. You know, since we are in such a new field right now, you know, I don't think that there has been much on this regarding particularly this issue.

But I think there is significant literature in other disorders regarding patients, healthy patients, learning to come to peace with or love the body that they have or reducing their distress about the body that they have.

Q So it sounds like you are not aware of any studies on body affirmation versus gender affirmation as it pertains to gender dysphoria, is that correct?

A Correct.

Q In Paragraph 121, Subsection (d) another one of your criticisms is that, "SOC-8 downplays concerns

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related to detransitioning."

Do you see where you wrote that?

A Correct.

MR. SELDIN: Joel, can you please pull up Exhibit 14.

Q Dr. Kaliebe, have you seen this document before?

A Yes. It's the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.

I was referring to that in my report as the SOC-8.

MR. SELDIN: Joel, can you take us to Page 43 of the PDF, please.

Q Dr. Kaliebe, do you see where it says Statement 5.7?

A Yes.

Q Do you see, "We recommend health care professionals assessing adults who wish to detransition and seek general-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professionals in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process."

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Do you see that?

A Yes.

Q There is a whole section of SOC-8 that talks about detransition, correct?

A Correct. I think if you look at the amount of pages devoted to it, and I do see 260 pages on the document, that is why I was saying underemphasized the component.

Q What would be an appropriate emphasis in the SOC-8 for detransition?

A Well, I think a more realistic approach in regarding the new patient population, which has recently emerged. And we do not know what the rates of detransition will be in this new different patient population.

And so I think while it generally downplays it, reporting it to be rare, which I think, you know, once again, we are not totally clear on, the data is not so clear on how rare it really is.

But, secondly, it's especially pertinent considering the large rise in these treatments among minors and minors that are very different than the minors that were in the Dutch protocol or other early interventions.

MR. SELDIN: Can you take us back to

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Exhibit 1, please.

Q In Paragraph 122, Doctor, in Paragraph 122 you say, "There have been several other episodes I have learned about that have caused me to conclude that I do not feel comfortable relying on WPATH or its U.S. affiliate, USPATH, to guide my care of gender dysphoric patients."

A Yes.

Q What do you rely on to treat your gender dysphoria patients?

A My experience as a child psychiatrist. And I think patients are all human beings. They all share a lot of qualities. We have a wealth of clinical and other research data, which gives us a general approach on how to approach patients.

And so when a new population and a new treatment model comes in and asks you to do something a different way and you see that it has flaws and it's not, it has not, it does not have the evidence base that it claims to have, then you have to use your, you have to use what you know about other treatments, which are, of course, you know, which are generalizable in order to approach that patient population.

Q Earlier we talked about how in total you have

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

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

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

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

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about these large, you know, concepts rather than talking about specifics.

I mean, you know, you could still be affirmative, meaning use the pronouns the person was working with, and be affirmative in that you are supporting them. But, also, want to work with them in coming to peace with the body that they have.

Q Is that your general practice with your minor patients that have gender dysphoria, to use the pronouns that they want to be known by?

A Yes.

Q Earlier you were talking about how you treat patients given your desire not to use WPATH or USPATH guidelines.

Is it fair to say then that you consider your clinical practice sufficient to sort of establish guidelines for yourself?

A Well, I think when you are a child psychiatrist and you treat all of the different conditions that could come in, people come in with autism. People come in with psychosis. People come in with bipolar disorder. They come in with PTSD. They come in with all number of different problems. And then they have problems in development.

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They have problems of identity that are not related to gender. They have problems academically. They have neurocognitive problems. They have problems related to school. They have problems relating to getting into fights. They have family conflict.

So when you approach a patient clinically, you are putting together a treatment plan and an assessment that speaks to them specifically. So I'm using what, you know, is the, I would say, mainstream psychiatric approach with all these patients, including the patients with gender dysphoria.

Q So your description then of your clinical experience, that is sufficient you think to establish good clinical practices?

A I don't think that patients with gender dysphoria are that different than other patients that I should throw out all my training for everything else I do and do something that WPATH has determined to be the right approach even though my assessment of the evidence is that it's not the right approach. So, correct.

MR. SELDIN: Joel, will you take us to Paragraph 129, please.

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Q Dr. Kaliebe, in Paragraph 129 you are discussing Dr. Shumer.

Do you recall writing this paragraph?

A Yes.

Q In this paragraph at the very end you say, "This virtuous sense of self must at least raise concerns as to whether Dr. Shumer and other advocates engage in sober reviews of the evidence."

Do you see where you wrote that?

A Yes.

Q Would you generally agree that patients should receive competent and compassionate care, medical care?

A Yes.

Q Do you generally agree that transgender people are emerging and demanding specific kinds of care?

A Emerging and demanding specific types of care?

Yeah. I mean, this is, I think some of the questions that we have is a child, you know, a transgender person, or are they a child with gender dysphoria? Or is this a teenager with gender dysphoria or a transgender person?

So I think, you know, as your identity is still developing I think it's important for us to

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step back and look that we are not necessarily dealing with someone who at the end of the day should be best conceptualized as a certain person.

And that the fact that someone, that there are some demands for care, once again, is detailed elsewhere in my report. Yes, people should be compassionate and we should be competent.

But often the type of care that patients request is often not the best type of care for them. So, you know, I am somewhat agreeing with your characterization. But I think there is some nuance there.

Q We talked about this a little bit earlier. I wanted to clarify.

You said you prefer to treat, to consider children with gender dysphoria as children with gender dysphoria and not as what you called transgender children, is that accurate?

A Correct.

Q You would agree, though, that some, that at least some children with gender dysphoria are, in fact, transgender, right?

A No. Because we don't know what their identity really is or what it will be at the end. I don't think we are, I mean, putting a label on a child

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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based on a specific patient or a hypothetical?
A Well, that is, that particular vignette would be a hypothetical.
Q So you are aware of that happening. That is an example that you came up with --
A There is evidence there is increased gender dysphoria after sexual assault. That is in my report. This is part of the concern that after a sexual assault there is evidence that there is more likely to be gender dysphoria.
Q That is a vignette that you came up with based on your reading of data, not a specific patient?
A Correct.
Q Okay. In Paragraph 145 you talk about some psychiatrists who are, many psychiatrists are "willing to use affirmative approaches selectively."
Do you see where you wrote that?
A Yes.
Q Is that what we talked about just now where you said depending on the therapeutic history it might be warranted to affirm someone by using their pronouns?
A Yes.
Q Do you think in a patient that had that kind of

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

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bottom of Page 53.
Do you see where you are discussing here Levine's list of assumptions misrepresented as facts.
Do you see that?
A Yes.
Q Then the third bullet down says, "All gender identity variations are biologically determined and inherently healthy."
Do you see that?
A Yes.
Q Do you believe that there are some gender identity variations that are inherently unhealthy?
A Do I believe there are some -- well, yeah. I mean, I think we have an open scientific question if some patient's gender identities are unhealthy for them, correct.
Q What do you mean by unhealthy for them?
A Well, we could go back to the data related to trauma and increased gender dysphoria. I mean, is the, you know, is this really an avoidance strategy to shield someone, you know, psychologically from the trauma that they had. Right?
So if someone develops a transgender identity

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

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

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

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

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

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

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

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Would you agree that it's good to minimize their suffering of going through puberty that does not match their identity?

A I don't know that we know enough right now to say whether that is -- even for the ones who end up being adults, I don't know that we know that it's not a better path, even if it's difficult, to go through puberty, become an adult, have a solidified identity and then make a choice to transition when you have gone through that even if it was painful or difficult or there was suffering involved.

So while, yes, we want to minimize suffering, I don't know that in your hypothetical that we would be. I think that is one of the many unknowns.

MR. SELDIN: Joel, will you take us to Paragraph 154 on the next page, please.

Q Five lines down you say, "Yet, the false binary of affirmative psychotherapy versus conversion for gender dysphoria is being used to push therapists away from consideration that acceptance of one's biological sex or resolution of gender dysphoria is a positive event."

Do you see where you wrote that?

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A Yes.

Q This false binary, what do you base that on?

A Well, a lot, there have been many attempts to call different types of therapy for gender dysphoria or approaches to people who are transgender as conversion therapy.

Conversion therapy usually was thought of as attempts to force changes in sexual orientation. Those are not any -- I mean, in the distant past those occurred. They were rejected by the mental health community a long time ago. They may exist in certain religious sects or in other parts of society.

But to then associate regular, you know, psychotherapy with conversion I think has done a lot of damage in that people don't want to engage in deep regular therapy with patients because for fear of this.

And because patients hear that therapy is not the solution to their problems. That they really just need to be affirmed and get medical treatments. So that can also interfere with the patient's willingness to do therapy when therapies are called conversion therapy.

Q So I'm trying to understand the distinction

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between this regular psychotherapy that you are talking about and affirmative therapy.

Earlier you said it would not necessarily be affirming for a therapist or psychiatrist to say, Great, I'll use those pronouns. Can you tell me more about that?

I mean, what is the difference between regular psychotherapy and affirmative therapy in that instance?

A Well, that would be fine. It's fine to choose that approach. But as long as we are getting to the, Can you tell me more about that, and we are really truly going down that road it seems like many proponents of medicalized transitions for youth are not emphasizing how important it is for there to be a true process of actual exploration and a completion of identity development before medicalized treatment.

And I just think that, you know, the, calling therapies for gender identity or addressing elements of gender identity conversion therapy is an inappropriate attempt to, it's, it makes therapy a pejorative and it argues against therapy for kids who really could benefit from therapy.

MR. SELDIN: Joel, will you take us to

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Paragraph 168.

Q Dr. Kaliebe, in Paragraph 168 you say in the second sentence, "Beyond standard psychotherapies, more specific and nuanced approaches for gender dysphoria exist, such as Exploratory Therapy." Then you include the URL for genderexploratory.com.

Do you see that?

A Yes.

Q Have you studied Gender Exploratory Therapy?

A I don't know what you mean by "studied." But I've looked at the site and the approach, yes.

Q What is the evidence base for this approach?

A Well, it's based on long-standing principles of psychotherapy. And as I note in other parts of my report, the evidence base in general for psychotherapy is quite good.

So since we are using lots of the techniques from standard therapy, my guess is that it would generalize and be quite good. Just like everything else, there are very few studies as we have a very new patient population.

Q You have a hypothesis that can work, but there is not an evidence base specifically for gender dysphoria?

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A There is a huge evidence base for psychotherapy. I don't see any reason that patients with gender dysphoria would be so different from all of the other patients. So we can look at the massive evidence base that there is for psychotherapy and assume that all human beings with struggles and problems and distress could benefit from talking.

People have been fine tuning and honing therapy for quite a while and there are lots of really well proven techniques. I have cited cognitive therapy in my report.

I mean, there is a really strong substantial base for this being a very effective tool. So I don't see any reason why it would not work in gender dysphoria.

Q You think you have a really good hypothesis, but there is not a study showing that --

A Yes. Yes. There is no study showing it does not work, right. There are a lot of studies that show it works for everything else. But, no, we do not have a specific study in this.

Q Right. Would you agree that gender dysphoria is distress based on the existence of psychological characteristics that don't align with their gender identity?

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A That is a complex question. I'm not sure that that is the primary driver for most of or --

Q Doctor, I don't mean to cut you off. I think maybe you misunderstood my question. I'm not talking about etiology. I'm just talking about what it describes.

As a descriptive matter, gender dysphoria as a distress because of having psychological characteristics that don't align with your gender identity, is that fair to say that is a descriptive matter?

A I'm not sure. I mean, I think those are elements of what is going on. But, in totality, we are not really sure what the children and teens, what factors are causing them to have the, you know, thoughts and feelings that they have.

But, yes, I mean, I would agree to that, you know, that part of the criteria is that there is distress about their physical characteristics.

So I think that there are some qualifications and that we really sort of have not fully developed theories and knowledge about what is driving gender dysphoria.

But, yes, I would agree that just by the criteria, you are talking about someone who has

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distress related to their secondary sex characteristics and physiology.

Q And even though you have talked about evidence for things like cognitive behavorial therapy as a treatment for other conditions, you are not aware of any studies regarding the effectiveness of CBT for the treatment of gender dysphoria, is that correct?

A Yeah. I'm not aware of any studies that don't say it treats it. But I'm not aware of any studies that say it does treat it.

There are lots of studies that say it works for a lot of things. It just has not been studied, correct.

MR. SELDIN: Joel, will you take us back to Page 56, please.

Q Dr. Kaliebe, in Paragraph 154 you say, "It is surely reasonable and compassionate for a psychotherapist to prefer a patient no longer to suffer with gender dysphoria."

Do you see where you wrote that?

A Yes.

Q It's your belief that gender dysphoria can resolve? Or it's your belief that gender dysphoria can possibly be resolved by a person

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accepting their biological sex, is that fair?

A I believe that a component of resolution of gender dysphoria could be in many cases, and maybe in all cases, that acceptance. So yes, that could be one component of it.

Q Would you agree that gender dysphoria can also be resolved by treatments that bring a person's body in line with their gender identity?

A I'm not so -- I think when you talk about the patient population of adolescents that we are treating, I'm not, I don't think that the evidence is overwhelming that that does resolve their gender dysphoria.

There's mixed evidence on that. So I would not say that that is a uniform response to gender affirming treatment. I would agree it does seem there is evidence in some cases it resolves gender dysphoria.

Q So I guess my question is if it's -- and we can disagree about the frequency. But if it's sometimes resolution through accepting their biological sex, or through changing physical characteristics to match gender identity, is it ethical to totally ban one of those two?

A Well, I would add there is a third that sometimes

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

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

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

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

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

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

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A Yes.
MR. SELDIN: Joel, will you scroll down. Keep going.
Q I believe this is -- does this look like the agenda from the conference that you were talking about?
A Okay. Hold on. This is the adult conference.
Q Okay. The adult conference. Okay. There was a separate child conference?
A Correct.
Q Well, let's stay here for a moment. So, Dr. Kaliebe, you said that you provided three different CME lectures at this weekend in Puerto Rico, is that right?
A Of the child. Two for adult and three for child.
Q Okay. So are these the two for the adult that you were talking about?
A Correct. Yes.
Q So the agenda would be listed separately for the child conference?
A Yes.
Q I'm asking because I only saw two of the three. I was not sure where the third had gone. We will take a look at that in a second.
MR. SELDIN: Joel, will you pull up

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

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can't we tell the truth about Lia Thomas?"
It links to an article on spiked-online.com. Do you see that?
A Yes.
Q Do you recall liking this tweet?
A I believe that is accurate that I probably did.
Q Do you recall reading this article?
A I don't know that I ever read the article, no.
Q Okay.
A I may have. I may not have.
MR. SELDIN: Joel, scroll down.
Q You liked another tweet on March 28, 2022. This was posted by communik8e to Jordan Peterson. It says, "The Party told you to reject the evidence of your eyes and ears. It was their final, most essential command."
That is a George Orwell quote from 1984 superimposed on a photo of Lia Thomas. Do you recall liking this tweet?
A No. I don't doubt that I did if it showed up in my profile.
Q What do you think this graphic means?
A What does the graphic mean? Well, I think there is, the graphic means that there seems to be a problem with inclusion of biological males in

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women's sports and that we, you know, that this is an issue that seems, I think, important and that we should have an honest proper discussion about it.
And my opinion is that it's important to keep women's sports to those who are biologically female with whatever, you know, definition that you have. Yes, I would agree that is the main part.
The bigger part, though, is the, you know, there is an Orwell quote. As I was mentioning regarding, regarding, you know, silencing of debate, it seems like that we have not had any sort of proper dialogue, especially in the medical journals and within medical societies about how we are going to handle these complex issues.
So, you know, therefore, the George Orwell quote I think is, you know, part of why I tweeted it. Or why I liked it. I have never tweeted anything as far as I know.
MR. SELDIN: Joel, scroll down to the last page.
Q You will see you liked a tweet from Andre MCato on March 28, 2022. The tweet that you are liking says, "Who has the courage to interview Thomas and

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ask him how he justifies winning among women? In a free society, that interview would have already happened."
Do you see that?
A Okay. Yes.
Q Do you recall why you liked that tweet?
A No. I think it speaks for itself.
Q What do you mean?
A Well, I think that we should have a close look at what is going on. And, you know, to me this is a problematic issue when someone swims as a biological male for three years in college and then transitions and then swims as a female.
So, once again, this is something that I think is challenging, but there is a clear answer that most people would support. And I support that biological sex when it comes to sports is very important.
It is quite unfair for female participants if someone who is a biological male and gone through biological puberty is then allowed to compete with biological females.
Q You would agree that Senate Enrolled Act 480 has nothing to do with sports?
A Correct.

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Q Okay. And you will see that this tweet uses male pronouns to refer to Lia Thomas. Do you think that is appropriate?
A You know, once again, I don't think it's a big deal. I don't know that I noticed whether it used male pronouns or not. I mostly was liking things that brought up this issue of fairness and, you know, basically allowing women to compete fairly in women's sports, which I think is an important issue.
MR. SELDIN: Joel, I'm dropping into the chat a link which I will call Exhibit 17 for purposes of this exercise. If you can take us there.
Q Is Exhibit 17 the agenda for the child portion of the Oasis conference?
A Yes. You would have to scroll down to see the rest.
Q You will see -- Dr. Kaliebe, do you see there are two CMEs listed with your name next to them?
A Yes.
Q "Social Media and Cyberbullying: Prevention."
A Yes.
Q The second one is, "Cannabinoid: New Forms and New Problems."

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A Yes.
Q I guess my question is earlier you talked about presenting on gender dysphoria specifically at the child portion of this conference.
I'm just wondering why it's not listed here?
A Yeah. Well, that's a good question. I've not accessed this before. This is also garbled because the presenters do not match up. I did not represent on cannabinoids. I did present on the social media. Some of this is messed up.
Q Okay. Did you present one or two CMEs?
A Three. I presented three.
Q Are the three that you did listed here?
A No. So only one is listed here. I presented the social media one. I'm not sure if the other ones are wrong or what is wrong on this. I presented on the three. It was Social Media and Cyber Bullying. It was Traumatic Brain Injury and Gender Dysphoria. What is listed there is incorrect.
Q Do you recall what the title of that CME would have been on gender dysphoria?
A I know gender dysphoria. It was Reviewing the Evidence or something like that.
MR. SELDIN: Joel, will you please bring

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up Exhibit 3.
Q Earlier today we talked about this as the C.V. that you attached to your report in Boe v. Marshall.
A Yes.
Q Look at Page 107 of this PDF. You will see, Dr. Kaliebe, on Page 21 it says at the top that you were a member of Zero To Three from 2017 to 2021.
Do you see that?
A Yes.
Q What is Zero To Three?
A Zero to Three is an organization devoted to young children. So this is, there's a field, sometimes people call it infant psychiatry or infant mental health.
The first few years of life are incredibly important. This is an organization devoted towards supporting children, infants, young babies and also their caregivers, especially their mothers.
So Zero To Three is a professional organization of those devoted to trying to promote support for moms and babies.
Q Why did you stop being a member after 2021?

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A I had presented a couple times at their conference. I do a lot of different things. So that was not totally, or, you know, I didn't feel like it was -- I just do so many things. I had to give some things up. It's a great organization. I would be happy to join or contribute again in the future.
Q And then we will look at Exhibit 8 next. This is an article on the Zero To Three website dated December 15, 2021.
It says, "Embracing Diversity: Developing a Gender Identity."
Do you see this article?
A Yes.
Q Have you seen this article before?
A No.
MR. SELDIN: Joel, scroll down to "Supporting Healthy Development."
Q I will read something. My question will be did I read that correctly.
Under Supporting Healthy Development it says, "Make sure your child knows they have your support. Gender identity is a central part of a child's identity and well-being. Parents don't make their children cisgender or transgender.

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This is also not a choice children make - it is simply who they are. To grow up healthy, every child needs to know that they are fully accepted, loved, and supported."
Did I read that correctly?
A Yes.
Q Do you agree with that?
A Yeah.
Q Dr. Kaliebe it says, "Read stories that feature all kinds of families, as well as stories that include transgender, non-binary, and gender expansive characters. Shared reading is a powerful way for all families to nurture an inclusive worldview and challenge stereotypes from the start."
Then it links to some suggested titles.
Did I read that correctly?
A Yes.
Q Do you generally agree with that advice?
A You know, I don't, I'm not sure that if we are talking about Zero To Three, you know, which is really like, you know, very, very young children. I think, you know, it's debatable what positive influence you would have in a very, very young child introducing these different characters.

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I don't think, you know, I'm not necessarily opposed to it. But I'm also not thinking that this is a, you know, that this is necessarily important.

I mean, yeah, I mean, once again, I think I would honestly, I personally would have a somewhat different emphasis. I don't think there is anything wrong with reading stories that include transgender or nonbinary, or gender expansive characters.

Q Dr. Kaliebe, further down there is a section that says, "Build an inclusive community."

It says, "This is important for all kids, and it's especially important for kids who may later identify as LGBTQ. In the past, one of the toughest things for kids discovering that their sexual orientation or gender identity was different than those around them was a feeling of being alone. Actors, politicians, teachers, sports stars, family, and friends who are upfront about their identities help make the world more comfortable for questioning kids. Make it clear that all people are welcome in your community and in your household. Living your values in this way shows your child that they will be loved however

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they show up and whoever they become."

Did I read that correctly?

A Yes.

Q Do you agree with that?

A Yes. It is important for us to have broad roles, or a broad range of how what, of how children can act. I do think it is important that we accept boyish girls and girlish boys and don't try to pigeonhole kids into my particular gender expression.

So I would definitely agree that allowing a wide range of gender expression is important.

Q Do you think that extends to people who are transgender?

A Well, I think we have had this conversation already. Children with gender dysphoria I would not categorize as transgender. I would say they are a child with gender dysphoria because I don't think it is appropriate to place an identity on a child.

So within their life we should make room for children to express themselves in any way, including gender nonconforming ways.

So, yes, we are in agreement that we need to make space for all children, including gender

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nonconforming children. And that it is important for society to create space for gender nonconforming children.

Where I think we are not on the same page or there is some difference of viewpoint is that I think it's important to emphasize that what we are talking about in, you know, we are saying gender nonconforming could be fine and not gender dysphoria.

But if we are talking about a gender dysphoria child, I'm not for labeling that child a transgender child. I think that we can label them a child with gender dysphoria.

Q In the middle of this paragraph it says, "Actors, politicians, teachers, sports stars, family, and friends who are upfront about their identities help make the world more comfortable for questioning kids."

Do you see that?

A Yes.

Q Earlier today we were talking about whether celebrities who are openly transgender are a source of social contagion. You thought they might be.

Do you remember us talking about that?

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A Yes.

Q Do you think these two, this sentence and that belief are in tension with each other?

A Well, I think there's a lot of nuance. As I said, I think we have to be careful about anything that may encourage children to want to change their body prior to them fully developing as individuals.

So I think that there is a challenge there in wanting to accept a child as they are whether that is gender nonconforming or not. So making space for all children, but not having children feel pressured that they would need to change their body prior to them fully developing.

Q But per this paragraph just about people being upfront about their identities, do you think just being upfront about identity as a transgender adult, that that is a source of social contagion?

A No, that is fine.

MR. SELDIN: Dr. Kaliebe, Mr. Patterson, it may be that I'm able to wrap up soon. I think another break might help me determine that.

Would you be opposed to a longer break, about ten minutes until 4:13?

MR. PATTERSON: Fine.

(OFF RECORD AT 4:02 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:09 P.M.)
MR. SELDIN: Dr. Kaliebe, thank you for the conversation today. Unless Mr. Patterson has questions that I want to follow up, I think we are at an end.
MR. PATTERSON: I don't have any questions. I think we are done.

AND FURTHER DEPONENT SAITH NOT

_____
KRISTOPHER KALIEBE, M.D.

attorneys for the respective parties.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____ 2023.

Wendi K. Sulkoske
_____
Wendi Kramer Sulkoske, Notary Public

Commission Number NP0661030
My commission expires December 1, 2030.
My County of residence is Boone.

STATE OF INDIANA)
) SS:
COUNTY OF BOONE)

I, Wendi Kramer Sulkoske, Notary Public in and for said county and state, do hereby certify that KRISTOPHER KALIEBE, M.D., the deponent herein was by me first duly sworn to tell the truth in the aforementioned matter;
That the foregoing deposition was taken on behalf of the Plaintiffs at the time and place heretofore mentioned with counsel present as noted.
That the deposition was taken down in Stenograph notes, reduced to typewriting under my direction, is a true record of the testimony given by said deponent, and was thereafter presented to the deponent for signature.
That this certificate does not purport to acknowledge or verify the signature hereto of the deponent.
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties or otherwise interested in the event of this action, and am not in the employ of the

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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-JHP-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
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