UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION
CASE NO. 1:23-cv-00595-JPH-KMB

K.C., et al.,)
)
Plaintiffs,)
)
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendants.)

The videoconference deposition upon oral examination of JAMES M. CANTOR, PH.D., a witness produced and sworn before me, Dana S. Miller, RPR, CRR, a Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiffs, appearing remotely from Ontario, Canada, on the 7th day of June, 2023, commencing at 9:35 a.m. pursuant to the Federal Rules of Civil Procedure.

CIRCLE CITY REPORTING
135 North Pennsylvania
Suite 1720
Indianapolis, IN 46204
(317) 635-7857

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APPEARANCES

FOR THE PLAINTIFFS: Chase Strangio, Esq.
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street
19th Floor
New York, NY 10004
cstrangio@aclu.org
-and-
Gavin M. Rose, Esq.
Stevie J. Pactor, Esq.
ACLU OF INDIANA
1031 East Washington Street
Indianapolis, IN 46202
grose@aclu-in.org
spactor@aclu-in.org

FOR THE DEFENDANTS: John D. Ramer, Esq.
COOPER & KIRK PLLC
1523 New Hampshire Ave., N.W.
Washington, D.C. 20036
jramer@cooperkirk.com

ALSO PRESENT: Chad Blackwelder
Charlie Ferguson
Brandon Splitter
Bailey Steinhauer
Andrew Shaw
Shay Storz
Mylene Laughlin

MODERATOR: Joel Scherer
Circle City Reporting

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Pursuant to the Indiana Supreme Court Case 20S-MS-236 signed March 31, 2020,
JAMES M. CANTOR, PH.D., having been first duly sworn or affirmed to tell the truth, the whole truth and nothing but the truth relating to said matter, was examined and testified as follows:

DIRECT EXAMINATION
QUESTIONS BY CHASE STRANGIO:

Q Good morning, Dr. Cantor. How are you today?
A I'm good. Thank you.
Q My name is Chase Strangio. I am a lawyer with the ACLU representing the plaintiffs in this case. And I'll be asking you some questions today.
As I mentioned, there are also some law student interns sitting in, as well as my colleagues, Gavin Rose and Stevie Pactor, from the ACLU of Indiana.
Can you start by just stating your full name for the record, please.
A I'm Dr. James Michael Cantor, C-A-N-T-O-R.
Q And you've had your deposition taken before; yes?
A Yes, I have.
Q So you, generally speaking, know how this process goes?
A Yes, I do.

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Q Okay. Still going to run through a few of the ground rules just to make sure we're on the same page.
So as you know, there's a court reporter here. When answering my question, I ask that you respond verbally out loud so that Dana can hear you. And to please wait for me to finish asking my question before you begin your response. Does that sound okay?
A Yep.
Q And if you don't understand my question, which is very possible, please let me know and I can try to word it differently. Is that okay?
A Yep.
Q And if you do answer my question, I will assume that you understood it. Does that make sense?
A I understand, yep.
Q And are you feeling okay today?
A Yes, I am. Thank you.
Q Okay. And are you on any medication that would impair your ability to truthfully and accurately answer my questions?
A No, I am not.
Q And is there any reason you don't feel able to give complete and truthful testimony today?

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1 A Nope.
2 Q Okay. Great. I think we can get started. And, as
3 you know, at any point if you need to take a break,
4 please let me know. I imagine we'll also break for
5 lunch at some point. But if -- the only thing I
6 ask is to just answer the question we're discussing
7 before we break.
8 A I understand.
9 Q All right. So just starting with a little
10 background. You have been retained by the
11 defendants as an expert in this case; is that
12 right?
13 A Yes, I have.
14 Q And how did you come to be retained as an expert in
15 this case?
16 A Oh, goodness. I'm involved in several very similar
17 cases. And it's difficult for me to remember
18 exactly which one -- which way I got what e-mail
19 from who for which case.
20 So I could speak in general, I don't -- as I
21 say, I don't remember exactly how the first e-mail
22 started, "Hi, Dr. Cantor, I was referred to you
23 from," but it was essentially along those lines.
24 Q So someone in the State of -- someone at the State
25 of Indiana Attorney General's Office contacted you

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1 and you didn't contact them; is that right?
2 A Yes, that's correct.
3 Q And do you remember who that was?
4 A As I say, because several of these offices often
5 involve, you know, several different people, I
6 can't remember exactly which e-mail came from which
7 without going through my own e-mails to see who
8 said -- who came in at what point in the
9 conversation.
10 Q And do you remember approximately when that was?
11 A Within the past four or five months, I think.
12 Again, as I say, there's a cluster of them. I'm
13 not good on people's names to begin with.
14 So I hesitate to, again, without checking
15 through my own e-mails, but it was roughly in
16 that -- within the past couple of months. But
17 without checking my e-mails, I can't be --
18 Q Understood.
19 A I know better than to depend on my memory when
20 there are several very similar things all standing
21 next to each other.
22 Q Understood. You said you were an expert in similar
23 cases currently. What cases are those?
24 A On my CV, I listed all of the current cases. The
25 states themselves would be Kentucky, Indiana,

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1 Montana, Arizona, Florida, Texas, Tennessee. And,
2 again, without checking my list, I'm very probably
3 leaving one or two out.
4 Q And Oklahoma?
5 A Yes. Thank you.
6 Q So that's in addition -- including -- excuse me.
7 Including Indiana, that's one, two, three,
8 four -- at least eight states currently in cases
9 involving similar issues to the one here?
10 A Yes, that sounds about right.
11 Q And just so we're grounded in this case, are you
12 aware that this case concerns an Indiana law called
13 Senate Enrolled Act 480?
14 A Yes, I am.
15 Q And when this law was pending in the Indiana
16 legislature, did you take a public position on the
17 bill?
18 A No. The only testimony I had, and the only
19 interest I've ever had, really, is in the content
20 of the science.
21 So whenever I'm asked by the media, you know,
22 representatives in any state or any country,
23 members of the public, random e-mails I get, I'm
24 always happy to share whatever I can about the
25 science, but -- oh, and if somebody asks me a

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1 particular opinion about it, I'm perfectly happy to
2 show, you know, whatever points -- where the
3 science seems to contradict or match up with any
4 given proposal.
5 But I haven't in this state, and I don't think
6 in any state, given any particular support or
7 detraction from any particular proposal. The only
8 one I can think of where I did, I was specifically
9 invited to come and appear in Ontario, none in the
10 U.S.
11 Q So did you testify in support of Senate Enrolled
12 Act 480?
13 A No, I did not.
14 Q Have you ever spoken with a member of the Indiana
15 legislature about Senate Enrolled Act 480?
16 A No, I haven't.
17 Q Did you speak with anyone about Senate Enrolled Act
18 480 while it was pending?
19 A Not in any kind of professional capacity. But with
20 so many states and so many conversations just
21 amongst my colleagues and friends, I can't say that
22 I've never had a comment about it in general. But
23 I've never taken any public stance or given any,
24 you know, public commentary on any of the -- on any
25 specific proposal.

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1 I tend very specifically -- I do my best very
2 specifically to speak, again, just to the science
3 and to the general ideas and what ideas in general
4 match what -- or fail to match up with whatever
5 point in the science.
6 Q Understood. So have you -- other than the Ontario
7 example, have you ever testified in any state
8 legislature in the United States over pending
9 legislation concerning transgender people or the
10 treatment of gender dysphoria?
11 A No, I have not.
12 Q What did you do to prepare for your deposition
13 today?
14 A Lots and lots of re-reading. I re-read, of course,
15 the case files that I had, my comments, my
16 responses to the other experts who submitted
17 declarations. Re-read my own CV in case those
18 relevant questions are asked. And I'm always
19 keeping up with the literature, so there's always
20 something I need to read, re-read.
21 Q You mentioned your case files. What are those?
22 A Oh, no, I meant because I'm involved in several
23 different of the legal cases, in order to help me,
24 you know, as much as possible keep straight which
25 one is which, pardon the pun, just keeping track of

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1 which ones are involving which subset of issues and
2 in what order things are happening, just to, again,
3 keep my -- help me, as best as my aging memory can,
4 which one is which.
5 Q So when you say your case files, you mean your
6 files for this particular case?
7 A Yes.
8 Q And did you meet --
9 A Well, I shouldn't say this particular case, but
10 they're in clusters. And so, it helps me, you
11 know, keep a cognitive map of what's going in which
12 direction.
13 But by case files, I don't mean patient cases.
14 I mean the various set of legal cases and the
15 various, you know, documentation that's available
16 for each one. And some of the cases pertain to
17 events that happened years ago and what was -- what
18 the state of the science was at the particular time
19 before.
20 So, again, keeping track of a rough timeline
21 of what was available to whom and when.
22 Q So what is the cluster that this case would fall
23 in?
24 A Oh, bans to medicalized transition of minors. The
25 other clusters are the athletics-related bills and

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1 a set of bills that I would describe more generally
2 as free speech bills, under what circumstances, you
3 know, what person has a -- that somebody's comments
4 which others are offended by, you know, to what
5 extent the actual content of their comments
6 actually line up with what the science and what the
7 evidence itself has. I would say roughly those
8 three main clusters.
9 Q So you --
10 A Oh, and I should add -- I'm sorry --
11 detransitioners. Now there are groups of
12 detransitioners who are taking actions against
13 their clinics and care providers.
14 Q So you're currently serving as an expert in cases
15 involving medical care, athletics, what you explain
16 as free speech and detransition. Is that a fair
17 summary?
18 A Yes. My hesitation really is that my involvement
19 in all of them is the same regardless of the
20 application to which it's being put, the question
21 is to me or I'm a scientist --
22 Q Understood.
23 A -- and, as I say I, I will tell anybody of any
24 political angle or view whatever I can about the
25 existing science. What we know, what we don't know

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1 and how to interpret science and the scientific
2 method.
3 So those are the clusters, the topics to which
4 that information is being put. But the information
5 from me is the same regardless of who and how it's
6 being put.
7 Q So just to simplify, you are offering your
8 scientific opinion in cases involving medical care,
9 athletics, free speech and detransition; is that
10 right?
11 A Yes. I'd say that's a fair way to put it, sure.
12 Q And did you meet with counsel in preparation for
13 today's deposition?
14 A Yes, I did.
15 Q How many times?
16 A Once.
17 Q And for how long?
18 A A full day, a long day.
19 Q So you met with counsel for one long day?
20 A Yes. Everything else has been mostly
21 organizational e-mails, a few short Zoom calls.
22 But specifically aimed at preparation for today was
23 one full day.
24 Q What were the few short Zoom calls?
25 A Oh, again, reviewing the documents that have been

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1 submitted, you know, the basic process, the
2 context.
3 Q Yes, I would only -- so I didn't know if you
4 meant -- is that part of your meeting with counsel,
5 or is that a separate part of your preparation? I
6 don't need to know what you did with counsel.
7 A Oh, yeah, the e-mails and Zoom calls were
8 background kinds of organization. The only
9 preparation specifically for today was the one full
10 day pre-prep -- or prep.
11 Q And who was present for that prep meeting?
12 A John Ramer and Roger Brooks.
13 Q Roger Brooks from ADF?
14 A Correct.
15 Q Is ADF involved in this case?
16 A I don't know the details of the arrangements, but
17 the sequence of events was the first substantive
18 case that I was involved in for which I was
19 preparing a sizeable review of the scientific
20 literature was a case in Alabama.
21 After that preliminary hearing -- preliminary
22 injunction hearing, Alabama, the state, then again
23 I want to use the word retained, but I don't know
24 if that's actually the proper arrangement, but they
25 then began to -- they took on Roger Brooks in order

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1 to help them coordinate the subsequent features --
2 not features, events, processing of that case --
3 Q Does Roger --
4 A -- and --
5 Q Sorry. Go ahead. You can continue.
6 A Then several other states, as I say, with very,
7 very similar cases going on, same questions, same
8 needs, also wanted to retain me.
9 They similarly began to coordinate with
10 Alabama in order to, you know, minimize, overlap,
11 you know, maximize the efficiency between each of
12 the cases. They signed common interest agreements
13 with each other.
14 So Roger then, in turn, became involved in
15 helping to coordinate, you know, these -- they're
16 not coordinated cases in any way that I'm aware of,
17 but in order to help, you know, streamline
18 everything, there is an amount of, you know, trying
19 to use the best resources available across each of
20 these various states and each of the people
21 available to them.
22 MR. RAMER: Yeah, and --
23 A All of that to say I'm not aware of a direct
24 relationship between Roger Brooks and Indiana, but
25 through this set of coordinations, he is therefore,

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1 you know, at least indirectly involved because of
2 his experience through all of it. You know, many
3 people take his input and advice, you know, very
4 seriously.
5 MR. RAMER: Yeah, sorry, I'll just -- I'm
6 going to object and instruct the witness not to
7 answer about the substance of conversations,
8 obviously, with me as counsel in Indiana and Roger
9 Brooks who is counsel in Alabama, subject to the
10 protections there and also the common interest
11 privilege and protections here, so --
12 MR. STRANGIO: Yes, understood. Not trying in
13 any way to get at the substance of what was talked
14 about, just who was there.
15 MR. RAMER: Right.
16 BY MR. STRANGIO:
17 Q Is Roger Brooks often present for your deposition
18 preps subsequent to your involvement in Alabama?
19 A This was the only one. And he wasn't involved in
20 the prep for Alabama. He became involved after the
21 preliminary injunction hearing.
22 Q Got it. Do you have a relationship with ADF?
23 A No.
24 Q Did you speak with anyone other than your counsel
25 and Roger Brooks about your testimony today?

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1 A Not other than in any logistical sense.
2 Q What do you mean by logistical sense?
3 A Making sure that I had a quiet place in order to
4 be, clearing out my calendar for the day. You
5 know, just old-fashioned logistical kind of, oh,
6 this is happening.
7 Q Understood. And you talked about reviewing case
8 documents and your report and the other expert
9 reports in this case.
10 Any other documents that you recall reviewing
11 in anticipation of today's deposition?
12 A Not specific documents, no.
13 Q Okay. And is there anything with you on your desk
14 in front of you at the moment?
15 A I cleared my desk. I gave myself a blank pad of
16 paper in case I need it, a clean copy of my report
17 itself. But I didn't have time to print out a copy
18 of my CV in case there was something I needed in
19 reference to that. Other than that, it's coffee
20 and water.
21 Q Understood. Okay. So the only printed document is
22 your clean copy of your report in this case. So
23 when we talk about that, you will have it in front
24 of you; is that correct?
25 A Exactly, yes.

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1 Q Great. Thank you for doing that, spare us some of
2 the difficulties of the electronics.
3 A I don't know even if Lieutenant Uhura could have
4 handled this much paper.
5 Q All right. Well, we will just jump right in, then.
6 So I want to start by just marking a few exhibits,
7 just for ease as we go along, starting with your
8 declaration in this case.
9 MR. STRANGIO: So, Joel, if you can go ahead
10 and pull up what's premarked as Exhibit 1, that
11 would be great.
12 BY MR. STRANGIO:
13 Q And that's what, Dr. Cantor, you have in front of
14 you, I gather.
15 Doctor, do you -- oh, wow, maybe I can
16 actually move this -- do you recognize this
17 document, Doctor?
18 A Yes, I do. It looks like the declaration submitted
19 for this case.
20 Q And you understand this to be a true and accurate
21 copy of the declaration that you submitted in this
22 case?
23 A As best I can see, yes.
24 Q I can go down to the list of appendices, the
25 bibliography. So, yes, it does appear to be that?

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1 A As best as I can tell, yes.
2 Q And who wrote this declaration?
3 A I did.
4 Q Anyone help you?
5 A No. Again, the legal team, you know, did some
6 proofreading, gave me heads-up with some formatting
7 issues. The American Foreign Law Association uses
8 a different bibliography method than I'm accustomed
9 to. In my profession, we use the APA standards.
10 So, as I said, you know, technical details
11 like that.
12 Q And did you discuss this declaration with anyone?
13 A Again, with the legal team to help ensure the
14 topics that needed coverage would be included.
15 Q Anyone else?
16 A Not specifically that I can recall. As I say,
17 because I'm involved in several cases, and the
18 science that they need input on is the same
19 science, using the same basic report updated, you
20 know, as necessary, and, again, with feedback from
21 the various groups in order -- various parties to
22 make sure -- sometimes just a clarification of a
23 sentence or to ensure that it includes the
24 information that they need it to include.
25 So I don't want to say blanketly that nobody

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1 else has, you know, had any input to it, but
2 everybody who has had input, it's been on that same
3 kind of basic back-and-forth, make sure it's clear.
4 And what I can only describe as formatting things
5 in the opposite way than we do in science.
6 In science, I'm accustomed to here's what we
7 know. Here's the project I did, and here are our
8 conclusions. Where legal documents tend to be
9 organized in the opposite order. Here is my
10 conclusion, then I'll get to subsequently the
11 backup for how I got there.
12 Q Other than the various legal teams involved in all
13 of the cases where you're currently serving as an
14 expert, did you discuss the contents of this with
15 anyone else?
16 A Outside of that, no, not that I recall.
17 Q And did you discuss the contents of your
18 declaration with the other experts retained by the
19 defendants in this case?
20 A No, I did not.
21 Q Does this declaration represent a complete
22 statement of the opinions you intend to provide in
23 this matter?
24 A Yes, it does, which isn't to say, you know, if
25 asked a question about something else in the

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1 research that I happened not to have covered in my
2 report, or if somebody presents an argument making
3 an error in scientific thinking, you know, other
4 information can become relevant. But this is -- it
5 summarizes my intention of everything I plan to be
6 able -- I plan to be expressing.
7 Q So up until -- up to the point of today, this
8 represents a complete statement of the opinions you
9 intend to provide?
10 A Yes, that is correct.
11 Q Are you aware of any inaccuracies in the
12 declaration that you submitted in this case?
13 A No, other than, as I say, I found missing half of a
14 pair of parentheses, because the editor in me.
15 Again, as soon as I submit something, that's
16 exactly when I find a typo.
17 Q Yes, I understand this. Anything you would --
18 other than the parentheses, anything you would like
19 to amend or correct in the declaration you
20 submitted in this case?
21 A No. I found no factual or content error.
22 MR. STRANGIO: And let's go ahead, Joel, and
23 pull up what's premarked as Exhibit 2.
24 BY MR. STRANGIO:
25 Q And just for your awareness, Doctor, this is going

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1 to be your CV. Do you recognize this document?
2 A Yes, I do. It looks like my CV.
3 Q And is this a current and complete version of your
4 CV, 32 pages?
5 A The only -- and there's -- yes, it's complete, with
6 the caveat that I would have updated it with any
7 additional cases that I've become involved with.
8 Q So the only thing that might be missing from this
9 would be the addition of cases in which you've
10 become involved as an expert witness; is that
11 right?
12 A Yes, to the best of my recollection. I don't think
13 there's been anything else that's changed since I
14 submitted it.
15 Q So in 2022, you testified at a hearing in Alabama
16 in a case concerning a law similar to SEA 480; is
17 that right?
18 A Yes, that is correct.
19 MR. STRANGIO: And let's, Joel, go ahead and
20 pull up what's premarked as Exhibit 3.
21 BY MR. STRANGIO:
22 Q And, Dr. Cantor, at the time this was the case
23 called Eknes-Tucker; is that correct?
24 A Yes, that's my memory of it.
25 Q Doctor, does this appear to be a copy of your

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1 testimony from that hearing? You can take a close
2 look.
3 A As best as I can tell, that's what it looks like.
4 The sentences that jump out at me match the --
5 match what I recall.
6 Q And did you testify truthfully in that hearing?
7 A Yes, I did.
8 Q Great. So that's all I have to premark for now.
9 So let's go back to your CV, which is Exhibit 2.
10 MR. STRANGIO: If you could, Joel. Thanks.
11 BY MR. STRANGIO:
12 Q And before we have that in front of us, in
13 paragraph 1 of your declaration in this case, you
14 describe yourself as a sexual behavior scientist.
15 What is that?
16 A That's a good question. It is a relatively small
17 field in numbers of people. Because of the import
18 of the issues to so many people in so many
19 circumstances, it is like a very, very highly
20 followed field.
21 I say that only because there isn't a very
22 simple universally-agreed-upon term, like if I said
23 I were an epidemiologist or endocrinologist or
24 something, very many of us would simply refer to
25 ourselves as sex researchers. But because sex

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1 research is itself such a highly interdisciplinary
2 field, saying one is a sex researcher describes the
3 questions that we're pursuing and the kind of
4 issues we're investigating, but within that one
5 could be anything from a psychologist to a
6 neuroscientist, an epidemiologist. It doesn't
7 refer to the academic field referring to the tools
8 that we use in order to address those questions.
9 So I usually would use a phrase like sex
10 researcher or sexual behavior scientist in order to
11 indicate the kind of questions in which I've spent
12 my career investigating.
13 Q And when you say sex researcher, what are you
14 referring to with respect to sex?
15 A Well, over the course of my career, I've handled,
16 you know, many, many different kinds of questions.
17 In general, because I have a more technical
18 background than most other sex researchers do, I've
19 been able to apply, you know, much more
20 sophisticated tools for doing those investigations.
21 For example, a lot of studies including, you
22 know, many of the studies that the public are most
23 aware of, really involve interviewing people or
24 surveys or questionnaires or other relatively
25 simple, relatively straightforward methods, but

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1 they don't answer questions in the kind of way that
2 have a great deal of weight.
3 For example, you know, is somebody born gay,
4 or does somebody, you know, become gay is a
5 question that very often comes down to, you know,
6 some very technical, very biological studies. But
7 because so many people who themselves call
8 themselves sex researchers are just interviewing
9 people, they just get a pile of what everybody
10 thinks the answer should be.
11 So as I say, when I use the term, I'm refer --
12 when I use the term to describe myself, I'm
13 refer -- using sexual behavior scientist because
14 I'm investigating, you know, the motivations and
15 the basis behind or supporting people's sexual
16 behaviors, but I don't want to limit it technically
17 to behaviors either.
18 For example, if there's somebody who's
19 uncomfortable or trying to deal with being gay
20 living in a straight world, you know, some of the
21 questions are, "Doc, why am I different from other
22 people?" Well, we're not talking about his
23 behavior. We're not talking about some -- yeah,
24 doing therapy with somebody in order to help them,
25 you know, gain the self-confidence that they need

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1 in order to live a happy gay life.
2 But for the research itself, again, now we're
3 talking more, you know, fundamental -- I don't know
4 if I want to say traditional kinds of science, but
5 we're applying the tools to sexual behaviors or
6 sexual desires, sexual experiences, sexual intents,
7 sexual fantasies, masturbatory fantasies.
8 Some of these, you know, are not visible
9 behaviors, although they, you know -- some of these
10 don't reflect external behaviors. They reflect,
11 you know, what we infer to be internal states. And
12 there is no one-to-one correspondence between
13 external observable, objective characteristics and
14 what people report being their internal
15 experiences. That's especially true for people
16 whose sexual interests are, you know, something
17 that's stigmatized. They hide it, feel like they
18 need to hide it. They hide it in different ways
19 from different people in different circumstances,
20 including to the themselves.
21 Q And what is your current job?
22 A I'm in private practice.
23 Q What kind of private practice?
24 A It's in clinical psychology as a clinical
25 psychologist. My hesitation is, of course, as

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1 these cases became, you know, more and more
2 frequent, it's now a larger and larger proportion
3 of my time.
4 The majority of my career, as my CV says, is
5 as a full-time scientist and member of the medical
6 faculty. When I left CAMH, it was to go into
7 private practice. And then as these various cases,
8 again, came to -- started coming up, I was devoting
9 more and more time to the cases.
10 So I'm in private practice and continue to see
11 patients, but a larger portion of my time, again,
12 is in consultation, expert witness testimony, and
13 in summarizing the existing science for the needs
14 of the various cases.
15 Q So let's take each piece separately. What
16 percentage of your time currently would you say is
17 occupied by your private practice?
18 A I guess my question is a little bit different if
19 we're talking about corporate structure versus
20 hours per week.
21 So far as the accountants are concerned, you
22 know, everything I do is part of my private
23 practice. If one means by private practice, you
24 know, one-to-one therapy and seeing patients in a
25 traditional clinical psychology kind of role --

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1 Q Yeah, that's --
2 A -- or used in a therapy kind of role --
3 Q What percentage of your week is spent seeing
4 patients as a clinical psychologist?
5 A Roughly 20 percent of my time.
6 Q And what percentage of your time is spent serving
7 as an expert witness?
8 A Roughly 80 percent, two-thirds of my time.
9 Q And are you regularly compensated $400 an hour for
10 your expert witness time?
11 A I am now, yes.
12 Q And approximately how many hours per week do you
13 spend serving as an expert witness?
14 A Oh, goodness. It's really hard to nail that down.
15 Although I'm now doing it, I'll say,
16 professionally, I'm still a scientist at heart. My
17 thinking is still what my thinking always is, I
18 want to know the right answer. I'm just genuinely
19 curious, and I want to know how all of this stuff
20 works.
21 So I will, for example, be posed a question
22 which, you know, whatever lawyer has about whatever
23 particular person's situation or case. I'll spend
24 whatever, half an hour answering an e-mail or
25 supplying whatever materials back up whatever the

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1 answer to their question is, but that then leads
2 to, oh, wait a -- that leads me to start thinking
3 about if that's true, wouldn't that mean. And now
4 I'm reorganizing my own notes, and I'm, you know,
5 reading and catching up on, you know, some obscure
6 statistic that was used in whatever set of
7 analyses.
8 And I'm, you know, now spending several
9 hours -- I don't know if self-educating is exactly
10 the right term, but scratching the itch of my own
11 curiosity for which, you know, I became a scientist
12 in the first place. And then later in the week I
13 will get another e-mail from another person in an
14 unrelated case asking a similar question, and I can
15 now give them a more fulsome answer.
16 So I still only, you know, spent a limited
17 amount of time working with either particular case,
18 but I will have spent several hours, you know,
19 investigating, thinking about and forming my own
20 thoughts about whatever a given issue is.
21 Q So understanding that it's combined somewhat across
22 cases, how many hours, approximately, per week
23 would you say you spend serving as an expert
24 witness?
25 A Typically, over the past few months, perhaps the

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1 past year, actually, might be a better guideline,
2 over the past year anywhere from just two or three
3 hours in bookkeeping and miscellaneous, you know,
4 admin tasks up through full-time, up through 40ish
5 hours, as an average, 10 to 15.
6 But, again, with the caveat that it runs
7 anywhere from practically zero for a long period of
8 time to, you know, almost obsessive because the --
9 some deadline is approaching with very little
10 notice, or I got caught up with, you know, my own
11 curiosity just leading me to that much more reading
12 and thinking.
13 Q Understood. And so, you said for the past year it
14 could range from anywhere between zero, two to
15 three hours, up to full-time. Did I get that
16 right?
17 A Yes, that would be about right.
18 Q And over the past year, about how much of your
19 income would you say derived from serving as an
20 expert witness?
21 MR. RAMER: Objection to the form.
22 A So if I'm remembering today's process correctly, I
23 do still answer a question even though there's an
24 objection in a deposition, even though --
25 Q Yes, sorry. Yes.

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1 A Got it. I'm just checking. Roughly 80 percent.
2 Q And on your CV, you're listed as the Director of
3 the Toronto Sexuality Centre from 2017 through the
4 present.
5 What is that position?
6 A When I left my hospital appointment, as I say it
7 was to go into private practice. My intent was to
8 begin a sex therapy clinic, which I did with
9 several staff people, you know, also clinical
10 psychologists, when I incorporated that group and I
11 began that clinic, I named it the Toronto Sexuality
12 Centre. And the legal designations appear just
13 automatically titled me, therefore, as Director.
14 As time went on and it became apparent -- a
15 bit clearer that a more substantial amount of my
16 own time was going to be involved with legal cases
17 rather than with clinical situations, I rebalanced
18 what was going on in the clinic so that I am
19 essentially just a solo private practitioner, but I
20 still have the name of the clinic as the corporate
21 entity.
22 Q So the Toronto Sexuality Centre signifies your
23 private practice; is that right?
24 A Yes. That's an accurate summary, yes.
25 Q And when you say you left your hospital appointment

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1 to begin your private practice, when was that?
2 A In 2017.
3 Q And before 2017, what was your job?
4 A I was a senior scientist at one of the large
5 psychiatric teaching hospitals -- well, the largest
6 psychiatric teaching hospital up here in Canada, in
7 Toronto, called the Centre for -- now called The
8 Centre for Addiction and Mental Health.
9 Q And when you were at the -- when you were a senior
10 scientist at that centre prior to 2017, did you
11 have a clinical practice?
12 A No, other than in the last year of it, as I was
13 preparing to leave it, I was, you know, building
14 my -- I was sewing together my parachute before I
15 jumped.
16 Q And in that role as a senior scientist at The
17 Centre for Addiction and Mental Health, what were
18 your responsibilities?
19 A They changed over the course of time. And as my
20 career advanced with them -- again, also as my CV
21 indicates, I began there as an intern the final
22 year of my doctoral studies, then a postdoctoral
23 fellow and so on progressing up the pretty
24 traditional ladder for academic researchers.
25 My duties as a senior scientist then were I

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1 was in charge of my specific research projects. I
2 was in charge of -- including obtaining the funding
3 in order to, you know, pursue those projects
4 itself.
5 I was then training and supervising the next
6 line of junior scientists, plus my own students
7 engaged in academic publications for the various
8 studies that I was running. And, also, in its
9 eccentric way as an ambassador to the field itself,
10 I was one of the higher profiled scientists in that
11 institution, largely due to my own, you know,
12 success and standing within my own field.
13 And because the issues that I was studying are
14 not just attention grabbing, but of the size of
15 legal weight or size of social import where the
16 results were not mere scientific curiosities, they
17 had very, very obvious and very, very important
18 potential implications for public health and public
19 safety.
20 So my media -- social media, and as I say
21 almost ambassadorial role itself became a large --
22 I don't know if I should call it official or
23 unofficial portion of my career, of my work --
24 Q When -- sorry. Continue.
25 A Of my career there.

1 Q And when you say ambassador to the field, what
2 field is that that you're describing?
3 A Sex research, several different fields. Again,
4 that's the nature of being part of an interdis--
5 such an interdisciplinary field.
6 Part of it was to sex research itself. Part
7 of it was to the field of psychiatry. Even though
8 I was not myself a psychiatrist, I was, you know, a
9 member of the faculty of the Department of
10 Psychiatry in the University of Toronto Medical
11 School.
12 So helping the public appreciate the role of
13 mental health, mental health research, psychiatry
14 within the public health system, and to help people
15 appreciate the potential benefits of scientifically
16 oriented, evidence-based mental health treatment.
17 So a chunk, as I say, was to psychiatry. A
18 chunk was to sex research. And a large chunk, as I
19 say, to public welfare and public safety. I was
20 specifically within the law and mental health
21 program of the -- the abbreviation to the
22 hospital -- again, it was the Center for Addiction
23 and Mental Health, or C-A-M-H, it's pronounceable
24 nickname is CAMH.
25 Q CAMH. Understood.

1 A So --
2 Q How -- sorry. Continue, you can.
3 A Lost the train -- oh, so because my specific role
4 was within their law and mental health program, a
5 lot of -- a large chunk of the group for which I
6 was -- you know, had an ambassadorial role was the
7 integration of psychiatry and the law or mental
8 health and the law.
9 What are the appropriate ways, what are the
10 most effective ways, what are the most
11 evidenced-based ways to ensure that people who were
12 engaged in the legal system in various capacities,
13 how does mental health interact with that.
14 So mental health issues not just in consent --
15 capacity to consent, but also people who break the
16 law. People who break the law, you know, during a
17 psychotic episode or people who break the law, you
18 know, as motivated by some mental illness. And
19 what's the correct way to get the right resources
20 to the right person, not only to help the patient,
21 but to also protect the health and safety of the
22 people around the patient.
23 Q Understood. I think that's probably a good
24 description of the field and your ambassadorial
25 role.

1 Going back to your clinical practice, your
2 current clinical practice. What is the average age
3 of the patients that you see?
4 A I don't think -- as we would say in statistics,
5 nothing can mislead as much as the mean group,
6 because you really need to know how dispersed they
7 are. If I calculated a number, it would be --
8 Q Do you primarily see adults in your clinical
9 practice?
10 A Yes.
11 Q Do you see any adolescents in your clinical
12 practice?
13 A Yes.
14 Q How many?
15 A Oh, goodness. Today I think it's just down to two.
16 As I say, I see very few people of any age, you
17 know, currently.
18 Q Got it. And so you see about two adolescents. And
19 how many adults?
20 A Roughly eight currently.
21 Q And any prepubertal children?
22 A No.
23 Q Has the -- oh, sorry, no. Just one more thing on
24 your CV here. You have psychologist 2004 --
25 May 2004 to December 2011.

1 Were you a clinical psychologist during that
2 period?
3 A Yes, that's correct. But the term clinical
4 psychologist isn't part of the formal title that
5 the institution gave.
6 Q Did you see patients during that period?
7 A Yes, I did.
8 Q And were the majority of your patients during that
9 period adults?
10 A Yes, they were.
11 Q Any adolescents?
12 A Yes.
13 Q What percentage of your patients during that period
14 were adolescent, would you say?
15 A Roughly 5 percent, perhaps.
16 Q And has the entirety of your professional career as
17 a psychologist been in Canada?
18 A Predominantly in Canada. I would hesitate to say
19 all. The gray part of the line would be I was
20 still in the U.S. while doing my master's degree.
21 And I was employed as a research assistant
22 specifically in neuroscience and in neuropsychology
23 for several years.
24 The topics were -- had no direct relationship
25 with the topics I study now, but it, of course,

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1 involved the same kinds of tools that are how to
2 assess somebody's brain health, neuropsychological
3 functioning, right down to the brain anatomy
4 itself.
5 So the tools include several of the tools I
6 still use today, but the topics and the behavioral
7 syndromes that the people were exhibiting are
8 different from the ones I study now. So I --
9 Q Have you had -- sorry. Go ahead, you can finish.
10 A So I was employed especially in a research context
11 within psychology for a few years in the U.S.
12 before I became Canadian.
13 Q Any clinical practice in the United States?
14 A Again, these overlap. The functions I was doing
15 then was to help analyze on the research end
16 information we were gathering from psychological
17 and neuropsychological assessment and clinical
18 assessment.
19 So it was clinical research, whether one
20 counts that as research or clinical reasonably and
21 appropriately checks both boxes. You can't do
22 research -- the kind of research we were doing was
23 based on the clinical work that we were doing. So
24 the same task is legitimately described as both.
25 Q And was that between 1990 and 1992?

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1 A Yes, that is correct.
2 Q And going back to your clinical psychology practice
3 or work from May of 2004 to December of 2011, you
4 said about 5 percent of your practice was
5 adolescent patients. Any prepubertal children?
6 A No.
7 Q You're not a medical doctor; correct?
8 A That is correct.
9 Q Not a psychiatrist?
10 A That is correct.
11 Q Not an endocrinologist?
12 A That is correct.
13 Q Have you ever prescribed puberty blockers to any
14 individual?
15 A No, I have not.
16 Q Hormone therapy?
17 A No, I have not. I'm wondering -- I guess I have a
18 question about your question.
19 How are you using hormone therapy to be
20 different from a specific hormone? To me those
21 are -- one is the subset of the other.
22 Q Well, do you prescribe medications?
23 A No, I do not.
24 Q So you've never prescribed puberty blockers to any
25 individual?

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1 A That is correct.
2 Q And you have never provided gender-affirming
3 hormone therapy to any individuals?
4 A That is correct.
5 Q Do you have any formal education or training
6 related to the treatment of gender dysphoria?
7 A Yes. The Canadian training model is different from
8 the American training model, however. So it's
9 difficult to compare them one to one.
10 Also, it's not -- clear is not the right
11 word -- to the extent that people who say that
12 they're offering training models, it's not clear,
13 and I don't want to take for granted that they are
14 legitimate training models.
15 They are usually a list of information, people
16 give it a title every -- and people in different
17 circumstances or context will accept it as that,
18 but these are not the kind of established,
19 validated testing programs where anybody's, you
20 know, tried to see what kind of outcomes and what
21 the appropriate content of such programs are.
22 But to get to your question more specifically,
23 the training model used up here in Canada is much
24 more similar to the European models than to the
25 American models. Where the American models, as I

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1 say, are, you know, here's a folder with a correct,
2 you know, title and description to it, and here's
3 the test at the end, that's that, we now call you
4 qualified, Canadian and European models apply a
5 much more apprenticeship-oriented model where here
6 are the readings, here are the patients. Let's go
7 over it all and start talking about it all and
8 develop a more comprehensive way of integrating all
9 of the information, acknowledging all of the
10 unknowns that we have.
11 So, as I say, in Canada we don't have the kind
12 of -- I don't know if credential-oriented is the
13 right description, but, you know, on-paper method
14 which is much more of the American model.
15 Q Well, when --
16 A I think there's also --
17 Q When did you have the Canadian model of formal
18 training related to gender dysphoria?
19 A I would divide that into two pieces, a clinical
20 portion and the research portion.
21 Q And when was the clinical portion?
22 A It was during my internship here. The final year
23 of my training as a clinical psychologist.
24 Q And what year was that?
25 A Oh goodness.

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1 Q I can look on your --
2 A '98/'99, I think it was.
3 Q And when was your research module of training?
4 A Again, it's hard to nail it down within those
5 terms, because it doesn't fit that kind of a model
6 quite -- it doesn't fit that way of thinking about
7 how the training works.
8 It's not like a plumbing or Calculus 1 where,
9 you know, it's a pretty set, known, widely used set
10 of material where people know what you get in
11 Calculus 1.
12 A great deal of the relevant research,
13 research methods would have been over the course of
14 my postdoctoral study -- over the course of my
15 postdoctoral studies, which would have been, you
16 know, in the first few years of 2000.
17 But, again, these -- because of the nature of
18 the model up here, because of the particular places
19 and people that I was training with, there's much
20 more of a blend across clinical and research.
21 I was in a research science facility in a
22 clinical research program where the difference
23 between clinical work and research is just how good
24 your documentation is. If you see a bunch of
25 people and have a rough memory, and you're only

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1 reflecting on your own recollections of it, you
2 know, calling it clinical experience or anecdotal
3 evidence, people would accept that as clinical
4 work.
5 But if you then write down exactly how many
6 people you saw, exactly how many people ended up
7 with exactly what kind of situation, and you do it
8 in a systematic way, now it's research, even though
9 the functions themselves are the same.
10 Q So taking aside the how, this blended process,
11 let's say, occurred between 1998 and the early
12 2000s; is that right?
13 A It's correct for timeline. But, again, I don't
14 mean to be evasive, but to leave enough, you know,
15 blurriness around the boundaries that there was no
16 end of -- as of June, you are now qualified or you
17 are no longer going to be doing any of this after
18 this semester, none of it was that kind of a
19 program.
20 Most training, as I say, is much more an
21 apprentice kind of model where, "Oh, you're good at
22 math. Could you give us a hand with" whoever it is
23 doing whatever kind of a study. And so, now we're
24 studying this kind of sexual or gender behavior
25 instead of that kind of sexual or gender behavior.

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1 MR. STRANGIO: I'm about to sort of move into
2 a slightly different section of the CV. Do you
3 want to take a break, John, for five or --
4 MR. RAMER: I'd welcome a break, but it's up
5 to Dr. Cantor, if he would welcome one.
6 THE WITNESS: Oh, more specifically, my
7 coffee's empty. So yes.
8 MR. STRANGIO: Okay. Let's do five minutes
9 and we'll come back in five. Thanks.
10 (A recess was taken.)
11 BY MR. STRANGIO:
12 Q On your website, Doctor, you describe the main
13 focus of your research as being on the role of the
14 brain and human sexual interests, especially
15 atypical sexualities; is that right?
16 A Yes, that sounds right.
17 Q So the majority of your work, as you describe it,
18 has been focused on what you describe as atypical
19 sexualities?
20 A That's the best all-encompassing phrase I can think
21 of to capture it quickly, but, yes.
22 Q What are atypical sexualities?
23 A As I say, I use the term specifically to be broad,
24 but it's not an official term. To break it down
25 into pieces, I would say it breaks down into sexual

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1 orientations other than, you know, predominant
2 heterosexuality.
3 So it would include, you know, the various
4 homosexualities, bisexualities, more recently
5 people referring to themselves as asexual, some
6 people adopt terms like hypersexual and so on.
7 For gender identity, you know, of course, it
8 includes identifying originally as male or female.
9 But now people, of course, identifying with, you
10 know -- again, adopting very many different terms,
11 describing it in very many different ways. And, of
12 course, in the group of atypical sexualities that
13 are called the paraphilias.
14 And, again, there's no concrete objective,
15 clear demarcation for what counts as a paraphilia
16 or not. In general, the phrase is used for people
17 with a sexual interest pattern or sexual
18 interest -- a sexual interest pattern either in
19 people, kinds of people, or in activities that are
20 not merely atypical, not merely statistically
21 unusual, but that they experience that interest
22 pattern as profoundly and as deeply as sexual
23 orientation.
24 To them, you know, if the thing that they're
25 attracted to is not involved in the situation, it

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1 to them is not a sexual situation at all.
2 Q Is being transgender an atypical sexuality as you
3 describe it?
4 A As I describe it, I would include it among -- I
5 would include gender identities and gender
6 dysphoria within the term as I use those terms, but
7 I also have to acknowledge that, again, these are
8 not official terms with very specific lines. There
9 are other people who would use, you know, these
10 terms in different ways. And as long as we clarify
11 who we're talking about, you know, we can have a
12 perfectly productive conversation.
13 But I don't want to say, you know, I use the
14 term one way; and, therefore, you know, if somebody
15 else says it counts or it doesn't count that there
16 even is a right or wrong to it. But I use the term
17 because of its breadth in order to include things
18 like gender identity.
19 Oh, and also in the atypical sexualities, I
20 would also include the various kinks. And, again,
21 what's a kink versus what's a paraphilia is not
22 very clear. One blends into the others. There are
23 kinksters for whom, you know, if the thing that
24 they're into, yeah, some sexual encounters will
25 include it, others not. But for others if it

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1 doesn't include whatever thing it is that they're
2 into, it doesn't count at sex.
3 So it's tough to come up with a -- there's no
4 good objective, definite, uniformly accepted
5 boundary between them.
6 Q And have you done any research relating to
7 transgender people and/or gender dysphoria?
8 MR. RAMER: Objection to the form.
9 A I have.
10 Q What was that research?
11 A I've done research on various relatively technical
12 aspects, including, you know, how to develop, you
13 know, formal questionnaires and the psychometric
14 properties of those questionnaires.
15 I guess by psychometric I mean the statistical
16 properties of how to form a test in order to make
17 sure that the test is testing what you want it to
18 be testing and not merely just asking the same
19 question over and over and over again 10 different
20 ways, but not providing 10 different pieces of
21 information.
22 I've also done research on the role of the
23 brain and age of puberty and how going through
24 puberty at different ages affects, you know, the
25 course of brain development.

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1 Q Any research on the mental health outcomes of
2 people with gender dysphoria?
3 A No. I don't think I've done any direct work on
4 clinical outcomes.
5 Q On page 10 of your CV, which is up here, I just
6 want to ask you about a few things. You have here
7 listed under your "Funding History" a five-year
8 grant September 2015 entitled "Effects of sex
9 hormone treatment on brain development: A magnetic
10 resonance imaging" -- oh, no, sorry, is someone
11 moving this? Okay. Sorry.
12 MODERATOR: It said you didn't have access to
13 move it. So I was trying to give you control
14 again. I think it's Zoom messing up. Sorry about
15 that.
16 MR. STRANGIO: Oh, no, it's okay.
17 THE WITNESS: Oh, we need Lieutenant Uhura
18 again.
19 MR. STRANGIO: I thought it was me.
20 BY MR. STRANGIO:
21 Q I'm going to start that over. So we have here
22 under "Funding History" on your CV a five-year
23 grant from September of 2015, "Effects of sex
24 hormone treatment on brain development: A magnetic
25 resonance imaging study of adolescents with gender

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1 dysphoria."
2 Do you see where I'm looking?
3 A Yes, I do.
4 Q And what is this grant?
5 A It was essentially as it sounds. It was an attempt
6 to investigate what happens -- you know, what
7 happens in the brain, doesn't happen in the brain.
8 You know, in what patterns does the brain develop
9 amongst people who are being treated and receiving
10 different kinds of treatment, whether medical or
11 nonmedical, over the course of puberty.
12 Q And you were not the principal investigator in
13 this -- was it a study?
14 A It was a -- well, is a research grant. And so, it
15 was the request for the government funding in order
16 to conduct the study --
17 Q Did the government --
18 A -- studies, I should say.
19 Q Did the government provide the funding for this
20 particular research question?
21 A Yes, it did.
22 Q And you were not the principal investigator for
23 this grant?
24 A That is correct. That one was done by
25 Dr. VanderLaan.

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1 Q What was your role?
2 A Again, I handled the technical parts. I was the --
3 I don't want to say the expert on brain anatomy,
4 but I was the connective tissue between the, you
5 know, neuroanatomists and the other sex researchers
6 involved in the project.
7 Especially then, I was one of the very few
8 people in the world at that time that had a foot in
9 each of those camps and was able to help everybody,
10 you know, coordinate and cross these various fields
11 helping the sex researchers, you know, asking these
12 questions, helping them understand how MRI research
13 works. How, you know, brain analysis works. How
14 the statistics are done. Why things are done the
15 way that they're done. The strengths and
16 shortcomings and different methodological
17 principles available -- procedures available to
18 them.
19 As I say, it's a highly, highly
20 interdisciplinary field. And in order to use
21 really these, you know, very, very high-end
22 research techniques, you know, there are only a few
23 people who can at the same time talk to both the
24 sex researchers and the statisticians and the
25 neuroanatomists.

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1 Q And this was a grant for a five-year period; is
2 that right?
3 A Yes, that's correct.
4 Q Were your findings published?
5 A I hesitate to say mine, because those, of course --
6 that was before I actually left the academic world.
7 But, yes, it's been published.
8 Q And where is it published?
9 A Oh, goodness. I don't remember. I'd have to look
10 it up.
11 Q Is it in your CV?
12 A No, I didn't participate. As I say, once I left
13 the academic world, then -- I was going to say left
14 the project, but that makes it sound a bit more
15 dramatic than true.
16 I'm, you know, in regular e-mail contact with
17 several of these people and answer questions where
18 I can here and there, but I wasn't dedicating --
19 Q But you didn't stay on as a co-investigator on this
20 particular grant?
21 A Yes, in the sense that I didn't have the kind of
22 active, ongoing, you know, regular input attending,
23 you know, the weekly meetings and so on. But I --
24 at the same time, it wouldn't be fair to say that
25 there was some kind of formal resignation process.

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1 It was just we all moved on, and that's that --
2 well, I moved on, I guess I should say.
3 Q And you're not listed in any of the papers that
4 were published as a result of this grant?
5 A That's correct.
6 Q And there's a second grant listed at the top. That
7 is from July of 2018 for five years. And this was
8 "Brain function and connectomics" --
9 A Connectomics.
10 Q -- "connectomics following sex hormone treatment in
11 adolescents experience gender dysphoria."
12 Was this a grant that was also received by
13 your -- by this research team?
14 A Yes.
15 Q And you were not the principal investigator on this
16 grant?
17 A That's correct.
18 Q Do you remain a co-investigator on this one?
19 A The situation is the same. This one, you know,
20 was -- it was awarded in 2018, but, of course, the
21 design and the submission was ahead of that.
22 My involvement was the same. I was
23 essentially the consultant, you know, helping
24 everybody communicate to each other, helping them
25 figure out, you know, what are the kinds of brain

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1 features they should be looking at as the next
2 logical steps.
3 Q And in what year did you leave -- or let's just --
4 I'll rephrase that.
5 In what year did you move on from this
6 particular academic position and, therefore, this
7 grant?
8 A I'd have to look through my e-mails to find the
9 actual date of my formal letter of resignation from
10 CAMH, but all of this was happening roughly around
11 2017, 2018.
12 Q And so you will not be an author on any of the
13 published findings out of this grant?
14 A I've learned never to say never. It's not my plan
15 and intent, but that isn't to say that if they come
16 to me with, "James, we found, you know, this
17 strange thing that we thought you'd find
18 interesting, or we need your input on, or we ran
19 into some piece of the mathematics we can't figure
20 out," again, I have no -- I'm still a scientist at
21 heart. I still enjoy the material. And I would do
22 my best to try to fit it in.
23 Q For the two pieces of grant funding listed in your
24 CV under "Funding History," you don't anticipate
25 being involved in the published findings of either

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1 of them?
2 A That's correct.
3 Q How were the study participants recruited for these
4 two grants?
5 A Through the clinics that see kids with gender
6 dysphoria.
7 Q And do you know approximately how many individuals
8 were enrolled in each?
9 A No.
10 Q More than 50?
11 A Again, I don't know. There are oftentimes changes
12 in design that would have happened, you know, once
13 the project itself got going.
14 As I say, I'm not involved in the day-to-day
15 running of the project. So I wouldn't be apprised
16 of progress or changes.
17 Q And how would you describe the study design of
18 these two grant projects?
19 A Case control.
20 Q And what does that mean?
21 A A group of people who are undergoing one set of
22 circumstances and series of brain scans, and we
23 come up with what's essentially an average brain,
24 if it could be called -- average brain image, if
25 one could be called that. And then compared to

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1 people as matched on as many variables as we can,
2 you know -- or they can, I should say, match them
3 on similarly developed and equivalent average brain
4 of the control group. And then through an
5 exquisitely bizarre set of statistics use what's
6 more like image analysis than, you know,
7 traditional statistics in order to identify
8 patterns in the averages of the images and connect
9 that back to what are those differences in the
10 images and the patterns, you know, tell us about
11 the structure of the brain itself.
12 And then in turn, what do those changes in the
13 structure of the brain tell us about the
14 developmental processes that led to those
15 differences.
16 Q And the control groups, were those study-enrolled
17 participants, or was that a control developed from
18 data of the general population?
19 A I'm sorry, could you ask that again? I'm not sure
20 those are different groups.
21 Q Was the -- were there particular individuals
22 enrolled in the study who were not receiving
23 treatment that represented a control group?
24 A The control group would be people not receiving any
25 kind of gender-related treatment, yes.

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1 Q And they also had a diagnosis of gender dysphoria?
2 A No, these would be -- depending on the question,
3 each of these, again, were grants, you know, that
4 were enabling the funding of several different
5 research projects all boiling down to neuroimaging,
6 but it wasn't like the final research paper which
7 reported a single set of analyses, you know, to
8 answer a specific question.
9 Different parts of the grant were aimed at
10 answering different questions, each using different
11 kinds of methods. Some would compare the gender
12 dysphoric kids to non-dysphoric kids. Some would
13 compare the gender dysphoric kids to their
14 non-dysphoric siblings.
15 Q Got it.
16 A And in early pilot studies, we would even do it
17 versus what I can only call stock brains, you know,
18 there exist large databases, you know, of images
19 that have been accumulated over many years, you
20 know, and are just available as gen -- I hesitate
21 to use the word generic, but generic-controlled
22 samples because -- especially because getting MRIs
23 on someone is so expensive that if we can get just
24 a group of healthy controls that anybody can use,
25 you know, with socioeconomic status already

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1 reported and controlled and age already reported
2 and controlled that they, you know, can be used as
3 a generic set of -- a generic control sample for
4 just about any study. Typically that would be done
5 early in development -- early in the development of
6 a study.
7 Q But for these particular studies, you had at least
8 two variables, one of which was experiencing gender
9 dysphoria and one of which was receiving sex
10 hormone treatment?
11 A My hesitation is a quibble in that, you know, those
12 are not necessarily separate variables, you know,
13 so they wouldn't get chopped apart so easily. But
14 the issues, the features, you know, being
15 investigated sometimes were the gender dysphoria
16 itself and sometimes were the effects of the
17 medications and treatments that they were receiving
18 or potentially receiving.
19 Q But your controls neither had gender dysphoria, nor
20 were receiving sex hormone treatment?
21 A That's my recollection of the plan, yes.
22 Q Okay.
23 A As I say, my involvement was in the design of --
24 was in the grant application which proposed the
25 design of the studies. And it's not unusual for

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1 you know, studies to need to be adjusted according
2 to whatever's going on, you know, once the feet hit
3 the laboratory ground.
4 So I couldn't say that, you know, as the
5 studies were conducted and after my involvement was
6 completed, I'll say, I can't speak to the current
7 status of the programs and whether any changes were
8 made, but the original plan was to do it as we
9 described.
10 Q So going back to your clinical practice, you're an
11 adult clinical psychologist; is that right?
12 A Yes, that's correct.
13 Q And as we discussed, you currently are treating
14 approximately 10 patients in your private practice?
15 A Yes.
16 Q Are any of those patients transgender?
17 A They're not. No one is transgender in the way that
18 most of the public uses the term currently. But,
19 as I say, especially the public use the term in
20 relatively vague ways that don't always match up
21 with the science.
22 But I do have one at the moment for whom
23 identity issues in general are a topic of their
24 concern but -- a topic of their concern. So it
25 really would depend on to whom I'm talking and in

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1 what context would this person's situation count is
2 a legitimate question. And it depends on how
3 people are using whatever terms and whatever ideas.
4 So if somebody, you know, gave me a
5 description or said, you know, is this a person
6 concerned with this, you know, we could say yes or
7 no. But whether the person, you know, counts as
8 gender dysphoric, counts as transsexual and so on
9 depends on how the person is using those terms.
10 Q Is that person an adult?
11 A Yes.
12 Q And you have never treated a prepubertal
13 transgender child; is that right?
14 A Yes, that is correct.
15 MR. RAMER: Objection to the form.
16 Q And you've never treated a transgender adolescent
17 under the age of 16; is that correct?
18 A Yes, that's correct.
19 Q Have you treated anyone under the age of 16?
20 A No, I have not.
21 Q And as I understand from previous testimony, the
22 extent of your clinical experience with transgender
23 adolescents has been providing counseling to eight
24 transgender patients between the ages of 16 and 18
25 in your career; is that right?

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1 A For being a formal clinician for cases, that number
2 sounds about right, yes.
3 Q And that was the number you gave in your testimony
4 in Alabama in May of 2022. So has that changed
5 since then?
6 MR. RAMER: Objection to the form.
7 A No, I don't think there's been anybody else in that
8 age range since that time.
9 Q Have you ever diagnosed a child with gender
10 dysphoria?
11 A No. Diagnosis, of course, is a subset of clinical
12 activities. So it's the same -- it's within the
13 same boundaries.
14 Q Since you've never treated a child, you've never
15 diagnosed a child with gender dysphoria it would be
16 fair to say?
17 A That is it exactly. Lovely when logic lines up.
18 Q It's rare.
19 A A rare pleasure we can call it.
20 Q Have you ever diagnosed an adolescent with gender
21 dysphoria?
22 A Not that I recall.
23 Q Have you ever monitored an adolescent patient with
24 gender dysphoria who was being treated with hormone
25 therapy?

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1 A That would depend on what one means by monitored.
2 I wouldn't have followed such a person or monitored
3 their medical treatment, for example. You know,
4 looking out for or interviewing regarding, you
5 know, physical side effects, that would have been
6 done by one of the physicians on the person's
7 clinical care team.
8 But I would have been involved in, you know,
9 progress and effects and so on on the person's
10 mental health status and development while they
11 were undergoing physical transition.
12 Q Well, you would have. Were you ever involved?
13 A I was involved in such cases, yes. I meant
14 hypothetically to be the different hypothetical --
15 to be the different ways to interpret the question,
16 not my role in the case.
17 Q So that would have been with the eight patients
18 that you have seen between the ages of 16 and 18,
19 some of those patients were on hormone therapy?
20 A Yes, that's correct.
21 Q And how were you monitoring their well-being on
22 hormone therapy?
23 A Oh, regular mental health assessment. As people
24 were going through, you know, transition, you know,
25 part of that, you know, during the clinical

1 standards, especially of that time, you know,
2 checking in regularly with their -- with
3 psychologists and mental health professionals, you
4 know, was part of the process.
5 So it was a combination of reviewing the
6 various documents such as from schools and
7 employers where relevant. And a lot of it, of
8 course, face-to-face interviews and with the
9 clients themselves.
10 Q And when was this?
11 A This would have been over the course of my -- while
12 I was at CAMH for my internship and a few years
13 after -- several years after.
14 Q Can you give me those particular range of years?
15 A Oh, 1998 through probably roughly 2005.
16 Q So you have -- since 2005, have you provided
17 clinical treatment to any transgender adolescent?
18 MR. RAMER: Objection to the form.
19 A Of the eightish, a small -- twoish, perhaps, were
20 between 2005 and today.
21 Q And when was the most recent adolescent patient
22 with gender dysphoria that you saw as a clinical
23 psychologist?
24 A Three years ago, four years ago. Again, depending
25 on, you know, who counts which way, there are

1 people who come in periodically for -- to check in
2 or catch up or somebody is now later experiencing,
3 you know, an unrelated issue, but because they know
4 who I am and we have a developed relationship, you
5 know, we can continue consultation or therapy or
6 whatever's appropriate, or there will be somebody,
7 again, not currently concerned with a
8 gender-related issue, but had gender-related issues
9 earlier in their lives.
10 So it's integrated as part of a comprehensive
11 assessment in getting to know the person, but not
12 necessarily the topic that brings them into therapy
13 to begin with or brings them into therapy to see me
14 specifically.
15 Q So just to summarize, in your career you have seen
16 approximately eight transgender adolescents as a
17 clinical psychiat -- excuse me.
18 In the course of your career, you've seen
19 approximately eight transgender adolescents between
20 the ages of 16 and 18, six of those were between
21 1998 and 2005?
22 MR. RAMER: Objection to the form.
23 A That sounds basically correct, yes. My, you know,
24 knowledge and expertise and the material, of
25 course, is about the science itself, not in the --

1 when I see these people, this is what I do, as I
2 say. I'm relying on the evidence itself, not my,
3 you know, personal anecdotal experience with them.
4 Q And for the eight patients that you saw as a
5 clinical psychologist, what was the nature of the
6 counseling that you provided?
7 A The nature of the therapy and counseling with them
8 really depended on whatever it was that was going
9 on in their lives.
10 The research demonstrates that the people who
11 do best are the ones who have -- who are able to
12 navigate and who have the support in order to
13 navigate typical, I'll say, life stretches and
14 developmental courses.
15 So for many of these people, it was dealing
16 with usual, you know, what do I do with my life, or
17 I'm upset about or I'm having difficulty finding
18 educational experiences or friendship groups or,
19 you know, significant others.
20 So they were often -- I don't want to use the
21 word generic, but they were, you know, very similar
22 issues to what, you know, other people attending
23 therapy would be experiencing. But the potential
24 role that these other indicators had was greater
25 for most of these people because they had

1 additional stressors to be going through; and,
2 therefore, needed that much more strength in order
3 to be able to handle the stresses that accompany
4 transition.
5 So the content of the therapy with them
6 usually would be the same content as with anyone
7 else, but there were -- there was for many of these
8 people more on the line, for a lot of people a
9 decision, for example, about what -- in the U.S.
10 you say college, in Canada we say university -- in
11 decisions about what university to attend would be
12 attached to social engagements, social
13 opportunities. The pressure on somebody who, of
14 course, is not just gender dysphoria, sexual
15 orientation often can have a similar impact, being
16 in urban versus rural environments, conservative
17 versus liberal environments. There's more on the
18 line for somebody -- for youth experiencing gender
19 dysphoria in planning or undergoing transition.
20 So the particular issues are the same. I'm
21 sorry, I'm repeating myself, but the circumstance
22 and context in which they're doing it is more
23 complicated or there's more involved in it.
24 So it's often very useful for them to
25 double-check their thinking or to receive, you

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1 know, feedback from somebody who's, you know,
2 familiar with and experienced with, you know, other
3 people going through similar issues.
4 Q So in some sense, you are providing to these eight
5 adolescent patients counseling comparable to what
6 you would provide to other patients?
7 A Predominantly. For some people it was specific
8 questions or curiosities or questions or their own
9 concerns about transitions, possibilities of
10 transitions, possible futures for them. But they
11 were not defined by their gender dysphoria or trans
12 status. They had all the regular issues that, you
13 know, very many youth have.
14 Q I want to talk for a minute about your appearance
15 in other cases as an expert. So I'm going to just
16 go right down to this last page here.
17 I'm trying to think, you mentioned a few
18 states that aren't listed here at the beginning.
19 So I guess my first question is: To the best of
20 your recollection, is this a complete list of the
21 cases in which you have been retained as an expert
22 witness?
23 A No. I think there have been some new ones since
24 then.
25 Q Can you tell me what those ones are?

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1 A I'm looking over, because on my bookshelf I have a
2 three-ring binder for each one, because that's my
3 list.
4 Q Why don't we do this, because you said -- is one
5 additional case Kentucky?
6 A Yes.
7 Q Is one additional case Montana?
8 A Yes. My hesitation with that is that it's going to
9 happen. They sent me the contract, but I haven't
10 signed it and returned it yet. But by the end of
11 business tomorrow, the answer will be yes.
12 Q Okay. So let's just say there's two or three
13 others that are in the works in which you have not
14 yet necessarily submitted any form of testimony.
15 Is that accurate?
16 A Again, perhaps I'm quibbling on the phrasing, but
17 for submitting testimony for Kentucky, I submitted
18 my declaration 48 hours ago, I think.
19 Q Okay. Understood. And for Montana, you have not
20 submitted anything yet?
21 A Correct. As I say, that -- you know, we're all
22 anticipating it about to happen. And I would not
23 be at all surprised if you're even more familiar
24 with my deadlines on this one than I am. But it
25 hasn't -- I'm waiting for the -- there's a funny

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1 old expression, dot and tittle. People used to dot
2 the "I" and cross the "T." Turns out that there
3 are words for those. The dot over the "I" is
4 called the jot, and the cross on the "T" is called
5 a tittle.
6 Q So that is where we are with respect to that.
7 Understood.
8 Among these cases listed, can you tell me
9 which ones you were deposed in?
10 A The Indiana case, A.M. versus. I would have to
11 check my notes for BPJ.
12 Q Anything else you recall?
13 A No, not that I recall, because several of the
14 cases -- well, a little less than half now were
15 Frye hearings, they don't involve depositions.
16 Q Those are the criminal cases -- or, sorry, civil
17 commitment cases?
18 A Yes. Again, I wasn't involved in the civil
19 commitment itself. I was involved in the Frye
20 hearing which, you know, was going to then get used
21 in the -- the questions to those were whether the
22 person was subject to civil commitment in the first
23 place, hence the Frye hearing in order to
24 investigate the scientific issues to decide whether
25 the civil commitment regulations pertained at all.

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1 Q So let's -- we'll say -- we will continue to update
2 as your testimony changes in these various cases
3 and call it an ongoing process. Does that sound
4 fair?
5 A That, yes, indeed sounds fair. As I say, the
6 nature of these particular set of cases, it's, you
7 know, me versus various combinations of, you know,
8 people from the AR office versus various subsets
9 of, you know, the same group of experts.
10 So it's, as I say, a rather bizarre, I don't
11 know if I can say unusual, but eccentric, novel
12 situation.
13 Q Well, going back to the cases involving transgender
14 people, did you ever reach out and offer yourself
15 as an expert in any of those cases?
16 A No, they all came to me.
17 Q And one of the cases you have listed here on your
18 CV, No. 5, is Dekker, et al. v. Florida Agency for
19 Health Care Administration. Do you see that?
20 A Yeah.
21 Q What was the nature of your involvement in that
22 case?
23 A They needed a -- well, my basic involvement was the
24 same as with the other cases. They needed, you
25 know, to know what the science said and, you know,

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1 what the -- and feedback on the experts -- what the
2 other experts have written and then, you know,
3 comparing their claims against the content of the
4 scientific literature again.
5 So the basic content of my involvement in that
6 case was exactly the same as my involvement with
7 each of the cases, is here are a bunch of claims,
8 which ones match up with the science.
9 Q And you wrote a declaration in that case?
10 A Yes.
11 Q But you were not called to testify at trial in
12 Dekker; is that right?
13 A That's my recollection, yes. I don't think it's
14 gone to trial yet.
15 Q I can represent to you that it has gone to trial.
16 So --
17 A Oh, okay.
18 Q -- if you haven't -- if you didn't testify there, I
19 gather you didn't testify at that particular trial.
20 A That would make sense. My amnesia gets me, but not
21 that bad.
22 Q So, yes, you did not unknowingly testify at the
23 Dekker trial we're going to say.
24 A I almost want to say, can I testify in my sleep?
25 Does that happen?

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1 Q I mean, you're the psychologist.
2 A Perfect answer.
3 Q And, yeah, so that was my only question on Dekker.
4 So in your declaration in this case, you write
5 about the practices of a selection of your European
6 countries with respect to treatment of adolescents
7 with gender dysphoria; is that right?
8 A Yes.
9 MR. STRANGIO: And, Joel, could we pull up
10 Exhibit 1, which is Dr. Cantor's declaration in
11 this case. I think I am -- am I in control?
12 That's a great question, but --
13 THE WITNESS: Is this another you're the
14 psychologist?
15 MR. STRANGIO: Yeah, I'm about to start asking
16 for advice over here, but for now I think I can
17 actually use this Zoom mechanism.
18 BY MR. STRANGIO:
19 Q Okay. So you do not provide a comprehensive
20 summary of all the practices of country -- excuse
21 me, you do not provide a comprehensive summary of
22 the practices of all of the countries in Europe; is
23 that correct?
24 A Correct. Again, my content was not about the, you
25 know, political situation, policy situation. My,

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1 you know, comments are about the science itself.
2 So I included -- what I included were the
3 systematic reviews that were available, all of the,
4 you know, comprehensive systematic reviews that
5 were available.
6 And so, the countries that I mentioned are the
7 countries that have used them, that have engaged in
8 them, but I haven't -- didn't attempt to make a
9 review of the political policy orientations of any
10 countries -- well, set of countries.
11 Q So England, Finland, Sweden, France and Norway are
12 the only countries that have done systematic
13 reviews of the evidence with respect to the
14 treatment of adolescents with gender dysphoria?
15 A That I am aware of. France didn't conduct its own.
16 They conducted a review, but not the -- but not a
17 systematic review of the original research.
18 Q Then why did you include France?
19 A They conducted a non -- a review, but not a formal
20 systematic review of the evidence as they were, you
21 know, evaluating their own set -- oh, actually,
22 that would be a better way of phrasing it.
23 That I included the countries that have, you
24 know, engaged in reviews of their policies, but, of
25 course, the ones that I deal with, you know, in its

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1 own section emphasizing are, of course, the
2 systematic -- the ones that conducted systematic
3 reviews.
4 Q So there are no other countries in Europe that have
5 engaged in reviews of their own policies other than
6 these five countries?
7 A I don't think I can claim negative in that I
8 haven't looked at every single country that did.
9 Essentially these are the ones who have done it,
10 who have conducted the kinds of reviews and then,
11 you know, made conclusions and asserted policies on
12 the basis of those reviews.
13 But I couldn't say that no other country has
14 done it more than feasible -- it's theoretically
15 possible, especially because they don't all publish
16 everything in English, it's certainly possible that
17 others have that I haven't become aware of.
18 Q But these were the ones that did reviews and came
19 to conclusions with respect to the evidence similar
20 to your own?
21 A Well, the ones that I reviewed, the ones that I
22 included would -- included their conclusions,
23 period. They happened to have come to the same
24 conclusions about the science that I've come to
25 about the science, but there was no -- I wouldn't,

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1 in fact I would work very hard to avoid, you know,
2 the kind of cherrypicking where I would only cite,
3 you know, or pick the ones who come to a particular
4 conclusion in any direction.
5 Q But you're just not sure whether there are other
6 countries in Europe that have done different
7 reviews?
8 MR. RAMER: Objection to the form.
9 A Again, I haven't attempted a country-by-country
10 search, you know, each in their various languages
11 to see if there's something that's been less
12 publicized or less internationally released.
13 So I can't say with any kind of certainty that
14 none exist, but these are the -- so I can't say
15 that none exist. I can only say that I'm not aware
16 of any.
17 Q So you didn't do a systematic review of all of the
18 countries' policies?
19 A Of countries' policies, correct.
20 Q On page 7, paragraph 16, you write here at the
21 bottom -- towards the bottom of paragraph 16
22 speaking about the European policies, "These range
23 from medical advisories to outright bans on the
24 transition of minors." Did I read that correctly?
25 A Those sounds like my words. I'm just squinting to

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1 take the --
2 Q Yeah, here we go.
3 MR. RAMER: And, Doctor, you have your -- am I
4 correct you have your blank printout as well?
5 Chase, is it okay if he consults that?
6 MR. STRANGIO: Yes, absolutely. I was about
7 to get my reading glasses, but I also made it
8 larger if that's helpful.
9 A Both are good, as I say. And here's my three-ring
10 binder for this one.
11 Q So, again, we're in paragraph 16, page 7. "These
12 range from medical advisories to outright bans on
13 the medical transition of minors."
14 A Yes.
15 Q Which of the countries that you identified in your
16 declaration have outright bans on the medical
17 transition of minors?
18 A The UK, Sweden, Finland. Am I forgetting somebody?
19 Q So is it your opinion --
20 A Yes, those three.
21 Q It's your opinion that the UK, Finland and Sweden
22 have outright bans on the medical transition of
23 minors?
24 A People can certainly quibble over the definition of
25 ban, but they have essentially, you know, reversed

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1 course from the wide availability that they had
2 restricting it only to specific formal approved,
3 you know, research studies.
4 Q So you consider accessing treatment in a formal
5 approved research study to be an outright ban on
6 medical transition?
7 MR. RAMER: Objection to the form.
8 A There's something funny embedded in that question.
9 That one is that they are restricted to research
10 studies which in turn select only particular people
11 under particular circumstances -- in particular
12 circumstances when they fit the -- whatever the
13 inclusion criteria are for the study. I don't
14 think it would be accurate to refer to that as
15 access.
16 It's not access. You know, what they would be
17 participating in, what they would be volunteering
18 for is participation in a research study as a
19 research subject, which is in turn medically
20 supervised and so on, which is -- again, especially
21 in countries -- this is one of the main
22 distinctions between the U.S. and the rest of the
23 world is that, you know, it's a public healthcare
24 system. Access means access.
25 And, you know, so participating in or

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1 volunteering for studies that involve, you know,
2 physical transition is not part of the you go to a
3 doctor and you show your health card and you get
4 access. That's -- as I said, that term does not
5 accurately depict their situation.
6 Q We're not talking about access. We're talking
7 about --
8 A I'm sorry, I thought you used the word.
9 Q -- outright bans on the medical transition of
10 minors.
11 So my question was: Do you consider
12 enrolling -- limiting treatment to a research study
13 to be an outright ban on the medical transition of
14 minors?
15 MR. RAMER: Objection to the form.
16 A Again, the use of the word treatment has some
17 assumptions built into it that don't very
18 accurately fit.
19 What the results of the systematic reviews of
20 the science and, you know, to the best of my
21 reading the science itself, says is that these are
22 not ready to be called treatments. These are
23 experiments. We're not sure when, for whom, under
24 what circumstances and in which way, you know,
25 these kind -- these interventions are helpful

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1 versus harmful and how to weigh the potential risks
2 with the potential benefits.
3 It's not yet ready for prime time. To refer
4 to it as a treatment would insinuate at least that,
5 you know, it has already, you know, been subject to
6 the kinds of analyses that we apply in providing
7 evidence-based medicine.
8 Q Okay. Well, let's ask more specifically. None of
9 the European countries that you mention in your
10 report have restrictions comparable to the one that
11 was passed in Indiana; right?
12 MR. RAMER: Objection to the form.
13 A Again, it's -- I can tell anybody, to the extent of
14 my knowledge, what the content of the science is.
15 And when I -- and to the extent that, you know, any
16 given, you know, legal proceeding or law is written
17 in lay language that a non-politician, non-lawyer
18 can read, I can, you know, compare it against the
19 content of the science.
20 The only distinction -- but I can't say that I
21 know the details of all the European various
22 regulations or those particular states within the
23 U.S. The only distinction I'm aware of is whether
24 research purposes are permitted exemption within
25 the ban. But I don't think it would be legitimate

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1 to say that if there's an exception to it then it's
2 not a ban.
3 Q So you would call it an outright ban even if it had
4 an exemption?
5 MR. RAMER: Objection to the form.
6 A It would depend on the nature of the exception.
7 Q So if there was an exception for research, for
8 example, you would call it an outright ban on
9 treatment? Sorry, excuse me.
10 If there was an exception for research, you
11 would call it an outright ban on the medical
12 transition of minors?
13 MR. RAMER: Objection to the form.
14 A I would hesitate to make a blanket statement in
15 case -- you know, I can imagine other at least
16 theoretical, you know, reasons that I would or
17 wouldn't call it. But I don't think that having an
18 exception -- for this particular situation, you
19 know, permitting -- again, we're not even talking a
20 particular research study that's ongoing in any of
21 these.
22 Such laws were -- regulations in Europe were
23 going on despite that there was no research going
24 on. That was one of the, you know, almost
25 ubiquitous criticisms, was the lack of research.

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1 And research programs have not been initiated in
2 these places yet.
3 So if a law, you know, permits -- in theory,
4 in the future if somebody else comes up with this
5 thing that doesn't yet exist, the current situation
6 is still such that it's not available, but we're
7 leaving room in the law just in case for the
8 future?
9 It's difficult -- in that circumstance, yes, I
10 think the word ban is including outright ban as a
11 perfectly legitimate descriptor.
12 Q So in the UK currently, can an adolescent with
13 gender dysphoria access puberty blockers as part of
14 an approved research protocol?
15 A That's my -- as I say, I don't study closely the
16 public policies of it. I can testify only to the
17 content -- really only to the content of the
18 science. But the way you describe it is roughly
19 what I recall of their current policy. But I don't
20 think that they have yet designed any such research
21 studies.
22 So even though it, you know, maintains and
23 reserves the potential, and as best as I can tell
24 the intent in the future to do that, the process
25 today, still for kids today, is that it's going to

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1 be a ban for the moment.
2 Things may -- as I say, exceptions, you know,
3 they're leaving room for potential exceptions in
4 the future, but they haven't happened yet.
5 Q So in paragraph 16 you talk about the various
6 policies and details about the policies.
7 Is it now your position that you're not
8 qualified to talk about the various policies in
9 these different European countries.
10 MR. RAMER: Objection to the form.
11 A I refer to the content of their reviews of the
12 science. And I, you know, share, re-review their
13 conclusions of the science. And I demonstrate not
14 their policies, but their changes to their policies
15 in response to their evaluations of the science.
16 Q But you might not be that familiar with how those
17 reviews are implementing the practice with respect
18 to the delivery of healthcare in these countries.
19 Is that fair?
20 MR. RAMER: Objection to the form.
21 A That's a bit overstated, I think. I haven't taken,
22 and I have no current plans to take thorough -- and
23 I speak as a scientist when I say thorough, I mean
24 almost obsessive -- investigation of the ins and
25 outs of the details. But on a relatively high

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1 level, I'm generally aware of their application or
2 of applications of science and how it's getting
3 used or misused in public policy.
4 But, as I say, I'm not a public policy expert.
5 I haven't, you know, gone into the details of, you
6 know, countries that are changing. I'm only
7 investigating, you know, the individual groups as
8 they are trying to gather the science for the
9 application of their policies.
10 I think it would be fairer to say that I've
11 spent some time and attention on the use of science
12 in policy -- or the uses of this present body of
13 science in policy, but I haven't studied, you know,
14 policy in and of itself.
15 Q So is it your position that no adolescents with
16 gender dysphoria are currently receiving puberty
17 blockers to treat their gender dysphoria in the UK?
18 A No, that doesn't sound correct to me. Exactly
19 because they're aware -- pardon the pun -- but
20 because their policies are in a transitional
21 status, there were, of course, you know, youth who
22 were already receiving medical transition services.
23 And that, as best as I recall, has been
24 grandfathered in. I don't think that they, you
25 know, stopped, you know, anybody who was already

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1 receiving treatment. So it wouldn't be fair to say
2 that nobody is currently receiving treatment.
3 What they say they're aiming to put
4 limitations on are the unnecessary or excessive or
5 over availability where medicalized transition
6 looks like is being used to displace other
7 interventions that very, very feasibly could be
8 better matched to these kids' needs and without the
9 sacrifices and risks that are associated with
10 physical transition.
11 Q So there are youth in the UK currently receiving
12 puberty blockers for gender dysphoria?
13 MR. RAMER: Objection to the form.
14 A Again, I hesitate to say that, you know, flat out
15 as a matter of fact, because that's not the --
16 they've already -- that's no longer a piece of --
17 you know, they've already completed their review of
18 the science. And so, that kind of completes how --
19 you know, that level of how closely I'm
20 following -- or that section of what I'm following
21 of what they're doing.
22 They're now -- the implementation or what --
23 the policies to which they're applying the science
24 is, you know, less a focus of what I follow than
25 the application of the science itself. Their

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1 review of the science is largely complete.
2 Q So at least as to individuals who had been
3 previously receiving puberty blockers for gender
4 dysphoria, that treatment -- or, excuse me, that
5 care is ongoing?
6 MR. RAMER: Objection to the form.
7 A My basic recollection is that they didn't cut off
8 from treatment people who were -- medical treatment
9 people who were already receiving medicalized
10 transition services or at least while a minor.
11 Q That would be true for hormone therapy as well?
12 A I'm including hormone therapy or what most people
13 call hormone therapy under medicalized transition,
14 yes.
15 Q And in your report you also reference Finland. And
16 just right now you referenced Finland as well; is
17 that right?
18 A Yes, that sounds right.
19 Q And do you read and write in Finnish?
20 A No, I do not.
21 Q Do you have a certified translation of the COHERE
22 2020 document regarding their review?
23 A Not of the full document, no, I don't think.
24 Q So you're basing your understanding of the Finnish
25 review on an uncertified translation?

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1 A No, that's not exactly true either. As a matter of
2 fact, I was due to go to Finland in the next couple
3 of weeks, but had -- you know, for a conference
4 that they're holding, you know, bringing together
5 the experts on exactly these topics.
6 And, of course, I'm in regular communication,
7 you know, with people all over the world within my
8 field and more and more commonly with this one.
9 You know, they've also been, you know, discussing
10 the issues themselves regularly in the media in
11 English and Finnish.
12 And, you know, to the extent that they have
13 also been, you know, releasing statements and
14 conversations with other people within the program
15 have been, again, in English. And all of it is
16 exactly consistent with each other. Nobody's
17 identified and nobody's, you know, claimed that
18 there have been any contradictions in any of the
19 available translations in any of the statements
20 that the scientists involved with it -- you know,
21 what they have said in English versus what they
22 have said in Finnish.
23 There have been no contradictions between the
24 conclusions that they came to versus the
25 conclusions that have been produced by scientists

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1 in other countries.
2 Q But typically are the only systematic review an
3 outline of the medical practices in Finland -- the
4 only official versions of the systematic review for
5 the Finnish medical authorities are in Finnish?
6 MR. RAMER: Objection to the form.
7 A I would have to check through my files to see if
8 that's still true. Another publication -- by
9 coincidence, not soon after I submitted this
10 declaration -- again, I would have to look through
11 and check to see if those were Sweden or Finland,
12 recently published in English a peer-reviewed
13 document, you know, summarizing the content of what
14 was originally in their native language.
15 And, again, I keep mixing up several of the
16 Scandinavian states, Finland and Sweden, and which
17 one contained within itself, you know, English
18 language summaries.
19 English is -- of course, you know, despite the
20 original languages that many reports are published
21 in, you know, throughout all of science, English is
22 still the lingua franca. The circulation of the
23 materials, the abstracts of the materials and so on
24 are still circulated in English.
25 And my conversations with the scientists

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1 themselves, including the ones who publish the
2 relevant studies, you know, we're in regular
3 contact with each other who, you know, certainly
4 have confirmed our whole conversations were based
5 on, you know, the idea of what the studies said --
6 of what the studies resulted. Also --
7 Q And by studies, you don't mean studies, you mean
8 systematic reviews; right?
9 A I'm kind of blending -- your mind is going exactly
10 where mine was headed. These two are blended. The
11 content of these systematic reviews -- of
12 systematic -- the content of systematic reviews is
13 largely the list of the papers getting reviewed.
14 So even though -- you know, and it is not at
15 all difficult to determine in any language Appendix
16 A is the list of studies included, you know, the
17 list of studies in Appendix B are the studies that
18 were not included. And those list of studies, you
19 know, have English titles published in English
20 journals and so on. And I'm very, very familiar
21 with every one of those studies.
22 So they have produced, you know, what are
23 entirely transparent lists of what was included and
24 what was not included. This was not a dense text
25 in which one needs a translation in order to

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1 identify subtle potential differences between how
2 something was originally written versus described.
3 The differences between what is included and what
4 is not, what was determined to be useful versus
5 not. And the result is very, very easy to
6 determine.
7 And, as I say, the studies themselves are
8 exactly the same studies that I'm very, very
9 familiar with to begin with.
10 MR. RAMER: Chase, if you have a good breaking
11 point, we've been going a little over an hour,
12 but --
13 MR. STRANGIO: I think if it's okay with you
14 both, I'd like to just finish up this section, and
15 then we could even break for lunch around noon, or
16 what are you thinking?
17 MR. RAMER: Over to Dr. Cantor, how he --
18 MR. STRANGIO: Yeah, are you --
19 THE WITNESS: That's fine with me.
20 MR. STRANGIO: Okay.
21 BY MR. STRANGIO:
22 Q So let's just take a step back. Finland has not
23 cut off puberty blockers and hormone therapy for
24 patients who had previously been receiving those
25 interventions, have they?

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1 A To the best of my knowledge, Finland has grand-
2 fathered people already receiving medical
3 treatments, and that the ban is for additional
4 cases.
5 They're attempting to stave off the -- or halt
6 the flood of new cases for which it is not at all
7 clear that the exist -- that the prior research
8 applies to the new demographic and to the new
9 phenomena that we're observing.
10 Q And for people prospectively seeking puberty
11 blockers and hormone therapy for gender dysphoria,
12 those interventions are available through clinical
13 trials?
14 A Again, I don't think it's accurate to refer to --
15 the word access and the word treatment, you know,
16 assumes that -- come with several assumptions that
17 I don't think are valid. For example --
18 Q Well, I think I said interventions and available.
19 Do you disagree with those formulations?
20 A Yes, for next-door neighbor kinds of reasons. That
21 is it assumes a current situation that is allowed
22 for, but is not assumed in the procedure itself --
23 policy itself. If, for example --
24 Q Let's pull up the Finnish policy, just so we are
25 talking about the same thing.

1 MR. STRANGIO: So that's Exhibit 7. Joel, you
2 do that part; right? Thanks. Exhibit 7.
3 A Again, this looks ouija boardish from over here.
4 You talk and magic happens.
5 Q Well, let's not go that far.
6 Is this the document that you're referring to
7 from Finland?
8 A Yes, that looks like it.
9 Q Okay. And I just want to go first to -- so this is
10 under the current care in Finland, "In clear cases
11 of prepubertal onset of gender dysphoria that
12 intensified during puberty, a referral can be made
13 for an assessment by the research group at TAYS or
14 HUS regarding the appropriateness for puberty
15 suppression." Did I read that correctly?
16 MR. RAMER: Chase, can you zoom in a little
17 bit?
18 MR. STRANGIO: Yeah, sorry about that.
19 A What you read was the content of that sentence, but
20 interpreting what that sentence means requires a
21 little more information -- well, chunks of
22 significant information.
23 That text indicates that that would be the
24 process and that they are leaving permission for
25 that to happen, except they leave permission for

1 that to happen. Missing from that sentence is that
2 neither -- I'm saying this in a backwards kind of
3 way -- they are limiting the permission to do that
4 to those two hospitals. But when that sentence is
5 isolated, it seems to suggest that, you know, those
6 two hospitals are engaged in such research
7 programs, and I don't believe they are.
8 It's, as I say, in the text of the policy it
9 leaves permission for them to do that, but they
10 have not set up the infrastructure to do it.
11 Also --
12 Q And you know that definitively?
13 A No, I don't know that --
14 MR. RAMER: Objection to form.
15 A -- definitively.
16 Q So they may have set up research program --
17 proto -- excuse me, they may have set up research
18 groups at the two hospitals listed?
19 MR. RAMER: Objection to the form.
20 A Again, some things are getting left out there. You
21 know, when this first came through, you know, the
22 best of my understanding in conversations with
23 these people was that there was no -- that there
24 did not then exist such a situation. But as, you
25 know, we've tripped over several times, these

1 things are changing quickly. People are making
2 plans, and I -- you know, the exact details of
3 every policy are not what I follow.
4 So I necessarily need to leave room for the
5 possibility that they have come up with one since
6 the last time I happened to have heard from anybody
7 there, but I -- they haven't received any kind -- I
8 don't want to say they've received no publicity,
9 they at least have not crossed my desk.
10 Also, in the establishment of their policy,
11 you know, the intention of the policy is put it in
12 place and then the government structure is move on.
13 If they conduct a study, find that, oh, it
14 doesn't actually help these kids so we shouldn't do
15 it anymore, the study wraps up and the rest of the
16 ban remains in place. It leaves, again, in theory
17 the opportunity for there being research, but it
18 would not be fair to say that the situation is more
19 limiting than it was meant to be.
20 They leave a loophole such that it can be used
21 if it can lead to potential changes in the future,
22 but none of those -- there's nothing in it that it
23 assumes that it will be this everliving alternative
24 way to receive medicalized transition services. It
25 just gives permission as just in case, but there's

1 no indication that -- no reason to interpret it
2 either as permanent or as current.
3 Q So based on your understanding, those who had
4 previously been receiving medicalized transition as
5 adolescents can continue to receive it; is that
6 right?
7 A So far as I know, they haven't cut off people
8 already in a medicalized pipeline.
9 Q And that there is -- they have left open the
10 possibility of future treatment through research.
11 Is that fair?
12 MR. RAMER: Objection to the form.
13 A Again, for the same reasons as before, I hesitate
14 to say treatment. They've left the door open
15 through research, and then it will be open to the
16 researchers, you know, whether to investigate
17 whatever kind of interventions, changes, whether
18 that counts as treatment, whether that cancels the
19 type of treatment we're envisioning now is unknown.
20 Q And that's the same as in Sweden; correct? They
21 have not -- in Sweden they have not cut off
22 treatment for those who had previously been
23 receiving medicalized transition, as you call it?
24 A That -- to the best of my knowledge, that's true,
25 yes.

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1 Q And in Sweden they have left open the possibility
2 that these interventions may be provided through
3 research?
4 MR. RAMER: Objection to the form.
5 A Again, I would phrase it a different way, that they
6 have -- that the regulation enables research. And
7 then it's up to the researcher to know exactly what
8 it entails, including the researchers not doing it
9 at all.
10 Q Is it your view that there is no research in this
11 area happening at all in Sweden at this moment?
12 MR. RAMER: Objection to the form.
13 A I don't recall there currently being such a study,
14 no.
15 Q But you don't know?
16 A Again, I just reflexively leave myself some wiggle
17 room in that these things are changing quickly, you
18 know, they are of enormous interest. And I do not
19 take for granted that, you know, in the very recent
20 past that things have changed.
21 Q And you mentioned in our conversation Sweden,
22 Finland and the UK, and then you also discuss
23 France and Norway.
24 But France and Norway would not be examples of
25 places that have, quote, outright bans on

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1 treatment; is that right?
2 A They have instead, you know, issued policy
3 statements and advisories, you know, indicating
4 their conclusion that medicalized transition is
5 being overused too quickly, too often without
6 sufficient consideration of less-risky
7 alternatives, but they have not implemented -- they
8 have not used the same policies strategies, I guess
9 is the best term I can come up with, that the other
10 countries have.
11 Again, I'm not a medical policy expert. And
12 each of these countries, you know, is run different
13 ways, and they have different tools available to
14 them -- each of these governments has different
15 tools available to them in the way that they
16 regulate medicine, all of which are, you know,
17 entirely unlike the American lack of government
18 control over -- in the U.S. I hesitate to call it a
19 medical system, it's more like a medical industry.
20 Q So these are all countries with medical systems
21 that are fundamentally different from the U.S., you
22 would say?
23 MR. RAMER: Objection.
24 A They have --
25 Q What was that?

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1 A Yes, each of these countries has an entirely public
2 healthcare system, you know, very -- relative to
3 which the U.S. remains a big international outlier.
4 Q Medicalized transition, as you call it, is
5 available in France for adolescents?
6 A It has not reached the level of -- it has -- the
7 documents they've released have not suggested the
8 level of restriction that other countries have.
9 But I don't know, and I don't recall any reports
10 discussing what portions of that, you know,
11 reflect, you know, local political interests or, as
12 I say, the methods by which each of these countries
13 controls -- manage is a better word, manage their
14 healthcare system.
15 I don't know what the alternative strategies
16 or controls the government had, how they get
17 implemented or the extent to which they're issuing
18 policy guidelines or advisories. You know, does
19 that reflect a difference in their conclusion
20 result of the science or just the political
21 facility and speed with which they can produce such
22 changes.
23 Q So based on your knowledge, neither France nor
24 Norway have outright bans on either puberty
25 blockers or hormone therapy for adolescents with

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1 gender dysphoria?
2 A It would be fair to say that current -- that
3 although they have, you know, reversed course, you
4 know, and they have scaled way back from the easy
5 facilitation of medicalized transition, they
6 haven't issued any language that suggests a yank as
7 far back as strongly as the other countries have.
8 Q Well, I'm not asking for such a descriptive answer,
9 just simply yes or no -- well, I'll say it this
10 way, just is medicalized transition, as you call
11 it, banned in either France or Norway?
12 A I'm not sure the question can be answered very
13 accurately in just a yes or no, but I think it
14 would be fair to say that the statements available
15 are not as definitive as the ones in Scandinavia,
16 for example.
17 Q Going back to the --
18 MR. RAMER: Hey, Chase --
19 MR. STRANGIO: Yes.
20 MR. RAMER: -- do you --
21 MR. STRANGIO: This will be my last question
22 on this topic, and then I was thinking we could
23 break for lunch.
24 MR. RAMER: Okay.
25 MR. STRANGIO: Yeah, sorry. I'm not going to

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1 take us down -- I'm not going through every
2 country, I promise, John. I was going to pull up a
3 map, actually, of the whole world, and we're
4 just --
5 THE WITNESS: I was just going to say and now
6 for Latvia.
7 MR. STRANGIO: Yeah. If we could just pull up
8 what I have premarked as Exhibit 6.
9 BY MR. STRANGIO:
10 Q And before it comes up, Dr. Cantor, you reference
11 in your discussion of the UK something called the
12 interim report from Dr. Cass; is that right?
13 A Yes.
14 Q And this is a document that Dr. Cass put together
15 that informed -- is this the document?
16 A Yes, it looks like it.
17 Q And what is this document?
18 A This was -- there were several documents that were
19 released as a bulk. And I can't remember just from
20 the particular date of this one exactly which one
21 was which.
22 This was part of the series of reports and
23 documents where she was indicating the basic
24 results of the systematic review and the
25 comparisons against -- comparisons of its

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1 conclusions of what the science said with their
2 what was then current policy and why those policies
3 needed substantial revision.
4 Q And then I just want to turn to page 9 here. And
5 this is "A letter to children and young people"
6 from presumably Dr. Cass. Is that a fair
7 assessment?
8 A So far as I can -- so far as I know, yes. Oh, I
9 should also add that I don't think it's fair to say
10 that this is a document that she put together.
11 Q Fair enough.
12 A This was a very -- she was a leader of a very
13 large, very substantial, very talented team. You
14 know, she provided the leadership, and she was
15 selected specifically because she was close enough
16 to the material in order to understand the science,
17 what was going on in the basic field, but not so
18 close as to being a part of it and receiving money.
19 You know, she wasn't making her living from it
20 either.
21 Q Who is the -- who made up the team that she was
22 leading?
23 A Oh, goodness, I couldn't name the particular
24 people. I couldn't name the particular people.
25 Q You said it was a substantial team. How many

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1 people?
2 A Oh, that's a good question. I remember running
3 across, you know, lists in which they were
4 provided, but I -- these were not -- as I say,
5 these aren't people who are regularly part of the
6 sex research community where I would have run into
7 them over the course of my career.
8 Q So you don't know exactly sitting here today the
9 nature of the team that Dr. Cass led?
10 A No, that's not fair either. The nature of the team
11 were people, you know, with expertise and
12 background in assessment and public healthcare
13 policy. They were, you know, people with the
14 appropriate backgrounds in order to conduct the
15 review. But I don't recall their names, and
16 they're not -- I would have to go through the names
17 to double-check. I don't think any of them was a
18 sex researcher.
19 These are, you know, experts in medical
20 outcomes and medical outcomes research and in its
21 application to public healthcare policy.
22 Q And so, on this page here in this interim report
23 authored by Dr. Cass, the second paragraph she
24 writes, "I have heard that young service users are
25 particularly worried that I will suggest that

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1 services should be reduced or stopped. I want to
2 assure you that this is absolutely not the case -
3 the reverse is true. I think that more services
4 are needed for you, closer to where you live."
5 Is that correct? Did I read that correctly?
6 A That's the sentence that she wrote. But, again, in
7 its context -- when removed from the context
8 surrounding it, it would seem to be saying
9 something other than what it seems to say when put
10 back into that context.
11 I mean, you know, when isolated like that, you
12 know, it almost sounds like she's saying that she
13 wants to create more gender clinics so that people
14 didn't all have to go to the same clinic in London.
15 That's not what she was saying.
16 In the context of the fuller report and all
17 the other changes, she was putting as
18 diplomatically as a person can in such a polarized
19 cultural situation that the services -- that they
20 need more services, but not necessarily the exact
21 kind of services that they were requesting. I'm
22 even being ambiguous about this myself.
23 She wasn't saying that these people need more
24 gender clinics, and we're going to put more gender
25 clinics in more cities in order to facilitate your

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1 access to medicalized transition. She was
2 recognizing that these people are, and they are,
3 suffering from very substantial mental health
4 issues that are getting unaddressed. Those are the
5 services that she wanted to distribute, make more
6 available. And she was recognizing that these
7 people had great unmet needs, but that the --
8 Q So is it your -- finish. I'm sorry.
9 A But that medicalized transition was not necessarily
10 the best, most-appropriate balance of the potential
11 risks and potential benefits of the alternatives
12 that were available to them.
13 So she wanted better access to services that
14 would help the kids, but one can't isolate that
15 sentence in order to say that she was taking for
16 granted that the service that they needed was
17 medicalized transition.
18 Q So is it your understanding that in England --
19 excuse me, is it your understanding that in England
20 they are not expanding access to services including
21 medical services outside of the central gender
22 clinic?
23 MR. RAMER: Objection to the form.
24 A I'm not sure I'm following your question. When she
25 says -- in general where she says services, she is

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1 referring broadly to mental health services and
2 social services and help because these kids are in
3 distress.
4 Q And excluding gender transition -- including
5 medicalized transition services?
6 MR. RAMER: Objection to the form.
7 A Again, she's saying what she can say and leaving
8 open possibilities acknowledging the large number
9 of remaining unknowns. And that there are
10 possibilities that things may change in the future
11 as we get better evidence or if research produces
12 something that we're not currently predicting.
13 So she's using carefully crafted language, in
14 my judgment, to leave open the possibilities, but
15 to not make particular promises or to lead anybody
16 down a -- to mislead people down a particular path.
17 It is conceivable that, you know, future
18 research may demonstrate that, okay, this is --
19 that this may indeed, at least for some number of
20 these cases, perhaps that it would be possible that
21 medicalized transition might be the best option,
22 but we can't take that for granted.
23 What is very, very clear is that these kids
24 are in genuine distress, and they're not receiving
25 the supports they need for that distress. And

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1 although she didn't say it, the research is
2 indicating that -- does suggest very, very strongly
3 that these people are -- that very many of these
4 youth are expecting that a physical gender
5 transition would help them meet their psychological
6 needs when it's not the best balance of potential
7 risks and potential benefits -- risks and benefits
8 for what they're aiming. So she --
9 Q She didn't say that, you're saying that?
10 A Correct. That would be -- that last part is my own
11 assumption -- are my own words, you know. It is --
12 you know, what she said is consistent with it, but
13 I can't say that that is exactly what she's saying.
14 I point out only that when take -- removed
15 from the rest of the context around it, you know,
16 it sounds like she's offering to expand medicalized
17 transition, but that's not at all the full story.
18 MR. STRANGIO: I think we can go ahead and
19 stop there. How long, John, and Dr. Cantor, do you
20 want for lunch?
21 MR. RAMER: Over to Dr. Cantor.
22 THE WITNESS: Oh, I'm from New York. I can
23 eat while talking.
24 MR. STRANGIO: I mean, same, but let's not do
25 that for the sake of the court reporter, at least.

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1 So 40 minutes? Do you want to come back at ten of
2 one Eastern Time?
3 MR. RAMER: 12:50 Eastern sounds good.
4 MR. STRANGIO: Okay. All right. See you
5 then.
6 (The deposition was recessed for lunch.)
7 BY MR. STRANGIO:
8 Q So coming back to a conversation we started a while
9 back, Doctor, just for the sake of this line of
10 questioning, so you're not a pediatrician; is that
11 right?
12 A Correct.
13 Q And you don't have any clinical expertise in the
14 treatment of children?
15 A I don't know if it's fair to phrase it that way. I
16 have no clinical experience in that I don't do the
17 activity itself. But, of course, the effects on
18 children and how it affects their development and
19 their sexualities and so on I have a great deal of
20 expertise in.
21 Q So you don't have any clinical experience in the
22 treatment of children?
23 A Correct.
24 Q And limited clinical experience in the treatment of
25 adolescents?

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1 MR. RAMER: Objection to form.
2 A Again, I don't know what limited means in the sense
3 that, you know, it's -- most people have absolutely
4 zero, and even a lot of the people who have
5 experience with it have no experience in any other
6 aspect of human sexuality and aren't able to
7 perform a proper differential diagnosis.
8 Q But, generally speaking, in your clinical practice
9 I think you said lasted -- or, excuse me, generally
10 speaking in your clinical practice, approximately
11 5 percent of your patients were adolescents?
12 A Those numbers are correct, yes.
13 Q And do you have experience in pediatric research?
14 A Yes, in the same sense that I published papers
15 regarding children -- the assessment of children,
16 the effects of development over the course of
17 childhood, or for that matter, you know, prenatal.
18 You know, I'm not a neonatologist, but by the
19 same token brain development and what happens in
20 the brain and during brain development even before
21 birth is the very center of my background and
22 expertise.
23 Q And that's -- you've published original research in
24 that regard?
25 A I'm sorry, in which regard -- which of the --

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1 Q Excuse me, so you -- let me rephrase that.
2 Have you done any research trials in the area
3 of pediatrics?
4 A What do you mean a research trial?
5 Q What does that mean to you?
6 A It doesn't mean anything to me.
7 Q So I don't know what a --
8 A Usually when somebody says trial they mean a
9 clinical trial.
10 Q Have you done any clinical trials in pediatric
11 research?
12 A No, I don't think so. Again, my hesitation is
13 that -- just without scanning through my CV, just
14 to make sure that there isn't one that I forget, as
15 I say, you know, very often my involvement in
16 projects is for the statistics or, you know,
17 whatever technical piece that's relevant to the
18 project that somebody on the team doesn't have.
19 My favorite analogy is with accounting. It
20 doesn't matter if you're doing the books for one
21 kind of an industry or the other kind of an
22 industry. You know the accountant, and you know
23 when the accountant is wrong. And it doesn't
24 matter if they're selling cars or beef.
25 Q Got it. Have you reviewed the evidence base

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1 supporting clinical guidelines for pediatric
2 conditions other than gender dysphoria?
3 MR. RAMER: Objection to the form.
4 A No, not that I recall.
5 Q So are you aware of whether other treatment
6 protocols for pediatric conditions are supported by
7 randomized controlled trials?
8 A Some are, some aren't. The question's a bit over-
9 restricted in the sense that each of these
10 questions requires several different aspects to be
11 investigated at the same time and compared against
12 each other.
13 Of course, the most relevant of those are the
14 risk-to-benefit ratio, and in the large majority of
15 investigations that are pertinent to children, you
16 know, there are relatively few instances that
17 are -- that make good comparisons to gender
18 dysphoria when they have to be applied to children
19 or when we're talking medical interventions
20 specifically to adolescents, not prepubescence.
21 Q And are you aware as a general matter as to whether
22 research is more limited in the area of pediatrics
23 as compared with adult medicine?
24 MR. RAMER: Objection to the form.
25 A I've never undertaken such a comparison myself, but

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1 as a matter of, you know, how research -- how
2 medical research is done, of course, I'm often
3 involved in investigating or reviewing grants and a
4 wide range of different topics.
5 It would be an error to isolate research on
6 adolescents and interpret it in -- it would be an
7 error to interpret the number of studies conducted
8 with adolescents as opposed to, you know, age 18
9 and up or, you know, age of majority in whatever
10 given state and jurisdiction, because very, very
11 many illnesses are age linked. Young people have
12 fewer diseases than older people.
13 So the priority is often, on average, lower
14 for children than adults, because on average
15 they're healthier, you know, they haven't had the
16 long-term effects of whatever situation they're in,
17 whether it's smoking, obesity and so on.
18 That isn't to say zero, and that isn't to say
19 if you're young you're healthy, it's just that the
20 difference of the people who suffer ill health, the
21 young people are necessarily un -- less is a better
22 word, less represented. So one has to be careful
23 in not accidentally asserting a pattern that isn't
24 associated with -- we can't take anything for
25 granted.

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1 Q And are you aware of whether there are randomized
2 controlled trials supporting medical treatment for
3 precocious puberty?
4 A I don't think that there have been randomized
5 trials for it, but it's not a fair comparison. But
6 it wouldn't be fair to compare precocious puberty
7 and puberty blockers for precocious puberty with
8 the use of those same drugs for gender dysphoria.
9 Q Well, I'm not asking about gender dysphoria. I'm
10 just saying just as to precocious puberty. There
11 are -- you're not aware of any randomized
12 controlled trials preventing medical treatments for
13 precocious puberty?
14 A I haven't conducted a search for them.
15 Q So you're not aware of any?
16 A Not offhand, no.
17 Q What about randomized controlled trials supporting
18 medical treatment for congenital adrenal
19 hyperplasia?
20 MR. RAMER: Objection to the form.
21 A No, I can't think of randomized -- I can't think of
22 a placebo-controlled randomized study. I would
23 have to search to see if there have been randomized
24 studies comparing different kinds of medicalized
25 treatments with each other.

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1 Q But you're not aware of any offhand?
2 A No, not offhand.
3 Q Do you have any reason to know -- actually, let me
4 rephrase that.
5 Do you know if pediatric conditions frequently
6 have the type of evidence supporting treatment as
7 available evidence for treatment of gender
8 dysphoria?
9 MR. RAMER: Objection to the form.
10 A Again, that's not really a meaningful comparison,
11 because there are very few issues that have the
12 same risk-to-benefit ratio. And the great majority
13 of disorders, especially with youth, we're talking
14 about, you know, objectively diagnosed.
15 You can take a blood test and you either have
16 it or you don't. It isn't a matter of, well, we'll
17 talk about it and kind of decide and the child is
18 telling you what their diagnosis is. So there are
19 really very few like apples-versus-apples
20 comparisons that can be made.
21 So if you just kind of add up how many are
22 there, again, the result is misleading, because the
23 population of related disorders are so small to
24 begin with.
25 Q Well, let's take CAH, congenital adrenal

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1 hyperplasia, and just the medical intervention
2 of -- surgical interventions on the genitals to
3 make them conform to a more typical female genital
4 presentation.
5 Are you aware of any data supporting the use
6 of that surgical technique on infants with
7 congenital adrenal hyperplasia?
8 MR. RAMER: Objection to the form.
9 A I'm sorry, am I aware of any --
10 Q Data on the efficacy of that surgical technique on
11 treatment of infants with congenital adrenal
12 hyperplasia?
13 MR. RAMER: Same objection.
14 A Not on mental health effects. There have been some
15 case studies on, you know, the physiological
16 outcomes, for whatever they're worth.
17 You know, does the cosmetic end point match up
18 with generic surgical success, I'm not aware of
19 such studies for mental health effects.
20 Q But it's possible, then, that that intervention
21 causes harmful mental health effects on individuals
22 with congenital adrenal hyperplasia. Is that true?
23 MR. RAMER: Objection to the form.
24 A It's certainly a fair hypothesis. In fact, there
25 have been case studies, I don't remember if it's

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1 the name of the patient or the name of the author
2 of the book, John Colapinto, who examined, you know
3 a series of, you know, interventions that were done
4 with children in order to make their physiology,
5 you know, better match whatever -- oh, that was it.
6 I'm thinking of the Reimer case. It wasn't a CAH.
7 Never mind.
8 Q So you don't know of any data studying the mental
9 health outcomes of surgical interventions on
10 intersex -- sorry, excuse me, on infants with CAH?
11 A Not quantitative studies, no. There have been, you
12 know, single case studies of people, you know,
13 describing individual people, but not on -- not
14 anything to which one would apply any statistics.
15 Q Do you have concerns about the impact of that
16 surgical intervention on infants with congenital
17 adrenal hyperplasia --
18 MR. RAMER: Objection to the form. Sorry.
19 MR. STRANGIO: No, no. Sorry, that was not a
20 good question. I'll rephrase.
21 BY MR. STRANGIO:
22 Q Do you have any scientific objections to the nature
23 of the evidence base supporting the surgical
24 interventions on infants with congenital adrenal
25 hyperplasia?

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1 MR. RAMER: Objection to the form. Beyond the
2 scope.
3 A The question's kind of -- has a foot in science,
4 and a foot in, you know, the related research
5 ethics. And where it's properly science versus not
6 is a legitimate conversation.
7 I have concerns in the usual medical and
8 clinical research concern that intervening puts us
9 in a position of responsibility, especially when
10 we're talking about, you know, surgical
11 interventions.
12 In all of medicine and medical researches -- I
13 don't want to say it in Latin, because I'll
14 mispronounce it -- but we're not going to -- we are
15 bound not to do anything until we have very good
16 evidence of its outcome.
17 So intervening surgically or medically at all
18 should be withheld until we have, you know, solid
19 objective evidence to demonstrate benefit.
20 So, again, I'm kind of -- you know, that's
21 kind of scientific and kind of not. But I have
22 concerns in that, you know, people were intervening
23 medically and surgically without having a
24 sufficient scientific research basis for dramatic
25 intervention at all.

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1 Q But the law in this case explicitly exempts from
2 prohibition those kinds of surgical interventions
3 on infants with CAH. Are you aware of that?
4 A Yes. But, of course, you know, my purpose and
5 testimony isn't about the law. It's about the
6 nature of science, what the science says. And how
7 any organization wants to implement it is up to
8 them. I don't mean either to attack or defend any
9 statute.
10 Q But you didn't weigh in as to the scientific base
11 supporting those exempted interventions in this
12 case?
13 A I didn't intervene at all. I --
14 Q I said weigh in.
15 A -- do have -- not exactly sure what the difference
16 is. But, again, for a specific statute, I haven't
17 said anything.
18 The only caveat I need to add is that it's
19 very possible, although I don't have a specific
20 recollection, it's very, very plausible that I
21 would have spoken publicly about the application,
22 again, of medical interventions in situations like
23 the John Colapinto book about John Reimer -- Dan
24 Reimer, John Reimer -- David Reimer, that was it --
25 about medically intervene -- about engaging in

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1 medical interventions without first having
2 objective evidence about its risk-to-benefit ratio.
3 Q So I'm going to pull us to, just if you want to
4 pull it up on your paper copy, page 46, paragraph
5 106 of your declaration, which is Exhibit 1.
6 A Got it.
7 Q Maybe I should have had that. Okay. And this is
8 at the bottom of the page, from 46 to 47. You
9 write, "Biologically, the sex of an individual (for
10 humans and almost all animal species) as male or
11 female is irrevocably determined at the moment it
12 is conceived. Terms such as 'assign' obfuscate
13 rather than clarify the objective evidence."
14 Did I read that correctly?
15 A That's the content of the sentence, yes.
16 Q What about infants with intersex traits?
17 A What about it?
18 Q Would this sentence apply to them?
19 A Yes. However, there's subtle and profound -- or
20 there's a distinction that can be both subtle and
21 profound, you know, in how people are using the
22 word sex, especially in this context and in today's
23 context, about what it means as a definition of sex
24 and in what ways, you know, exceptions can and
25 should be made.

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1 There are relatively few characteristics for
2 which there don't exist, again, details,
3 atypicalities for which not everything can be taken
4 for granted, but they do not -- but these are often
5 examples that prove rather than disprove the rule.
6 Q So what is the definition of sex that you're using
7 here?
8 A That is exactly one of those profound and subtle --
9 distinctions that are both profound and subtle. In
10 the context of gender dysphoria, it's a mistake to
11 be saying that there is a definition of and that's
12 that.
13 And then with people picking either
14 chromosomes or hormones or, you know, subjective
15 experiences, sex itself in science would be -- let
16 me say this a different way. People are confusing
17 definitions with construct validity.
18 In mathematics, we have a definition, and it
19 will apply to the definition of the real numbers is
20 the definition of the real numbers and there are no
21 exceptions.
22 In science, we have what's called construct
23 validity. There's -- although we will use the word
24 fact, there is no such thing as a fact. We only
25 have the best explanation we have for the

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1 observations we've made. And it remains eternally
2 possible for some future exception to be made, and
3 we just haven't seen it yet. There is no such
4 thing as settled science as popular as the phrase
5 has become.
6 Sex is not like defining a real number versus
7 irrational number versus an imaginary number for
8 which there exists no exceptions. Sex is, again,
9 in science or in statistics what we would -- what
10 is the overlap amongst each of the pieces,
11 including all of chromosomes and genetics and so
12 on, all of which overlap and match the great,
13 great, great majority of the time.
14 Sex is that overlap, not the individual
15 ingredients that are put into the very -- the
16 overlap. So the identification of exceptions do
17 not break the rule.
18 In most situations, you know, at birth visual
19 inspection of the genitals is, you know, a
20 perfectly convenient, if I can use that term, way
21 to go about, you know, identifying the sex of the
22 kid, because it matches up with all of the other
23 features in the great, great, great majority of
24 instances.
25 But phrases such as the one that I was talking

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1 about here assigned at birth, well, if the mother
2 got a sonogram when she was six months pregnant,
3 she knew what the sex of the kid was going to be in
4 the great, great, great majority of cases months
5 before the birth happened.
6 So, as I say, but that -- so the presence of
7 exceptions in a long complicated chain of events
8 going from conception, and in some cases even
9 before conception for some, you know, chemical
10 interactions with the mother's body, you know,
11 through life experiences, you know, some of them
12 chemical, some of them biological, some of them
13 social, again, these are a large, large complicated
14 set of interrelated factors which are irrelevant in
15 the great majority of the time, but we only have an
16 issue when there is some exception.
17 So then we need to look more deeply into the
18 situation in order to decide what, if anything,
19 would be the most helpful to the person in
20 question. But as I say, these are all questions
21 about construct validity. And, you know, if I ask
22 a person what a house is, they can give me, you
23 know, a rough idea that will fit in the great,
24 great majority of the time. But then we can ask,
25 you know, "Well, is this an exception? Does this

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1 cave count as a house? Does this hut count as a
2 house? Does a hotel that you're living in" -- I'm
3 just making these up. And one can come up with,
4 well, there can be certain exceptions to certain
5 pieces of it, but what makes the house the house is
6 the consistent overlap of each of these
7 characteristics. But that there can be an
8 exception to one of the useful rules of thumb that
9 we use does not mean the overall concept -- that
10 the entire structure itself is wrong.
11 Q Well, I'm not asking if it was right or wrong. And
12 I think in some sense maybe you're trying to
13 respond to why I'm asking, not what I asked,
14 because I am just focused on these words in your
15 declaration, "The sex of an individual as male or
16 female."
17 What did you mean by "The sex of an individual
18 as male or female"?
19 A The overlapping set of -- again, because of the
20 context in which I wrote the sentence, it isn't so
21 easy to just lift the sentence out from the others.
22 By the sex of the individual, I mean the
23 overall set of characteristics, you know, ranging
24 from and including, you know, the multiple
25 biological features which are mostly -- again, it's

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1 the exceptions that are hitting my head -- that are
2 mostly determined at the point of conception and
3 the chromosomal combination.
4 Q Mostly, but not always determined at the point of
5 conception?
6 MR. RAMER: Objection to form.
7 A I wouldn't say always. Again, I'm leaving room for
8 there are certain, you know, chemical interactions
9 between the chromosomes, the mother's body, the
10 potential zygote and so on which can influence
11 what's going on biologically. They're rarely of
12 interest to very many circumstances, situations,
13 but they exist.
14 Q And so, coming back to your previous discussion,
15 you would say that overall sex is a set of --
16 sorry, the overlapping set of characteristics,
17 including multiple biological factors?
18 MR. RAMER: Objection to the form.
19 A Close. I would say it is the overlap --
20 Q Okay.
21 A -- amongst those biological features.
22 Q And what are those biological features?
23 A I don't know if they can be enumerated in full, but
24 the primary ones are, of course, chromosomes,
25 hormones. And biology, I'll say, from the neck

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1 down, you know, morphological form. And then
2 neuroanatomy, anatomy from the neck up.
3 Q And all of those biological features are part of
4 sex?
5 A Again, to say part of is to insinuate or the word
6 kind of involves a way by which they go together.
7 The best way I have -- I'm avoiding a mathematical
8 term, factor analysis, but it is the overlap itself
9 that forms the construct.
10 Science and biology don't work like
11 mathematics or law where you can write a definition
12 and then make all of your decisions based on that
13 definition and expect the result to be correct.
14 That's not how science works.
15 We give a best guess, and then we have to
16 check to see if we were correct by making -- you
17 know, designing a clever experiment to see if
18 something might be an exception. And we remain
19 tentative, because there remains always, at least
20 in theory, the possibility of something being
21 different.
22 Q Then in paragraph 107 regarding gender identity,
23 you write, "In science, a valid construct must be
24 both objectively measurable and falsifiable with
25 objective testing."

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1 Did I read that right, correctly?
2 A Yes.
3 Q What did you mean by that?
4 A Well, again, I was pitting it specifically against
5 trying to define or describe a concept according to
6 something that is none of, that doesn't fit --
7 well, specifically against claims of an inner
8 sense.
9 In science, there is no such thing as an inner
10 sense. The purpose of science was to replace
11 concepts based merely upon one's -- it's even more
12 ephemeral than inner sense, it's what one says is
13 their inner sense.
14 Q In medicine, though, there are phenomena that are
15 not objectively measurable beyond patient report;
16 right?
17 MR. RAMER: Objection to the form.
18 A Yes and no. There exists situations where when
19 it's low cost, consistent with other measures which
20 are objective and for which there are no major
21 risks, a convenient way to identify it could be
22 through something relatively subjective.
23 For example, you know, pain receptors in the
24 brain, fine and important and very relevant for
25 certain kind of research, but at the same time if

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1 there aren't enormous social pressures and enormous
2 risks, we don't need to send to a brain scan
3 everybody who comes in saying, "Doctor, my hand
4 hurts."
5 If, however, there are other situations where,
6 you know -- there also exists situations like
7 phantom limb pain. Now all of a sudden we're
8 looking at an exceptional circumstance and we can't
9 take for granted what the person says their
10 individual experience is.
11 So just saying that there exists exceptions,
12 again, we can't from that say -- those exceptions
13 don't disprove any such rule. There is a balance
14 of risks and benefits.
15 If it's low cost and pretty low risk, then we
16 can afford, we have the luxury of just going along
17 with the subjective self-report. If, however,
18 we're talking about something -- if that subjective
19 self-report is now in contradiction with the
20 objective available data, now we have a question.
21 We can't so easily take for granted the accuracy of
22 that subjective self-report.
23 Q But subjective self-report is often the basis for
24 some medical interventions; is that correct?
25 MR. RAMER: Objection to the form.

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1 A They exist in certain circumstances, which as I say
2 are when they're low risk and not in conflict with
3 objective information we do have.
4 Q Do you think gender identity is real?
5 MR. RAMER: Objection to the form.
6 A That's a pretty philosophical question, if not
7 outright Cartesian. Different people, of course,
8 use that phrase, you know, to mean many different
9 things in many different circumstances.
10 So there are different senses in which that,
11 you know, can be a useful descriptor, but only
12 partially accurate. And there are situations in
13 which, you know, people completely either misuse
14 the term or misidentify their own experiences by
15 application of the term because they don't have a
16 better term. They haven't been exposed to a better
17 term, or they're under some kind of social or other
18 pressure to use that term or use another term, for
19 that matter.
20 So whether it exists really depends on what a
21 person means and in what context.
22 Q Do you mean -- excuse me, do you use the term
23 gender identity?
24 A The words will come out of my mouth in -- if we're
25 in a context where what I'm trying to say is --

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1 will be well understood. If one is asking, you
2 know, very detailed questions or very specific
3 questions, then I'll use terms that, you know, more
4 precisely and more accurately capture what a person
5 is trying to say in using the phrase gender
6 identity. It's even more --
7 Q What are some of those terms that people might --
8 that you think would be -- that would more
9 accurately capture what people are trying to say?
10 A Oh, it depends on whatever it is I can infer about
11 what they're trying to say, again, by the context
12 of it. Very many people use the word, for example,
13 to mean -- to assert their belief that they would
14 be happier in a different social role if people
15 treated them in a different way.
16 And the only -- and so they use the word
17 gender identity, because it's now such a ubiquitous
18 term. And in many parts of society, a lot of
19 people feel pressure to just nod their heads and
20 say uh-huh, even though they're not sure what it is
21 exactly that they mean. And both of them are
22 working from a series of assumptions, and each one
23 is completely miscommunicating.
24 Again, with my scientific hat on, that's not
25 an acceptable situation. That's not how

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1 information can, you know, be assessed or
2 self-corrected, and we can't help each -- we can't
3 help people that way. In fact --
4 Q How would -- excuse me. Go ahead, you can finish.
5 A In doing -- probably one of the most common
6 questions in doing any kind of therapy with
7 anything is, "What do you mean by that?" A person
8 says whatever emotion it is, or they feel whatever
9 emotion they're feeling about, you know, their
10 mother, their brother, their significant other,
11 whoever it is, "What do you mean you hate love?"
12 Like/dislike are confused by, and it's the what are
13 the criteria that led you to use whatever word or
14 concept is the important part.
15 There are so many social, political and
16 emotional pressures influencing gender issues now
17 that, again, the term itself -- so many people are
18 using the term in so many different ways, the term
19 itself is not useful. People are using it for its
20 cachet as much sometimes, if not more, for its
21 accuracy.
22 Q So let's say -- how would you describe someone who
23 40 years ago, as a natal boy, let's say, said, "I
24 am certain that I am a girl."
25 What is that -- what would you describe that

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1 certainty of being a girl?
2 MR. RAMER: Objection to the form.
3 A Again, there are a couple of things embedded in
4 that. It's that, you know, if a child says it, you
5 know, a child being certain is not reflective of a
6 child being certain, you know. Very often children
7 phrase things, you know, in dichotomous or
8 simplified ways, you know, just as part of their
9 not yet having developed more subtle understandings
10 of them.
11 They will often assert things strongly because
12 they feel emotionally strongly about them, so they
13 use terms that are strong, even though that doesn't
14 reflect actual certainty or evidence.
15 It's an almost ubiquitous experience for gay
16 men to say that they -- or including myself even in
17 this particular one -- to have memories or feelings
18 of not being a boy or I'm a girl on the inside.
19 But even though they will have used those terms,
20 it's not an accurate perception. It's a use of the
21 only vocabulary that they have available to them
22 with a child's perception and experience of it.
23 Q What about an adult, 30 years ago none of the same
24 social political context of now, who is a natal
25 male asserts understanding or certainty of one's

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1 self as female?
2 MR. RAMER: Objection to the form.
3 A I'm almost self-conscious about I don't have to
4 project I was there and listening to these people
5 and in a -- you know, working in a clinic helping
6 adults, you know, with gender dysphoria exactly to
7 transition. And we had exactly this conversation,
8 but not quite 30 years, closer to 25. And that's
9 not how they described it. That's one of the flags
10 that's -- you know, that increases my, you know,
11 critical thinking ear, if I can mix my metaphors.
12 25 years ago, people felt -- at least the ones
13 that I was encountering, people felt comfortable
14 admitting to their doubt and uncertainty and "I'm
15 not so sure, and I want to try this out and see how
16 it goes."
17 Where the people coming into clinics now
18 are -- the expression -- I'm losing the expression,
19 are reporting to the test. They're -- you know,
20 they think they know the right answer. And if they
21 express doubt, then they won't be permitted to
22 transition, so they don't express doubt. Or flip
23 side that, you know, they're afraid that whatever
24 services will be changed if they start describing,
25 you know, I feel depressed or whatever negative

1 emotions, so they don't tell the clinician.
2 So people today are describing in much more
3 dichotomous, black-and-white terms things that to
4 those of us who have been in this field for a while
5 recognize as different. People were willing to
6 express their doubt a generation ago, and they're
7 not now.
8 Q What are you basing that on, your assertion about
9 what's happening when people present themselves to
10 clinics today?
11 MR. RAMER: Objection to the form.
12 A It's a combination of my own experiences, the
13 reports of clinicians on both sides of the issues,
14 those who, you know, basically see things, you
15 know, with a critical eye that I apply, as well as
16 clinicians who do not, you know, they also
17 describe, you know, very, very dichotomous reports
18 from their patients.
19 But there's a huge generational divide. The
20 clinicians I should -- the large, large majority of
21 clinicians, even calling themselves advocates and
22 activists, are all very young. They didn't
23 experience these clinics, these patients, these
24 populations, these problems, these difficulties
25 before the social media age.

1 This is all they know. They didn't notice a
2 difference. So far as they're concerned, things
3 have always been like this, and this is a permanent
4 situation. It's only the people who have been
5 working in this field over a longer period of time
6 who are able to look back at it and say, this
7 doesn't match the evidence. These are not the
8 people on whom we gathered that evidence.
9 The situations that suggest that, again, for
10 the adults for whom this was a good idea, this is a
11 different profile of what we were seeing before.
12 And the research we gathered on that prior group
13 does not automatically translate to the group that
14 we're seeing now.
15 Q You said your experience with patients presenting
16 to clinics, but you aren't currently seeing
17 patients in clinics, are you?
18 A I'm not seeing the patients directly, no. Usually
19 these would be either individual people coming to
20 me, other clinicians coming to me to consult on
21 whatever cases that they're seeing, the public
22 discussions amongst, you know, groups fall along
23 the spectrum. I should use a better term than
24 spectrum, it's getting overused.
25 Q What clinicians have been coming to you to express

1 this?
2 A I'm not sure what you mean by what clinicians. Are
3 you asking for names?
4 Q Yeah.
5 A I don't know if I'm comfortable giving particular
6 names. Usually these would be clinicians, again,
7 from all over the world, you know, the U.S.,
8 Canada, Europe, asking for input or a contrast or
9 observations that they have known -- that they have
10 noticed with subsets of their patients whose
11 stories are different, or they don't know how to
12 interpret the story because the models they used to
13 use don't seem to be fitting. They're not getting
14 feedback from their clients in the same way the
15 clients they used to see.
16 And, of course, you know, the clinicians and
17 other sex researchers, you know, at a sex research
18 and sex therapy clinic -- sex therapy conference
19 that I'm a regular member of -- again, these are,
20 you know, to me -- I've been going to these, I'll
21 say it again, 25 years, you know, and these are
22 common conversations among them. I feel like I
23 need to add a caveat to that, too.
24 Conversations have also become -- I don't know
25 if quieter is the right term. People now are

1 almost ironically less comfortable now talking
2 about it than it used to be. When gender identity
3 and sexual orientation were more stigmatized, you
4 know, height of the HIV era, clinicians and
5 scientists would pride themselves on resisting the
6 social stigma in order to talk about the issues.
7 The mantra of those days was silence equals death.
8 It's reversed today. People now are often --
9 I shouldn't say moderates, the middle 80 percent
10 are less comfortable discussing the issue, because
11 people want to ask questions where they feel there
12 is a vagary or uncertainty. But they've seen so
13 many examples, and there exists -- again, since the
14 onset of social media especially -- so many
15 examples of where people are getting pilloried not
16 merely -- not because they said what somebody
17 thinks is the wrong thing, but for saying,
18 basically, that they agree, but not strongly enough
19 that they're leaving out another opportunity to be
20 still more extreme.
21 Q What's an example of that?
22 A I can really only talk about them in a family of
23 examples where somebody will talk about a point
24 about a particular study. Actually, Twitter
25 probably is the best example, because --

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1 Q So you're referring to things that happened on
2 Twitter, not in medical communities?
3 A They --
4 MR. RAMER: Objection to the form.
5 A The situations don't divide quite so easily. It's
6 because I'm, you know, a well-known member of that
7 professional community that many of my Twitter
8 conversations or Twitter threads are with other
9 people that I know, again, from conferences,
10 experts and the same background.
11 So it's not the same kind of a conversation
12 that, you know, a member of the lay public would
13 have --
14 Q Let me ask you this --
15 A -- with another, you know, stranger member of the
16 lay public. These would be two professionals and
17 experts in a topic having a conversation mediated
18 by Twitter, but it's not the same as just two
19 random nonexperts having a conversation.
20 Q Well, when you say -- when you referenced the
21 examples of being pilloried, is that on Twitter?
22 A It includes Twitter. And because the nature of the
23 medium allows for it, you know, happens like --
24 they happen louder and more often. But, no, these
25 kinds of examples happen in every venue in which

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1 sex researchers have conversations.
2 Q Do you have examples from outside Twitter of this
3 happening?
4 A Yes. Again, just about any conversation -- any
5 social gathering -- social gatherings, for example,
6 the social hours at conferences where usually, you
7 know, it's at the end of the day, you know,
8 whatever cocktail somebody is holding as people are
9 just chatting and catching up since, you know,
10 we're all old friends to each other -- most of us
11 are old friends, you know, and then new batches of
12 students and so on. But the conversations are now
13 followed by who's listening. People are looking
14 over their shoulders. People are adding phrases
15 and caveats to their conversations that didn't used
16 to be there.
17 Two specific examples come to mind. Again,
18 I'm running through my head, because I don't want
19 to, you know, be inappropriately naming other
20 people in the context where they wouldn't have me
21 do. Both of these happen to involve Ken Zucker by
22 coincidence.
23 One would be a talk that he was giving at the
24 Society for Sex Therapy and Research, SSTAR. And
25 it was, you know, very much like other talks that

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1 Ken Zucker gives describing -- you know, sometimes
2 he's giving talks about specific research that he
3 was doing at the time on gender-dysphoric kids and
4 their development.
5 And then, you know, when he was involved in
6 the DSM, you know, many of his talks were about the
7 ongoing negotiations in the formation of the
8 clinical criteria for the DSM-5 this was. But
9 rather than just raise their hand or disagree and
10 have a conversation, the conversation was how dare
11 you say whatever it is that the person disagreed
12 with. Unlike not very many years before, you know,
13 it wasn't agree to disagree, it wasn't even just
14 disagree. It was if all I have to do is declare
15 myself offended and now you're not allowed to say
16 it, which was anathema to sex research, sex
17 research is what it is exactly because of sex
18 researchers who were willing to say things that
19 were unpopular amongst whatever other groups.
20 Q But Dr. Zucker was the one giving the presentation
21 in this example?
22 A Yes.
23 Q So he was speaking?
24 A Yes.
25 Q And you're describing the reaction of someone in

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1 the audience?
2 A Yes, interrupting it, and essentially the word
3 cancellation hadn't yet existed, but were so upset
4 that they didn't think that he should be allowed to
5 complete his thought discussion, or said another
6 way, other people didn't have the right to hear it.
7 Q When was this?
8 A Early 2010s.
9 Q And your other examples that you can think of are
10 in social hours and conferences and on Twitter?
11 A Those are, of course, much more common, because
12 those, you know, kinds of conversations are, you
13 know, so very much more common than an annual
14 conference.
15 And the other one -- specific one involving
16 him, again, was at a conference -- that I was at a
17 conference. I'm trying to remember the name of the
18 researcher who did it. Again, Ken Zucker was
19 giving a presentation. She had just finished hers
20 and happened to have been sitting right behind me.
21 And she was at full voice, you know, continuing to
22 talk to herself, essentially, saying what she'd
23 like -- well, didn't like about his conversation,
24 until I finally turned around, you know, "Do you
25 mind, you know, he's talking?"

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1 To which her response was, "Oh, I don't need
2 to hear that."
3 Q So coming back to your --
4 A I couldn't --
5 Q -- declaration, just to ground us there. You write
6 in some sections about social transition in
7 prepubertal children.
8 What is your understanding of what social
9 transition is?
10 A I hesitate to say my understanding is -- I hesitate
11 to say my understanding in that my understanding is
12 that, you know, many people use that phrase to say
13 many different things.
14 So step number one is find out, you know, what
15 it is the person I'm communicating with is trying
16 to say even before we know if we're agreeing or
17 disagreeing over any particular point.
18 So my understanding is the range of different
19 definitions and applications people use. And then
20 if we're actually going to do any kind of research
21 or assert any kind of meaningful fact, we start
22 with, well, in this circumstance what do me and
23 whoever it is that I'm talking to or I and whatever
24 author of the paper I'm reading, how is it being
25 used in this instance so we can be talking about

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1 the concept -- the relevant concept.
2 Q So you don't have a singular definition of social
3 transition that you use?
4 A I don't think it's -- I don't think anyone could
5 say that there exists a singular definition.
6 Q And if you use it at various points in your
7 declaration, is that based on how it's used in
8 other places that you're referencing?
9 A Again, I would have to look through each time I
10 mentioned it, but I, as a matter of habit, try to
11 either make it explicit how I'm using it or make
12 explicit -- if I'm addressing somebody else's
13 comment, then I do my best to make sure that it's
14 clear that, you know, I'm using that person's
15 definition or I'm addressing whatever that person's
16 conceptualization is.
17 Q And in your table of contents here pulled up on the
18 screen, which I think it's IX.B.1, you have a
19 section on what in the table of contents is,
20 "Eleven cohort studies followed children not
21 permitted social transition, all showing the
22 majority to desist feeling gender dysphoric upon
23 follow-up after puberty."
24 A Yep.
25 Q What does social transition refer to there?

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1 A There I was referring to Olson's study, recently
2 out of California, which was the one exception
3 among -- well, I shouldn't say exception among,
4 exception in addition to that 11. Hers was the one
5 study that followed kids who had already begun
6 living as the other gender when they came into her
7 clinic.
8 So when she reported her results of relatively
9 few of these kids having desisted by puberty,
10 exactly the opposite as the first -- as the prior
11 11, then, of course, I needed to cleave that, you
12 know, there was an important difference between her
13 one study and the other 11. That difference was,
14 again using her words, I'm pretty sure, that they
15 had socially transitioned.
16 So in that context, the meaning was, you know,
17 that the relevant definition was the one that made
18 the sample she was reporting on so distinct from
19 the others, from the other studies.
20 Q Well, you describe all the others as following
21 children who were not permitted social transition.
22 So presumably there has to be a definition that
23 applies to those 11 to know that children were not
24 permitted to social transition.
25 MR. RAMER: Objection to the form.

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1 A Again, that's not a definition. These were
2 studies, you know, that predated the existence of
3 the term. So the studies themselves didn't say
4 these kids were not permitted to transition
5 socially. These were studies that did what the
6 studies did.
7 And so, here we are, you know, sometimes
8 decades later trying to summarize in an
9 understandable, accurate, but still pithy --
10 pithy's not the right word -- succinct or concise
11 way to capture what is it that made, you know,
12 these 11 different from that one.
13 And the, you know, most applicable, shortest,
14 easily -- hardest to misunderstand phrase would be
15 social transition. But those papers didn't use
16 that term at all, but they're meaningfully
17 described with that term.
18 Q So what does it mean that they're meaningfully
19 described with that term, since you're the one who
20 applied that term to these 11 cohort studies?
21 A Oh, I think anybody reading the studies, the
22 methods, the contents of them would very
23 immediately come to the same conclusion that I did.
24 As I say, I'm not asserting that there was a
25 specific definition with a set of criteria that

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1 says fit or not fit. There really is no overlap
2 between what the set of 11 did and what Olson's
3 recent one did.
4 It was an active part or it was an explicit
5 part of the original 11 studies where the kids were
6 not permitted to crossdress and adopt new names.
7 They were, you know, encouraged to be as
8 comfortable as possible in their biological selves,
9 which is in -- which is exactly opposite to what
10 Olson did, which was to let the kids -- I don't
11 think it would be fair to say encourage, but --
12 indulge probably isn't the right word either, but
13 the way she, basically, described it is that, you
14 know, the kids came in very often already living
15 socially as the other sex.
16 So because this was, you know, such a large,
17 large difference between the original 11, we're not
18 in a situation where subtle differences in wording
19 or definition would change. You know, maybe one of
20 these two 11 really were more like Olson -- the
21 Olson study, the people -- the treatments, the
22 therapies that kids who were coming into Olson's
23 study were night and day different from the
24 treatments being received by the first 11.
25 Q So the first 11 you have on this page 51; is that

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1 correct? This table?
2 A That sounds right. Just seeing what you have up
3 there, that looks right, yes.
4 Q And seven of those were from the 1970s and '80s?
5 A Yes. As I say, this was ubiquitous, I would say
6 since the '70s. It would be an error to say that
7 all studies are old and, therefore, wrong.
8 Q I'm just not asking you to say whether they're old
9 or not. I'm just asking a factual matter whether
10 seven of them were published in the 1970s and the
11 1980s?
12 A That looks right, yes.
13 MR. STRANGIO: I'm happy -- I can keep going.
14 It is an hour now if you want to take five.
15 MR. RAMER: Yeah, why don't we take five.
16 MR. STRANGIO: Okay.
17 (A recess was taken.)
18 BY MR. STRANGIO:
19 Q So I'm going to fill in this exhibit, which is
20 one -- I'm going to take us to another section. So
21 we're in -- here on paragraph 135, page 59 of your
22 declaration, Doctor. It's at the bottom of the
23 page discussing what you're referring to as
24 adolescent childhood -- sorry, "Adolescent-Onset --
25 A Yep.

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1 Q -- Gender Dysphoria." And so, you write, "This
2 group typically presents in adolescence, but lacks
3 the history of cross-gender behavior in childhood
4 like the childhood-onset cases have. It is that
5 feature which led to the term Rapid Onset Gender
6 Dysphoria (ROGD)," citing to Littman 2018.
7 Did I read that correctly?
8 A Yes, that sounds correct.
9 Q And rapid-onset gender dysphoria is not a
10 recognized diagnosis; is that right?
11 A Not in a diagnostic manual itself, but that
12 shouldn't be interpreted to mean that the
13 phenomenon doesn't exist.
14 Q And the paper that you cite, Littman 2018, was
15 corrected as you note; right?
16 A There was a change to it, but nothing that
17 meaningfully altered any of its actual conclusions.
18 Q On footnote 5 you reference, "After initial
19 criticism, the publishing journal conducted a
20 reassessment of the article. The article was
21 expanded with additional detail and republished.
22 The relevant results were unchanged."
23 Is that a correct reading of the footnote
24 there?
25 A Yes.

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1 MR. STRANGIO: If we could, Joel, pull up
2 Exhibit 8.
3 Q Does this appear to be the notice of republication
4 of the Littman 2018 article?
5 A It appears to be, yes.
6 Q And at the top it says -- and I can zoom in so we
7 can look more closely -- "After publication of this
8 article" -- sorry, do you see where it begins that?
9 A Yes.
10 Q And then going down to the next paragraph -- oh,
11 sorry. Under the second part of this corrected
12 republication, there's a heading that reads,
13 "Emphasis that this is a study of parental
14 observations which serves to develop hypotheses."
15 Do you see that?
16 A Yes.
17 Q And then here at the top, about four lines down,
18 "Rapid-onset gender dysphoria, (ROGD) is not a
19 formal mental health diagnosis at this time. This
20 report did not collect data from the adolescents
21 and young adults (AYAs) or clinicians and therefore
22 does not validate the phenomenon."
23 Did I read that correctly?
24 A That's what that text says, but it's very difficult
25 for a person to know what that means and what it

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1 doesn't mean without having a better idea of how,
2 you know, science publishing works.
3 Q Well, so you noted that there was correction to the
4 article, but did not reference that ROGD is not a
5 formal mental health diagnosis.
6 Why didn't you mention that?
7 MR. RAMER: Objection to the form.
8 A It's not pertinent to the decision or question --
9 to the decision -- to the clinical question and the
10 pertinent decisions that followed from it.
11 In the situation, the whole point of the
12 current difficulty is that the profiles of the
13 people coming to clinics and expressing profound
14 often discontent that they do not match what is in
15 the existing manuals and on which our existing
16 knowledge base sits, that's the point.
17 Whether this new profile of person is better
18 helped and better served by ROGD as a diagnosis
19 unto itself, or if they actually are suffering
20 other kinds of problems but we're just noticing the
21 ROGD part of it because it's what they're saying on
22 its face value, or if, you know, the previously --
23 you know, the well-characterized distinction
24 between the adult-onset gender dysphoria -- and
25 adult-onset gender dysphoria, if this is now just a

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1 new way of expressing one of those, well, we need
2 to know that in order to know what to do with these
3 kids. That this new presentation is not in the, in
4 this case DSM is usually what people are referring
5 to, that's the whole point.
6 This is new and we don't know what to do with
7 it. Therefore, the medically and clinically
8 appropriate thing to do is nothing until we have a
9 better idea of what the potentials are, the risks
10 and benefits are.
11 When we're talking the removal of healthy
12 functioning tissue, that's a method of last resort
13 until we've exhausted the other alternatives which
14 don't involve as much potential harm.
15 If, you know, after we've exhausted the other
16 possibilities and realize, yeah, this really is the
17 best balance of the potential risks and benefits,
18 okay, let's go ahead. But that entire set of
19 questions was skipped.
20 We don't know if this is an independent
21 phenomenon, a new subset of an old phenomenon, and
22 if it is which phenomenon. These are people coming
23 in, you know, in great emotional distress. Okay,
24 but that doesn't mean that it's automatically what
25 it is that they're saying out loud. We can't take

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1 for granted that they're like one of the other
2 forms of gender dysphoria.
3 Q But in this paper, they're not saying it out loud;
4 right? It's their parents?
5 A Oh, in studies of youth that is -- that's very
6 common. That is -- as I say, it's difficult to
7 interpret that sentence once lifted out of, you
8 know, the rest of how this research is done.
9 Interviewing parents and caregivers and so on is a
10 very, very routine method of studying minors.
11 Q Exclusively interviewing parents and not the minors
12 themselves is routine?
13 MR. RAMER: Objection to the form.
14 A For one particular study, absolutely. It's when
15 asking a question, you know, it is exquisitely,
16 exquisitely rare for any one study to be -- to
17 answer -- you know, to answer any question.
18 Usually what we need, and the only way we know
19 that we're on the correct path that we have the
20 correct answer is when several different
21 researchers working independently using different
22 kinds of methods keep coming to the same result
23 over and over. That's when we can be confident.
24 So in any research investigating or that's the
25 pursuit of any question including this one, we need

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1 studies that talk to the kids, that talk to the
2 parents, that talk to their psychologists, that
3 talk to the physicians and other studies that don't
4 talk to a person at all and stick to objective
5 measures, you know, of whatever is appropriate to
6 the question.
7 So this one particular study was the one that
8 interviewed parents. It is neither the beginning
9 nor the end. Is it one piece of the puzzle and an
10 important piece when we need, you know, and it goes
11 in the pattern of all the others.
12 So it's that, you know, contribution one piece
13 at a time, yes, that is absolutely a routine method
14 for investigations studying minors.
15 MR. STRANGIO: If we could go back, Joel, to
16 Exhibit 1. Sorry, Joel, did you hear that, Exhibit
17 1? Thanks.
18 BY MR. STRANGIO:
19 Q Okay. Still on paragraph 135, you write after
20 reference to the Littman article, "The patterns" --
21 and this, let me -- I can zoom in for you, although
22 I think you have this in front of you, Doctor.
23 "The patterns reported by Littman have now
24 been independently replicated by another study
25 which also found it to be a predominantly female

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1 phenomenon, associated with very high rates of
2 social media use, among youth with other mental
3 health issues, and in association with peers
4 expressing gender dysphoria issues." Citation to
5 Diaz 2023.
6 A Yes.
7 Q Is that right?
8 A That reading of the text is correct, yes.
9 Q And if we can pull up -- well, let's see if we can
10 do this without pulling up the exhibit for the sake
11 of our limited technological skills.
12 Are you aware of changes to the Diaz article
13 subsequent to publication?
14 A Yes, I am.
15 Q And you're aware that the second author of the
16 publication, Michael Bailey, has since made public
17 that the paper has been retracted?
18 A Yes. Of course, I need to add the caveat that arm
19 of the drama happened after I submitted this. So
20 it wasn't -- you know, I didn't have that knowledge
21 when I wrote and submitted it. But, yes, I know
22 that that's happened in the interim.
23 Q So the article that you cite further the prop --
24 the article that you cite for the proposition that
25 the patterns reported by Littman have now been

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1 independently replicated was retracted?
2 A Again, there are some nuances in that. There are
3 some nuances in that. The paper wasn't -- the
4 basis of the retraction of the paper, which is
5 itself now a means of enormous controversy, was not
6 actually about whether the contents were accurate.
7 No one has, you know, presented any demonstration
8 that the results that they reported were incorrect.
9 So to the extent that one is actually seeking
10 the truth in that if one wants to know what's going
11 on, as best as we could tell with these kids, you
12 know, the conclusions they came to are perfectly
13 valid and, again, exactly the same. They, you
14 know, completely independently come to the same
15 conclusion as the Littman paper.
16 To the best of my knowledge, the nature of the
17 controversy, I guess I can call it, which led to
18 the formal retraction was -- oh, goodness -- was
19 the database was pre-existing. The nature of the
20 data were already collected by the time -- I guess
21 it was Bailey became involved.
22 And in research ethics, there are different
23 criteria that they use for pre-existing databases
24 versus, you know, actively going and recruiting
25 people in order to participate in a study or

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1 whatever.
2 The way that these data came, it was
3 ambiguous. There are, you know, different groups
4 that have different policies and different
5 principles for, you know, under what circumstances
6 should people have undergone how thorough of an
7 informed-consent process.
8 In this particular one, the relevant
9 guidelines would be those of the publisher itself,
10 Springer who publishes the journal that this was
11 printed in.
12 The policy of Springer is that it was up to
13 the discretion of the editor in chief. And the
14 editor in chief which said that, yep, nope, fine
15 with him.
16 However, after the publication of the article,
17 you know, the nature of it and that people didn't
18 like the conclusions that it came to started a --
19 what I can only call a campaign to have it declared
20 unethical, because they don't think that the
21 editor's discretion was what they wanted it to be.
22 So, again, that became, you know, whatever
23 pressures. And then it goes, you know, behind
24 closed doors, and I don't know what's going on.
25 And then the publisher ultimately decided to --

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1 that the paper should be officially retracted. But
2 there were never any allegations, and there were
3 never any conclusions that the content or the
4 conclusions themselves were in error.
5 So whether that should be -- so does that
6 count or does that not count? It's hard for me to
7 come to any conclusion that people are going to
8 accept or reject the contents of that paper
9 according to whether they accept or reject its
10 implications. The content of the paper, however,
11 has not been in question.
12 Q But just as a factual matter, in this paragraph one
13 of the papers was corrected and one was retracted?
14 A I don't think -- such a characterization, again,
15 just kind of insinuates a situation that is the
16 opposite of the truth.
17 The correction -- again, in general publishing
18 a correction is the formal name of a post-
19 publication change. It is -- you know, but in the
20 context where people are, you know, liking or
21 disliking a finding, the word correction is getting
22 used to imply that one of the conclusions was wrong
23 or something in it was incorrect, which is not the
24 case.
25 The content that was changed to Littman was

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1 adding detail. None of the conclusions changed, no
2 errors in it were found. It's the decision was,
3 well, add the necessary detail in order to
4 demonstrate that nothing was skipped because this
5 particular audience isn't going to take anything
6 for granted.
7 So she added the detail, but the nature of
8 editorial publishing is that such changes are
9 called correction. So, again, to just take that
10 sentence out is to -- is easily mistaken as an
11 assertion that something was incorrect.
12 Same with the Diaz paper. To call it a
13 retraction without the, you know, details of what
14 led to the retraction is to insinuate or to kind
15 of, you know, leave a reader or listener the
16 impression that there was something wrong, that
17 there was an error in the conclusions of the paper,
18 and so its conclusions ought not to be given any
19 weight.
20 That's not the case. The conclusions were
21 never in question, and nobody's changed any of the
22 conclusion -- nobody's asked for any changes to the
23 conclusions or demonstrated that there was an
24 error.
25 People have been -- there were people who were

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1 upset and protesting about -- well, again, their
2 motivations are, you know, pretty -- are relatively
3 clear, but the content -- the rule that was being
4 contested was the method and amount of disclosure,
5 you know, of the people who participated in the
6 study. But there was never any question in the
7 accuracy of the study itself.
8 Q Is your view that it was only retracted because of
9 external pressures?
10 MR. RAMER: Objection to the form.
11 A I haven't seen any evidence, and I haven't -- I
12 don't think I've heard any accusations otherwise.
13 Q So you think that the journal just retracted it
14 because of external pressures, not concerns about
15 the informed consent as --
16 A The journal didn't retract it. The publisher did.
17 Q Excuse me, the publisher retracted it out of
18 concerns about a lack of informed consent, that was
19 not a true reason?
20 MR. RAMER: Objection to the form.
21 A I don't think the situation breaks down quite that
22 way. And it's essentially what the publisher
23 themselves said. They indicated that they were
24 receiving those kinds of communications. There
25 was -- I'd have to go back and read the original

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1 letter they sent. The policy that they have, you
2 know, it was entirely explicit that it was left up
3 to editor's discretion. So essentially they as
4 publisher overturned the editor's use of that
5 discretion.
6 Again, I don't think any of that is ambiguous.
7 And I'm not aware of anyone anywhere in that
8 pipeline -- at least the parts, you know, to which
9 I'm privy, I've not seen any communications or
10 evidence or discussion otherwise.
11 Q Going to page 62 -- uh-oh, what have I done? So
12 beginning on page 62 of your declaration, you
13 distinguish between suicide and suicidality; is
14 that right?
15 A Yeah, again, I hesitate to say that, you know, I
16 distinguish. I'm just, you know, orienting people
17 to the proper uses of the vocabulary. So people
18 who are, you know, not psychologists, you know,
19 reading this don't accidentally mistake one to mean
20 the other, which, again, especially in this context
21 very many groups are actively doing.
22 Q So, I mean, in essence you note that they're
23 distinct clinical phenomena; is that right?
24 A I know that these are distinct phenomena, yes.
25 Q You note, sorry. I know that you know that. You

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1 note?
2 A Oh, I note that, yes.
3 Q I don't actually know, so --
4 A And perfectly legitimately, the public doesn't.
5 That's not their job. You know, this isn't the
6 kind of stuff that people discuss. And that's what
7 leads so many people to misunderstand the content
8 of these studies, especially when things are being
9 lifted out of context.
10 So in order to understand the context of these
11 studies, you know, I have to start out with, as I
12 say I do, here are the definitions. Here's how I'm
13 going to use them. If you read these other, here's
14 how they use them. Which one we use, I don't care,
15 but as long as we're all using the same one, we can
16 have a productive conversation.
17 Q And so, understanding they're distinct clinical
18 phenomena, you would agree that both should be
19 clinically addressed?
20 MR. RAMER: Objection.
21 A Oh, yes, absolutely.
22 Q And that reducing suicide and reducing suicidality
23 are both positive outcomes?
24 A Yes, absolutely. The difficulty that society comes
25 to is that it is exactly because it is part of

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1 these being such different phenomena that the way
2 to deal with them effectively is very different.
3 So --
4 Q Understood.
5 A -- not merely a matter of -- you know, using
6 suicide when we mean suicidality, that's not
7 merely, you know, exaggerating. It's failing to
8 help get the right kind of help to the right group
9 of people. And so, you're disadvantaging them
10 both. And everybody's harmed or failed to be
11 helped.
12 Q In paragraph 142, and this is on page 63, you
13 write, "Social media voices today loudly advocate
14 'hormones-on-demand' while issuing hyperbolic
15 warnings that teens will commit suicide unless this
16 is not granted."
17 Did I read that correctly?
18 A Yes, that's the content of my sentence.
19 Q What are hormones-on-demand?
20 A With minimal assessment consideration of
21 alternatives, it's removing whatever safeguard one
22 can find an excuse to remove.
23 This is another one of the differences that
24 have changed over time, which is relatively
25 apparent to those of us who have been in this field

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1 for long periods of time and have watched the
2 removal of safeguards as opposed to people who have
3 recently come into the field and are only aware of
4 the current status and don't realize that this is a
5 change.
6 So people are often referring to, you know,
7 history's long-standing criteria. No, the current
8 criteria are not long-standing at all. These are
9 brand-new and untested.
10 The subset of studies which suggest success
11 use the relatively high standards that used to be
12 in place at that time. Today people have removed
13 the real-life testing requiring months, years in
14 some cases, of psychotherapy and expect still to
15 get the same results.
16 Q There's no citation on this sentence about
17 hormones-on-demand; right?
18 A Correct. And that's also why I put it in quotes.
19 I'm using it as a general description to capture
20 the basic idea of what's going on.
21 Q So that's not based on any specific practice?
22 MR. RAMER: Objection to the form.
23 A No, that's not true either. It's the -- you know,
24 the term itself is, you know, my own expression in
25 order to describe the situation. But the situation

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1 that I'm describing is, you know, quite concretely
2 real.
3 As I say, it's the -- I'm referring very
4 specifically to the removal of the safeguards that
5 were in place when the available data were first
6 gathered. And the reason why, that just because
7 we're -- that after removing those safeguards and
8 after removing the assessment procedures and so on,
9 that expecting different -- expecting the same
10 result after changing the -- after removing those
11 safeguards is what makes the current situation an
12 experiment, you know, without the knowledge of the
13 experimentees.
14 And I use the word hormones-on-demand to refer
15 to situations where -- and to clinicians who
16 believe that asking for hormones or medicalized
17 transition services is sufficient, and from that
18 point forward, the clinician's predominant duty,
19 now with only very rare exceptions, to find ways to
20 provide them. Rather than to accept it as one of
21 the possibilities, let's try the less potentially
22 risky ones first.
23 Q And what -- who are the social media voices?
24 A Oh, again, the ones whom I happen to run into
25 regularly. There's certainly no shortage of them,

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1 only because his name is forefront of my mind for
2 the moment, would be, for example, Jack Turban.
3 Q So you would consider Jack Turban to be a social
4 media voice?
5 A Yes, I think it would be fair to describe him that
6 way. I don't want to be unfair to him either. I
7 wouldn't say he's limited to being a social media
8 voice.
9 Q So you mean clinicians on social media?
10 A I would include clinicians on social media.
11 Q And you think that non-clinicians on social media
12 are relevant to your assessment of current clinical
13 practice?
14 MR. RAMER: Objection to the form.
15 A No, I wouldn't say that either. How I use that
16 phrase, and how I would still use that phrase,
17 really, is that that is the medium through which
18 one would run into, you know, such voices. I mean,
19 if one is looking to find, you know, how these
20 ideas are getting communicated, they're largely
21 getting communicated through social media.
22 It is hard to avoid the observation that it
23 was the onset of social media that changed, you
24 know, the public perception and treatment,
25 including professional treatment, of gender

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1 dysphoria is one of very many, very profound
2 changes that all started with identical timelines.
3 Among them is this sudden and exquisitely rapid,
4 literally exponential increase in rates of mostly
5 adolescents, mostly biological female reporting
6 gender dysphoria.
7 It's unfortunate, it is not helping that
8 generation at all. Gender dysphoria -- or that
9 enormous exponential increase in gender dysphoria
10 is only one of several dysphorias, all of which
11 have exponentially been increasing since the onset
12 of social media.
13 Q What are the other dysphorias?
14 A The other major ones are reports of depressions,
15 anxieties and, again, suicidality.
16 Q On page 91, paragraph 204 -- Joel never should have
17 given me control of this.
18 A Would it be inappropriate for me to say, oh, this
19 sounds like a significant other kind of a comment?
20 Q Okay. 204. Here, Doctor, you are talking about
21 sterilization without proven fertility preservation
22 options. You write, "Clinical guidelines for the
23 medical transition of gender among children include
24 the need to caution and counsel patients and
25 parents about what are euphemistically called

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1 'options for fertility preservation.'" And then
2 you cite the Endocrine Society Guidelines.
3 Is that -- did I read that correctly?
4 A That's that one sentence, yes.
5 Q Shouldn't clinicians counsel patients about options
6 for fertility preservation?
7 MR. RAMER: Objection to the form.
8 A Again, that's why I'm pointing it or was trying to
9 emphasize that what I'm pointing out is that
10 they're doing that euphemistically, where the term
11 they're using is sterilization, which is
12 essentially guaranteed for somebody who goes from
13 puberty -- or halted puberty with puberty blockers
14 to cross-sex hormones.
15 The very phrase "fertility preservation" works
16 under the assumption that you were fertile in the
17 first place. And the sequence of blocking puberty
18 and taking prepubertal gonads and putting them on
19 cross-sex hormones is the prevention of
20 ever-developing fertility. It's not preservation.
21 That's an adopting of the term -- adoption of
22 a term if, for example, a man with testicular
23 cancer is going to undergo chemotherapy, which,
24 again, would, you know, interfere with, if not
25 outright destroy, his ability to produce viable

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1 sperm. That would be a person who is fertile, and
2 we are trying to maintain, we're trying to preserve
3 his fertility. To say that --
4 Q So I understand that. This is a reference to the
5 clinical guidelines for medical transition
6 generally.
7 So taking aside puberty blockers, there are
8 fertility preservation options for persons who
9 undergo hormone therapy, are there not?
10 MR. RAMER: Objection to the form.
11 A Again, that to me is why I referred to this as
12 you've -- as a euphemism. There exists a range of
13 interventions and a range of their harms.
14 To pick the mildest phrase which describes the
15 mildest harm, and then generalize that to apply to
16 the entire range where the controversy is at the
17 other extreme where there is again sterilizing
18 these children, you know, we end up with a
19 situation where the terminology is being used in
20 accordance with the person's political or other
21 views rather than my automatic preference as a
22 scientist make the word -- make the phrase precise
23 and accurate.
24 And fertility preservation is amongst the
25 terms that is, again, being a euphemism and not

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1 accurately describing the risks and potential harms
2 in a way that would allow for a legitimate and
3 meaningful calculation of the risk-to-benefit
4 ratio.
5 Q But you don't think that counseling a patient that
6 there are no options for fertility preservation in
7 some instances, and then counseling a different
8 patient that there are some options for fertility
9 preservation in other instances is an appropriate
10 way to describe a range of medical intervention?
11 MR. RAMER: Objection to the form.
12 A I haven't seen a document that does that. I don't
13 believe the Henbury policy did that. It consisted
14 only of the use of the mildest terms.
15 I also think it's an error to use, again, an
16 all-encompassing term like patient. We are talking
17 a prepubescent child and having an adult
18 conversation about whether they want to have
19 children. That conversation is not comparable in
20 any meaningful way to a 30-year-old adult male,
21 with in this example testicular cancer, who is able
22 to come to an adult brain decision over children,
23 not children, the potential for his own future
24 fertility.
25 Asking a prepubescent that is using a global

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1 all-encompassing term like patient is another
2 example of obscuring the most, you know, severe and
3 dramatic of these situations using exactly the same
4 term that we should use, you know, in describing
5 the most mild of the range of issues and the
6 risk-to-benefit ratio.
7 Q In that paragraph you write, "The decision to
8 undergo medicalized transition also represents the
9 decision never to have biological children of one's
10 own."
11 Do you think that might be the most extreme
12 interpretation of a range of potential outcomes?
13 MR. RAMER: Objection to the form.
14 A Oh, again, the same. When somebody is giving one
15 extreme, I'm pointing that out to -- you know, I'm
16 red flagging it by pointing out the missing part of
17 the extreme, which requires me to name the missing
18 part of the extreme. The whole point is that this
19 is a wide range.
20 Q But someone who, say, undergoes a double mastectomy
21 can still have biological children of one's own?
22 MR. RAMER: Objection to form.
23 A The situation, at least in theory, can exist. But
24 there are no reliable numbers, I think either in
25 the U.S. or Europe, about the proportions and

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1 overlap of, in your example biological women,
2 undergoing mastectomy versus cross-sex hormones
3 versus puberty suppression.
4 Of course, you know, sterility and decisions
5 about the sterility being made by a prepubescent
6 brain comes from people who are on puberty blockers
7 pretty much as puberty starts and then going on to
8 cross-sex hormones.
9 Q So you're describing a subset of the people who
10 undergo medicalized transition in this sentence?
11 MR. RAMER: Objection to the form.
12 A Hang on, I was still stuck on the prior part.
13 Again, the sterility is for people who are on
14 puberty blockers followed by cross-sex hormones.
15 A biological female put on puberty blockers
16 and then put on cross-sex hormones doesn't develop
17 the breasts for which a double mastectomy would be
18 required in the first place.
19 Q So, I'm sorry, your phrase undergoing a medicalized
20 transition only refers to people who go from
21 puberty blockers to gender-affirming hormones?
22 MR. RAMER: Objection to the form.
23 A I didn't mean my sentence to be a complete review
24 of, you know, several different potential
25 combinations of the several different variables.

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1 Again, my purpose was to demonstrate that it
2 is inappropriate to the point of misleading for a
3 professional medical society of all groups to use
4 only the mildest and most euphemistic of language
5 ignoring -- again, in a document meant for
6 physicians, not meant for the patients themselves,
7 describing, you know, only the most optimistic
8 balance of risk-to-benefit ratio as opposed to
9 recognizing the full range of varying situations.
10 And, again, in the case specifically of the
11 Endocrine Society statement, in complete absence of
12 the consideration -- I shouldn't say complete
13 absence, but at the same time as failing to
14 integrate the large number of complete unknowns and
15 still unexplored alternatives before we get to the
16 most dramatic of the options.
17 Q I'm just trying to understand this sentence that
18 you wrote --
19 A I'm sorry.
20 Q -- which is, "The decision to undergo medicalized
21 transition also represents the decision never to
22 have biological children of one's own."
23 In that sentence, medicalized transition only
24 refers to patients who go from puberty blockers to
25 hormone therapy; is that right?

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1 MR. RAMER: Objection to form.
2 A No, my one sentence cannot be considered on its own
3 without the other sentences that I purposefully put
4 it together with.
5 Q So you're not willing to say -- you're not willing
6 to accept that someone who only undergoes a
7 mastectomy, for example, could still have
8 biological children of their own?
9 MR. RAMER: Objection to the form.
10 A In its context, my sentence doesn't contest that.
11 I'm filling in the missing pieces. So the one
12 sentence taking out just, you know, ends up leaving
13 different pieces missing. It takes the whole set
14 of them where I'm pointing out, you know, the
15 pieces of the puzzle are missing. So I'm alerting
16 the reader to the missing pieces.
17 Well, it's true that I am not alerting people
18 to the not missing pieces. I only need to alert
19 people to the missing pieces.
20 So the one sentence on its own is what, in my
21 view, is one of the missing pieces. There's no
22 purpose to that sentence to point out the pieces
23 that were already there to begin with.
24 Q Do you think that testosterone impairs fertility
25 for every natal female who takes it?

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1 A For everyone? No. The most -- the powerful
2 effect, the essentially sterilizing issue happens
3 with the combination -- that happens from the
4 combination essentially applying cross-sex hormones
5 to gonads that still have prepubertal cells.
6 Q Got it.
7 A So the automatic sterilization goes from the --
8 goes to people who essentially were going from
9 puberty blockers to cross-sex hormones without time
10 in between to develop adult quality viable gonad
11 tissue, that I don't remember if it was in this
12 report, but it was exactly that error for which I
13 was faulting several of the other experts, as they
14 report, you know, some of the relatively mild side
15 effects of one or the relatively mild side effects
16 of the other where the actual danger is in the
17 combination, and nobody mentions the combination.
18 Q Understood. Earlier you were talking about
19 prepubertal children making these decisions about
20 fertility, but in the United States it's their
21 parents consenting to treatment; right?
22 MR. RAMER: Objection to form.
23 A I don't think -- that doesn't really describe the
24 full sentence. It's not like the parents are
25 deciding -- the parents aren't talking with each

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1 other should we have grandchildren. The parents
2 are trying to figure out, you know, what would
3 help, you know, increase the mood or discomfort of
4 the profound unhappiness of their child.
5 And so, from their point of view, they're
6 doing their best to do what they think their kid
7 wants or what they imagine their kid would want or
8 will have wanted when the kid is later an adult and
9 looking back on the whole thing.
10 So the parents generally are trying to guess
11 what the kid would want is -- what the kids would
12 want. It's also, I think, unfair to describe the
13 parents' decision-making process as consent as if
14 it's a cognitive process, when the consent is in
15 the legal meaning they are providing on paper what
16 we deem to be consent. But it's a misleading use
17 of the term to equate legal consent with making the
18 kid's decision for the kid, when the basis of what
19 the parent's legal decision is going to be is their
20 best guess for what they think the kid would want
21 if the kid were an adult, which the kid isn't.
22 Q And that's the nature of pediatric medicine as a
23 general matter?
24 MR. RAMER: Objection to form.
25 A This isn't like pediatric medicine as a general

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1 matter. That's the whole problem. In pediatric
2 medicine in general, we have objective evidence of
3 an objective process for which we can give -- I'm
4 making this part up -- a blood test to verify that
5 the kid has -- you know, to use a usual example,
6 whatever intersex condition.
7 This is exactly the opposite condition. We
8 have zero objective evidence, only subjective
9 self-report from a prepubescent kid which conflicts
10 entirely with all of the available objective
11 evidence. That is entirely unlike the rest of the
12 pediatric medicine -- or that is entirely unlike,
13 if I can talk in italics, the process of general
14 pediatric medicine.
15 Q On page 109 --
16 A I'm there. Speak of the devil.
17 Q Okay. So this is in paragraph 259. You write of
18 Dr. Turban, "Dr. Turban's employment as director of
19 a gender program in child and adolescent psychiatry
20 represents a significant conflict of interest: The
21 income he derives from his medical treatment of
22 these children would be directly affected by the
23 outcome of this case."
24 Did I read that correctly?
25 A Those are the sentence -- that's the sentence I

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1 wrote, yes.
2 Q And Dr. Turban is a psychiatrist; correct?
3 A Yes, so far as I know.
4 Q And he is employed in a child and adolescent
5 psychiatry program?
6 A Yes. Is it up to a year yet? Recently, but, yes.
7 Q But you maintain that his income is derived from
8 endocrine treatments?
9 A Did I say endocrine?
10 Q You said his medical treatment. I don't know what
11 you're referring to there.
12 A I meant it relatively broadly. It's -- again, I
13 don't know details about how the specific hospital
14 works. But the usual procedure, and I don't recall
15 him ever pointing out an exception, is to engage in
16 these procedures as a multidisciplinary team.
17 As a psychiatrist, he would ultimately be
18 responsible for the mental health assessment or
19 lack of mental health assessments used in deciding
20 who would go on to endocrinological treatments.
21 And the endocrinologist would be responsible then
22 for ensuring the physical ability of the child to
23 respond to the medications as desired, but not the
24 decision whether to.
25 Q Do you think that everyone who works in a

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1 multidisciplinary gender clinic has a conflict of
2 interest in these cases?
3 MR. RAMER: Objection to the form.
4 A I don't see any way around the idea that when the
5 legality of providing a service is in question that
6 there is a conflict of interest for the people
7 providing that service.
8 Q Well, Dr. Turban doesn't provide any of the
9 services directly that are the subject of the
10 Indiana law; right?
11 MR. RAMER: Objection to the form.
12 A I don't know what director would -- I don't know
13 what you mean by direct. If one is in charge of --
14 I don't mean to equate the situations, but if one
15 is the manager of a McDonald's, just because you're
16 not serving the hamburgers doesn't mean that you
17 are not affected if they shut down the whole
18 restaurant.
19 Q So if they ban puberty blockers and hormones and
20 surgery, it's your view that not only are the
21 endocrinologists and the surgeons conflicted --
22 possessing a conflict of interest, but the
23 psychiatrists are as well?
24 MR. RAMER: Objection to the form.
25 A Yes, everybody involved in the provision of the

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1 service. And if the -- to the extent that the
2 provision of the service is multidisciplinary, and
3 he is the doctor -- he is the director directing
4 the entire process, he is ultimately responsible
5 for it.
6 And it would be that entire -- it would be the
7 entire service he is directing that would be
8 switching to the other use of the term directly
9 influenced by regulations and findings that limit
10 or ban or restrict the provision of that very
11 service.
12 Q So is it just the directors of the program or every
13 physician who works at a gender program?
14 MR. RAMER: Objection to the form.
15 A I don't think I necessarily need to allow for the
16 possibility that there could be an exceptional
17 situation that doesn't immediately come to mind,
18 but to -- it's I can't think of a situation in
19 which one can be a specialist in providing a
20 specialized service that -- for which one would not
21 be in a conflict of interest if that service is
22 prevented.
23 The only exceptions, and I'm not even sure
24 they count as exceptions, depending on -- again, in
25 different hospitals in the U.S. is the

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1 international outlier in this again, there can be,
2 or I can imagine there existing a situation in
3 which, for example, a nurse is simply assigned a
4 department. And if one department is restructured
5 or canceled, then he, she, or they are reassigned
6 to another clinic so that it's, you know,
7 relatively invisible to them, I can imagine the
8 possibility for certain circumstances like that.
9 I cannot imagine such a situation from the
10 person -- from a person legitimately holding the
11 title director.
12 Q Do you believe that the physicians who treat
13 patients at gender clinics would not have jobs if
14 puberty blockers and gender-affirming hormones were
15 banned?
16 A I would be surprised certainly if they became
17 unemployed. But, again -- but they would be, you
18 know, in any meaningful way highly impacted.
19 Q They couldn't practice other aspects of their
20 specialties?
21 MR. RAMER: Objection to the form.
22 A They would be forced to. As I say, they would be
23 impacted, but I would be surprised if they ended up
24 unemployed.
25 Q So their income wouldn't necessarily be impacted?

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1 MR. RAMER: Objection to the form.
2 A I don't think that fairly describes the situation.
3 It's -- I don't think that fairly describes the
4 situation, no.
5 Having one's means of income being required,
6 you know, against one's will to have to change what
7 one does for a living in order to maintain one's
8 income represents a significant conflict of
9 interest.
10 Q So based on that, are the only legitimate experts
11 those who do not treat adolescents with gender
12 dysphoria?
13 A That's --
14 MR. RAMER: Objection to form.
15 A That's a different question. And as I enumerated
16 within my report, it is a standard procedure in
17 producing a systematic review in order to get
18 people who do not have a direct interest in the
19 outcome of it.
20 And that's exactly how Vivienne Cass in the UK
21 was chosen. And that's how all of the other groups
22 in all of the other countries were selected. To
23 pick an odd example, if one wanted to know if
24 reading fortune tea leaves were scientifically
25 valid, you could not do it by asking only the

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1 fortune tea leaf readers.
2 One needs to be able to -- in order to be
3 without a conflict of interest, one needs to be one
4 step further away than receiving income from the
5 provision of the service in question.
6 Q So you believe Dr. Turban is biased because you
7 think his compensation is tied to a certain
8 clinical outcome?
9 MR. RAMER: Objection to the form.
10 A I don't think I said biased. I'm, you know,
11 acknowledging he's in a conflict of interest. The
12 nature --
13 Q So you -- okay. Go ahead. Sorry.
14 A The nature of his writings suggest that, you know,
15 he has very, very strong beliefs about the
16 situation. But, again, the term bias is for me to
17 engage in some mind reading that I'd hesitate to.
18 It is perfectly legitimate, and it's a matter of,
19 you know, objective evidence to indicate that this
20 is a legitimate conflict of interest.
21 Bias is more cognitive -- is a more cognitive
22 situation, which is, I think, a legitimate
23 accusation, but I couldn't say that I have an
24 objective means of demonstrating it unlike conflict
25 of interest.

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1 Q So you think that compensation can have an improper
2 influence on a clinician's perspective?
3 MR. RAMER: Objection to the form.
4 A That's not a reference to the proper audience. The
5 people who are in need of protection, and the
6 people who are meant to be protected by
7 conflict-of-interest principles are not the
8 providers of the service, but the recipients of the
9 service.
10 Q What are conflict-of-interest principles?
11 A Oh, I don't mean them -- as I said, I mean them
12 generically. If I were going to receive, you know,
13 any medical service, I expect of the institutions,
14 whether it's government or medical boards depending
15 on one's jurisdiction, that if I'm going to be
16 receiving what I expect to be evidence-based
17 medicine, I expect that evidence to be evaluated by
18 people other than the person actually providing me
19 the service.
20 If I knew that the only person reviewing my
21 provider was my provider, I would be in a very
22 different situation of confidence in making my own
23 healthcare decisions than if a person at arm's
24 length were in charge of reviewing the procedures
25 my provider provides.

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1 Q Do you think being paid by an advocacy organization
2 might have an improper influence on a clinician's
3 opinion?
4 MR. RAMER: Objection to the form.
5 A I can imagine situations where it would, and I can
6 imagine situations where it wouldn't. So I
7 wouldn't automatically -- it would be a legitimate
8 conclusion, but it doesn't have the automatic
9 people provided -- the quality of service provision
10 or the -- tenability's not the word. The safety
11 and effectiveness of providing a service has to be
12 conducted by people at arm's length from it.
13 If one is at a -- is in a position where one
14 is advocating a particular view, then it's
15 completely transparent that one is, you know, of
16 that view or advocating for whatever that situation
17 is.
18 That's entirely unlike healthcare where one is
19 expected to be -- expected and depended upon to be
20 entirely objective, but it's not -- the
21 expectations and the people who were meant to be
22 protected by it are of a different kind.
23 Q Were you aware that Indiana's expert, Daniel Weiss,
24 testified before multiple state legislatures in
25 favor of laws like SEA 480?

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1 MR. RAMER: Objection to the form.
2 A I'm not even sure who that is.
3 Q And that he was compensated by Do No Harm for that
4 testimony?
5 MR. RAMER: Objection to the form.
6 A Same, I don't think I know who that is.
7 Q Is that a conflict of interest to testify before a
8 state legislature regarding a law and be
9 compensated by an advocacy organization?
10 MR. RAMER: Objection to the form.
11 A I'm still missing a piece. I don't know who or
12 what it is that we're talking about.
13 Q Well, I don't think you even have to know who he
14 is. He's one of Indiana's experts in this case, an
15 endocrinologist. But he testified regarding a law
16 like SEA 480, and for that testimony was
17 compensated by Do No Harm, an advocacy
18 organization.
19 I'm just trying to understand under your
20 framework for conflict of interest, would that be
21 one?
22 MR. RAMER: Objection to the form.
23 A No, I don't think so. Acting in a political
24 capacity advocating for a political view doesn't
25 have the same expectations of neutrality as would a

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1 physician -- as a patient coming to a physician
2 expecting to receive objective feedback and advice
3 from the physician.
4 In a governmental situation, there will --
5 there would generally be people advocating on one
6 side, people advocating on the other side. And the
7 influence of whatever money for whatever decision
8 it is, is almost, I don't know how cynical -- one
9 could be -- it would be perfectly fair to be
10 cynical. But that is not the same decision-making
11 process or position of vulnerability that a patient
12 has in expecting the advice they get from their own
13 doctors to be.
14 Q So is the conflict of interest you describe with
15 respect to Dr. Turban about a conflict of interest
16 with his patients, not as an expert in this case?
17 MR. RAMER: Objection to the form.
18 A The conflict I'm referring to is the combination of
19 them.
20 Q Page 124 --
21 MR. RAMER: Hey, Chase, we've been going
22 for --
23 MR. STRANGIO: So the question I have is, I'm
24 close to the end. Do you want to sort of go 20
25 more and try to wrap it up, or do you want to take

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1 a break and then finish? We can take a break, I
2 can check in with my side, and then we'll just
3 finish up after the break?
4 MR. RAMER: I'd appreciate the break.
5 MR. STRANGIO: Yeah, yeah, yeah, let's do it.
6 Let's do it. I was trying to get us done, but
7 understood.
8 MR. RAMER: No, I appreciate that, too.
9 MR. STRANGIO: Yeah, it's fine. It's fine.
10 Five minutes?
11 MR. RAMER: Works for me.
12 Doctor?
13 THE WITNESS: Okay. See you in five.
14 (A recess was taken.)
15 BY MR. STRANGIO:
16 Q Okay. I'm on page 124, paragraph 299 regarding
17 Dr. Shumer, you write, "Despite his use of dramatic
18 terms, Dr. Shumer is not a mental health expert
19 qualified to assess mental health outcomes, and he
20 cites no evidence to justify any predictions of
21 suicidality or other predictions of outcomes."
22 Did I read that correctly?
23 A Yes.
24 Q Do medical doctors not typically assess their
25 patient's mental health?

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1 A Not in the manner -- not in that manner, no.
2 Again, not -- they're generally, unless they have
3 specific training, again, specifically for
4 assessment of such mental health concerns, it tends
5 to be limited to what a brief screening and
6 standardized questions of, in general, things to be
7 on the lookout for. But that's not the context or
8 situation that he's describing or -- that he's
9 describing period -- semicolon. Nor is it the
10 basis for predicting what future situations that do
11 not currently exist will bring, you know, on the
12 basis of no evidence whatsoever.
13 Q And in the previous paragraph you write,
14 "Dr. Shumer's report provides a highly misleading
15 discussion of the risks of GnRH agonists and
16 cross-sex hormones."
17 Did I read that correctly?
18 A Yes.
19 Q And are you an endocrinologist qualified to make
20 assessments of the risks of GnRH agonists and
21 cross-sex hormones?
22 MR. RAMER: Objection to the form.
23 A That statement doesn't require an endocrinological
24 background.
25 Q Do you use social media?

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1 A A little bit.
2 Q Twitter as we've been discussing?
3 A Yeah, I try to keep it to roughly, you know, a
4 tweet or two a day. Usually I'm working on
5 something else and it occurs to me, oh, people
6 would be interested to hear that and I'll post it,
7 or there's a precious pithy thing that, ooh, that
8 kind of crystallizes it, so I'll release that.
9 Q And is your handle @JamesCantorPhD?
10 A Yes, that's correct.
11 MR. STRANGIO: Can we pull up what's marked as
12 Exhibit 11.
13 BY MR. STRANGIO:
14 Q On February 23 of this year, do you recall
15 tweeting, "The only ones who crave affirmation more
16 than trans teens are their doctors"?
17 A I recall that tweet, yes.
18 Q What did you mean by that?
19 A The interactions that I've had with them, with the
20 ones who in turn discuss or refuse to discuss the
21 relevant issues on social media are unlike the
22 healthcare providers I interact with in any other
23 aspect of human sexuality and unlike the scientists
24 I interact with on any other issue. There's much,
25 much less discussion of the content and much, much

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1 more discussion of how it's going to look.
2 Q And when you're talking about the interactions,
3 you're talking about interactions on social media?
4 A Not just. Of course, you know, it is exactly
5 because the bar for entry into social media is so
6 low that, you know, the proportion of the publicly
7 available statements, it takes up so much more than
8 it. But, no, it's not limited to social media.
9 Q Do you think that doctors who treat transgender
10 adolescents are doing so for reasons other than
11 concern for their patients?
12 MR. RAMER: Objection to the form.
13 A As happy as I am to call out what I think is an
14 unhealthy influence of one's personal
15 characteristics in one's professional practice, I
16 wouldn't dichotomize it either.
17 I would not say as a general rule that -- I do
18 believe, or I have every reason to believe, that
19 they genuinely believe that they are helping, but
20 the set of cases, situations, willingness to take
21 on risks, willingness to disagree with a popular
22 idea in the face of evidence suggests that there
23 is, as I say, an unhealthy or disproportionate
24 balance of the several inputs and motivations to
25 behavior.

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1 And, again, I don't mean to isolate people
2 involved with this issue versus rest of world so
3 much as I've been involved with very many, you
4 know, controversial issues. That's not only the
5 nature of sex research, but it's the nature above
6 all the other branches, even of sex research, it's
7 much more a part of the study and of atypical
8 sexualities.
9 So relative to other care providers and other
10 scientists involved with providing professional
11 care to people with other atypical sexualities, the
12 cluster of personalities, the type of conversations
13 that are had and not had, the unwillingness to
14 respond to the most legitimate, even published
15 criticisms, this group of people are unlike those
16 working in any other area of atypical sexuality.
17 Q And what is -- who is this group of people?
18 MR. RAMER: Objection to the form.
19 A People publicly advocating. I really want to say
20 extremists, I think I want -- I have a hard time
21 finding a different word than extremists, but
22 people with an un -- with a disproportionate
23 conviction of what they're doing is correct without
24 having balanced it against the enormous number of
25 unknown potential alternatives -- or potential

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1 alternatives.
2 Q And is that description one that you would apply to
3 all doctors that treat trans teens?
4 MR. RAMER: Objection to the form.
5 A No, I would automatically hesitate to -- I would
6 automatically -- I would reflexively refuse to --
7 Q What about would you apply that description to most
8 doctors that treat trans teens?
9 MR. RAMER: Objection to the form.
10 A I don't think there's a meaningful way -- no, I
11 would have to couch it more than that. Again, I'm
12 speaking, you know, on social media referring to
13 the other people involved in the discussion on
14 social media. And today, more than ever, the
15 number of people that -- I think I was making this
16 point earlier, that people with relatively moderate
17 or relatively balanced or nuanced perspectives are
18 silencing themselves for fear of being attacked by
19 either extremists on one side or extremists on the
20 other side for not being far enough to that given
21 extreme.
22 So it's because they've self-silenced. Again,
23 outside of the people who were speaking publicly,
24 and I mean to be speaking of the people who are
25 speaking publicly, I would not reflexively

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1 generalize that to people who are keeping quiet --
2 publicly quiet.
3 Q Including those people who are keeping quiet
4 publicly and continuing to treat adolescents with
5 gender dysphoria with medical interventions?
6 MR. RAMER: Objection to the form.
7 A Well, again, the continuing to treat is to assume
8 that there was a baseline against which to compare
9 them that doesn't exist. This really wasn't
10 getting done in the way and by the numbers of
11 people and without the supervision or tracking or
12 external review that --
13 Q I wasn't referring to the temporal in the way
14 you're responding. I just meant someone who's
15 currently prescribing, let's say, gender-affirming
16 hormone therapy to adolescents but isn't speaking
17 publicly on the matter.
18 Would this tweet apply to them?
19 MR. RAMER: Objection to the form.
20 A No. Again, I pretty much mean it to be people who
21 were speaking -- other people who were
22 participating in the same forum.
23 Q And so, when you refer to extremists, are
24 extremists those who support the provision of
25 hormone therapy to adolescents with gender

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1 dysphoria?
2 MR. RAMER: Objection to the form.
3 A Not necessarily. There are -- what's missing are
4 the people who merely support. There are very --
5 there are few speakers who merely support.
6 The people I would call extremists would be
7 those for whom there exists no alternative. There
8 is that -- the person asked for it has sufficient
9 basis to do everything you can to make sure that
10 they get it. Rather than cover bases, let's try
11 other things first. Let's not start with the most
12 dramatic of alternatives. Let's skip all of the
13 many unknowns and we're not so sures and use it as
14 a method of first resort. And any resistance is
15 immediately dismissed as politically anathema
16 rather than we're not so sure, let's be more
17 careful until we can be more sure.
18 Q Is the Endocrine Society Clinical Practice
19 Guideline on treatment of gender dysphoria with
20 respect to adolescents an extremist's position?
21 MR. RAMER: Objection to the form.
22 A I don't have an objective way to differentiate
23 extremists from going farther than it should
24 relative to the quality of evidence available.
25 Q Have you treated any of the individual plaintiffs

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1 in this case?
2 A No, I have not.
3 Q Have you ever practiced as a clinical psychologist
4 in Indiana?
5 A No, I have not.
6 Q And do you have any personal knowledge of how
7 treatment for gender dysphoria is provided to
8 adolescents in Indiana?
9 A Not in any direct way. Again, the nature of my
10 expertise is not the specifics of the policy or the
11 patients involved, but on the science according to
12 which the legal system and legislatures are
13 attempting to establish policy.
14 MR. STRANGIO: Just one sec. I'm going to --I
15 don't have anything else on my end.
16 THE WITNESS: That was a fast 20 minutes.
17 MR. STRANGIO: So I'll pass -- it was slightly
18 less. I'll pass the witness.
19 MR. RAMER: And I have no questions for the
20 witness. And we'd just like to review and sign.
21 AND FURTHER THE DEPONENT SAITH NOT.
22

23 JAMES M. CANTOR, PH.D.
24
25

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1 STATE OF INDIANA)
) SS:
2 COUNTY OF BOONE)
3 I, Dana S. Miller, RPR, CRR, a Notary Public in
4 and for the County of Boone, State of Indiana at
5 large, do hereby certify that JAMES M.
6 CANTOR, PH.D., the deponent herein, was by me first
7 duly sworn to tell the truth, the whole truth, and
8 nothing but the truth in above-captioned cause.
9 That the foregoing deposition was taken on
10 behalf of the Plaintiffs, appearing remotely from
11 Toronto, Canada, on the 7th day of June, 2023,
12 pursuant to the Applicable Rules.
13 That said deposition was taken down in
14 stenograph notes and afterwards reduced to
15 typewriting under my direction, and that the
16 typewritten transcript is a true record of the
17 testimony given by said deponent; and thereafter
18 presented to said deponent for his/her signature;
19 That the parties were represented by their
20 aforementioned counsel;
21 I do further certify that I am a disinterested
22 person in this cause of action; that I am not a
23 relative or attorney of either party, or otherwise
24 interested in the event of this action, and am not
25 in the employ of the attorneys for either party.

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1 IN WITNESS WHEREOF, I have hereunto set my hand
2 and affixed my notarial seal this _____ day of
3 ________________________, 2023.
4
5 Dana S. Miller
Dana S. Miller
6
7 Commission Number 0675790
8 My Commission Expires:
January 17, 2024
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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1 (Originating Party)
Chase Strangio, Esq.
2 AMERICAN CIVIL LIBERTIES UNION
125 Broad Street
3 19th Floor
New York, NY 10004
4
5 NOTICE OF DEPOSITION FILING
6 UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
7 INDIANAPOLIS DIVISION
CASE NO. 1:23-cv-00595-JPH-KMB
8
K.C., et al.,)
9)
Plaintiffs,)
10)
-vs-)
11)
THE INDIVIDUAL MEMBERS OF THE)
12 MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
13 capacities, et al.,)
)
14 Defendants.)
15
In compliance with the Indiana Rules of
16 Procedure, Federal Rules of Civil Procedure and/or
the Rules of the Industrial Board, you are notified
17 that the signed original deposition of JAMES M.
CANTOR, PH.D., taken on the 7th day of June, 2023,
18 has been sealed and submitted to the originating
party, along with the attached Errata Sheet(s), if
19 applicable.
20
21
____
22 (Date received by Circle City Reporting)
23 CIRCLE CITY REPORTING
135 North Pennsylvania
24 Suite 1720
Indianapolis, IN 46204
25 (317) 635-7857

$

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28:9

@

@JamesCantorPhD (1)
185:9

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1 MS. EAGAN: No, Your Honor.
2 THE COURT: All right. State's case.
3 MR. DAVIS: Your Honor, the State calls Dr. James
4 Cantor when you are ready.
10:39:28 5 THE COURT: I'm ready.
6 JAMES CANTOR, MD,
7 having been first duly sworn by the courtroom deputy clerk, was
8 examined and testified as follows:
9 DIRECT EXAMINATION
10:39:46 10 BY MR. DAVIS:
11 Q Good morning, Dr. Cantor.
12 A Good morning.
13 Q Would you state your full name?
14 A James Michael Cantor.
10:40:02 15 Q What is your profession, Dr. Cantor?
16 A I am a clinical psychologist and neuroscientist.
17 Q What degrees do you have? Academic degrees.
18 A Bachelor's degree in computer science and mathematics, a
19 master's degree in applied psychology, and a Ph.D in clinical
10:40:17 20 psychology.
21 Q Where do you work?
22 A I am currently in private practice in Toronto, Canada.
23 Q And what is the nature -- are there any particular focuses
24 of the counseling you provide or the research that you have
10:40:32 25 performed?

1 A Human sexuality and atypical sexualities.
2 Q Would that include studies of gender identity?
3 A Yes, it is. Yes, it does.
4 Q Are you knowledgeable about the research surrounding
10:40:47 5 gender dysphoria?
6 A Yes, I am.
7 Q Have you analyzed research concerning the benefits and
8 harms of different ways of treating gender dysphoria?
9 A Yes, I have.
10:40:54 10 Q Do you have skills and expertise assessing the strengths
11 and weaknesses of scientific studies?
12 A Yes, I do.
13 Q And do these skills and expertise include judging what
14 those studies do and do not prove as a matter of science?
10:41:13 15 A Yes.
16 Q Have you treated people who presented with gender
17 dysphoria?
18 A Yes.
19 MR. DAVIS: Your Honor, we proffer Dr. Cantor as an
10:41:25 20 expert on psychology, human sexuality, research methodology,
21 and the state of the research literature on gender dysphoria
22 and its treatment.
23 THE COURT: Any objection?
24 MS. EAGAN: No, Your Honor.
10:41:37 25 THE COURT: All right. He will be accepted for that

1 purpose.
2 BY MR. DAVIS:
3 Q Dr. Cantor, there is a notebook in front of you with a
4 blue cover. Would you please turn to the second tab?
10:41:51 5 A I'm sorry. It just occurs to me I didn't bring my reading
6 glasses. They're in my brief case.
7 MR. DAVIS: Your Honor, can the witness get his
8 glasses?
9 THE COURT: Absolutely.
10:42:43 10 THE WITNESS: Part 2, you said?
11 BY MR. DAVIS:
12 Q Yes. Tab 2, which is Defendants' Exhibit 2.
13 Can you identify that document, Dr. Cantor?
14 A Yes. That is my report, which I submitted for these
10:42:54 15 proceedings.
16 Q Thank you.
17 I think actually, since we just heard Dr. Antommaria, I
18 would like to begin with addressing some things that we heard
19 this morning.
10:43:02 20 Did you have the opportunity hear this morning's testimony
21 by Dr. Antommaria?
22 A Yes, I did.
23 Q Did you understand Dr. Antommaria to testify that randomly
24 controlled studies are not available in this area of medicine?
10:43:16 25 A Yes.

1 Q Did he then say, if you understand -- as you understand,
2 that because the randomly controlled trials are not available,
3 we can rely on observational trials?
4 A That is roughly what I understood him to say, yes.
10:43:33 5 Q Do you have any response to that?
6 A Yes. That's not -- it is true that none of the existing
7 studies are randomized, but it is entirely untrue that we
8 therefore can rely -- can make decisions based on the least
9 reliable kinds of studies.
10:43:48 10 There is a wide, wide range of studies in between, and
11 there's a wide, wide, range of different scientific
12 methodologies that we can employ in order to minimize the laws
13 that we get from completely randomized studies.
14 It's also actually possible if we wanted to conduct such
10:44:09 15 studies such as by allowing people to undergo different parts
16 of a treatment at different times, so we can compare the
17 differences between them when one group has started on that
18 type of treatment and the other hadn't yet.
19 Q Okay. So the randomized trials would be considered like
10:44:29 20 the gold standard, the top-tier level of scientific research?
21 A Randomization is one factor in determining how high
22 quality a study is. It is not a -- it's neither an all or
23 nothing.
24 Q I understand. But did I understand you to say that if you
10:44:47 25 assume that's not available, that's no reason to drop down to

1 the lowest quality of evidence?
2 A That is correct.
3 Q I understood Dr. Antommaria to testify that the level of
4 evidence supporting the WPATH and Endocrine Society guidelines
10:45:05 5 is comparable to the level of evidence supporting other
6 treatments in pediatrics. Can you respond to that?
7 A I am not aware, of course, of all the other treatments in
8 pediatrics. However, there are no studies yielding positive
9 effects of either the Endocrine Society standards or the WPATH
10:45:24 10 standards.
11 The studies which have shown effects have used the Dutch
12 model, which uses a higher set of standards than either the
13 Endocrine Society or the WPATH group.
14 Q Speaking of the Dutch study, I also understood
10:45:42 15 Dr. Antommaria to say there is no high quality evidence
16 supporting the use of psychotherapy alone for gender dysphoria.
17 Do you agree with that?
18 A No, I do not.
19 Q What would you say in response? What's the countervailing
10:45:56 20 evidence?
21 A There exists roughly 15'ish studies following up these
22 kids at all. All of the studies, which without exception that
23 used medical interventions also used psychological --
24 psychotherapy at the same time. So all of the studies which
10:46:17 25 could seem to show a benefit for medical interventions are

1 unable to distinguish that it was the medical intervention
2 causing the benefit, versus the psychotherapy causing the
3 benefit.
4 Of those studies, two were designed in a way that it was
10:46:33 5 possible to peel apart the effects of psychotherapy versus
6 medicine -- the Costa study and the Achille study. The full
7 references are in my report.
8 In the Costa study, there was a -- there were two phases.
9 There was a phase that people went through when they received
10:46:52 10 psychotherapy alone. And then in the subsequent phase, they
11 received both psychotherapy and medical interventions.
12 There were no significant differences between the group.
13 Both groups improved, and there were no significant differences
14 between the group that received psychotherapy alone and the
10:47:08 15 group that received psychotherapy plus medical interventions.
16 The other study, the Achille study, used a statistical
17 method to control for the effects of psychotherapy. That group
18 also improved after medical intervention, but when the effects
19 of psychotherapy were statistically controlled, there was no
10:47:28 20 additional benefit of the medical interventions after that.
21 Q I want to break some of that down. You mentioned studies
22 where all the participants were receiving both psychotherapy
23 and medical-affirming care at the same time, right?
24 A Correct.
10:47:48 25 Q Is that the Dutch -- oh, is the Dutch protocol, the Dutch

1 study an example of such a study?
2 A Both Dutch studies, the 2011 and the 2014, yes.
3 Q If, at the end of that trial, you look and see the people
4 that were receiving both psychotherapy and medical-affirming
10:48:06 5 care at the same time, improved in mental health at the end of
6 the trial, can you as a scientist tell whether the improvement
7 is the result of the pharmaceuticals or the psychotherapy?
8 A Not in the design of those studies, no. That's what in
9 science is called a confound.
10:48:27 10 Q Confound?
11 A Correct.
12 Q What does that mean, confound?
13 A It describes exactly that situation. When two things are
14 done at once, when you see the result, you can't peel apart
10:48:37 15 which -- which of those two interventions was responsible or
16 the interaction between those two interventions was
17 responsible.
18 Q Okay. But the Costa and Achille study, on the other hand,
19 they do provide scientific evidence that psychotherapy alone is
10:48:53 20 helpful, did --
21 A That's correct.
22 Q Okay.
23 A That psychotherapy is helpful and not the medical
24 interventions.
10:49:01 25 Q I also understood Dr. Antommaria to say that he had not

1 read studies about detransitioning. But if it ever became
2 relevant, he would make an effort to review such studies.
3 You are familiar with the body of the literature
4 concerning gender dysphoria, correct?
10:49:21 5 A Yes.
6 Q In your opinion, are the studies of detransitioning
7 relevant to someone trying to assess the benefits and harms of
8 these treatments?
9 A Yes, of course. It's very difficult -- detransition would
10:49:35 10 be the situation that one is trying to avoid. The best way to
11 avoid a situation is to understand that situation.
12 Q Dr. Antommaria said that there are prospective
13 observational trials that demonstrate the efficacy of puberty
14 blockers in gender-affirming care, and then later said the
10:49:59 15 trials he is referring to were primarily the Dutch group
16 studies.
17 Are those the studies you just mentioned, the 2011, 2014
18 studies?
19 A Those are the Dutch studies that usually we use. I can't
10:50:12 20 know if he is referring to some other study that I didn't make
21 a specific reference to.
22 Q That's fair.
23 In this area of medicine, when someone's talking about the
24 Dutch studies, the Dutch group studies, is it your
10:50:25 25 understanding they're generally referring to these 2011 and

1 2014 studies from the Dutch project?
2 A Almost always, yes.
3 Q Okay. And those are the studies you just mentioned that
4 have the confound problem, right?
10:50:36 5 A Correct.
6 Q You can't unpack whether it's the psychotherapy or -- not
7 from that study, you can't unpack whether it is the
8 psychotherapy or the pharmaceuticals that are making the
9 difference?
10:50:47 10 A That's correct.
11 Q Okay. More generally, I'd like to read for you a
12 statement from the plaintiffs' brief in support of their
13 preliminary injunction motion.
14 For the record, it's Doc 8 at page 18.
10:51:07 15 Dr. Cantor, the plaintiffs wrote in that brief, For more
16 than four decades, medical organizations have studied and
17 created an evidence-based standard for the medical treatment of
18 transgender patients. This standard confirms that transition,
19 including puberty blockers and hormone therapy where
10:51:26 20 appropriate, is the only safe and effective treatment for
21 gender dysphoria?
22 Dr. Cantor, does the research literature support that
23 statement?
24 A No, it does not.
10:51:37 25 Q Do you understand the plaintiffs primarily to be pointing

1 to the guidelines of medical organizations such at WPATH and
2 the Endocrine Society and the American Academy of Pediatrics to
3 support their positions that wish to continue giving these
4 treatments to children?
10:51:52 5 A Yes. They cited those repeatedly.
6 Q Okay. What observations have you had about the WPATH
7 guidelines and whether they have support in evidence?
8 A The WPATH guidelines and the Endocrine Society guidelines
9 have been tested among the set of -- as I say, roughly 15
10:52:13 10 outcome studies, some of them have used the WPATH guidelines or
11 Endocrine Society guidelines instead of the Dutch protocol.
12 And those studies demonstrated that there was no improvement at
13 all.
14 I shouldn't say none at all. One of them used several
10:52:36 15 kinds of measures of improvement, and I think it was all but
16 one demonstrated no differences at all. And one small one gave
17 an indication that suggested the possibility.
18 Q Have these organizations acknowledged anything about
19 desistance rates -- these organizations, I'm referring
10:52:57 20 specifically to WPATH and the Endocrine Society?
21 A I can't say that they've never addressed it, but to the
22 extent if it was ever addressed, they are grossly, grossly
23 minimized.
24 Q Can I refer you to paragraph 12 of your report on page 4?
10:53:33 25 A I got it.

1 Q You say in that paragraph that the plaintiffs'
2 documentation -- and I assume by documentation, you mean
3 their -- the pleadings in this case and the briefs that you had
4 seen?
10:53:50 5 A That's correct.
6 Q You said the plaintiffs' documentation misrepresents the
7 contents of the associations' policies themselves.
8 Which associations were you speaking of there?
9 A They mentioned several other societies which made short
10:54:04 10 statements in general support of sexual diversity, but without
11 actually issuing specific standards about how to treat people
12 in that community with what or at what ages.
13 Q And what inconsistencies did you see between what those
14 organizations have said and the arguments you saw in
10:54:23 15 plaintiffs' briefing?
16 A The plaintiffs referred to the societies as if they were
17 providing very specific support for very specific policies
18 rather than general recommendations to provide, for example,
19 respect and values for diversity, but no specific guidelines.
10:54:48 20 Q Okay. Well, looking at paragraph 12, is one of your
21 points here looking at the bullet points that even WPATH and
22 Endocrine Society acknowledge as you write, that desistance of
23 gender dysphoria occurs in the majority of prepubescent
24 children?
10:55:04 25 A That is correct.

1 Q And then turning the page, were there other issues you saw
2 that the statements -- that these organizations believed and
3 plaintiffs' briefing was inconsistent with what the
4 organizations had stated?
10:55:16 5 A That the issue of mental health and that mental illnesses
6 and similar concerns need to be resolved before considering
7 transition rather than depending on transition to be the
8 resolution of, for example, depression and anxiety.
9 Q And have any of these organizations acknowledged that
10:55:42 10 puberty-blocking medication is an experimental not a routine
11 treatment?
12 A Yes, they have used that phrase.
13 Q Which organization?
14 A Again, I would have to look up to see exactly who used
10:55:52 15 which word. I believe it was WPATH, but I again have to go
16 back and check to make sure that it was they.
17 Q And let's turn to the American Academy of Pediatrics. And
18 I will refer you to your appendix.
19 And, Dr. Cantor, if you look at the top of the page, you
10:56:12 20 will see a line of blue figures. And it's page X out of 106.
21 The appendix I am referring to is page 100 out of 106.
22 A Got it.
23 Q What does the American Academy of Pediatrics or AAP, what
24 do they recommend in this area of care?
10:56:42 25 A They recommend what I can best describe as affirmation on

1 demand.
2 Q Okay. Did you review their recommendation when it came
3 out?
4 A Specifically I reviewed the sources on which they based
10:56:58 5 their recommendations.
6 Q Okay. Did you write about that?
7 A Yes, I did.
8 Q And does that appear as an appendix to your report
9 beginning at page 100 of that pdf?
10:57:09 10 A That is correct. I summarized all of my comments. I
11 submitted them to a journal where they underwent peer review.
12 And it's an official published peer-reviewed paper.
13 Q This is not a letter to the editor?
14 A That is correct. This is part of a scientific -- now part
10:57:22 15 of the scientific literature.
16 Q What did you comment upon?
17 A I really just checked what the authors of the AAP policy,
18 Dr. Rafferty, what their claims were, what they said was in
19 their references versus what was actually in their references.
10:57:43 20 And not only did their sources not contain what they were
21 alleged to have obtained, they often contained the very
22 opposite of what the AAP policy said they contained.
23 Q Did you have an agenda to disprove -- to prove or disprove
24 anybody when you undertook that review of the evidence?
10:58:01 25 A I wouldn't say an agenda other than to set the record --

1 pardon the pun -- straight.
2 This was a situation where these sources I had known for
3 many years. I had read them when they had first came out.
4 And when AAP came out with its policy, I was stunned by
10:58:21 5 its content. And as I read what they were basing it on, my
6 recollection was immediately this is not what those sources
7 said.
8 So immediately I just started double checking myself. Did
9 I misread something? Am I misremembering something?
10:58:36 10 And as I just checked in my own files with copies of these
11 papers -- most of these papers already in it, my memory was
12 correct. They said as -- the kinds of things I recalled them
13 to be saying.
14 Because we were now talking a major medical association
10:58:51 15 rather than an individual other scientist. This was different
16 from just one scientist like me disagreeing with another
17 scientist. This was now -- now had the potential to cause a
18 great deal of damage to a great number of people.
19 So because I had the ability to do it, I simply summarized
10:59:11 20 the contents of the original paper and contrasted point by
21 point the claims being made by AAP and simply quoting verbatim
22 what was in the original studies.
23 That entire thing was published, and the AAP has never
24 responded. They were approached by the media, and they just
10:59:33 25 would refuse to talk even to the media. They have yet to have

1 any response.
2 Q So to date, the AAP has not responded to the criticisms
3 that you raised?
4 A That is correct.
10:59:42 5 Q I will refer you now to page 6 of your report. Going by
6 the numbers at the bottom of the pages.
7 A Yep.
8 Q As you noted in your review of the plaintiffs' expert
9 report -- well, first off, did you review the expert reports
11:00:08 10 submitted by the plaintiffs by Dr. Hawkins and Dr. Ladinsky?
11 A Yes, I did.
12 Q And did you note that they studied a 2016 Olsen study
13 claiming that it proves that transition reduces the risk of
14 mental illness? That that was their claim?
11:00:23 15 A Correct.
16 Q Does the Olsen study show that?
17 A Just referring to my own report. Ultimately, no, it did
18 not. There was several statistical errors in the Olsen study.
19 The data were obtained then by the -- they -- upon request, and
11:00:45 20 Olsen provided their data to another author who reanalyzed -- I
21 should say, correctly analyzed the Olsen data, who demonstrated
22 that Olsen's data did not contain evidence of improvement. In
23 fact, it contained evidence of deterioration.
24 Q So in your opinion, does the 2016 Olsen study support
11:01:04 25 plaintiffs' position that children need these affirming --

1 these medicalized affirming treatments in order to improve
2 their mental health?
3 A No, it does not. Making such a claim is a half truth. It
4 would ignore the subsequent entries in the scientific
11:01:20 5 literature.
6 Q And what about the de Vries study that plaintiffs cited in
7 which you address on page 9 of your report? And does it show
8 that medical transition of minors improves mental health?
9 A No. It contains part of the confound. The de Vries study
11:01:43 10 as part of a Dutch group also included psychotherapy during
11 transition. So it is not possible to differentiate which type
12 of therapy, medical or psychotherapy, is responsible for the
13 benefits reported in that study.
14 Q I see. So participants in that study did have improved
11:02:00 15 mental health, correct?
16 A Yes.
17 Q But it's just not possible scientifically to tell what
18 caused the improvement?
19 A Correct.
11:02:06 20 Q And what about the Greene and Turbin studies plaintiffs'
21 experts cited which you discuss in paragraph 24 of your report?
22 A Yep.
23 Q Do those studies show that medical transition improves
24 mental health?
11:02:25 25 A No, they do not. These are retrospective correlational

1 studies. They are not able of describing any causal effect
2 coming to any causal conclusion.
3 Q Okay. Now, you mentioned there that -- you say this very
4 pattern is what one would predict from clinical gatekeeping.
11:02:43 5 What do you mean by clinical gatekeeping?
6 A One of -- across the various clinical standards are to
7 prevent somebody with mental illness from undergoing
8 transition. So such people are being held back. They're being
9 filtered out of groups who do undergo transition.
11:03:03 10 So when a clinic then compares the people who underwent
11 transition to the people in their files who did not undergo
12 transition, they are necessarily comparing a group of people
13 from whom the mental illness was removed and comparing them to
14 a group of people from whom the mental illnesses were not
11:03:22 15 removed.
16 So when you see better mental health amongst the people
17 who had transitioned, the improvement is not because of the
18 transition, the improvement is because you have removed the
19 people with the worst mental health from the group in the first
11:03:40 20 place.
21 Q Okay. So is it correct, then, that one thing you might
22 see in these studies is by picking out the people with the best
23 mental health, and giving them the treatment, then comparing
24 them to the people with lower mental health, then, of course,
11:03:57 25 the people who went through the study would do better?

1 A That is correct.
2 Q Did you review any of the other studies that plaintiffs
3 have submitted into evidence such as the Allen study, the
4 Turban articles, the Biggs (phonetic) study, the Lopez de Lara
11:04:24 5 study, Tordoff?
6 A Yes, I have.
7 Q Do you have any comments on those studies and whether they
8 support plaintiffs' position?
9 A They suffered from the same methodological problems as the
11:04:35 10 other studies.
11 Q Did any of those studies support the position that medical
12 transition improves mental health?
13 A No, they did not.
14 Q In minors with gender dysphoria?
11:04:47 15 A Correct. No, they do not.
16 Q Oh. What has been called the Yale study by Brouware,
17 B-R-O-U-W-A-R-E, was the first named author. Did you review
18 that one?
19 A Yes, I did, but it wasn't a study.
11:05:07 20 Q What was --
21 A Apparently, that was a report submitted by those authors
22 for another -- or for a combined set of court cases.
23 Q Okay. But you would not refer to that document as a
24 scientific study?
11:05:21 25 A From the Yale group with -- again, the name I don't -- I

1 hesitate to try to pronounce, but, no, it was not a study at
2 all. It was those authors' report reviewing the literature and
3 providing their opinions.
4 Q Okay. As a matter of fact, Dr. Ladinsky was asked about
11:05:39 5 that study yesterday. And for the record, that testimony
6 appears on page 116 of the rough transcript.
7 The question was: In this document, do the authors also
8 cite a number of peer-reviewed studies that contradict some of
9 the supports or the principles that the State articulated as
11:06:00 10 the reasons for SB 184? And Dr. Ladinsky responded, They do, a
11 considerable compendium of them.
12 Is she right? Did those authors show that there are
13 studies that contradict the State's position in this case?
14 A There was such a statement. There was no meaningful way
11:06:21 15 to try to put together what claim went together with what
16 source. Rather than -- what's done more typically either in
17 science or in pause, best as I understand, is here the claim
18 and here is the source justifying it. Here is next claim, here
19 the source justifying it.
11:06:38 20 Instead, that document made a long series of unsourced
21 claims and then provided a long series -- a series of very
22 large footnotes with 20 and 30 references. And there was just
23 no way to see what fact was alleged to have come from what
24 source.
11:06:56 25 Q So we've talked about whether the literature the

1 plaintiffs' -- the studies that plaintiffs cite to support
2 their position. Let's talk about whether the literature
3 supports the State's position. But a little background first.
4 Could you describe from your review of the literature just
11:07:17 5 what's the difference between adult onset gender dysphoria,
6 child onset, and adolescent onset? And I know this is a broad
7 question, but I just mean like age groups.
8 A Usually we would be referring to these as a prepubescent
9 onset. Then the literature is very, very long, but reported on
11:07:37 10 adult onset. And by adult, on average, these were people in
11 their 20s and in their 30s and 40s. It was very, very
12 distinct. It was not, you know, a bell-shaped curve with some
13 midpoint around 18 or 19 years old.
14 It's only within the past --
11:08:02 15 THE COURT: Hold on one second.
16 Go ahead. Sorry.
17 THE WITNESS: It's only within the past ten years or
18 so that a different profile has begun to emerge and was noticed
19 by clinicians. And that now is being called either adolescent
11:08:20 20 onset or rapid onset.
21 Now, all three of these groups have in common that they're
22 complaining about the same thing. Doc, I feel like I am in the
23 wrong body. Doc, I am the brain of one, but in the body of the
24 other.
11:08:34 25 So the way that they describe it is similar. But every

1 objective way we have of measuring these people shows that
2 these are independent phenomena. They are not related except
3 in the way that people describe the situation, describe what
4 they're experiencing.
11:08:50 5 The best analogy I have would be if somebody came to a
6 doctor saying I have a headache. Okay. I got it. Got that's
7 a symptom. I have some more questions. But we cannot from
8 that say that a migraine headache is the same thing as a
9 tension headache is the same thing as having just suffered a
11:09:08 10 head injury.
11 The causes are different. How we respond to them is
12 different. And the other characteristics about each of these
13 are different. They only resemble each other in the most
14 superficial ways.
11:09:19 15 Childhood onset or prepubescent onset gender dysphoria
16 appears to be entirely unrelated to adult onset gender
17 dysphoria. And the two of those appear to be entirely
18 unrelated to the rapid onset or adolescent onset gender
19 dysphoria.
11:09:40 20 BY MR. DAVIS:
21 Q Well, let's break that down. Adult onset, typically
22 people who present with what you're referring to adult onset
23 gender dysphoria, what age are they when they come into the
24 doctors' office and say, something's wrong?
11:09:50 25 A On average, in their 30s and 40s.

1 Q Okay. Has there been research considering whether
2 those -- that universe, the adult onset universe does well
3 after transitioning?
4 A Those who are mentally healthy by and large do, do well
11:10:08 5 after transition.
6 Q Can you apply those studies to consider whether someone
7 with child onset gender dysphoria is going to do well after
8 transitioning?
9 A No. Because these are independent phenomena. The
11:10:23 10 information from one does not -- from one group does not
11 generalize to the other.
12 Q Comparing the adult and the child onset, what is the
13 difference that makes the studies of one, you know, it's not
14 apples to apples?
11:10:35 15 A Correct.
16 Q Okay. What is the difference between those patients?
17 A The -- they -- as I say, differed in just about every
18 objective measure we've been able to apply to them.
19 There are, of course, the ages themselves. Something --
11:10:53 20 the sex ratios in them are different. The adults are almost
21 100 percent biological male. There's more of a mix amongst the
22 childhood onset.
23 The adults are almost always attracted to females. That
24 is to say, relative to being biological male, they are almost
11:11:13 25 always heterosexual.

1 The childhood onset almost always are attracted to the
2 same biological sex. They are almost always homosexual.
3 Q Talking about the child onset, is that a new phenomenon,
4 child onset gender dysphoria?
11:11:31 5 A I wouldn't say new. It's been systematically studied for
6 20 to 30 years'ish.
7 Q From the literature that you reviewed, do most of these
8 kids, if not socially transitioned and given hormones, will
9 they want to transition after reaching puberty?
11:11:52 10 A Generally not.
11 Q And page 36 -- excuse me -- paragraph 36 of your report,
12 Dr. Cantor, what statistics do you provide about the rates of
13 desistance among those presenting with childhood onset gender
14 dysphoria?
11:12:15 15 A The exact numbers are between 61 to 88 percent of them
16 desist. In the appendix in my report, I list all of the
17 studies that have ever been conducted with that group, all the
18 outcome studies that have been conducted with that group.
19 Q We probably both need to slow down just a little bit
11:12:37 20 for...
21 A I'm from New York. It just happens.
22 Q We'll do our best.
23 Dr. Hawkins was asked about your paragraph 36 yesterday.
24 And I will represent that on page 30 of the rough transcript,
11:12:54 25 she said that when the study such as the ones you're citing

1 offers this elevated rate of desisters, quote, what we tend to
2 find is that the initial cohort that was given the diagnosis of
3 gender dysphoria is actually false.
4 My question, Dr. Cantor, is: Does the research literature
11:13:15 5 support Dr. Hawkins's statement?
6 A No. As I say, I listed every single such study.
7 Q Do we have any tools today that reliably tell us which
8 kids will desist and which kids will persist?
9 A No, we do not. There have been some attempts to develop
11:13:34 10 such a test, but they have never been able to find a good
11 characteristic, a feature, a pattern, a test result in which
12 the majority continued to want to persist.
13 The best that they have ever been able to do was find a
14 tool which distinguished unlikely to want to persist versus
11:13:54 15 even less likely to want to persist.
16 Q There's been testimony about something called the DSM-5.
17 Do you know what that is?
18 A Yes, I do.
19 Q What is it?
11:14:04 20 A The full name is the Diagnostic and Statistical Manual of
21 Mental Illnesses, published by the American Psychiatric
22 Association.
23 Q If someone were to claim that now that we have the DSM-5
24 we may be able to do a lot better with identifying who's the
11:14:24 25 desister and who is the persister, is there any research on

1 that?
2 A No. Nobody's ever tried to differentiating any of the
3 DSMs from DSM-I through its various versions to the current
4 one.
11:14:38 5 Q So there have been at least five?
6 A There was a I, a II, a III, III-R, IV, IV then had a text
7 revision. They switched some of the commentary around the
8 diagnoses, but they didn't change any of the diagnostic
9 criteria themselves. There was then the 5. And there is as of
11:15:01 10 last month a 5 again with a text revision, but no changes to
11 any of the actual diagnostic criteria.
12 THE COURT: Mr. Davis, how much longer do you think we
13 will be?
14 MR. DAVIS: Your Honor, direct will take us up to
11:15:14 15 about noon, I would predict. There's just a lot to cover with
16 Dr. Cantor.
17 THE COURT: I am not rushing you. I am just trying to
18 get a road map of that.
19 So how long do we think cross might be?
11:15:25 20 MS. EAGAN: It's difficult to predict because I am not
21 sure what else he may say, but maybe an hour, hour or less, I
22 would think.
23 THE COURT: All right. I am leaning toward an earlier
24 lunch than we did yesterday. So maybe -- if it's okay with
11:15:45 25 you, let's just go ahead and find a stopping point at your

1 leisure, and we will just pick back up after lunch.
2 MR. DAVIS: Thank you, Your Honor. This is as good as
3 any.
4 THE COURT: Is it?
11:16:00 5 MR. DAVIS: Yes. We have just talked about DSM-5.
6 Going to watchful waiting next. This is as good a place as
7 any.
8 THE COURT: Okay. Good. Good. With that said, then
9 are we still on target with your last witness?
11:16:17 10 MR. DAVIS: Yes, Your Honor. Ms. Wright is here. I
11 don't know if she is in the courtroom yet or not, but she is in
12 Montgomery, and she will be ready to go when we finish with
13 Dr. Cantor.
14 THE COURT: We think the length of that witness would
11:16:30 15 be what?
16 MR. DAVIS: Oh, I would say direct would be well under
17 30 minutes, but I don't know about cross.
18 THE COURT: Okay. All right. Okay. Well, I think
19 we're on target.
11:16:38 20 Let's take a good long lunch today. Let's see here.
21 Let's come back at 12:45.
22 MR. DAVIS: Thank you, Judge.
23 THE COURT: Thank you.
24 MR. DOSS: Judge?
11:16:54 25 THE COURT: Yes?

1 MR. DOSS: Closing, how long would you like?
2 THE COURT: You know, I mean, this is important. I'm
3 not going to, you know, jack everybody up on this, but to the
4 extent you can hold it to around 25, I think would probably be
11:17:07 5 a good thing.
6 And in your openings, I think you really road mapped it
7 very well, both sides did.
8 So, you know, again, I know the arguments. I'm really
9 interested in, you know, some analysis with case law. And I am
11:17:22 10 going to be directly asking about a few cases. I'm very
11 interested to know parallels between the Arkansas decision and
12 that law. And then I may give you some hypotheticals that you
13 won't like.
14 See you after lunch.
11:17:40 15 (Recess.)
16 THE COURT: All yours, Mr. Davis.
17 MR. DAVIS: Thank you, Judge.
18 BY MR. DAVIS:
19 Q Welcome back, Dr. Cantor.
12:51:00 20 We spoke earlier about the Dutch protocol. Did the
21 participants in those Dutch studies have psychotherapy before
22 beginning treatment? Before that study?
23 A They were receiving treatment as part of their
24 participation in the study. I don't think they reported
12:51:21 25 whether anybody happened to have attempted psychotherapy before

1 approaching the clinic at all.
2 Q Okay. Forgive me if I'm mistaking which study is which.
3 I was reading about a study that described the psychotherapy
4 that was available to the participants as extensive. And that
12:51:40 5 that extensive psychotherapy was at least two years. Which
6 study am I thinking of?
7 A That wouldn't have been a particular study so much as what
8 they use in their process in general.
9 And then the Dutch group was reporting the results, you
12:51:56 10 know, of -- periodically over the course of the study.
11 Q I see.
12 A But by the time the first set of results, their earlier
13 study, the 2011 study, the participants in it will have already
14 been through a substantial amount of therapy.
12:52:13 15 Q Okay.
16 A They also emphasize that in assessing the children that
17 it's a very extensive assessment, and the assessment itself was
18 also ongoing over the course of the study.
19 So even before deciding who might be eligible for
12:52:30 20 hormones, they have now many, many months to years' experience
21 with the particular case even with a particular child even
22 before making a decision. That's very, very different from
23 just having an appointment, taking a test, and then having a
24 diagnostic decision an hour later.
12:52:46 25 Q That is exactly what I was meaning to ask you about. I

1 was using sloppy language.

2 So this extensive assessment that happened before some of

3 these children began treatments, they were assessed, you said,

4 over a course of a couple of years?

12:52:59 5 A Correct.

6 Q Okay. So does literature support having such an extensive

7 assessment period before subjecting someone to these

8 treatments?

9 A I don't know if I would say support it, but all of the

12:53:16 10 conclusions that come from the literature depend on it.

11 Q Thank you.

12 Is there a way of treating gender dysphoria that some

13 practitioners refer to as a watchful waiting approach?

14 A Yes. Watchful waiting usually refers specifically to

12:53:40 15 withholding any decision about medical interventions until they

16 have a better idea or feel more confident for a particular case

17 about whether that kid is going to be a persister or desister.

18 It is given the knowledge that that's available that the

19 majority of these kids do desist. Nobody wants to make a

12:54:00 20 decision upon first appointment.

21 And so -- so they tend to provide psychotherapy, whatever

22 kind of care, whatever is appropriate to the individual kid

23 until enough time has gone by to give -- to suggest is this a

24 kid whose feelings like they're feelings are slowing down and

12:54:19 25 they just need more time, are they building up, or are they

1 staying steady?
2 So the watchful waiting period would be postponing any
3 decision about medical interventions until the clinicians had
4 some confidence.
12:54:31 5 Q While you are watching and while you are waiting, are you
6 just leaving him alone, or her?
7 A No. That would be the time during which one would be
8 supplying a therapy for whatever else is going on in the kid's
9 life.
12:54:42 10 Q Okay.
11 A Usually they're associated with -- there's a great deal of
12 what we call comorbidity. They're also suffering from other
13 problems at the same time, either depressions, anxieties, early
14 evidence of personality disorders, for example. And it's never
12:55:00 15 clear whether their gender dysphoria is a result of those other
16 psychological problems.
17 So by helping them develop the tools to deal with those
18 other problems, if they remain dysphoric afterwards, we know
19 that the dysphoria wasn't the result of those other problems.
12:55:17 20 So rather than just leaving them alone, they're still receiving
21 support, and the family is still receiving support over that
22 period.
23 Q So I believe you pointed out in your report that clinical
24 guidelines suggest that mental health issues such as the
12:55:33 25 comorbidities you mentioned should be resolved before

1 transition; is that correct?
2 A Yes.
3 Q Okay. Why?
4 A Because it's never clear what's causing what. We cannot
12:55:44 5 from a correlation conclude anything about a causation. It's
6 very possible, and it's been frequently observed that a lot of
7 these kids are using gender issues as an explanation for the
8 unhappiness that they're experiencing elsewhere in their life.
9 So rather than developing the skills to -- for example --
12:56:04 10 better social skills. If a person feels awkward and they're
11 withdrawing from kids their own age, we are not sure if they
12 want to transition because they're blaming gender dysphoria for
13 why they feel unpopular or uncomfortable, and we're not --
14 versus we can't tell if anxiety or depression is a result of
12:56:27 15 how they're being treated by the rest of society.
16 So it's only by helping them deal with and by giving them
17 the skills to overcome those other disorders that we can see if
18 the gender dysphoria itself resolves just as a result of that.
19 Q So if a person is suffering from depression, or is
12:56:48 20 struggling with their own sexual identity, or some type of
21 abuse, or any of these other comorbidities, explain how this
22 psychotherapy process would work, how a psychotherapist such as
23 yourself would try to dig down into the issue and see if that
24 is something that's generating these feelings that are being
12:57:08 25 mistaken as gender dysphoria, or whether the gender dysphoria

1 is its own thing.
2 A Just to be specific, I'm specifically an adult clinical
3 psychologist. I see clients ages 16 and up. So it wouldn't be
4 me personally.
12:57:23 5 What the literature shows about these kids is that they
6 can be very, very diverse. It certainly is feasible that they
7 are experiencing, for example, depression or anxiety as a
8 result of social transphobia, but that doesn't explain the
9 other things that we're observing.
12:57:41 10 For example, a transphobia doesn't cause autism, which is
11 another very, very common disorder in that group. Transphobia
12 wouldn't cause the development of borderline personality
13 disorder, which we're seeing in very, very, large proportions
14 among the teenagers.
12:57:58 15 So although certain symptoms like anxiety and depression
16 can feasibly be the result of social reactions to being trans,
17 but that does not explain the overall phenomenon. What does
18 better explain the overall phenomenon is that there is some
19 thing troubling this kid, and it is resulting in both the
12:58:20 20 psychological symptoms, depression, anxiety in someone, and
21 also producing the gender dysphoria, that discomfort with being
22 their natural sex.
23 Q I would expect this could vary wildly from patient to
24 patient, but if you -- and I recognize and thank you for
12:58:37 25 clarifying that you deal with a more adult-age group.

1 But if you're helping someone, an adolescent, work through
2 some of these issues, how often do you think a psychotherapist
3 would want to see the patient and over what period of time?
4 A It does vary widely. And the kind of disorders that
12:58:57 5 they're reporting do tend to be the kinds that require very
6 long-term interventions.
7 As I say, autism, and related Asperger's syndrome, and
8 also very, very high rates of borderline personality disorders,
9 which, again, is a very, very long-term disorder to help
12:59:14 10 somebody deal with.
11 Q Fair to say this would not be two or three sessions?
12 A Correct. This would be over the course of months or
13 years.
14 Q Does the research literature show that there are risks
12:59:30 15 associated with medical transitioning?
16 A Yes, quite substantial, including both loss of --
17 primarily loss of function, and depending on the person's point
18 of view, whatever the cosmetic effects are.
19 Q What are the risks of the watchful waiting approach in
12:59:48 20 providing psychotherapy in helping the child deal with any
21 underlying emotional issues?
22 A There don't appear to be any, at least any concrete.
23 Q I will refer you to paragraph 68 of your report,
24 Dr. Cantor.
13:00:06 25 Tell me what the advantages there are to a patient, what

1 opportunities it opens up to him or her if any emotional issues
2 are dealt with before the decision to transition.
3 A If a person fails to deal with whatever emotional issues
4 before it transition, and then transitions and discovers that
13:00:30 5 they continue with whatever psychological issues are pervading
6 them, they have gone through the entire transition process
7 entirely unnecessarily. They haven't been helped. They have
8 now lost whatever -- they have now been sterilized, lost
9 whatever sexual -- or other functions, but it hasn't actually
13:00:49 10 resulted in any improvement in their psychological function.
11 If you go the other way around and you help the person
12 deal with psychologically whatever it is that's going on, they
13 still retain the option for transition after that. And it's
14 that situation that the professional societies have
13:01:05 15 repeatedly -- that the standards of care have repeatedly
16 pointed out.
17 Q So watchful waiting approach does not eliminate a person's
18 ability to transition to the opposite sex later in life if they
19 so choose?
13:01:19 20 A Correct.
21 Q Does the research literature show there's any relationship
22 between children who present with gender dysphoria and those
23 who later in life turn out to identify as gay?
24 A Yes. The large majority of the ones who believe that they
13:01:42 25 were born the wrong sex turn out to be gay or lesbian.

1 To a prepubescent child who doesn't yet have a sex drive,
2 they have no way to interpret why they feel different from
3 other boys or other girls their age. It's only with the onset
4 of sex drive that they start -- and start developing crushes
13:01:58 5 and physical attractions that they now have the information
6 they need to realize why they're different. But to an eight
7 year old or to prepubescent children, the only explanation they
8 have for why they're not like other boys or not like other
9 girls is they must be the wrong sex. They're misinterpreting
13:02:18 10 their feelings.
11 THE COURT: Let's take a quick time out.
12 So, you know, I guess I'm wondering how both sides are
13 wanting me to use all this expert testimony. I mean, the
14 Eleventh Circuit has said more than one time that, you know,
13:02:31 15 medical psychiatric professionals are in a far better position
16 to make decisions about medical and psychiatric issues than
17 judges are.
18 So I guess I want to know from each side real quickly, how
19 do y'all envision that I use these experts? I mean, are you
13:02:48 20 asking me to say, well, this guy's science is junk and this
21 guy's science is perfect; or something in between? What am
22 I -- tell me how you envision me using this.
23 MR. LACOUR: May I?
24 THE COURT: Perfect. Absolutely.
13:03:05 25 MR. LACOUR: Your Honor, as we began the opening

1 statements, when there's an area of medical uncertainty, the
2 State has wide discretion to regulate. So if it's not so clear
3 to you as to which side's experts have it right, if you see
4 that uncertainty, then under Supreme Court precedent, the State
13:03:29 5 is allowed to regulate.
6 The State has to think about all 5 million Alabamians. We
7 have to take all that into account when regulating in these
8 areas where it is not certain.
9 The judge has an important but a limited role in our
13:03:45 10 federal system to see whether those judgments the State has
11 reached in those areas of uncertainty somehow conflict with the
12 Constitution.
13 And we submit we have come forward with evidence to at
14 least put into question whether there is this consensus that
13:04:03 15 has been proclaimed by the plaintiffs here.
16 Again, I think the bar on the plaintiffs is quite high, to
17 show an absence of uncertainty, or to show some great
18 certainty.
19 And when you look at the international studies and the
13:04:19 20 literature reviews, when you hear from very qualified experts
21 like Dr. Cantor, who have applied great rigor to these studies
22 that are being relied upon by the plaintiffs, by their experts,
23 by the AAP, for example, then I think that is enough to create
24 that doubt to create that space for uncertainty. And when that
13:04:45 25 is there, the State can step in.

1 So that's how we see it. We don't think that you sit here
2 as an independent medical board to assess whether a particular
3 treatment is going to be the best for any particular
4 individual. The role of the federal courts in our federal
13:05:01 5 system, the laboratories of democracy is to see if we have done
6 something that is somewhat inexplicable.
7 I think there is ample evidence to explain why the State
8 has done what it's done in addition to the lengthy legislative
9 findings in SB 184.
13:05:22 10 We have come forward with multiple experts from fields of
11 endocrinology, psychology, and pediatrics, and have brought
12 forward substantial amount of other peer-reviewed research and
13 literature reviews to show that this very novel area of the
14 law -- keep in mind the UAB clinic didn't open until
13:05:44 15 seven years ago. This is a novel area of medicine, rather --
16 is just, in the State's judgment, too risky. And if that's a
17 reasonable judgment for the State to make, then that's the end
18 of the case.
19 THE COURT: All right. Mr. Doss.
13:06:03 20 MR. DOSS: Your Honor, I'm unaware of a case that
21 establishes that principle that's so long as there's
22 uncertainty and a reasonable judgment, then that alone is
23 sufficient for the State to violate constitutional protections.
24 The standard of review is what I think helps frame some of
13:06:23 25 this testimony. So, for example, if strict scrutiny applies,

1 it is the State's burden to establish a compelling state
2 interest. And that its infringement on the constitutional
3 protection has been narrowly tailored.
4 And I guess to preview Your Honor for closing, that is a
13:06:40 5 key focus that I plan to spend some time with in closing on why
6 this testimony we've heard yesterday and today, number one,
7 does not establish a compelling State interest. But number
8 two, even if you assume that it does establish some interest by
9 the State, the interest that the State has identified and the
13:06:58 10 regulation that it has imposed are mismatched. It's not
11 narrowly tailored for the very reasons offered by the State
12 through its witnesses.
13 And based on the standard of review, it is not a reasoned
14 judgment. That's not the test for when a constitutional
13:07:13 15 violation has occurred. The test is whether there is
16 satisfaction of this demanding standard for the law's
17 viability.
18 And so as I mentioned in opening, I don't think that Your
19 Honor's job for the purpose of this hearing is deciding
13:07:31 20 ultimately maybe even who is right. It's to show that there is
21 scientific -- there are standards of care that exist, there are
22 approved approaches to dealing with these issues. These are
23 real medical diagnoses. These are real medical treatments.
24 And though the State may disagree them, that's not enough
13:07:50 25 to establish the violation of the constitutional rights, Your

1 Honor.

2 THE COURT: And on that note, at least from what I can

3 tell from both sides, State and government, and original

4 plaintiffs, am I correct to say that everybody agrees that

13:08:07 5 these are real diagnoses? Or no?

6 MR. LACOUR: Your Honor, could you --

7 THE COURT: And I am going to say this one more time.

8 I don't need head nods. It is out of hand. This is not

9 entertainment. This is the real world and the law. So we're

13:08:25 10 not in a movie theater. I don't need head nods. I don't need

11 approval or disapproval. If you want to do that, take it

12 outside.

13 Go ahead.

14 MR. LACOUR: Your Honor, I think -- Your Honor, we

13:08:46 15 agree that gender dysphoria is a psychological diagnosis, but

16 as we have shown in both our written evidence and through

17 witness testimony from both defense witnesses and plaintiffs'

18 witnesses, we don't know whose gender dysphoria is likely to

19 persist. And that's very important.

13:09:07 20 Even Dr. Antommaria this morning said that if you -- the

21 level of certainty you have --

22 THE COURT: You are giving me more detail than I want.

23 I just need you to answer my question.

24 MR. LACOUR: Okay. Can I respond to something

13:09:21 25 Mr. Doss said before?

1 THE COURT: Very quickly.
2 MR. LACOUR: He is unaware of the standard. We cited
3 it multiple times in our P.I. response. It's Gonzales vs.
4 Carhart, a 2007 decision from the Supreme Court where the
13:09:32 5 federal government had regulated partial birth abortion. That
6 was an area of medical uncertainty.
7 There were -- I will go back and I will look at the
8 filings in that case, but I would be shocked if the AMA did not
9 chime in, in favor of the plaintiffs who were challenging the
13:09:46 10 ban on partial birth abortion there saying that it was a safe
11 or necessary -- medically necessary treatment for some people.
12 It was enough that Congress found medical uncertainty
13 there. And there were values, as well, in unborn life that
14 Congress was able to promote even though there were medical
13:10:04 15 organizations.
16 I will confirm this before closing, but I am fairly
17 certain there were medical organizations who were not fans of
18 Congress's action there.
19 Even so, and even in an area like abortion where there is
13:10:16 20 more law at least for the last 49 years in that space,
21 addressing some right to abortion, even then, that ban was
22 upheld by the Supreme Court.
23 THE COURT: And I'm sure you can get into that on
24 closing.
13:10:31 25 Let's go back to my original question. Just answer it

1 succinctly for me.
2 MR. LACOUR: And that would be are these real
3 diagnoses?
4 THE COURT: Yes. Just answer my question in two
13:10:41 5 sentences.
6 MR. LACOUR: Gender dysphoria is a diagnosis. I think
7 the debate is how should it be treated. And SB 184 is
8 expressed in Section 6.
9 There's no ban on psychotherapy whatsoever. The ban only
13:10:58 10 applies to these novel risky potentially long-term
11 harm-inducing or causing medications.
12 THE COURT: So no argument from the State on status,
13 diagnosis, any of that? You are only -- your only issue is
14 treatment; is that correct?
13:11:17 15 MR. LACOUR: Correct, Your Honor.
16 THE COURT: Got it. Thank you.
17 Anything else, Mr. Doss? And I will give the government a
18 shot --
19 MR. DOSS: No, Your Honor.
13:11:25 20 THE COURT: -- if they want to be heard.
21 MR. CHEEK: Nothing else to add that hasn't already
22 been said, Your Honor. Thank you.
23 THE COURT: Okay. All right.
24 Mr. Davis, I have gotten right in the middle of your
13:11:34 25 witness again. Sorry. Pick it back up.

1 MR. DAVIS: I certainly understand, Judge.
2 BY MR. DAVIS:
3 Q Okay. Dr. Cantor, we to try to pick up where we were.
4 Let's take two young boys, eight years old, say. So
13:11:52 5 puberty hasn't started yet. They both have gender dysphoria,
6 even though they may not really understand it yet.
7 And I know I'm asking you to assume some things that an
8 outside observer may not be able to confirm just by looking at
9 that child.
13:12:06 10 And let's assume that both those young boys would, if not
11 intervened with transitioning care, would both grow up to
12 identify as gay.
13 So the boy who is left alone to go through natural
14 puberty, what does he come to understand once puberty kicks in?
13:12:24 15 A Once he -- as puberty kicks in, of course, sex drive comes
16 in as a part of that, and he starts experiencing sexual
17 attractions and sexual arousal.
18 That, then, because he is experiencing it towards other
19 men, teachers, peers, whoever it is, he can now -- he now has
13:12:41 20 the opportunity to understand the nature of his experiences and
21 why he doesn't feel quite like other boys, why he doesn't feel
22 as masculine, and why he doesn't feel as masculine.
23 Now, in otherwise healthy circumstances, he will grow up
24 to be a healthy gay man.
13:12:57 25 Q Now, the other boy is given puberty blockers. What

1 happens in his case?
2 A Such a person who does not develop sexual -- the capacity
3 for sexual arousal and sexual attractions because the very
4 biological features which produce that have been held from him,
13:13:14 5 he never experiences an orgasm. He never experiences sexual
6 arousal, and doesn't have the opportunity to understand the
7 other potential explanations for why he feels the way he does,
8 and go from a child's understanding of why he doesn't feel like
9 other boys, to an adult's understanding of why he doesn't feel
13:13:36 10 like other boys.
11 By blocking puberty, you are blocking the very information
12 that he needs to understand his own situation.
13 Q And you are not claiming to describe every person who is
14 experiencing gender dysphoria, I take it?
13:13:49 15 A Correct.
16 Q Does the evidence show that sexual orientation changes
17 after a person identifies as gay or lesbian?
18 A No. There is no evidence to suggest that sexual
19 orientation is unstable or changes.
13:14:05 20 Q What does the evidence show about whether a person's
21 gender identity can change?
22 A That shows the very opposite. Among the children, it
23 changes in the majority of them.
24 They're even people who identify and describe themselves,
13:14:19 25 for example, as being fluid, the very definition of which is

1 that their gender identity changes on a constant basis.
2 Q Are you familiar with the argument that if we do not allow
3 minors to transition medically, the result will be increased
4 suicides within these group of young people?
13:14:38 5 A I've heard that said, yes.
6 Q Does the research literature support the argument that
7 denying these treatments will lead to an increase in
8 suicidality?
9 A No, it does not.
13:14:50 10 Q Are you familiar with what other countries are doing, with
11 respect to treatment of gender dysphoria?
12 A Yes, I am.
13 Q Are there any changes going on in recent years?
14 A Very much. In fact, things -- it's almost as if the
13:15:10 15 pendulum has reached its far point, and it's now coming back to
16 a much more moderate evidence-based tone.
17 There was really -- sparking off of the social media age
18 more than anything else, we're able to identify a greatly,
19 greatly accelerated, great and greatly expanded number and type
13:15:31 20 of person who was potentially going to go through transition
21 entirely, unlike the groups which we had previously studied.
22 Several countries, especially in Europe, permitted them
23 with lower and lower standards. And then once the reports
24 started coming out that that was failing greatly, they're now
13:15:53 25 restricting very, very quickly and very, very greatly.

1 The two most substantial bans have been in Sweden and in
2 Finland. And there are also now very, very strong statements
3 urging the medical field to pull things back in the UK and in
4 France.
13:16:08 5 Q Dr. Ladinsky testified yesterday that -- I don't have her
6 exact words in front of me -- but she said that what's going on
7 in the UK and Sweden and Finland isn't as relevant here because
8 those countries have a centralized health-care system, whereas
9 we have a less centralized health-care system, and all these
13:16:35 10 experts unrelated can see the same child.
11 That's a poor paraphrase. The record will speak for
12 itself. But assume she made that type of testimony. Would you
13 agree with her?
14 A No. I can't see the logic of it. It's certainly
13:16:53 15 feasible, in fact, more than likely that decisions are made
16 differently when there are centralized boards and a centralized
17 authority charged specifically with reviewing the evidence that
18 will be the basis of the medical procedures of that country,
19 and the U.S. lacks that.
13:17:11 20 But there's no reason to think that that situation would
21 change the actual outcomes of the actual children getting the
22 actual interventions.
23 Q So is it possible, then, that a more centralized
24 health-care system may provide the ability -- an even greater
13:17:24 25 ability to study and evaluate the risks and benefits of

1 gender-affirming care?
2 A That's demonstrably true. That is exactly the process
3 they have gone through. They have published the results of
4 exactly their reviews, and that is how their health-care
13:17:40 5 systems -- that is what their health-care systems are
6 responding to.
7 The American professional associations have not gone
8 through such a comprehensive process. They're merely coming up
9 with policies and citing only individual pieces of studies that
13:17:54 10 appear to support it, rather than a comprehensive review.
11 Q I want to close a loop on adolescent onset gender
12 dysphoria. We talked about ways different groups are
13 different.
14 What's unique about this group of adolescent onset, or you
13:18:11 15 referred to it also as rapid onset gender dysphoria?
16 A Yeah. It's been called both.
17 Where both the childhood onset and the adult onset are
18 primarily male, the adolescent -- the adult onset and childhood
19 onset are primarily male. The adolescent onset is primarily is
13:18:28 20 female. They present with a different set -- it's a different
21 epidemiological set of characteristics, and the evidence that
22 we have about both adults and children don't seem to apply to
23 that middle group.
24 Q Does this group of people presenting with gender dysphoria
13:18:45 25 in their adolescence -- you said primarily female?

1 A Yes.
2 Q Do they tend to have any issues or comorbidities in common
3 with each other?
4 A The most common one of those would be borderline
13:18:57 5 personality disorders and other difficulties with integrating
6 socially into their environments. As I say, such as autism and
7 Asperger's syndrome.
8 Q You are not saying that's true for everyone presenting
9 with gender dysphoria for the first time in their adolescence?
13:19:13 10 A Correct.
11 Q But many?
12 A Correct.
13 Q What does the research literature show about the
14 desistance or detransition rates of people who transition after
13:19:25 15 first presenting with gender dysphoria in their adolescence?
16 A There has never been any such study.
17 Q Did you review the plaintiffs' reply brief, Dr. Cantor?
18 A Yes, I did.
19 Q Did you see any response to your report in plaintiffs'
13:19:41 20 reply?
21 A Not a single comment. My name was never mentioned. None
22 of the studies that I cited were referred to. None of the
23 arguments were addressed. I don't believe I was quoted
24 anywhere in it, unlike the other experts.
13:19:56 25 Q I did note a line that the plaintiffs criticized the

1 defendants' experts in general for relying on older studies.
2 A Yes. I saw that claim. I was a bit confused by it.
3 In my report, I provided a comprehensive list of every
4 single study. There were 11 in total. So the old studies were
13:20:18 5 listed, the new studies were listed. It was comprehensive.
6 It was also a tangential argument. As I said, the 11
7 studies which have been conducted were unanimous in their
8 findings. They all found the same thing. The majority
9 desists.
13:20:33 10 So it doesn't matter even if one did rely only on the
11 older studies, the newer studies showed exactly the same thing
12 as the older studies.
13 Q We spoke a little bit about some of the things we heard
14 from Dr. Antommaria this morning. I want to turn to some of
13:20:55 15 the things in his report.
16 You reviewed his written expert report, did you not?
17 A Yes, I did.
18 Q He -- Dr. Antommaria wrote on -- in paragraph 17 of his
19 report -- and I will find a copy if you need it, but this is
13:21:07 20 one sentence.
21 Quote, gender-affirming medical care is supported by
22 clinical studies. Is he right?
23 A That's true for adults, but that's not true for the other
24 groups.
13:21:21 25 Q And Dr. Antommaria spoke about how if a drug is FDA

1 approved in one area, it's okay to use it off label in another
2 area?
3 A That's what he said, yes.
4 Q What does the research literature say, or what opinion do
13:21:44 5 you have about using the same drug, a puberty-blocker in the
6 case of a person who's six, seven, eight, the purpose is to --
7 precocious puberty, what about the cases of precocious puberty
8 and using puberty-blockers to help someone medically transition
9 at the beginning of normal puberty?
13:22:03 10 A Well, the ability to use a medication off label is not a
11 blanket permission to give any drug you want for any reasons
12 you want or for any conditions you want.
13 Ultimately, it's going to depend on what the scientific
14 literature itself says, which in turn is what the various
13:22:22 15 regulatory bodies use to make their decisions to decide what's
16 off label or on label to begin with.
17 So because a medication would be useful for some people in
18 some situations and some circumstances, does not mean it's
19 automatically going to be useful for other people in other
13:22:37 20 circumstances. Indeed it could be deleterious.
21 If you use a puberty-blocker in somebody with precocious
22 puberty, you are pushing somebody who is far below the average
23 age of puberty, and you are bringing them closer to the
24 species-typical range of puberty.
13:22:55 25 If you give that same drug to somebody who is already

1 having a typical age of puberty, you are now pushing them
2 outside of the species-typical age.
3 Q Thank you, Dr. Cantor.
4 I am going to sum up. Does the research literature
13:23:21 5 support plaintiffs' claims that we need to treat children and
6 adolescents with gender dysphoria with social transition
7 puberty-blockers and cross-sex hormones?
8 A I'm sorry. Could you say that -- I missed the first half
9 of that sentence.
13:23:33 10 Q My apologies.
11 Does the research literature support plaintiffs' claims
12 that we need to treat children and adolescents with gender
13 dysphoria with social transition, puberty-blockers, and
14 cross-sex hormones?
13:23:46 15 A No. That's terrible overstatement.
16 Q Does the research literature support Alabama's description
17 of these treatments as experimental?
18 A Yes. They're fairly called experimental.
19 Q When does a drug or a course of treatment stop being
13:24:02 20 experimental?
21 A That's an excellent question. There is no real test for
22 it. There is no objective way to decide something is one
23 versus the other.
24 Science is never finished. It's always possible for there
13:24:14 25 always to be some future piece of information that changes what

1 we know.
2 There are, of course, you know, different situations --
3 drugs, issues under active investigation, where it's very clear
4 that it's still experimental, and others where, you know, there
13:24:32 5 is only very little question left.
6 For this particular situation, we have a very small number
7 of studies that in certain situations might look like they
8 might be helping, but a much larger body of better performed
9 studies showing that the improvement is not actually coming
13:24:47 10 from the transition itself.
11 Indeed, there were other areas of the report that were
12 referred to already ongoing studies testing exactly these
13 interventions. Well, that there exists ongoing tests of these
14 interventions is pretty much the definition of calling
13:25:05 15 something experimental.
16 Q If scientists are eventually able to replicate the same
17 results under the same conditions over and over again, can you
18 then pretty much say something is established?
19 A Yes.
13:25:17 20 Q Has anybody been able to replicate the results of, say,
21 the Dutch study that showed at least some positive results with
22 a combination of treatments?
23 A No. Most of the studies have demonstrated no improvement
24 in these children from medical transition.
13:25:32 25 Q Do you understand plaintiffs to argue that Alabama is out

1 of step with groups like the American Academy of Pediatrics?
2 A Yes, I've heard them say that.
3 Q What's your response?
4 A Well, it's actually the American Academy of Pediatrics
13:25:54 5 which is out of step with the international standards.
6 Q Is there a consensus, a medical consensus internationally
7 in support of these treatments?
8 A There is now a very quickly developing one. It is still
9 ongoing debate, so I would hesitate to describe it -- describe
13:26:12 10 that there is a solid consensus.
11 As I say, really what we have seen is a pendulum swing
12 which is overswung and now is substantially and very quickly
13 correcting itself.
14 Q Is the pendulum swinging in favor of medical transition
13:26:27 15 use of puberty-blockers and cross-sex hormones for children and
16 adolescents?
17 A No. It's swinging now against that.
18 Q Is there a medical consensus in the United States for the
19 best way to treat gender dysphoria?
13:26:39 20 A No, there is not.
21 MR. DAVIS: Thank you, Dr. Cantor.
22 THE COURT: So I do have a question myself.
23 Dr. Cantor, you said that an adult should be affirmed in
24 their transgender status.
13:26:58 25 THE WITNESS: An otherwise mentally healthy adult,

1 yes.
2 THE COURT: All right. So make it clear to me, then,
3 when should an adolescent or a child be affirmed in that
4 status?
13:27:10 5 THE WITNESS: That, to me, is an empirical question.
6 We are not sure actually when the best time do that is.
7 Every time we check, we keep finding that, no, that's not
8 exactly the right way. No, that's not exactly quite working.
9 And when we do think we have run into a clue that gives us
13:27:26 10 an idea of when, we are not able to recreate that situation.
11 THE COURT: Is that case by case, then?
12 THE WITNESS: I would hesitate to say case by case
13 exactly because --
14 THE COURT: Let me rephrase it. Under what
13:27:44 15 circumstances would you affirm a child or an adolescent?
16 THE WITNESS: I can't say that there's a situation --
17 all of the situations will be gray. I can't think of any
18 evidence that would give us the kind of certainty in any case
19 that would outweigh the potential risks.
13:28:19 20 THE COURT: So you would never affirm a child or an
21 adolescent?
22 THE WITNESS: Not with the current evidence available,
23 no.
24 THE COURT: Okay. All right. Cross?
13:28:28 25 CROSS-EXAMINATION

1 BY MS. EAGAN:
2 Q Good afternoon, Dr. Cantor.
3 A Good afternoon.
4 Q Dr. Cantor, you are an adult clinical psychologist,
13:29:15 5 correct?
6 A Yes.
7 Q You are not a medical doctor?
8 A Correct.
9 Q Your private practice -- in your private practice in
13:29:22 10 Toronto, the average age of your patients is 30 to 35 years
11 old?
12 A Average, that would be about right, yes.
13 Q You've not ever provided clinical care to transgender
14 prepubertal children?
13:29:39 15 A Correct.
16 Q You have not provided care to a transgender adolescent
17 under the age of 16?
18 A Correct.
19 Q The extent of your experience, Dr. Cantor, working with
13:29:52 20 transgender adolescents consists of counseling six to eight
21 transgender patients between the ages of 16 and 18; isn't that
22 correct?
23 A Yes.
24 Q So your clinical experience with gender dysphoria really
13:30:09 25 lies in the counseling of adult patients?

1 A Correct.
2 Q And you acknowledge that gender dysphoria in children does
3 not represent the same phenomenon as adult gender dysphoria,
4 correct?
13:30:24 5 A Correct.
6 Q And, in fact, to use your words, they differ in every
7 known regard, from sexual interest patterns to responses to
8 treatments?
9 A Correct.
13:30:36 10 Q Dr. Cantor, you have never diagnosed a child or an
11 adolescent with gender dysphoria?
12 A Correct.
13 Q Never treated a child or an adolescent for gender
14 dysphoria?
13:30:48 15 A Correct.
16 Q You have no experience personally with monitoring patients
17 who are undergoing puberty-blocking treatment?
18 A Correct.
19 Q You don't know what type of monitoring is typically done
13:31:04 20 or not done on those types of patients; isn't that fair?
21 A No.
22 Q No, that's not fair?
23 A Well, you -- I personally didn't do it, but I am aware of
24 the procedures that are done.
13:31:15 25 Q Okay. But you have no experience with that?

1 A That's correct.
2 Q Similarly, you have never monitored -- or you have not
3 monitored an adolescent or teenage patient on hormone therapy?
4 A Correct. Until -- well, I wouldn't be monitoring the
13:31:34 5 status in any case, so, yes, that's correct.
6 Q I am going to switch to UAB Children's, the gender clinic
7 here in Alabama.
8 Have you ever spoken to a child or adolescent who was
9 treated at the gender clinic here in Alabama?
13:32:00 10 A No.
11 Q Have you ever spoken to any former patients of the clinic?
12 A No.
13 Q You weren't here yesterday to hear Dr. Ladinsky talk about
14 the treatment protocols they have at children's UAB, were you?
13:32:12 15 A Correct.
16 Q You weren't here to listen to the results of treatments
17 provided to adolescent patients at UAB's Children's in the
18 gender clinic; fair?
19 A Yes. They have never published them.
13:32:27 20 Q And you weren't here to hear them?
21 A Correct.
22 Q Dr. Cantor, you have no personal knowledge of the
23 assessment or the treatment methodologies that are used here in
24 Alabama at UAB Children's Hospital, correct?
13:32:42 25 A Correct. Correct.

1 Q You do not know the disciplines of the medical providers
2 who are part of the treatment team involved in that assessment
3 at UAB Hospital?
4 A Correct.
13:32:56 5 Q Now, I heard your opinion that it's important to assess
6 the mental health issues of an adolescent patient to see
7 whether that is a potentially contributing factor to gender
8 dysphoria and whether there's a need to address. That's a fair
9 statement of your opinion?
13:33:17 10 A I'm sorry. Would you repeat that, please?
11 Q Sure. It's your belief that mental health issues need to
12 be assessed and addressed before a transition occurs?
13 A Correct.
14 Q Do you know what assessment protocols at UAB Children's
13:33:31 15 are to address mental health issues before a child is put on
16 any transitioning medication?
17 A No, I do not.
18 Q Do you have any idea or do you know what the doctors at
19 UAB Children's discuss with their adolescent patients about the
13:33:48 20 risks and the benefits of medical treatments at UAB?
21 A No.
22 Q Wouldn't you agree -- well, never mind. I am going to
23 move on.
24 Dr. Cantor, I want to talk with you a minute about -- or a
13:34:18 25 little bit about your criticisms of the various studies

1 regarding the efficacy of puberty blockers and hormone
2 treatments, okay?
3 A Yep.
4 Q As I understand your report and your testimony today, one
13:34:36 5 of the criticisms you have of some of those studies is that it
6 relies on participant's self-assessment I believe is the
7 language that you used.
8 Essentially, it is based upon what socially transitioned
9 youth and their family is reporting about their mental health
13:34:53 10 in these studies?
11 A I would say that's incomplete. My criticisms would be
12 relying on such subjective accounts entirely for all the
13 decision making rather than using it as one part of the
14 decision making.
13:35:08 15 Q In other words, basing your study based upon what the
16 participants in the study tell you how they're feeling at
17 different points in the study?
18 A Being limited to that is a problem, yes.
19 Q And I believe the way that you phrased it, you said,
13:35:22 20 subjective self-reports about how one is doing may not be
21 reflecting reality objectively.
22 A Correct.
23 Q But, Dr. Cantor, self-reports about how one is doing may
24 reflect reality, fair?
13:35:38 25 A That's correct.

1 Q So when somebody says, I am doing well, my mental state is
2 better, that very well may be the case?
3 A May be the case, yes.
4 Q Another complaint that you have, I believe, is what you
13:35:58 5 call confounded data. And I believe you referred to the de
6 Vries study for that?
7 A The two de Vries's studies, yes. As a matter of fact,
8 it's all but two of all papers in that set of literature.
9 Q And by confounded data, the way that I am understanding
13:36:13 10 it, what you're saying is that you are not able to tell because
11 the data is, quote, confounded, whether one's improved mental
12 health for a minor who has socially transitioned, whether that
13 came from the actual medical services, whether it came from the
14 psychotherapy, or whether it came from the combination of both?
13:36:34 15 A Correct.
16 Q But one thing, Doctor, that you do have to admit is when
17 adolescents with gender dysphoria have transitioned through a
18 combination of medical services and psychotherapy, you have to
19 admit that based upon the studies, their mental health
13:36:55 20 improved, correct?
21 A No. There were several studies that showed no improvement
22 even though -- even though they were receiving both. I've
23 listed them in my report.
24 Q Can you direct me to where in your report those are,
13:37:11 25 please, sir?

1 A Sure.
2 THE COURT: While he is looking, did you say your
3 target is an hour; is that right?
4 MS. EAGAN: Yes, sir. I believe I should be able to
13:37:33 5 be done in an hour.
6 THE WITNESS: Page 20, footnote 40.
7 BY MS. EAGAN:
8 Q I'm sorry, sir?
9 A Page 20, footnote 40. The Carmichael study, the
13:37:48 10 Hisle-Gorman, et al, study, and Kaltiala.
11 My full sentence was, New studies continue to appear at an
12 accelerating rate, repeatedly reporting deteriorations or lacks
13 of improvement in mental health, footnote 40 -- or again, those
14 were the specific studies -- and then or lack of improvement
13:38:23 15 beyond psychotherapy alone, footnote 41.
16 Q Certainly, Dr. Cantor, though, there are many study -- or
17 there are studies that indicate when adolescents with the
18 combination of medical service and psychotherapy transition,
19 their mental health has improved. You agree with that
13:38:40 20 statement?
21 A I would have to check to see if the number is zero or a
22 handful. There have been reports of there having been such
23 improvement, such as the Branstom study, which once it was
24 reanalyzed, discovered to have problems, and the finding was
13:39:00 25 withdrawn.

1 So there -- again, I would have to go through and check to
2 be sure that it's not zero. It would be fair to say that there
3 might have been a study which found such a thing. But the
4 majority of studies are finding either no improvements or
13:39:17 5 deteriorations, or it's a situation that we call a failure to
6 replicate.
7 Q Sir, I am a little bit confused, because I want to go to
8 two of your studies that you have actually talked about today,
9 the Costa study and the Achille study.
13:39:33 10 Now, as I understand your testimony today, in those
11 studies, there was -- the studies reported that there was an
12 improvement in mental state for adolescents who were treated
13 with medication and psychological treatment in transition that
14 there was an improvement, but in those, you said you can't tell
13:39:58 15 whether it's from the medication or from the psychological
16 treatment?
17 A No. The Costa study and the Achille study associated the
18 improvement specifically with the psychotherapy and ruled out
19 that the effects were due to the medical interventions.
13:40:13 20 Q Okay. Well, let's pull those studies, Doctor, and let's
21 look at those.
22 If you could, there should be a notebook up there that has
23 plaintiffs' exhibits in it. Is that one plaintiff, sir?
24 If you could please, sir, turn to Plaintiffs' Exhibit 34.
13:40:55 25 A Yes.

1 Q All right. Plaintiffs' Exhibit 34, is this the -- do you
2 say Costa or Costa?
3 A I'm sorry?
4 Q Do you say Costa?
13:41:05 5 A My guess is Costa. I have never met the person.
6 Q All right. Exhibit 34 that you have in front of you, is
7 that the Costa study?
8 A Yes, it is.
9 Q All right. So, Doctor, I first want to focus in on --
13:41:18 10 well, let me ask this: This study was aimed at assessing
11 gender dysphoric adolescents' global functioning after
12 psychological support and after puberty suppression, correct?
13 A Yes.
14 Q Bear with me. I am going to take this out so I can put it
13:41:42 15 up on the Elmo, sir.
16 All right, sir. I am going to direct your attention to
17 results that I have highlighted on my copy. Okay? According
18 to the abstract here, the results?
19 A Yes.
13:42:18 20 Q At baseline, gender dysphoric adolescents showed poor
21 functioning with -- it defines the mean scores. So baseline
22 means at the start of the study, correct?
23 A Usually it does. I would have to check that that's
24 exactly how they used the term.
13:42:35 25 Q All right. We will get to the details of that in a

1 minute.

2 Okay. Gender dysphoric adolescents' global functioning

3 improved significantly after six months after psychological

4 support. And then it goes on to say, Moreover, gender

13:42:49 5 dysphoric adolescents receiving also puberty suppression had

6 significantly better psychosocial functioning after 12 months

7 of puberty suppression compared to when they had received only

8 psychological support.

9 Did I read that right, sir?

13:43:07 10 A Yes.

11 Q Do you remember the methodology that was used for this

12 study, sir?

13 A Roughly.

14 Q Pardon?

13:43:14 15 A Yes. Roughly.

16 Q Sorry. I meant to -- all right. And do you recall that

17 the methodology was everybody started at baseline. For the

18 first six months all of the adolescents received psychological

19 counseling. And then for the next 12 months beyond that, one

13:43:36 20 group received puberty blockers, and one group just continued

21 to receive psychological counseling. Do you recall that?

22 A Yes.

23 Q All right. And then I am going to direct you, sir, to

24 page 2211 of the -- if you look at the blue writing on the top,

13:44:12 25 it's page 6 of 9.

1 A Yes.
2 Q All right. And I am going to direct you, sir, to on the
3 CGAS on follow-up?
4 A Yes.
13:44:32 5 Q All right. And I am going to start at the second
6 paragraph where it says delayed eligible. Do you see where I
7 am talking about?
8 A Yes.
9 Q This is talking about there were three follow-ups, right,
13:44:43 10 at 6 months, at 12 months, and at 18 months for this study; is
11 that correct?
12 A That sounds familiar to me, yes.
13 Q And let's read through that together.
14 Delayed eligible gender dysphoric adolescents, who
13:44:55 15 received only -- and gender delayed, GD adolescents, is your
16 recollection that those were adolescents who were eligible to
17 receive puberty blockers, but they delayed them for six months
18 so that they had everybody at a -- doing psychological study?
19 Do you remember this is the group that gets the puberty
13:45:17 20 blockers?
21 A Yes, that sounds correct.
22 Q Okay. The delayed eligible gender dysphoric adolescents
23 who received only psychological support for the entire duration
24 of the study -- excuse me -- I take that back.
13:45:29 25 This was actually the group that just got the

1 psychological -- had significantly better psychosocial
2 functioning after six months of psychological support, okay?
3 However, despite scoring better at the following
4 evaluations, they did not show any further significant
13:45:47 5 improvement in their psychosocial functioning.
6 Did I read that right?
7 A Yes.
8 Q Also, the delayed eligible group continued to score lower
9 than a sample of children adolescents without observed
13:46:04 10 psychological psychiatric symptoms even after 18 months of
11 being in psychological support.
12 So what that's saying is after 18 months, they were still
13 below a group that did not have psychological therapy or
14 issues, correct?
13:46:20 15 A Yes.
16 Q On the contrary, the immediately eligible group, who at
17 baseline had a higher, but not significantly different
18 psychosocial functioning than the delayed eligible group, did
19 not show any significant improvement after six months of
13:46:40 20 psychological support. However -- and this is the key --
21 immediately eligible adolescents had a significantly higher
22 psychosocial functioning after 12 months of puberty suppression
23 compared to when they had received only psychological support.
24 Did I read that correctly?
13:47:03 25 A Yes.

1 Q Then you see at the top of this, there is a chart. And
2 when you look at this chart, the bottom is actually the three
3 different check-ins. Time zero is baseline, when the study
4 started, right?
13:47:18 5 A Yes.
6 Q Time one is the six-month check-in, correct?
7 A Yes.
8 Q And during that six months, both groups are getting just
9 psychotherapy, correct?
13:47:31 10 A Yes, I believe so.
11 Q The rest -- and just to orient us.
12 The red group, the red line is the group of adolescents
13 who only got psychotherapy or psychotherapy through the entire
14 18-month study, right?
13:47:46 15 A Yes.
16 Q The green line that you see that goes up -- goes up and
17 keeps going up, that is the line of adolescents who receive
18 puberty blockers; fair?
19 A Yes.
13:47:59 20 Q And so, Doctor, to get to the ultimate conclusion of this
21 study that you say shows that puberty blockers don't work or
22 don't give any improvement in mental condition over
23 psychotherapy, the conclusion, this study confirms the
24 effectiveness of puberty suppression for gender dysphoric
13:48:37 25 adolescents. Recently, a long-term follow-up evaluation of

1 puberty suppression among gender dysphoric adolescents after
2 that CSHT, which is hormone therapy and GRS, which is puberty
3 blockers, has demonstrated that gender dysphoric adolescents
4 are able to maintain a good functioning into their adult years.
13:49:00 5 This present study, together with this previous research,
6 indicate that both psychological support and puberty
7 suppression enable young gender dysphoric individuals to reach
8 a psychosocial functioning comparable with their peers.
9 Did I read that conclusion correctly?
13:49:17 10 A Yes.
11 THE COURT: Ms. Eagan, when you reach a comfortable
12 spot, let's take a post-lunch break.
13 MS. EAGAN: Perfect. We're good, Judge. We can go
14 ahead and break now.
13:49:35 15 THE COURT: Okay. I will see you in 15 minutes.
16 (Recess.)
17 THE COURT: Go ahead, Ms. Eagan.
18 MS. EAGAN: Thank you, Your Honor.
19 BY MS. EAGAN:
14:09:00 20 Q Dr. Cantor, my understanding from paragraph 63 of your
21 declaration is that the other study that you point to in
22 support of your assertion that testing revealed that puberty
23 blockers did not improve mental health any more than mental
24 health does on its own is the Achille study you mentioned
14:09:29 25 earlier today; is that right?

1 A Yes.
2 Q If you, please, sir, could turn to Plaintiffs' Exhibit 42
3 in that binder in front of you, and this would be the
4 plaintiffs' exhibits that we were looking at earlier.
14:09:42 5 A Yep. Got it.
6 Q All right. Is Plaintiffs' Exhibit 42 the Achille study
7 that we just mentioned?
8 A Yes.
9 Q All right.
14:09:59 10 MS. EAGAN: Your Honor, do you mind if I take this off
11 of this?
12 THE COURT: That's fine.
13 BY MS. EAGAN:
14 Q All right. I am going to -- so this is Plaintiffs'
14:10:15 15 Exhibit 42.
16 And the Achille study, again, was -- in this case if we
17 look at the abstract, the background of the study or the
18 purpose of the study was to examine the associations of
19 endocrine intervention puberty suppression and/or cross-sex
14:10:35 20 hormones therapy with depression and quality of life scores
21 over time in transgender youths.
22 That was the purpose of the study, correct?
23 A Yes.
24 Q And looking down to the results section, between 2013 and
14:10:56 25 2018 -- so this went over a five-year period, right?

1 A Yes.
2 Q And there were 50 participants in the study, correct?
3 A That sounds right, yes.
4 Q All right. And that they received endocrine intervention
14:11:17 5 both -- some were in the form of puberty blockers, and some
6 were in the form of cross-sex hormones, but endocrine -- and
7 over that time period and completed three waves of
8 questionnaires.
9 Is that your recollection of this study?
14:11:30 10 A Yes, roughly.
11 Q Okay. And when that was -- with those treatments, mean
12 depression scores and suicidal ideation decreased over time,
13 which means their depression was -- went down, or they got
14 better. Suicidal ideation went down, which is improvement,
14:11:50 15 correct?
16 A Yes.
17 Q While mean quality of life scores improved over time.
18 And then it goes on to say, When controlling for
19 psychiatric medications and engagement in counseling,
14:12:03 20 regression analysis suggested improvement with endocrine
21 intervention. And then it goes on to say that this reached
22 significance in male to female participants. And the male to
23 female participants, those are ones that were receiving hormone
24 therapy, correct?
14:12:23 25 A I believe they were both receiving hormone therapy. It

1 was not significant in one group, and so they're just reporting
2 the successful in the other and not reporting the nonsuccessful
3 group.
4 Q Well, let's talk about that. Let me pull up paragraph 63
14:12:39 5 of your declaration.
6 When you're discussing this study, here is what you said.
7 You said that upon follow-up, some incremental improvements
8 were noted; however, after -- so, in other words, upon
9 follow-up, they saw improvements.
14:13:07 10 But after statistically adjusting for psychiatric
11 medication and engagement and counseling, quote, most
12 predictors did not reach statistical significance.
13 And that's your basis -- that statement is your basis to
14 say there was not a statistical significance of difference
14:13:26 15 between just counseling versus with meds; is that right?
16 A I'm sorry. Could you say that part again?
17 Q The language that you seize onto, to say that puberty
18 blockers did not improve mental health more than mental
19 healthcare did on its own --
14:13:43 20 A Right.
21 Q -- was the statement in the study that most predictors did
22 not reach statistical significance.
23 A Well, I wouldn't say that I derived that just from that
24 sentence. It's just easier to convey that idea to readers by
14:13:56 25 using the sentence. My evaluation of the study is by those

1 statistics directly.
2 Q All right. Let's go to the language in the study that
3 they talk about, the regression analysis that you were just
4 referencing there.
14:14:11 5 Okay. And this is here in the regression analysis.
6 Let me first say this: The mean changes over time. And
7 it does say, Mean depression scores decreased. Quality of life
8 improved, but did not reach statistical significance.
9 But then when you go on to the regression analysis, here
14:14:39 10 is what it says. It says, Given our modest sample size --
11 which in this case was 50 people, right?
12 A Yes.
13 Q Given our modest sample size, particularly when stratified
14 by gender, most predictors did not reach statistical
14:14:57 15 significance.
16 So one of the contributing factors to that, of course, was
17 the size of the number of participants, correct?
18 A Yes. In statistics, that's a truism. The precision of
19 the statistics is the direct -- direct result of the sample
14:15:20 20 size.
21 Q Okay. And then it goes on to say, That being said, effect
22 sizes values were notably large in many models. In the male to
23 female participants, only puberty suppression reached a
24 significance level. And it gives the number in one of the
14:15:43 25 sample -- one of the tests, and associations with the two other

1 scores approached significance.
2 And then it goes on to say, For female to male
3 participants, only cross-sex hormone therapy approached
4 statistical significance.
14:15:57 5 All right. Statistical significance are not -- on all
6 planes, the numbers improved, correct?
7 A No. That's -- the very meaning of determining --
8 factoring in whether something is statistically significant or
9 not.
14:16:15 10 Q Ultimately, the writers of this study stated, if you look
11 at the next paragraph -- or look on the discussion part if you
12 want -- can you see the screen up here?
13 A Oh, I have the same thing on this screen.
14 Q Oh. You have got one. Okay, good.
14:16:31 15 Our results suggest that endocrine intervention is
16 associated with improved mental health among transgender youth.
17 Did I read that right?
18 A Yes. Those are their words.
19 Q Doctor, to be clear, you agree that the U.S.-based medical
14:17:15 20 association guidelines and position statements are in support
21 for the use of medical treatment combined with mental health
22 treatment for adolescents with gender dysphoria, correct?
23 A I don't think I would phrase it quite that strongly. Most
24 of the associations are using relatively vague terms. And it's
14:17:35 25 not clear when they're talking about adults or children, when

1 they're talking about transition, medical services versus
2 psychotherapy, or a relatively blanket statement of
3 demonstrating respect. I can only accept that they're
4 endorsing a particular treatment when they're endorsing a
14:17:54 5 particular treatment.
6 So is there a specific association or specific statement
7 you have in mind?
8 Q The major medical associations that were involved in this
9 space endorse the use of medications to treat gender dysphoria
14:18:08 10 in children -- excuse me -- gender dysphoric adolescents once
11 they reach puberty when appropriate?
12 A I can think of two medical associations, one
13 interdisciplinary association, and the other -- and all of the
14 others are, as I say relatively, vague words of support, and
14:18:44 15 it's not clear exactly what it is that they're recommending.
16 Q Well, my understanding is what you like to look at is the
17 international standards. That's what you're talking about
18 today in support of your opinions?
19 A Oh, I looked at each of them, and I think I described each
14:18:59 20 of them. I did my best not to leave any out.
21 Q So, and according to you, the Dutch approach is
22 internationally the most widely-respected and utilized method
23 for the treatment of children who present with gender
24 dysphoria?
14:19:13 25 A Yes.

1 Q And the Dutch approach is also, I believe, what you call
2 that watchful waiting approach?
3 A No.
4 Q Okay. The Dutch approach is what is accepted -- I have
14:19:24 5 already said what you said.
6 The Dutch approach says social transition can happen at
7 age 12, puberty blockers may be prescribed at age 12, hormones
8 at age 16, and then resolve other mental health issues before
9 transition. That's the Dutch method?
14:19:43 10 A Yes.
11 Q Do you know how that approach aligns with protocols that
12 are utilized at UAB Children's in Alabama?
13 A I don't know.
14 Q In any event, what you say is internationally the most
14:20:03 15 widely-respected and utilized method for treatment of children
16 who present with gender dysphoria, you would agree that that
17 approach would be a felony in Alabama with this new law,
18 correct?
19 A Yes. It's true that the Alabama law didn't leave an
14:20:26 20 exception for research purposes.
21 Q Okay. So let's talk about the European countries that you
22 mentioned very briefly, the UK, Finland, Sweden and France.
23 When you look at those four European countries, Doctor,
24 not one of them has enacted a ban to puberty blockers and
14:20:46 25 hormone treatments as Alabama has done here, correct?

1 A No.
2 Q That's not correct?
3 A Correct. That is not correct.
4 Q UK has not fully banned puberty blockers and hormone
14:21:00 5 treatments in youth 18 and younger?
6 A That's correct.
7 Q Finland has not banned -- let me ask it this way: Has
8 Finland banned blockers and hormone treatments in youth ages 18
9 and under for gender dysphoria?
14:21:16 10 A Yes, I believe it has.
11 Q It has?
12 A I believe so.
13 Q A blanket ban? Should I refer you to paragraph 131 of
14 your declaration, sir?
14:21:47 15 A Hang on. That's just where I am now.
16 Q Okay.
17 A Oh, yes, they did leave an exception for hormones. The
18 total ban was on surgery.
19 Q Thank you, sir.
14:22:05 20 Sweden, has Sweden put an absolute ban on puberty
21 blockers?
22 A Yes.
23 Q And bear with me. Have they put a ban on puberty blockers
24 and hormone treatments in youth ages 18 and under for gender
14:22:23 25 dysphoria in Sweden?

1 A 18 and under?
2 Q Yes, sir.
3 A No. They allowed exceptions for 16 year olds -- 16 year
4 olds within research circumstances.
14:22:32 5 Q Has France banned the use of puberty blockers and hormone
6 treatments for adolescents ages 18 and under?
7 A No.
8 Q Can you point me to a single country, Doctor, in Europe
9 that has put a blanket ban on the use of puberty blockers or
14:22:50 10 hormone treatments for youth ages 18 and under for gender
11 dysphoria?
12 A Blanket ban in the way you're describing it, no.
13 THE COURT: How about any country?
14 THE WITNESS: No, not that I know of.
14:23:04 15 BY MS. EAGAN:
16 Q I want to turn very briefly to the subject of -- I will
17 use your word desistance.
18 If you turn to paragraph 36 of your declaration.
19 A Yes.
14:23:36 20 Q In that -- you state, Among prepubescent children who feel
21 gender dysphoric, the majority cease to want to be the other
22 gender over the course of puberty ranging from 61 to 80 percent
23 desistance across the large prospective studies.
24 I know that's a point that you also raised earlier today.
14:23:59 25 So I want to ask this question: Of those that number, do

1 you know, Doctor, what percentage of those kids cease to want
2 to be the other gender -- that's using your words -- before or
3 as they enter puberty, in other words, before they actually get
4 into puberty? Do you know how many of those desisters are in
14:24:27 5 that window?
6 A I must not be understanding your question, because it
7 makes me want to say the same number that's in the report, 61
8 to 88 percent. What's different from what I said and what
9 you're asking?
14:24:39 10 Q The 61 to 88 percent, is that children that realign with
11 their birth sex before -- or as they're entering into puberty,
12 that's that number?
13 A Yes.
14 Q Okay. All right. So I want to focus on a different
14:25:01 15 category of youth. Let me ask you this: The medications in
16 the United States, puberty blockers and hormone treatments
17 cannot be given to kids for gender dysphoria until after
18 they've actually entered into puberty, correct?
19 A Very many clinics are doing it as close to the beginning
14:25:23 20 as soon as puberty starts as they are able.
21 Q But it's once they have entered puberty?
22 A Yes.
23 Q So let me ask you about that category of youth.
24 And that is adolescents who have entered into puberty,
14:25:38 25 okay, and who have been -- have suffered from gender dysphoria

1 persistently, consistently, and insistently in childhood
2 leading up to puberty, okay?
3 A Okay.
4 Q Do you have any data regarding what percentage of those
14:25:58 5 individuals desist after they enter into puberty?
6 A No. I don't think that level of follow-up has yet been
7 conducted.
8 Q And, Doctor, in fact, it's your belief that the
9 majority -- that while the majority of prepubescent kids cease
14:26:35 10 to feel trans, you know, to puberty or during puberty, in other
11 words, as they enter into puberty, the majority of kids who
12 continue to feel trans after puberty rarely cease?
13 A That does seem to be the case, yes.
14 Q Okay. Doctor, are you being paid to be here to testify
14:27:10 15 today?
16 A Yes.
17 Q What's your rate?
18 A 400 an hour.
19 Q Who is paying your fees?
14:27:14 20 A The Alabama state -- State of Alabama.
21 Q Okay. Dr. Cantor, have you attempted to recruit parents
22 in Alabama whose children have gender dysphoria and were
23 prescribed or referred to gender-affirmative treatments, have
24 you tried to recruit them to give a witness statement in this
14:27:38 25 case that they believe the treatments are harmful?

1 A No.
2 Q Do you tweet?
3 A Yes.
4 MS. EAGAN: Your Honor, may I approach?
14:27:49 5 THE COURT: Yes.
6 BY MS. EAGAN:
7 Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet
8 Dr. James Cantor retweeted. And it's -- let me say this: Is
9 this a tweet that you actually did?
14:28:40 10 A No. I --
11 Q You retweeted?
12 A Retweeted, exactly.
13 Q From a group called Genspect, or what's -- I don't tweet.
14 Would you call that a group? I guess it's a group called
14:28:56 15 Genspect?
16 A It's there is a group called Genspect, and this is their
17 Twitter account.
18 Q All right. And then you retweeted it?
19 A Yes.
14:29:03 20 Q And it says, Urgent. Attention. Alabama parents, if your
21 child experienced gender dysphoria and was prescribed or
22 referred to gender-affirmative treatments and you believe these
23 treatments are harmful, please direct message, e-mail us at
24 once. We are looking for witness statements. Can be anon.
14:29:26 25 By anon, I guess that means anonymous, correct?

1 A That would be my reading, yes.
2 Q All right. Doctor, have you seen a sworn statement under
3 penalty of perjury for any Alabama parent whose kid received
4 puberty blockers or hormones and the parent said the
14:29:50 5 medications hurt their kid more than they helped them?
6 A I'm sorry. Did you ask have I seen such a statement?
7 Q Yes, sir.
8 A Not that I recall.
9 MS. EAGAN: Nothing further.
14:30:05 10 THE COURT: Any redirect?
11 MR. DAVIS: Short.
12 THE COURT: Ms. Eagan, did you intend to offer that
13 into evidence or no?
14 MS. EAGAN: Oh, yes. Thank you, Judge. I offer
14:30:37 15 Plaintiffs' Exhibit 45.
16 THE COURT: It will be admitted.
17 REDIRECT EXAMINATION
18 BY MR. DAVIS:
19 Q Dr. Cantor?
14:30:51 20 A Hi.
21 Q Is it true as a clinician you are not treating anyone who
22 has presented with gender dysphoria as an adult or as a child?
23 A I treat adults with gender dysphoria, not children.
24 Q You are not treating them while they are adolescents or
14:31:09 25 children, you are not currently treating someone who is like

1 under age 16?
2 A Correct.
3 Q Okay. But you are familiar with the research literature
4 on these issues, correct?
14:31:19 5 A Yes, quite.
6 Q And even those that are studying -- or children in
7 adolescents?
8 A Of course.
9 Q You're knowledgeable about the treatment they're
14:31:29 10 receiving?
11 A Yes, very.
12 Q And are you knowledgeable about what the research shows
13 about the efficacy of these treatments?
14 A Yes.
14:31:35 15 Q You had an exchange with Ms. Eagan where you admitted that
16 a fact that is self-reported by a participant may be true?
17 A Correct.
18 Q What's the rest of that sentence?
19 A It is certainly not necessarily true. We need something
14:31:53 20 objective before we can make any decisions upon it.
21 Q Let's turn to the Costa study. That's at Tab 38 of the
22 book of plaintiffs' exhibits.
23 MR. DAVIS: Your Honor, I'm sorry. I left a notebook.
24 May I step over?
14:32:40 25 THE COURT: Certainly.

1 THE WITNESS: I'm sorry. You said Tab 38?
2 BY MR. DAVIS:
3 Q I was mistaken, Dr. Cantor. It was 34.
4 A 34 of the defendants'?
14:33:02 5 Q No. Of the plaintiffs' book.
6 A Yes. Now I'm back there.
7 Q Okay. Now, you have a line in your report in paragraph 57
8 of your report that I will just read to you.
9 It says, Both groups improved in psychological functioning
14:33:25 10 over the course of the study, but no statistically significant
11 differences between the groups was detected at any point?
12 A Correct.
13 Q Okay. Are the three groups represented by the three
14 colored lines -- the three groups you're talking about, the
14:33:41 15 three groups on the three colored lines on this chart I'm
16 showing you?
17 A Part of the information is contained in that graph, yes.
18 Q Okay. Does this table tell us more about the statistical
19 significance or lack thereof shown in the Costa study?
14:34:02 20 A Yes, it does. The results of this table, although much
21 harder to read, indicate that there was no statistical
22 significance between the groups.
23 Q Okay.
24 A What was changing in the groups was change over time
14:34:13 25 within the group relative to the same group previously. But

1 there were no changes -- no significant differences between the
2 groups themselves.
3 Q Okay. What does it mean in a study if a finding lacks
4 statistical significance?
14:34:29 5 A That there was a substantial probability of getting a
6 pattern like that just by random chance.
7 Q And are there any reasons other than puberty suppression
8 that the delayed group did not have the same change over time
9 as the immediately eligible group?
14:34:45 10 A It's not exactly clear if they didn't change just as much.
11 That's one of the ambiguities that, again, comes from
12 statistics. When you look at it in different ways, you can see
13 different aspects, different aspects of it.
14 Q And the authors actually noted statistical significance or
14:35:11 15 lack thereof, did they not, in the language that are bracketed
16 there? It says, this difference failed to reach significance
17 possibly because of sample size?
18 A That is correct.
19 Q Have you said anything about the Costa study in your
14:35:24 20 report that you need to withdraw after your exchange with
21 Ms. Eagan?
22 A No. Everything I said is accurate.
23 Q Okay. Is the same true for everything that you have said
24 about the Achille study?
14:35:39 25 A Yes. Everything I said was accurate. Nothing in the

1 prior discussion changed it.
2 Q The UK is still reviewing these treatments, are they not?
3 A They are in the middle of deciding what to do with what
4 they have now discovered from their comprehensive review of the
14:35:57 5 literature, which showed what they were doing was wrong.
6 Q What did they discover?
7 A They discovered that they said exactly what I said, that
8 there is no evidence to support the medical transition of these
9 children.
14:36:09 10 Q And they have not yet decided how to respond to that
11 revelation, correct?
12 A Correct. They have now taken that report, and they're now
13 reorganizing and deciding exactly what it is that they're going
14 to do.
14:36:21 15 Q And in France, is it not correct that they've said about
16 hormones that the greatest reserve is required for their use?
17 A That is correct.
18 Q And is it true that, quote, they have said that speaking
19 of hormones, they're irreversible nature must be emphasized?
14:36:38 20 A That is correct.
21 Q And in Sweden, is anyone under 16 getting puberty blockers
22 or hormone treatments?
23 A No. That is banned.
24 Q And what about over 16? Youth -- like --
14:36:51 25 A Between 16 and 18, they're permitted to do it, but only

1 within recognized research programs. A regular physician
2 can't.
3 Q And how many such research programs are going on at
4 present?
14:37:04 5 A Oh, in Sweden?
6 Q Are you aware of any?
7 A I am aware of one lab that has two locations. I don't
8 know what its current status is with its current research
9 program.
14:37:20 10 Q Okay. Can you say whether a single child under 18 is
11 currently receiving hormones for the purpose of transitioning
12 in Sweden?
13 A I don't know.
14 MR. DAVIS: Thank you, Dr. Cantor.
14:37:39 15 THE COURT: Any recross?
16 MS. EAGAN: No, Your Honor.
17 THE COURT: May this witness be excused?
18 MR. DAVIS: Yes, of course, Your Honor.
19 THE COURT: All right. You can step down, sir.
14:37:48 20 THE WITNESS: Thank you.
21 THE COURT: All right. Call your next witness.
22 MR. DAVIS: Your Honor, the State calls Ms. Sydney
23 Wright.
24 THE COURT: All right.
14:37:54 25 SYDNEY WRIGHT,

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James Cantor
@JamesCantorPhD

The only ones who crave affirmation more than trans teens are their doctors.

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EXHIBIT 11
Witness: James Cantor
Date: 6/7/23
Dana Miller, RPR, CRR