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

K.C., et al.,)
)
Plaintiff(s),)
)
-vs-)
)
THE INDIVIDUAL MEMBERS OF THE)
MEDICAL LICENSING BOARD OF)
INDIANA, in their official)
capacities, et al.,)
)
Defendant(s).)

The videoconference deposition upon oral examination of PROFESSOR DIANNA T. KENNY, a witness produced and sworn before me, Brandy L. Bradley, RPR, a Notary Public in and for the County of Hamilton, State of Indiana, taken on behalf of the Plaintiffs at the remote location of the witness, Sydney, New South Whales, Australia, on the 30th day of May, 2023, pursuant to the Indiana Rules of Trial Procedure.

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Pursuant to the Indiana Supreme Court Case 20S-MS-236 signed March 31, 2020, PROFESSOR DIANNA T. KENNY, having been first duly sworn 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 GAVIN M. ROSE:

Q Good morning, Doctor. How are you today?
A I'm fine. Thanks.
Q Can you state your name for the record, please.
A It's Dianna Theadora Kenny.
Q That's Dianna with two Ns; correct?
A Yes, and Theadora with an O, not an A, so T-h-e-a-d-o-r-a, and Kenny there's no E, K-e-n-n-y.
Q And I heard you before we went on the record say that you would prefer to be addressed as Dianna; is that correct?
A That's fine, yeah.
Q If I fall into old habits, do you prefer doctor or professor?
A Professor.
Q Dianna, have you ever had your deposition taken before?

A Not in America, no.
Q Have you in Australia?
A Yes. Well, I mean, you don't call them -- it's not exactly the same process, but yes.
Q You've been asked questions under oath for purposes of a court case?
A That's right, yes.
Q I, obviously, know nothing about the rules of depositions or their equivalent in Australia, so I will go over the rules real quick with you. You understand that this is a formal asking and answering of questions under oath; correct?
A Yes.
Q Okay. The court reporter has asked me to remind you, which I would have done anyway, that because she is writing down everything that we say it is very important that you wait until I finish my question before providing your answer.
A Okay.
Q And I will try to give you the exact same courtesy; is that fair?
A Yes, it is. Could I get you to sit back a fraction because I can only see that much of your face?
Q I'm sorry. Is this better?

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A That's better, yes.
Q Can you still hear me okay?
A Yes, I can.
Q Okay. We had an issue with Zoom not long ago where I had it set to the wrong microphone so I'm used to leaning over something and I don't have to now that it's set correctly, so I apologize.
A Thank you.
Q The court reporter has also asked me to remind you that because of the distance between you and us there very well may be a lag time in the video or in our communication, so, for that reason, too, it's important for you to wait until I finish to begin your answer, okay?
A Okay.
Q In other depositions in this case we have been taking a short break every hour or so. My plan, if everybody is tolerating it, is to go a little longer than that, at least for the beginning, simply because we're already in the evening hours right now, but if at any time you feel like you need a break to stretch your legs, get a drink of water, use the restroom, please, speak up and we can certainly make that happen.

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Is that okay?
A I'm perfectly happy to go for -- I'm used to doing long stretches. I have a long attention span. I know it's going to get very late over there, so it's fine with me to just, yeah, extend those breaks.
Q Well, I have a short attention span and horrible knees so, please, forgive me if I'm the one that needs a break.
A Okay.
Q Do you have any questions about the process?
A No.
Q Okay. What did you do to prepare for today's deposition?
MR. FISHER: I'm going to object to the extent it calls for communication with counsel.
Q Without telling me the content of anything you spoke with your attorneys about today's happenings, did you speak with your attorneys in advance of today's deposition?
A Yes.
Q And when did you speak with them?
A Over the course of the last month. Well, speaking means communicating, documents, you know, going through what was required in my

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report, things like that.
Q Did you have a meeting or conversations specifically for the purpose of preparing you for today's deposition?
A A brief meeting.
Q When did that take place?
A I think that was last Thursday morning, my time.
Q Of course. Did you speak with anyone other than the attorneys for Indiana to prepare for today's deposition?
A No.
Q Did you review any documents in advance of today's deposition?
A Yes.
Q Which documents did you review?
A The primary documents that I reviewed are listed on the front of my declaration. Do you want me to go through them? You'll have them in front of you, but I have them here if you need them.
Q That was going to be my next question. Do you have any documents in front of you that you plan on referencing during the deposition?
A I have my declaration.
Q Okay. Is that the only document you have in front of you?

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A I was advised that that was the only document I was permitted.
Q That's perfectly fine with me. I just want to make sure.
The declaration that you have in front of you, does it have the attached exhibits, I think A through E?
A Yes, A through E. The ones you just sent like 10 minutes ago?
Q The declaration that your attorneys provided to us have, I think, five attachments. The first was your CV and then the other four were medical records pertaining to each of the plaintiffs. Do you have those attachments in front of you?
A No, I don't, no.
Q And it sounds like you have received copies of several exhibits that I e-mailed to your attorneys a short while ago?
A Yes, I received them about three minutes before this call.
Q Okay. And is anyone else in the room with you?
A No.
Q And are you physically located in your home?
A Yes, in my office, yes.
Q Your home office?

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A My home office, yes.
Q And you said this while we were off the record, but that's in Sydney, New South Whales, Australia?
A That's right.
Q While we're talking today, Doctor, I have several exhibits that I am going to show you. Unlike the other attorneys in this case, I have decided to go out on a limb and explain to the court reporter that I will try to use the share-screen function to show them myself. Because of how that works, you will only be able to see one page or part of one page on your computer. I promise I'm not trying to trick you. If you need me to scroll down or anything like that, please, just let me know and I'm more than happy to do so. Is that fair?
A Yes, that's fine.
Q You will also notice as we go through some of them that I have highlighted portions of the exhibits. The only reason for doing so -- and I freely admit that that was me that did so -- is to try to direct my eyesight so that I don't waste your time as I try to find what I'm looking for, but that's why some portions will

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be highlighted.
MR. FISHER: Gavin, can I interject for a second?
MR. ROSE: Of course.
MR. FISHER: To the extent that she needs full context for any of those documents, do you have an objection if she opens the full document that she received by e-mail?
MR. ROSE: Of course not.
Q Okay, Doctor, I'm going to pull up using the share-screen function what I have marked as Exhibit 1. And do you see that in front of you right now?
A Yes.
Q And I can scroll down if you need for me to; although, I can tell you that it's 14 pages long. I assume you recognize this as your curriculum vitae?
A Yes.
Q And this is the version that your attorneys provided to us just over the weekend. I assume that it's still current; is that correct?
A Yes, that's correct.
Q Okay. And you're currently employed, I understand?

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A Yes.
Q And it looks from your CV like you're employed as a consultant presently?
A That's right.
Q And that's for a business called DK Consulting?
A Yes.
Q And I assume the DK is you?
A Yes.
Q Are you the -- I'm sorry, I talked over you.
A That's okay. I just said it's not very original. No symbolism in that at all, yeah.
Q Are you the only employee of DK Consulting?
A I have an assistant, like an administrative assistant.
Q Okay. Is that the only other employee?
A Yes.
Q And has this been your only employment since 2019?
A Yes.
Q And by "since 2019," I mean since you retired from being a professor.
A That's right, yes.
Q Do you currently have any patient care responsibility?
A I'm in full-time private practice, so yeah.

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Q Is that through DK Consulting or just separate?
A No, no, that's through DK Consulting.
Q Okay. And I assume that you provide psychotherapy to your patients?
A Yes, I provide psychotherapy; I provide marriage and family therapy; I do child and adolescent assessments; and I do mediation and family dispute resolution.
Q When you do child and adolescent assessments, is that for anyone in particular?
A Well, in recent times, it's children being brought for gender dysphoria, so a large part of my practice currently are children and families with a young person who is declaring themselves transgender.
Q And when you say that you work full time in private practice, is that more or less 40 hours a week that you see patients?
A It's more like 60 hours a week.
Q And approximately what percentage of that would you say are for patients who have identified themselves as transgender?
A I'd say two-thirds, but they're not all patient contacts, the 60 hours, because I include preparing depositions for Indiana among the

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hours that I spend working. So, in my clinical hours, I would say at the moment two-thirds.
Q And, I'm sorry, that was just a bad question then. About how many hours each week are you working as a clinician?
A About 30.
Q Okay. So about 20 hours or so each week you're treating or assessing patients for gender dysphoria?
A Yes.
Q And are all the patients with gender dysphoria that you see minors?
A Yes, I specialize in minors.
Q I'll come back to your clinical practice in just a little bit. It looks from your CV like you served as a professor at the University of Sydney in various capacities from 1988 through 2019. Is that accurate?
A That is.
Q Your last position was as an honorary professor of psychology and a professor of music?
A Yes.
Q I'm just curious, but why music?
A Sorry?
Q I said I'm just curious, but why music?

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A Why music? It's a very long story and it's probably for another time, but I, you know --
Q Let me ask you this because I couldn't tell from your CV. Is it teaching music or is it teaching the psychology of music or performance anxiety or what have you?
A I established a research center at the Sydney Conservatorium of Music which is a faculty of the University of Sydney. So, when the Sydney Conservatorium of Music amalgamated with the university, it was a freestanding tertiary institution, and then there was a lot of legislative changes to reduce the number of tertiary institutions and the Sydney Conservatorium amalgamated with Sydney University and became a faculty, but we were a research-led university and it didn't have any research as a tertiary institution. It was primarily concerned with training young musicians.
And they were looking for somebody who had research expertise and who knew about music and how the university structures ran, applying for research grants, setting up a research laboratory, so the magic finger was pointed at

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me. And, for those years, I had two professorships that I had to juggle and get this search established. So I didn't do any undergraduate lecturing in that position. It was all as a director of research center and I was primarily supervising Ph.D. students but also doing a lot of research, applying for grants, writing papers, and so forth, yeah.
Q Thank you. In your role as a professor of psychology or I guess before that a lecturer in psychology, were there specific subjects that you taught?
A Yes, I was specifically hired for my expertise in developmental psychology and so I was primarily responsible for both the undergraduate and the postgraduate teaching in subjects like infant and child psychology, developmental psychology, developmental psychopathology. What else? Current issues in adolescent psychology, all those kinds of subjects, child and adolescent assessment.
Q Of the psychology courses that you taught, did any of them concern treating gender dysphoria or providing gender-affirmative care?
A There was no such thing when I started at the

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university and there were no courses anywhere in Australia because the incidence and prevalence of that condition was estimated to be minutely small and we, therefore, focused on the much more prevalent conditions that children present with in childhood. So it wasn't on the radar. Let me put it that way.
Q Did you teach any courses about that subject toward the end of your career with the University of Sydney?
A No. Towards the end of my career as a professor, I was primarily supervising Ph.D. students and executing research grants, conducting research, and generally organizing the research program that I've described before.
Q Have you taken any courses pertaining to gender dysphoria?
A Well, there aren't any formal courses even now that I'm aware of in Australia and I would have to vet them very carefully before I book any of those courses because Australia has unquestioningly, and without due thought and consideration, adopted what we call here as gender ideology and as soon as I see the contents of the description of gender ideology,

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I become, you know, quite twitchy and disturbed by the scientifically fallacious information that's being propagated, particularly in our entrance primary and secondary schools.

So I have engaged in a very detailed undertaking to educate myself based on my thorough training and many, many years of clinical experience developing my own model and my own clinical practice approach to these young people.

Q In the middle of your answer there you used the phrase "what we call here as gender ideology," and I'm just curious who "we" is in that sentence.

A Well, it's generally referred to in that way in the media and media who are somewhat less than supportive of things like gender-affirming care, for example, and all the new lexicon, the new terminology, you know, that's being propagated by the machinery of the trans advocates.

Q Okay. And I asked if you had taken any courses pertaining to gender dysphoria and maybe I didn't ask the question in the right way. Other than your personal investigation and review of the literature and certain materials, do you

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have any professional training specific to gender dysphoria or its treatment?

A As I explained, there are no such courses. People have just adopted practices from overseas. And, I mean, there are courses within courses, so, for example, in cultural studies there's a subcourse called gender and sexuality and within that course they would cover the discourses, the current discourses, but it's more in the area of sociology or critical studies. And my field is psychology so there's not really any intersection unless I choose to read some literature in that field, but there's no such discrete course as gender-affirming care.

Q Okay. During your time as a professor for, if I'm doing the math right, 30, 31 years, did you have patient care responsibilities at the same time?

A Yes, I had rights to private practice throughout my academic career.

Q And about how many hours each week were you seeing patients? And I'm sure --

A About 10.

Q Okay. And was that more or less consistent

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throughout your time teaching?

A Yeah. I mean, it varied according to, you know, circumstances, but, on average, I would say that would be about right.

Q So, prior to your time in private practice following your tenure with the University of Sydney, were any of the patients that you saw diagnosed with gender dysphoria?

A Do you mean when I was at the university?

Q Yes. I'm sorry.

A No. I only kind of became involved in about 2019 when a colleague of mine, who is an adolescent psychiatrist, called me and said a few psychiatrists are getting referrals of these young children who are gender dysphoric and wanting to transgender and none of them had very much experience with child and adolescent psychology or psychiatry. And he asked me if I would review a couple of cases that he had been referred and have a case conference, a peer consultation. And it was from that point that I started to take on cases myself and to really intensively educate myself about what was going on and what was happening in this field, so it's really been for the last coming into five years.

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Q And do you remember what time of the year in 2019 you left the University of Sydney?

A July.

Q So would it be after that time that you began looking into gender dysphoria?

A Yes.

Q Okay. And then it looks from your CV like from '86 through '87 you were a psychologist in private practice?

A Yes, I was.

Q During this time did you see or treat any patients with gender dysphoria?

A No. I might say that they didn't exist in Australia in 1986/'87.

Q Okay. Then I want to, if it's okay, just briefly focus on your clinical experience after you left the University of Sydney where you've been seeing patients and looking into gender dysphoria. Is that okay?

A Yeah.

Q Approximately how many patients with gender dysphoria or gender identity issues did you see over this period or have you seen over this period?

MR. FISHER: I'm going to object to the

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form of that question. It's unclear whether those are two separate categories or you're conflating them together?

MR. ROSE: That's a perfectly fair objection and if Tom had not called me, I would have rephrased it myself.

Q How many patients diagnosed with gender dysphoria have you seen since you left the University of Sydney, more or less?

A Well, it depends on whether you're talking about seeing them for assessment or seeing them for therapy. If I just counted the young people that I had seen for assessment, it would be in the vicinity of 150 to 180, and, of those, I would have taken probably 50 to 60 into long-term therapy.

Q And pretend I know almost nothing about the practice of psychology, but what is, I guess, the assessment? A patient gets referred to you from some source and what happens then when you're assessing them?

A Well, I always meet with the parents first and I get a full developmental history because there's a great deal of dispute about onset and I want to get a very clear picture from the parents

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about when their child first expressed ideas about being transgender and so forth. So I do a very careful historical overview of their developmental milestones. I also want to understand how they're performing at school. I also want to review any of the previous assessments that they've had for intellectual ability, any intellectual disabilities, learning disabilities, have they had an assessment for autism spectrum disorder, ADHD, have they ever been diagnosed with depression and anxiety, are they on any medications. So that is quite an extended interview with the parents.

And during that time I'm also assessing the marital and parental dynamic so I'm looking for power imbalances in the marital diet, I'm looking for whether there's a lack of respectful interactions between the parents, and I'm also looking for whether there's any disagreement about how they should proceed with their child. And quite often you'll see one parent who is more supportive of allowing the transition and another parent who is not approving. So all of these things are extremely important.

And then I will see the child on his or her

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own and that might go from one to three sessions depending on what I'm exploring with the child and what I think is happening in terms of this child's life.

After that assessment of the child, I meet again with the parents and I give them an overview of my opinion and how we should proceed or how I recommend that the family proceed.

Q Just a couple of questions about that.

MR. FISHER: Gavin, I'm sorry to interrupt you. I just want to alert you. Because you're sharing your screen, when people are sending you text messages they're popping up on my screen. I'm doing my best to ignore them and not look at them, but I noticed at least one of them was from Chase so I thought I'd better alert you because probably you don't want me to see those.

MR. ROSE: I appreciate that. Thank you. Can we go off the record for just a second?

(A discussion was held off the record.)

QUESTIONS BY GAVIN M. ROSE:

Q Okay. Doctor, you just explained the assessment process when you see a patient for the first time for gender dysphoria, and my question to you is going to be whether there is an age range

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of the children that you assess.

A I've seen children as young as three to four and I usually -- I have seen some young adults in their 20s, but the majority are under 18 years of age or around. You know, I've seen quite a few like 17, 18-year-olds.

Q Would you say the majority are in their adolescence?

A Yes, I would.

Q Approximately how many children preadolescence have you assessed for gender dysphoria?

A I think it would be less than a quarter of the presentations.

Q So, if I'm doing the math, maybe 30-ish?

A Yeah. I mean, it depends on whether you count the peripubertal children, you know, the 11 and 12-year-olds because some children are reaching puberty at younger than average ages. So a child might be pubertal at 10 and so it would be a question of whether you would count that child as a child or as an emerging adolescent, so it gets a little bit gray if you wanted to strictly categorize them. The majority, I would say, would be between 10 and 18.

Q Okay. And of the 150 to 180 patients you've

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assessed, how do you decide which ones will become the 50 or 60 that you accept for longer-term treatment?
A I make an assessment about whether the young person is capable of entering into a psychotherapeutic process. That's one criterion.
Another is whether it is more (inaudible) to work directly with the parents and, quite often, I will choose to do that in the first instance. So I will meet with the parents more regularly than the child and I will -- I suppose the word is coach, you know, coach them about parenting and how to manage, you know, the child's behavior generally and how to manage the statements or, you know, gender sort of related issues, so that's another way that I work.
And, in some cases, I'll work with the family, usually the young person and the parents together. In most cases I don't include siblings. If I do do family therapy, it's just with the identified child.
So I have a very broad perspective on the kinds of interventions that I undertake and they're based on very careful assessment of the

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dynamics of the family, the capacity to engage in particular psychotherapeutic processes, and that involves a capacity for insight and reflective function. And, you know, if not, I step it down to psychoeducation, behavioral management. But I do find that an open exploratory psychodynamic/psychotherapy approach is more effective if it's suitable for that young person and the family.
Q And you began that answering by saying that one of the things you look at in determining whether to accept a patient for longer-term treatment is whether they're capable of entering into the psychotherapeutic relationship or possibly the process. What type of patient is not capable of doing that?
A Well, you have to be very careful about young people with autism spectrum disorder. In the early days and even now, I did take some of those into individual therapy because they were extremely distressed young people. And, because of their cognitive rigidity, cognitive immaturity, their literal interpretation of the world, and some of them display quite obsessional features in both their behavior and

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their thinking, you come to a point where it does not seem to be the best intervention for that type of young person and so I seek other methods, usually primarily working intensively with the parents.
Q And when you assess a patient are you attempting to -- are they coming to you with a diagnosis or are you attempting to diagnose them?
A I'm not primarily focused -- I presume you're meaning a diagnosis of gender dysphoria?
Q Sure.
A Yeah. The parent will usually tell me in the first assessment interview what their child is saying and doing with respect to gender and what their demands are and expectations. When I see the child, I'll ask them why they've come to see me, what is their understanding of why they've visited with me today, and I usually take the assessment from that point. And you would be amazed at how many of them don't start with gender.
Q How many minor patients have you diagnosed with gender dysphoria, if any?
A I think one.
Q And how old was that patient?

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A Four.
Q And when you diagnosed that patient with gender dysphoria, what diagnostic criteria did you use?
A Well, I mean, the only acceptable one in current situation is DSM-5 that you will see from my declaration that I have great concerns about the DSM-5 as do a large number of my colleagues.
Q Are those the criteria that you used in diagnosing that one patient, though?
A I look at those criteria, but I primarily am concerned with the behavior of the child.
Q What, if any, criteria other than the DSM-5 did you consult in diagnosing that patient?
A I look at their general adaptation, whether they're meeting developmental milestones, whether they're capable of expressing an independent idea about themselves because quite often there are subtle communication dynamics happening between parents and children, and, you know, I mean, of course, the simplest one is that mother speaks for the child and that's why it's important to spend some time with the child alone. And, often, because I do a lot of work for the family court in Australia and for the Office of the Department of Public Prosecutions

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where there are allegations of child sexual abuse, they're really, really, you know, very damaging custody disputes and so on.

Q I'm sorry for interrupting, but I was going to ask: Did the tools or criteria that you used in addition to the DSM-5, do they come from any publication? Are they written down anywhere?

A Well, they come from the development psychology literature and also the literature on dynamic psychotherapy.

Q But there's no specific one page, two-page list of criteria that you can point me to for these?

A Well, I have been a coauthor of two clinical guides for the management of children with gender dysphoria. One of them was an international consortium that I contributed a very significant portion of that document. I've also contributed in a major way to the clinical guide published by the National Association of Practicing Psychiatrists, and I've also written some therapeutic treatment guides for clinicians that I've presented at meetings and conferences for consideration.

Q You described this one patient that you diagnosed with gender dysphoria. Were any of

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the other patients that you saw for gender dysphoria diagnosed with gender dysphoria by another professional?

A By and large, my practice involves what's called tertiary referral, so a lot of these young people come to me when the parents have been horrified by what's been going on in the gender clinics.

So one of the typical ways that it happens is that the child declares him or herself transgender. The mother takes the child to the general practitioner. That's the family treating doctor. The doctors will then refer these children to either gender-affirming (inaudible) pediatricians or to the gender clinics. And once you're on that, as the Swedish call it, the "trans train," there's almost only one stop and that's transition.

And, so, when the parents go to these establishments, they're actually excluded from the process. They're being made to wait outside. If the parent wants to contribute their perceptions of their child and their worries about their child and maybe transition isn't the right thing for them, they're taken

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off and told that they're the problem and to get out of the child's way. And, you know, as soon as this child starts the transition process, all of these serious psychological problems up to and including self harm and school refusal and, you know, the old standards of depression and anxiety, they're all going to magically disappear if you start pumping the child with puberty blockers and cross-sex hormones.

Q I'm sorry, Doctor.

A I'll finish my answer.

Q I'm sorry, Doctor. You've actually gone well beyond the question that I've asked so I'd like to turn back to the question that I asked which is: Other than the one patient that you diagnosed with gender dysphoria, had any of the other patients that you've seen for gender dysphoria been diagnosed with that condition by some other professional?

A Well, I was about to finish my answer when you cut me off. So the answer is yes and I'm telling you the root by which they've been diagnosed after maybe one half-hour session by the gender clinic.

Q And the reason I ask that question is I'm trying

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to hone down on, I guess, whether you believe that you have only had one patient with an accurate diagnosis of gender dysphoria or whether you believe you've had a number of patients with an accurate diagnosis of gender dysphoria.

A Well, I was attempting to answer that question in your previous question which is I am a tertiary referral source. So the parents who become horrified at what's going on at the gender clinics are the people who are most likely to come to see me so they're already convinced that the diagnosis of gender dysphoria is inaccurate and inappropriate for their child, and, so, that would be the patient group that I see. I'm not seeing the captured parents. They're staying at the gender clinics.

Q Okay. And, other than that one patient that you diagnosed with gender dysphoria, did you agree with the assessment of the parents that every other patient you saw for gender dysphoria had been inaccurately or inappropriately diagnosed with that condition?

A I don't make definitive statements of that kind until I've worked with the parents and with the

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child. It's an open question that has to be explored very carefully as well as all of the other comorbid presentations that the child usually presents with. I can tell you one thing for sure and that is I haven't seen a child without a comorbid presentation who comes telling me that they're gender dysphoric, so there's usually serious pathology in the child and the family.

Q Have any patients come to you with a diagnosis of gender dysphoria where your assessment and prolonged treatment, if it goes that way, confirms the diagnosis?

A I don't confirm the diagnosis.

Q Okay. You keep medical records for each of your patients; is that correct?

A Of course.

Q And on the medical records that you keep, do you have a list of diagnoses for which the patients have presented or been confirmed? Do you have a list of diagnoses for each patient?

A Yes.

Q And how many patients of the 50 or 60 that you've accepted into long-term treatment do your records reflect a diagnosis of gender dysphoria?

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A Zero.

Q And what about the one person that you diagnosed with gender dysphoria?

A I didn't make a definitive statement. I said it was likely a diagnosis that needed to be considered seriously, but because of the child's age and, you know, cognitive immaturity, I suggested that the parents engage in active watchful waiting for a significant period of time before taking any action.

Q And do you continue to see that patient?

A I see the parents. I don't see the patient at this point.

Q Have you ever seen a patient who was taking either puberty blockers or gender-affirming hormones?

A Yes.

Q And were those subsequently discontinued?

A No. Oh, well, I mean, one has to look at each case individually, but there's only a small number that I'm seeing who had already started that process and, to date, they have not discontinued and I'm not pressuring them to discontinue. You know, these young people on cross-sex hormones around 16, 17, 18, so I

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engage in an exploratory process with them, but, once they do start taking the cross-sex hormones, the landscape changes because these medications, of course, affect the total body and the way they think about themselves and their neurological as well as physical functioning.

Q And, please, correct me if I'm wrong because I might have just misheard a word. Did you say that you've only seen one patient taking hormones?

A No, I've seen three or four.

Q Okay. And were those three or four patients patients that you simply assessed or were they accepted into longer-term treatment?

A I have one in long-term treatment. I've been seeing him for two years, and when I started to see him he wasn't taking hormones. The others have turned 18 during their therapy and decided that they were going to proceed to cross-sex hormones. And, yeah, I don't know if that answers your question.

Q It does. Thank you. And I didn't ask it right the first time and I apologize for that, but same questions about puberty blockers. How many

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patients have you seen who are taking puberty blockers?

A Probably not many, two or three.

Q And, again, same question. Were those patients that you accepted into longer-term treatment?

A Well, I did attempt to, yes.

Q Attempt but did not ultimately?

A Well, when the decision was made, you know, that puberty blockers were the magic bullet, that kind of foreclosed any further discussion.

Q Why did it foreclose any further discussion?

A Well, they found the magic solution.

Q A short while ago in talking about the one patient who you diagnosed with at least likely gender dysphoria, you said that you told the parents to wait and evaluate for I think you said a considerable amount of time. Does that sound right?

A Yes.

Q How long do you consider to be a considerable amount of time?

A It varies with different patients, but I was very mindful if I communicated this to the parents that one of the only robust studies that looked at childhood onset of gender dysphoria

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and followed them for 20 years, 88% of them desisted by like adulthood and I think it was 60% identified as gay young men. And I communicated that developmental trajectory to the parents and said that they needed to exercise extreme caution in allowing the child to follow his natural developmental trajectory and that any social transition or prescription of puberty blockade would derail that developmental trajectory.

Q And, I'm sorry, how are you defining social transition?

A Where the child changes his or her names or pronouns. They start to dress in the stereotypically style of the opposite sex where they grow their hair long or cut their hair short, that kind of thing.

Q When you have a patient that presents to you as transgender, do you use particular pronouns in referring to that person?

A I avoid pronouns altogether because I'm having first person conversation with a young person and I do not use --

Q Well, you talk about the patient with their parents, though; right?

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A Not often, no. I usually separate the consultations with parents and children.

Q I'm so sorry for the misunderstanding, Doctor. I did not mean you talk about the patient with the parents in the same room. I meant you have a separate conversation with the parents about the patient; correct?

A Yes.

Q And when you're speaking to the parent do you use pronouns to refer to the child?

A I follow the parent and, in the majority of the cases that I see, the parent is insisting on the child's birth name and natal pronouns.

Q Are there cases where the parent has referred to their child using their non-natal pronouns?

A Yes, I had one last night and, I mean, it wasn't her first session. I've seen her before and she is now using her daughter's preferred name and masculine pronouns. And I have discussed that with her, you know, why is she doing that and how does she think it's helping her child, and I then seek permission from the parent to call the child by his or her given name and pronouns.

Q And I assume your medical records use the sex the child was assigned at birth when they have

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to?

A Yes. I need to do that for clinical purposes because I need to get a picture in my own mind, a template of this child, and quite often I have to do file reviews and case reviews and you will notice in my declaration that I have referred to these four young people using pronouns of their natal sex and their given name except in one case where the given name has been expunged completely, but that is my clinical practice.

Q Okay. Doctor, in your CV, which should still be in front of you, Page 2 lists your membership in various professional organizations; is that correct?

A Yeah.

Q And I assume you remain a member of each of the organizations you list here?

A No, I said that I -- well, in my CV, obviously, it doesn't say that, but somewhere I said, I think it was in the bio, you know, preceding this, I was a member or eligible for membership if I let the membership lapse and in some cases I have let the membership lapse because the fees are ridiculous and you have to be very selective.

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Q Okay. Of the professional societies you list on your CV, which of these societies or organizations do you remain a member?

A Only the Australian Psychological Society, but I have at one time or another been members -- oh, and the International Association of Relational Psychoanalytic Psychotherapy. Oh, and I'm a member of the Australian Dispute Resolution Association, yeah.

Q And when was the last time you were a member of the American -- or an international affiliate, it looks like, of the American Psychological Association?

A I let those go after I left the university.

Q So 2019 or so?

A Yeah.

Q Is that because the university was paying your membership dues?

A Oh, no. No, we have to pay our own membership dues.

Q Why did you let your membership lapse then?

A There's just so much available on the Internet now. It just wasn't value for money. I mean, the Australian Psychological Society, the fees are $1,000 a year and you just have to be

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selective.
Q And what does it mean to be an international affiliate of the American Psychological Association? I just don't know what that means.
A That means that if you're not American, you can't be a full member.
Q Gotcha. Other than the organizations that you list here on Page 2 of your CV, are you currently a member of any other professional organizations?
A Yes, I'm a council member of the University of Sydney Association of Professors and I'm a council member of the Australian Association of University Professors. I'm a member of the Society for Evidence-Based Gender Medicine.
Q And if I refer to that organization just as SEGM, S-E-G-M, you'll know what I mean?
A I will.
Q How did you become a member of SEGM?
A I was invited.
Q By whom?
A There were two founding directors and I think one of them is Australian and he put my name up to the American cofounder and they invited me together.

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Q And when did you first become a member?
A I'd say maybe three to four years ago.
Q Have you ever held a leadership position with the organization?
A No, I avoid administration and hierarchies and, you know, political positions like the plague. I'm a clinician, I'm a researcher, I'm a writer, and I don't have time for that and I'm not interested in that, yeah.
Q Have you ever been compensated by SEGM for any reason?
A Yes, I have been on one occasion.
Q I assume this was for giving a talk or presentation to a meeting?
A I wrote some extensive material for their clinical guide.
Q I'm sorry, I missed a word there. Wrote some what material?
A Extensively. I wrote some very long documents for them when we were putting together the clinical guide and it was an honorarium. I didn't ask for payment, but they appreciated the amount of time and effort that I devoted to that. And I was perfectly prepared to do it voluntarily so it was just a gesture rather than

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-- it wasn't a contract. It was an honorarium.
Q Does SEGM hold meetings or conferences?
A Yes.
Q How often?
A I believe about once a month there's a Zoom meeting and from time to time, you know, people get together in person but it's very difficult when you're in Australia. You have to be very selective where you travel.
Q Do you have to be invited to become a member?
A I believe so.
Q Are you aware that statements by SEGM have been cited in support of a formal opinion in Texas that took the position that the provision of certain gender-affirming care to a minor constitutes child abuse?
A Yes.
MR. FISHER: I was just gonna object. I wasn't sure what formal opinion. Could you maybe --
MR. ROSE: I can state for the record, Tom, but when Attorney General Paxton issued his formal opinion declaring the provision of certain care to be child abuse under Texas law he cited SEGM, I think, a couple times.

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MR. FISHER: Paxton did, okay. Thank you.
MR. ROSE: And I didn't see a point to bring that up and I apologize, bringing the actual document up.
Q And I guess my question to you, Doctor, is whether you believe that providing gender-affirming care to minors in the form of puberty blockers or hormones constitutes child abuse.
A I would prefer to avoid a motive language. I do believe it's very poor medicine to derail a child's natural developmental trajectory precipitously when the drugs that have been prescribed have known demonstrated (inaudible) to the human body.
Now, child abuse in this country, and I'm sure in yours, carries with it a legal definition and so I don't think it's helpful to use a motive language when trying to discuss the best treatment and management of young people who are declaring themselves gender dysphoric.
Q And, I'm sorry, Doctor, I would know the answer to this question if you were a psychologist in America. As a psychologist in Australia, are you authorized to prescribe medications?

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A No.
Q Are you a member of any advocacy or political organizations?
A No.
Q Have you been in the past?
A You mean advocacy for gender-affirming care?
Q I meant in general and we can narrow it down from there.
A No, I'm not a member of any political party. I'm not a member of any religious organization. I'm not a member of any gender or sexuality-based organization. I am a completely free agent.
Q Okay. My understanding is that you have testified before several legislatures and other decision-making bodies concerning transgender persons or the provision of gender-affirming care; correct?
A Well, only one formally in America and that was in Alabama.
Q And I'll do that one first. Do you mean that you played a role in the Alabama bill similar to Indiana's before that bill was passed?
A Yes.
Q You, I assume, submitted written comments

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advocating for it to be passed?
A The original bill, yes.
Q And have you testified before legislatures or other decision-making bodies in Australia about the issue?
A I have provided written and oral submission to the New South Whales Parliament and the Queensland Parliament and written submissions to the National Parliament in Canberra on various bills associated with gender.
Q Let me take those one at a time, I'm sorry, because I just don't understand how broad your answer was. For the parliament in New South Whales, was there more than one bill that you submitted comments on?
A Just scroll down so I can see and just remind myself.
Q I apologize.
A Just keep going. Keep going down to the submissions. Okay. Stop. The submission to the New South Whales Parliamentary Inquiry for the Education Legislation Amendment of Parental Rights, I had a written submission and appeared. I was invited to appear to the parliamentary inquiry. Then there was the submission and

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invited presentation to the Queensland government inquiry into the Health Legislation Bill in 2019 to outlaw conversion therapy. And the submission to the ACT -- that stands for Australian Capital Territory -- government into the proposed amendments to outlaw conversion therapy. And I believe I submitted a similar submission to the Victorian Parliament on conversion therapy as well and I've just neglected to put that in.
Q Okay. And other than -- maybe this would have been a better way to do this. Other than the possible submission to the Victorian Parliament, is every time you have testified or submitted written testimony to a decision-making body in Australia about gender-affirming care, is that contained on Page 6 of your CV here?
A Yes.
Q And the one to the Victorian Parliament was also on conversion therapy?
A Yeah.
Q Have you been compensated for your testimony to any of these bodies?
A Only Alabama and Indiana. The other have been all pro bono.

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Q And, by your compensation in Alabama and Indiana, you mean after a lawsuit was filed?
A I don't understand.
Q I'm sorry, Doctor. I'm trying to figure out whether you were paid for submitting testimony to the legislatures while a bill was being contemplated or whether you're just talking about being paid to serve as a witness after a bill was passed and challenged in court.
A I think they -- the Alabama and Indiana situations are similar, so, yeah, a bill was passed, now there's an appeal, and I have written a report. Tom will be able to explain that a lot better than me. I don't want to say the wrong thing.
MR. FISHER: I'm of no use to Gavin in any of this.
Q I understand. Thank you. Page 3 of your CV describes some of your activities for court-referred clients. Do you see that?
A Yeah.
Q And when did you assume these responsibilities?
A Oh, I've been doing that kind of work 10 to 15 years.
Q You mean you have over the past 15 years?

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A Yeah.
Q And I assume these are cases where a court in Australia, for one reason or another, wants a child to be evaluated; is that fair?
A Yes, and they can also be referred for court-mandated therapy.
Q In your responsibilities for court-referred clients, did any of the issues arising from that concern gender dysphoria?
A No, because the work that I've done for courts related to gender dysphoria have been written review and literature review and clinical practice documents, so these court-referred clients are usually to do with parental capacity, custody, time with, and, you know, any assessment that would make it necessary for the child or the family to enter into a therapeutic process.
Q Okay.
A I'll say no to that in terms of gender dysphoria. This work, more or less, preceded my work on gender issues.
Q Okay. And then Page 4 of your CV indicates that you also consult for the Tribunal of the Catholic Church; correct?

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A I have, yeah.
Q Is that something you currently do?
A The last case I did was probably about a year ago, maybe more, but I have been doing it for a very long time but I've kinda pulled back because I've just got too much work in other areas.
Q And, just very briefly, what did your consultancy for the church or does it entail when they refer something to you?
A Usually cases of marriage where one party is -- one or both parties is seeking an annulment of the marriage, and it's a very arcane system and it actually behaves very much like a court of law. There's a defender of the faith and a defender of the couple so it's quite adversarial, it can be, and, extraordinarily, the Catholic Church will sometimes find that there are no grounds for annulment. And usually people who go and seek annulments, they're devout Catholics and they wanted to remarry in the Catholic Church, but they can't remarry in the Catholic Church. They can only have a civil marriage unless their previous marriage has been annulled, and so they're the people who seek

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annulments.
So I do a marriage assessment and I see the couple and, you know, I do all the normal things that I would normally do as a psychological assessment of these couples to assist them and support them in -- you know, it's usually a very fraught and stressful time for these couples.
Q Okay. And then I'm going to scroll through this real quick. And, I'm sorry, Doctor, did you say that you have a copy of your CV in front of you?
A No, I don't, no.
Q Okay. Then I will scroll through real quick. I'm going to scroll through Pages 5 through 8 of your CV real quick, and my question to you is going to be whether this, as it purports to, the articles, reports, presentations that you have given specifically concerning gender dysphoria-related issues is going to be my question. Spoiler alert.
Look through to the bottom there. Is that an accurate description of what you identify in Pages 5 through 8?
A Yeah, pretty much.
Q Okay. The very last entry under that subheading related to gender dysphoria appears to be a

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radio interview that you gave in 2015. Do you see that?
A Yes.
Q I've read the transcript to this interview. It's my assumption it was mistakenly placed here, but I will just ask you. Did this interview specifically concern gender dysphoria or any issues related to it?
A I'm sorry about that. Let me just turn my phone off. It is misplaced, I'm afraid to say, because the date of 2015 is prior to my work in the gender dysphoria area, so I apologize for that error.
Q That was my assumption. I just wanted to make sure the record reflected that. And if that's the only error you make in a 14-page CV, you have done quite well for yourself.
Okay. The date you've given for when you started focusing on gender-related issues of 2019 you've indicated, more or less, coincides with when you left the University of Sydney. I'm wondering, first and foremost, why you left the University of Sydney.
A Well, after 31 years, I'd had enough and I was wanting to get back into clinical work and the

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tertiary system in this country is somewhat less than conducive to genuine academic work. It's just turned into a corporate bazaar and I no longer felt the affinity that I've always felt for academic life and my academic institution in particular, but it was time for a change.

I wanted to work clinically and I wanted to be free to express my firmly-held positions on certain topics. And you, no doubt, are very aware that there have been several academics around the world who have been sacked from the universities for expressing a contrary view, but that didn't motivate me. I have to be very clear about that because I hadn't really written or published anything or even formed my opinions firmly in 2019, but I did note with interest how other academics were being treated around the world if they dared to express a contrary view and I wouldn't find that acceptable.

Q Was there anything specific at the University of Sydney that indicated to you you would not be allowed to express your opinions related to gender dysphoria?

A Oh, absolutely. You just had to look at the new policies and, you know, colleagues using -- you

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know, you can see our names up here on the Zoom and suddenly putting in preferred pronouns and there were all sorts of indications that, you know, the opinions were only going one way and there was no room for academic debate, but I do stress that that was not a motivator for me personally.

Q Okay. I'm going to scroll back up to Page 5 of your CV. Toward the bottom of the page is an article with the lead author R. D'Angelo that you coauthored titled One Size Does Not Fit All. Do you see that?

A Yeah.

Q Other than this publication, have any of your writings concerning gender dysphoria or its treatment been published in any peer-reviewed journals?

A No, not at this point.

Q But this D'Angelo article was published in a peer-reviewed journal?

A Yes, it was.

Q And it's my understanding from looking at the article that it's a direct response to an article that had been published by Jack Turban and others?

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A Correct.

Q Pages 7 through 8 of your CV identify keynote and invited presentations and podcasts that you have given pertaining to gender dysphoria. Do you see that?

A Yes.

Q Is this a complete list of the presentations that you have given concerning gender dysphoria?

A Look, it might not be complete. I, you know, was under extreme time pressure to get all the materials prepared for this deposition and I did focus very much on the content, you know, reviewing the literature, writing, and then I had to focus an enormous amount of attention on doing the case file reviews of the four plaintiffs so it may not be an exhaustive list.

Q Is it fair to say that you intended it as an exhaustive list but there might have been some presentations that simply slipped your mind as you were preparing this?

A Quite possibly, yes.

Q Are there any presentations that you intentionally left off?

A No.

Q Okay. First of all, we've been going for about

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an hour and a half. Are you still good to go for a while?

A Yes, I'm fine.

MR. ROSE: Please, if anyone needs a break, feel free to speak up, but, as I say, I'm more than happy to keep talking as long as anyone will let me.

THE WITNESS: I just wonder if I could have a one-minute adjournment. I'll be back in one minute.

MR. ROSE: That's perfectly fine.

(A recess was taken.)

DIRECT EXAMINATION CONTINUING,
QUESTIONS BY GAVIN M. ROSE:

Q My understanding is that you have been retained by the State of Indiana to offer expert testimony in this case. Is that your understanding as well?

A Yes.

Q And you understand that this litigation generally challenges a complete ban on providing certain gender-affirming care to minors diagnosed with gender dysphoria?

A Yes.

Q In order to become involved in this case, did

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you reach out to Indiana or did Indiana or its attorneys contact you?
A The latter.
Q And you're being compensated at an hourly rate of $400 U.S.?
A Yes.
Q Do you know approximately how many hours you've devoted to this case so far?
A I've kept a running total, but it's well over 100. Well over, yeah.
Q How does the hourly rate of $400 compare with the rate that you charge to clients for psychotherapy?
A It's extremely generous.
Q What is your hourly rate to provide psychotherapy?
A I work on a sliding scale so people who are in financial hardship I work for what's called the Medicare rebate, which is the amount that is covered by the nationalized healthcare cover in Australia, and for people who own planes, boats, and tennis courts I charge about, depending, 250.
Q I'm sorry, did you say 350? 250?
A 250. And that's a lot less in American dollars

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because our Australian dollar is only worth about $.68 to your dollar at the moment.
Q And that's what I was going to ask. That's in Australian dollars?
A Yeah. Yeah.
Q Okay. At the outset of this deposition you indicated that you had your expert declaration in front of you?
A Yes.
Q Is that still the case?
A Yes, it is.
Q Okay. I'm going to share my screen just very quickly right now and pull up what I marked as Exhibit 2. And I assume that you recognize this as the expert declaration you have submitted?
A Yes.
Q And I will tell you at the outset that I did not include any of the attachments that your attorneys provided to us. If it's okay with you, I am going to stop the share of this and both you and I can reference our hard copies and I assume that will be much quicker than me scrolling up and down through this. Is that okay?
A That's okay.

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Q Okay. Did you draft your declaration yourself?
A Yes.
Q Did anyone other than you draft any portion of it?
A No.
Q Did anyone other than Indiana's attorneys review or comment on it before you finalized it?
A No.
Q Have you conferred with any other professionals about this litigation?
A No.
Q Are you familiar with -- and by familiar, I just mean do you know who they are. Are you familiar with the other individuals that Indiana has designated as expert witnesses in this case?
A No, I don't think I am. I haven't been specifically advised, no.
Q And my only question to you is whether you have conferred with any of them about this case.
A No.
Q Okay. I'm pulling up just very quickly what I have marked as Exhibit 3. Do you see that?
A Yes.
Q Have you seen this document before?
A Yes.

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Q It's my understanding that this is a summary prepared either by Indiana's attorneys or by you in conjunction with Indiana's attorneys indicating which medical records you have attached to your declarations as Exhibits B, C, D, and E. Is that correct?
A Yes.
Q Since leaving the University of Sydney, are there any conditions or diagnoses other than gender dysphoria that you consider yourself specialized and emphasize your practice in?
A I'm best known for developmental and educational psychology type diagnoses, but I also have an international reputation in the treatment of music performance anxiety and I have many peer-reviewed international publications and have developed a completely new theory about music performance anxiety so that would be an expertise I'm well known for.
The other well-known area is the area of sexual offending and I've written extensively on child sexual abuse and juvenile sex offending.
So they would be kind of super specialties that I have, but, in general, in the field of developmental and educational psychology.

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Q Okay. You indicate in your expert report -- and I don't think you have to look at it, but I think it's Paragraph 9 -- that you have become a tertiary referral source and you mentioned that here as well.
A Yeah.
Q What does that mean, becoming a tertiary referral source?
A Well, it means people have gone through other steps before they get to me.
Q Okay. And are there particular persons or entities from whom you receive a significant number of referrals?
A I get most of my referrals directly from parents who have spoken with each other. There are some parent support organizations who will recommend parents to me and so they'll come through that route as well.
Q Okay. In your declaration you indicate that you are one of only a few clinicians practicing exploratory psychotherapy with persons with gender dysphoria because of so-called conversion therapy bans that have been passed in some Australian states. I assume you're familiar with that.

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A Yes.
Q What Australian states have passed a ban on conversion therapy?
A Queensland, Victoria, the ACT, and I think one in Tasmania is about to go through. And, yeah, I think that they're the four, yeah.
Q And I assume you've reviewed the laws that were being proposed and then passed in these states?
A Yes.
Q Are they all, I guess, functionally identical, for lack of a better word?
A Yeah. Yeah, I would say.
Q I'm going to pull up what I have marked as Exhibit 4. Do you see that document in front of you?
A Yes, but I can't read it.
Q That's perfectly fair. I will represent to you that the, I guess, fifth page of the PDF, which has an internal pagination No. 1, says "The Parliament of Victoria enacts:" And I'm just wondering if you recognize this as Victoria's ban on conversion therapy.
A Yes, I recognize it, yes.
Q And my assumption is that you, yourself, practice in New South Whales?

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A That's right, yes.
Q Is there a conversion therapy ban that has been enacted in New South Whales?
A Not a legal ban, but there's a huge amount of pressure against therapists who are not practicing gender-affirming care.
Q And, I'm sorry, I just didn't understand from your declaration. Are you saying that the psychotherapy that you perform to patients with gender dysphoria would be illegal if you did the same thing in Queensland, Victoria, or the ACT?
A Yes.
Q My understanding is that Australia is at least considering a nationwide ban. Is that your understanding?
A Yes, that's my understanding.
Q Has it been passed yet?
A No.
Q Okay. In Paragraph 10 of your declaration you indicate that you're unable to list the Australian cases in which you've testified as an expert because of laws protecting the identity of minors; correct?
A Yeah.
Q But there have been approximately 100 of those

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cases?
A That includes my child sexual abuse cases. They're not all related to gender dysphoria. And it also includes the family court cases and the children's court cases. They involve custody disputes but not related to gender dysphoria.
Q And that was going to be my question is we looked at the court-referred clients portion of your CV. Is that what those 100 cases refer to?
A No, no, no. That's post the court process, the court referred. These are assessments for or expert witness regarding the actual call of matter.
Q Of those 100 cases, approximately how many concern gender dysphoria or related issues?
A Oh, I think only about three.
Q And I assume those were in the last few years?
A Yeah.
Q And then the one American case you identify is the case challenging a ban similar to ours in Alabama?
A Yes.
Q And you identify the case as Bowman, but I assume, if you know, it's the same case that I

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know as Eknes-Tucker?
A I'll take your word for that.
Q Okay. Doctor, I am ready to move into slightly more substantive matters. Thank you for your patience as I went through that.
I want to be perfectly clear from the outset. Do you consider gender dysphoria to be a valid medical diagnosis?
A No.
Q Are there any circumstances under which you believe a patient may accurately be diagnosed with gender dysphoria?
A Let me put it this way. I think there is a phenomenon that one could describe as gender dysphoria, but the diagnostic process is what I'm referring to as lacking validity. So, in answer to your first question -- could you just repeat your first question about gender dysphoria?
Q My first question was whether you consider gender dysphoria to be a valid diagnosis.
A Diagnosis, no. I have major diagnostic concerns with the way in which gender dysphoria is being diagnosed, but I'm not challenging the existence of a phenomenon, a clinical phenomenon, that can

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be described as gender dysphoria.
Q What does that mean, a clinical phenomenon?
A Well, you know, if a patient comes to you and says, "Look, I've got very low mood, I'm not sleeping, I've lost my appetite, I've got no motivation," you'll say, "Well, you know, that sounds like a depressive process," and I need to explore that further with the patient.
Similarly, with gender dysphoria, you know, children will come with their narrative about I've always wanted to be a boy and I've always wanted to play with boy things and, in the extreme cases, they want to cut off their sexual organs and so forth. So, of course, one has to be alert to the possibility that there is a clinical process in which the child is uncomfortable in his or her own body and that needs to be explored.
Q Do you believe that there are any circumstances under which a child who presents with that clinical phenomenon should be allowed to receive puberty blockers or gender-affirming hormones?
A Under almost no circumstances would I think that is a valid approach to take.
Q You qualify that with "almost no." What are the

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circumstances where you think that might be a valid approach?
A Well, if you look at the historical literature and, you know, the amount of writing that occurred, you know, pre sort of 2005 to '10, this was a vanishingly rare diagnosis, vanishingly rare. For example, some of the population figures given for the prevalence of gender dysphoria pre the common era of gender dysphoria, let's put it that way, Sweden was reporting one in one million. The DSM-5 reported 1 in 27,000 females and one in 10,000 males. So, you know, these figures are extremely low so I'm not going to be absolutist and say there is no circumstance under which it's not an appropriate diagnosis, but the degree to which it's being diagnosed today is of great clinical concern.
Q And, Doctor, my question was: How would a child have to present to you for you to believe it to be appropriate for that child to receive puberty blockers or gender-affirming hormones or is that just off the table entirely?
A It's very close to being off the table.
Q How about for adults? Do you think adults

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should have the ability to receive gender-affirming hormones or even gender-affirming surgery?
A Under very special circumstances. Under the original treatment protocol for an adult seeking transgender surgery was that they had to live in their chosen sex for two years and undergo intensive psychotherapy before they would be cleared for surgery. None of those safeguards are in place for young people.
Q If they were in place, would you believe it would be appropriate for them to receive this sort of gender-affirming care?
A In vanishingly rare cases.
Q And can you imagine a child who presents who has consistently over a number of years presented as a sex different than the birth sex who has been in therapy for years and who is presenting with no comorbidities and a certain level of distress, can you imagine yourself thinking it appropriate for that person to receive gender-affirming medications?
A I don't think such a person exists.
Q Okay. I want to turn, at long last, to social contagion and your description of social

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contagion. My understanding is that you separate your declaration into two chapters; correct?
A Yes.
Q And will you flip to Paragraph 21 of your declaration on Page 11?
A Okay. So I'm going to have to change glasses frequently when I'm looking at my declaration. So you said 21?
Q 21.
A Alright.
Q Are you there?
A Yes.
Q You don't have to do so out loud, but will you read Paragraph 21 to yourself real quick?
A Yeah, I've read it.
Q Okay. We'll get to the specifics momentarily, but my first question is if this paragraph provides a fair summary of the conclusion that you offer in the first chapter of your declaration.
A Yes.
Q You use the language "social contagion may have a major role" to play, and I'm curious about your use of the word "may" in that sentence.

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A Well, I'm not absolutist or prescriptionist because I am not omnipotent and my paper is based on very careful analysis and inference. And the reason that it is based on analysis and inference is that there has been no empirically-driven epidemiological study to test my hypotheses and that's why I say "may."
Q And you're familiar, I assume, with an article and ultimately a correction to that article that was published by Dr. Lisa Littman who was then with Brown University?
A Uh-huh.
Q I'm sorry. Yes?
A Yes.
Q And you're aware, I assume, that she describes her work as "generating hypotheses, not conclusions"?
A Yes.
Q And you just used that word, too. Is it fair to say that you are describing to us a hypothesis?
A Yes, it is fair to say that, but some hypotheses are more robust than others and I believe this to be a very robust hypothesis.
Q Will you turn to Paragraph 108 of your declaration?

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A Did you say 108?
Q 108 on Page 55.
A Yes.
Q Are you there?
A Yes, I am.
Q And in that paragraph you describe a "core group of 'actual' cases," I assume of gender dysphoria. Do you see that?
A Yes.
Q And by "core group of 'actual' cases," you meant actual cases of gender dysphoria?
A Yes.
Q And it appears to me that you're indicating in this paragraph that social contagion may affect some "actual cases" of gender dysphoria but may also affect some other, I assume, nonactual cases. Is that a fair statement?
A Yes, that's a fair statement.
Q And how does the social contagion affect the actual cases?
A Well, it's the disinhibition effect that if -- you see, I'm trying to cover all my bases here because all of the literature that I've read, all the epidemiological literature available on gender dysphoria, will identify a case. It

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might be 1 in 84,000. It might be 1 in 1 million. It might be 1 in "twenty-two hundred and fourteen thousand." There's data predating 2010 that shows, you know, very consistently that there are cases but they're vanishingly rare. It wouldn't even qualify for -- well, an orphan diagnosis qualifies because --
Q Let me stop you there because I think you've gone well beyond the --
MR. FISHER: Gavin, let her finish the answer, please. You keep doing this. You gotta let her answer. She's trying to provide you an answer.
MR. ROSE: I think she keeps stepping well beyond my questions, Tom.
A I'm sorry. I'll be very specific. It's okay. It's okay. The answer is: Yes, there are some actual cases. We don't know how many. And of those actual cases, the current (inaudible) of transgender affirming everything would help that vanishingly rare case who had not yet enacted or done anything about their genuine gender dysphoria to come forward for treatment.
Q And I think you referred to that at the outset as a disinhibition effect. Is that fair?

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A Yeah. Yeah.
Q It might make some people just feel more comfortable coming forward?
A Yes.
Q Okay. I want to make sure I understand generally now what types of things might serve as the social contagion you described as capable of causing persons to mistakenly identify as transgender. You describe, first and foremost, influences from peers, celebrities, social media. Is that a fair statement?
A Yeah. It obviously goes way beyond that, but, yes, they are factors that are included.
Q And I guess my question is: If a celebrity or other influential person does nothing more than openly identify themselves as being transgender, is that something that you think can have this social contagion effect?
A Yes.
Q There does not need to be any attempt at overt coercion of any sort?
A No.
Q What if a public library or a school library chooses to either carry or display books pertaining to gender-related issues, is that

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something that can have a social contagion effect?
A Absolutely. Particularly as they're universally full of misinformation.
Q What if a person is simply subjected to a book with a transgender protagonist, can that have a social contagion effect?
A Yes, it can. The Internet site Anime was recently boasting that it now had 279 characters that were known cisgender.
Q Do you know how many cisgender characters it has?
A Half a dozen.
Q And the Internet site Anime, is that anime.com?
A I presume.
Q You know throughout your declaration that in recent years there have been significant increases in persons identifying as transgender or in seeking care from gender clinics. I assume you agree that's a fair summary?
A Yeah.
Q I assume you agree that there are other factors in addition to social contagion that might also cause an increase in persons identifying as transgender?

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A Well, you have to go back to my paragraph that tries to explain the statistical complexity. I would argue that what explains the exponential increase in young people presenting as transgender is primarily accounted for by the phenomena of social contagion.
Q And I understand that and you used the word "primarily." I'm just wondering what other factors might also account for that.
A Well, the other factors I see as secondary factors. So gender dysphoria has become a vehicle for young people who are very distressed about themselves in some way that something has gone wrong with their development, so they're unhappy, they're discontent, they don't have a peer group, they're lonely, they may be in conflict with their parents, they may have and they will have significant comorbid conditions. So gender dysphoria has become, you know, the overarching umbrella on which disturbed young people are hanging their hats, so to speak, because they get such a receptive response to declaring themselves transgender, whereas if they said, oh, I'm depressed or I'm anxious, well, that's very garden variety and it doesn't

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get above the threshold of concern, whereas young people presenting with gender dysphoria have this whole machine around them now. It really gets their parents' attention. It really gets them noticed and, you know, managed and so forth. So these are secondary things.
But, I mean, I have parents coming to me who show me thousands of text messages that their child had received from groomers and predators on the Internet trying to convince young people to transition. You're really trans. If you say this about yourself, it means that you're really trans. And some of them have gone to the point of actually sending minors cross-sex hormones through the Internet as a gift to the young person.
Q Do you believe that better understanding of gender dysphoria has played any role in the increase in the number of persons identifying as transgender?
A I don't think there's any better understanding that I've noticed in the last 10 years.
Q Do you think increases in the availability of treatment have led more persons to come forward as transgender?

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A Absolutely, but in a socially contagious way.
Q Are you aware of studies indicating that more persons will seek care for a condition when that condition becomes destigmatized?
A You know, the destigmatized argument has a small amount of merit, but it can't possibly account for the numbers and the trajectories on graphs that we're seeing with gender dysphoria.
Q Are you familiar with a body of professional literature specifically concerning increased numbers in patients seeking treatment for HIV as the condition became destigmatized?
A Sure.
Q And you agree that there were significant increases in persons seeking treatment for that condition?
A Yes, because they had a diagnosable medical condition that could be treated with scientifically evidence-based medications.
Q In your opinion, can social contagion work the other way around if someone is subjected to messages that being transgender is wrong or simply does not have access to any books with a transgender protagonist? Can that cause a transgender person to remain in the closet, so

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to speak?
A There is absolutely no evidence for that assertion one way or the other, but if you want me to give an educated guess, it's possible but it would be extremely unusual.
Q In the report that you submitted in the Alabama case -- and I didn't print it out or pull it up for you -- you noted that the "ominous trend" whereby more persons are identifying as transgender has "rarely been systematically studied" either theoretically or empirically. I understand you might not recall the precise verbiage, but do you recall expressing sentiments similar to that?
A Yes.
Q And I assume that's still an accurate statement of your beliefs?
A Well, it's not my beliefs. It's an empirical fact.
Q Are you aware of any peer-reviewed studies at all that attempted to systematically study whether social contagion has led to increases in transgender identification?
A Did you use the word "peer-reviewed" or -- what was the wording exactly?

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Q Sorry, I will repeat the question. Are you aware of any peer-reviewed studies at all that attempted to systematically study whether social contagion has led to increases in transgender identification?
A Well, Jack Turban actually claims that he's systematically and emphatically disconfirmed social contagion, but, given that I only deal with robust scientific literature that uses a scientific method, I will say no because his study does not fall into that category.
Q Are you aware of any peer-reviewed studies at all that attempted to determine what proportion of the increase in transgender identification over recent years can be attributed to social contagion?
A I have stated at the outlet that my conclusions are inferential and deductional. I looked at social contagions in a range of other adolescent psychopathologies and the same mechanisms and the same dynamics and the same upward swings in prevalence have occurred in at least six adolescent psychopathologies that have been systematically studied. Now, there's no will to systematically study social contagion and gender

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dysphoria and the reason for that is that it will disprove the basic tenant of gender ideology.
Q Doctor, I'm sorry to cut you off. I don't mind that you're trying to explain your answer, but the question I asked you first was a yes or no question. We do need to make sure the record is complete and clear so I do want to make sure I get a yes or no to the question about whether you're aware of any peer-review studies that attempted to determine what proportion of the increase in transgender identification can be attributed to social contagion.
A I've already answered that question and then I tried to qualify it and was unable to finish my answer.
Q Is it fair to say that there are no peer-reviewed studies that attempt to determine what proportion of the increase in transgender identification over recent years can be attributed to social contagion?
A Yep.
Q I'm sorry. Did you say yes or no?
A I said yep.
Q Is that a yes?

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A Yes, it's a yes.
Q Okay. I'm going to pull up for you real quick what I have marked as Exhibit 5. And do you see that in front of you?
A Yes.
Q Beginning in -- and you can go there if you want, but in Paragraph 81 of your declaration you describe an article that was written by Dr. Littman who we mentioned.
A Yes.
Q And I understand that there was ultimately a correction to that article, but you recognize what I have in front of you as the original article that Dr. Littman authored?
A Yes.
Q And both you and Dr. Littman discuss "rapid-onset gender dysphoria"; correct?
A Yes.
Q Prior to Dr. Littman's article in 2018, are you aware of any professional literature that used that term?
A No.
Q Is rapid-onset gender dysphoria a diagnosis listed in the DSM-5 or its text revision?
A No.

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Q Is it identified in the International Classification of Diseases, ICD-9?
A No.
Q Is there an objective measure that you or Dr. Littman are using to determine when or weather the onset of gender dysphoria is "rapid"?
A It's adolescent onset as opposed to early childhood onset.
Q And that was going to be my question. Is the term saying anything other than that a person first identified themselves as transgender during their adolescency rather than earlier?
A Well, it's the timing but also the rapidity of the onset so it becomes manifest in a very short period of time during adolescence.
Q Do you have a way of distinguishing between someone with "rapid-onset gender dysphoria" and someone who had dysphoria for a longer period of time but simply delayed in coming out through pressures or family dynamics or what have you?
A That would be very unusual, but the way that I assess it is through very detailed clinical interview.
Q Do you have any patients that you've diagnosed

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with rapid-onset gender dysphoria?
A Well, I don't tend to be beholden to diagnoses, but the majority of my caseload would, if you wanted to use that term, would fit into that categorization.
Q Okay. It's my understanding that for her study Dr. Littman posted a survey on three different websites where parents had reported sudden or rapid onsets of gender dysphoria in their children; is that correct?
A That's my understanding, yes.
Q And then I understand they were subsequently reposted to a fourth website, a Facebook group?
A Uh-huh.
Q Sorry. Yes?
A Yes.
Q And of the three websites that Dr. Littman originally posted the survey, are you aware that they have all taken a position on the provision of gender-affirming care to transgender youth?
A The parents?
Q The websites.
A Oh. No, I don't think I was completely clear about that.
Q Do you have an understanding that all three of

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those sites have taken a position that was "unsupportive" of gender transition?
MR. FISHER: I'm going to object. I'm not sure that the meaning of that is clear or where it's coming from.
MR. ROSE: Why don't I get an answer first and then I can explain, if that's okay.
Q Do you need me to repeat the question, Doctor?
A Yes.
Q Do you agree that all three of the sites on which Dr. Littman posted the survey have taken a position that is "unsupportive of [gender] transition"?
MR. FISHER: Same objection. You may answer.
A Okay. Concerned and questioning.
Q Would it surprise you to know that in her notice of correction to this article Dr. Littman characterized all three of these websites as being "unsupportive of [gender] transition"?
A Look, I probably read it, but I've been reading hundreds of papers since then and details will sometimes escape one's attention.
MR. ROSE: And, just for the record since I'm speaking instead of writing, the "gender"

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there is in brackets. The quote is "unsupportive of transition" and the "gender" is taken from context.
Q One of the websites that Dr. Littman indicates the survey was posted to is called Youth Trans Critical Professionals. Are you familiar with that website?
A Yes.
Q Have you ever visited it?
A I tend not to spend a lot of time visiting websites.
Q Have you ever visited it?
A I've clicked to it.
Q The reason I ask is that if you go right now, you pick up a language saying that the website is now private and it cannot be accessed, and I'm wondering if you were aware of that.
A No.
Q Okay. And you understand that Dr. Littman directed her survey toward the parents of transgender youth, not the youth themselves; right?
A Yes.
Q When you provide psychotherapy to one of your patients, are there any circumstances at all

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where you would rely exclusively on a parent's report about what was going on with their child?
A No, I do what's called triangulation and I include in my case formulation information from every possible source that is available to me.
Q And one of those sources is obviously speaking with the child themselves; correct?
A Of course.
Q And I assume in speaking with the child you would want to know not just what they're going through but also if there were any reasons that their parents would not be aware of what they're going through; is that fair?
MR. FISHER: I'm going to object. I'm not sure what is meant by "what they're not going through."
THE WITNESS: Yeah, I know. Thank you.
Q Do you understand the question, Doctor?
A I think you'll have to reword it.
Q Let me just ask this more generally. In your field of psychotherapy, I assume that self-reporting provides a useful and sometimes vital source of information; is that fair?
A Yes.
Q Okay. And you're aware, I assume, that the year

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after Dr. Littman first published her article she published a corrected version of the same article along with a notice of correction?
A There was a (inaudible) after the publication of her article and it was taken down after it had already gone through a rigorous peer-review process, so, to please the naysayers, a couple of sentences were added and so I wouldn't call it a substantive correction. The data remained unchanged and the conclusions remained unchanged.
Q Okay. But there was a corrected version published; correct?
A Well, there was a slightly altered version published.
Q And at the same time of that publication there was also a separate notice of correction explaining the reasons for the revision that was published in the same journal?
A Yes.
Q I'm going to click over to Exhibit 6. Do you see that in front of you?
A Yes.
Q And you recognize this, I assume, as the notice of correction?

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A Yes.
Q In this notice, Dr. Littman says that "This report ... does not validate the phenomenon," and it appears from context that the phenomenon is rapid-onset gender dysphoria. Do you see that in the middle of the --
A Yeah. Yeah.
Q Do you agree that Dr. Littman's study does not validate of phenomenon of rapid-onset gender dysphoria?
A Absolutely. It was a very preliminary early notice of something interesting, and all new discoveries are made through noticing changes in patterns in the environment and that can lead to all sorts of astounding new discoveries. So it would be foolish, and nor did she do so, claiming that this study proved anything other than the report of this group of parents.
Q Okay. Do you know Dr. Littman personally?
A No.
Q Okay. And I'm going to click over to Exhibit 7. And do you see that in front of you?
A I do.
Q A short while ago, you mentioned a study by Dr. Turban and others that sounded like you took

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issues with, and am I correct that this is that study?
A Yes, it is.
Q This was published in a journal called Pediatrics?
A Yeah.
Q And that's a peer-reviewed journal; correct?
A Let's just say they have a peer-review process that has been degraded in recent times.
Q Has the process itself changed to your knowledge?
A No, the process is still the same.
Q If it had not been for the article's publication of Dr. Turban's article or others like it, would you believe that the peer-review process of Pediatrics had been degraded in recent years?
A I would have to judge that article by article, but it's astounding to me that some of the papers that I see published on the subject have actually got through a peer-review process if it was truly anonymized and objective.
Q I understand that you might take issue with some of the data or the source of the data, but you understand that Dr. Turban and others analyzed data from several states that was collected by

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the Centers for Disease Control and Prevention; correct?
A That one, I believe from memory, is from the Youth Risk Behavior Survey.
MR. ROSE: Okay. Doctor, if you don't mind, my bladder is desperately requesting that I call a break. I'm okay with just five minutes. If anyone needs a longer break, I'm more than happy with that, too.
THE WITNESS: Five minutes is fine with me.
(A recess was taken.)
DIRECT EXAMINATION CONTINUING,
QUESTIONS BY GAVIN M. ROSE:
Q Doctor, do you still have your declaration in front of you?
A Yes, I do.
Q I will have you turn to Paragraph 85 on Page 41 if you don't mind.
A Yeah.
Q In this paragraph, you mention an August 2021 statement by the Coalition for Advancement & Application of Psychological Services or CAAPS calling for the elimination of the use of rapid-onset gender dysphoria; correct?
A Yes.

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Q It's my understanding that CAAPS, with two As to our court reporter, is a nonprofit coalition of various professional organizations involved in the science of mental health. Is that a fair summary?
A I guess so, yes.
Q Well, I took it directly from their website, so I hope it is. Okay. I am going to show you what I've marked as Exhibit 8. Do you see that in front of you?
A Yes.
Q And you, I assume, recognize this as the statement to which you were referring in Paragraph 85 of your declaration?
A That's right, yes.
Q And you understand, I assume, that numerous other -- I won't count them, but numerous other organizations also signed on to the statement?
A Yes.
Q Including both the American Psychological Association and the American Psychiatric Association, I think?
A Yes.
Q I'm looking, I guess, generally at Paragraph 87 of your declaration. I don't know, Doctor, if

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you will need to look at it for this series of questions, but I certainly invite you to if it would be useful to you. In this paragraph --
A Sorry for interrupting. It's very hard. I've got a visual impairment and it's very hard for me to go from screen to page, back and forward, and I'm just wondering if you would be able to quickly put that up on the screen for me.
Q I can certainly do that. I can't promise it will be quickly, but I can certainly do that.
A Okay.
Q Do you see that in front of you?
A Yeah.
Q It's Paragraph 87 of your declaration; correct?
A Yes.
Q And I'm not going to get into precise numbers, but it sounds here like you're describing, I guess, differences in the share of persons identifying as transgender between adolescents and younger children over several decades; is that fair?
A Yes.
Q I think you say that prior to 2000, children age 3 to 12 years identifying as transgender greatly outnumbered adolescents?

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A Yes.
Q And my understanding of your report is that you believe the increase in the percentage of adolescents identifying as transgender is because that group, and particularly persons assigned female at birth in that group, are particularly susceptible to social contagion; is that fair?
A Yes.
Q Is it fair to say that you think that social contagion played a minimal role before the year 2000 in causing persons to identify as transgender?
A Yes.
Q Is there an age at which you think persons assigned female at birth have matured enough that they're less likely to be susceptible to social contagion?
A Could I register my disagreement with the phrase "assigned female at birth"? Could you, please, just say "a natal female" because sex is not assigned at birth. Sex is determined at conception by the presence of X and Y chromosomes. It is not assigned at birth, so I would appreciate if you could just use the

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phrase "a natal female" or "a natal male."
Q Why don't I just state for the record that when I use the phrase "assigned female at birth," I am referring to what you would refer to as a "natal female," okay?
A But I don't want any more documents than necessary to reflect flawed and fallacious scientifically-lacking gender ideology of which the phrase "assigned female at birth" is a major contributor.
Q Do you understand what I mean when I say "assigned female at birth"?
A I understand what you mean, but you're expressing it incorrectly.
MR. FISHER: I'm concerning along these lines that it's gonna end up putting words in her mouth that she doesn't want, and I think that that's probably part of her concern, too.
MR. ROSE: Well, she can certainly answer however she feels comfortable, but I am going to use the verbiage with which I feel comfortable.
Q And, as I stated for the record, when I use the phrase "assigned female at birth," I'm referring to what you would refer to as "a natal female." Is that fair?

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A Yes.
Q Okay. The question that precipitated this was whether there is an age at which you believe that persons assigned female at birth have matured enough that they are less susceptible to social contagion?
A There's a clear set of studies that shows that susceptibility decreases with increasing age and cognitive maturity, so children are more susceptible, in general -- we're talking in population figures here but there's a lot of, you know, variation at an individual basis, but, statistically, in general, at a population level, children tend to be more susceptible than young adolescents; young adolescents tend to be more susceptible than older adolescents; and older adolescents tend to be more susceptible than young adults, onwards.
So there's not a cut-off. There's not, you know, 15 is the cut-off at which you're susceptible and then after 15 you're not susceptible. It's a gradient rather than categorical, but that, from a statistical perspective, is what the findings have been.
Q And I apologize for repeating you. I really

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just think I missed a word. It sounded like you were saying that children are the most susceptible, young adolescents next, older adolescents next, and adults are the less susceptible; is that fair?
A From a population statistically, a generalized perspective, yes.
Q I understand there may be variants with particular individuals; correct?
A Well, one variation that has been noted is that children who are securely attached to their parents are less susceptible compared with children who were not securely attached and that could occur anywhere from early childhood to late adolescence, so there's very important modifiers of that statement.
Q I had asked the initial question about whether there was an age at which persons assigned female at birth are mature enough, and you gave me that hierarchy and that's perfectly fine. I assume the same hierarchy exists for persons assigned male at birth?
A The natal males, yes, the same hierarchy exists.
Q And we were talking in general, but as it relates to the social contagion effect of

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transgender identification, it's the same hierarchy, right, children most susceptible, then young adolescents, then older adolescents, then adults?
A Well, when you look at the literature on uptake of behavioral phenomenon in different age groups, you find this effect across the board whether it's substance abuse, self harm, suicidality, and so forth, so it's a fairly robust finding.
Q Okay. I'm going to scroll up on your declaration again to Paragraph 84. Do you see that?
A Yes.
Q And in this paragraph you're describing, at least for most of it until the last sentence, a study published by Indremo and others?
A Yes.
Q And this was a study that tracked a number of referrals to clinics providing gender-affirming care after positive or negative media coverage?
A Yes.
Q And it sounds to me from your language like you're describing in this paragraph increases in referrals following positive media coverage and

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decreases following negative media coverage; is that fair?
A That's fair.
Q And the study you cite concerning the negative media coverage is the Indremo, the Swedish study from 2020?
A Yes.
Q I'm flipping over to Exhibit 9 now. And do you see that in front of you?
A Yes, I do.
Q And I assume that you recognize this as the Indremo and others study?
A I know where you're going with this and it's a question of emphasis, but the results are the results. Indremo is trying to present it as, you know, let's get all the media coverage positive, but his study is, in fact, a perfect example of social contagion. Negative coverages reduces clinic numbers and positive coverage increases them and so it's really quite a robust demonstration of social contagion.
Q I'm sorry, Doctor, my question was literally just do you recognize Exhibit 9, the Indremo study that you cite?
A Yes, I do. I do recognize it, but I was

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anticipating where you were going with it.
MR. FISHER: Doctor, let me just suggest let's not anticipate. We'll get through it faster.
THE WITNESS: Thank you. Okay. I'm sorry.
Q You're perfectly fine. I don't mind at all. I just wanted to make sure the record was clear on that front.
A Okay.
Q And my understanding is that the Indremo study actually studied the relationship between three different media events and referrals to gender clinics; correct?
A Yes.
Q One positive media event and two negative media events?
A Well, the two negative were connected. They were Part 1 and Part 2 of the same series.
Q And then there was also one positive media event?
A Yes.
Q And do you understand that for the positive event and for the first of the negative events the Indremo study actually found no relationship between media coverage and transgender clinic

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referrals?
A Say that again. Sorry.
Q You understand, don't you, that for both the positive media event and the first of the negative media events the study actually found virtually no change in the number of referrals to gender clinics following the media coverage; correct?
A It's been some time since I've read the details of the article. It's just not my memory of it. I thought -- let me just see that conclusion.
Q I've moved you down to the results section. Do you see that on the --
A Yeah.
Q And you agree that the majority of this section describes the changes in referrals following the second negative media event; correct?
A Okay. So we're looking at time-specific changes. So in the three months following the event, referrals decreased by 25% overall, by 32% for individuals being natal females, and by 25% for those aged 13 to 18.
Q And you understand that those statistics that you just recounted relate to the changes in referrals following the second negative media

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event; correct?
A Yeah. Yeah.
Q Do you see the last line of the results section that says for the other two media events no changes in referral counts or time trends were observed?
A Yes, I do see that and I actually forgotten that part of it.
Q Is it fair to say that in your expert report you only described one of the three events studied in the Indremo study?
A I was reporting the three-month follow-up data, so I'd have to go back and just revisit that.
Q Okay. Then flipping back to your expert report still on Paragraph 84, the last sentence of that paragraph after you talk about the Indremo study says, "On the contrary, increased positive media coverage of trans issues resulted in an increase in referrals to gender clinics." Do you see that?
A Yeah.
Q The study you cite for that is Pang and others?
A Yes.
Q And, just for the record, I think you cite the same study earlier in your report for a similar

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proposition.
A Yes.
Q Just proving to you that I read the entire thing.
A I'm very impressed.
Q I was gonna say I could write my memoirs three times over and end the night with your report here.
Okay. I'm flipping over to Exhibit 10. And, again, my first question to you is whether you recognize this as the Pang report that you cite.
A Yes.
Q And I will just tell you the page numbers on this exhibit do not line up with page numbers that you cited elsewhere in your report simply because of where I got it from, I assume.
Okay. My understanding is that Dr. Pang and others studied referral rates to gender clinics in Australia and the UK following media coverage related to transgender issues. Is that your understanding?
A Yes.
Q Okay. I'm going to flip over to the PDF Page 5 where I have highlighted a portion beginning

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with "The search strategy." You don't need to do so out loud, but can you read the highlighted portion to yourself?
A Yes, I'm familiar with it, yes.
Q And this describes the search criteria or terms that Pang and others used to find media items to study in their report?
A Yes.
Q And you agree that these criteria included any media coverage that contained the words gender, transgender, or gender dysphoria as well as child or adolescent; correct?
A Yes.
Q If there had been stories in the UK or Australia during the relevant time period similar to the negative media events that were covered in the Indremo study, do you agree that they would almost certainly have fallen within the search criteria?
A It would only be a surmise, but it's likely.
Q It would have been very difficult to write about that without using the words transgender and either child or adolescent; right?
A Sure.
Q Okay. I'm going to scroll down to Page 9. And

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at the bottom of that carry-over paragraph at the top, Pang and others write, "Testing whether negative media coverage is associated with reduced referral rates (and conversely whether positive coverage is associated with increased referral rates) would thus be a useful next step." Did I read this correctly?
A Yes.
Q Would it surprise you to learn that this is the only sentence in the entire study where media coverage is referred to as either negative or positive?
A Could you go back up to the top of the article?
Q Tell me where to stop.
A I just want to see the abstract. Okay. Keep going. Okay. Just stop there. Come back down actually. No, go up.
Q Sorry.
A There. Stop there. Okay. And you're saying that he's talked about media coverage generally as opposed to positive or negative media coverage.
Q And do you agree with that?
A What in particular?
Q Do you agree that the study authors are talking

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about media coverage in general and not media coverage as either positive toward transgender issues or negative toward transgender issues?
A Well, saying it's positive or negative is kind of drilling down, but the fact that he showed a strong association between media coverage and increased referrals is a demonstration of social contagion.
Q I'm going to flip back over to Exhibit 2 where you say, "On the contrary, increased positive media coverage of trans issues resulted in an increase in referrals to gender clinics," and I want you to explain to me where you got that "increased positive media coverage" language.
A I'd probably have to read the whole paper again to tell you where I got it. I hope it wasn't an overstep inference on my part, so I presume, obviously, that I inferred from the paper, but I would have to review the paper again to identify how I drew the conclusion that it was positive media coverage as opposed to any media coverage.
Q Prior to today, when was the last time you looked at that study?
A Oh, it was some time ago.
Q Okay. I'm going to scroll down still on your

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declaration to, I think, Paragraph 129. Do you see that in front of you?
A Yes, I do.
Q And do you see at the bottom of that paragraph you state, "The authors, however, did concede that ... increased media content (specifically via social media) might act as a ... means of social contagion"?
A Uh-huh.
Q I'm sorry. Yes?
A Yes.
Q And you underlined "might act as a ... means of social contagion"; correct?
A Yes.
Q And that was still in reference to the Pang study; correct?
A Yes.
Q I'm going to flip back over to Exhibit 10 and scroll down to Page 9. And you will see at the top of the paragraph immediately above the Limitations heading, Pang and others begin their statement with, "However, we are also mindful that others have speculated that increased media content (specifically via social media) might act as a double-edged sword or a means of social

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contagion." Did I read that correctly?
A Yes.
Q And that is the language from which you are quoting?
A Yeah.
Q The declaration?
A Yeah.
Q And what I want to know is how the authors saying "we are mindful that others have speculated" in their article translated to "the authors, however, did concede that" in your expert declaration.
A The very fact that he mentioned it, you know, implies that it has to be considered as a serious hypothesis.
Q You think that him mentioning that others have speculated about the effect of increased media content means that he's conceding that it might act as a means of social contagion?
A Yes, I think his disarming that possible conclusion.
Q Okay. In Paragraphs 94 and 95 of your declaration -- and, I'm sorry, it won't all fit in on one page, but you understand that these paragraphs generally concern various data from

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the United Kingdom and from Australia; correct?
A Yeah.
Q And, for much of this data, the citation is provide is to either Kenny, DT 2021 or Kenny, DT 2022. Do you see that?
A Yep.
Q And these citations are obviously you; correct?
A They're obviously me, yes.
Q And are they referencing something that has been published or simply data that you've collected?
A Well, it's been published on my website, but the figures were provided by the gender clinics and I converted them from either text or tabular form into a graph.
Q Has this data been published in any peer-reviewed journal?
A I think similar data has been used in peer-reviewed publications. (Inaudible) had to have used similar data to have done his study.
Q Your chart wherein you reference both referrals to gender clinics in the UK and Australia provides under it that Australian data was provided by "gender clinics under freedom of information applications." Do you see that?
A Yeah.

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Q Did the UK data come from similar requests?
A No, the UK data was published on the NIH website.
Q And I understand that -- and I'm looking at Figure 3 here. Do you see the entirety of Figure 3 on this screen?
A Yeah.
Q I understand that the figure is in thousands so you can't garner precise numbers from this, but, from looking at the chart, it appears to me that the Australian data shows either zero or roughly zero referrals to gender clinics all the way through 2013; is that correct?
A Yeah.
Q And the UK data shows roughly zero through 2006 or 2007 at which point it starts increasing slowly?
A Yes.
Q Is this because there were simply no gender clinics prior to these dates?
A My understanding is that the UK only had the Tavistock gender service. Right up until it's closure, I think it was the only service offering so-called gender-affirming care, so it was a sole referral agency.

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Q I'm sorry, I didn't mean to cut you off. Just while it was fresh on my mind, I was going to do it for the court reporter, but T-a-v-i-s-t-o-c-k. Do I have that correct, Doctor?
A Yeah. Yeah.
Q So my question was whether it's your understanding that there were no gender clinics in these countries during the periods of time where the chart indicates that there were zero or roughly zero referrals to clinics.
A Well, as I've just answered for the UK, that there was a clinic, but it did receive a very low number of referrals. In Australia there would have been a couple of clinics but nowhere near as many as there are now.
Q A couple of gender clinics even before 2013?
A Look, I can't give you the precise numbers and dates of clinics. I believe that they were incorporated into the pediatric departments of the major children's hospital, so it would have been people consulting about children who were presenting with gender dysphoria, but they were probably not called gender clinics and there wasn't a specific service for that purpose until

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more recently.
Q So, when these charts indicate zero or near zero, you agree it's likely because people were receiving care through something other than formal gender clinics; is that fair?
A Yes, it's probably fair, yeah.
Q And do you know when Tavistock opened?
A I know there's data before like 2000, I mean back as far as 2000, but beyond that I don't know.
Q Do you know when it closed?
A I think it's formally closing September 2023.
Q Okay. In Paragraphs 97 and 98 of your declaration, we'll start here, but do you generally see what these paragraphs are talking about?
A Yes.
Q It looks to me like you're describing data showing increased referrals to gender clinics in certain Australian states. Do I understand that right?
A Yeah.
Q And Figure 4 separates it out by each state?
A Yes.
Q And I think you describe in text that the

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increased referrals were primarily in three states, Western Australia, Queensland, and Victoria. Do I have that right?
A Yes.
Q I assume on your chart WA is Western Australia?
A That's right.
Q And VIC is Victoria?
A Yes.
Q And QLD is Queensland?
A Yes.
Q My understanding is that Melbourne is the largest city in Victoria. Do I have that right?
A Sydney is the largest.
Q I'm sorry. Is Sydney not in New South Whales?
A Sydney is in New South Whales.
Q Sorry. I said Victoria. Is Melbourne the largest city in Victoria?
A Oh, I see what you mean. , it is, yes.
Q Okay. I'm sorry. I have to admit my knowledge of Australian geography is less than yours so I would've been happy to be told I was wrong there.
A Well, my knowledge of your 51 states is very sparse in my mind as well, so we're even.
Q We're somewhere between Los Angeles and New

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York. That's all you need to know.
A Okay.
Q Certainly that's all people in either Los Angeles or New York care about.
Okay. My understanding, and please tell me if I'm wrong, is that the first health clinic catering solely to the needs of transgender persons or gender diverse persons in Melbourne was opened in 2016. Is that your understanding as well?
MR. FISHER: I'm gonna object just because there's lack of definition behind those descriptions you just provided.
Q And you can answer the question, Doctor.
A I was just going to say a plane was flying overhead and I missed the substantive issue in your question.
Q Sure. My understanding is that the first health clinic in Melbourne catering solely to transgender and gender diverse persons opened in 2016. Is that your understanding as well?
MR. FISHER: Same objection. You can answer.
A I couldn't give you the precise year, so, if you have researched the question and found that it

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was 2016, I will accept that answer.
Q You understand that it opened sometime in the last 5 or 10 years; right?
A Yeah. Yeah.
Q And what's the name of that clinic in Melbourne?
A It's called the -- it's in the Royal Children's Hospital -- the Adolescent Gender Service, I think it's called, or something of that nature.
Q Okay. And then in Western Australia, the capital and the largest city is Perth; right?
A Yeah.
Q I don't know why I didn't have an exhibit for you for Victoria and I made you guess at that. I'm sorry for making you do that, but I'm going to pull up Exhibit 11 and see if there's a rotate button.
MR. FISHER: You have to subscribe.
Q Okay. Why don't I flip to my own Exhibit 11 and read you the highlighted portion that I have taken there. And I will tell you that this is a printout that I took from the web page of the Government of Western Australia's Mental Health Commission, and the portion I have highlighted says that the gender identity service "was created in 2015 to address the gap in services

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available to young people in WA experiencing problems with their gender identity."
Is it your understanding that the gender identity service opened in Western Australia in 2015?
A Yes.
Q And I assume that that's the largest gender clinic in Western Australia?
A Yes.
Q And then Exhibit 12 is another printout that I've taken from the website of the Government of Queensland wherein the article they published has someone saying that there was no multidisciplinary gender service in Queensland before the establishment of the gender clinic at Children's Health Queensland in 2017. And my question to you is: Is it your understanding that the gender clinic at Children's Health Queensland first opened in 2017?
A Yes.
Q Okay. In Paragraph 105 of your declaration, which spans two pages, but do you see the top of Paragraph 105 there?
A Yes. Yep.
Q And you provide a citation here to Tegg, 2022,

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personal communication?
A Yep.
Q And I assume that the citation is to something that was just relayed to you by whoever Tegg is?
A Yes.
Q And Tegg, I assume, is Simon Tegg?
A Yes.
Q And are you aware that Mr. Tegg is part of a group called Fully Informed?
A Yes.
Q Are you aware that that group has played an active role in advocating in favor of policies in New Zealand that would prevent children from accessing gender-affirming medications?
A Of course.
Q To your knowledge, has the data you received from Mr. Tegg been published in any peer-review journal?
A Not to my knowledge.
Q Okay. I'm going to scroll down just as an example to Paragraph 107. Do you see that there?
A Yeah.
Q The citation that you provide at the end of that paragraph is to a -- your guess is as good as

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mine on the pronunciation -- Respaut & Terhune, 2022; correct?
A Yep.
Q This article here, Respaut & Terhune, is it published in a peer-review journal?
A I'd have to look at the reference.
Q I will just tell you that I found it and your references are at the end of your declaration, but Respaut & Terhune are actually reporters for Reuters. Does that refresh your recollection?
A Well, I have quoted some journalistic pieces from reputable journals, yes, because they have access to information that's very difficult for people, you know, to obtain by any other means, so I have done that on a couple of occasions.
Q And when you have relied on media stories for the information you provide in your expert report, you provide the citation in roughly that format, right, just the author and the year?
A Yeah. Yeah. That is the accepted APA referencing convention.
Q Is it fair to say that there are several other citations that you provide in your expert report that are just media stories?
A There's a small handful out of 200 plus

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references and it's because I wasn't able to source the information from anywhere else.
Q And every media story that you relied on, is that cited in the references portion at the end of your declaration?
A Yes.
Q I'm going to scroll down to Paragraph 131 real quick. And I don't know how every single paragraph I've chosen actually spans two pages, so I apologize for that, but do you see the beginning of Paragraph 131?
A I do.
Q And in this you are describing an article published by Dr. Turban and others in 2021?
A Yes.
Q I'm going to bring up Exhibit 13 and ask you, first and foremost, if Exhibit 13 is that article that you're citing.
A Yep.
Q And, generally speaking, in your expert declaration you're relying on Dr. Turban's article to describe the detransition rates amongst persons who had previously been diagnosed with gender dysphoria. Is that a fair summary?

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A No, because in this study Turban conflates transgender with gender diverse and that's a fatal flaw for any study to do that.
Q Okay. And I apologize, that wasn't the portion that I was trying to focus on and that's just my verbiage, but you're relying on Dr. Turban's study to discuss the detransition rates. Is that a fair summary?
A Not detransition rates generally but the detransition rates that he reports in that study.
Q Okay. Do you understand that Dr. Turban's article did not just seek to collect data on the rate of so-called detransition but also sought to analyze why persons detransitioned?
A I don't think he's capable of psychoanalyzing anything and I don't necessarily think he claimed to do so.
Q Do you understand that the report itself purports to provide data on why persons detransitioned?
A Yes.
Q Do you understand that the data set that he relied on was of people who currently identify or identified at the time of the article as

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transgender?
A Or gender diverse.
Q Or gender diverse. I'm sorry. You understand that; correct?
A Yes.
Q So every person in the article who had "detransitioned" subsequently retransitioned. Is that your understanding of what the article purports to report?
A It's very difficult to work out exactly what it purports to report.
Q Okay. Well, you're relying on the article to talk about detransition rate and my question to you was whether you were aware that everyone in the article subsequently retransitioned; correct?
A I'm not sure I'm aware of that now only because it's been some time since I read the paper.
Q The article speaks for itself so if you're not aware of it, that's perfectly fine and I don't have to prolong the issue.
Are you aware that the article also classified the reasons for "detransition" --
A Yes.
Q -- as either -- I'm sorry, I wasn't done with

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the question. Why don't we start there, though. You're aware that the article also classified the reasons for detransition; correct?
A Yes. Yes.
Q And it classified them, while having specific categories as well, into external and internal reasons. Is that your understanding?
A Yes.
Q And you're aware that the article found that the overwhelming majority of persons with a history of detransition cited at least one external reason for that; correct?
A Yes.
Q Do you agree that that finding is consistent with your social contagion hypothesis?
A Look, I'm afraid that I don't base any of my inferences or conclusions on the work of Jack Turban because it's almost all universally flawed research, methodologically suspect, and one cannot draw conclusions or make generalizations from the purported conclusions that he draws from his own research.
Q Well, imagine some professional other than Dr. Turban who you respected. If they published a scholarly article finding that of 100 persons

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who "detransitioned," 82.5% of them cited at least one external factor as a reason for their detransition, would you believe that that is consistent with your social contagion hypothesis?
A Well, that eventuality has never occurred. It's never been reported before or since, so it would be merely an assumption to say that a reputable scientist had found those results. So, to take the next leap and say whether it was consistent or not consistent with social contagion, my hypothesis, is really not appropriate.
Q Okay. I'm going to click over to Exhibit 14.
MR. FISHER: Gavin, can I interrupt for just one second?
MR. ROSE: Of course.
MR. FISHER: I just want to point something out. Please go off the record for just one second.
(A discussion was held off the record.)
Q Doctor, I have in front of you right now what I've marked as Exhibit 14, and I assume that you are familiar with this?
A Yes.
Q This is an article that you authored and was

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published in 2021. Do I have that correct?
A Yeah.
Q I understand that there is significant, I guess, elaboration in your expert declaration, but is it fair to say that many of the opinions you express in your expert declaration are also expressed in this article Exhibit 14?
A Yes.
Q And my understanding is that this article was published in a collection of articles by various Australian professionals. Do I have that right?
A Yes.
Q And the collection was devoted to the "transgendering" of children and adolescents; is that right?
A Yeah.
Q Was your article published anywhere else?
A Not at this point, no.
Q Has it been published -- I'm sorry, I was confused by your response. By "not at this point," do you mean not currently or do you mean not at the time that it was published in the collection of articles?
A No to both questions.
Q Okay. My understanding is that the article

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collection was edited and published by a sociologist in Australia named Geoffrey Holloway. Do I have that right?
A Yes.
Q Were you compensated for writing or submitting your article?
A No.
Q Okay. I'm pulling up Exhibit 15 and I will just tell you before we get into this that I have not taken the entire publication. What I have here, I think, is the cover page, the table of contents, and the editorial that appears as Section 1 to the publication. Do you recognize this as those portions of that collection in which your article appear?
A Yes.
Q The editorial that appears indicates that one of the key objectives of the publication was "to promote the campaign for a national, public inquiry into the transgendering of children and adolescents." Do you see that?
A Yes.
Q Is that your understanding as one of the key objectives of the publication?
A Yes.

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Q Is that one of the reasons that you submitted your article for inclusion?
A Yes.
Q What is the transgendering of children and adolescents?
A The transgendering refers to a process of persuasion that children are "born in the wrong body," that their gender identity, however defined, does not align with their natal sex, and the transgendering is the process whereby medical professionals assist the child to bring their sexed body into line with their reported gender identity using means such as puberty blockade, cross-sex hormones, and sex reassignment surgery.
Q In your declaration you refer on several occasions to the "trans activist lobby." You're familiar with that, I assume?
A Yes.
Q Is the transgendering of children and adolescents being accomplished or attempted by the trans activist lobby?
A Absolutely.
Q Is there anyone other than the trans activist lobby that is performing the transgendering of

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children and adolescents?
A Well, the lobby is an open social network that has a number of means of propagation, one of which is the Internet, social media, the misteaching of children, schools using curricular that is scientifically incorrect, so they're being coquetted at very young ages, five and six.
If you have a look at some of the educational materials and curricula, children as young as five and six are being told that girls can have penises and boys can have vulvas and there are crude drawings, anatomical drawings, for which children are not really ready and should not be exposed. They're also being told that they can have whatever gender identity they like.
And, furthermore, you know, there are other means of propagation including this whole movement of drag queen story time where drag queens go into schools and libraries, community libraries, and other public places where very young children assemble and play and they're read transgender story books about transgender theories and transgender (inaudible) and a

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gender unicorn where further incorrect information is disseminated and propagated. That's what we call the transgendering of children.
Q Your article, Exhibit 14, were you solicited to submit an article to that publication?
A Well, the word "solicited" is slightly loaded. I was invited to contribute an article.
Q And I wasn't trying to load anything. I was asking whether they invited you or whether they had an open call for articles and you just happened to submit one. But they invited you to submit an article?
A I believe so, yes.
Q Okay. Did you submit your article for publication anywhere else?
A Not that particular article. I did attempt to get it published in a peer-reviewed journal and, unsurprisingly, it was not considered politically correct enough and so I was unable to get it published.
Q What journal was that?
A The Archives of Sexual Behavior.
Q And when did you submit it to that journal?
A A version of it was submitted about a year ago,

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maybe about that.
Q So after it appeared in this collection?
A Probably.
Q Other than that journal, did you submit it for publication anywhere else?
A I've done versions of it under invitation to other sources and publications and so forth. It's never the same version. It's always tailored and very much shorter than the declaration. The declaration is probably the longest and most detailed version of my work on this topic.
Q Other than the one peer-reviewed journal from which it was rejected, did you submit it to any other peer-reviewed journals?
A I think I already answered that question and I said no.
Q Oh, I'm sorry. I thought you had two. I'm not trying to trick you up. I just don't have a realtime transcript, so I apologize.
A The chapter that I submitted to the Brunskell-Evans edited volume was peer-reviewed and I just haven't really been focused on peer-reviewed publications. (Inaudible) at the moment having left the university to publish and

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most of my colleagues have had the experience of putting a huge amount of work into a paper and not even get past the first round of reviews, so I haven't pursued that avenue of dissemination, but I do have over 200 international peer-reviewed journal articles. So I'm not incapable of reaching a bar for peer review, but it's almost impossible to get articles critical of the current transgender position past a peer review.

Q Okay. I'm back in your declaration right now and I am going to bring up, I guess, the end of Paragraph 140 and the beginning of Paragraph 141. Do you see that in front of you?

A Yep, I do.

Q It appears to me that Paragraph 140 ends with a quote from a British neurosurgeon about lobotomy; correct?

A Yep.

Q And then in Paragraph 141 you apply this quote to the practice of transgendering children and young people. Is that a fair summary?

A That's a fair summary.

Q And you have in that paragraph a statement that "These young people are also 'totally ruined as

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social human beings.'" I assume that by "These young people" there, you're referring to transgender persons?

A I'm referring to young people who have had their bodies medically and surgically altered in a vain attempt to change their sex.

Q What does it mean to be totally ruined as a social human being?

A It means that one suffers, as I say later on in that paragraph, pervasive mistreatment and violence, severe economic hardship and instability, discrimination, significant negative physical and mental health impacts, and so forth.

Q Do you believe that the plaintiff children in this case have been totaled ruined as social human beings?

A I think they have suffered enormously. They're very vulnerable young people and, I mean, obviously, I wouldn't apply that phraseology to very young children, you know, who still have the opportunity to be rehabilitated if they received the right care rather than the one-size-fits-all care of gender affirmation for which, you know, they are, in all likelihood,

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not appropriate.

Q Sorry. One second, please. I'm sorry, Doctor, my co-counsel heard something that I didn't hear and we're probably both wrong on one front or another.

What role does whether or not a person has had gender-affirming surgery play in your determination as to whether they are totally ruined as social human beings?

A What role does surgery play in ruining them? Is that what you're asking?

Q Sure, let's start there.

A Okay. It's a significant traumatic insult on the body to remove perfectly healthy organs, the result of which will impair their sexual function. Many of them suffer ongoing and significant medical complications including chronic pain, infection, fistulas, bleeding, and, you know, in the case of male to female, they have to constantly dilate which I'm told causes significant pain. Many of them are sexually dysfunctional or are not able to feel comfortable enough to expose their naked bodies to other people. So, to the extent that those situations have eventuated from sex reassignment

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surgery, the answer to your question would be yes.

Q Do you believe that children who have been given access to gender-affirming medications, either puberty blockers or hormones, but have not had surgery, do you believe that they are totally ruined as social human beings?

A I don't think it's fair that you characterize my view as everybody who's had gender-affirming care of some kind or another are totally ruined human beings because it depends on the age of the child, it depends on the nature of the treatment, what age it was commenced at, and, you know, the kind of support they got and what was the final outcome, but if your question was about puberty blockade -- is that correct? Were they totally ruined human beings?

Q I said puberty blockers or gender-affirming hormones, but if you have different --

A Okay.

Q -- for the two, please --

A Well, some of the adverse effects of puberty blockade are -- I mean, I'm sure I'm not going to be able to include everything right at this moment, but the ones that come to mind are

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questions of future fertility, bone density and bone grown and their final height. It carries significant risks of weight gain and there are a significant number of children who report headaches and hot flashes and, more recently, a phenomenon called pseudotumor cerebri which, if not treated promptly, may cause blindness.

So this drug is not safe and, in some respects, it's not reversible because what it, in fact, does is delay puberty including the growth of the sexual organs, and if the child remains on puberty blockers for longer than two years, the growth of their sexual organs may not return to what they would have been had they been allowed to mature without puberty blockade.

The other thing that happens with puberty blockade is, of course, their peers are going through puberty and so all of the factors that made them feel different and gender dysphoric in the first place are often exacerbated because they remain in a prepubertal state while what used to be their best friends and peers are all moving into the next stage of development which is sexual maturation. So there are the possible problems caused by puberty blockade.

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So, if we move on to the cross-sex hormones, some of the problems with prescribing testosterone to women are, of course, well, first of all, the suppression of menses, the permanent infertility, and ovarian uterine atrophy that occurs with longer-term use often necessitating the removal of a young woman's uterus and ovaries because they atrophy and cause enormous pain. Then we have clitoral discomfort, vaginal atrophy which, of course, makes sexual intercourse very difficult. They often have cyst formation on the ovaries, pelvic pain, a condition called polycythemia which means that they develop too many red blood cells which carry medical risks. There's increased dyslipidemia, acne, oily skin. Some of them develop hypertension, some of them develop Type 2 diabetes, mood swings, increased frustration and anger and aggression, a risk for deep vein thrombosis.

That's what I can think of at the moment. I'm sure there are more, but, you know, these drugs are touted as being, you know, oh, wow, this is really going to get you what you want, but these issues are skated over, at best.

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So, if we move to the adverse effects of estrogen on males, we see things like, again, deep vein thrombosis, high triglycerides. Some of them will get hyperprolactinemia which means they will start to have discharge from their nipples. They can develop a condition called hyperkalemia which is excessive potassium which can really upset the metabolic balance in the body which can affect the heart. Again, Type 2 diabetes, hypertension, weight gain.

Yeah, these drugs are dangerous drugs. They're synthetic dangerous drugs to be pumping into young children and adolescents.

Q And, just to be clear, Doctor --
A I beg your pardon.
Q I'm sorry, I didn't mean to cut you off there. I thought you were done.
A Well, I'm sure I've missed something, but that will have to do for now.
Q And, just to be clear, Doctor, you're not a medical doctor, are you?
A I'm not.
Q In your CV you make reference to what appears to me to be a two-part podcast called The Medical Scam of the Century. Do you know what I'm

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talking about?
A I do know what you're talking about.
Q Is it fair to say that you consider the "transgendering of children and adolescents" to be the medical scam of the century?
A Yes.
Q You're familiar, I assume, with the Australian Psychological Society; correct?
A Of course.
Q And, I'm sorry, I just forget. Is this one of the organizations you're still a member of or is it something --
A Yes, it is. Yes, I'm still a member.
Q And you're aware that this organization has published an information sheet recommending mental health practices that affirm transgender people's experiences?
A Yes.
Q And I'm pulling up Exhibit 16 for you. Do you see that in front of you?
A Yes.
Q You recognize this as that information sheet?
A Yes, I do.
Q And you understand that, along with this, the same organization published a one-page summary

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of its information sheet; correct?
A I do.
Q And I'm pulling up Exhibit 17. And you recognize this as that summary; correct?
A Correct.
Q You previously mentioned the Royal Children's Hospital in Melbourne; correct?
A Yes.
Q And my understanding is this is the largest children's hospital in Melbourne?
A Yes, it is.
Q Is it the largest one in Australia? I just don't know.
A No, there's the Westmead Children's Hospital and the Prince of Whales Children's Hospital in New South Whales.
Q But you're aware that it has published treatment guidelines for the treatment of transgender and gender diverse children and adolescents; correct?
A Yes.
Q And what's the relationship, if you know, between The Royal Children's Hospital and AusPATH?
A Well, the director of the gender service at The

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Royal Children's Hospital is one of the coauthors of AusPATH.
Q I'm pulling up for you what I have marked as Exhibit 18. Do you see that in front of you?
A Yes, I do.
Q You recognize these as the treatment guidelines that have been published by AusPATH for the treatment of transgender and gender diverse children and adolescents?
A Yes.
Q And these are the treatment guidelines that you reference in your declaration occasionally as the AusPATH guidelines?
A Yes.
Q And my understanding is that this is the Australian body similar to WPATH?
A Yes.
Q We just briefly touched on this, but in your declaration you repeatedly describe the influence of the trans activist lobby and I'm wondering -- and maybe I asked you this or something close to this, but I'm wondering who, in your estimation, comprises the trans activist lobby.
A Look, I think in a footnote I said I'm using it

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as a summary term for the vast network of individuals and organizations who are propagating gender-affirming care.
Q Do you believe that the trans activist lobby has a leader or a leadership structure?
A The trans activist lobby, which is my summary term so that I don't have to list multiple individuals and organizations, is an open system network so it's got many, many influencers and many networks and subnetworks that have, you know, been -- it's been a very, very effective marketing machine.
So it's got very great many modes, you know, that can attract children, so we've got TikTok, we've got Insta -- Instagram not so much. What are the others? I'm having a mental block about these websites, but there's many of them that spend a great deal of time, you know, attracting young people to these sites and, you know, talking to them in very positive terms about transgendering and they can be whatever gender they like. And it often attracts young children who are marginalized and who are looking for a group, looking to belong, looking to be important and special.

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And, yeah, so it's not any one individual, but I did do a social network diagram for what's going on in Australia and the network consists of politicians, sadly the Australian Human Rights Commission, the Commissioner for Children and Young People, the eSafety Commissioner. They're all singing the same song and there's no capacity to (inaudible) the unanimous kind of voice about gender-affirming care.
So, you know, I'm not being extremist or, you know, it's not a conspiracy theory to call it a trans lobby. It's a summary term for what's happening in society currently and it's very, very concerning.
Q And the deep dive that you said you took -- and I'm sorry if I'm putting words into your mouth -- into persons in power in Australia, it's my understanding that that is available on your website?
A What particularly?
Q I'm sorry, I will pull that up at the next break and make sure we're talking about the same thing.
I assume you believe that the trans activist lobby is global and not limited to

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Australia; right?
A Oh, absolutely.
Q And The Royal Children's Hospital in Melbourne is a member of the lobby?
A Look, I don't want you to put that kind of notion into my mouth. I'm not kind of reifying the transgender lobby as some, you know, star chamber organization that's infiltrating the world, but The Royal Children's Hospital acts as a major harbor of this open social network disseminating misinformation and advocating for gender-affirming care very strongly, both politically and in the courts. These are facts. They're not part of a conspiracy theory.
The Australian standards of care have been strongly influenced by the WPATH guidelines and the WPATH guidelines have been strongly influenced, so there's this mutual kind of network of social influence to the point that you would call it brute think because if you have a look at the early documents like the standards of care, you'll see the same authors across different guidelines and standards of care. So we've got Henriette van de Waal and Peggy Cohen-Kettenis from the Amsterdam Clinic

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who were authors of the 2006 Dutch protocol and we see their names appear repeatedly on these standards of care compilations over the last few years as well as the Endocrine Society. And there are other names as well that keep coming up like Louie Myer (phonetic) and so forth.
So there is this group think that has developed around the guidelines including the Australian Psychological Society. It's one voice speaking and there's no room for doubt. And, so, there is this collective rationalization of thinking where there's a lot of -- you know, there's no admission of any other alternative point of view. They don't survey the alternatives and every time an alternative is offered like social contagion or like the fact that many of these gender diverse children will grow up to be gay adults if left alone. They don't admit any other possible way of helping and managing these young people, so they do not appraise properly the risks of their own preferred solution which is gender-affirming care. They scoff at the idea of the reversibility of some of their treatments. They selectively choose information and they have

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this err of invulnerability that if you belong to this group of gender-affirming care, clinicians, politicians, teachers, et cetera, then we have the truth. We have the absolute truth. And all I'm saying, people outside of that network are saying: Please think about alternatives, please think about possible harm, please think about irreversibility. And it's not happening.
Q Is it fair to say that you believe that the American Medical Association has been improperly influenced by the trans activist lobby?
A Yes.
Q Is it fair to say that you believe the American Psychiatric Association has been improperly influenced?
A Yes.
Q How about the American Psychological Association?
A Look, I've put a big list in my declaration and if you have a look at all of their position statements, there's very little variation, you know, between them and it's --
Q I'm sorry, Doctor. We're gonna be here all night if you don't just answer the question.

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A Okay.
Q The question was whether you believe the American Psychological Association has been improperly influenced by the trans activist --
A Yes.
Q And the same for the Endocrine Society?
A Yes.
Q Earlier in your deposition I showed you what was Exhibit 8, the statement by the CAAPS organization that had been signed by a couple dozen other organizations. Do you remember that document?
A Yes, I do.
Q Is it fair to say that you believe that each of those organizations has been improperly influenced by the trans activist lobby?
A Well, they're part of it so they influence each other. It's a bidirectional influence.
Q And the various Australian state governments that have passed bans on conversion therapy, have they been improperly influenced by the trans activist lobby?
A Well, I mean, I'm afraid I have to seriously question their intellectual capacity to put a bill like the banning of conversion therapy into

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parliament. It's an extremely poorly-worded document and it's unlikely to catch anyone in its net, but what it has done is scare off therapists from treating these children in any way whatsoever. So now there is an extreme shortage of skilled child and adolescent therapists to help these young people because almost no one wants to touch this patient group because of that legislation.

Q You understand, I assume, that a federal judge in the Alabama case where you submitted an expert report issued an injunction against the statute banning certain types of gender-affirming care for minors; correct?

A Issued an injunction against gender-affirming care?

Q I'm sorry, that's lawyer talk. Issued an order for preventing the statute from taking effect.

A Yes.

Q Is it your position that that judge was improperly influenced by the trans activist lobby?

A I don't have an opinion on that.

Q I'm pulling up for you what I have marked as Exhibit 19. Do you see that document in front

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of you?

A Yes.

Q I assume you're familiar with this?

A Yes.

Q These are the informed consent standards that AusPATH has promulgated for gender-affirming hormone therapy?

A Yeah.

Q I'm popping Exhibit 18 back up for you and my question to you is whether you use any portion of this document, the AusPATH treatment guidelines, when you provide therapy to transgender persons or persons who identify as transgender.

A Was your question: Is there any part of the document that says children should have therapy?

Q My question was whether there's any portion of this document that you rely on when treating a patient who walks through your door.

A No.

Q And is the same true for Exhibit 19, the informed consent standards?

A There are more general informed consent standards that every practicing clinician must adhere to, but the gender-affirming therapists

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don't even adhere to their own standards of informed consent and most of them don't even understand what constitutes informed consent.

MR. ROSE: Off the record for a sec.

(A discussion was held off the record.)

Q Doctor, you ready to power forward?

A Sure.

Q Chapter 2 of your declaration -- excuse me. You have a separate what you call chapter of your declaration that specifically concerns the named plaintiffs in this case; is that fair?

A Yeah.

MR. ROSE: And, Tom, before we plow forward, just a matter of housekeeping. We want to make sure that Exhibits B, C, D, and E of the doctor's declaration as well as I think they will be Exhibits 20 and 21 of this deposition and any testimony about those are maintained as confidential. I assume that's not an issue and we can obviously figure out how that needs to work for the Court?

MR. FISHER: Right. Agreed. No objection to that.

Q Okay, Doctor. Just very generally, have you personally evaluated any of the plaintiffs?

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A As stated in my report, no, I haven't.

Q Have you interviewed them at any time?

A No.

Q Have you interviewed any of their parents?

A No.

Q Have you ever communicated in any fashion with either them or their parents?

A No.

Q Have you ever communicated about the plaintiffs with any professional who has evaluated or treated any of them?

A No.

Q It's fair to say that your opinions about them come exclusively from a review of the medical records that you were provided; is that correct?

A As stated in my report.

Q Sorry. That's a yes?

A Yes.

Q Do you have an understanding as to whether each of the plaintiffs received mental health therapy before seeking or being prescribed either puberty blockers or gender-affirming hormones?

A Did you say do I have an understanding?

Q Do you understand whether the plaintiffs received mental health therapy before seeking or

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being prescribed gender-affirming medications including puberty blockers?
A It wasn't entirely clear exactly what they received by way of psychotherapeutic support because, as I say, in the documents before me only vague references were made. So I didn't see any process notes, I didn't see any case formulation, I didn't see any progress, goals, or anything that one would normally see documented in a clinical process.
Q Okay. I am bringing back up your expert report, Exhibit 2. Do you see that in front of you?
A Yeah.
Q I am going to scroll down to Paragraph 198. Okay. Do you see Paragraph 198 and the associated footnote 34?
A Yes.
Q In this portion of your declaration you're describing a visit that Plaintiff K.C. had with the doctor managing her Type 1 diabetes. Do you see that?
A Yeah.
Q And you underscore in your report that K.C. was reported to have "no dysmorphic features." Do you see that language?

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A Yes.
Q And you speculate in the footnote that it's unclear whether the doctor meant dysphoric or dysmorphic or was --
A Yes.
Q -- using the terms interchangeably; is that correct?
A Yes.
Q I assume you understand that gender dysphoria and body dysmorphic disorder are two entirely separate diagnoses; right?
A They're not two entirely separate diagnoses, but they have different emphases.
Q And they're listed separately in the DSM; correct?
A Yes.
Q Do you have an understanding that persons with diabetes are more likely to develop an eating disorder that might lead to body dysmorphia?
A Yes.
Q So do you agree that for a doctor managing a patient's diabetes whether a patient displays dysmorphic features might be particularly noteworthy?
A Yes.

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Q But you still think the diabetes doctor, despite using the phrase "dysmorphic features," might have been intending to reference K.C.'s gender dysphoria?
A Well, he then goes on to say "sweet transgender girl," so it's ambiguous.
Q Okay. I'm going to scroll down to Paragraph 229. Do you see that in front of you?
A Yes. Yes.
Q You're describing here an assessment of M.W. that you indicate took place on January 4th, 2022. Is that a fair statement?
A Yes.
Q My review of the medical records, I'll just tell you, does not reveal anything from January 4th but does indicate that M.W. had an initial evaluation at Riley Gender Health Connect on April 14th, 4/14/22. Is it possible that you simply got the dates wrong?
A Well, given that I had to scroll through literally thousands of pages on Notepad formatting, it is possible I got the date wrong. And, also, Americans reverse the date and month and it may have occurred for one of those two reasons.

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Q I understand that and I'm not blaming you. And, for the record, I did go through other portions of your declaration to see whether you were adopting the American style of month/day or whether you were not. I'm certainly not blaming you.
In your report of this encounter you indicate that M.W. was neutral about certain secondary sexual characteristics, satisfied with other things, and also neutral about characteristics such as hair, voice, and general appearance. I understand that I'm not quoting everything, but you see the language I'm referencing; right?
A Yes. Yes.
Q And you underlined "voice"; right?
A Uh-huh.
Q Sorry. Yes?
A Yes.
Q Why did you underline "voice"?
A Because voice is one of the characteristics around which young people claim extreme dysphoria.
Q So is it fair to say that you underlined "voice" because you thought M.W. being neutral about

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that was more noteworthy than some of the other items reported?
A Yes.
Q I'm going to flip over to what I've marked as Exhibit 20 which, as you will see, is the encounter on April 14th, 2022. And I will scroll down to, I guess, Page 3 of the document using the PDF page numbers. I have highlighted a couple aspects of the report there. Do you see the portions I have highlighted?
A Yes.
Q And I will just tell you that this -- and I'm not trying to trick you. I can scroll back and forth if you want me to. The language I highlighted matches almost verbatim the language that you report in Paragraph 229 of your declaration. Is it fair to say that this is the document that you were looking at?
A Well, I didn't get it in that form. In that form it's actually interpretable, but I got it in incredibly narrow paragraphs and the average scores were kind of above the text interpretation so it was quite difficult for me to make sense of it. I mean, presented like that, it looks much more interpretable than the

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form that I got it in which was a Notepad document.
Q So is it possible that you misinterpreted M.W.'s medical records as you were going through them?
A I hope I didn't. I took great care not to, but it looks as if I did not misinterpret anything on this occasion.
Q Okay. And all of the medical records that you reviewed, did you receive them all in the same format that was difficult to read?
A Most of them were in Notepad format. I got a couple that were scanned Word or PDF documents, but they weren't like -- the text was fuzzy, and they were the two primary forms in which I got the records.
Q And the Notepad format was the one that you were indicating was difficult to read?
A Yeah, and I had hundreds of those files to go through.
Q Okay. I will scroll up just a little bit on Exhibit 20 now to the top of that Page 3. It looks to me like what Page 3 is doing here is providing a summary of the intake paperwork that M.W. and, under the caregiver's portion, M.W.'s parents completed. Is that fair?

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A Yeah.
Q I assume you were provided a copy of that pre-intake paperwork itself as well?
A As I said, but not in this form.
Q Okay. I understand the formatting might have changed, but I'm flipping over to Exhibit 21 and I will ask you whether this appears to you to be the pre-intake paperwork for M.W. that is summarized in Exhibit 20.
A I don't believe I've seen that document.
Q Okay. Is there a reason you would not have seen it?
A I don't know. I would remember that if I had seen it and I haven't seen it.
Q I'm going to scroll down just a little and I will represent to you this is the self-report portion and I'm on Page 6 right now. Do you see the highlighted portion about how M.W. feels about his breasts?
A Yes.
Q And you acknowledge that he indicates that he was very dissatisfied with them?
A Yep.
Q I'm scrolling down just a little bit farther. You see the same thing about voice and chest?

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A Yes.
Q And I'm looking at Page 7 now, but you see that M.W. actually reported that he was very dissatisfied with his voice?
A Yes.
Q So is it fair to say that the statement in your declaration that M.W. was neutral about his voice is inaccurate?
A According to the document that I reviewed, no, it's not inaccurate because that was the information in front of me, but, as I said in the beginning of my Chapter 2, that had I been presented with any information subsequent to my report, it might cause me to change my opinion.
And just because a child says they're dissatisfied with their breasts and voice, it doesn't mean that you automatically jump into a diagnosis of gender dysphoria and send them off for gender-affirming care.
Q Okay. Well, we've established that Exhibit 20 which indicates "Tended to report feeling neutral about characteristics such as hair, voice, and general appearance" is what you were looking at for that portion of your declaration; correct?

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A Correct.
Q I'm going to scroll up on the same document then to the top of Page 2 where it says that M.W. "Reports feeling significant dysphoria related to chest, voice, and menstrual periods." Do you see that?
A Yep.
Q And do you still think it was accurate for you to report that M.W. is neutral about his voice?
A From the documents that were in front of me, I reported that accurately.
Q This is part of the same document, Doctor.
A Look, I would like you to have a look at the Notepad files that I was sent. They were disjointed. They didn't necessarily even follow one sentence continuing on the next line. Sometimes I had to scroll down several lines to get the end of a sentence. I was under extreme time pressure. I was given some medical records two days before I had to file my report. I was up all night for three nights in a row trying to complete the work.
But, even under all of those circumstances, even if a young child reports dysphoria in relation to chest, voice, and menstrual periods,

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I do not jump to the conclusion that this child is suitable for gender-affirmation care.
Q And the circumstances you described about your difficulties reviewing the medical records, I assume that applies to the medical records of all four plaintiffs?
A Well, most of them were given to me in that format, in Notepad format.
Q Is that a yes?
A Yes.
Q Okay.
A But I didn't just rely on those medical records. I also was given the declarations of the parents and I had the parent reports from their lawyers as well, so it was multiple sources of information.
Q I'm back in Paragraph 229 of your declaration. In the middle of this paragraph you say "there is no evidence of a marked incongruence between M.W.'s experienced/expressed gender and (all) primary and/or secondary sex characteristics." Do you see the language that I have just quoted?
A Yeah.
Q Why is "all" in parentheses?
A Because, generally speaking, the child would

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need to express a global dissatisfaction with their body overall. I mean, you know, quite often children will not like something about themselves. I don't like my hips or I don't like my shoulders. That doesn't make them either body dysmorphic or gender dysphoric.
So, perhaps, it would've been better to put "most" rather than "all," but I was just drawing that point so that people wouldn't misconstrue that one dissatisfaction or a few dissatisfactions would meet criteria.
Q Let me put it this way, Doctor. Is "all" in parentheses because the rest of that sentence is a direct quote from the DSM-5 criteria for gender dysphoria?
A Yes, it is. I am quoting from the criteria from DSM.
Q So you added the word "all" to the criteria?
A Well, I probably did add it, yes, for emphasis.
Q Okay. Doctor, I was reading an interview that's linked from your website to a website called xxxkidernet.com. Are you familiar with the interview that I'm referencing?
A Yep.
Q And I don't have it up in front of me, but I did

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copy this quote. And I'm going to read this quote to you and then the questions I'm going to ask is going to be whether you recall making this statement and whether it is an accurate statement of your beliefs.
You were quoted as saying, "Transgender advocates state that in transgenderism -- the belief/assumption that one has been born in the wrong body -- the body must be aligned to one's gender belief, not one's belief to one's biological body. They assume that the mind is correct in its perceptions and beliefs and the body is diseased and must be treated."
Do you recall making that statement or something similar to it?
A Yes.
Q And is what I quoted an accurate statement of your beliefs?
A Yes.
Q When you provide psychotherapy to a transgender patient or a patient identifying as transgender, is one of your methods to attempt to align their belief to their biological body?
A This is a grave misunderstanding of the process of exploratory psychodynamic psychotherapy. I

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don't try to do anything except provide a safe space for the young person to know their true feelings and to express them, and whatever conclusion they draw at the end of the psychotherapeutic process is not any attempt on the part of the therapist to engineer a particular outcome.

And what I find in the majority of cases is that after the first few sessions the child just stops talking about gender dysphoria and wanting to transition and we start talking about their emotional distress and pain in relationship to what is happening in their primary attachment relationships and also other issues that are of great concern to them such as bullying and discrimination, isolation, lonliness, a fear of not meeting expectations. Many of them have very deeply entrenched self-punity, internalized self-punity xxthat need to be dealt with and often we have to deal with how they manage their emotional distress through self harm.

So every time a child or anybody comes into an exploratory psychodynamic psychotherapy it's what's on the mind of the patient, what the patient brings to that session that the

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therapist focuses on. So, no, I do not have a goal of aligning anything with anything else.

Q Okay.

A It's to support the young person to understand themselves better.

Q Okay, Doctor. I'm going to pull up what I have marked as Exhibit 22. Do you see that in front of you?

A Uh-huh.

Q Sorry. ?

A Yes.

Q That's for the court reporter, not for me.

A I understand. I understand.

Q You recognize this as a presentation that you gave in November 2021 to the organization that we previously called SEGM?

A Yes.

Q And this presentation is not listed on your CV. Does this refresh your recollection as to whether there are presentations that you omitted?

A Right. Okay. I'll be sure to add it next time.

Q Was this presentation given at a conference of some sort?

MR. ROSE: You're on mute, Tom, if you're

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trying to talk.

MR. FISHER: Is there any reason you can just make it bigger for the doctor?

MR. ROSE: Oh, I had no idea, Tom.

Q I'm sorry, Doctor, I didn't realize you were leaning forward to try to read it.

A Right.

Q Is this better for you?

A Yes. Thank you. Yes.

Q Okay. I'm sorry, Doctor, let me repeat the question. The question was whether this presentation was given at a conference of some sort.

A Yes, it was, yes.

Q Did you give it in person, online?

A Given that it's November '21, it was probably online.

Q It would have been a conference of the Society for Evidence-based Gender Medicine?

A No, not necessarily. I'm just characterizing -- I'm just situating myself as a member of that organization.

Q Gotcha. And I don't know where I got this from, but it's in my notes so I'll just ask you. Was this given at a conference of the National

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Association of Practicing Psychiatrists?

A Oh, that's highly likely, yes.

Q I'm positive I saw it somewhere, but I don't know where I got that from. Is that an Australian organization?

A Yeah, it's a national organization, yes.

Q But the nation of Australia?

A The nation of Australia.

Q I assumed by how practicing was spelled.

Okay. And what we have here is the PowerPoint, I assume, that accompanied this presentation?

A Yes.

Q Did you create the PowerPoint yourself?

A Yes, I did. This is a presentation of a distillation of my theory development of what is required in assessment and therapy of young people presenting with gender dysphoria, so, yeah, it is a model that I've developed.

Q Okay. And on the very last page of your presentation you included an image of what appears to be a rose with the verbage "TRANS IS NOT BEAUTIFUL," correct?

A Yes.

Q Do you consider this image to be a hateful one?

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A The image with or without the "NOT"?
Q As you presented it at the conference.
A Hate was not in my heart. Why didn't you show more interest in the slides in between?
MR. ROSE: Doctor, I have no further questions. Thank you very much for your time this morning for you/this evening for us.
MR. FISHER: Can we take maybe 20 minutes?
(A recess was taken.)
CROSS-EXAMINATION,
QUESTIONS BY THOMAS M. FISHER:
Q Dianna, you were asked earlier by Mr. Rose about -- and this was a while ago so I'm certainly paraphrasing here, but I think the discussion was treatment of children who had started puberty blockers. Do you remember that discussion?
A Yes.
Q And I think the question from Mr. Rose was something along the lines of: Well, did you continue treating them, that child? And you said no. And then the follow-up, of course, was: Well, why not? And your response was something like: Well, they had found the magic solution. And that was the end of the

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discussion. Do you remember that?
A Yes.
Q Okay. So I was hoping you could explain to us a little bit more about what you meant when you said that.
A What I meant was that families go through a lot of heartache when a child declares themselves transgender, not all but most, and parents have difficulty tolerating their children's distress and most parents want to do what's going to make their children happy. And by "magic solution," I'm referring to a treatment that they've been convinced is going to improve their child's not only gender dysphoria but all the comorbid presentations that the child has as well.
And there is, not always but very, very often, a honeymoon period where everything seems to settle down. It's like, you know, the child is getting this almost magic treatment that's going to take away all the gender dysphoria and everybody then breathes a sigh of relief, but they're really breathing a sigh of relief over this very short-term period and all the complications that may come in the future are brushed aside because peace is being restored

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and the child appears happier in the short term.
But most studies show that pubic blockade has no positive effect on mental health presentations. It's just a placebo effect, but it feels like magic at the time.
Q So, in that circumstance then, because there was that honeymoon period, the family would discontinue seeing you at that point?
A Yes. Yes, they would discontinue other forms of therapy.
Q Okay. Alright. Later in Mr. Rose's questioning he asked about so-called conversion therapy bans in some of the Australian states. Do you recall that discussion?
A Yes, I do.
Q And I think that the sum and substance was pretty much all of those so-called conversion therapy bans were materially identical. Is that your recollection?
A Yes.
Q Tell us about what that means, the conversion therapy bans that those Australian states have enacted. What, in particular, are they trying to ban?
A Well, they're actually based on a completely and

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utter red herring. I don't know if you know that expression in America, but it means that it's a (inaudible). It's just based on shimmering sand because what they're claiming -- like conversion therapy is defined as trying to change the sexual orientation of homosexual individuals to heterosexual, and there was some conversion therapy practiced many, many years ago, decades ago, and maybe there are tiny little pockets in religious groups and so forth that is still trying to practice that but it's certainly not accepted in mainstream medicine, and it has never been practiced in its form, which was created for homosexuality, on transgender individuals. So there is no such thing as conversion therapy for transgender individuals.
And the definition of conversion therapy is a question that Mr. Rose put to me about my psychotherapy and that is: Do you aim to change the child's perception of the gender identity to align with their body? Now, that's conversion therapy, but psychotherapy doesn't try to do that.
So the only conversion therapy is

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gender-affirming care. It doesn't exist in any other form and it's a defunct treatment. It's proven to be inhumane, unethical, and medically ineffective. So it's all part, I'm sorry to say, you know, the transgender machinery, building up straw men to attack and pull down, and then there was so much dancing in the street when these conversion therapy laws got through parliament.

Q What can you do in your practice that psychologists in those states with conversion therapy bans cannot do when it comes to treating gender dysphoria?

A Well, there's two ways of looking at it. One is that anything that isn't gender-affirming care may be interpreted as conversion therapy, but you can only be prosecuted under that act if an actual patient makes a complaint about you. So a trans group or an advocacy group making a complaint that they know you're practicing something other than gender-affirming care cannot bring a complaint, so the patient or the patient's parent needs to directly complain about you.

But, in reality, it carries 18 months jail

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and a $30,000 fine if you're convicted under this act, but I doubt very much whether anybody could be convicted under that act because conversion therapy is not even defined properly in these new laws and it's never been practiced to anybody's knowledge in the transgender space.

Q But, just to be clear, your understanding of those laws is that they mean to say that anything other than gender-affirming care is conversion therapy?

A Yes.

Q Okay. Then at the end of Mr. Rose's questioning, he brought up a slide at the end of a long presentation that you gave, I think, and -- well, first of all, do you recall what that presentation was?

A Yes, I do. Yes, I was presenting my new model of exploratory psychodynamic psychotherapy starting with what I thought were essential assessment examinations that need to be done at the beginning, and then I outlined some of what I believe underlies the genesis of gender dysphoria and then how I work with the family to resolve some of those issues.

Q Well, and when Mr. Rose was asking you about the

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last slide, you, I think, made a comment about how you wished he would be more interested in what came before that. Do you remember making that comment?

A Yes, I do. Yes.

Q I was wondering what sparked that. What was it that you had hoped Mr. Rose would have been more interested in?

A Well, it was a very serious presentation presenting a new model of therapy that has not been presented before or outlined, you know, actually put into a coherent form so that clinicians can meet and discuss, compare notes, and, you know, talk about the process of psychotherapy. So it was the result of, you know, four to five years of very intense study on the subject and, you know, working constantly with young gender dysphoric people, and to go to the last slide, I mean, all we saw was the first slide and the last slide, which I think is a little bit cheap.

Q And what about that last slide that said, as I reall, it had said "TRANS IS BEAUTIFUL" and you put the word "NOT" in, "TRANS IS NOT BEAUTIFUL." Do you remember that?

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A Yes, I do, yes.

Q What did you mean by that?

A Well, if you look at the foregoing slides, you would see that the life of young people after they transition is actually worse in so many ways compared to before they transition. Yes, they're already having difficulties, there are a lot of problems, a lot of comorbidities, but when you look at studies that show what happens to these young people after they transition, that's when the suicide rate increases.

A long-term Swedish study that followed up people who'd had transgender surgery for 30 years showed that their suicide rate was 19 times higher than in the general population matched for age and sex. So transgender cross-sex hormones and sex reassignment surgery does not cure suicidality. It actually exacerbates it.

And the same goes for the other common comorbidities that you see with young people premorbid and that is vastly increased rates of depression, suicide, self harm, acting out, unemployment, homelessness.

And that was my summary way of saying

becoming transgender is not beautiful. In other words, it's not la dolce vita, the beautiful life that people envisage/fantasize about because their previous life was so difficult and in some cases traumatic. So it was part of a whole kind of complex constellation of factors that I had been talking about previously.

MR. FISHER: I don't have any further questions.

MR. ROSE: Just another hour, hour and a half maybe, Doctor. Doctor, it's 11 o'clock at night here. My boss is in my office and I have been told that if I ask you a single question, I will be fired on the spot, so I have no further questions.

MR. FISHER: We'll take signature.

AND FURTHER THE DEPONENT SAITH NOT.

_____
PROFESSOR DIANNA T. KENNY

STATE OF INDIANA)
) SS:
COUNTY OF HAMILTON)

I, Brandy L. Bradley, RPR, a Notary Public in and for the County of Hamilton, State of Indiana at large, do hereby certify that PROFESSOR DIANNA T. KENNY, the deponent herein, was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the above-captioned cause;

That the foregoing deposition was taken on behalf of the Plaintiffs at the remote location of the witness, Sydney, New South Whales, Australia, on the 30th day of May, 2023, pursuant to the Applicable Rules;

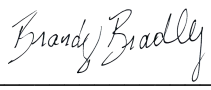
That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction, and that the typewritten transcript is a true record of the testimony given by said deponent, and thereafter presented to said deponent for his/her signature;

That the parties were represented by their aforementioned counsel.

I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of either party, or otherwise interested in the event of this action, and am not in

the employ of the attorneys for either party.

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



_____
Brandy L. Bradley, RPR

Commission No. NP0682101
My Commission Expires:
April 13, 2024

(Originating Party)
Gavin M. Rose
ACLU of Indiana
1031 W. Washington Street
Indianapolis, IN 46202

NOTICE OF DEPOSITION FILING

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

K.C., et al.,)
Plaintiff(s),)
-vs-)
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,)
Defendant(s).)

In compliance with the Indiana Rules of Procedure, Federal Rules of Civil Procedure and/or the Rules of the Industrial Board, you are notified that the signed original deposition of PROFESSOR DIANNA T. KENNY, taken on the 30th day of May, 2023, has been sealed and submitted to the originating party, along with the attached Errata Sheet(s), if applicable.

_____
(Date received by Circle City Reporting)

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Change or Suppression (Conversion) Practices Prohibition Act 2021

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Change or Suppression (Conversion) Practices Prohibition Act 2021†

No. of 2021

[Assented to]

The Parliament of Victoria enacts:

Part 1—Preliminary

Division 1—General

1 Purposes

The main purposes of this Act are—

(a) to denounce and prohibit change or suppression practices; and

(b) to establish a civil response scheme within the Victorian Equal Opportunity and Human Rights Commission that will—

(i) promote understanding of the prohibition on change or suppression practices under this Act and matters relating generally to change or suppression practices; and

(ii) consider and resolve reports of change or suppression practices; and

(iii) investigate serious or systemic change or suppression practices; and

(c) to prohibit engaging in change or suppression practices, including through creating offences in relation to engaging in change or suppression practices and certain related activities; and

(d) to amend the definitions of ***sexual orientation*** and ***gender identity*** in the **Equal Opportunity Act 2010**; and

(e) to include sex characteristics as a protected attribute under the **Equal Opportunity Act 2010**; and

(f) to make consequential amendments to certain Acts.

2 Commencement

(1) Subject to subsection (2), this Act comes into operation on a day or days to be proclaimed.

(2) If a provision of this Act does not come into operation within the period of 12 months beginning on the day on which this Act receives the Royal Assent, it comes into operation on the day after the end of that period.

3 Objects of this Act

(1) The objects of this Act are—

(a) to eliminate so far as possible the occurrence of change or suppression practices in Victoria; and

(b) to further promote and protect the rights set out in the Charter of Human Rights and Responsibilities; and

(c) to ensure that all people, regardless of sexual orientation or gender identity, feel welcome and valued in Victoria and are able to live authentically and with pride.

(2) In enacting this Act, it is the intention of the Parliament—

(a) to denounce and give statutory recognition to the serious harm caused by change or suppression practices; and

(b) to affirm that a person's sexual orientation or gender identity is not broken and in need of fixing; and

(c) to affirm that no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming; and

(d) to affirm that change or suppression practices are deceptive and harmful both to the person subject to the change or suppression practices and to the community as a whole.

4 Definitions

In this Act—

associate, in relation to a body corporate, means the following—

(a) an employee or agent of the body corporate to the extent that the employee or agent is acting within the actual or apparent scope of their employment or within their actual or apparent authority;

(b) an officer of the body corporate;

Australian Health Practitioner Regulation Agency means the Australian Health Practitioner Regulation Agency established by section 23 of the Health Practitioner Regulation National Law;

board of directors means the body (by whatever name called) exercising the executive authority of a body corporate;

change or suppression practice has the meaning given by section 5;

Chief Commissioner of Police means the ***Chief Commissioner*** within the meaning of the **Victoria Police Act 2013**;

Commission has the same meaning as it has in the **Equal Opportunity Act 2010**;

Commissioner has the same meaning as it has in the **Equal Opportunity Act 2010**;

compliance notice means a compliance notice issued under section 45(1);

corporate culture of a body corporate means an attitude, policy, rule, course of conduct or practice existing within the body corporate

or within a part of the body corporate, as the case requires;

Director of Public Prosecutions means the Director of Public Prosecutions appointed under section 87AB of the **Constitution Act 1975**;

enforceable undertaking means an undertaking accepted under section 43;

gender identity has the same meaning as it has in the **Equal Opportunity Act 2010**;

Health Complaints Commissioner means the ***Commissioner*** within the meaning of the **Health Complaints Act 2016**;

health service has the same meaning as it has in the Health Practitioner Regulation National Law;

health service provider has the same meaning as it has in the Health Practitioner Regulation National Law;

IBAC means the Independent Broad-based Anti-corruption Commission established by the **Independent Broad-based Anti-corruption Commission Act 2011**;

injury has the same meaning as it has in section 15 of the **Crimes Act 1958**;

investigation means an investigation under section 34;

officer, in relation to a body corporate, means an officer (as defined by section 9 of the Corporations Act) of the body corporate to the extent that the officer is acting within the actual or apparent scope of their employment or within their actual or apparent authority;

Ombudsman means the person appointed as the Ombudsman under section 3 of the **Ombudsman Act 1973**;

organisation means an unincorporated body or association, whether the body or association—

(a) is based in or outside Australia; or

(b) is part of a larger organisation;

person affected by a change or suppression practice means a person towards whom a change or suppression practice is being, or has been, directed;

police officer has the same meaning as it has in the **Victoria Police Act 2013**;

produce includes permit access to;

protected information has the meaning given by section 50;

serious injury has the same meaning as it has in section 15 of the **Crimes Act 1958**;

sexual orientation has the same meaning as it has in the **Equal Opportunity Act 2010**;

Tribunal means the Victorian Civil and Administrative Tribunal established by the **Victorian Civil and Administrative Tribunal Act 1998**;

Victoria Police has the same meaning as in the **Victoria Police Act 2013**;

Victorian Inspectorate means the Victorian Inspectorate established by the **Victorian Inspectorate Act 2011**.

5 Meaning of *change or suppression practice*

(1) In this Act, a ***change or suppression practice*** means a practice or conduct directed towards a person, whether with or without the person's consent—

(a) on the basis of the person's sexual orientation or gender identity; and

(b) for the purpose of—

(i) changing or suppressing the sexual orientation or gender identity of the person; or

(ii) inducing the person to change or suppress their sexual orientation or gender identity.

(2) For the purposes of subsection (1), a practice or conduct is not a change or suppression practice if it—

(a) is supportive of or affirms a person's gender identity or sexual orientation including, but not limited to, a practice or conduct for the purposes of—

(i) assisting a person who is undergoing a gender transition; or

(ii) assisting a person who is considering undergoing a gender transition; or

(iii) assisting a person to express their gender identity; or

(iv) providing acceptance, support or understanding of a person; or

(v) facilitating a person's coping skills, social support or identity exploration and development; or

(b) is a practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—

(i) to provide a health service; or

(ii) to comply with the legal or professional obligations of the health service provider.

(3) For the purposes of subsection (1), a practice includes, but is not limited to the following—

(a) providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy;

(b) carrying out a religious practice, including but not limited to, a prayer based practice, a deliverance practice or an exorcism;

(c) giving a person a referral for the purposes of a change or suppression practice being directed towards the person.

(4) For the purposes of subsection (1), a practice or conduct may be directed towards a person remotely (including online) or in person.

6 Act binds the Crown

This Act binds the Crown in right of Victoria and, so far as the legislative power of the Parliament permits, the Crown in all its other capacities.

7 Contravention does not create civil or criminal liability

A contravention of this Act does not create any civil or criminal liability except to the extent expressly provided by this Act.

8 Extra-territorial application

(1) This section applies if—

(a) a person engages in conduct outside, or partly outside, Victoria; and

(b) there is a real and substantial link between the conduct and Victoria.

(2) This Act has effect in relation to the conduct as if it had been engaged in wholly within Victoria.

(3) For the purposes of subsection (1), there is a real and substantial link with Victoria if—

(a) a significant part of the conduct occurs in Victoria; or

(b) the conduct occurred wholly outside Victoria, but the effects of the conduct occurred wholly or partly in Victoria.

Division 2—Change or suppression practices are prohibited

9 General prohibition on change or suppression practices

A person or organisation contravenes this Act if the person or organisation engages in a change or suppression practice.

Note

A contravention of this Act by a person or organisation may result in a report being made under Part 3, which sets out the civil response scheme.

Part 2—Offences relating to change or suppression practices

Division 1—Offences

10 Offence of engaging in one or more change or suppression practices that cause serious injury

(1) A person (***A***) commits an offence if—

(a) A intentionally engages in a change or suppression practice directed towards another person (***B***); and

(b) the change or suppression practice causes serious injury to B; and

(c) A is negligent as to whether engaging in the change or suppression practice will cause serious injury to B.

Penalty: In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A intentionally engages in change or suppression practices directed towards another person (***B***); and

(b) any or all of the change or suppression practices, considered as a group, cause serious injury to B; and

(c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause serious injury to B.

Penalty: In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

11 Offence of engaging in one or more change or suppression practices that cause injury

(1) A person (***A***) commits an offence if—

(a) A intentionally engages in a change or suppression practice directed towards another person (***B***); and

(b) the change or suppression practice causes injury to B; and

(c) A is negligent as to whether engaging in the change or suppression practice will cause injury to B.

Penalty: In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A intentionally engages in change or suppression practices directed towards another person (***B***); and

(b) any or all of the change or suppression practices, considered as a group, cause injury to B; and

(c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause injury to B.

Penalty: In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum.

12 Offence of taking a person from Victoria for a change or suppression practice

(1) A person (***A***) commits an offence if—

(a) A takes another person (***B***) from Victoria, or arranges for B to be taken from Victoria; and

(b) A intends that a change or suppression practice directed towards B will be engaged in outside Victoria (whether by A or another person); and

(c) a change or suppression practice directed towards B is engaged in outside Victoria; and

(d) the change or suppression practice causes injury to B; and

(e) A is negligent as to whether the change or suppression practice will cause injury to B.

Penalty: In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

(2) A person (***A***) commits an offence if—

(a) A takes another person (***B***) from Victoria, or arranges for B to be taken from Victoria; and

(b) A intends that change or suppression practices directed towards B will be engaged in outside Victoria (whether by A or another person); and

(c) change or suppression practices directed towards B are engaged in outside Victoria; and

(d) any or all of the change or suppression practices, considered as a group, cause injury to B; and

(e) A is negligent as to whether any or all of the change or suppression practices, considered as a group, will cause injury to B.

Penalty: In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

13 Offence of advertising a change or suppression practice

(1) A person commits an offence if—

(a) the person publishes or displays, or authorises the publication or display of, an advertisement or other notice; and

(b) the advertisement or other notice indicates, or could reasonably be understood as indicating, that the person or any other person intends to engage in one or more change or suppression practices, other than

for the purposes of warning of the harm caused by such practices.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

(2) It is a defence to a charge under subsection (1) if the accused proves that the accused took reasonable precautions and exercised due diligence to prevent the publication or display.

14 Production of documents relating to advertising offence

(1) For the purpose of proceedings under section 13, the Commission may, by written notice, require any person to produce any documents specified in the notice to the Commission.

(2) A person must not refuse, without reasonable excuse, to produce a document referred to in subsection (1) to the Commission.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

Division 2—General matters relating to offences against this Part

15 Corporate criminal responsibility for offence against this Part

(1) For the purposes of a proceeding against a body corporate for an offence against this Part, the following must also be attributed to the body corporate—

(a) relevant conduct engaged in by an associate of the body corporate;

(b) knowledge of an associate of the body corporate;

(c) intention—

(i) of the body corporate's board of directors; or

(ii) of an officer of the body corporate; or

(iii) of any other associate of the body corporate if a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the formation of that intention.

(2) If an officer of a body corporate engages in conduct that constitutes an offence against this Part, the body corporate must be taken to have also engaged in conduct constituting the offence, and may be proceeded against and found guilty of the offence whether or not the officer has been proceeded against or found guilty of that offence.

(3) In a proceeding against a body corporate for an offence against this Part brought in reliance on subsection (2), it is a defence to the charge for the body corporate to prove that it exercised due diligence to prevent the conduct engaged in by the officer.

16 Who may bring proceedings for an offence under section 13

Proceedings for an offence under section 13 may be brought by—

(a) the Commission; or

(b) a police officer; or

(c) a person who is authorised to do so, either generally or in a particular case, by the Commission.

Part 3—Civil response scheme

Division 1—Functions and powers of Commission

17 Functions and powers of Commission

(1) The Commission has the following functions—

(a) to develop and provide education in relation to change or suppression practices;

(b) to receive reports about change or suppression practices from any person;

(c) to request further information regarding reports of change or suppression practices from persons who make a report and persons or organisations alleged to be engaging in change or suppression practices;

(d) to determine appropriate responses to reports on the basis of information provided and the wishes of persons affected where those persons are involved in making reports;

(e) to offer education to persons and organisations engaged in change or suppression practices;

(f) to establish processes for facilitating an outcome in relation to matters in certain reports that meet the needs of persons affected by change or suppression practices;

(g) to focus on ensuring that persons affected by change or suppression practices receive support by directing them to appropriate support services;

(h) to support persons who are or may be victims of criminal offences under this Act to voluntarily report these to police.

(2) The Commission has all the powers necessary to enable it to perform its functions.

18 Functions of Commission—educative function

(1) The Commission must—

(a) establish and undertake information and education programs in relation to change or suppression practices; and

(b) promote and advance the objects of this Act and be an advocate for this Act.

(2) The Commission must undertake programs to disseminate information and educate the public with respect to—

(a) the objects of this Act; and

(b) any other matters relevant to the provisions of this Act.

19 Functions of Commission—research function

(1) The Commission may undertake research into any matter arising from, or incidental to, the operation of this Act that it considers would advance the objects of this Act.

(2) The Commission may collect and analyse information and data relevant to the operation and objects of this Act.

20 Commission may report on educative or research functions

The Commission may, at any time, submit a report to the Attorney-General on any matter arising from the performance of the Commission's functions under section 18 or 19.

21 Functions of Commission—receiving reports and facilitating outcomes

The Commission must—

(a) receive reports under section 24 from persons affected by change or suppression practices (or persons acting on their behalf), or other persons; and

(b) establish policies and issue procedures and directions on the manner in which such reports should be dealt with; and

(c) in the case of a reports made by persons affected by change or suppression practices (or persons acting on their behalf), establish policies and procedures for the facilitation of an outcome in relation to the matters in the report.

22 Staff of Commission

Any staff that are necessary for the purposes of administering this Act are to be employed under Part 3 of the **Public Administration Act 2004**.

23 Delegation

The Commission, by instrument, may delegate to the Commissioner or a member of staff of the Commission referred to in section 22 any of the Commission's functions, duties or powers under this Act other than this power of delegation.

Note

Under an Order made by the Governor in Council under section 16 of the **Public Administration Act 2004**, the Commissioner has all the functions of a public service body Head in relation to employees of the Commission.

Division 2—Reporting change or suppression practices to Commission

24 Reporting change or suppression practices

(1) A person affected by a change or suppression practice, or any other person, may make a report to the Commission in relation to an alleged change or suppression practice.

(2) A report must be in the prescribed form (if any).

25 Principles for responding to reports

The principles for the Commission responding to reports are—

(a) a response should be provided to the person who made the report; and

(b) a response should be informed by the needs and wishes of persons affected by change or suppression practices; and

(c) a response should be appropriate to the report; and

(d) a response should be fair to all persons; and

(e) a response should be consistent with the objects of this Act.

26 Commission may request more information

The Commission may request a person who makes a report or a person or organisation who is alleged to be engaging in a change or suppression practice to provide any further information that the Commission considers necessary to assist in determining its response to a report.

27 Consideration of reports

(1) This section applies if, in considering a report, the Commission is satisfied that a person or organisation is engaging in, or has engaged in, a change or suppression practice.

(2) In responding to the report, the Commission must as far as practicable have regard to the following matters, to the extent that information about the matters is reasonably available to the Commission—

(a) the wishes of the person or persons affected by the change or suppression practice;

(b) whether the change or suppression practice was a one-off event or a pattern of behaviour;

(c) the number of people affected by the change or suppression practice;

(d) the nature and extent of the harm caused by the change or suppression practice;

(e) any steps taken by a person or organisation to stop engaging in the change or suppression practice or to address the harms caused by the change or suppression practice.

28 Responding to reports

(1) The Commission, after considering a report, may do one or more of the following—

(a) offer targeted education to persons or organisations reported to have engaged in change or suppression practices;

(b) in the case of reports made by persons affected by a change or suppression practice, offer facilitation of an outcome in relation to the matters in the report;

(c) refer the report to another person or body under section 29;

(d) decline to respond to the report in accordance with section 30.

(2) Participation in facilitation of an outcome in relation to matters in a report is voluntary.

29 Referral of reports

(1) Subject to subsection (3), if the Commission considers that a report relates to conduct that would be more adequately dealt with by another person or body, the Commission may refer the report to the other person or body.

(2) The persons or bodies to which the Commission may refer a report include, but are not limited to, the following—

(a) the Health Complaints Commissioner;

(b) the Australian Health Practitioner Regulation Agency;

(c) the Ombudsman;

(d) Victoria Police.

(3) The Commission must not refer a report under subsection (1) without the consent of the person affected by the change or suppression practice to which the report relates, unless required to do so by a law dealing with mandatory reporting.

30 Discretion to decline to respond to report

The Commission may decline to respond to a report if—

(a) the report refers to persons or organisations who can no longer be located; or

(b) the report relates to conduct in respect of which sufficient information is no longer available; or

(c) the report relates to conduct that has been adequately dealt with in another forum or would be more appropriately dealt with in another forum; or

(d) having regard to all the circumstances, the Commission considers it is not appropriate to respond to the report.

31 Withdrawal from facilitation of an outcome

If the Commission is facilitating an outcome in relation to a matter in a report, any person involved in the facilitation may withdraw at any time by informing the Commission that the person no longer wishes to participate.

32 Agreements resulting from facilitation

(1) This section applies if, after the Commission facilitates an outcome in relation to a matter in a report, the persons engaged in the facilitation (the ***parties***) reach agreement with respect to any of the matters.

(2) Any party may request that a written record of agreement be prepared by the parties or the Commission.

(3) A request must be made within 30 days after the agreement is reached.

(4) If a record of agreement is prepared by the Commission following a request under subsection (2)—

(a) the record of agreement must be signed by or on behalf of each party; and

(b) the Commission must certify the record of agreement.

(5) If a record of agreement is prepared by the parties following a request under subsection (2)—

(a) the record of agreement must be signed by or on behalf of each party; and

(b) on the request of a party, the Commission may certify the record of agreement.

(6) If the Commission certifies a record of agreement under subsection (4)(b) or (5)(b), the Commission must give each party a copy of the signed and certified record of agreement.

(7) The refusal of the Commission to certify a record of agreement does not affect the validity of the agreement.

33 Registration of agreements

(1) Any party to an agreement reached under section 32 may, after notifying each other party in writing, lodge a copy of the signed and certified record of agreement with the Tribunal for registration.

(2) Subject to subsection (3), the Tribunal must register the record of agreement and give a certified copy of the registered record of agreement to each party.

(3) If the Tribunal, constituted by a presidential member, considers that it may not be practicable to enforce, or to supervise compliance with, a record of agreement or part of a record of agreement, the Tribunal—

(a) in the case of a record of agreement, may refuse to register the record of agreement; or

(b) in the case of a part of a record of agreement, may refuse to register the part of the record of agreement that it considers may not be practicable to enforce, or to supervise compliance with.

(4) On registration, a registered record of agreement or a registered part of a record of agreement—

(a) is taken to be an order of the Tribunal in accordance with its terms; and

(b) may be enforced accordingly.

(5) The refusal of the Tribunal to register a record of agreement or any part of a record of agreement does not affect the validity of the agreement.

Division 3—Investigations

34 When investigation may be conducted

The Commission may conduct an investigation under this section into any matter relating to this Act—

(a) that raises an issue that is serious in nature or indicates change or suppression practices that are systemic or persisting; and

(b) that indicates a possible contravention of this Act; and

(c) that relates to a class or group of persons; and

(d) that would advance the objects of this Act.

35 Commission to conduct investigation as it considers fit

(1) Subject to this Division, the Commission may conduct an investigation in the manner it considers fit.

(2) In conducting an investigation, the Commission is bound by the principles of natural justice, unless otherwise expressly provided in this Division.

36 Power to compel provision of information and production of documents

(1) If the Commission reasonably believes that—

(a) a person is in possession of information or a document that is relevant to an investigation; and

(b) the information or document is necessary for the conduct of the investigation—

the Commission may by written notice require the person to provide the information or document or both.

(2) A notice referred to in subsection (1) must specify that the person must do either or both of the following within a reasonable period specified in the notice, or on a reasonable date and at a reasonable time specified in the notice—

(a) give the Commission a document containing information required by the notice;

(b) produce to the Commission the documents specified in the notice.

(3) A document referred to in subsection (2)(a) must be signed by the person or, in the case of a notice served on a body corporate, an officer of the body corporate.

(4) If a document is produced to the Commission in accordance with a notice under this section, the Commission may—

(a) take possession of the document; and

(b) make copies of the document or take extracts from the document; and

(c) retain possession of the document for as long as is necessary for the purposes of the investigation to which the document relates.

(5) The Commission must allow a document retained under this section to be inspected, at all reasonable times, by any person who would be entitled to inspect the document if it were not in the possession of the Commission.

37 Power to compel attendance

(1) The Commission by written notice may require a person to attend before the Commission, at a reasonable time and place, to answer questions if the Commission reasonably believes that—

(a) the person has information that is relevant to an investigation; and

(b) the information is necessary for the conduct of the investigation.

(2) A person who is required under this section to attend before the Commission—

(a) is entitled to be paid a reasonable sum for the person's attendance; and

(b) is entitled to have a legal or personal representative present.

38 Compliance with notice requiring attendance or production of documents

A person must not, without reasonable excuse, fail to comply with a notice of the Commission under section 36 or 37.

Penalty: In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

39 Protection against self-incrimination

It is a reasonable excuse for a natural person to refuse to give information, answer a question or produce a document under this Act if the giving of the information, the answering of the question or the production of the document would tend to incriminate the person.

40 Disclosure of identity of persons who give information or documents

(1) This section applies to a person who has given or who will give evidence, information or documents to the Commission as part of an investigation, whether or not the person is compelled to do so under section 36 or 37.

(2) The Commission may give directions prohibiting the disclosure of the identity of the person, or prohibiting the disclosure of information that would be reasonably likely to identify the person, if the Commission considers that preservation of the person's anonymity is necessary—

(a) to protect the person's security of employment, privacy or any right protected by the **Charter of Human Rights and Responsibilities Act 2006**; or

(b) to protect the person from victimisation.

41 Publication of evidence, information or documents

(1) The Commission may give directions prohibiting or limiting the publication of—

(a) any evidence given before the Commission or any information given to the Commission as part of an investigation; or

(b) the contents of any document produced to the Commission as part of an investigation.

(2) Subsection (1) applies whether or not a person was compelled to give the evidence or produce the information or document under section 36 or 37.

(3) In deciding whether or not to give a direction under subsection (1), the Commission must have regard to the need to prevent such of the following as are relevant to the circumstances—

(a) prejudice to the relations between the Government and the Commonwealth Government or between the Government and the Government of another State or a Territory;

(b) the disclosure of deliberations or decisions of the Cabinet, or of a Committee of the Cabinet;

(c) prejudice to the proper functioning of the Government;

(d) the disclosure, or the ascertaining by a person, of the existence or identity of a confidential source of information in relation to the enforcement of the criminal law;

(e) the endangering of the life or physical or psychological safety of any person;

(f) prejudice to the proper enforcement of the law or the protection of public safety;

(g) the disclosure of information the disclosure of which is prohibited, absolutely or subject to qualifications, by or under another Act;

(h) the unreasonable disclosure of the personal affairs of any person or organisation;

(i) the unreasonable disclosure of confidential commercial information.

42 Outcome of an investigation

(1) After conducting an investigation, the Commission may take any action it considers fit.

(2) Without limiting subsection (1), the Commission may do any of the following—

(a) take no further action;

(b) enter into an agreement with a person about action required to comply with this Act;

(c) accept an enforceable undertaking;

(d) issue a compliance notice to a person.

Division 4—Remedies

43 Enforceable undertakings

If, following an investigation, the Commission believes that a change or suppression practice has occurred, is occurring or is likely to occur, the Commission may accept a written undertaking from a person under which the person undertakes to take certain actions or refrain from taking certain actions to comply with this Act.

44 Register of enforceable undertakings

The Commission may keep a register of enforceable undertakings that is available to the public.

45 Compliance notices

(1) If, following an investigation, the Commission believes that a change or suppression practice has occurred or is occurring, the Commission may issue a compliance notice to a person who is wholly or partly responsible for the change or suppression practice.

(2) A compliance notice must set out the following—

(a) the basis for the Commission's belief that a change or suppression practice has occurred or is occurring;

(b) the provisions of this Act (if any) that the Commission believes the person has contravened;

(c) the date by which the person must take or refrain from taking specified actions in relation to the change or suppression practice;

(d) the further action that the Commission may take if the person does not take or refrain from taking specified actions;

(e) that the person may apply to the Tribunal for review of the issuing of the notice or any term of the notice.

(3) A person may, within 28 days of receiving the compliance notice, apply to the Tribunal for a review of the issuing of the compliance notice or of any term of the compliance notice.

46 Failure to comply with enforceable undertaking or compliance notice

(1) This section applies if—

(a) the Commission has accepted an enforceable undertaking from a person; or

(b) the Commission has issued a compliance notice to a person.

(2) If the person fails to comply with the enforceable undertaking or the compliance notice—

(a) the Commission may apply to the Tribunal to enforce the undertaking or the notice; and

(b) the Tribunal may make an order requiring the person to comply with the undertaking or notice.

Note

Under section 133 of the **Victorian Civil and Administrative Tribunal Act 1998**, non-compliance with an order of the Tribunal is an offence.

47 Vicarious liability

(1) For the purposes of this Part, if a natural person engages in a change or suppression practice in the course of employment (including as a volunteer) or while acting as an agent—

(a) subject to subsection (2), both the natural person, and the employer or principal, as the case requires, are taken to have engaged in the change or suppression practice; and

(b) the person towards whom the change or suppression practice was directed or another person may make a report under section 24 in respect of—

(i) the natural person; or

(ii) the employer or principal; or

(iii) both the natural person and the employer or principal.

(2) The employer or principal is not taken to have engaged in the change or suppression practice if the employer or principal proves, on the balance of probabilities, that the employer or principal took reasonable precautions to prevent the natural person engaging in a change or suppression practice.

48 Who may bring proceedings for an offence under this Part

Proceedings for an offence under this Part may be brought by—

(a) the Commission; or

(b) a police officer; or

(c) a person who is authorised to do so, either generally or in a particular case, by the Commission.

49 Reports etc. that relate to organisations

If a report under this Act relates to change or suppression practices alleged to have been engaged in by an organisation—

(a) the Commission may request information under section 26 from the president, secretary or other similar officer of the organisation; and

(b) the Commission may offer targeted education to the president, secretary or other similar officer of the organisation; and

(c) the president, secretary or other similar officer of the organisation may be a party to facilitation of an outcome for the purposes of Division 2 of this Part.

Part 4—General matters

Division 1—Secrecy

50 Definition

In this Division—

protected information means information concerning the affairs of a person or organisation, being information obtained by a person to whom section 51 applies—

(a) in the course of performing functions or duties or exercising powers under this Act; or

(b) as a result of another person performing functions or duties or exercising powers under this Act.

51 Secrecy

(1) This section applies to a person who is or has been—

(a) the Commissioner; or

(b) a member of the staff of the Commission referred to in section 22;

(c) a person (other than a person referred to in paragraph (b)) acting under the authority of the Commission or the Commissioner.

(2) A person to whom this section applies must not, either directly or indirectly, make a record of, disclose or communicate protected information to any person unless —

(a) it is necessary to do so for the purposes of, or in connection with, the performance of a function or duty or the exercise of a power under this Act; or

(b) it is necessary to do so to prevent a credible and imminent threat of harm to one or more persons; or

(c) it is necessary to do so to comply with a mandatory reporting obligation; or

(d) the disclosure, communication or production is to a court in accordance with section 52; or

(e) the information is already in the public domain; or

(f) the information does not identify any person or organisation; or

(g) all persons or organisations identified by the information have consented to the disclosure of the information.

Penalty: Level 9 fine (60 penalty units maximum).

52 Disclosure to courts

(1) Subject to this section, a person to whom section 51 applies must not be required—

(a) to produce in a court any document containing protected information; or

(b) to disclose or communicate protected information to a court.

(2) Subsection (1) does not prevent a person to whom section 51 applies disclosing or communicating protected information or producing in a court any document containing protected information if the disclosure, communication or production —

(a) is necessary for the purposes of, or for a prosecution under or arising out of, this Part; or

(b) is required by an order of a court for the purposes of a criminal proceeding; or

(c) is with the consent of the person or organisation to whose affairs the information relates.

Division 2—Provisions relating to certain proceedings

53 Commission not to prejudice certain proceedings or investigations

(1) The Commission must not perform the functions or duties or exercise the powers of the Commission under this Act in a manner that would prejudice any—

(a) criminal proceedings or criminal investigations; or

(b) investigations by the IBAC or the Victorian Inspectorate.

(2) For the purposes of ensuring compliance with subsection (1), the Commission may consult any of the following—

(a) the Director of Public Prosecutions;

(b) the Chief Commissioner of Police;

(c) the IBAC;

(d) the Victorian Inspectorate.

54 Person bringing proceedings presumed to be authorised to do so

In a proceeding for an offence against this Act it must be presumed, in the absence of evidence to the contrary, that the person bringing the proceeding was authorised to bring it.

55 Commission may assist in proceedings as amicus curiae

(1) The Commission may assist a court or tribunal as amicus curiae in the following proceedings, with the leave of the court or tribunal—

(a) proceedings in which the Commission considers that the orders sought, or likely to be sought, may significantly affect the rights relating to change or suppression practices in relation to persons who are not parties to the proceedings;

(b) proceedings that, in the opinion of the Commission, have significant implications for the administration of this Act;

(c) proceedings where the Commission is satisfied that it would be in the public interest for the Commission to assist the court or tribunal as amicus curiae.

Division 3—Annual report and review of Act

56 Annual report

In its report of operations for a financial year under Part 7 of the **Financial Management Act 1994**, the Commission must include a description of the performance of its functions in relation to change or suppression practices during the financial year.

57 Review of this Act

(1) The Attorney-General must ensure that an independent review of the operation and effectiveness of this Act commences 2 years after the commencement of this Act and is completed within 6 months.

(2) The Attorney-General must ensure that the review is conducted by a person who, in the opinion of the Attorney-General, possesses appropriate qualifications and expertise related to change or suppression practices.

(3) The person conducting the review must consider the following—

(a) whether the criminal offences contained in this Act are effective;

(b) whether the civil response scheme is effective, including whether broader investigation and enforcement powers are required;

(c) whether a redress scheme should be developed.

(4) A person who undertakes the review must give the Attorney-General a written report of the review as soon as practicable after completing the review.

(5) The Attorney-General must cause a copy of the review to be laid before each House of the Parliament within 15 sitting days of that House after receiving the written report.

Division 4—Regulations

58 Regulations

(1) The Governor in Council may make regulations for or with respect to the following matters—

(a) forms to be used for the purposes of this Act;

(b) any other matter or thing required or permitted by this Act to be prescribed or necessary to be prescribed to give effect to this Act.

(2) Regulations made under this Act—

(a) may be of limited or general application; and

(b) may differ according to differences in time, place or circumstance; and

(c) may confer powers or impose duties in connection with the regulations on any specified person or specified class of persons; and

(d) may apply, adopt or incorporate, with or without modification, any matter contained in any document, code, standard, rule, specification or method formulated, issued, prescribed or published by any person—

(i) wholly or partially or as amended by the regulations; or

(ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or

(iii) as formulated, issued, prescribed or published from time to time.

Part 5—Amendment of definitions in the Equal Opportunity Act 2010

Division 1—Amendment of definitions

59 Definitions

(1) In section 4(1) of the **Equal Opportunity Act 2010**, for the definition of ***gender identity*** **substitute**—

"***gender identity*** means a person's gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references;".

(2) In section 4(1) of the **Equal Opportunity Act 2010 insert** the following definition—

"***sex characteristics*** means a person's physical features relating to sex, including—

(a) genitalia and other sexual and reproductive parts of the person's anatomy; and

(b) the person's chromosomes, genes, hormones, and secondary physical features that emerge as a result of puberty;".

(3) In section 4(1) of the **Equal Opportunity Act 2010**, for the definition of ***sexual orientation*** **substitute**—

"***sexual orientation*** means a person's emotional, affectional and sexual attraction to, or intimate or sexual relations with, persons of

a different gender or the same gender or more than one gender;".

60 Attributes

After section 6(o) of the **Equal Opportunity Act 2010 insert**—

"(oa) sex characteristics;".

Division 2—Transitional provisions

61 New Division inserted

After Division 2 of Part 14 of the **Equal Opportunity Act 2010, insert**—

"Division 3—Transitional provisions relating to the Change or Suppression (Conversion) Practices Prohibition Act 2021

197 Definitions

In this Division—

commencement day means the day on which Part 5 of the **Change or Suppression (Conversion) Practices Prohibition Act 2021** comes into operation;

old Act means the **Equal Opportunity Act 2010**, as in force immediately before the commencement day.

198 Conduct, disputes and investigations before commencement day

(1) This section applies to—

(a) conduct engaged in before the commencement day; and

(b) a dispute brought to the Commission before the commencement day that had not ended before the commencement day; and

(c) an investigation of the Commission that had not been finally determined before the commencement day.

(2) The old Act continues to apply in relation to the conduct, dispute or investigation, as the case requires, as if the amendments made by Part 5 of the **Change or Suppression (Conversion) Practices Prohibition Act 2021** had not been made.".

Part 6—Consequential amendment of Acts

Division 1—Amendment of the Equal Opportunity Act 2010

62 Obstructing Commission

In section 185(1) of the **Equal Opportunity Act 2010**, after "Act" **insert** "or the **Change or Suppression (Conversion) Practices Prohibition Act 2021**".

63 False or misleading information

In section 186 of the **Equal Opportunity Act 2010**, after "Act" **insert** "or the **Change or Suppression (Conversion) Practices Prohibition Act 2021**".

Division 2—Amendment of the Family Violence Protection Act 2008

64 Meaning of *emotional or psychological abuse*

In section 7 of the **Family Violence Protection Act 2008**, after the second dot point under the heading "**Examples—**" **insert**—

"• an adult child repeatedly denigrating an elderly parent's sexual orientation, including by telling them it is wrong to be same-sex attracted and that they must change or the adult child will no longer support them;".

Division 3—Amendment of the Personal Safety Intervention Orders Act 2010

65 Meaning of *harassment*

In section 7 of the **Personal Safety Intervention Orders Act 2010**, at the end of the paragraphs under the heading "**Examples**" **insert**—

"A repeatedly leaves pamphlets in B's mailbox that state that it is wrong to gender transition and that everyone's gender expression should match the sex they were assigned at birth.".

Part 7—Repeal of amending Parts

66 Repeal of amending Parts

Parts 5 and 6 and this Part are **repealed** on the first anniversary of the first day on which all of the provisions in those Parts are in operation.

Note

The repeal of these Parts does not affect the continuing operation of the amendments made by these Parts (see section 15(1) of the **Interpretation of Legislation Act 1984**).

Endnotes

1 General information

See www.legislation.vic.gov.au for Victorian Bills, Acts and current authorised versions of legislation and up-to-date legislative information.

† *Minister's second reading speech—*

Legislative Assembly:

Legislative Council:

The long title for the Bill for this Act was "A Bill for an Act to prohibit change or suppression practices, to amend certain definitions in the **Equal Opportunity Act 2010** and for other purposes."

By Authority. Government Printer for the State of Victoria.

PLOS ONE

CORRECTION

Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria

Lisa Littman

Notice of republication

After publication of this article [1], questions were raised that prompted the journal to conduct a post-publication reassessment of the article, involving senior members of the journal's editorial team, two Academic Editors, a statistics reviewer, and an external expert reviewer. The post-publication review identified issues that needed to be addressed to ensure the article meets *PLOS ONE*'s publication criteria. Given the nature of the issues in this case, the *PLOS ONE* Editors decided to republish the article, replacing the original version of record with a revised version in which the author has updated the Title, Abstract, Introduction, Discussion, and Conclusion sections, to address the concerns raised in the editorial reassessment. The Materials and methods section was updated to include new information and more detailed descriptions about recruitment sites and to remove two figures due to copyright restrictions. Other than the addition of a few missing values in Table 13, the Results section is unchanged in the updated version of the article. The Competing Interests statement and the Data Availability statement have also been updated in the revised version. The original version of the published article is appended to this Correction as S1 File.

This Correction Notice serves to provide additional clarifications and context for the article in response to questions raised during the post-publication review of this work.

Emphasis that this is a study of parental observations which serves to develop hypotheses

This study of parent observations and interpretations serves to develop the hypotheses that rapid-onset gender dysphoria is a phenomenon and that social influences, parent-child conflict, and maladaptive coping mechanisms may be contributing factors for some individuals. Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon. Additional research that includes AYAs, along with consensus among experts in the field, will be needed to determine if what is described here as rapid-onset gender dysphoria (ROGD) will become a formal diagnosis. Furthermore, the use of the term, rapid-onset gender dysphoria should be used cautiously by clinicians and parents to describe youth who appear to fall into this category. The term should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals. This article has been revised to better reflect that these parent reports provide information that can be used to develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Because this is a study of parent reports, there is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives. Examples

Citation: Littman L (2019) Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE 14(3): e0214157. https://doi.org/10.1371/journal.pone.0214157

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where parent answers reflect their perspective of the AYA include answers concerning the child's mental well-being, the parent-child relationship, and whether the child has high expectations about transitioning. However, it is also important to note that there are other survey items where the parent would have direct access to information about their child and that those answers reflect items that can be directly observed. Examples of this type include age, natal sex, diagnoses given by medical providers in the presence of the parent, directly observed behaviors of the child and the child's friend group, school performance, whether the child has dropped out or required a leave of absence from school, has been unable to hold a job, whether the child went to a clinic, or received treatment. Readers are reminded to keep in mind that this is a study of parent report and consideration of what information parents may or may not have access to is an important element of the findings.

Questions on whether the article describes adolescent-onset gender dysphoria or if it describes something new

There is some controversy over whether what is described as rapid onset of gender dysphoria, particularly in natal females, falls under the existing definition of late-onset or adolescent-onset gender dysphoria or whether it represents a new kind of development or presentation. This controversy might be a false dichotomy because both might be true. Although recent observations of adolescents and young adults who are predominantly natal female having a sudden onset of gender dysphoria symptoms beginning during or after puberty might technically fall under the existing definitions and criteria for adolescent and adult gender dysphoria [2], the substantial change in the demographics of patients presenting for care, the inversion of the sex ratio with disproportionate increase in adolescent natal females [3–5], and the new phenomenon of natal females exhibiting adolescent-onset and late-onset gender dysphoria [6–8] signal that something new may be happening as well. These changes may indicate that there are new etiologies leading to gender dysphoria and it is unclear, particularly without research about these new populations, whether gender dysphoria in this context has the same outcomes, desistence and persistence rates, and response to treatment as the gender dysphorias that have been previously studied.

Expanded discussion of qualitative analyses

Because this is a descriptive, exploratory study into a new topic with very little existing data, the addition of the qualitative analysis of two questions in addition to the quantitative analysis allowed for a greater depth of information to be used in the development of hypotheses. A grounded theory approach was selected as the strategy of choice for handling the qualitative data. There were two reviewers consisting of a professor with a PhD degree and expertise in qualitative methods (MM) [9] and the author (LL) who holds an MD and MPH degree, and has published both qualitative and quantitative research papers [10–11]. Each reviewer independently read and re-read the open-text responses in an iterative process to identify major themes arising from the data. Once each reviewer independently listed major themes and coded the open-text responses according to those themes, both reviewers compared notes to collaboratively revise and refine the major themes identified. Once an agreed-upon final list of themes was developed, attention was turned back to the data to code the open-text response with the final list of themes. After this task was completed, LL selected salient quotes to reflect each major theme, shared the quotes with MM, and both discussed collaboratively until agreement for the final list of major themes and associated quotes was reached. The incorporation of both the qualitative and quantitative analysis allowed for a more vivid picture of parent

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perspectives about the friendship group dynamics and behaviors and clinician interactions than could have been obtained from just one type of analysis.

Clarification of study design, methods, and related limitations

As mentioned in the article, the study design of this research falls under descriptive research: as such, it did not assign an exposure, there were no comparison groups, and the study's output was hypothesis-generating rather than hypothesis-testing [12]. Descriptive studies often represent a first inquiry into an area of research and the findings of descriptive studies are used to generate new hypotheses that can be tested in subsequent research [12–13]. Because of the known limitations of descriptive studies, claims about causal associations cannot be made [12], and there were none made in the article. The conclusions of the current study are that the findings raise certain hypotheses and that more research is needed. Simple descriptive metrics to describe the quantitative characteristics of a sample in a descriptive study are the appropriate measures to use in this study. Additionally, because the data were collected at one point in time, no claims of cause and effect can be made.

All research methods have advantages and limitations. Obtaining information from parents (and guardians) about the health and well-being of children and adolescents is an established method of research [14]. Parental report, used elsewhere and in this study, offers the advantages of collecting data from adults who are knowledgeable about the child, who are able and willing to complete research activities such as detailed surveys, and who can provide details that are not available by other methods. Limitations of parental report include information that parents may not be aware of and parental biases. Anonymous surveys, used elsewhere and in this study, are advantageous for topics that might be stigmatized and can allow participants to be more honest in their responses but introduce the limitation that the researcher cannot verify the identity and experiences of the participants. The use of targeted recruitment and convenience samples, used elsewhere and in this study, offers the benefit of connecting with hard-to-reach populations but introduces limitations associated with selection bias that can subsequently be addressed by further studies. For the current study, selection bias may have resulted in findings that are more positive or more negative than would be found in a larger and less self-selected population. Subsequent studies should address these issues.

Updated Information about recruitment

Concerns were raised that this study only posted links to the recruitment information on selected sites that are viewed as being unsupportive of transition. However, announcements about the study included requests to distribute the recruitment information and link, and because information about where the participants encountered the announcement was not collected, it is not known which populations were ultimately reached. It has come to light that a link to the recruitment information and research survey was posted on a private Facebook group perceived to have a pro-gender-affirming perspective during the first week of the recruitment period (via snowball sampling). This private Facebook group is called "Parents of Transgender Children" and has more than 8,000 members. This means that parents participating in this research may have viewed the recruitment information from one of at least four sites with varied perspectives. Specifically, three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender. And, one of the sites that posted recruitment information is perceived to be pro-gender-affirming. The rest of the Correction notice will refer to recruitment from the four sites that are known to have posted the survey in the first week of

recruitment: 4thwavenow, transgendertrend, Youth Trans Critical Professionals, and Parents of Transgender Children.

Parental approaches to gender dysphoria and views on medical interventions

To oversimplify parental approaches as simply "accepting" or "rejecting" misrepresents the range of responses and complexity of approaches that parents take when addressing the needs of their gender dysphoric children. Parental approaches are complex and cover many variables. For example, one parental approach might be to affirm the child as a person, support gender nonconformity, support gender exploration, support mental health evaluation and treatment as needed, support the exploration of potential underlying causes for the dysphoria while expressing caution about medical interventions. Another approach might be to affirm the child's newly declared gender identity, support gender nonconformity, support a liberal approach to medical intervention while expressing caution about mental health evaluation and caution about the exploration of potential underlying causes for the dysphoria. To categorize the former as "rejecting" and the latter as "accepting" would be inaccurate.

This study recruited participants based on whether participants thought their child exhibited a sudden or rapid onset of gender dysphoria beginning during or after puberty and did not recruit based on parental beliefs about what types of approaches toward gender dysphoric AYAs are best. Although one of the sites posting recruitment information might be considered to hold a pro-gender affirming perspective and three sites might be considered to hold a cautious or even negative perspective about medical or surgical interventions, the site where a participant first heard about the study may not be an accurate reflection of their beliefs and whether they endorse or disagree with the content of the websites. Data about where participants first heard about this study were not collected. Future studies should seek a wider array of websites to post recruitment information, recruit from clinicians with varied approaches to gender dysphoria, and ask specific questions about parental beliefs regarding their approach to their child's gender dysphoria, including: whether parents support or don't support gender exploration, gender nonconformity, mental health evaluation and treatment, exploration of potential underlying causes for dysphoria, non-heterosexual sexual identity, and whether they hold a liberal, cautious or negative view about the use of medical and surgical interventions for gender dysphoric youth. Exploration about what types of affirmation are endorsed by parents including affirmation of the child as a person and affirmation of the child's gender identity would also be valuable.

Expanded discussion about limitations and biases

Regarding the reporting of gender dysphoria, an absence of childhood gender dysphoria and whether the AYA was gender dysphoric at the time of survey completion were based on parent report of whether certain indicators of gender dysphoria were observed prior to puberty or at the time of the survey. These determinations were not diagnoses made by clinicians. Three of the indicators listed in the DSM-5 include information that a parent might not have access to (unless the child told them directly) [2], and therefore answers based on parent perceptions may not accurately reflect the experiences or traits of the AYAs themselves. However, the other five indicators include readily observable behaviors and preferences that would seem difficult for a parent not to notice such as: strong preference or strong resistance to wearing certain kinds of clothing; strong preference or strong rejection of specific toys, games and activities; and strong preference for playmates of the other gender [2]. It is possible that a parent could have ignored some of these indicators, though other people in the child's life may

have observed them. To improve the reliability of this measure, future studies should include evaluation from clinicians with input from parents, AYAs and from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members who knew the youth during childhood to verify the whether the readily observable behaviors and preferences were present or absent during childhood.

For a clinician to make a diagnosis of gender dysphoria in childhood, a child would need to exhibit at least six of the eight indicators. Given that 97.6% of the participants reported 2 or fewer readily observable indicators, even if hypothetically all participants incorrectly underreported all three of the subtler indicators, 97.6% would still have fewer than six indicators. So, although no clinical evaluation was performed and a clear presence or absence of a diagnosis cannot be verified, given the reports of the easily observed behaviors and preferences, it can be said that it would be very unlikely for these AYAs to have met criteria for childhood gender dysphoria if they had seen a clinician for an evaluation.

There is expected variation in how objective parents can be about their own children. Some individual biases may limit the objectivity of parents. This descriptive study was not designed to explore or measure the objectivity of participants. Participants may have first learned about this study from one of four (or more) sites described previously where recruitment information was posted. It is possible that exposure to websites that take a cautious or negative approach to transition during adolescence and young adulthood and exposure to websites that take a pro-gender-affirming approach might influence how parents report about their children's experiences. There have not been any studies to determine if parents who seek information from online sites in general, don't seek information from online sites, or seek information from specific online sites, including the four sites noted for this study, differ in their ability to provide objective assessments of their children. However, if there were an excess of participants who, compared to other parents who take surveys reporting on their children, were less able to be objective about their children, it could limit some of the findings of the study, particularly for findings that are more interpretive rather than the findings that are more concrete.

The research survey did not specifically ask whether parents supported their AYAs' exploration of gender identity, so whether and what numbers of participants supported their child's exploration of gender identity is unknown. However, if there were an excess of parents who did not support the exploration of gender identity, it could potentially result in higher reports of declining mental health. The parents' perception that their child's mental health and the parent-child relationship were worse after the child announced a transgender-identification could be due to several variables such as conflict between parent and child, maladaptive coping mechanisms, or worsening psychiatric issues unrelated to gender. The trajectories for adolescent-onset gender dysphoria are not well understood and additional research is desperately needed.

There are many ways that parents can provide support for their child which include: affirming them as a unique and valuable person and as a loved member of the family; supporting their emotional and financial needs; supporting them in pursuing their interests; supporting them to develop the skills needed for self-sufficiency; supporting their choices of gender nonconforming clothing and interests; supporting their exploration of their identity; and supporting them in their critical thinking skills. Parental support is multifaceted and should not be oversimplified into a binary of whether a parent agrees or disagrees with a specific medical course. This study was not designed to measure different types of support provided by parents or levels of support. If there were an excess of parents who were unsupportive of their children, it might affect some of these initial findings. The nature and extent of parental support—including the many different ways that parents can support their children in becoming healthy, self-sufficient adults—is well worth further study.

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Clarification of Fig 1

The purpose of Fig 1 was to provide the reader with a quick sense of what kinds of advice can be found and shared on Reddit and Tumblr. One example includes an excerpt from a publicly available Tumblr blog that posted a list of purported indirect signs of gender dysphoria. This excerpt is indeed an example of advice that can be found on Tumblr. Note, however, that the excerpted Tumblr post itself does not reflect the full content of the original blog it refers to, nor does the excerpt in Fig 1. The original blog is titled, "'That was dysphoria?' 8 signs and symptoms of indirect gender dysphoria" [15].

Discussion of the ICD-11 change from "gender dysphoria" to "gender incongruence"

The ICD-11 will go into effect in January 2022, and, with this change, the new diagnosis of "gender incongruence" will replace "gender dysphoria." Because the current descriptive, exploratory study raises hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria and concludes that more research is needed, it is unlikely that the change in diagnostic criteria will appreciably change the conclusion of the study, although the terminology may become outdated.

Supporting information

S1 File. PDF of the original article version that was published on August 16, 2018 (two figures removed due to copyright restrictions).
(PDF)

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Coalition for the Advancement & Application of Psychological Science

CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD)

As an organization committed to the generation and application of clinical science for the public good, the Coalition for the Advancement and Application of Psychological Science (CAAPS) supports eliminating the use of Rapid-Onset Gender Dysphoria (ROGD) and similar concepts for clinical and diagnostic application given the lack of rigorous empirical support for its existence.

There are no sound empirical studies of ROGD and it has not been subjected to rigorous peer-review processes that are standard for clinical science. Further, there is no evidence that ROGD aligns with the lived experiences of transgender children and adolescents.

Despite the lack of evidence for ROGD and its significant potential for creating harm, it has garnered increased attention in the general public and is being misused within and beyond the field of psychology. For example, recent medical articles have started including ROGD in their overview of adolescents with gender incongruence, and there has been an increase in books, videos, podcasts, and training directed to parents and clinicians offering strategies for diagnosing and treating ROGD. The proliferation of misinformation regarding ROGD is also infiltrating policy decisions. Currently, there are over 100 bills under consideration in legislative bodies across the country that seek to limit the rights of transgender adolescents, many of which are predicated on the unsupported claims advanced by ROGD. Thus, even though ROGD is not a diagnostic classification or subtype in either the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), nor is it under consideration for inclusion in future editions, it is critical to address the misinformation regarding ROGD now.

Research on gender identity development in children and adolescents continues to evolve and these advances will likely influence diagnosis and empirically-based standards of care, as well as the legislative landscape impacting trans people's access to care and legal protections. The available research is clear that transgender people are subjected to marginalization, stigmatization, and minority stress, which have significant detrimental effects on health and well-being. Terms, such as ROGD, that further stigmatize and limit access to gender-affirming and evidence-based care violate the principles upon which CAAPS was founded and public trust in clinical science.

CAAPS supports eliminating the use of ROGD and similar concepts for clinical and diagnostic application given the lack of empirical support for its existence and its likelihood of contributing to harm and mental health burden. CAAPS also encourages further research that leads to evidence-based clinical guidelines for gender-affirming care that support child and adolescent gender identity development. CAAPS opposes trainings that encourage others to utilize this concept in their clinical practice given the lack of reputable scientific evidence to support its clinical utility. Finally, CAAPS recommends expanding community education about these topics to reduce the stigma and marginalization that contribute to mental health burden.

Signatories:

American Psychological Association (APA)

Society for the Psychology of Sexual Orientation and Gender Identity, American Psychological Association, Division 44

Society for a Science of Clinical Psychology (SSCP)

Society of Clinical Child and Adolescent Psychology (SCCAP), American Psychological Association, Division 53

Society of Behavioral Medicine (SBM)

Society for the Psychological Study of Social Issues (SPSSI)

Association for Behavioral & Cognitive Therapies (ABCT)

National Association of School Psychologists

Council of University Directors of Clinical Psychology (CUDCP) Board

Asian American Psychological Association (AAPA)

Society for the Psychological Study of Culture, Ethnicity, and Race

MSU Research Consortium on Gender-based Violence

State, Provincial and Territorial Psychological Association Affairs (Division 31, APA)

American Psychological Association, Division 22 Rehabilitation Psychology

New York Association of School Psychologists (NYASP)

Society for Community Research and Action (SCRA)

Society for the Study of School Psychology (SSSP)

Society for Child and Family Policy and Practice (Division 37 of the American Psychological Association)

Society of Personality and Social Psychology

Association for University and College Counseling Center Directors (AUCCCD)

Psychologists' Association of Alberta

Saint Louis University, Clinical Psychology Program

American Psychology-Law Society; Division 41 of APA

Michigan State University, Department of Psychology, Clinical Science Area

Psychologists in Public Service, American Psychological Association, Division 18

American Psychiatric Association

Society of Pediatric Psychology (SPP), Division 54 of the American Psychological Association

Society for Research in Child Development

National Association of Psychological Research and Graduation Programs

Council on Social Work Education

Stony Brook University, Clinical Psychology Program

Michigan State University Twin Registry (MSUTR)

Society of Counseling Psychology, Division 17, American Psychological Association

National Latinx Psychological Association (NLPA)

Anxiety and Depression Association of America

The Society of Clinical Psychology, APA Division 12

American Group Psychotherapy Association

University of Miami Department of Psychology

Portuguese Psychologists Association

Diverse Sexualities Research and Education institute

National Association of Social Workers

Puerto Rico Psychology Association

Association for Psychological Science

Connecticut Psychological Association

Howard Brown Health

American Association for Marriage and Family Therapy

British Columbia Psychological Association

World Professional Association for Transgender Health (WPATH)

Associations for Psychologists in Academic Health Centers

Nebraska Psychological Association

GLMA: Health Professionals Advancing LGBTQ Equality

Michigan Psychological Association

Arizona Psychological Association

New Hampshire Mental Health Counselors Association

Florida Psychological Association

Minnesota Association for Marriage and Family Therapy (MAMFT)

AIP— Italian Association of Psychology

Manitoba Psychological Society

Georgia Psychological Association

Vermont Psychological Association

Illinois Psychological Association

Delaware Psychological Association

CAAPS

About Contact Follow

PSYCHOTHERAPY FOR TRANSGENDER DECLARING ADOLESCENTS

Dianna Kenny PhD MAPsS MAPA
Professor of psychology (rtd), The University of Sydney
Society for Evidence-based Gender Medicine

15 November 2021

Four distinct groups

- ***Early onset during preschool.*** I have not been referred a case of early onset GD. They are very rare.
- ***Adolescent onset (ROGD).*** By far, most referrals to my practice are for young people aged 12-17, predominantly girls. This presentation will focus on this group.
- ***Over 18s and young adults*****.** Unlike the bias towards females in ROGD referrals, the over 18s referred to my practice are more equally distributed between males and females. The majority are referred by parents. Their management is complicated by the fact that they are legally adults and able to make their own decisions independently of parents.
- ***Mature aged adults.*** Many present after the breakdown of their marriages with a history of long term cross-dressing and fantasies about being the other sex. Others present as single adults who have been socially transitioned for many years, having first identified as butch lesbians, and decide to finalize their transition surgically.

Intake assessment

- **Family constellation**, family conflict /dysfunction, marital and sibling dynamics
- **Psychological evaluation** – ADHD, ASD, self-harm, suicidality, suicide attempts, anxiety, depression, incipient BPD, and psychosis
- History of **body dysmorphia**, eating disorders
- **School life experiences** e.g., attitude towards school, peer rejection, bullying, truanting, academic performance, post school aspirations
- **Cognitive immaturity, concrete thinking, cognitive rigidity, and cognitive distortions**, lack of understanding or misunderstanding of gender ideology and capacity to critically review it (given the illogical and scientifically unsound basis of the ideology)
- **Understanding of the gravity and irreversibility of medical/surgical transition**; what GA treatment entails, and the consequences of treatment (e.g., infertility, sexual dysfunction, complications of cross-sex hormones and surgery, lifelong patienthood).
- **Sexual experience** history – sexual relationships, sexual abuse experiences, sexual knowledge, sexual anxiety
- Emerging awareness of **ego dystonic sexual orientation** - > internalized homophobia
- **Social contagion** (influence of social milieu e.g., schools, gender clinics, internet, online transgender communities)
- Perceptions and misperceptions of **gender roles**
- **Systemic function of ROGD** e.g., defiance of parents, finding an “in group,” being “seen”, denying the development of their sexed bodies, fear of adulthood, fear of sexual relationships.

TRANSITION, SELF HARM AND SUICIDALITY

The vulnerable (traumatized) part of the self is hated so it is subsumed into the omnipotent self which is the part that suppresses doubts and anxiety and presses for transition.

If the traumatized self pushes for recognition of psychic pain, the young person may resort to self-harm and suicidal ideation which is a form of acting out of their self-hatred against their bodies.

Affirming clinicians collude with the patient's own attacks on the traumatized self by "traumatizing" their bodies with cross-sex hormones and mutilating surgery.

Hope that transition will restore young person to an ideal state – medics become omnipotent creators of this ideal state. When this fails, the patient sinks into further self-hatred which is enacted through self-harming and suicidal states.

Mechanisms of social contagion

- Peer contagion
  - has a powerful socializing effect on children beginning in the preschool years.
  - By middle childhood, gender is the most important factor in the formation of peer associations, highlighting the significance of gender as an organizing principle of the norms and values associated with gender identity.
  - ROGD have often experienced peer rejection, bullying, hostility and/or social isolation and hence feel marginalized from peer groups. They will gravitate to the Rainbow clubs in schools where everyone is accepted without question, especially if they declare an alternative gender, whereupon they are lauded and validated, even when they had no previous intentions to do so.

Social contagion

A very powerful phenomenon underlying the staggering increases in primarily adolescent girls declaring themselves transgender.

Social contagion identified as a mechanism in eating disorders, self harm and suicide, substance abuse, emotion, and now gender dysphoria.

Mechanisms of social contagion

- Deviancy training
  - deviant attitudes and behaviours rewarded by the peer group
- Co-rumination
  - a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer dyad.
  - Results in increases in internalizing disorders and gender confusion.
  - Girls more affected

Social contagion

A very powerful phenomenon underlying the staggering increases in primarily adolescent girls declaring themselves transgender.

Social contagion identified as a mechanism in eating disorders, self harm and suicide, substance abuse, emotion, and now gender dysphoria.

A boy has a special needs younger sister who gets all the attention. Watching his mother tend to his sister one day, he said “Mummy, you will only love me if I am a girl.”

A loved father appears to love her brother more than his daughter and spends much more time engaged in male pursuits with his son. She says, “I want to be close to Dad but he spends all his time with my brother and never with me.” She concluded it was better to be a boy and declared herself transgender. Now she is in a perpetual rage that her father does not accept her transgender identity because she feels she has nothing more to offer him.

A mother tells her pre-adolescent daughter who is described as a “tomboy” about the sexual abuse she experienced as a child by her stepfather and the sexual assaults she endured as a teenager. Her daughter formed the view that girls are unsafe in the company of men and are constantly at risk of harm particularly as they approach puberty. She decided that being a female “sucked” and that she would prefer to be a male in order to keep herself safe and strong.

A 15-y old girl has a mother who has been diagnosed with BPD. She has lived with her mother’s emotional storms and capriciousness all her life. When she has an outburst, her father says, “You have your mother’s BPD, and I don’t want to have to deal with that again.” He would then leave the house. Her father told her, “It is because you were the firstborn - the firstborn girl in Mum's family always got the worst mental illness.” This girl formed the view that men and boys are saner than women and girls and that it would be preferable to change gender rather than turn out like her mother.

Family Constellation

Identity is not hard-wired – it develops in a social world where the young person experiences attachments, trauma, abuse, or misperceives the meaning of experiences because of cognitive immaturity or concrete thinking.

Need to explore identifications (I want to be like…) and dis-identifications (I do not want to be like…)

A 14-year-old natal boy first came out to his parents as **GAY**.

He soon changed that declaration to **BISEXUAL** when he experienced a powerful crush on a female classmate. After she rejected him, he came out as **TRANS** and demanded puberty blockade and cross sex hormones.

In therapy, his demands for transition were strident and incessant. He constantly asked me when I was going to tell his parents that he could go ahead with his transition.

He shaved his legs, arms and body hair, grew his hair long, and started to wear eye makeup and nail polish. He ordered female clothing from the internet and wore it secretly in his room. When his parents confiscated these clothing items, his female friends lent him their clothes to wear until I advised his parents to put a stop to this. Teachers at his school started calling him by his preferred name and pronouns until I advised his parents not to allow this.

Several months after therapy commenced, while still vehemently protesting his trans-female identity, he wrote a letter to his parents apologising for misleading them. He said he now realised that he was not a trans-female but a **DEMIGIRL** (denoting partial non-binary, partial female gender identity).

He changed this orientation shortly thereafter to **DEMIBOY**, before again writing to his parents, telling them that he was only joking about the whole thing and that they were the only people who had taken it seriously.

I advised his parents to eat humble pie to give their son the opportunity to exit the gender maze without losing face.

The next day he asked his parents to take him for a haircut. **STRAIGHT**

Sexual orientation

Many young people are confused about their sexual orientation and often conflate sexual orientation with gender identity.

ROMANTIC AND SEXUAL RELATIONSHIPS

Majority of young GD adolescents

(i) have had no sexual experience (crushes from a distance, hand holding and kissing)

(ii) disdain genital sex as "gross"

(iii) are indifferent to loss of sexual function, fertility

(iv) are confused about the nature of "trans" relationships e.g.,

A self-declared non-binary male (natal sex = male) in a relationship with a transgender declaring natal female (i.e., a trans man) told their parents they were in a gay male relationship. Similarly, two natal females, both transmen, rejected the suggestion that they were a lesbian couple and stated that they were a gay male couple.

Anime character against a pansexual flag

Case example: Artem, aged 15

Artem, aged 15, from a Middle Eastern country that is homophobic, was referred by his mother for a range of issues but specifically because he had declared himself **transgender**. He was post pubertal, facially and bodily hirsute with a deep male voice. Artem was insistent that he was transgender and was impatient to commence his social transition and to obtain prescriptions for cross sex hormones.

Of himself:

I see myself as **bisexual**. I have feelings for guys and girls, more like a **pan**-thing. I have had a boyfriend who identifies as male and pan since last year. We get together just the two of us - we visit each other's houses. I guess I would be OK with being **GAY**. For me, it fluctuates.

Of his mother, Artem said:

Mum knows I have this friend. She doesn't know that he is **my boyfriend**. I don't think Mum will take it well because she asked me if I still liked girls. She wouldn't take kindly to knowing I am gay and have a boyfriend.

Of his father, Artem said:

Dad is trying to suppress his **queer phobia**, but he says bad things about LGBTQ. He is anti it all; he got angry with me for refuting what he was saying. Dad said **gay is about anal sex and that is gross**. Then Mum told him to shut up and I went to my room and cried. Dad is anti queer for sure, he tries to suppress it because he still loves me. I felt very disappointed in Dad when he expressed these sentiments. He will be very freaked out if he thinks I am **queer, gay, or trans**.

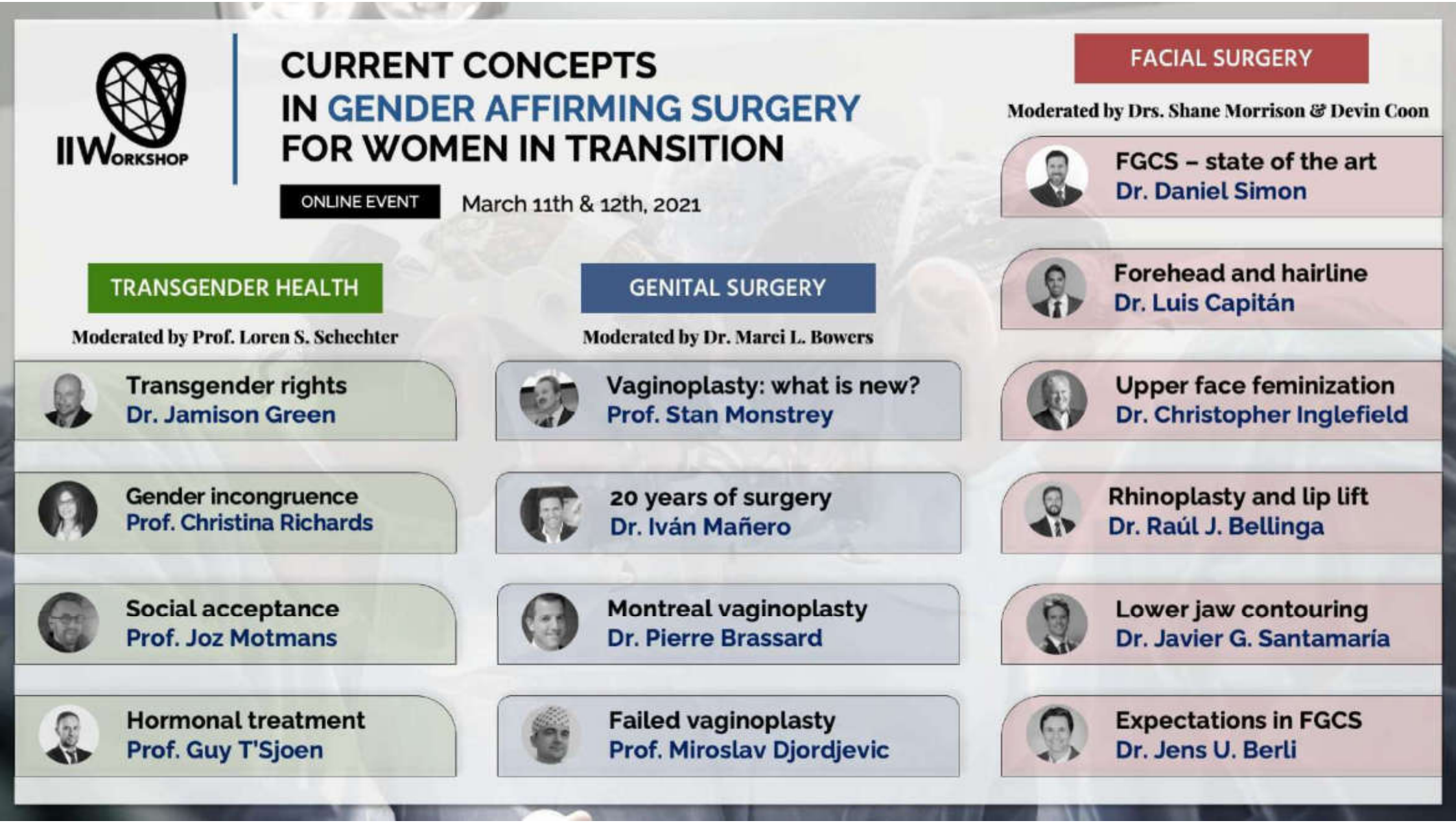
Internalized homophobia

An adolescent realises that s/he is same-sex attracted. Finding this unacceptable, due to parental and/or internalized homophobia, the adolescent reasons as follows:

Being same-sex attracted is bad and shameful. My parents will reject me if I am gay. If I am a boy attracted to other boys, I must be a girl and therefore need to transition so that my attraction to boys becomes heterosexual.

Conclusions

- Imperative to keep the **developmental path** open into adulthood (need **frontal lobe maturation** that occurs in early 20s)
- **Psychological trauma** from the past forms part of their psychic structure in the present. The expression of these **traumas are socio-culturally embedded** (i.e., social contagion permits particular forms of "acting out" these traumas).
- Envy and rivalry part of human condition -> **unconscious envy** is a factor in trans identification
- GD adolescents need assistance to explore their **defences and internal psychic conflicts and managing their psychic pain** before irreparably altering their bodies. "The body is used to act out something that cannot be accepted or processed by the mind." (Evans & Evans, 2021, Ch 2, p. 28).
- **Clinicians should not collude with the phantasy that the "embodied" self can be altered or removed.**


IIWORKSHOP
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IN GENDER AFFIRMING SURGERY
FOR WOMEN IN TRANSITION
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March 11th & 12th, 2021
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Transgender rights
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Gender incongruence
Prof. Christina Richards
Social acceptance
Prof. Joz Motmans
Hormonal treatment
Prof. Guy T'Sjoen
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Moderated by Dr. Marci L. Bowers
Vaginoplasty: what is new?
Prof. Stan Monstrey
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Dr. Iván Mañero
Montreal vaginoplasty
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Failed vaginoplasty
Prof. Miroslav Djordjevic
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Dr. Luis Capitán
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Dr. Raúl J. Bellinga
Lower jaw contouring
Dr. Javier G. Santamaría
Expectations in FGCS
Dr. Jens U. Berli

Conclusions

- **Sexual development poses a threat** to young people as it signifies approaching adulthood, the demands of which they feel ill equipped to manage.
- **ROGD** as a "trauma" or **a response to the reality of puberty** that one now has a **sexed body**.
- Rigid **adherence to peer norms** temporarily assuages vulnerabilities because the young person has found others like him/her who are acting out in the same way.

TRANSITION could be

i. related to a grievance against the parents and a struggle for autonomy/individuation
ii. related to an idea that one can create an ideal self
iii. protective against feelings of inadequacy, anxiety, jealousy, and disappointment
iv. a triumph over feelings of vulnerability
v. a repudiation of the sexed body and adulthood


TRANS IS NOT
BEAUTIFUL