No. 24-43

In the Supreme Court of the United States

STATE OF WEST VIRGINIA, ET AL.,

v.

B.P.J., BY NEXT FRIEND AND MOTHER,
HEATHER JACKSON,

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

JOINT APPENDIX (VOLUME IX OF X)

(Pages 3563-4041)

MICHAEL R. WILLIAMS
Solicitor General
Counsel of Record
OFFICE OF THE
WEST VIRGINIA
ATTORNEY GENERAL
State Capitol Complex
Building 1, Room E-26
Charleston, WV 25305
mwilliams@wvago.gov
(304) 558-2021

Counsel for Petitioners
West Virginia, et al.

JOSHUA A. BLOCK
Counsel of Record
AMERICAN CIVIL
LIBERTIES UNION
FOUNDATION
125 Broad Street Floor 18
New York, NY 10004
jblock@aclu.org
(212) 549-2593

Counsel for Respondent
B.P.J.

[additional counsel listed on inside cover]

PETITION FOR WRIT OF CERTIORARI FILED: JULY 11, 2024
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(continued from front cover)

JOHN J. BURSCH
Counsel of Record
ALLIANCE DEFENDING FREEDOM
440 First Street, NW, Suite 600
Washington, DC 20001
jbursch@ADFlegal.org
(616) 450-4235
Co-Counsel for State of West Virginia and Counsel for Lainey Armistead

AMY M. SMITH
Counsel of Record
STEPTOE & JOHNSON PLLC
400 White Oaks Boulevard
Bridgeport, WV 26330-4500
(304) 933-8000
amy.smith@steptoe-johnson.com

Counsel for Harrison County Board of Education and Dora Stutler

KELLY C. MORGAN
Counsel of Record
BAILEY & WYANT, PLLC
500 Virginia St. E., Suite 600
Charleston, WV 25301
(303) 345-4222
kmorgan@baileywyant.com

Counsel for West Virginia State Board of Education and W. Clayton Burch, State Superintendent

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[Due to a formatting error, the deposition transcript of Aron Janssen, M.D., set to appear on JA3563-3770 is instead reproduced in a separate supplemental appendix.]

ERRATA SHEET

AFFIDAVIT
STATE OF ~~PENNSYLVANIA~~ Illinois
County of Cook

I, Aron C. Janssen, MD, certify under oath or affirmation that I have read the transcript of my testimony dated 4/4/2022 and that the transcript of my testimony is accurate with the following corrections:

Page	Line	Error	Correction	Reason
49	20	"identity"	"idea"	incorrect word
109-10	24-1	"that is being positive"	Remove words	incorrect insertion
153	6, 18	"team"	"teen"	incorrect word
190	5	"cause"	"pause"	incorrect word
280	21	"nine people"	"twenty-two people"	incorrect number
33	14	"reported"	"report"	incorrect word
85	17	"Ulson"	"Olson"	incorrect word
147	20	"precise"	"imprecise"	incorrect word

149	5	“provision”	“revision”	incorrect word
166	8	“performance”	“informants”	incorrect word
310	19	“ceiling”	“floor”	incorrect word
324	20	“gender disorder”	“gender identity disorder”	missing word
333	19	“attestable”	“a testable”	misspelling

Are there additional corrections on a following page?

X NO __ YES

Signature of Deponent/Affiant /s/ Aron C. Janssen

Sworn to and subscribed to me, a Notary Public, on this 9th day of May, 2022

/s/ Alexander Rodriguez

Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
WEST VIRGINIA
CHARLESTON DIVISION

B.P.J. by her next friend and mother, HEATHER JACKSON,

Plaintiff,

vs.

WEST VIRGINIA STATE BOARD OF EDUCATION, HARRISON COUNTY BOARD OF EDUCATION, WEST VIRGINIA SECONDARY SCHOOL ACTIVITIES COMMISSION, W. CLAYTON BURCH in his official capacity as State Superintendent, DORA STUTLER, in her official capacity as Harrison County Superintendent, and THE STATE OF WEST VIRGINIA,

Defendants,

LAINEY ARMISTEAD,

Defendant-Intervenor.

No. 2:21-cv-00316

VIDEOTAPED DEPOSITION OF
STEPHEN LEVINE
Wednesday, March 30, 2022
Volume I

***

[13]

STEPHEN LEVINE,
having been administered an oath, was examined and testified as follows:

[14]

EXAMINATION

BY MS. HARTNETT:

Q Good morning, Dr. Levine.

A Good morning.

MS. HARTNETT: Before we start, I'm just going to put a housekeeping matter on the record that the attorneys discussed before we went on the record and that is that objection to form preserves all objections other than privilege and that the parties will make an effort to use "form," "scope" and "terminology" as the shorthand objections. In addition, an objection by one defendant is an objection for all defendants.

Could any counsel for the defense let me know if they have any disagreement with that?

MR. BROOKS: We have agreed, in fact.

MS. HARTNETT: Thank you very much.

BY MS. HARTNETT:

Q So again, my name is Kathleen Hartnett, and I'm with the law firm called Cooley, LLP.

Can you hear me okay?

A I do. At this point, yes.

Q Okay. Please let me know if that changes.

I use she/her pronouns.

Would you please state and spell your name for the record. **[15]**

A Stephen Barrett Levine, S-T-E-P-H-E-N B-A-R-R-E-T-T L-E-V-I-N-E.

Q And what pronouns do you use?

A He/him.

Q Thank you. Dr. Levine, you've been deposed many times before; correct?

A Yes.

Q Was the most recent deposition that you gave in September of last year, 2021?

A No.

Q What was the most recent deposition that you gave?

A In -- within the last month, I was deposed in a Connectica- -- a Connecticut case involving a transgender prisoner.

Q Do you know the name of that case?

A Probably Clark versus the department of corrections in Connecticut. Connecticut Department of Corrections (sic).

Q Okay. And what was your -- the nature of your testimony in that Connecticut case, this recent deposition that you gave?

A Well, I provided a psychiatric evaluation of the patient and made recommendations. It -- it was -- I'm hesitating because -- I provided a thorough **[16]** psychiatric evaluation of the developmental history and the in prison history of the patient and the -- the psychology of his new transgender identity.

Q And you say "new transgender identity."

Was the new identity of -- male or female?

A The -- the new identity as a transgender woman.

MR. BROOKS: And -- and, Counsel, I will caution that obviously any detail about a psychiatric evaluation of an individual prisoner is a matter covered by confidentiality that Dr. Levine is not free to get into detail about.

MS. HARTNETT: I hear you. I -- this is not a disclosed matter on his CV and is a recent deposition, so we'll have to just determine whether we need more information, but thank you.

BY MS. HARTNETT:

Q Could you let me know what -- without giving any personal identifying -- or, I guess, any more detail than you believe appropriate, could you tell me what the nature of any recommendations you made were in that matter?

A My recommendations were to provide a pathway towards further evaluation so that eventually a decision could be made about whether sex reassignment **[17]** surgery would be appropriate.

The -- the reason I'm hesitating is that that really did not come to be the subject of the deposition. The subject of the deposition really was the contents of my evaluation, which was done two years before, and -- so lots of things had happened in the two years since I saw the patient or interviewed the patient and -- so I was not able to make recommendations based on current knowledge of the patient, and so I did not.

Q And was the -- prior to this recent deposition in Clark, was the most recent deposition before that the deposition in September of last year?

A Yes.

Q Thank you. And I'm asking that by way of introduction just because I want to make sure we're on the same page about the ground rules for the deposition, and it sounds like you've been through this before, but I'll just let you know my basic ground rules and make sure we're on the same page.

So I will ask questions, and you must answer the questions unless your counsel instructs you not to answer.

Do you understand that?

A I do.

[18]

Q And if your counsel objects, you'll still need to answer my question unless you've been instructed not to answer.

Do you understand that?

A I do.

Q If you don't answer (sic) my question, could you please let me know, and I'll be happy to try to rephrase it or make it clear for you?

Does that make sense?

A I'll try to remember.

Q And if you answer, I will assume you understood the question.

Do you understand that?

A Yes.

Q I'm going to ty -- try to take a break every hour or so. If you need a break at a different time, please let me know.

Do you understand that?

A I understand.

Q And if I've asked a question, you'll need to provide an answer before we take a break.

Do you also understand that?

A I do.

Q I will do my best not to speak over you -- and please use verbal answers so the court reporter can **[19]** transcribe your answers. Nodding or shaking your head can't be captured on the transcript.

Do you understand that?

A I do, but I can guarantee you you'll have to remind me of that.

Q Well, you may have to do the same for me, but we'll try.

I also just want to explain what I'm going to mean when I use a couple of terms today.

For purposes of this deposition, when I say "cisgender," I will mean someone who's gender identity matches the sex that was recorded for that person at birth.

Do you understand that?

A Yes.

Q And then when I say the word "transgender," I will mean someone whose gender identity does not match the sex for which was recorded at birth.

Do you understand that?

A Yes.

Q And when I say "B.P.J.," I'm referring to the plaintiff in this case.

Do you understand that?

A Yes.

Q Do you understand that you are testifying **[20]** under oath today just as if you were testifying in court?

A Yes.

Q Is there anything that would prevent you from testifying truthfully today?

A No.

Q Are you taking any medication that would affect your ability to give truthful testimony?

A Well, I took a sleeping pill last night, but I feel reasonably alert today.

Q Okay. So you don't -- you don't have a belief that that medication you took last night will affect your ability to give truthful testimony today?

A I -- I don't think it will.

Q Do you know what case you're being deposed in today?

A Well, I -- yes.

Q What case is that?

A B.P.J. versus Department of Education.

Q And do you know what jurisdiction this case is from?

A West Virginia.

Q And do you have -- sorry.

Do you have an understanding of the issue presented by this case?

[21]

A I have an understanding. I'm not sure it is the correct understanding, but I do have an understanding.

Q Understood. What is your understanding of this case?

A The plaintiff and next friend and mother wish the young person to be able to compete in athletics according to their current gender identity and apparently the State Board of Education is -- disagrees.

Q Okay. Thank you.

So we already touched on that you had been deposed previously. I just want to ask you about a couple of specific depositions you gave to see if you recall those?

There was a matter in North Carolina called Kadel that you gave a deposition in September of 2021 regarding state employee healthcare.

Do you recall giving that deposition?

A Would you repeat -- regarding what? I didn't hear that last phrase.

Q I'll try to speak more slowly.

That was regarding -- so let me just start that one again.

So do you recall giving a deposition in a **[22]** North Carolina matter called Kadel in September of 2021 regarding state employee healthcare?

A Yes.

Q Do you recall giving a deposition in a Florida case in December of 2020 called "Claire"? That was also about state employee healthcare.

A Yes.

Q There also was a case called Keohane in Florida where you gave a deposition in 2017 and that was a prisoner case.

Do you recall that?

A Yes.

Q Did you give true and correct testimony in those depositions?

A Yes.

Q Have you always given true and correct testimony in your depositions?

A To the best of my knowledge, yes.

Q Thank you. And you've had depositions in cases involving prisoners who were seeking care for gender dysphoria; is that correct?

A Yes.

Q Have you ever testified in favor of a prisoner who was seeking medical care for gender dysphoria?

A Yes.

[23]

Q Can you describe those instances where you've testified in favor of a prisoner seeking medical care for gender dysphoria?

A In the last case involving a prisoner by the name of Soneeya, S-O-N-E-E-Y-A, I recommended transfer to a female prisoner and -- sorry -- transfer to a female prison and the opportunity to have sex reassignment surgery if, after a year of adaptation there, there were no significant decompensations or problems.

Q And do you remember what year you made that recommendation?

A I think it was 2019.

Q Okay. And can you -- are you aware of any other examples of you having testified in favor of a prisoner seeking medical care for gender dysphoria?

A I'm hesitating because medical care includes many things. And so the answer is yes. It involves accommodations to their current gender identity in terms of canteen items, for example, and it includes the prescription of cross gender -- cross-sex hormones. So I've been involved in the provision of those kind of things repeatedly over the years for prisoners.

Q Have you ever, other than in the Soneeya matter, recommended that a prisoner -- sorry -- **[24]** testified that a prisoner should receive gender confirmation surgery?

A I'm hesitating to answer the question because it's about testimony. In my work as consultant, I have repeatedly recommended both surgery and, more -- more commonly, hormone treatment, electrolysis treatment, canteen item treatment. Most of -- the vast majority of these cases never come to trial.

Q When is the last time that you recommended that a pres- -- a prisoner should have hormone treatment?

A It would have been the third Thursday in March, this year.

Q And where is that prisoner located?

A Massachusetts.

Q Can you estimate how many prisoners you've given a recommendation about through the course of your career?

A That would be very difficult. I've been the consultant to the department of corrections gender identity committee since, I think, 2008 and every month since that time, with less than one handful of exceptions, I've been present at discussions, and we've recommended accommodations in prison to people who declare identity as a trans woman. And I would say **[25]** probably, and I ask you not to hold me to this number, 40 times.

Q Sorry, 40 times describes what?

A That -- that I've joined a group of people who decided to provide electrolysis, canteen item -- special privileges for canteen items, that is, female canteen items, the ability to shower alone, the ability to be tapped down or searched by a female attendant, not a male attendant, a correction officer, hormone -- the beginning of hormone treatment and -- and, of course, bilateral mastectomies and -- and on several occasions, male gender confirming surgery for biologic males who are living as trans women. In other words, the whole gamete of services.

Q So 40 times you've recommended something -- or joined in a recommendation for something for -- a prisoner to receive medical care, as you've broadly described that term?

A Yes.

Q And then how many times can you estimate where you had made a recommendation that the prisoner should not receive medal care, as you've broadly defined it?

A I don't think I've ever recommended that no treatment be offered to this person. The -- the -- because the treatment involves that entire array of **[26]** matters that I just delineated.

And so prisons -- or at least Massachusetts, where I work as a consultant, has been very -- eventually, by 2008, has been -- have been very interested in providing individual services to -- to help these people diminish their pain about their incongruence, and I have been one of the people who devised the program.

Q The prisoner that you reco- -- you recommended -- sorry -- that you were referring earlier to, the one in the Clark matter, do you recall us discussing that?

A I do.

Q And that person identifies as female; correct?

A Yes.

Q Do you view that person as a female?

A I view that person as a trans woman.

Q You have just testified that you've never recommended that a -- no treatment be offered to a prisoner for gender dysphoria; is that correct?

A I'm hesitating because "no treatment" includes -- would include all of the above, of the array I previously listed, and at this moment, I don't recall ever saying no treatment should be given to this individual, no accommodation should be given to this **[27]** individual.

Q Do you recall if you've ever recommended that no surgery be permitted for an individual in prison?

A Oh, yes, I have. I have said that I didn't think sex reassignment surgery -- in those days, that's what we called it, but it's now called gender confirming surgery -- I have said I did not think sex -- that kind of surgery was indicated or necessary -- medically necessary.

Q And so how many times did you say that surgery was medically necessary?

A Would you repeat that, please.

Q How many times did you say that surgery was medically necessary for a prisoner?

MR. BROOKS: Objection; ambiguous.

THE WITNESS: You may or may not know that I do not like the term "medically necessary." I prefer to use the term "would be psychologically beneficial to this person." So that's the reason I'm hesitating answering your question.

I generally avoid using the term "medical necessity." Instead, I try to make a determination whether I think, in the -- in the long run, this particular intervention that we're talking about would be psychologically beneficial to the patient.

[28]

BY MS. HARTNETT:

Q My question is whether you've ever recommended any gender confirming surgery as medically necessary for a prisoner.

A Yes, I -- I have signed my name to such documents, such recommendations, because where I work, in Massachusetts, this is the way that the -- most of the staff and -- and -- that -- that is the common term used to -- to justify that kind of intervention.

Q How many times have you signed your name to that kind of intervention for a prisoner?

A Perhaps five times.

Q And you referenced the Soneeya matter; correct?

A Correct.

Q And years earlier than the 2019 recommendation that you just described, you testified against surgery for that prisoner; correct?

A That is not correct.

Q What's not correct about that?

A That I did not testify -- I did not testify against sex reassignment surgery.

Q Did you testify against something earlier in that matter?

A I testified the recommendation to -- to have **[29]** what the judge called a soft landing, like first transferring the person to a female facility, and then, based upon her adaptation there, to have sex reassignment surgery.

In fact, that was really -- the issue was not whether the person should eventually have sex reassignment surgery, but -- but whether it should be done before transfer to the female facility or after transfer.

Q Did that prisoner seek sex reassignment surgery before transfer?

A Please repeat that.

Q Did that prisoner seek sex reassignment surgery before transfer?

A She did until we presented this idea to her, and she jumped at the idea. She thought it was a very good idea when we interviewed her. And by the time this case got to court, her attorneys were arguing for immediate sex reassignment surgery. But --

Q So she -- by the time you were -- oh, pardon me. Please complete your answer.

A So we were aware that, because we were in the room when we -- I discussed this with her, she was very happy with the idea of transfer with the -- because she was very positive that she would have a fine adaptation **[30]** among women prisoners, and she was delighted.

And then months later, when this came to trial, the – her attorney arg- -- was arguing against that.

Q So you testified against her wishes as expressed by her attorney at trial; correct?

A I never conceived that I was testifying against Soneeya. You may do that, but I -- that's not my concept.

Q In the cases where you've given testimony about employee healthcare coverage, you were testifying against the employee healthcare coverage for gender dysphoria; correct?

A Incorrect.

Q What's incorrect about that?

A What I was testifying to is my understanding of the state of science. I was not taking a stand that people should not have healthcare coverage. I was trying to inform the Court about what we knew about this subject and what we don't know about this subject. I didn't take a position that -- that I knew what should be done. I was just here as a -- to offer what I understood about the state of science, about various aspects of surgical and medical and psychological care for the trans population.

[31]

Q Are you aware in the Kadel and the Claire matters -- those are the North Carolina and Florida employee healthcare coverage matters -- your testimony was

submitted by the defendants in that case against the relief being sought? Are you aware of that?

A I was aware that -- who employed me and what their purposes were, but -- but I was not enjoining psychologically with the idea that I was doing anything but offering the Court what I hope to be an objective appraisal of the state of knowledge based upon literature and, you know, participation in trans care over the years.

Q So were you, in those two matters, agnostic as to whether the employees received the healthcare coverage or not?

A Agnostic?

Q That you didn't have a view.

A Would you -- would you mind explaining that term? I'm -- I usually understand that in terms of religious notions.

Q That you did not have a view -- in those cases, Kadel and Claire, is it fair to say you did not have a view as to whether the healthcare coverage should be extended or not?

A I felt insufficient to make a societal **[32]** decision. I'm not an expert in the insurance industry at all. I -- I am certainly not an expert in the political processes in any particular state. The only -- the only knowledge base that I feel I have comes from the study of the literature and the participation in trans care, both in the community and in prison systems. And so the fact that the State used my testimony does not really equate, in my mind, with my position on whether or not people should have healthcare insurance. I -- again, to repeat, my understanding is I am somewhat knowledgeable about the state of science in this area and that the various people on law -- on the side of --

in -- in -- in judicial issues -- judicial matter want somebody who can articulate the state of -- of knowledge. And that's what I do. The state of knowledge should be applied, in my view, to both sides of the issue, not just, you know, the State or the Board of Education. It should be -- it should be established -- it should be relevant to the plaintiff's side.

Q Were you paid by the State in the North Carolina and the Florida matters for your testimony?

[33]

A Ultimately, I think I was paid by the State, but the check did not come from the State. The check came from the lawyer who employed me.

Q Understood. Have you ever provided testimony with your -- what you've described as your expertise in favor of -- on the side of extending the healthcare coverage to tran-- to people seeking care for gender dysphoria?

A No attorney representing that side of the issue has ever hired me, but if they would, I would be happy to present my knowledge or -- to, and they can do what they want with that testimony.

Q You were deposed in at least one child custody matter in Texas where a child wanted to transition; is that correct?

A I was.

Q And you testified in trial at that matter, too?

A I did.

Q And was your testimony in that case in opposition to the desired transition?

A The testimony in that case was to present the state of knowledge about this matter. I did not take a position

that a child should or should not have a particular treatment. I was just informing the Court, [34] as I previously described to you. I thought I was a witness about the nature of knowledge about trans children.

THE WITNESS: Could you get me some water, please.

BY MS. HARTNETT:

Q Sorry, is your testimony that you, in that case, in the -- this is the Younger matter; is that correct?

A Yes. That's what I understand you to be referring to.

Q And your testi- -- your testimony today is that you were not testifying in opposition to the transition that the child -- of the child in the Younger matter?

A I was hired by the lawyer who was representing the father who did not want his son to be transitioned to a little girl, socially. But I was not testifying that the child should not be transitioned. I was testifying -- I had no knowledge of that -- I wasn't asked for that question. That -- that was never asked of me, Ms. Hartnett. What was asked of me was what we knew about this subject. And, therefore, I felt comfortable sharing the state of knowledge and -- and what is missing from our knowledge.

[35]

Again, it -- it has the appearance that I was testifying against the socialization of the child, but I think if you look closely at that, what I was doing was telling the Court what was known and what was not known and what the consequences were, the implications of treating the child one way versus another.

Q So you did not testify in that matter that desistance was preferable to affirmation?

A I actually don't recall if I made that statement. It's -- I just don't recall.

Q Okay. Has your testimony -- oh, sorry. Have you testified in any other matters of -- similar to the Younger matter, in which parents were disputing the proper care of their child who sought care for gender dysphoria?

A Yes. There was a case that I believe is sealed in the Tucson court. I don't know if I'm allowed to give the name. I presume I can give the name. I don't know.

MR. BROOKS: If -- if it's sealed, I would not give any identifying information.

THE WITNESS: But the answer to your question is yes.

BY MS. HARTNETT:

Q And in that matter, did your -- was your **[36]** testimony used by the party who was opposing the treatment for gender dysphoria for the child?

A In that particular matter, it was the parents, who hired me, who objected to losing custody of their child when the child was hospitalized for a suicide gesture and told the people in the hospital that her evil parents were preventing her, at age 13, from transitioning to being a boy. And her parents --

MR. BROOKS: I'm just going to interrupt and caution the witness. I'm not part of that case, but I -- nor do I want Dr. Levine to violate any confidentiality obligations.

So as you answer, whatever level of generality you think is appropriate, just be very careful not to disclose information that you believe you received in confidence and that remains confidential given the conduct of that

case. So I -- I don't want us in our proceedings to violate any obligations of that proceeding.

THE WITNESS: Well, given that, I actually think anything I would say about this would violate the confidentiality rule here, and I think I've told you enough about the case.

MS. HARTNETT: Well, I don't want to waste our time on the record discussing this, but we have a right **[37]** to discovery into your testimony, so we will follow up with counsel to figure how to get it.

BY MS. HARTNETT:

Q When was this testimony given?

A In the spring of 2021. And if I'm wrong, it was in the spring of 2020.

Q Thank you. And, sorry, what -- was the testimony given in deposition or trial or some other fashion?

A In juvenile court.

Q In what form did the testimony take?

MR. BROOKS: Objection; vague.

BY MS. HARTNETT:

Q Just, sorry, meaning written or oral.

A Oh, in person? I was in -- I was in person by video, and I was cross-examined, you know.

I also submitted a report of the psychiatric evaluation.

Q Any other testimony that you've given in a case involving parents and the potential care of a child with gender dysphoria?

A I submitted a rebuttal to a report in a case in Cincinnati I think the first week of January of this year.

The case is called Siefert, S-I-E-F-O-R-D (sic), or E-R-T, something like that. Siefert versus Hamilton [38] County, which is the Cincinnati county.

So that would be the answer to your question.

Q And what's the nature of that matter, the Siefert matter?

A The -- the child, who was identifying as a trans male, were treated -- the parents were treated during the hospitalization as persona non grata and the hospital refused to discharge the patient even though the patient did not meet criteria for continued hospitalization and -- so the -- the parents were objecting to the loss of parental rights.

Subsequently, the child reidentified as a female and -- so I don't know what the outcome has been legally. It's in process.

And I just commented on the limitations of the -- another expert who felt that it was justified to keep the child in the hospital against the parents' wishes, for two and a half months.

Q In the Tucson matter that you discussed, which, again, we will follow up on, but can you just tell me if that's been resolved? Do you know if that's reached a conclusion?

A Yes, that -- the -- the particular judicial issue was -- was resolved. Whether or not the parents are going to continue to sue the -- the child welfare [39] organization, I -- I don't know. I haven't heard -- I haven't had any follow-up on the case since it was adjudi- -- since it was resolved.

Q Thank you. Has your testimony ever been excluded by a court?

A Yes.

Q When?

A 2015.

Q What matter was that?

A It was in the matter of a prisoner named Noseworthy (sic) in California.

Q And what is your understanding of how your testimony was excluded?

A Well, I didn't actually have testimony. I submitted a psychiatric evaluation and a recommendation, and I was never invited to a -- a courtroom for that.

The judge -- I presented, in my written deposition, an account of a female prisoner who had a very extremely negative outcome from genital surgery, and the judge -- the judge thought I was lying about this case, and he also did not think that -- that I followed the Harry -- the WPATH standards of care, and he dismissed my -- without asking me one question, without asking me do I have any evidence to show that I **[40]** wasn't lying about this case, he -- he dismissed my recommendation.

So I'm aware that judges have their -- judges can make mistakes. Because I, in fact, have in my possession the case history, I saved the case history that was presented to me by the California Department of Corrections, and that -- no one seems to know that. Or at least the judge did not inquire about that. I never had a chance to defend myself and -- so that's -- that's when my testimony was dismissed.

Q Thank you. Is there any other time where your testimony has been excluded by a court?

MR. BROOKS: Objection; vague.

THE WITNESS: Well, I believe that the impact of that judge in the Noseworthy -- Norsworthy case has influenced two other cases to discredit my position, at least whatever I said on those other cases -- on one other case.

One of the cases that -- that my name gets brought up about, I actually never submitted any testimony to, but someone quoted what I had taught in a workshop; and, therefore, the judge dismissed that testimony.

You should understand that since that time and even before that time, my testimonies have been [41] accepted by various courts, and -- for example, in the district court of Arizona, in a case involving insurance coverage, the judge quoted my testimony. That -- that was appealed to the Ninth Circuit Court, and the Ninth Circuit Court made -- made a reference to, but did not name my testimony.

And so it seems to me that since -- before 2015, in that particular case, and subsequent to 2015, my testimony has been accepted by various courts, in various matters involving, you know, trans issues that I am asked to opine about.

Q Thank you. Is there any other example you can think of where your testimony has been excluded by a court?

MR. BROOKS: Objection, vague.

THE WITNESS: Well, I'm aware of the Noseworthy case, the -- the Edmo case, and there's a Hecox case.

But again, all these exclusions were objections to my expertise derived from the judge in the Norsworthy case.

And the answer to your specific question, I am not aware of any other situation where my testimony was excluded.

Q Thank you. For the Noseworthy case, you did **[42]** submit an expert report; correct?

A I -- I -- yes.

Q So you understand this case involves sports; correct?

A Yes.

Q What, if any, prior testimony have you given, whether by declaration or report or oral testimony, about transgender participation in sports?

A I believe that both in the Connecticut case and in the Hecox case the expert opinion report that I gave about the state of knowledge in this field has been submitted for the Court's consideration.

I am not an expert, as you probably know, in matters of athletics and physiology. I am only providing information that I feel I know about, which is the knowledge and the lack thereof about certain issues related to trans care.

So I -- I've never really, as far as I know, as far as I remember, made an opinion about this should happen or this should not happen. I'm just providing information to the courts about what I know and what is not known by society or by science.

Q Thank you. So in this case, for example, B.P.J., is it fair to say you do not have an opinion as to whether she should be permitted to play sports?

[43]

A I do not have an opinion.

Q Have you -- setting aside the context of transgender participation in sports, have you ever given any testimony of any kind in a matter related to sports?

A I can't think of any.

Q Have you given any prior testimony, whether by declaration, report or oral testimony, about prepubertal trans- -- transgender children?

MR. BROOKS: Let -- let me ask you to restate that question. Not to rephrase it, necessarily. I just want to hear it back.

MS. HARTNETT: Sure.

BY MS. HARTNETT:

Q Have you given any prior testimony by declaration, report or oral testimony involving prepubertal transgender children?

A I'm hesitating because I have written about informed consent and -- and that my writings about informed consent have covered all trans, beginning with prebu -- prepubertal children. But your question is about giving testimony about that. I would imagine that in the Younger I may have raised the issue of -- of what we know -- I mean, I did raise tissue of what was known and what is not known.

[44]

So I would imagine the answer to your question must be yes.

And the Arizona case that is sealed is not about a preber -- prepubertal child. But, of course, in taking a history of any child in adolescence, we certainly take histories of their prepubertal period and the behaviors evidenced during that time.

So I just find the answer to your -- I'm not actually sure what the answer to your question should be.

Q Did the Younger case involve a prepubertal child?

A It did.

Q And the Arizona case did not involve a preber -- prepubertal child; is that correct?

A That's -- that's correct.

Q And how about the Cincinnati case you mentioned, was that a prepubertal child?

A No.

Q Can you think of any other -- and I'm setting aside your nonjudicial work, but any -- any testimony -- and I -- that was my question. Thank you for focusing on that -- but any testimony you've given other than these examples that you consider to be related to prepubertal transgender children?

[45]

A The key word to your question is "testimony." And so I have played -- I have -- I have offered opinions to lawyers that never rose to the point of testimony. So the -- The answer to your question must be no.

Q And let me be clear. And for this question, I was just trying to be clear when I said "testimony," whether by written declaration, written report or oral testimony. And so I want to -- just using that understanding of "testimony" for this question, other than the Younger case, have you given any prior testimony regarding a prepubertal -- in a case involving a prepubertal transgender child?

A I'm trying to be helpful and -- and informative to your question.

I think the -- I think the -- the -- to the best of my knowledge, the answer is no, but people use my knowledge, in my previous publications, and call me sometimes and ask me opinions about matters -- the lawyers, I mean, or guardian ad litem persons -- and -- but it's not testimony per se. I guess it would be consultation.

Q Thank you. And then just again sticking with testimony, which for this question I'm meaning to be **[46]** written or oral testimony in a judicial proceeding, have you given any testimony about a case involving a transgender adolescent, other than the Arizona case and the Cincinnati case?

A At the moment, I can't think of any.

Q And have you -- and this is, again, for the purposes of this questions meaning -- "testimony" to mean written or oral testimony in a judicial proceeding. Have you ever given testimony in support of a transgender party?

A In support of a transgender what?

Q Party.

A Party. Please repeat that question.

MS. HARTNETT: Could the reporter read that back. I'm not sure I could do it.

(Record read.)

THE WITNESS: I guess the key word in your question is "support." And I want you to know that when I testify about the state of knowledge, I actually think that because my perspective is a long-term life cycle perspective, I think of that my knowledge base sometimes suggests that I'm actually being quite supportive in -- in trying to have people understand what the consequences

of -- of, quote, affirmative or supportive care actually may mean, what the risks are.

[47]

So I believe your understanding of the word "support" is different than my understanding of the word "support."

But once again, I want to repeat, I conceptualize what I'm doing is accurately stating the state of science, of what is known, what is not known and what we need to do in order to get the answers to the unknown questions. That's what I'm doing.

I'm not supporting this or supporting that. I'm not against this. I'm not against that. I'm trying to give an appraisal of what we know, in a scientific sense. Because of the one principles of medical ethics is that science should lead our therapeutics.

BY MS. HARTNETT:

Q Dr. Levine, you understand that your testimony in this matter has been provided by the State, the defendants, in support of their position; is that correct?

A Yes.

Q And so when I use the word "in support of," in the context of a judicial proceeding, you understand that your testimony, what has been submitted in these proceedings, is submitted in support of one party or in support of another party; correct?

[48]

A Yes. But that has to do with legal processes. What -- what I am supporting is to inform the court of what is known and what is not known. If you were to hire me to tell what -- the Court what is known and not known, I think I would be giving the same testimony.

Q Let me ask you again, then. Which of -- have you ever previously given written or oral testimony that was submitted in support of the transgender party in a judicial proceeding?

MR. BROOKS: Objection.

THE WITNESS: You asked that question before, so I'm going to answer it in the same way I answered it before. It depends on your notion or my notion of "support."

BY MS. HARTNETT:

Q I'm using the notion of "support" that we just discussed, which is -- like, for example, your testimony in this matter is being submitted in support of the defendants. You understand that?

A I do.

MS. DENIKER: This is Susan Deniker. I just want to place on the record an objection to the form.

BY MS. HARTNETT:

Q And using that understanding of "support," do you agree with me that you have not previously had your **[49]** testimony submitted in a judicial proceeding in support of the transgender party; correct?

MR. BROOKS: Objection.

THE WITNESS: Incorrect. I already told you that I have recommended transfer to a female prison and ultimate sex reassignment surgery and that -- for -- for the Soneeya case, and there were -- there was another case -- another prisoner at the same time that we made the same recommendation for.

And I've already told you that I have -- I -- I -- I have participated in the support of -- of bilateral mastectomies for female prisoners, but that -- none of those cases have gone to court. So I -- I guess that's not relevant to your question.

BY MS. HARTNETT:

Q Right. I was asking about whether you've submitted, in a judicial proceeding, an opinion on the side of the transgender party. Have you?

MR. BROOKS: Objection.

THE WITNESS: I already answered that question three times about Soneeya.

BY MS. HARTNETT:

Q Can you please answer my question?

Have you ever submitted an expert opinion on the side of the transgender party?

[50]

MR. BROOKS: Objection.

THE WITNESS: In your narrative --

BY MS. HARTNETT:

Q In a --

A In your --

Q Sorry, I'm just trying to be really clear since I understand you're disputing the term "support," which I thought was clear, but I -- I -- I'm listening to you, and now I'm asking you whether, in a judicial proceeding, you've ever submitted testimony on the side of the transgender person, the formal side of the case.

MR. BROOKS: Objection. Experts don't themselves submit anything in court.

You may answer, if you recall.

THE WITNESS: I may answer?

MR. BROOKS: If you recall.

THE WITNESS: I -- I find myself unable to answer that question.

MS. HARTNETT: Okay. I'm going to introduce an exhibit now, so we'll see how this Exhibit Share works for you. Just a moment here.

MR. BROOKS: Tell me when you've placed it in the folder, and I will then refresh the folder --

MS. HARTNETT: Will do.

We're starting with 86. Okay. Just one **[51]** moment, please.

(Exhibit 86 was marked for identification by the court reporter and is attached hereto.)

MR. BROOKS: Are you doing all right, or do you want to take a break?

THE WITNESS: Well, she said we would have a break in an hour. It's a little over an hour.

MR. BROOKS: If you're -- you're about to introduce a document and you're taking a little time to get that straight, let's take a short break.

MS. HARTNETT: That works for me. Thank you.

MR. BROOKS: All right.

THE VIDEOGRAPHER: We're off the record at 10:13 a.m.

(Recess.)

THE VIDEOGRAPHER: We are on the record at 10:23 a.m.

BY MS. HARTNETT:

Q Now, Dr. Levine, you've been retained as an expert witness in this case, B.P.J.; correct?

A Correct.

Q Who retained you?

A Initially, David Tryon.

Q And was there someone who retained you after that?

[52]

A I -- I think David Tryon, in the matter and means that I don't understand, created a liaison with Alliance for Defending Freedom, Mr. Brooks, and then they became -- so then I am -- I've been recruited by both Mr. Tryon and Mr. Brooks, their -- their particular institutions.

Q And with respect to Mr. Brooks, he's affiliated with the Alliance for Defending Freedom, is that your understanding?

A Yes.

Q Have you previously worked with the Alliance for Defending Freedom on any matter?

A Yes. I -- I think of it as working with Mr. Brooks.

Q And I don't want to --

A Mr. Brooks is associated with the Alliance for Defending Freedom, so I guess the answer to your question is yes.

Q When did you first work with Mr. Brooks?

A In the Young -- Young -- in the Younger case.

Q And that was the Texas matter we discussed?

A Yes.

Q And I think you testified in your deposition in the Claire matter, that's the Florida case, that you worked with a lawyer from the Alliance Defending **[53]** Freedom to write your report in Younger; is that right?

A In -- the question is a little confusing to me because you brought up the Florida case, and I don't -- could you repeat the question and ask me just one question?

Q Sure. I was trying to orient you that I understand that you gave a deposition in that Florida matter of Claire; correct?

A I did.

Q And in that case, you were asked some questions about your report. Do you remember that?

A You mean my report in the Younger case?

Q Correct.

A I don't remember that. I'm not denying it, but I just don't remember that.

Q Yeah, was just curious about the kind of genesis of your report in this case, and so what -- I guess what I'll ask you is, is it -- is it fair to say that you worked with a lawyer from the Alliance for Defending Freedom to prepare your report in the Younger matter? Correct?

A Yes.

Q And then your report in the Claire matter in Florida was derivative of the Younger report; correct?

A I don't think that's correct.

[54]

Q What's not correct about it?

A I think the Florida case was about three -- the plaintiffs, I think, were three adults. The Younger case was about, as we established before, a very young child.

Q Okay. So your testimony is that the report you submitted in the Claire case was not a derivative of the report that was submitted in Younger; is that right?

MR. BROOKS: Object to the form.

THE WITNESS: It's -- it's very difficult for a person like me to know how my clinical activities and my consulting activities interplay and influence one another.

I am a very busy person, doing a lot of different things, and I often think about, in a very pleasing way, how my various activities cross-fertilize my -- and stimulate my views, and what I read in one case for one particular matter may stay with me and help me understand yet another matter.

So this cross-fertilization is a very intellectually stimulating process, but it makes me very unable to answer the question about what influenced what. You know, sometimes I read a novel and it influences, I think.

[55]

But it's hard -- I -- I can't really track, with any degree of certainty, what influences what.

Perhaps if you had specific -- more specific questions, I may be able to give you an opinion. But based on what you just said, I -- I -- I'm at a loss to answer it definitively.

BY MS. HARTNETT:

Q So I think my -- just to be clear for the record, then, you cannot answer definitively whether the report you submitted in the Claire case was a derivative of the report that was done in the Younger case; is that fair?

MR. BROOKS: Objection; vague.

THE WITNESS: Based on how I currently think at the moment, I think it's correct.

BY MS. HARTNETT:

Q Sorry, correct that you -- you can't take a view on that?

A It is correct that I don't know whether the Younger case influenced my -- a specific -- I mean, I -- I probably wrote many, many pages for the Florida case, and so, you know, maybe there's a sentence or a paragraph or two that, in my mind, was conceptualized in part because of -- of my experience in the Younger case.

[56]

But at this moment, I cannot tell you definitively this influenced me or this did not influence me. Number one, that was a couple of years ago. Lots of things have happened in my brain in the last couple of years.

Q Did any novels affect your expert opinion in this case?

A Not that I can think of.

Q You mentioned that you first encountered Mr. Brooks on behalf of ADF in the Younger case. Can you tell me how you got connected with him in that matter?

A He called me. He had read two papers, I believe, that I had published, and he wanted to talk to me.

Q So for this case, B.P.J., what were you asked to do in terms of presenting an expert opinion?

A He wanted me to present the state of knowledge, what is known and what is not known, about trans care as a background for this particular case. But he was aware, and -- and I told him very clearly -- that he was quite aware. I didn't have to tell him. I just reminded him that I am not an expert in the physiology of estrogen and testosterone blockages for **[57]** athletic capacities, I'm not an expert in lung volumes and cardiac capacities. And -- and I asked him why -- why he would --

MR. BROOKS: I'm going to instruct you not to disclose the substance of conversations with your attorneys.

THE WITNESS: All right. Thank you.

BY MS. HARTNETT:

Q Was that a conversation you had before you were retained in this matter, Dr. Levine?

A Was that a conversation?

MR. BROOKS: Counsel, the -- the witness can answer that question, but any conversations surrounding the retention, I will instruct the witness not to answer.

THE WITNESS: I wondered why he needed my testimony in this case. He provided an answer for me.

BY MS. HARTNETT:

Q Do you view your testimony as relevant to this case?

MR. BROOKS: Objection.

THE WITNESS: Insofar as you make claims -- you -- that your side may make claims that is not -- that are not scientifically correct or established, it may very well be relevant.

[58]

But that is not a question for me to decide. That's a question for lawyers on both sides and for the judge. Again, I'm just -- I'm just -- I just have a certain limited understanding and knowledge which I believe the Court might benefit from having.

BY MS. HARTNETT: Q Did you prepare for the deposition today?

A Yes.

Q What did you do to prepare? And please don't disclose your communications that you had -- the substance of the communications that you had with counsel.

A I reread my report Sunday evening. I met with counsel yesterday afternoon.

Q How long did you meet for yesterday afternoon?

A I'm sorry, how long, did you say?

Q Yes, how long did you meet with counsel yesterday afternoon?

A Between 1:30 and quarter to 7:00.

Q Did you review any documents to prepare for this deposition other than your expert report?

MR. BROOKS: And you -- you can answer that question yes or no without identifying specific **[59]** documents.

THE WITNESS: Yes.

BY MS. HARTNETT: Q Did you review the rebuttal report of Dr. Safer?

MR. BROOKS: I'm going to instruct the witness not to answer questions about what specifically he reviewed with counsel yesterday.

MS. HARTNETT: I believe I have a right to know what, if any, additional documents he's reviewed before the deposition other than his report.

MR. BROOKS: On the contrary. I believe that selection is my work product. And I stand by my instruction.

BY MS. HARTNETT:

Q Outside the presence of your counsel, is there anything other than the expert report that you reviewed to -- before your deposition?

MR. BROOKS: On your own, outside our session yesterday, did you review anything else in preparation for your deposition?

THE WITNESS: No.

BY MS. HARTNETT:

Q Do any materials other than those cited in your expert report inform your opinion in this matter?

MR. BROOKS: Objection.

[60]

THE WITNESS: As was -- if you have read my curriculum vitae, I have recently published two papers about issues. One is titled the Reflections of a Clinician about the trans -- the care of trans youth that was published in November, in the Archives of Sexual Behavior. And about 16 days ago, a new article appeared online about informed consent, Reconsidering Informed

Consent in the Treatment of Trans Children, Adolescents, and Young Adults.

And so I can't really separate the processes of writing these papers from, you know, the submission of documents in this particular case.

But in a literal answer to your question, did I -- did I review any particular documents in -- in -- in preparation for this testimony today, this deposition today? The answer is no. But the process of writing articles is a deep, you know, dive into all kinds of issues and -- so I'm busy with this -- these sub- -- these topic areas.

But I guess the answer to your question is no.

BY MS. HARTNETT:

Q Thank you. And what I need to understand and -- and find a way to get that information from you, notwithstanding your counsel's objection, but he should make any direction he sees fit to make, in -- in your **[61]** expert report, you refer to certain materials in this case that you had reviewed as a basis for your opinion. Do you recall that?

MR. BROOKS: Do you want to direct the witness's attention to what you're referring to?

MS. HARTNETT: Yeah, I can do that, I guess.

BY MS. HARTNETT:

Q You reviewed Dr. Adkins' and Dr. Safer's declarations before you -- as part of your materials that you rely on in your expert report; correct?

A Yes.

Q And what I'm trying to understand is whether or not you are going to rely on Dr. Adkins' or Dr. Safer's

supplemental declarations as part of your expert opinion in this matter.

MR. BROOKS: Counsel, let me -- I'll object and, I think, make a suggestion.

The -- is your question whether he has considered those rebuttal reports submitted by Dr. Adkins and Safer? Or did you mean something else?

MS. HARTNETT: I would like to know if he has reviewed the expert -- supplemental expert report of Dr. Adkins.

Will you allow him to answer that question?

MR. BROOKS: I will.

[62]

THE WITNESS: I think at one point I did.

BY MS. HARTNETT:

Q Do you understand that Dr. Adkins wrote an initial report and then a rebuttal, including to your report?

A Yes.

Q Have you reviewed Dr. Adkins' rebuttal, including to your report?

A Not -- not in preparation for this deposition, no.

Q And did you review Dr. Safer's rebuttal declaration in this case, ever?

A I think I have. Yes, I --

Q And have you --

A I --

Q Okay.

A I have, yeah.

Q And have you reviewed the declaration of Aron Janssen in this matter?

A Of Aron who?

Q Janssen.

A I can't recall that. I may have.

Q He's a physician at Chicago Children's Hospital. Is that ringing a bell?

A No.

[63]

Q Okay.

A It's ringing a faint bell.

Q All right. If you could go into your "Marked Exhibits," there should now be a marked Exhibit 86.

MR. BROOKS: I have that on the screen.

MS. HARTNETT: Thank you, Roger.

And this is a document that starts with the page that says "Exhibit A," and then it goes on to -- it's an attached expert declaration.

BY MS. HARTNETT:

Q Do you see this document, Dr. Levine?

A We're scrolling through it here.

Expert declaration of Dr. Levine. Robert Ferguson -- Tingley, yeah, okay.

Q And so what -- what is this document, if you know?

A This is something I submitted several years ago of -- I think it was about an attempt to censor a psychologist who wanted to provide a certain exploration with a patient, and -- and so I was offering an opinion about, I guess, the

psychotherapeutic evalua- -- the evaluation of pyscho- -- the psychotherapeutic processes involving patients.

Q And just turning to page 2 of this document, **[64]** do you see it says -- are -- are you on page 2 of the PDF?

A Let's see. How do I know that?

Q The page after the page that says "Exhibit A."

A I -- I'm on the page that is the title page that says, Expert Declaration of Dr. Stephen Levine.

Q And, Dr. Levine, the caption of this page says "Expert Declaration of Dr. Stephen B. Levine in Support of Plaintiff's Motion for Preliminary Injunction"; correct?

A Correct.

Q And I know we had some discussion before the break about what the word "support" means. In this case, did you understand that your declaration was being submitted in support of the plaintiff challenging the practice that you were referring to?

A I guess I now understand that, yes.

Q Okay. And just flashing back to the end of -- this is a declaration that was submitted in a matter in court in Washington State.

Do you see that?

A Yes.

Q And then at the -- it's -- you can page through, but it appears that you signed this declaration on May 10th, 2021; is that correct?

[65]

MR. BROOKS: Well, we'll go to the end and see what we see.

THE WITNESS: Let's see. May 2021.

BY MS. HARTNETT:

Q Okay. And what -- what, if any, additional involvement have you had with the Tingley matter other than submitting this declaration?

A I think none.

Q Okay. Now, just turning back to the first page or any page, frankly, in this document, you can see there's a caption on the top of the page there.

Do you see "Case 2:21-cv-00316"? Do you see that?

A Yes.

Q And that, I would represent, is the caption for the current case, B.P.J.

And this was Exhi- -- this -- this declaration, the version that I put before you, is actually the version that was attached in opposition to plaintiff's motion for preliminary injunction in this case.

Did you have an understanding that your declaration from the Washington case was going to be submitted as an attachment in support of the defendants in this matter at the preliminary injunction stage?

[66]

MR. BROOKS: Objection.

THE WITNESS: No.

BY MS. HARTNETT:

Q Were you asked to -- for permission before the defendants in this case attached your Washington declaration to the opposition to the preliminary injunction motion in this case?

A No.

Q Do you recall whether you were asked to submit an expert declaration at the preliminary injunction phase of this case?

A Would you clarify that question? I'm not exactly sure what you're asking.

MS. HARTNETT: Could the reporter read back my question.

(Record read.)

MR. BROOKS: Objection.

THE WITNESS: I don't know what the preliminary injunction phase was. I don't know the -- who the implied person who might have asked me. I -- I -- I'm -- I'm a psychiatrist. I am not a -- I'm not very knowledgeable about your -- about the law and the legal processes.

So I -- I just can't answer the question because I don't I understand the terms.

[67]

Perhaps you can simplify the question for me.

BY MS. HARTNETT:

Q What I'm trying to understand -- and thank you for -- for that.

I'm trying to understand whether you are aware that your declaration from the Tingley matter was submitted in opposition to the plaintiff's motion for preliminary injunction in this case.

MR. BROOKS: Objection; asked and answered.

THE WITNESS: I thought I already answered that question.

By MS. HARTNETT:

Q Okay. Right. And you said, I think, that you were not aware. And then what I'm asking you is, were you asked to prepare a declaration specifically for this case at the preliminary injunction phase?

MR. BROOKS:

Objection; asked and answered.

THE WITNESS: Again, I don't know the phases of this case. And the preliminary injunction phase is -- I don't understand specifically what that means in terms of the long process of adjudication in this case.

I was asked to submit a report for this case, but I was not told it was for a preliminary injunction or what- -- an injunction that's not preliminary.

[68]

I simply don't know the answer to your question.

BY MS. HARTNETT:

Q Thank you. When were you retained in this case, B.P.J.?

MR. BROOKS: Objection.

If you recall.

THE WITNESS: I presume it was sometime in 2021, but I don't recall the specific date. I -- you know, I could find out, but right now, I -- I -- I can't tell you a specific date. I would presume in the last half of 2021.

BY MS. HARTNETT:

Q Do you have any objection to your declaration from one case being submitted in another case without your approval?

MR. BROOKS: Objection.

THE WITNESS: Personally do I have an objection for people using my previous testimony? Yes. I don't -- I don't think that's fair to me because every case is somewhat different. And it feels like it's my work product and that -- but the truth is that I'm naive about the -- about the legal processes, and I think when -- the first time I submitted an expert opinion report, I was shocked that people had read it **[69]** who weren't involved in the case.

So there was this problem with Dr. Levine not being a forensic psychiatrist, just did not understand about what is public and what is not public when it comes to legal documentations.

I think I subsequently learned that -- that lots of people read my reports who have nothing to do with the matter at hand because lawyers are looking for experts and precedents and so -- and arguments and so forth.

So in a -- in a personal sense, I have some kind of objection to that. It doesn't feel fair to me, but it's also a reflection of my naivety about this -- my past naivety about this matter -- about legal matters.

BY MS. HARTNETT:

Q Thank you. I have added a different -- another exhibit that I would like to introduce into the folder, if you could refresh.

MR. BROOKS: 87?

MS. HARTNETT: That's correct.

MR. BROOKS: Shall I open that now?

MS. HARTNETT: Yes, if you would.

(Exhibit 87 was marked for identification by the court reporter and is attached hereto.)

[70]

BY MS. HARTNETT:

Q And, Dr. Levine, I've marked as Exhibit 87 your expert report and declaration in this matter dated February 23rd, '22.

Could you please just take a moment to look through the document.

MR. BROOKS: Well, Counsel, the document, I think we'll all agree, is perhaps, what, 70-some pages long, plus bibliography.

Would you -- what do you mean by asking the witness to look through the document?

MS. HARTNETT: I was just giving him the courtesy of making sure he agrees it's his expert report.

THE WITNESS: Well, my -- my signature is on the first page.

BY MS. HARTNETT:

Q Excellent. So what is this document, Dr. Levine?

A Well, I believe it is the report that I submitted at the end of February about -- in this matter.

Q Okay. And did you prepare this report?

A Yes.

Q And do you notice that this one has the **[71]** caption for this case on it, on the first page; correct?

A It does, yeah.

Q How much time did you spend preparing this report?

A I could -- I would say approximately 20 to 25 hours. I would say closer to 25 hours.

Q And were you -- as a basis for this report, did you use a kind of prior report that you had submitted in a different case?

A Yes.

Q What was the basis -- like, the prior report that you used as a basis for this report?

A Well, as I've told you already, I have provided reports about the nature of what is known and what is not known in a scientific sense about this whole matter and -- so that's just part of my thinking. And one report is a sort of modern refinement of a previous report that -- that is selected, added to or deleted from based upon the relevance to the case in point.

So every -- every submission that I have made, in a sense, has contributed to the -- to this current report with the understanding that things have been added and things have been deleted every time that I -- **[72]** I submit a report for a case.

I hope that's an answer to your question.

Q Thank you, yes. I guess what I'm trying to get at is was there a particular past report that you used as a template to work from as you made your refinements and edits for this report?

A No. That's -- that's -- I think the answer is my -- my -- my knowledge -- my -- I think the answer is to all, all my reports. I guess the answer to your question is no, there's not a particular one, but there are a series of reports, and I sometimes will select from various reports.

Well, for example, this -- the -- the simplest thing is if -- in the beginning of the report, when I provide my credentials, for much of that, there is a cut and paste phenomenon and -- and it doesn't much matter which report I cut and paste from, but I only added to it or subtract to it depending on, I think, the relevance.

So, for example, if you looked at my report on the North Carolina matter, probably there's much similarity in the beginning of the report.

Q Thank you. So this document indicates that the -- at least by my reading of it -- the only documents specific to this case, B.P.J., that you **[73]** reviewed in preparing your report were the Adkins declaration and the Safer declaration; is that correct?

A I think so.

Q Are you familiar with the concept of a reasonable degree of scientific certainty?

A I hear it as "medical certainty." Is this a reasonable degree -- can you offer this with a reasonable degree of medical certainty, Doctor? And when I've asked what that -- what that meant, I've been told 51 percent certainty.

Q Okay. What is your understanding of -- so your understanding of a reasonable degree of medical certainty means 51 percent certainty?

A No. I think that's my understanding of the legal definition of medical certainty. My clinical idea and my scientific idea would be very different.

I -- I often smile when I think that -- if I'm correct -- that in the legal world, medical certainty refers to 51 percent.

Q And what is, in contrast, your clinical standard that you were referring to?

A Repeat that, please. What is what?

Q The -- I think you were contrasting it with a clinical standard; is that correct?

A Right. Oh, clinical or scientific.

[74]

You know, in -- in science, we have -- in clinician, we have the idea of what is the risk of a false positive and what is the risk of a false negative, and it's a complicated statistical balance between the ability to get it right or to get it wrong.

And I am -- I am one who is very humbly impressed by the inability to be certain about things, and I distrust certainty because facts change in medicine.

And -- and if I could just tell you a -- an experience that I've had. As a young person, I was interested in becoming a physician, and I went to a premed program at the University of Pittsburgh, and somebody in that program held up Harrison's textbook of medicine, which requires considerable arm strength to lift over your head because it's probably, you know, 900 to a thousand pages. And he said, This is what you have to learn when you're in medical school, by the time you graduate medical school. I want to tell you, ladies and gentlemen, that 90 percent of the things in this book are probably not true. They probably will not prove to be true in time. The trouble is I and other people in medicine can't tell which of the 10 percent -- which of the facts are correct and which of the facts are not. This is the nature of medical **[75]** science as it -- and clinical science as it moves forward. We have, at any given time, a set of facts, a set of principles and -- and

controversy occurs, people disagree and studies are done, and the facts disappear and new facts take their place.

That was my introduction to medical science.

And as I've spent most of my -- the majority of my years in this field, I still believe that that little example remains to be -- remains salient and something that all of us need to remember.

And so I say to you, 51 percent medical certainty is a joke to me. It -- it -- I always smile.

Q Thank you. That -- that's helpful.

If we could just go through your CV attached to your report, we can -- I have a few questions on that, and then I'll turn to your report.

You'll have to page down a bit. It starts repaginating about page -- after page 81.

MR. BROOKS: We are at the beginning of where it says "Brief Introduction," "Curriculum Vita."

MS. HARTNETT: Okay. Thank you.

BY MS. HARTNETT:

Q Dr. Levine, is this your CV?

A It is.

Q Are you aware of anything, sitting here today, **[76]** that needs to be updated or corrected?

A Probably if you scroll to the end of the articles, article 151 -- publication 151.

MR. BROOKS: We're scrolling. We're scrolling.

MS. HARTNETT: I think it might be 147.

MR. BROOKS: There's a lot. Pardon me. 86. Here we are at -- just before --

THE WITNESS: Oh --

MR. BROOKS: -- where it says "Book Chapters."

THE WITNESS: I'm sorry, 147. 147 is -- I can -- you know, today -- if I were to give you my CV today, I would give you the exact citation of that article.

And if we scroll down to the end of the CV, I will show you something else.

MR. BROOKS: I'm not sure there's a further question --

THE WITNESS: Oh.

MR. BROOKS: -- pending.

Or is there a question pending?

MS. HARTNETT:

Well, yeah, I can -- I can ask one.

BY MS. HARTNETT:

Q So I take it that 147 has now been published.

[77]

Is that the difference?

A Yes.

Q Did you -- is there a -- a more updated version of your CV that goes up to 151?

A I think last week, I -- I rearranged the numbers and somehow -- I may be -- I may -- I may not be accurate at 151.

Q Okay. And then 146 there is what you were talking about earlier, the November piece about the reflections on a clinician's role?

A Yes.

Q Thank you. And is there anything further on here you'd like to draw my attention to is in need of updating?

A I don't know if -- if this -- this thing has a -- this CV has a -- my -- a podcast I participated in. I never -- unlike many of my colleagues, I never put in my CV the talks I give and the -- you know, and now there's this whole thing about podcasts. I -- I gave a -- I didn't -- I was invited to give a podcast recently and -- so I think it's on my CV, but I'm not sure.

Q That was in January of this year?

A Was it in January? It was -- it was within several months ago, yeah.

[78]

Q Have you given any podcasts other than the one you gave in January of this year?

A The -- the answer to that question is I don't know. I mean, sometimes people come and talk to me and -- and film me on camera and I never know what happens to -- what hap- -- what -- what -- that happens. I never know what happens to it.

Q Are you aware of any other -- sorry.

A The answer to your question is I'm not aware that I have been in any other podcast, but, you know, you may dig up some other conversation that is -- that I've had somewhere along the line.

Q Thank you. If we could just turn back to the first page of your CV, I would appreciate it.

Let me know when you're there.

MR. BROOKS: Yeah. We're there.

MS. HARTNETT: Okay.

BY MS. HARTNETT:

Q So on page 1, it notes that you are -- board certified in -- in June of 1976; correct?

A Yes.

Q In neurology and psychiatry; is that correct?

A That's the name of the board that psychiatrists get certified in. It's a little bit of a joke that I'm -- that any psychiatrist is certified as **[79]** a neurologist.

Q Have you been recertified with that certification?

A No. I don't need to be. I'm grandfathered in, as they say.

Q Thank you. Do you have any other board certifications?

A No.

Q So you are not board certified in child and adolescent psychiatry; correct?

A No, I'm not board certified.

Q Do you have any specialized training in child development?

A Yes.

Q Can you describe that?

A I'm a psychiatrist. All psychiatrists are trained in child development. I, in particular, have been interested in

the whole process of adult -- of -- of development throughout the life cycle and have -- I think I quoted in my expert opinion report that Tom Insel, who was the head of the NIH, NIMH, said that 75 percent of adult psychopathology, that is, suffering as a result of mental disorders, have their origins in childhood.

So it's hard for me to conceive that any -- [80] any -- any psychiatrist is not knowledgeable about the processes of growing from birth to death. And I, in particular, am interested in that process. I often say to my -- to other people that I -- development is my field. In fact, when -- when people talk about psychoanalysis and psychodynamic psychiatry, I like to rephrase those terms as developmental psychology.

Q Thank you. I just -- my -- my question, though, was whether you have any specialized training in child development.

Do you have any specialized training?

A Well, of course, I rotated through child psychology when I was a resident. For the purpose- --

Q Anything else?

A For the purposes of questioning my expertise, I have no specialized credentialed, certificated training in child psychi- -- in -- in child development.

However, what I'm saying to you is that my understanding of being a psychiatrist and listening to people's stories about their development all day long, I don't need a special certificate to testify that I am trained in -- in -- in child, adolescent, young adult, middle-aged and older-aged development.

Q And would the answer be the same if I asked [81] you whether you had any specialized training in -- in children or adolescents with gender dysphoria?

A Specialized training? I was in on the ground floor of these things when there was no specialized training. I was part of the -- I was part of the process that was trying to figure out what this all was about, you see. And --

THE WITNESS: Sorry.

-- I very much object to that term "specialized training" because I have an understanding of what that really -- the connotation of that term is, and I don't accept that -- the legitimacy of specialized training.

I feel what you may mean is indoctrination training. I'm -- I like to distinguish between indoctrination and education.

BY MS. HARTNETT:

Q Are you an endocrinologist?

Are you an endocrinologist?

A No.

Q And you would not hold yourself out as an expert in endocrinology; correct?

A I'm not an expert in endocrinology.

Q And are you an expert in sports medicine?

A No, I'm not an expert in sports medicine.

[82]

Q Are you an expert in athletic performances?

A I've already testified to that. The answer is no.

Q Yeah, I'm asking because I think your attorney at some point indicated that might be part of your privileged conversation. That's why I'm asking you again.

Do you have any -- have you ever had any complaints made against you related to your medical practice?

A Yes.

Q Could you tell me about those?

A Yes. We had a trans adult who wanted hormones, and I was supervising a psychology intern, and the -- we decided the person was mentally unstable and was not in a position to be given hormones just yet, and the patient threatened to murder the psychology intern who told her that -- who told the patient that answer.

And I -- when she told me that, I went in and I saw the patient, and I told the -- and I discharged the patient. And I said that patients have obligations and doctors have obligations and you have justified the rule, you have crossed over the line, and I cannot allow you to continue to get care here.

[83]

The patient then left and then reported me to the State Medical Board, and the State Medical Board investigated and -- and found -- and found that I was perfectly justified in what I did.

That is the only awareness that I have of -- of complaints to the State Medical Board about my work.

Q Thank you. Just back to the point, we -- we were discussing the notion of specialized training a minute ago.

Do you recall that?

A I recall.

Q So do you -- do you accept the legitimacy of the notion of specialized training in child and adolescent psychiatry?

A For people who are interested in having a more extensive experience and plan to spend their lives with young -- young people only or primarily, I think it's a fine thing to -- to -- to -- it's just one of the many houses in the big -- in the mansion of medicine and one of the -- one of the subspecialties in psychiatry. I have no objection to people becoming child and adolescent psychiatrists.

Q And just to be clear, that's not a specialty of yours; correct?

MR. BROOKS: Objection.

[84]

THE WITNESS: It's not formally. I -- I don't define myself as a board-certified child and adolescent psychiatrist, but I do define myself as a psychiatrist.

And as -- as I've already stated, I believe that psychiatrists, over the -- during the course of their training and -- that is, their initial education and their subsequent life education, practicing psychiatry, comes to understand or should come to understand the influence of childhood positive and negative experiences on their subsequent mental life and behavioral life.

BY MS. HARTNETT:

Q In your mind, are the concepts of having an understanding of child psychology and actually working with child patients distinct notions?

A Well, I think they're -- they are to be separated. One's -- one's theoretical understanding of the processes of development, the stages of development and understanding childhood adversities that -- that we hear

about all the time from adolescents and from adults, that's different than actually, you know, seeing five-year-old children or six-year-old children.

So I make a distinction between that, sure.

Q And how much of your practice throughout your career has involved actually seeing children or **[85]** adolescent patients?

A Well, I -- I spend a lot of time with adolescent patients, and I spend much less time with -- with children per se. I spend an enormous amount of time talking about children to their parents. I mean, conversations about childhood are about the -- my -- my older patients, about their childhood, and the parents that I see about their children's processes, that's a -- I would say a daily occurrence in my practice.

Q How many child patients have you had in your career?

MR. BROOKS: Objection; vague.

THE WITNESS: I -- I would have a very hard time answering that question. I've had -- you know, when -- when parents talk to me about their children, for insurance purposes, the patient is the mother or father or both; right? But the subject of our conversation is the child.

So I don't know -- you see, and one of the therapeutic activities that I do, I call "parent guidance." And so parent guidance involves the focus on the child's environment and how to improve the child's anxiety problems or whatever, you see.

So I don't know if I -- if that constitutes how many children. Can I answer that question in terms **[86]** of parent guidance?

I have a pediatrician, for example, as an adult patient now, and he and I have spent a lot of time talking about his daughter and -- and some of the things I've said to him have really helped his daughter overcome a problem. But he's my patient, you see.

I don't -- so I can't answer your question with numerical terms and --

BY MS. HARTNETT:

Q Children can be patients; correct?

A Children can be patients, certainly.

Q And so I'm just asking you how many actual children patients you've had over your career, if you could estimate that.

MR. BROOKS: Objection; vague as to the term "children."

THE WITNESS: Can you clarify whether -- what a child is versus what a teenager is?

BY MS. HARTNETT:

Q Yeah, I'll ask you for two categories.

I'll ask you for prepubertal children.

How many prepubertal children have you had as a patient in your career, approximately?

A And if I saw that prepubertal child one time, would that -- would that constitute a patient?

[87]

Q Why don't you give me your estimate of how many prepubertal children you've ever seen as patients, and then we can ask more questions.

A I would say a handful. Six.

Q And how many of those -- of those approximately six did you see more than one time?

A I can't recall one.

Q And then I'll ask the same question about adolescents, which I'll mean minors from puberty through being a minor.

How many adolescent patients have you had in your career, approximately?

A 50.

Q And how many of those have you seen more than once?

A Most.

Q And were most of those, of the adolescent patients you've seen, late adolescence?

A No.

Q Turning back to your CV, you list yourself -- you're listed as a clinical professor at Case Western Reserve University School of Medicine; correct?

A Yes.

Q Do you work at Case Western Reserve University School of Medicine full-time?

[88]

A No. No.

Q When did you stop working full-time?

A In 19- -- November 1992.

Q Are you currently teaching any classes at Case Western?

A I've never taught classes per se. That's not how my teaching has ever been. If you think about a college course, I have never -- I don't teach college courses or graduate school courses. I provide seminars sometimes. I've written articles about the sex education of doctors and -- so over the years, I've taught a number of seminars to our residents in psychiatry. I teach -- I give workshops.

I recently, for example, gave a four-hour work- -- a four-hour workshop at the Harvard student health service for their mental health professionals where I presented, you know, ideas to them, and we had discussions.

So I teach -- I teach sometimes by giving grand rounds. I -- there -- there is a named lectureship in my honor at Case Western Reserve, and once a year, I invite someone to give a talk from another university about some sexual topic.

So I have residents who come to spend -- for -- I can't -- for probably -- probably – since [89] 1992, 1993, I've always had a resident with me who comes and sees my patients with me, and they usually spend six months with me, sitting in and seeing my patients together.

So my teaching is not in the classic sense that -- that the average layperson would think of teaching classes. It's -- it's much more -- you know, coming in and seeing how an older doctor does work, has, quote, therapy.

I also, since 1977, have led two clinical case conferences a week, and residents and medical students, depending on the year, medical students, residents and members of the community come in to those conferences and we discuss cases.

So I have multiple avenues, multiple ways of being a teacher, but none of them are through coursework per se.

Q Thank you.

A I forgot to tell you. I also sometimes am invited to give continuing education lectures. And, for example, at the -- I've given courses, for seven years in a row, at the American Psychiatric Association on sex and love, mostly love I use as -- as the title, and we talk about sexual problems and the barriers to loving.

[90]

And this year's APA meeting, I -- I am presenting a symposium with three colleagues on whether or not this is time to reexamine the best practices for transgender youth.

So all those things are -- in my review, are -- are my teaching.

Q I was going to ask you about the May presentation.

Who are your copresenters for that?

A Sasha Ayad, Lisa Marciano and Ken Zucker.

Q Thank you. When is that expected to be presented?

A May 24th.

Q And do you know if there are other panels or presentations regarding the care of transgender patients at that conference?

A There probably are, but I'm -- I haven't seen the entire program. But -- but there are usually -- there usually are one or two presentations.

Q And you said it was Sasha Ayad, Ken Zucker. And who was the third person?

A Lisa Marciano.

Q Right. So I just had one -- a couple of follow-up questions about the discussion we were having about seeing prepubertal and adolescent patients.

[91] Q When is the last time you saw a prepubertal child patient?

A Physically saw?

Q Or -- or virtually. I mean, as your patient.

A Maybe two years ago.

Q And how about an adolescent, meaning puberty while -- through being a minor?

A Three weeks ago.

Q And what was the age of that patient?

A 17.

Q Okay. Let's just turn to page 2 of your CV. I had a couple of questions there.

MR. BROOKS: Just checking -- Since it's been an hour, I was just checking. The witness says he's fine and doesn't need a break yet.

MS. HARTNETT: Okay. Please let me know. This is --

MR. BROOKS: We're on -- the next page. If you'll direct -- I can't fit the whole page on the screen at a time, so you have to direct me to portions of it.

MS. HARTNETT: Okay. It's -- I'm looking **[92]** at -- under "Professional Societies."

MR. BROOKS: All right. I have it up.

Q Dr. Levine, on page 2 of your CV, you list professional societies; correct?

A Yes.

Q Is the Cochrane Collaborative a professional society?

A Is the what?

Q The Cochrane Collaborative.

A I don't know the answer to that question. The Cochrane Library, you're talking about?

Q The Cochrane Collaborative.

A Cochrane Collaborative.

Well, I -- the word "Cochrane" is -- is what comes to mind. It -- the second word changes from whomever is using it.

I don't think it's a society. It's an organization that does objective appraisal of -- of scientific questions or controversies. And I -- I don't -- I never thought about that as a society; therefore, it's not listed there.

Q Okay. And I apologize. I believe I misstated the name of it. It's on paragraph 4 of your report, which you can look back to, but it then will require **[93]** flipping forward again.

You discussed being an invited member of the Cochrane Collaboration subcommittee, and so I was just trying to understand whether the Cochrane Collaboration is a professional society.

A Well, it's an organization, and it's an organization devoted to the objective appraisal of issues that are controversial in medicine, throughout medicine, every branch of medicine, every specialty of medicine. It's an older institution, and it's among the most highly respected institutions about objective scientific appraisal of clinical

work, and I -- I am on the -- one of their committee- -- I'm on two of their committees, actually.

Q Which committees are you on?

A It's the evaluation of puberty blockers and the evaluation of cross-sex hormones for transgender teens.

Q Do you know how many committees the Cochrane Collaboration has?

A No. I think it's many decades old, and it -- that's -- but the answer to your question is I don't know.

Q Are you a member of the Cochrane Collaboration?

[94] A I'm a member of those subcommittees.

Q And can you describe your work on those subcommittees? What does that entail?

A I'm hesitating to answer that question because you're going to ask a follow-up question, and it is my understanding that until the publication of our work is finished -- is published, our work is published, that we are not to discuss the processes and the content of -- of that.

So I -- I feel constrained to, you know, ask you not to ask me more questions about that.

MR. BROOKS: Well, I -- I'm -- I'm not going to instruct the witness either way. I will advise the witness that we can, I'm sure with counsel's agreement, designate a portion of the transcript as confidential and kind of proceed question by question as you are comfort- -- as you are -- as you feel able, given -- I -- I don't know the nature of your commitments to the organization.

But we can designate a portion of the transcript as confidential, which will make it available to attorneys

representing parties in this case but would prevent it from being published generally.

So I -- I -- I offer that. I don't -- I don't **[95]** represent Dr. Levine, and I don't know that in connection with that -- that professional activity, and I don't know the nature of the obligations, but I'd just advise the client of that pos- -- of that -- Dr. Levine of that possibility.

If you want --

BY MS. HARTNETT:

Q Does your work with the Cochrane -- does your work with the Cochrane Collabor- -- Collaboration affect your -- sorry.

Has your work on the Cochrane Collaboration informed your opinions in this matter?

A My work with the Cochrane group, in reading about the evidence on those two -- on that subject of puberty blockers adds to my -- I should say there's -- I'm hesitating because I really don't know whether I should be saying anything about this, even answering your reasonable question.

Q I appreciate that, but --

A Pardon me?

Q -- we do need to know this for you views, and so I would ask if we -- could you -- could -- are you able to answer my questions and we can designate this portion of the transcript as confidential, meaning it would not be publicly disclosed?

[96]

A There's nothing that I have -- there's nothing that I have seen in my work with Cochrane that has led me to modify what is in that report.

Q Can you please generally describe what the nature of your work is with Cochrane?

A It is to read and respond to summaries of the data, various studies. It has been to help conceptualize what the issue is and what measurements we need -- are needed in order to answer the question in the future about a more -- to provide data in the future if -- based on studies. It's been about trying to limit the number of issues that need to be measured to -- in outcome studies in order to be practical versus comprehensive.

So my work has been to participate with other people in Zoom discussions after we read documents and to given our opinions about draft documents.

And you may or may not know how Cochrane works, but it's a series of -- like, our subcommittee goes through a number of other committees above them to be consistent and -- with the traditions of Cochrane.

And so I'm not, you know, privy to the committees above the subcommittee. I just sometimes hear about, learn about, their -- their responses to druff -- draft reports.

[97]

So I think that's my answer to your question.

Q Okay. Are you a member of the Society for the Scientific Study of Sexuality?

A The -- oh, no longer.

Q What is the Society for Scientific Study of Sexuality?

A It's a bunch of clinicians who are interested in -- it's a bunch of clinicians who are interested in providing services for people's sexual problems.

Q And you ended your membership there in 1999?

A Yes, apparently so.

Q Why?

A Apparently so. I -- I -- if I hadn't looked at my CV, I wouldn't have been able to answer your question.

Q Okay. I'm sorry, I was asking why you stopped being a member in 1999.

A Oh. Because I felt that the majority of the membership thought very differently than me. They weren't -- they were mostly Master's prepared people. They included people who were sexual surrogates. It was a potpourri of people interested in human sexuality that did not have my academic interest in sexuality.

I was interested, I guess -- back then, in the **[98]** '90s, there was the -- there was the Society for Sex Therapy and Research, and there was this society.

A Quadruple S, it's called. And this was -- and there was another society called AASEC- -- AASECT. And the -- the range of professional degrees, the people who had -- the people in those societies had different ranges of professional degrees, and they had different interest in -- sort of an understanding of sexual disorders and in research, and I thought that the society for scientific study of sex really -- I thought that the activities of the organization did not rise to the level of -- of the title of their organization, that it really wasn't scientific.

And, you know, it is amazing to me what -- what people call -- who wrap themselves in the mantle of science that really don't have a concept of science.

So I -- you know, when I was younger, I wanted to be part of the scene and -- and when I got into part of the scene, I didn't want to be part of the scene.

Q Are you aware of the Society for Evidence Based Gender Medicine?

A Yes.

Q And does that go by an acronym?

A Is what?

Q Does that go by an acronym?

[99]

A Yes. SEGM.

Q SEGM. Are you a member of SEGM?

A I contributed -- when I -- when I learned about SEGM probably a year and a half ago, two years ago, I -- I felt that I -- I wanted to support that because they were interested in evidence, in scientific evidence, so I sent them a check for $200.

So I don't know if I'm a supporter of it or -- but I -- they consider me to be an integral and important member of their society. So I guess, based on the fact that I gave them a one-time check of $200 and they hired me to write a -- to -- to develop a paper and they put me on a subcommittee to talk about psychotherapy of adolescents, so I guess I am a member of SEGM.

I think I'm a valued member of SEGM.

Q Understood. Sorry, you said you were on the psychotherapy -- child psychotherapy subcommittee?

A I think we should call it an adolescent -- it doesn't exist anymore. We met -- we met every two weeks for almost a year, but I certainly was an active participant of that.

Q And what -- what was the work of that subcommittee?

A It was talking about what -- it was talking **[100]** about how to develop case histories that would teach mental health professionals, in general, on how to approach a -- an -- an approach to transgender children and adolescents.

As you probably know, there has been, in the last ten years, a dramatic increase in the number of teenage children who are declaring themselves to be trans people. And so the number of, quote, experts -- the epidemiology is such that there is enormous pressure on a -- on the few people who say they're interested in gender, taking care of gender cases.

So SEGM was trying to develop concepts that could be taught to people in the community who are not experts. We are trying to interest them in providing psychiatric services, psychological services to families and to the -- the patients themselves.

And so we were talking about how to -- how to achieve that, whether we should publish -- whether we should give a conference, whether we should -- they just -- they talked about various ways of -- of informing -- of getting more mental health professionals to -- to stop ignoring this problem and to be interested in -- in how to help these kids and their families.

Q Okay. Thank you.

[101]

So you said that that subcommittee is no longer meeting?

A That particular committee is no longer meeting, as far as I know. But that -- but SEGM sponsors many things that I'm totally unaware of.

Q Was there a work product that came out of that committee?

A Well, in some sense, my paper, my most recent paper, didn't come out of that committee, but it came out of the deliberations of that committee because one of the strategies that SEGM had is that they wanted to -- they wanted to put things in the literature that -- that were based on evidence rather than based on precedent.

And so I think that led to the publication of my -- of 147.

Q What do you mean, precedent?

A Well, as you may or may not know, there's a 60-year history of -- of trying to find treatments for transgendered individuals and -- so there has been a precedent of treatment over the years that has preceded the -- the -- the scientific demonstration of the efficacy and the long-term outcomes of that treatment.

So I would say that precedent is a -- is a very important influence in how transgender people are **[102]** being treated today and -- so that's how I use the term "precedent." That is, we have patterns or fashions of treatment that have gone in -- far in advance of the scientific demonstration of the efficacy and were the -- and the long-term outcomes of those treatments.

So that's the term precedent, as I -- as -- as how I use it or how I think about it.

Q And was your -- I think your testimony was that you were in the kind of ground floor of starting that precedent; is that correct?

A I -- well, if -- well, the ground floor really began in the '70s, and I was --

Q I'm sorry, did your counsel say something?

MR. BROOKS: No. I looked at him. He looked at me. I didn't say anything.

THE WITNESS: Yeah.

MS. HARTNETT: Just for the record, the counsel and the witness appeared to be exchanging some sort of a glance, but please continue.

THE WITNESS: So the ground floor has to do with the Harry Benjamin International Dysphoria Association, which I think I joined in 1974 or something like that, and I was in that program or in that -- that associ- -- whatever you call that, a society or something. I was in that professional **[103]** organization for many, many years. And in 19- -- when the fifth standard of care was being thought about, I was named to be the chairman of the writing group that made what was called the Fifth Edition.

So --

Q So you were part of creating the precedent; correct?

A Yes. The only objection I had, what is ground floor. That's the only word I was responding to. I didn't know what ground floor meant.

Q Fair enough. So back to SEGM. Were you part of helping to develop treatment guidelines for the treatment of gender dysphoria with SEGM?

A I don't know that SEGM has ever issued treatment guidelines. In a sense, my latest publication is -- is probably in that ballpark.

What we're trying to do is to -- I think what we are trying to do is -- is create treatment guidelines.

You know, Sweden, Finland, the UK and France have all come out and said that -- let's slow this down, let's be very careful. Even -- even in the United States, there are people who used to be on this -- sort of on a different -- they **[104]** had a -- they had a different treatment guidelines.

There's been a wave of objectivity --

Q I'm sorry to interrupt. I'm sorry to interrupt you, but I -- I really need to ask you to answer my question. And I -- I think we're -- my -- my question was just whether SEGM is developing treatment guidelines.

A I think it's the aspiration of SEGM to develop development treatment guidelines in keeping with what is happening scientifically and -- in terms of objective reviews.

So I'm not so sure that SEGM has published treatment guidelines yet, but I do think they're interested in -- in providing a different set of guidelines that may have dominating the United States and European countries in the past. And Australian and compani- -- countries in the past --

Q Are you part -- are you part of any effort at SEGM to develop treatment guidelines on a going-forward basis?

A No, not directly, but I do --

Q Are you involved --

A I do believe that my recent article will be read by people and considered by people who are going -- if -- if they do develop treatment guidelines.

[105]

Q Is -- is -- am I understanding correctly that your article was an effort, in conjunction with SEGM, to affect the practitioner community about how you view treatment should be provided?

A To the extent that treatment should be provided based upon a thorough informed consent process, that my article describing informed consent would be affirmative answer to your question that I -- I'm hoping that the influence of my article will influence all treatment guidelines in the future, regardless of who issues those guidelines.

MR. BROOKS: Counsel, when --

BY MS. HARTNETT:

Q Are you --

MR. BROOKS: When you come to a convenient point, let's take one more break and have one more stint before lunch. I don't mean to disrupt the line of questioning, but when you come to a point, it would be good.

MS. HARTNETT: I appreciate that. I have a couple more questions on this, and then we can take a break.

BY MS. HARTNETT:

Q Are you actively involved in any SEGM work currently?

[106]

A No.

Q Do you know where SEGM receives its funding from?

A I believe that -- that the hundred or so people that are, quote, members contribute something, but it's something as modest, perhaps, as I gave, $200. There must be a large donor or set of donors.

And the answer to your question is I don't know the answer.

Q Is there someone at SEGM that you think would know that answer?

A Yes.

Q Who is that?

MR. BROOKS: Objection.

THE WITNESS: There are several people. May I answer that question?

MR. BROOKS: You may answer.

THE WITNESS: Stephen Beck, Dr. Stephen Beck, and Ema Zane, E-M-A Z-A-N-E.

MR. BROOKS: And, Counsel, we will designate the testimony about finances of SEGM as confidential.

MS. HARTNETT: We can -- oh, we can provisionally do that. That's fine.

BY MS. HARTNETT:

Q You mentioned -- I have just one more.

[107]

You -- you mentioned you were a valued member of SEGM. Is that just your -- is there a special group of people that are valued, or do you just kind of view yourself as having a valued role in the organization?

A Well, I was asked to develop this paper or a series of papers on informed consent, and to me, I considered that a compliment, and it was based upon my previous publications about this matter.

And in the concept -- and in the discussions of the committee on psychotherapy, I just got the sense that -- I offered an opinion and people really -- they often said that was helpful or clarifying or, you know, really good or "Can I use that term?" or whatever.

So whatever the subjective appraisal I was making of my role, my status, among these very respected people, I believed that I was a valued member. You know, I could be --

Q Do you think you're the most --

A -- delusional about that.

Q Do you think you're the most -- are you the most highly credentialed professional in SEGM?

A No.

Q Huh?

A No.

MS. HARTNETT: Okay. I think this is a good **[108]** time for a break.

MR. BROOKS: All right.

THE VIDEOGRAPHER: Off the record at 11:49 a.m.

(Recess.)

THE VIDEOGRAPHER: We are on the record at 12:01 p.m.

MS. HARTNETT: Thank you.

BY MS. HARTNETT:

Q Welcome back, Dr. Levine.

A Thank you.

Q I think I want to turn from your -- we were talking through your CV a bit and now just go to your report. So if you could -- I'm going to be asking a question about paragraph 5, if you want to pull up that page?

MR. BROOKS: We now have paragraph 5 on the screen.

MS. HARTNETT: Great.

BY MS. HARTNETT:

Q So you, in the first sentence of paragraph 5, say you first encountered a patient suffering with what -- sorry -- "what we would now call gender dysphoria in July 1973."

Do you see that?

[109]

A Yes, I do.

Q Who was that patient?

MR. BROOKS: I will, of course, object to the extent you're asking the doctor to disclose confidential --

THE WITNESS: Actually --

MR. BROOKS: -- identifying information.

THE WITNESS: Actually, the patient and I wrote a paper together and -- and so the patient has used the name, so I feel like I can tell you the name.

BY MS. HARTNETT:

Q That's why I was asking.

A Yeah. So the name was Rutherford Shumaker.

Q And did you refer to the patient as "Rutherford" or some other name?

A Well, the name of the -- the name of the article was Increasingly Ruth: Towards an understanding of sex reassignment surgery.

And so Rutherford, in, I think -- became Ruth. So Ruth and I published that paper, and then I wrote a follow-up to that paper after Ruth committed suicide in her family's home. But that was 1983. I'd have to check the CV.

So that was my -- the man coming to me as Rutherford, who eventually became Ruth, came to me in **[110]** July of 1973.

And do you recall how long after you first encountered that patient you encountered your next patient that was suffering from what we would now call gender dysphoria?

A Oh, it probably -- it was probably a couple of months. The answer to your question, I don't specifically recall, but --

Q Okay.

A -- I -- I -- there was enough pressure by patient request for care that we started this -- this clinic.

Q Understood. And you note here, on your paragraph 5, you also founded the Case Western Reserve University Gender Identity Clinic; correct?

A Correct.

Q And you note, later in that paragraph, that in 1993, the Gender Identity Clinic was renamed.

A In 1993, I left full-time employment at Case Western Reserve, and I continued the program, but we changed the

name of the program, but our work evaluating and providing services for trans individuals continued.

Q And what did you change the name of the **[111]** program to?

A Well, I think we just called it the Gender Identity Clinic of Levine, Risen -- Althof, Levine and Risen, which was the name of our clinical practice, Althof, Levine and Risen. So it --

Q Okay.

A Gender Identity Clinic at ALR.

Q And when you -- when the university kind of discontinued -- or you discontinued the affiliation with the university in 1993, did you consider that to be a dark day in the department, in the politics of the department?

MR. BROOKS: Objection; compound question.

THE WITNESS: Number one, I did not discontinue my affiliation. I changed my affiliation. That is, I was salaried until 1993, and then I left the university and personally, for a while, I did consider it a -- a great disappointment that I left the university.

BY MS. HARTNETT:

Q Did you consider it a dark day in the department, in the politics of the department, at the university?

A That per se wasn't the source of the darkness. That day wasn't it. In my view, it's a very **[112]** prejudicial view, the dark day came when a new chairman was selected, who came aboard, who then basically ran the department into a great debt, and then I and several other program- -- my program and several other programs needed to be cut from the department in order to get the department back into solvency.

So the fact that one day I left was the by-product of things that had happened over a three-year period.

So the dark days began, I think, on day one when the chairman came.

Q Thank you. Are you familiar with the University Hospitals?

A The department of psychiatry was part of the University Hospitals of Cleveland.

Q And you did your psychiatric residency at the University Hospitals of Cleveland?

A Yes.

Q Do you have an affiliation there now?

A I do. I'm a clinical professor.

Q And how often do you -- if at all -- do you go to the University Hospitals?

A Not very frequently. The -- the resident comes to me, and I -- but I am probably going to be teaching a seminar at University Hospitals in the next **[113]** three months because I'm part of a committee to plan the curriculum on sexuality and gender.

Speaking of education, the university -- other -- other institutions also asked me to teach about this subject. And on August -- on April 7th, I'm going to Akron to teach -- or virtually I'm going to teach a three -- a two-and-a-half-hour seminar.

And I forgot to mention to you before, and I'd like you to hear this, that when you were questioning me about my credentials or not having a certificate about -- in child psychiatry, you should know, I forgot to tell you that Cleveland Clinic, department of child psychiatry, and the

University Hospitals, the department of child psychiatry, sends residents to be with me as part of their training in child development and child clinical issues, child and adolescent clinical issues.

So I think -- I just forgot to mention that.

Q Are you familiar with the University Hospitals' LGBTQ and gender care program?

A I'm aware that it exists, yes.

Q Have you ever talked to any clinicians in that practice?

A No one has ever talked to me in that practice. The only time I have interaction with them is when – **[114]** if I present grand rounds, some of those people ask me a question. But they've never consulted me whatsoever in the formation of their clinic and in the ongoing work of their clinic.

A Although, Cleveland Clinic has a very similar program, and they have called me up and -- for some advice sometimes.

But my -- my, quote, own University Hospitals' place I don't really think has any people from child psychiatry in it, but I'm not sure because they have kept me away.

Q What do you mean they have kept you away?

A Just what I explained. They have never communicated with me. It is -- you know, other people know me as being published in this area. You know, I think I've written 20 articles on this -- you know, I have 20 or so publications in this area. You would think that they would invite me or consult with me or ask me questions, but I think they recognized that they are part of what is called affirmative care and what I would say, rapidly affirmative

care, and -- and they sense that I'm not so interested in rapid, that -- that I believe that -- that I have long believed that people who have this kind of dilemma need some patient time in talking about this matter.

[115]

And while I can't tell you how they feel about me, I can only deduce that they're not interested in my concepts because --

Q Have you --

A -- they must be different than their concepts.

Q Have you offered your -- your services to them?

A No.

Q You said your understanding is that they provide rapid affirmative care; is that correct?

A I presume so. I -- you know, I can't understand why -- why the organizers and the leaders of those -- that team are not interested in anything I have to say because they've never asked me.

Q So just because someone hasn't asked you for your view, do you assume that they're not interested in what you have to say?

A This -- I wouldn't say as a general principle, but I would say in this case, I have long assumed that, correctly or incorrectly.

Q It sounds like you don't agree with rapid affirmative care; is that fair?

A Yes. I don't believe that people, after meeting someone for an hour, for example, ought to be given a firm diagnosis and a prescription for hormones.

[116]

Q Is that your definition of rapid affirmative care?

A That would be one definition, yes.

Q Can you give me a more general definition of what rapid affirmative care is?

A It would be -- it would be a commitment to be affirmative in -- in being a cheerleader for social transition or taking hormones or having one's breasts removed after what I would consider to be an inadequate evaluation.

So it begins with an adequate evaluation. It -- it requires having an understanding of the elements of informed consent. And in dealing with minors, it has to do with working with not only with the patient but with the parents.

So rapid affirmative care would be care that does not meet my criteria for thorough evaluation, including a developmental history, a process of informed consent and involvement, over time, with the parents so they consider the weighty -- the weighty implications of -- of what affirmative care represents.

So anything short of deliberation in this and careful consideration I would kind of dismiss as rapid.

Q If affirmative care is given with deliberation and informed consideration, do you disagree with that?

[117]

A No. No. I think parents -- parents have a weighty decision to make, but they ought to be informed about the state of science. The -- the health tour benefits have to be understood in terms of the scientific likelihood of achieving those benefits. And they have to understand the short-term medical but more important the long-term psychosocial risk of what they're doing.

And if those competent parents, knowing the child as they know them, decide, after they're informed, they -- they have my blessing to socialize their child in the opposite gender.

Whether I think in that particular case it's a wise thing or not, it's not my decision to make. I don't actually believe that people like me ought to be recommending. I think we ought to be educating, evaluating and informing and the parents and the child make the decision with my supportive help, both on the positive side and the negative side.

I am to be the trustee, informer of what science knows, and I believe that clinicians who don't know science, who actually think they can evaluate this in a -- in -- in a -- in an hour, I just think that's not good care.

Q Is your view that the clinicians at the **[118]** University Hospitals LGBTQ and gender program don't know science?

A I don't know what they know. I don't know what they know. I have no views about that because I have no means of knowing, only that I get to see people brought to me after they've gone to various affirmative care programs and the parents are horrified at the recommendations that are being made. So --

Q How many -- sorry. Go ahead.

A But in answer to your specific question, since I don't even know the people there and I don't know what they're doing, I'm not -- I would just -- I would just -- I pose these standards, and I don't know whether they meet them or not.

I have not been impressed in general that affirmative care programs in various cities that I get to hear about meet those criteria.

I'm just trying to help people, you know, realize the importance of trans care and -- and trans care, to me, includes careful evaluation and -- and addressing the comorbidities that are frequently present in these kids.

And by "kids," I mean even teenagers.

Q Have you had -- sorry, so you -- but your understanding is that the University Hospitals LGBTQ **[119]** and gender care program does provide the rapid type of affirmative care; is that right?

MR. BROOKS: Objection.

THE WITNESS: I already --

MR. BROOKS: Asked and answered.

THE WITNESS: -- answered that question. I'm not -- I'm not aware of what they do. I -- I am --

BY MS. HARTNETT:

Q Okay. Sorry, I thought you had said you thought that they provided rapid affirmative care, which is why I was asking.

A I wouldn't be surprised if their definition of inadequate evaluation is different than my evalua- -- my -- my definition of an adequate evaluation.

Q Do you know what their definition is of an adequate evaluation?

A No. And because I don't know, I don't want to endorse them, nor do I want to condemn them.

Q What is the basis for your understanding that there is kind of rapid transition care being provided out there?

MR. BROOKS: Objection; vague.

BY MS. HARTNETT:

Q Sorry, let me just use your term.

You said rapid affirmation.

[120]

A Well --

MR. BROOKS: I was objecting to the outlier as vague. I'm not sure what you -- are you referring to the clinic you've been discussing or something else?

BY MS. HARTNETT:

Q What is your basis for your view that there are clinicians in the United States performing rapid affirmation care?

A Thank you for asking that question.

I have been in contact with -- that is, parents -- there -- there are parent groups who cannot find -- there -- there are groups of parents who brought -- were brought together, who came together, bounded -- bound together in organizations who are objecting to what they call rapid affirmation and the inability to find a therapist in their community who is willing to just do psychiatric care like they would do psychiatric care if a child presented simply with anxiety or depression or substance abuse or some other behavioral problem.

The -- the basis for -- for my -- the answer to your question is parents, both Cleveland parents, national -- parents from all over the country and parents from the UK. I am aware that parents are particularly perturbed by rapid affirmation and its **[121]** treatment, and they --

they have complaints that their child is not understood; that is, their problems have not been understood.

Q How many parents have you talked -- how many parents have you talked to about their concern with what you call the rapid affirmation model?

A Well, I gave a talk to 35 parents probably a year ago. In 2017, I think I wrote about it in the article that -- the last four or five cases that I was involved with, the parents all said the same thing; that is, they were horrified that after one hour, their -- their child was diagnosed and -- and had recommend- -- and had recommendations that horrified them.

Q Sorry, how -- where was the talk that you gave to the 35 parents? What -- what was that?

A It was in -- it was in my easy chair in my bedroom.

Q What was the convening? What was the venue for that?

A It was a group of parents who invited me to give a talk, and what I gave a talk on was -- the aspects of what -- what I knew about human identity, not just --

Q What was --

[122]

A -- not just gender identity.

Q Was this group of parents affiliated with an organization, or how did they -- how did they present themselves? As some sort of an organization?

A A woman contacted me and said that she belongs to an organization of -- of concerned parents of trans teenagers or children. I'm not sure which. Mostly teenagers. She actually sent me an analysis of -- of -- of --

that she made, a little research that she had done that demonstrated a very high intelligence in -- of their -- all the children in this group and very high incidents of autism and other developmental problems and -- so she sent me that data, and she wanted some advice to -- from me about how to get that published.

And -- and then she invited me to give a talk. When we talked, she then said she would get back to me, and she got back to me and invited me to give a talk to the parent group. And so that's what happened.

Q Is the parent group called Genspect?

A No. I think -- it -- it might -- it -- this was an American group of people and --

Q What was the parent's name that did the research?

A You know, I -- I would have to look that up. **[123]** I don't remember.

Q I'm just going to try to -- so I appreciate what you've explained.

Could you tell me how many actual parents have described to you, personally, an experience where their child was diagnosed and prescribed treatment in an hour?

A Well, if -- some people, it would be two hours, okay?

Q Let me just start with one hour.

How many parents have told you directly that their child had been prescribed -- diagnosed and prescribed treatment in an hour?

A I would say perhaps 50 percent of the people who -- who have consulted me.

Q And how many people have consulted you?

A I really can't answer. You know, if I told you 11, if I told you 16, if I told you four, I would -- I would have no conviction that I -- that -- that that answer is correct.

I'm telling you I had the impression that over and over again parents complain about this. They complain about affirmation. They're afraid of affirmation, what that will mean to their child's future. And they complain that they can't get their **[124]** point of view to influence their thera- -- the -- the person -- their gender expert that they took their kid to and -- and that they can't find anyone else who has -- who has the courage, they say, to just talk to their kid without saying they believe in affirmation because that's the right thing to do.

Q Thank you. I -- I just -- you've talked about the importance of scientific data; correct?

A Correct.

Q And you've made the representation that there is a practice of rapid affirmation happening in the United States; correct?

A As -- as far as I know, yes.

Q And what I'm trying to understand is the basis for your understanding that there is a phenomenon of rapid affirmation happening in the United States. And so --

A Well --

Q -- I guess my question is -- sorry.

A -- the basis. And I've tried to answer the basis is -- is that the parents who consult me all tell -- pretty much all tell me the same story. It is multiple patient reports.

And when I -- when I was on that committee that we talked about before, of psychotherapy, people **[125]** in Australia, people in Ireland, people in London, in various

parts of the UK and -- let me think where this is a source of -- and the United States have all reported to me the same thing. Everyone says the same thing, that the parents complained to them about going to specialty care which rapidly confirms the diagnosis and recommends affirmation and tends to make the parents feel like they're -- they're doing a terrible thing by resisting transition.

Q You mentioned --

A So the answer to your question is multiple sources, both directly in my clinical practice, both -- what I read about sometimes in these legal proceedings, legal documents and in -- and -- and from my colleagues.

I -- I just want you to know that if -- that professionals all claim to do thorough evaluations, but I -- I'm not sure that our definition of thorough evaluation is -- is correct.

Q Have you talked to any gender-affirming professional to learn what their practice actually is?

A Well, I've read Dr. Adkins, for example, reassurance about the thorough evaluations done in her clinic.

And -- have I talked to any affirmation -- **[126]** well, I did talk to the Cleveland Clinic people and -- who are -- were sharing with me their angst about what they should do with these borderline personality kids, kids who aren't doing well, who don't want to focus on anything but their transgender state. So they consult me about these -- these case- -- you know, they consulted me about this.

So I guess the answer is yes.

And if you ask me the number, I would say it's not a large number. I don't -- and I don't --

Q Sorry, other than Dr. -- other than Dr. Adkins and whoever you talked to at the Cleveland Clinic, have you -- are you -- sorry.

You've never talked to Dr. Adkins; correct?

A I've never personally spoken to her, no.

Q So other than the people at the Cleveland Clinic that you referred to, have you spoken to any other gender-affirming professionals about their practices?

A Well, in these various legal matters, oftentimes I'm asked to review case material, and I -- and I -- I haven't visibly, virtually, talked to -- the answer to your question is no, but I -- I certainly have seen materials that indicate the -- the quality of the interactions that have been between the affirming **[127]** and the professional and the patient and sometimes the parents.

Q And you mentioned -- you mentioned multiple patient reports, I think, when you were saying what the basis was for your review.

Do you recall that?

A Yes.

Q Are you -- and there, you're talking about the patient would be the -- the parent of the child that's being cared for; right?

A Yes. I think if --

Q In other words, you were -- you were not getting complaints from the -- the child or adolescent that was being discussed; you were getting the complaint from the patient parent; is that right?

A Oh, I've heard -- I -- I've heard patients say that they were a little surprised by the rapidity of things, yes.

Q Sorry, one of your child or adolescent --

A So it's --

Q -- patients --

A It's not entirely parents, but it's largely parents.

Q And then I've asked you how many parents you've directly heard reports of -- let's just say **[128]** two-hour or less diagnosis and treatment. How many parents have you heard that from directly?

MR. BROOKS: Objection; asked and answered.

THE WITNESS: I would say 15 sets of parents. And if you allow me to accept the reports of the people on the committee, probably it's over a hundred. But, you know, as I already answered, I can't really -- I'm just giving you numbers because you're asking for numbers.

BY MS. HARTNETT:

Q Well, isn't it important to have good data?

A You're right, it is important to have good information. And data varies in its nature. And parental reports that are consistent over time, to me, is good data. That represents good data. That are good data, rather.

Q Have you ever had a parent report to you a positive experience from an affirming practitioner, as you describe them?

A Ever had a positive experience. Well, last Sunday morning, I gave a talk at a church, and a grandmother told me that her very disturbed granddaughter has transitioned to a -- living as a boy and she's far less disturbed and much happier and she's beginning to restart her life as a student **[129]** now, when she couldn't function as a student before.

So if a grandparent -- I mean, it's -- it's -- today's Wednesday. So that was Sunday morning.

So I think -- that is not the first time I've ever heard from somebody. I've also heard from grandmothers who were deeply concerned about their grandchild.

And, actually, come to think of it, I had an interview -- yes, I -- I have heard about a -- another trans male teenager who is doing very well now as -- and much better than they were doing living as a -- as a distressed female.

So I do have positive reports of people doing well.

And in -- in my years of taking care of -- of adults, I've seen some people, at least who have came back in follow-up after transition, who seem to be doing very well in life.

I'm not saying that -- so I -- you know, I get both sides of the coin here.

Q You haven't undertaken a scientific sampling, though, to figure out what parents' experiences are with affirming practitioners; correct?

A I -- no, I have no follow-up study on this. I am like other people who don't have follow-up studies.

[130]

Q And it could be that parents that are having negative experiences are the ones that are seeking you out; correct?

A Yes. There's always a selection by a -- in -- in clinics. When -- when you have data coming from any clinic, one of the methodologic questions is, What is the selection bias?

And so I -- I represent a person who has some kind of unknown or known reputation in the community, and so people come to see me because they think I have

knowledge or attitude that is consistent with their position.

But, you see, in the -- in the fundamentals of -- of the use of statistics and creating scientific methodology, selection bias is a well-known problem, and that's one of the reasons why some studies need to -- that's one of the advantages of having multisite studies and multicultural -- studies from multiple countries, is -- is what we're going to do about selection bias.

Q I believe earlier you said that your view is that the doctor's role isn't to recommend the treatment for the minors who may be experiencing gender dysphoria but, rather, to provide information to the parents and the children and the parents and the children should **[131]** make the decision; is that fair?

A Yes. This is the idea that I am trying to educate the world about, that, actually, doctors don't know what the best treatment is for a particular child and that they shouldn't pretend to know because there's no follow-up data that are -- there's no compelling follow-up data. There's just anecdotal reports like you and I were just discussing. Or anecdotal reports.

And so given the fact that -- that people believe doctors and they believe that doctors know things and that I know doctors don't know things, you see, what I'm saying, what I'm trying to influence the world to think about is that we should make a -- we -- we recommend that you go to surgery for appendicitis because we know the consequences of not having surgery. You're going to die from this condition if you don't have surgery, you see.

So we -- based on the consequences, we know what is indicated medically to save life or preserve function.

But in this particular area, the long-term follow-up of children or adolescents or even adults who undergo transition are not known. And I -- they're not -- they're simply not known.

And because we are -- some doctors make **[132]** recommendation to transition a seven-year-old or transition a 14-year-old or remove the breasts of a 14-year-old, and I would say that what is the scientific basis of your recommendation to tell parents, who are often trusting of your knowledge base, what is the scientific basis of your recommendation?

And I say, given what we know about science, I'm not opposed to transitioning a child or transitioning a teenager or an adult. What I'm saying, that we should be able to educate, objectively, the parents and the child themselves, you see, so that they know the issues here.

And it's their child. They are legally responsible and they're morally and ethically responsible for the welfare of their child. And so I think they need to be informed.

And -- and what I'm saying is, in the past, doctors have recommended things, and I'm -- so I'm questioning the wisdom of making a strong recommendation because it's based on the allusion that we know what is best for this kid or this adult. And I'm saying, please, doctors, please be humble about what your knowledge is here. Please respect the limitations of your knowledge. That's all I'm saying.

So I -- I am objecting. I'm trying to teach **[133]** the world. If -- I know that sounds rather grandiose, but I'm trying to teach the world that based on our lack of information about the long-term follow-up, we can give options for the treatment of this condition and that option includes what you would call affirmative care.

But we should understand the scientific basis of affirmative care, you see, and we should understand the limitations, and we should understand that even the advocates of -- of gender-conforming surgery have published two papers recently saying that the -- the long-term psychosocial outcomes are not clear, that the benefit of -- of -- of genital surgery or breast surgery, in the long run, is not -- they're not clear.

And so people have undergone -- undertaken two studies in the last year or two years to prove that there are benefits. So why are we, in 2020 (sic), doing studies to prove there are benefits if -- if we already know the answer.

We don't know the answer. And I say because we don't know the answer, there's an ethical responsibility, a professional responsibility, to teach the parents, teach the adult what is known and what is not known.

What they decide is their business. It's **[134]** their prerog- -- it's their prerogative. It's their child. It's their seven-year-old. It's not my seven-year-old. See? It's not your seven-year-old. It's not your 14-year-old. It's theirs. And it's a weighted decision. And the idea that it's not a weighted decision requires you to be an ostrich and bury your head in the sand.

Q Do you think that politicians should be making that decision?

MR. BROOKS: Objection.

THE WITNESS: Well, I -- I do ask myself the question who should be making decisions about the delivery of medical care, you see. And I do realize that in some circumstances, politicians make decisions that influence medical care and medical treatment.

I don't know the answer to that question, but I don't know that doctors per se who are not informed about the -- about the state of science really should be making these decisions with the illusion that they know best. I am not sure politicians know what's best. I mean, when it comes to politicians, you know, we -- we all have skepticism.

But nowadays, what -- who is making decisions are -- are judges, you see. I don't think juries as much as judges and -- and state legislature and **[135]** governors are making decisions. I don't like that either.

I would prefer that an informed medical professional -- I would -- I would prefer that doctors make these decisions based upon accurate scientific information and not political ideology and not mixing up civil rights concerns with medical decision-making.

So I realize we're in a -- this is a morass, and I -- all I -- all -- my point to you today is let's look at the science and let -- let the doctors decide or let the politicians decide, let the governors decide, let the judges decide, but on the basis of science.

Q And are you aware of any scientific study showing that affirmative care practitioners in the United States are providing rapid affirmation, a scientific study, not just anecdotal reports?

A There was a study out of the UK about 20 years ago. I kind of think the author of the study was M-O-L-E. I'm not certain. And they did a follow-up study of people who were given sex reassignment surgery immediately because they asked for it, with -- with very little screening, versus people who were treated as usual, because in that days, people had psychiatric evaluation and psychotherapy, and I think they found in **[136]** the small numbers of patients that they operated on versus the

people who weren't operated on, that there seemed to be -- they seemed to be happier in the short term after surgery than the people who didn't have surgery.

But you know what I've been saying to you in -- well, maybe I haven't quite said it yet. What I'm saying is, when we come to evaluate the impact of these treatments, we need to agree upon -- we have to have a consensus, and it should be an international consensus, about what is the ideal way to evaluate the effects of these treatments.

Should it be, like, at six months, at twelve months, should it be at six -- two years, five years, ten years. And we should agree upon the mecha- -- the measurements that we're going to use prior to actually doing the study so that we all agree upon both -- both the strengths and the limitations of the methods.

So what I'm --

Q Yeah, maybe my question --

A What I'm trying to do is to refine the requirements to answer your question.

Q Thank you. And I think maybe my question may have been unclear.

[137]

What I'm trying to figure out is that you've testified about a perception that there's this widespread practice of providing rapid affirmation service in the U.S.; is that fair?

A Yes, I do have that perception.

Q And what I'm trying to figure out, is there any kind of scientific or other -- otherwise kind of an analysis of a -- of that healthcare market to determine whether in fact that is actually happening or in fact whether these are just anecdotal occurrences that you've learned of?

A There -- your question is one of a series of questions that I would have to answer as far as I know, there are not -- there are not respected scientific methods demonstrating my -- my impression.

Q Thank you. If you could turn to page -- paragraph 6 of your -- or it's probably on the same page you have there, but I'm going to just ask a question about paragraph 6 of your declaration -- or your report.

And you talk about -- you can read the whole thing. I'm not trying to misread it into the record, but I wanted to focus on the sentence that says (as read):

I have at one time or another **[138]** recommended or prescribed or supported social transition, cross-sex hormones, and surgery for particular patients, but only after extensive diagnostic and psychotherapeutic work."

Do you see that?

A I do.

Q Have you ever recommended cross-sex hormones for a minor patient?

A No.

Q Have you ever prescribed cross-sex hormones for a minor patient?

A Is that a different question than you just asked me?

Q Well, you have recommended or prescribed or supported, and so I could go into asking you what the difference is, but I just figured I'd ask you -- is there a differences between recommended, prescribed and supported?

A Oh, yes. I feel like my view of my role is to write a letter of recommendation describing the patient in detail,

the -- the diagnosis, the patient's sensibilities, whether I think this would be beneficial to the patient at this time in his life.

The last person that I wrote, I was doing **[139]** psychotherapy with a young person, starting at age 16, and saw this person over the course of a year and a half. I promised that if they continued talking to me, at the end of the time, I -- if patient still wanted hormones, I would give hormone- -- I -- I wrote a letter of recommendation.

And I did write a letter of recommendation, and the patient did take hormones. He went off to college, failed miserably at college, transferred college, and I sadly I tell you, and I -- I sadly tell you, this person died of a heroin overdose in his dorm room at Ohio State University.

And I know from the parents, postmortem, that he acquired a girlfriend, and he then said that it's not so bad -- he's rethinking this matter. It's not so bad being -- being a male and having sex with someone.

But I don't know whether -- I -- his heroin overdose, which was his third heroin overdose, was accidental death or suicide.

So I have provided hormones. I do have that really negative taste in my mouth from that experience. I don't -- I don't -- I don't have remorse about giving hormones to this person because I promised that if -- that it is his decision.

His parents weren't happy with that decision, **[140]** but they also agreed with the decision. And now they're, of course, in perpetual mourning for their deceased 18-year-old child.

So, yes, listen, I also have given hormones to someone else who is living okay, who is not made any suicide

attempts. But it is, as I described in that paragraph, after I get to know these people. And to tell you, I -- as best as I can tell, they appreciate that.

Q Thank you. I'm just -- sorry for the -- for the person that you -- your -- your patient that you mentioned, the -- the 18-year-old, I'm -- I'm sorry to hear about that.

Sorry, when was that? What -- what time period?

A That was --

Q Datewise.

A -- March 17th, 2021.

Q And did you prescribe the -- or, sorry, write a letter for the hormones before the person was 18 or only once they were 18?

A I think the person turned 18 in August or September, and I think I wrote the letter right near the person's birthday. Whether it was before or after, I'm not sure.

[141]

Q How about social transition, have you ever recommended or prescribed or supported social transition for a minor?

A A minor being someone less than 18?

Q Correct.

A Have I ever recommended, prescribed -- I have never prescribed. I have met people who already had social transition, and I had supported them even in the face of their parents' objection. But I don't think I have ever prescribed social transition to a person. I cooperate with it. I recognize that -- I recognize that it is the patient's decision. And while I may not have thought it was a wise decision to transition or to surreptitiously take hormones,

you know, from China or something, I -- I don't interfere with it. I just talk about it.

So -- but if you're really asking have I said, oh, Parents, you should transition your child, I think the answer is no.

Q Yeah. So I'm trying to -- that's -- thank you for clarifying that. I -- I'm trying to figure out if you've supported the transition of a -- the social transition of any minor patients.

A Yes.

MR. BROOKS: Objection; vague.

[142]

BY MS. HARTNETT:

Q When was the last time you supported the social transition of a minor patient?

A Two years ago, I'm guessing.

Q Okay. Let me -- do you know who B.P.J. -- B.P.J. is the plaintiff in this case. Do you know if B.P.J. is a girl or a boy?

A I know nothing about B.P.J.

Q So you've reviewed none of her medical records or anything like that?

A Yeah, I would presume that this is a trans boy -- a trans girl who was born a -- a boy, but I wouldn't -- I have no certainty.

Q What makes you presume that?

A Well, because trans -- trans girls generally -- I mean -- how should I say it? Trans girls -- trans adolescent girls generally don't -- wait a -- I'm getting confused here. Excuse me.

I presume that B.P.J. is an -- was born and assigned and is a natal -- was a natal male.

But if it's a natal female, I -- I've not heard anything where a natal female becomes a trans boy and wants to compete against boys. If there is a lawsuit like that, that has been raised, I am unaware of it.

[143]

When I read these things in the newspaper, it's -- it's -- they're -- they're always about natal boys who live as trans women or girls and want to compete against women. So that's why I presume that B.P.J. must be a natal male.

But because my role in this case had nothing to do with the athletic side, it's just to -- to provide some basis of -- some background basis on the science of transgender knowledge and the lack of knowledge, I didn't spend time investigating that.

Q Okay. And are you familiar with the law that's being challenged in this case that's called H.B. 3293?

A No.

Q Could we just turn to page 20 of your declaration, paragraph 50 -- or your -- sorry, I'm saying declaration. I mean report.

MR. BROOKS: We're getting there.

MS. HARTNETT: No, take your time. Page 20, paragraph 50.

MR. BROOKS: Let's see. This is under -- just simply -- since I can't fit it all on the screen at once, it's under the heading that says, "The affirmation therapy model (model #4)." And now, under that, I have paragraph 50 showing on the screen.

[144]

MS. HARTNETT: There is a way to, I believe, make that -- I don't know if he needs that to be that large to read it, but there is -- if you hover over the document, you can zoom in or out.

MR. BROOKS: Perhaps. But this is, I think, much smaller, and it would be hard to read.

THE WITNESS: I have the entire paragraph 50 in front of me.

BY MS. HARTNETT:

Q Okay. Thank you.

So I was looking through your report, trying to see if there was a connection to the context here, which is this sport -- whether the plaintiff can play sports, and I'm just looking -- you can look at all of paragraph 50, if you need to, but I'm going to be focused on -- well, feel free to take a look.

But you're -- under this part called "the affirmation therapy model." That's the heading that's above paragraph 50.

Do you see that?

A Yes.

Q And you're referring to -- what -- you say that -- you're referring to some advocates and practitioners that go much further. That's in your second line there. And then I'm going to just read one **[145]** sentence in the middle of the paragraph. (As read):

"They argue that the child should be comprehensively resocialized in grade school to (sic) their aspired-to gender. As I understand it, this is asserted as a reason

why male students who assert a female gender identity must be permitted to compete in girls' or women's athletic events."

Did I read that correctly?

A Yes, you did.

MR. BROOKS: And I will -- well, you can ask a question. I'm going to ask the witness to read the entire paragraph so we don't lose the --

MS. HARTNETT: He should feel free. I'm not -- this is not a trick.

MR. BROOKS: Nope.

BY MS. HARTNETT:

Q Let me know when you're ready.

A I've read the paragraph.

Q Do you know whether the law being challenged in this case applies to grade school?

A I don't -- I don't know the law being challenged here.

Q So you don't know whether the law at issue **[146]** requires that transgender youth be comprehensively resocialized; is that fair?

MR. BROOKS: Objection.

THE WITNESS: When I talk about comprehensively resocialized, it was not in relationship to this law; it was in relationship to the American Academy of Pediatrics' recent study, I think in 2018, by Rafferty, et al., where it was asserting -- they were asserting such things that I'm summarizing here.

And, see, for them, participation in athletics just follows their fundamental assumption that they know

what's best for these children even though they have no long-term -- they don't even have adolescent follow-up, let alone adult follow-up.

And so I just think that the case of athletics -- the issue of athletics is a secondary derivative issue about the more fundamental matter of when and how, to what extent, and before -- what requirements are necessary before we socialize a child, you see.

So if you think about the -- your issue today about athletics, it's what I would call a downstream issue, downstream from the fundamental thing that we were talking about before the last break about what are **[147]** the requirements to ethically enable parents to make this decision without doctors pretending like they know what's best for a seven-year-old or an eight-year-old or a 12-year-old or a 15-year-old, you see.

So this is a downstream question about which I feel I have no legitimacy to pretend expertise.

So I think every question you ask me about this, I'm going to have to say, listen, this is not my -- this is not my wheelhouse. This is not my knowledge base. My knowledge base is about what we were talking about, you know, about the evaluation of children and teens.

BY MS. HARTNETT:

Q So here, where you say, "this is asserted as a reason why male students who assert a female gender identity must be permitted to compete in girls' or women's athletic events," when you say -- asserted by whom? Is it the American Academy of Pediatrics? Is that who you're referring to there?

A No, I don't think it's entirely that. I think it has to -- you know, this is a -- this is a big cultural issue in many,

many states. They made -- the NCAA, you know, the high school athletic associations, whatever the names, the acronyms of those organizations, they have made policies based upon **[148]** information that they've gotten from various, quote, expert groups, and -- and there is this -- in education services today, there is this enormous emphasis on diversity and support for all forms of diversity, and so I -- I think the answer is not it's just from the American Academy of Pediatrics. I think the American Academy of Pediatrics is influenced by these larger social trends that have recognized how much harm we've done to various -- to women, for example, or to African Americans or to Asians, and we are trying, as a society, to make things more open and to -- to represent more people in the public discourse in arts, in music, in the theater and so forth.

So there's just a broad, broad cultural trend towards being much more inclusive, you see, and -- and I just thing the trends -- athletic issue must be viewed in terms of the larger social questions that are being answered in a political sense in our culture.

MR. BROOKS: Counsel, when you get to a breaking point, I think it is one o'clock, and it would be a good time to take a lunch break.

MS. HARTNETT: We can break now. I have a couple more questions on this paragraph, but we can pick it up after lunch. What would you prefer?

MR. BROOKS: You can finish up the paragraph.

[149]

MS. HARTNETT: Sure.

BY MS. HARTNETT:

Q So -- so is it your view that allowing a transgender youth to participate on the team of their -- the sex that

they present as, is that a psychotherapeutic intervention that would dramatically change the outcome for that child?

A I'm not certain.

Q What is your concern -- I'm sorry, please.

A I think if -- I think if a child, let's say a 14-year-old, wants to run track or play a sport as a member of a female -- the female side of the sport and if the school or the -- the State or the -- the organization that -- that organizes high school athletics or junior high school athletics says, no, you can't because you were a natal male and you -- trans is not accepted as -- for athletic purposes, I think that person would be disappointed. I think that would be disappointed. And disappointment may look like depression. It may increase the person's anxiety for a while. But like many, all of us get disappointed in life, and, you know, we deal with it. And sometimes we grow from our disappointment.

So I would think they would be disappointed. Whether that is to be considered harm, you see, I don't **[150]** think we would -- we should, just on the basis of disappointment, refer to that as harm. Harm is a different concept, you see.

And -- so I guess the answer to your question is I'm not sure.

Q But do you think that permitting them to play with -- in that example, allowing the 14-year-old person that identifies and is a girl to play with the girl team, do you believe that that would make them more likely to continue to identify as transgender when they otherwise would not?

MR. BROOKS: Objection; ambiguous.

THE WITNESS: They would otherwise continue -- you -- you mean -- if I understand --

BY MS. HARTNETT:

Q I'm sorry, I'll ask a better questions. I'm just trying to figure out if your opinion is that allowing transgender, let's just say, adolescents to play on sports teams that match their gender identity will cause them to continue to identify as transgender when they otherwise would not.

A I have no idea the answer to that question. I would imagine that they would continue to identify as a trans female, but I don't know what would happen to their identity if they didn't. That was the other side **[151]** of your question, the last part of your questions. So I guess I can answer part of the question.

It would be my opinion, if we allowed a child who currently identifies as a trans girl to participate in a girl's athletic -- organized athletics, that that would do nothing -- that would -- that would reinforce the idea that she continues -- that she is a trans girl. Not that she is a girl, but that she's a trans girl. That's -- I think that would be my opinion.

About the other aspect to your question, I don't know the answer.

Q But is your opinion that there's a -- is that a -- in your opinion, is there something wrong with reinforcing the girl being on -- sorry -- the girl's gender identity of being on the team?

Like, do you have a problem with that, or are you okay with the 14-year-old girl playing on the -- transgender girl playing on the girls' team if the rules allow it?

MR. BROOKS: Objection; vague, compound.

THE WITNESS: If you -- if you look narrowly at the individual girl, we get one set of considerations.

If we look at fairness, if we look at the perspective of the other girls, the natal girls who are **[152]** participating, we get another perspective.

If we look at the parents' perspective of the very talented athletes who are natal girls who may be defeated by these trans girls, we get yet a third or fourth perspective.

BY MS. HARTNETT:

Q Well, that's not your area of expertise; correct?

A But you -- you just anticipated what I was going to say. I mean, you're asking me opinions that I have no legitimate expertise to answer. I -- I'm just -- I'm separating the perspectives for you. And I say your -- your question is not as simple as it sounded because there are these other perspectives to be considered which people other than me are going to consider.

There is -- shall I repeat?

There is the child --

Q No, I don't think so. I don't think you should repeat. But what I do -- would like would be before we have lunch, just an answer, which is do you object --

MS. HARTNETT: Can you -- can the reporter read back my last question, please.

THE REPORTER: Yes.

[153]

(Record read.)

MR. BROOKS: Objection; compound, form of the question, vague.

You can answer, if you are able and know what the question is.

MS. HARTNETT: That's -- enough coaching.

THE WITNESS: Pardon me? I didn't hear what you just said.

BY MS. HARTNETT:

Q I was telling your counsel to please stop coaching you. And I can ask a better question.

A Oh.

Q Is it your perspective that allowing a transgender girl to participate on a girl team, consistent with her gender identity, is harmful to the transgender girl?

A No, I don't think it's harmful in the short run to the transgender girl. In the long run, if the transgender girl detransitions, say, in five years, I wonder what he will now think about what happened five years before when she was competing against girls as a girl.

But in the -- I presume your question is in the short term, you see? And I guess in the short term, I don't think it would harm the child to the **[154]** extent that it reinforces their current identity.

But as you may or may not know, gender identity can evolve over time. And so when people detransition and return to presenting themselves as a boy and thinking of themselves as a boy, they then have to -- they then have to consider what happened when they were -- when they were presenting themselves as a girl and believing that they were a girl. They no longer believe that they're a girl, but they did back then, you see?

So I don't know, I don't think anybody knows, what implications, what harm, might come from their -- what retrospective view of the harm that -- that they cause

themselves by presenting -- by competing against girls. So --

Q Does anybody know the implications of the disappointment that the transgender girl might experience from exclusion, or is it similarly indeterminant?

MR. BROOKS: Objection.

THE WITNESS: Well, I -- I think I've already answered the question, that disappointment -- I would expect it if a -- if the girl -- the trans girl wanted to participate and was prohibited by some larger force from participating, they would be disappointed, and it **[155]** may have -- it may have -- it -- and I couldn't predict the outcome of the disappointment, whether it would precipitate depression or whether it would precipitate giving up their trans identity, as being unrealistic, that other people are saying I am very unrealistic and -- and this is unfair and I'm asking for an unfair advantage.

So, you know, I can't -- I don't -- these are not areas that I -- that anyone has had any experience with, you see. And -- and I -- it's hard for me to give you a simple answer.

It feels to me, Ms. Hartnett, that you are trying to get me to answer a question in a certain way, and I'm just trying to say I think it's more complicated. And I think you're asking me to give an opinion about which I don't have adequate knowledge, and I don't -- that's all. Period.

Lunch.

MS. HARTNETT: Let's go to lunch.

THE VIDEOGRAPHER: We are off the record at 1:11 p.m.

(Lunch recess.)

THE VIDEOGRAPHER: We are on the record at 2:11 p.m.

MS. HARTNETT: Thank you.

[156]

BY MS. HARTNETT:

Q Welcome back, Dr. Levine. I think before the break, we had -- I'm not sure what page you have up, but I -- I'm at paragraph 50 of the declaration.

A So are -- so am I.

Q Okay. Let's -- I was trying to -- and the reason why we were talking about that is there was a mention of athletic events there, and the other mention of athletic events in your declaration is at paragraph 130. So if you could go to 130, I'll have a question about that.

Let me know went you get to 130, please.

MR BROOKS: We are at 130, which fits on the screen.

BY MS. HARTNETT:

Q Great. So here in this paragraph, you say, in the third sentence, the following (as read):

"It is evident from the scientific literature that engaging in therapy that encourages social transition before or during puberty——which would include participation on athletic teams designated for the opposite sex——is a psychotherapeutic **[157]** intervention that dramatically changes outcomes."

Do you see that?

A I do.

Q And you don't know if H.B. 3293 applies to prepubertal kids; right?

A I'm sorry, would you repeat that question.

Q You don't know if H.B. 3293 applies to prepubertal kids?

A I already testified that I don't know the content of the deal.

Q So is it your opinion that allowing transgender children and adolescents to play on sports teams will continue -- will cause them to continue to identify as transgender?

A I think it -- well -- well, you know, my hesitance is because you used the word "cause."

Q I'm just trying to --

A A child --

(Simultaneous speaking.)

BY MS. HARTNETT:

Q Oh, sorry, go ahead.

A That's why I have taken so long. I'm -- I'm thinking about the word "cause" and its implications in my mind. I -- I do think that various aspects of [158] social transition tend to continue the child on a life course consistent with trans life, whether or not they're aware of the risk that they're entailing or not.

I think that's as close to an answer I can give you.

Q Are you aware of any research indicating that by preventing children from playing on sports teams consistent with their gender identity that will prevent them from continuing to identify as transgender going forward?

A I'm not aware of research literature about athletic teams and its impact, positive or negative, at all. I'm totally unaware.

Q Okay. Do you think that by excluding transgender girls from playing on the girls' team the law that's being challenged in this case stigmatizes transgender girls?

MR. BROOKS: Objection.

THE WITNESS: I think it may disappoint transgender girls. Stigma has another concept. You know, it has to do with social things.

I -- I think a reasonable mental health professional could assume that if a child wanted something and was prohibited from it, they would be **[159]** disappointed, at least initially.

Other than that, I -- I don't care to comment.

BY MS. HARTNETT:

Q Well, say a child wants a cookie and they aren't allowed to have it. That's disappointing; right?

A Yes.

Q Is the disappointment that a transgender child would have from being excluded from a sports team consistent with their gender identity essentially that, equivalent of the cookie denial?

MR. BROOKS: Objection; calls for speculation.

THE WITNESS: I don't know if you even put my smile into the text.

Obviously, you know, there -- there are degrees of disappointment in the universe. And to equate that with a cookie, I don't know. I prefer not to even answer that question.

BY MS. HARTNETT:

Q Well, your -- your point of view is that people that experience being transgender also generally experience a wide range of other distressing feelings and conditions; correct?

A My point of view is what?

Q That people who are transgender also **[160]** experience a wide range of other concerns and -- and issues; correct?

A Yes, I think -- yes.

Q That they're subject to serious mental health issues, that's your point of view; correct?

A I think they're apt to encounter a number of frustrations in their future lives that could add to their social anxiety, their sense of pervasive sadness and it lead to solving the problem in ineffective ways, like substance abuse.

So, yes, I do think that being transgender, for -- for many, many people, poses adaptive challenges in the present and in the future.

Q How do you know that that's based on being transgender as opposed to how the transgender people are being treated, or do you not distinguish between the two?

A Because -- because some of the -- in children, some of the psychiatric problems that they have are -- occur well before there's any awareness of the society.

And in every cross-sectional study of adults in the transgender community have shown that the -- that they're a vulnerable population and they're vulnerable to many psychiatric difficulties, and the common explanation

for that, among trans advocates, is **[161]** that it's entirely due to social discrimination whereas I think if you look at the premorbid and the accompanying psychiatric difficulties of many trans people, these -- these -- the social discrimination has only added to the -- the internalized conflicts about what they're doing.

So I think it's far more complicated than it's merely a result of stigma, so to speak. "Discrimination" would be a better word, I guess.

Q Yeah, I'm -- thank you. And I'm trying to reconcile that view with the notion that excluding a transgender youth who, in your view, might be subject to these various preexisting psychological problems, why -- where you're having -- where -- what is the basis for you believing it would just be a simple source of disappointment for the trans youth to be excluded from a team, consistent with their gender identity, as opposed to a more severe harm?

MR. BROOKS: Objection.

THE WITNESS: Number one, I don't think there's any research in this area. So whatever -- whatever you would like to conclude, I think there's no basis for it.

I'm just trying to understand, based on my knowledge of human beings, that for one person, it **[162]** would be a major disappointment and it might lead to harm for that person, and for another person, it might be a major disappointment that leads to no harm, and for another person, it might be, oh, well, so what, and it's not a big -- not a big deal.

Every study of human beings shows the variety of human beings. And we can't predict that if you exclude a child from anything on the basis of their gender identity,

that it's going to cause -- automatically, you can guarantee it will cause harm. There's just no reason to think that.

It doesn't mean there isn't a child who might not be harmed, but it doesn't mean that all the children will be harmed, and it doesn't mean that the harm will follow in the same manifestation.

Human beings have a variety of responses to everything.

BY MS. HARTNETT:

Q So is your view for the trans girls that would be excluded under a policy of not allowing them to play on the team consistent with their gender identity, that they should just toughen up and stomach the disappointment?

MR. BROOKS: Objection.

THE WITNESS: You're putting words in my **[163]** mouth. That's not my view. That's not how I was -- that's not how I have spoken about it. You're summarizing it in a very negative way for me. I don't accept your language. It's not me.

BY MS. HARTNETT:

Q Okay. You don't have to. How would you put it?

A I already put it.

MR. BROOKS: Objection.

BY MS. HARTNETT:

Q You mentioned before the break that you also, in your view, had to look at the potential harms or the effects on the other people at issue, and I think you mentioned the other girls on the team; is -- did I hear you right?

A I think I did mention that.

Q Are you giving an expert opinion in this case about the harm to girls on a team where they would have to include a transgender girl?

A I don't know how many times, Ms. Hartnett, I have to tell you that I don't consider myself having an expert opinion on this subject. I have stated what I stated, but I don't -- I don't -- I don't feel like I represent an expert.

And so the answer to your question is, no, I **[164]** don't have an expert opinion on that.

Q Thank you. I have a few questions about your expert report. I'm just going to go back to the beginning and go through sequentially, and I'll -- please feel free to read the paragraphs I cite to you while I'm asking you questions.

My first one is going to be back on paragraph 5, page 2.

MR. BROOKS: Getting there.

Paragraph 5 is on the screen.

MS. HARTNETT: Yeah, we were there before.

BY MS. HARTNETT:

Q I just had a question about -- so I was comparing this report to the declaration that was submitted at the beginning of the case. That was the one from the Washington State declaration that had been attached to an earlier motion in the case. And that's something I introduced as Exhibit 86. So if you need to refer to it, feel free.

But I will just represent to you that in the version of paragraph 5 that was in your earlier declaration, you had certain language that's no longer in this report. I'll read it to you and then -- just curious as to why you removed it.

You -- this is the declaration that you signed **[165]** in May of 2021. (As read):

"As the incidence of gender dysphoria has increased among children and youth in recent years, larger numbers of minors presenting with actual or potential gender dysphoria have presented to our clinic. I currently am providing psychotherapy for several minors in this area. I also counsel distressed parents of these teens."

Do you know why you removed that language from your -- this report?

MR. BROOKS: And, counsel, are -- asking that question, are you representing that that or similar language doesn't appear somewhere else in the report?

MS. HARTNETT: I was unable to find that language in this report. It was in paragraph 4 of the PI declaration, which is now paragraph 5 of this report, and I was not able to find that language.

THE WITNESS: I would imagine the answer to the question is I didn't think it was relevant to this particular document.

Please understand, in preparing this document, I did not read the -- Exhibit 86.

[166]

BY MS. HARTNETT:

Q Is it true that larger numbers of minors have been presenting with actual or potential gender dysphoria to your clinic?

A No. It's true that across the world larger numbers of minors are requesting services for gender. That's an epidemiologic phenomenon that exists on four continents.

Q Is it true that you are currently providing psychotherapy for several minors in this area?

A Yes.

Q How many?

A It depends on what era you're -- what month, what week, what -- what year you're talking about. If you're talking about within the last year, I would say probably four or five kids.

Q Can you give me the ages of those kids?

A Probably from 14 to 17.

Q And how many of those have you seen more than one time?

A Each of them.

You should -- well, okay.

Oh, one of them I've seen once, I'm sorry. I -- let me correct that.

Q For the other four, do you see them on a **[167]** monthly basis?

A No. I -- I tend to see them more often.

Q Are there any of those patients that you have seen on a monthly or less basis, other than the one you only saw once?

A Well, I hear from patients I see in the past periodically, sometimes. I hear from their parents. I sometimes hear from them. But it's -- it's not anything regular.

Q Yeah, I'm -- thank you. I'm just trying to understand. There was a statement made in your May 2021 declaration that you were currently providing psychotherapy for

several minors in this area, and I'm just trying to figure out, is that actually true today?

A No, it's not true today to the same extent that it was when I wrote the original -- the Tingley declaration.

Q Thank you. Moving down in here, you have on page -- paragraph 7 and paragraph 8, you identify a couple of cases where you previously provided testimony.

A Yes.

Q There's the -- the case in the Eastern District of Massachusetts, in the First Circuit, that you refer to in paragraph 7.

[168]

Do you see that?

A Yes.

Q And then there's the Younger litigation in paragraph 8.

Do you see that?

A Yes.

Q And you do cross-reference your CV list and then the Tavistock case.

Do you see that?

A Yes.

Q Why did you choose to highlight the Massachusetts and the Younger case here?

A Well, the Massachusetts case, under Judge Wolf, Judge Wolf asked me to be a judge's witness. That was the beginning of my legal involvement in that whole area of transgenderism. So I think that that's noteworthy. It's also noteworthy because that became -- among the DOC

attorneys across the nation, that's a very landmark case, and it's often quoted in various other legal matters.

So it seemed to me that you ought to know that I began in that area in 2006 with Dr. -- with Judge Avery.

And what was the second part of your question?

Q Oh, the Younger case and why you included that **[169]** here.

A I included that because that was my entry case into transgender children and the -- when parents don't agree on the treatment of their trans child and -- and courts are involved and -- I mean, that is not just happening in the Younger case. That's happening in other jurisdictions as well. And so I --

Q In the Younger -- oh, sorry.

A That that's the kind of thing you wanted to know. That is a credential, in a sense. Or I thought that you would like to read that case, if you could.

Q Are you aware the jury rejected the father's claim in the Younger case and awarded the decision-making to the mother?

MR. BROOKS: Objection; mischaracterizes the record.

THE WITNESS: One of my complaints about my participation is I -- I often am not informed about the outcome and the progress of the cases that I've testified in.

I did -- I did hear something like you -- what -- what you said, but it seems to me that it was a more complicated decision than you summarized.

BY MS. HARTNETT:

Q Are you aware that -- of the more recent **[170]** litigation in Texas regarding a directive from the attorney general about the investigation of the -- sorry -- by the directive of state officials to investigate those providing transgender care for child abuse? Does that ring a bell?

MR. TRYON: Objection.

THE WITNESS: I only know about that because I read it in the papers. I have not --

BY MS. HARTNETT:

Q Okay. That's what I was going to ask you. Were you involved in that? Were you asked to provide an expert opinion in that case?

A Never.

Q Is there a reason why you didn't include the Nosewor- -- Norsworthy case when you were summarizing your background here in paragraph 7 and 8?

A The Noseworthy case is one of, I don't know, seven or eight cases. I -- if you look at my CV, I'm sure it's listed in my CV.

This is a prisoner case. I didn't think it had to do with -- it just didn't seem it had to do with athletics and -- and teenagers.

Q Are you aware that your testimony was partially excluded in a case called Claire in Florida that was about the -- it was precluded with respect to **[171]** testimony about the motivations that plaintiffs had for seeking gender confirmation surgery.

A I was not --

MR. BROOKS: Objection.

THE WITNESS: I was not aware.

BY MS. HARTNETT:

Q Just flashing forward to paragraph 13 here. This is a paragraph where you're discussing, in part, Dr. Adkins' declaration. And my first question is, at the end of this paragraph, you talk about a life course perspective?

A Yes.

Q I'm just curious if that's a term that you coined or that's from somewhere else in the literature.

A If I took credit for coining that term, I think it would be -- I didn't -- I didn't coin the term "life perspective."

I'm a -- I'm a psychiatrist, and I see people throughout the life cycle, and so I am constantly confronted with the consequences of early life decisions and of behavioral patterns.

I have a natural life perspective on matters. I certainly didn't -- I don't believe I coined the term.

Q Well, I ask because it's in quotes, and so I'm **[172]** just wondering if it's something that you refer to your method as the life course perspective or if that's a method I could look to in the literature somewhere.

A I think it's in quotes -- I think it's in quotes because I wanted to emphasize the perspective that this whole question about how to take care of trans youth needs to be understood, not does it make them happy in the current life, but what will it do to the whole course of their life.

And so by putting it into italics (sic), I -- I -- perhaps -- perhaps I shouldn't have done that, but I was just trying to bring the reader's attention to the perspective here that the decisions that are made in teenage years, for example, or in their 20s or in their 30s have implications, serious

implications, for 10 years, 20 years, 30 years down the pike.

And as an adult psychiatrist who deals with people, you know, from 96 down, I certainly see the impact of previous life decisions on their current suffering.

And so that's all it refers to, that -- and I do believe that if you spend your time in pediatrics, you probably don't have as -- as sharp a focus on the life perspective that an adult person -- adult -- a per- -- specializes in adults or who has a lot of **[173]** experience with adults have. That's all I'm trying to say.

Q Is it your view that Dr. Adkins' approach is to make the young person happy as opposed to creating a happy, high-functional, mentally healthy person for the next 50 to 70 years of life?

A I believe that Dr. Adkins has hope that she is going to create a happy, functional human being for the next 70 years of life, but I do believe she's influenced, primarily, on making her child -- her current patients happy.

The question is does Dr. Adkins have any evidence whatsoever that the decisions that she has been making with teenagers and younger children, does -- does she know that creates happiness in ten years or in five years. And certainly, I don't think she knows what happens in 30 years.

But I think as a society, you and I as representatives of society, can recog- -- recognize the relevance of the question.

We want to separate, at all times, physicians' beliefs from the evidence that supports those beliefs.

Q What's the basis for your notion that Dr. Adkins lacks an understanding of how to create a happy, highly

functional, mentally healthy person for **[174]** the next 50 to 70 years of life?

A Because she's a pediatric endocrinologist. Because she's a busy person dealing with young people. Because she doesn't follow-up her patients, I'm sure, for 30 years.

Q Do you follow-up your patients for 30 years?

A Some of them, yes. You know I published a paper about a 30-year follow-up of a trans person. Maybe you don't know. I published a paper about returning to the male gender role after 30 years.

Now, I can't say that I have, you know, 20 patients I've followed for 30 years, but I -- I have certainly written about that case, and in -- in writing about that case, I have raised certain issues that are germane to your questioning right now. That is, a life perspective, a life course perspective is something that's reasonable and that an educa- -- a physician needs to be thinking about the long-term outcome of what is being done today.

Q What is the basis for you -- but you're -- sorry, I think you've already stated it, but I -- is there any other reason you have to believe that Dr. Adkins is not informing herself about the consequences of her actions on her patients 30 -- 30 years from today?

[175]

A Only that she could not know what happens. She hasn't been practicing 30 years, I don't believe. And I don't believe she is in a position, considering the work that she does, to have systematic follow-up, even for shorter periods of times, on her patients.

If, for example, she has systematic follow-up on 80 percent of the patients she's ever given a hormone treatment for, that should be in the literature. And she

knows, she should know, given the -- the -- what's absent from the literature, how welcome such a study would be, such a report would be.

But as far as I know, she hasn't published that information.

Q So your testimony is that you're basing your assumption that Dr. Adkins doesn't conduct systematic follow-up on her failure to publish a study showing her systematic follow-up?

A I'm sorry, you'll have to repeat that. Too many similar phrases.

MS. HARTNETT: Can the -- well, I'll try.

BY MS. HARTNETT:

Q Is the basis for your assumption that Dr. Adkins doesn't engage in systematic follow-up of her patients her failure to publish research indicating her systematic follow-up?

[176]

A No. I am sure Dr. Adkins follows her patients, but she's a pediatrician, basically, and usually, and I can't be certain about this, that at 18, pediatrics people turn the kids over to adult endocrinologists.

And so I think just in the nature of being a pediatric endocrinologist, although she may see some kids into their 20s, I would imagine that the usual trend in pediatrics is to hand kids off, when they're 18, to other practitioners; and, therefore, she probably has limited systematic follow-up after 18.

And if you extend that by years, like five years and ten years and so forth, I would imagine that she may have a

case or two that she follows or knows about, but it would not be anything like systematic.

So the answer to your question is the basis -- did she not publish, and that's the basis. I'm giving you an additional basis.

Q Thank you. You mentioned one patient you had followed up over the course of 30 years, and I think said something like maybe 20 or -- how many patients, overall, do you feel like -- do -- do you believe that you followed up with over a period of decades in your practice?

A Very -- very few. Because I exist in America, **[177]** and in America, we have no means of guaran- -- of -- of insisting on follow-up.

And on -- in -- another reason why is that when people transition, they -- they want to get rid of their professionals who dealt with them, and they don't naturally come back.

In fact, all attempts at follow-up, not just in my clinic, but elsewhere, we -- we reach -- we reach very few people.

For example, in a 2002 study of everyone who had sex reassignment surgery by one surgeon, only 30 percent of the people who ever had surgery by this one surgeon actually were available for follow-up.

And all follow-up studies -- very few follow-up studies can have a hundred percent of the data of all the patients.

Follow-up is a problem. It's a much better problem -- it's solved much better in Scandinavia than it is in the United States. The United States have 50 states. They have different rules. Nobody -- I don't think we -- we don't publish follow-up studies in the United States very often.

Q What do you do to try to follow up with your patients?

MR. TRYON: I think we have a connection **[178]** problem.

MS. HARTNETT: Is that me? It could be me.

THE VIDEOGRAPHER: We're just going to pause and see if he -- there he is. He's back.

MR. TRYON: There -- he came back.

BY MS. HARTNETT:

Q Sorry, I think you froze. Did you hear my question?

MR. BROOKS: No, I think we don't -- we did not hear a pending question in this room.

Can you hear us now?

MS. HARTNETT: Okay. Sorry. The video froze from your end.

MR. BROOKS: We -- we see --

BY MS. HARTNETT:

Q My question was, what do you do to follow up with your patients?

A I ask them to follow up with me after their surgery, for example, or after their consultation with another person, another professional, and they actually rarely do.

Q Do you try to find them if they don't come back to you --

A Yes.

Q -- afterwards?

[179]

A Yes.

Q How?

A I write them notes. I write them a letter. Sometimes I write them a cute little postcard reminding them of who I am. But they know what I mean.

Q If you have such limited follow-up with your own patients, how do you know your method has -- what the effect of your method is on people 30 years later?

A I don't know. And I -- I am like other people in this field. I don't know the 30-year implication of what we're doing. I don't know the 20-year implication of what we're doing. I'm just raising the question, shouldn't we be concerned about a life course perspective.

I don't know and the people who are advocates don't know, you see. I don't know how they can be so sure that they're going to create a happy life.

Q So for all you know, your method could actually be harming your patients more than the other methods; is that fair?

A You mean in the long run I may be harming them by talking with them, say, for six months about their decision, what -- what they should go -- what -- what they want to do?

I can't imagine that -- that my **[180]** psychotherapeutic -- my relationship with them that is helping them to consider their thoughts, their feelings and their futures is -- is harming them and in 30 years they're going to have some terrible result of my intervention, you see.

What you're trying to contrast is talking to a person, say, for six months, every -- twice, three times a month for six months with socializing them in a new gender or supporting, giving them hormones and -- and saying yes

to genital surgery or mastectomy or sterilizing procedures, you see.

You're comparing Dr. Levine or psychotherapeutic talking, conversation, extended evaluation, with major biologically sterilizing, sexually dysfunction in causing interventions.

I really think -- we're not talking about apples and oranges here. I think we're talking about apples and zebras.

Q Your report discusses four competing models of therapy; correct?

A Correct.

Q So you have the apple, the zebra and two other things in that; correct?

MR. BROOKS: Objection

THE WITNESS: No.

[181]

BY MS. HARTNETT:

Q The four competing models are watchful waiting, sub 1; sub 2, psychotherapy; and the affirmation model.

That's what you've set forth; correct?

A That's right.

Q And I'm asking you whether, for all you know, the psychotherapy model may be creating more harm for people than the affirmation theory model. You just don't know?

A I think I've already testified that it's hard for me to even conceptualize that I'm causing harm. Sometimes I'm causing frustration because "I want hormones now" and

you're 14, and I'm sorry, we have -- I want to talk about this.

But I don't really think that's harm in the way that when I look at the cross-sectional data on adults who have transitioned and -- and the comorbidities that they have, I consider those to be manifestations of harm, you see.

I don't really think that talking briefly and -- and honestly and examining things is -- is a source of harm.

It is --

Q But your -- your practice isn't to talk **[182]** briefly to someone. You're talking -- right?

The -- the -- the model that you're setting forth is to talk with them at length and get to know them; correct?

A Yes, this used to be the model -- before 2011, this was the endorsed model by the World -- by WPATH, you see. I'm not talking -- I'm not inventing a new model here. This was the model we had in the '60s, the '70s, the '80s and the '90s and in the 2010s and --

Q And it's your view that the psychotherapy --

A The view model changed.

Q It's your view that the psychotherapy model cannot, by its nature, harm anyone?

A I know some people think that it harms people. I don't believe that, actually.

Q Well, let me give you an example.

Say you're meeting with a patient and they want to talk you about their need or their perceived need for cross-sex hormones and you don't agree or choose not to support them with a letter.

Do you -- is that a fair -- just assume that, okay?

And that person then goes on to stop seeing you, has been taken off course from getting the cross-sex hormones, ends up becoming distraught at **[183]** their condition and commits suicide.

Is that a situation where the psychotherapy model might be responsible for causing harm?

MR. BROOKS: Objection; calls for speculation.

MR. TRYON: Objection.

THE WITNESS: If that -- such a patient goes to me -- comes to me and after -- in the first session wants a letter and I refuse to provide it, I will help that person -- if the person doesn't know, I will refer them to clinics -- to other resources.

The idea that my refusal would cause them to suicide is enormous and deep that leaves out so many intervening factors as to make me say I can't possibly agree with what you said.

BY MS. HARTNETT:

Q But it's possible that your patients, for example, have higher rates of suicide than other patients that have gone through a different model; correct? You just don't know?

MR. TRYON: Objection.

THE WITNESS: It's equally possible that the patients have a lower rate of suicide that have gone through Dr. Levine's care.

BY MS. HARTNETT:

Q But it's also possible that they have had a **[184]** higher rate of suicide going through Dr. Levine's care; correct?

MR. BROOKS: Objection --

MR. TRYON: Objection.

MR. BROOKS: -- calls for speculation.

BY MS. HARTNETT:

Q You said it's possible that they have a lower rate. It seems that the flip side of that is it's possible that they had a higher rate; is that correct?

A You're --

MR. BROOKS: Same -- same objection.

THE WITNESS: You're asking me to speculate about something you know I don't have the answer to, so why should I give you an answer that I don't have? Why are you asking --

BY MS. HARTNETT:

Q You testified that it's possible that --

MS. HARTNETT: I'm going to ask for an answer to my question without coaching, please.

BY MS. HARTNETT:

Q My -- I asked if it's possible that the patients of Dr. Levine have a higher rate of suicide than patients going through another method, and then you responded it's possible that they have a lower -- lower rate. That's an answer.

[185]

I'm asking you, is it possible that they also have a higher rate?

MR. BROOKS: And I have objected to the question as calling for speculation.

BY MS. HARTNETT:

Q Please answer.

A In order to -- in order to have an answer to a rate question, one has to have a denominator and numerator. I have neither a denominator or numerator; and, therefore, I can't really ask -- in any expert way, I cannot answer a question about the rate.

You're asking me theoretical possibilities, and there probably are at least three theoretical possibilities, and I could probably think of more, but --

Q What are the three?

A There would be no difference in the rates, right? The rates could not be ascertained because the denominator -- the numerator and the denominator couldn't be determined. And then the fifth one would be because the numerator can't be determined.

So if you ask me a question about rate, it's a mathematical question. It's a scientific question. But you're not asking it in a scientific way at all. And I can't answer it.

[186]

To the extent that I have any expertise, it's on the science. It's not on the speculation side of things.

Q Your expert opinion is that the affirmative model is more harmful than the psychotherapy model; correct?

A My -- my expert opinion is that the affirmative model does not have the scientific justification to declaim -- to -- to declare it to be the best practice. That's my expert opinion that --

Q Does the psychotherapy model have any more justification than the affirmative model?

A Only the tradition that if any other psychiatric problem presented in a 14- or 15-year-old, no one, no one would object to an extended evaluation, a psychotherapeutic exploration and the use of a medication to a drug -- to address some comorbidity.

It's just that when a -- when the child declares themselves trans, we want to create a whole different approach to this situation. That's my point.

Q And just to make sure that we close the loop on the other point, because I'm not quite sure what the answer was there, is it your testimony that it's possible that your -- that Dr. Levine's patients could have lower rates of suicide than other methods?

[187]

MR. BROOKS: Objection; calls for speculation.

THE WITNESS: I'm afraid -- although you don't understand my answer to the question, I feel like I've answered the question repeatedly already.

BY MS. HARTNETT:

Q Well, you've said that it could be -- I thought you -- I thought I understood you to say you could have lower rates, you could have a missing numerator or denominator or equivalent, but I didn't hear whether or not you think another possibility is in fact that the rates of suicide could be higher from your patients.

A Well, perhaps you missed the implication of what I said, that it could be higher, it could be lower, it could be the same, it could be indeterminant because of the denominator issues, and it could be indeterminant because of the numerator issues.

Q I appreciate that. Thank you.

We've talked about Dr. Adkins a bit here. I just wanted to ask you -- this is flashing back to -- I think we're in paragraph 13.

You then go on, in paragraph 16, to talk about Dr. Safer. Let me know when you're there.

A Got it.

Q Other than reviewing Dr. Safer's expert [188] report, do you have any other familiarity with Dr. Safer's practices?

A I believe he's the head of a New York gender team, clinic.

Q Have you ever met him before?

A Not that I am aware of.

Q Have you ever been to his clinic?

A No.

Q Have you ever spoken to any of his patients?

A Not that I'm aware of.

Q How about Dr. Adkins, have you been to her clinic?

A No.

Q Have you spoken to any of her patients?

A Not that I'm aware of.

Q So do you know whether or not Dr. Safer's approach is focused on creating a happy, healthy -- sorry -- happy, highly functional, mentally healthy person for the next 50 to 70 years?

A Ms. Hartnett, I think everyone in this field is hoping that what they're doing is creating that outcome. I would presume that Dr. Safer believes that and Dr. Adkins

believes that. I just go back to the fact that we don't know the answer in what they're doing and what they're doing is a rather dramatic **[189]** interventions in a person's biology, their physiology, their anatomy and their social roles, and it seems to me that if we're making such a very, very life-changing -- or cooperating with such a life change, a profound life change, that's going to effect every aspect of their lives, or most aspect of their lives, we ought to at least acknowledge that we don't have the follow-up data to match our belief systems.

And as I wrote about in the most recent publication, I do think that ethically we have a responsibility to inform people of what science knows and what we as professionals believe, but it's not supported by science.

So in answer -- to summarize my answer, I believe that your experts believe that they are creating a happy, healthy, functional life, even in the face of the fact that they -- cross-sectional studies of adults who are transgender and those who have had complete medical surgeries have significant problems.

And so what I have been saying, in summary, is that we -- we should separate our beliefs from what science knows.

Q You said "cross-sectional studies." You're just saying that those are lacking to -- to -- to -- to substantiate their approach. Is that what you're **[190]** saying?

A Please repeat that. You sort of -- I couldn't understand.

Q Sorry. You had -- yeah, fair -- fair enough. I think you said something about cross-sectional studies being lacking to support their approach. Is that what you were saying?

A Yes. Not only cross-sectional studies failed to support the idea that everyone is living happily ever after

or the majority are living happily ever after, the -- the Swedish study that was published in 2011 that had outcome data on everyone who had sex reassignment surgery over a 30-year period. You may know that as the D-H-E-N-J-A (sic) study, et al. They demonstrated -- the -- the recommendation of that study is that everyone after sex reassignment surgery should have lifelong psychiatric care because the suicide rate was 19 times higher after this than the general population. The death rates were higher of cancer and of heart disease, the criminal rates were higher, and the admission rates to psychiatric hospitals were higher, after, then general population.

So that group in Sweden, in 2011, said, wow, these people are not necessarily doing so well as a group; that is, everyone that was -- everyone who had **[191]** sex reassignment surgery was in that. So we wouldn't -- we wouldn't call that a cross-sectional study. We would have a life perspective study, you see. You are aware --

Q Was that -- was that comparing it to the general population, though? Not transgender people that had gone untreated, right?

A That study did not include people who were not treated with surgery, that's right.

Q Right. So to figure out if surgery makes a difference, wouldn't you study a population that had had surgery versus the population that had not had surgery, all of transgender people?

A Yes, I often wondered why the authors of that study did not study those people that they had records on who didn't have surgery. It's one of the missing issues about that. It doesn't take away from the fact that relative to non-transgender people of either sex, these people don't do nearly as well in life. But it doesn't answer the question

that you're raising, and that's been amazing -- that's an amazing absence. One wonders why that is absent. I don't know why.

Q So just to be clear, the -- the thing that's absent is testing whether or not it's actually the medical interventions with the transgender people that **[192]** are accounting for the difference in suicide from the -- is that what you were saying?

MR. BROOKS: Objection; vague.

THE WITNESS: I'm saying that it would have been nice to have four control groups. And they only had three control groups. And I don't --

BY MS. HARTNETT:

Q Right.

A I don't understand why there wasn't the fourth control group that you are raising because it does -- you know, I already testified that nothing is certain, but this would have increased our conviction about whether or not people are dying of cancer and heart disease and HIV and suicide and so forth at a higher rate compared to those who are transgender but who weren't getting the surgery.

So I don't know the answer.

Q Could I go to -- paragraph 18 has several subparagraphs. I just have a couple of questions on this. The first is on paragraph 18A.

I just had a -- it was a minor reference, but I'm just curious about your own use of terminology. You had, here in the second sentence of 18A (as read): "While hormonal and surgical procedures may enable some individuals **[193]** to 'pass' as the opposite gender during some or all of their lives..." And the sentence continues.

In the declaration you had -- that had been filed, your declaration that was filed at the PI stage, the words "female identifying male" were used instead of "some individuals."

Is -- is there a reason why that would have been changed?

A In the original -- what was in the original draft that you looked at?

Q It said "a female identifying male" as opposed to "some individuals."

MR. BROOKS: I'll object to the question as characterizing that as original.

BY MS. HARTNETT:

Q Well, it was the declaration -- I compared the declaration that was apparently submitted without your knowledge on your -- in -- in the PI stage of this case with the report, thinking that you had done both of them, and I'm -- what I'm just observing was that the words "female identifying male" had been used in this paragraph and then now has been replaced by "some individuals," and I'm just curious as to why that change was made, if you know.

[194]

A I don't know. I don't remember that phrase. That seems like -- that seems like a rather awkward phrase, you know, that you quoted.

Q Yeah, why -- is that a phrase you use -- "female identifying male," is that a phrase that you use?

A I -- I may have at one time or another used that phrase.

Obviously, for everyone concerned, the language -- the vocabulary -- the -- the -- the socially acceptable vocabulary in this field changes so often.

So, you know, as I told you, I spent probably 25 hours developing this, and there are numerous changes here and there which I could not possibly recall.

And I can't answer your question. I really don't know the answer.

Q Okay. Well, I'll ask one more in that vein, and then we'll move on.

For paragraph 18L, which is at the top of page 8 -- and this a paragraph where you're describing -- you say that (as read):

"Hormonal interventions to treat gender dysphoria are experimental in **[195]** nature and have not been shown to be safe, but rather put an individual at risk of a wide range of long-term and even life-long harms..." And then you go on to list all that.

A Yes.

Q The prior version of this -- in the same place had -- had language that said -- I'm going to just read it to you. (As read): "Putting a child or adolescent on a pathway towards life as a transgender person." And that has been removed. I'm just curious as to why that was removed.

MR. BROOKS: Late objection.

THE WITNESS: I actually -- I can't give you a specific answer to the question. I have no memory of -- of -- of making that editorial change.

I -- I -- I am sensitive to and actually have a preference to not using the same phrase endlessly in any document. And one of my concerns about previous documents has

been the redundancy of phrases, and so I -- I try not to repeat certain powerful phrases. I -- I think they actually have more impact on the reader if they read them once or twice and not 15 **[196]** times. So that may have been an example of that.

As a writer, I'm very sensitive to redundancy, and I prefer to have things done short -- in shorter versions than in longer versions, but that is not always in keeping with legal requirements.

Q Turning to paragraph 19, this is -- I'm not going to -- there's a couple of questions I had about -- or, sorry, not -- 20. You're talking about biological sex.

Do you see that?

A Yes.

MR. BROOKS: Sorry, you want 19 or 20?

MS. HARTNETT: I'll move to 20.

BY MS. HARTNETT:

Q You say that (as read): "Sex is not 'assigned at birth' by humans visualizing the genitals of a newborn; it is not imprecise. Do you see that?

A Yes.

Q Do you have any experience with the process of assigning sex to newborns at birth?

MR. BROOKS: Objection.

THE WITNESS: You know, I -- probably for a week in my medical school pediatrics rotation I was **[197]** part of the newborn nursery and delivery -- and in obstetrics. The newborn delivery room phenomenon of saying, Mother, your -- you have a daughter. Or, Mother, you have a son.

So I guess that's part of my experience. I'm a parent, so I've had that experience.

What I -- period. I think that's an answer.

BY MS. HARTNETT:

Q Thank you. You also say in this paragraph, among other things, that sex is determined at conception; correct?

A Yes, when -- yes, I do -- that's when sex is determined, yes.

Q You say that at the end of the first sentence of -- sorry -- the second sentence of paragraph 20. And the source that you cite in this paragraph for everything in this paragraph is a document that says "NIH 2022."

Do you see that? That's at the top of page 9.

A Yes.

Q What is NIH 2022?

A I think the first author's name is Aditi B-H-R-A-R- -- Bhar- -- Bhargara or something like that, but it has probably 15 authors, the paper.

Q So that's a paper that you were citing?

[198]

A Yes.

Q Okay. Let me move down to section D. So that starts on page 14 of your report.

MR. BROOKS: We have it.

BY MS. HARTNETT:

Q And you -- this is your section about "Three competing conceptual models of gender dysphoria and transgender identity." Do you see that?

A Yes.

Q Is this your construct, these three models?

A Yes.

Q Paragraph 37, you describe the developmental paradigm, I guess; is that fair?

A Yes.

Q I was comparing the declaration submitted at the earlier stage of the case with the report here, and I noticed that some language was deleted, and I will double-check to represent to you that it is not still here.

But the language that was deleted from paragraph 37 is as follows (as read): The developmental paradigm does not preclude a biological temperamental contribution to some patients' **[199]** life (sic); it merely objects to assuming these problems are biological in origin. All sexual behaviors and experiences involve the brain and the body."

Is there some reason that you removed this language from this report?

A Well, I think I said it in a different way. I said (as read): "The developmental paradigm is mindful of temperamental, parental bonding, psychological, sexual, and physical trauma influence (sic), and the fact that young children work out their psychological issues through fantasy and play and adolescents work out their issues by adapting various interests and identity labels."

This is -- this is the material that I prepared as the expert witness report for this particular case.

Over time, you see, I have a different -- I -- I say things more efficiently, I believe.

I could elaborate that, but I don't think it's relevant.

[200]

Q No. Thank you. I appreciate it.

But you agree, sitting here today, that all sexual behaviors and experiences involve the brain and the body?

A I agree that all behaviors involve -- well, the brain and the body is really one thing, you know. They're just part of the biology of a -- of the human -- of human beings, and that -- those biology -- multiple biologic factors interact with other psychosocial factors throughout life to shape our feelings and our behaviors and so forth.

Q In paragraph 38, you refer to a Littman 2018 study. Do you see that?

A Paragraph 38, yeah. Yeah.

Q Are you aware that that article was -- had to be withdrawn and corrected and republished?

MR. BROOKS: Objection.

THE WITNESS: I am aware that there was a lot of political brouhaha about that and that various trans advocates accused that author of bad things or whatever but that the restatement of the study really did not -- did not amount to a great change.

But -- but, in fact, there was a brouhaha by **[201]** the publication objecting to her methods so to speak, but really were -- they were objecting to her conclusions.

BY MS. HARTNETT:

Q Was her method an anonymous survey of parents?

A Her -- it was a survey of parents, right.

Q Do you know if they were anonymous or not?

A At this moment, I don't know.

Q You go on in section E here, starting on page 16, to talk about four competing models of care.

MR. BROOKS: Sorry.

BY MS. HARTNETT:

Q I also was wondering --

MS. HARTNETT: Oh, sorry.

MR. BROOKS: I hit the wrong thing, and the document disappeared off the screen. Let me -- I'm not sure what's going on here.

Okay. Sorry, I -- it accidentally closed as I tried to get rid of some pop-up on the screen, and we will get us back.

And, I'm sorry, what paragraph were you at?

MS. HARTNETT: It's section header E, page 16.

MR. BROOKS: Page 16.

BY MS. HARTNETT:

Q I'm just asking whether the four competing **[202]** models of care is your schema.

A I think it borrows from other things in the literature. I wouldn't want to claim, you know, authorship for that per se. It's really hard for me to know where all my ideas come from because I read so much and go to meetings and so forth, and I hear things, and it influences me.

I -- I -- it's my summary of -- when we think about what are the options that we can offer to people, this is all I think of. Maybe tomorrow --

Q Okay.

A -- I'll think of a fifth option.

Q Can you go down to paragraph 53?

And this is after you walk through the watchful waiting model, A and B, a psychotherapy model and then the affirmation model and then coming to paragraph 53.

MR. BROOKS: Let me just find the heading above it.

So we're under the affirmation therapy model number 4, if I'm scanning the --

MS. HARTNETT: Yeah.

MR. BROOKS: Okay.

MS. HARTNETT: That's correct.

And then paragraph 53.

[203]

MR. BROOKS: Okay.

BY MS. HARTNETT:

Q Out of these four models, you do not know what proportion of practitioners are using which model; is that correct?

A Yes.

Q Okay. Oh, sorry, I had one question about 49, which was within the psychotherapy model area, if you could flip up to there.

MR. BROOKS: Yes, let me just find the heading again so we understand how much material --the psychotherapy model begins at the top of page 18, and you now want to direct us to paragraph 49? Was that the paragraph you mentioned?

MS. HARTNETT: Correct.

MR. BROOKS: All right.

BY MS. HARTNETT:

Q And is the psychotherapy model the model you follow, Dr. Levine?

A It's the model that I approach new patients with, and depending on the situation of the patient in the family's life, I then go from there. So individual patients, I may counsel the support of the -- I may counsel parents to support the transgender identifications of their child.

[204]

But it begins with trying to figure out what's going on here and going on here with the child and the child's history and the parents and their history and the interactions between the -- the parents and the child.

So it's not my model for all therapy. As I've said, I think earlier, that I have supported trans care for individuals, affirmative care for individuals. But if you ask me how I begin, I don't not -- I do not begin with the affirmative model. I begin with let's investigate this situation thoroughly so we can eventually make a prudent decision.

Q You say in paragraph 49 (as read): "To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women."

Do you see that?

A I do.

Q And you stand by that statement?

A Yes.

[205]

Q Paragraph 50, this is at the beginning of the affirmative therapy model, on the next page. I think we've already covered this, so we don't need to belabor it, but here, you -- among other things, you say that, under the affirmation therapy model, practitioners -- and I'm going to read from the first sentence. And I'm not reading the whole sentence, but you can obviously read whatever you want. I'm reading from the middle of it. (As read):

"...promote and recommend that any expression of transgender identity should be immediately accepted as decisive..."

I'm just going to stick on that part, the "immediately accepted as decisive."

What is your basis for believing that the affirmation model proceeds with an immediate acceptance as decisive?

A Because --

MR. TRYON: Objection.

Go ahead.

MR. BROOKS: Mr. Tryon is objecting. You have to give him time.

THE WITNESS: In a previous -- in a -- in a previous portion of this informed consent, I said that **[206]** it is my impression that many people in the affirmative model have a number of beliefs that I don't think are scientifically accepted or acceptable or correct and including the fact that this is biologically dictated, that anytime a person, any stage in life, declares a transgender identity, it's because prenatally that was determined and it merely unfolded at a different rate at different times.

So the -- the justification for immediate affirmation is based upon this idea, one, that it's biologically dictated; and, two, that it's unchangeable.

BY MS. HARTNETT:

Q Yeah, I'm sorry, I think -- just given that we're -- have only so much time and I -- I think my question, though, was what was your basis for understanding that the practitioners engage in this practice.

MR. BROOKS: Objection; vague as to "this practice.

BY MS. HARTNETT:

Q Well, the practice of immediate acceptance as decisive.

A I think I've already testified how many parents have told me these things and how many patients **[207]** have told me these things and -- and -- well, I won't repeat what I began to tell you about.

Q No. Thank you. That -- that just helps me connect that that -- that basis of evidence is the same that's at issue here.

Paragraph 56, I had a question there.

MR. BROOKS: And, Counsel, we should take an hourly break soon.

MS. HARTNETT: Now is fine.

MR. BROOKS: All right. Now is it -- now it is.

THE VIDEOGRAPHER: We are off the --

MS. HARTNETT: Come back at --

THE VIDEOGRAPHER: Off the record at 3:21 p.m.

(Recess.)

THE VIDEOGRAPHER: We are on the record at 3:36 p.m.

MR. BROOKS: And -- and --

MS. HARTNETT: Thank you.

MR. BROOKS: -- Josh, if you would turn off your camera, you will -- will be able to see the questioner better.

There we go. Thank you.

MS. HARTNETT: Okay. Great.

[208]

BY MS. HARTNETT:

Q Before the break, we were talking, at least a bit, about the four models that you had in the psychotherapy model, and I was asking you if you follow that, and we were having a discussion. And I want to make sure I don't misconstrue your approach.

Is it fair to say that you kind of follow the psychotherapy model, but also not to the exclusion of providing medical care or recommending medical care, if it's appropriate, after some course of psychotherapy?

A Yes, I -- to summarize, the initial approach to a patient, I believe my model, what I endorse, is an extended evaluation, an opportunity to talk over time in what I call psychotherapy. Other people may call it extended evaluation. And then depending on what I understand about the patient and his or her life and their aspirations and their capacities to understand the present and the future and the past, then I may in fact say, you know, Fine. You know, do what you -- do what you -- use your best judgment. And I will write a letter for you, you know, telling your -- the surgeon or telling the endocrinologist about you.

And I do that.

Q And was that general approach extended to minors as well?

[209]

A Well, if -- if minors are children, I actually have never recommended socialization of a child in that -- that is, in a new gender. I have seen -- I have never recommended that.

When it comes to teenagers, the closer they get to 18, the more I'm willing to talk to them about the possibility of hormones and being supportive of it after a certain period of time.

When it comes to older people, it's -- it's not as broad a question.

Q And how long is your -- when you discuss an extended evaluation, how -- how long is that?

A It doesn't have a definable length.

Q Is there -- and I'm just trying to really understand. Is it a matter of hours, days or longer?

A It's certainly -- a -- a psychotherapeutic hour is typically one; right? But when people come to Cleveland for an evaluation, I often spend two days. And so I may spend, you know, four hours over two days or maybe even more with a patient and then separately with their parents and sometimes together with their parents.

But when I'm talking about an extended evaluation, I mean that in two terms. One is for people who want to come for an intense evaluation that **[210]** at the end of two days will give some -- give some feedback to them and -- but the usual sense for people who live in Cleveland, where I reside, that is over weeks and months of talking over

time, considering various -- the things I've already articulated.

Q Have there been situations where after the sort of intense extended evaluation, the two days and -- four hours over two days period, where you've supported or recommended any medical treatment after that period?

A Well, about -- about a year ago, a -- a -- a -- a college student who wasn't doing very well, who got actually hormones on a one-hour visit, to the student health service, the -- we recommended that the patient could decide whether to continue hormones or not. The parents did not want the person to continue hormones, and the patient continued hormones. And we just made a recommendation. We thought there was an advantage to stopping and reconsidering life, but it was the patient's choice, you see. It wasn't the parents' choice. It wasn't my choice, you see. But it's the respect for the patient's autonomy.

Q Did you write a letter there or some sort of authorization for him to get the hormones?

A No. He already had the hormones. As I said, **[211]** he got the hormones after one hour with a person who knew nothing about his background, really, that -- what I would say, relatively nothing.

Q Where was that treatment?

A That was at the University of Rochester.

Q Okay. So -- and then my question is just for kind of -- I guess, what's the shortest period of extended evaluation that you've performed after which you've written a letter for someone to get transgender medical care?

A I'm going to elaborate your question into me or my staff because in some --

Q Thank you.

A It's a whole -- it's a committee of work, a group of people.

I would say four hours.

Q Thank you. You had mentioned your -- the recently published article about the -- the reconsidering informed consent piece; correct?

A Yes.

Q And in there, you note that -- kind of -- you're talking about the affirmation -- what you characterize as the affirmation approach; right?

A Correct. There's a section on that, yeah.

Q And then you note that the "research about **[212]** alternative approaches, such as psychotherapy or watchful waiting, shares the scientific limitations of the research of more invasive interventions; there are no control groups, nor is there systematic follow-up at predetermined intervals with predetermined means of measurement."

Does that --

A Yes.

Q Is that something you have in the article?

A I think I made the same point in -- in this document that I gave to you.

Q Right. I was just trying to connect the two.

So that's basically the same point you've been making, that -- the kind of lack of evidence, from your perspective,

as to which approach is kind of scientifically based; is that right?

A Yes.

Q Okay. If we could flip forward, I -- sorry, going backward for a minute and then we'll go forward again, in your declaration, but I had a question about paragraph 18, little L. Sorry, that's not right. It is 18, little -- sorry, one second.

I'll try again.

Can I direct your attention to paragraph 18H, on page 7?

[213]

MR. BROOKS: And let me just first start on the top of 18 so we know what the major proposition here -- a summary of key points. All right.

And, I'm sorry, you said H?

MS. HARTNETT: Correct.

BY MS. HARTNETT:

Q So I'm going to direct your attention to paragraph H, on page 7, which you talk about administration of puberty blockers not being a benign, quote, pause of puberty.

Do you see that?

A I do.

Q And this, I noticed, was something newly added to this declarations from the one that you had submitted at the preliminary injunction stage.

My question for you is what the basis is for your qualification, in your perspective, to talk about the effects of puberty blockers.

MR. BROOKS: Object to the form of the question.

THE WITNESS: What is the basis of my objection to the use of puberty blockers?

BY MS. HARTNETT:

Q Sorry, the basis for your understanding of whether -- how they function on the body and whether **[214]** they're a benign pause of puberty or not.

A The initial justification for puberty blockers being a benign thing is that it merely was a pause and that if it was fully reversible, puberty would -- would return when puberty blockers were removed, if they were chosen to be removed.

I often reacted to that word "pause" because I was aware that I was unaware of the rich biological details that puberty changes every organ in the body. Puberty not only causes growth of bones, but puberty causes growth of the liver, of the lungs, of the heart, of the brain. You name the organ, and the pubertal changes are occurring, and they occur in a sequence. And one of the developmental aspects of development is that there are windows of opportunity for development, and when the window closes, we're not sure whether things can be totally reversed.

And I noticed that there was a benign connotation to the word "pause" which did not strike me as true or possibly true or certifiably true.

And so I began looking at various statements from various authors about saying this.

And in the early years, people talked about complete reversibility and it's only a pause, but I realized, in reading their subsequent sentences, that **[215]** they didn't consider -- they were talking about bone. They were

talking about the onset of puberty. They weren't talking about the subtle changes of -- of, say, for two or three years of interfering with the processes that were naturally happening in your and my children and the children of society.

So -- and then I looked closer at it, and I said, what about the impact, the psychological, social, sexual impact of having one's peers have these major changes in every aspect of their body while the person was paused in a puerile state, has anyone considered that when they said it's completely reversible.

Nowadays, I think people are not certain it's completely reversible, and they're beginning to articulate the possibility that I just articulated.

They're beginning to say we don't know what the psychosocial impact of being puerile while your peers are pubertal.

And while your peers are pubertal, you're getting -- you're starting to deal with your sexual feelings and your sexual conflicts, and you're getting to operationalize your -- what the early orientation aspects of early puberty are, you see. And the puerile child is not.

And so I thought the word pause was a kind of **[216]** rhetoric that -- that justified doing something that was much more complicated and had not been articulated well by the people who began using it.

I'm not sure that today's people are talking in the same way that they did when -- 20 -- ten years ago.

Q When did you come to --

A I think they're more sophisticated today.

Q When did you come to this understanding or view about the -- your kind of concern with using the term "pause"?

A I think it's been evolving in my mind over the last two or three years.

Q Do you know whether the pubertal response would be the same -- basically, if the puberty blockers were used and then a child were to go off the puberty blockers, do you know whether it would be the same pubertal response that would have been had without the blockers?

A Well, I think endocrinologists have said that it's same, but I don't know if they have even the -- I don't know that -- I don't know that I trust that they're right about that. I don't know that they're wrong. I just don't know that they're right. Because in concepts of development -- for example, if you **[217]** don't -- if you don't hear at a certain stage in life, say the first two years of life, and even if we do a cochlear implant, and we put -- we -- you can hear starting at age three or age four or age five, you can't speak as clearly as you and I can speak.

So, you see, there's a window of opportunity when the brain is changing and we -- it's -- that -- that other -- other aspects of life develop. And I think this is probably true throughout life as a principle.

So the idea that, oh, we can give a kid for three years or four years and keep them paused while they decide what they want to do, whether they want to go cross-sex hormones or not, and then if they decide not to go the cross-sex hormone route, that they will just go into puberty and everything be normal, I just think that's a naive idea. But I was proposing that, you see. I can't prove it and either can -- either can the endocrinologist prove it. That's my point.

Q Thank you.

MS. HARTNETT: I've put in the "Marked Exhibits" folder Exhibit 88. If you -- your counsel could look at that.

Let me know if you see that.

(Exhibit 88 was marked for identification **[218]** by the court reporter and is attached hereto.)

MR. BROOKS: I do see it now.

BY MS. HARTNETT:

Q This is -- Dr. Levine, do you see -- this is testimony that you gave to the Pennsylvania legislature in March of 2020.

A Okay.

Q Do you recall giving this testimony?

A I recall testifying, yes.

Q Okay. I'm -- I have a question that -- you had your kind of prepared remarks, and then you got some questions from the legislators, and what I would like to do is ask you about something on page 61, which was your response to a question about puberty blockers, if you could page forward to 61.

MR. BROOKS: Will you direct us to the question?

Let me see here. I -- I --

MS. HARTNETT: Okay. If -- yeah. It's a question from Representative Zimmerman, and it's asking about the reversibility of puberty blockers, on page 61.

MR. BROOKS: Oh, the question on 61 is fragmentary; right?

"If puberty blockers are started," is that the **[219]** question you're referring to?

MS. HARTNETT: You can feel free to look above, but I'd like to ask about the passage on 61.

He asked a two-part question, and he had then asked to be reminded about the second part of the question.

And Representative Zimmerman said, "Yes. If puberty blockers are started."

And then Dr. Levine said, "Oh, reversible, yes, sorry."

And what I'd like to ask him is to read this passage -- hear his testimony and just whether he continues to believe what he's testified to.

THE WITNESS: I've read the paragraph.

MR. BROOKS: The --

BY MS. HARTNETT:

Q I guess, just --

MR. BROOKS: Just continue --

THE WITNESS: Oh, you want me to continue?

MR. BROOKS: I want you to read to the end of that answer.

MS. HARTNETT: Correct. Thank you.

THE WITNESS: Okay.

BY MS. HARTNETT:

Q Do you stand by the testimony that you gave in **[220]** these two paragraphs?

A I don't see a -- a major difference between what I just said to you except -- than what I said here. Here, I was talking about one year. And -- and it depends on -- you know, if you give a puber- -- an eight-year-old child a puberty blocker versus a nine-year-old child versus a 14-

year-old child. I think we're talking about different phenomenon, you see. The -- not only biologic phenomenon, but psychosocial phenomenon. Because if you give it to an eight-year-old, their peers are still puerile, you see. And -- and when -- if you give it to 14-year-old or a 12-year-old, their peers are rapidly growing and changing and being involved in all kinds of psychosocial and -- processes that -- that a nine-year-old is not, the eight-year-old is not.

So I think today's testimony elaborates upon what I was saying in a less sophisticated way to Mr. Zimmerman.

Q Thank you. You talk about desistance at length in your report; correct?

A I hope so, yes.

MR. BROOKS: Counsel, do you want me to take down 88 or leave it up?

MS. HARTNETT: You can take down 88.

[221]

BY MS. HARTNETT:

Q Do you believe that desistance should be the goal of treating patients with gender dysphoria?

A I think I previously stated that the goal of treating gender dysphoria is to have an informed consent process in a brain -- for a person whose brain is old enough to consider the possibilities about the risks, and the goal of -- of their gender expression has to rely primarily on them and their process of coming to grips with what it needs, not just in fantasy, but in reality, for them to portray themselves as a trans person.

So I don't -- your question has previously been answered by me. Parents would very much like me to be

able to return their child efficiently and quickly to a tran-- to a cis state, but I can't promise that as a goal. I can't even hold that out as a goal. What I hold out is what I just said to you.

Q If you could -- you -- so you don't believe it's possible to talk somebody out of being transgender; is that fair?

MR. BROOKS: Objection.

THE WITNESS: It's not the language that I would ever use. I don't talk people out of things. I don't talk people out of getting married to a person. **[222]** I don't talk people out of going to this college versus that college.

I -- I -- I sort of elicit their feelings. I help them see where there is conflict. I help them articulate the pluses and minuses, as we can predict the future. I look at trends.

I don't talk people out. It's not what a -- what Dr. Levine, the psychiatrist, does, talk people out of X, Y or Z. And Z may be transgender identity.

Q If you could treat everyone to have them cease being transgender who -- sorry.

For the transgender patients you have, if you were able to treat them such that they would no longer be transgender, would that be your preferred outcome?

MR. TRYON: Objection.

THE WITNESS: It depends what cost it would have to be -- to return to living as a cisgender person. It would not be my goal if it would cost them their sanity, for example, if it would cost them continued anguish. My goal is -- is stated to -- I've already stated my goal.

The -- there is a belief that life is hard enough as a cisgender person, you see. But these things -- you see, I -- I -- I'm interested in what it is about being a cisgender

person that is so hard for **[223]** you, you see. Why is it that this is so difficult for you. What is it about femaleness or maleness or your -- your -- your sex, your original sex, you know, your sex, what it is about it that is so offensive and offending to you. Why is there such incompatibility. Tell me. Teach me.

Q But using the language from your -- at least your declaration earlier in the case where you had described, you know, the -- the risks and harms that would come from, quote, putting a child or adolescent on the pathway towards life as a transgender person -- I'm just trying to understand if -- if you, Dr. Levine, could put all the young people that were experiencing gender dysphoria on a pathway toward being non-transgender, would you do that?

A What I would say about that, if I could put them on a pathway of being non-transgender, I would expect that the vast majority of them would end up to be homosexual in their orientation. And the cisgender with -- you know, if they were males, they would probably be cisgender with a little feminine aspects to them, but they would be homosexual. And if they were biologic females, they would be cisgender lesbians with a little touch of masculine patterns and so forth.

[224] So that would be cisgender to me, but I wouldn't be cisgender heterosexual. I think we already know scientifically the outcome of gender atypicality. Cross-gender atypicality in boys and girls is homosexual orientation.

Q Is it your opinion that it's better to be a cisgender homosexual than a transgender heterosexual?

MR. BROOKS: Objection to the form of the question.

THE WITNESS: Well, you do no harm to your stability. You do no harm to your anatomy. You do no harm to your physiology. In that sense, I think -- you don't -- you don't risk any of the complications of cross-sex hormones, and you don't risk any of the complications of surgery. And I think it's probably -- although I can't tell you the facts, but I do believe it's probably easier to be a gay person in society than to be a trans person. And I don't mean it's easy to be any sexual minority in our society.

BY MS. HARTNETT:

Q Do you know what autogynephilia is?

A I -- I didn't understand what you just said.

Q Apologies. Do you know what autogynephilia is?

A Yes.

[225]

Q What is autogynephilia?

A Well, "autogynephilia" is a word that means love of the self as a woman. It's a characteristic of internal life that was popular in the trans literature, beginning in about 1988. It was a concept suggested by Ray Blanchard of Toronto. It was a supposition that -- that autogynephilic trans people had a form of paraphilia and that it -- I think it was a concept that replaced pretty much the concept of fetishistic transvestism that had existed since the 1900s, early 1900s.

So at about -- the trans community objected to the idea of autogynephilia, very profoundly objected to the idea.

Anne Lawrence, who is a transsexual researcher, wrote a book on men who are trapped in men's bodies, and it was all about gyne- -- autogynephilia, men who -- who recognized that they were autogynephilic.

I recently had a patient who came to see me because he couldn't find anyone who knew anything about autogynephilia.

But I think you don't find that word used in the literature -- in the modern literature anymore. Because I think with 2011 standards of care, there was **[226]** much less interest in the pathways to transgenderism and more interest in the treatment of transgenderism, and so it became too many advocates, politically irrelevant and obnoxious to -- to even use the term "autogynephilia."

Q Do you find autogynephilia to be a helpful concept?

A For some people.

Q Have you ever heard it said that transgender people are either gay, mistaken or have autogynephilia?

MR. BROOKS: Objection.

THE WITNESS: I don't recall hearing that sentence before.

BY MS. HARTNETT:

Q Do you think that that -- is that something that you would agree with, that being transgender -- people think that transgender are either gay, mistaken or have another malady, like autogynephilia?

MR. BROOKS: Objection.

THE WITNESS: It's not something that I would summarize by saying. Those three options seem pejorative and unscientific.

BY MS. HARTNETT:

Q Do you think the term --

A I'm sorry, I -- I object to the idea of **[227]** mistaken.

Q Do you think the term or that use of autogynephilia is obnoxious?

A No.

Q Do you think that being transgender is a paraphilia?

MR. BROOKS: Objection.

THE WITNESS: To the extent that -- to the extent that autogynephilia is a paraphilia and that some men develop a transgender identity as a consequence of autogynephilic behaviors, that was -- that may be one pathway towards transgender identity.

But I wouldn't certainly -- I -- I certainly would not say that at all transgenders or most transgendered people are autogynephilic.

BY MS. HARTNETT:

Q I mentioned the -- one possible formulation that people that are identifying as trans are just gay, mistaken or have a malady like autogynephilia, and I think you said that you took issue with the notion of, among other things, the idea of it being a mistake; is that fair?

A I -- yeah, I take -- I take issue with that, yeah.

Q Why?

[228]

A A mistake is something that a patient decides after they've trans- -- detransitioned and they say it was a mistake to do that.

It's not something I would say. I would say that they -- they have a current gender identity, and I'm not sure they're -- I'm not sure anyone's gender identity is not going to evolve in some way in the future. Especially I would like to say that about young adolescents.

But please don't -- please don't quote me because I have never authored that sentence.

Q Thank you. Do you think that transgender identity is something that can be cured?

A Can be cured?

Q Yeah.

A Is that what you said?

MR. BROOKS: Objection.

BY MS. HARTNETT:

Q Cured.

A If you read the end of my paper on the patient who trans- -- detransitioned 30 years ago, I think I said something like even though medical psychiatric knowledge does not know how to transform a person from a trans state to a cis state or a previous state, it doesn't mean that life doesn't transform people into **[229]** detransitioned people.

We need to understand the modesty and the differences between what we know how to do to create behavioral change, which is quite modest throughout psychiatry and what happens to people over time if we take a life course perspective.

So my case illustration in that case was Dr. Levine did not change his -- did not cause his detransition at all; right? Life processes, which he described in great detail in the that paper, changed, and it took him years to make that change, years of anguish, years of the sense of inauthenticity as a woman, which at first he tried to deny.

So I would -- I would refer you to the last paragraph in that paper if you wanted to find out how I said it. I can't -- I can't quote it. I'm just paraphrasing it if for you.

Q But is that an example of someone that you think was cured?

MR. BROOKS: Objection.

THE WITNESS: It was an example of a person who changed their presentation and now is terribly embarrassed about what he had -- I can call him "he" now -- what he had done, or what she had done; right? And now -- and it is now a person who -- I think I'm **[230]** quoting -- hates all the advocates of the -- in the trans world for, he believes, misleading people that they can have a happy life.

But that's just one person's opinion, you know.

But if you read the paper, I think, you know, there's lots to think about in the paper.

Q Is it embarrassing to be transgender?

A In -- in some settings, it probably is, yes.

Q Do you think that transitioning, for a transgender person, is something that you find to be an embarrassing concept?

A No.

Q Well, you said that your -- I'm just -- I'm not putting your patient's words in your mouth, but you were describing him as having been embarrassed by the whole thing. I -- I took that to mean he was embarrassed by having transitioned; is that right?

A Yes, he's now angry at himself and angry at those who facilitated his original transition.

But that's one person, you know.

Q But do you feel embarrassment for your patients that have to go through transition?

MR. BROOKS: Objection.

THE WITNESS: Do I feel embarrassment? No. I **[231]** feel --

BY MS. HARTNETT:

Q I'm just --

A No. That's -- that would not describe a dominant feeling I have. I have concern for my patient. I have worry about this, but I'm not embarrassed by it.

Q Is shame one of the feelings?

MR. BROOKS: Objection.

Of whom?

BY MS. HARTNETT:

Q Do you (technical difficulty) shame for them?

MR. BROOKS: Objection.

THE WITNESS: I'm a little hard of hearing, and I actually could not discern what you said.

BY MS. HARTNETT:

Q Sorry, I'll speak up.

I was asking if you felt shame for your patients experiencing transition.

A No, I'm not -- am I ashamed?

Q Yes.

A No.

Q Do you think that people can change their sexual orientation?

MR. BROOKS: Objection; outside the scope of **[232]** this witness's testimony.

THE WITNESS: I think the work of Lisa Diamond has demonstrated that among women who are -- who assert a lesbian identity, that that lesbi- -- there is a lot of two-way traffic between a heterosexual identity and a homosexual identity, or orientation, we would say, and -- so I don't know how to change a person's sexual orientation, but I do think, especially among natal women, sexual orientation is -- people experiment with different ways of life and that there are -- there's more two-way traffic between lesbian and a heterosexual life among women. There's much more bisexual behavior and bisexual eroticism among natal born females than there is among natal born males.

So that would be my answer to your question, without a yes-or-no answer.

Q Do you agree that gay people, on average, have a harder time than straight people, on average, just navigating life?

A Yes.

MR. BROOKS: Objection.

BY MS. HARTNETT:

Q Do you have similar views to those you've expressed about caution before encouraging youth to be transgender -- or to inhabit their transgender gender **[233]** identity? Do you have similar views about youth expressing homosexuality?

A No.

Q Why not?

A Well, again, I think I'm going to make a distinction between homosexuality as it occurs in men, as it occurs in women, and the eroticism of a person is a bunch of fantasies and thoughts and attractions that makes sex comfortable or anxious and makes romance easy or hard to -- to participate in, and given the power of orientation, I believe that people have to come to grips with -- with who they are attracted to and -- and what is easy for them and what is difficult for them.

And so I just think that that's part of the human landscape and that people can -- can -- they know -- they know their orientation, and then they have to choose how -- how to act or not act on their orientation, and it's a very personal, private and often difficult decision, and I respect that, and I'm happy to hear about it when it comes up in my gay patients.

And, you know, I see a lot of people who have orientations that are not heterosexual.

Q I'm just curious why the same principle doesn't hold for people that have a gender identity of **[234]** transgender, if they have an innate sense that that's their identity, why would you not approach that the same way you approach homosexuality.

MR. BROOKS: Objection.

THE WITNESS: Because homosexuality does not involve the -- it's not against the first principle of medical ethics; above all, do no harm.

It doesn't involve changing the body's reproductive capacity. It doesn't change the body's sexual physiology, you see. It doesn't change the ability to find a love partner, a stable mate. It -- it -- it doesn't -- trans- -- we're talking

about here changing the anatomy, changing the physiology, creating the inability to have a child, interfering with the ability to have sexual pleasure as we understand it in the general population as, you know, orgasm.

So -- so we understand -- transsexuality is exposing yourself to surgical complications. And surgical transformation of a teenager, before a child has lived long enough to -- to come to grips with the multiple dimensions of being an older person, that is, a 20-year-old or a 19-year-old, and romance and so forth, that's why it's different. It's not the same.

You're trying to take a principle and -- and apply it to a group of people that -- that you're **[235]** talking about the possibility of harming them. Not just their -- their -- their reproductive capacity, but harming them in numerous ways. And they have to take responsibility for that choice, and they -- I just have been saying all morning and all afternoon, I just want them to be informed.

And, you know, 13-year-old passionate kids cannot be informed easily.

Q I'm glad you brought that up.

Could you turn to paragraph 202 of your declaration, page 69.

MR. BROOKS: Yeah. And it was long. I didn't think it was that long.

Page 69. Let's see here.

You said 202. Yes, we have that on the screen.

BY MS. HARTNETT:

Q Yeah, I wanted to ask you, these are within a larger section, well, about various harms that come from, I guess,

treating or -- or validating a transgender person's identity. But this paragraph 202 talks about harm to family and friendships, and then 203 talks about sexual-romantic harms.

Do you see that?

A Yes.

[236]

Q And my question is, the harms you set forth in these paragraphs -- first of all, you cite your -- only your own publications for these two paragraphs; is that correct?

A Yes, it's my only citation.

Q Is there any other basis for these assertions?

A Well, there's an article in the Archives of Sexual Behavior about being the fetish object, when -- a transsexual adult talking about -- a survey of transsexual adults, that they get really upset that people want to have sex with them because they're what they call a fetish object, that they're -- they -- they have attractions to transsexuals and they want to have an experience.

And so it's really about the frustration of adult tran- -- sexually active transsexual, I think -- transsexuals who are complaining about difficulties in romantic relationships because they feel they're being used by people with perverse adventures, some curiosities, as opposed to genuine romantic relationships.

So I was happy to read that article because it had confirmed one of the stories that I had been hearing from many patients over the years by --

Q Can you direct me -- **[237]**

A Sorry.

Q What article is that? Can you direct me --

A I -- I certainly can get you the reference. It's in the Archives of Sexual Behavior. It's probably within the last two years. And I think the first author's name is either -- starts with an A, B or C. Anyway, I -- you -- it's about tran-- -- in the title, there's something like "transgender and fetish objects." So I --

Q Okay.

A I can -- if you want, I will eventually give you the exact reference, yeah, but --

Q That's --

A -- you're -- you're not interested in wasting time, I'm sure.

Q No, no, I -- I -- I just want to know the basis for these -- these paragraphs, so I appreciate you telling me that.

My question is -- you know, I read 202 and 203, and you say -- you list various perceived harms and challenges from being transgender; is that fair?

A Yes.

Q What I'm confused about is, is this premised on the notion that there's a way to dissuade someone from being transgender so that they don't have these **[238]** outcomes?

A Exactly. I -- this is what I'm trying to do. This is why I say to parents, you know, we have to support and love this child regardless of what -- what -- what they pass through because mental health is determined, in part, by the ability to -- to be valued by your family before you can be valued by other people.

And I think the outcomes -- I mean, so many of my patients have in fact been alienated from their families.

And -- sorry -- you've heard about runaway kids and throwaway kids and -- and I --

Q Well, why isn't -- sorry, why isn't that the family's --

MR. BROOKS: Counsel -- Counsel, the witness is busy talking, in the middle of his --

MS. HARTNETT: Yeah, I'm aware of that, but he's also taking a long time to respond to straightforward question.

BY MS. HARTNETT:

Q My question is whether or not --

MR. BROOKS: Counsel, the witness is entitled to finish his answer.

MS. HARTNETT: He's not entitled to filibuster.

[239]

MR. BROOKS: He's not filibustering; he's answering your question.

MS. HARTNETT: I've been very permissible all day with his answers, but I'm happy to have him finish his answer.

MR. BROOKS: Thank you.

If you have -- if you feel that you haven't finished, you may finish.

THE WITNESS: I have heard considerable stories over the years about family relationships, about alienations, about isolation. And in answer to your question, in -- in hearing those stories, it has led me to counsel both the patient and the parents to do whatever they can to maintain their relationships, despite what the child or the grownup, the adult, has decided because I

know the suffering of mothers and fathers and grandmothers and grandfathers and of patients.

And so it's an adverse outcome to have family alienation. And from the very beginning, I say the first principle evaluation is to preserve family relationships, and I think you can read that in my 2021 paper.

BY MS. HARTNETT:

Q My question is -- so in the example of the **[240]** child who's -- or the adolescent who's experiencing gender dysphoria and would like to be affirmed and the parents that are horrified, why isn't the answer to try to work with the parents to be more tolerant and understanding rather than to try to change the child?

A I think I do work with the parents. I do. But it's not an either-or thing. It's not an either-or phenomenon. And just because --

Q Is your --

A Just because we work with a parent doesn't mean I'm capable of changing the parent's behavior, changing the parent's values, changing the parent's knowledge of the child and changing the parent's fear for their future.

Q I'm just puzzled by these paragraphs because it strikes me that the person is going to be transgender regardless if they get transgender healthcare and, therefore -- I don't understand the point that giving them healthcare is going to harm them more than they would have otherwise been harmed if they were transgender, but just without healthcare.

MR. BROOKS: Objection; assumes facts not in evidence, argumentative.

THE WITNESS: I accept the fact that you don't **[241]** understand.

BY MS. HARTNETT:

Q Can you explain to me why -- so, I guess -- let me ask you this: Do you disagree that these people are transgender even if they don't get the healthcare?

MR. BROOKS: Objection.

THE WITNESS: I agree that the patient who says that "I'm transgender" is currently transgender. That's what I believe. They're currently transgender.

Do I believe they will always be transgender? No.

Can I predict which ones will be transitioned and not? Not -- not with any certainty, no.

But, you see, I believe that many of the assumptions behind your questions is that transgenderism is a fixed phenomenon, it never changes, and I -- if I am correct that that is your assumption, then you and I disagree.

BY MS. HARTNETT:

Q And do you agree that there's no evidence to -- assuming those are different assumptions, that there's not evidence out there that would prove either of us correct on that one?

MR. BROOKS: Objection.

THE WITNESS: No, I don't agree with that at **[242]** all. Not at all.

BY MS. HARTNETT:

Q Do you believe that --

A I -- and -- and I give you evidence of detransition.

Q Is there anything other than anecdotal evidence to say whether or not gender identity is fixed versus not labeled?

MR. TRYON: Objection.

THE WITNESS: You know, you and I have different ideas of what is anecdotal.

Is Lisa Diamond's work anecdotal, about homosexuality? Is that anecdotal?

And -- and, you know, there is something called a proof of concept study that if you can demonstrate that it is possible, for example, to cure a particular cancer with a new drug that has never been tried before, that proof of concept then leads to more definitive studies.

And we're in -- we're -- we already have proof of concept that -- that there are many people who detransition.

In fact, if you look at the UK studies, the two UK studies that have been done in the last, I think, six months, we all now have a rate of **[243]** detransition. We now, for the first time, have a rate of detransition data.

And so I would say it's not anecdotal. It's -- it's an emerging new branch of transgender science, so to speak, or knowledge that the error rate in trans -- in -- in -- in affirmative care is now becoming more clear than it ever was.

Q You are aware that some transgender -- many transgender people have fulfilling romantic relationships and family relationships; correct?

MR. BROOKS: Objection.

THE WITNESS: I am aware.

BY MS. HARTNETT:

Q In paragraph 203, you say (as read): After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished."

A Yes.

Q Do you have any basis for making that statement other than your own anecdotal experience?

A Well, if you look at -- if you look at cross-sectional data about the percentage of people who are married and cohabitating among trans people versus **[244]** cis people, there are -- there are far less marriages, and there are far less stable relationships.

If you look at a series of psychosocial histories of -- of patients, many of them do not come to us with stable functional relationships. I don't --

Q You --

A I actually -- I actually don't think this is -- this is anecdotal, but it is perhaps impressionistic based upon 50 years of taking care of these people.

Q Is it possibly also dated?

MR. BROOKS: I'm -- I'm sorry, I couldn't hear the question.

BY MS. HARTNETT:

Q Is the notion also possibly dated?

A Well, the big hope in the trans advocate community has been as society improves, the lives -- society recognizes and accepts transgender people, there will be less suffering and less isolation in trans people. That -- that is -- you can find that in many, many studies that --

that articulate the -- the frequency of psychiatric problems. And there's the hope that as -- the whole idea of the minority stress theory is that if we improve society, fewer people will suffer.

[245]

I don't know whether that -- I hope it's true that as society has improved its defense of -- of gender diverse people, that more gender diverse people will be able to have satisfying, intimate, stable relationships. I hope that is true. And I hope it will be worked through in ten years.

Q Thank you. In the paragraph 202, you say, in the middle of that paragraph (as read):

"By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often 'virtual' friends known only online) and the generally limited set of others who are comfortable interacting with transgender individuals." Do you see that?

A Yes.

Q Is there a basis for that beyond your own -- you cite yourself for that, but are you aware of whether or not that actually represents the lived experience of transgender individuals in 2022?

A Well, I think in that sentence, if I could edit it, I would emphasize rather than "by adulthood," I would say "during adolescence." And the basis is not **[246]** just my clinical experience. The basis is the clinical experience of the people in the psychosocial therapy group that I mentioned earlier this morning. That seems to be a broad consensus, that many of their trans people are -- have social isolation problems in their friendships and their

romances, and I've seen this in my practice. They really are occurring through -- through the Internet.

And when they're not occurring through the Internet, they're occurring with people in the sexual minority community, other people who may not be trans themselves, but who are excited by their trans and supportive of their trans status.

So that's the basis of it.

Q You've referred to the trans community, at times, in our conversation today; correct?

A I'm sure I've said that, yes.

Q Are you aware that the trans community, as a general matter, takes issue with your viewpoint?

MR. BROOKS: Objection.

THE WITNESS: Yeah, I am aware that there are members in the trans community who find me a hateful person and who believe that I'm against medical, surgical and social care and against the civil rights of transgender people.

[247]

I can't control what they believe about me, you see. But I am aware that some people are very appreciative of me and other people think I'm an enemy.

BY MS. HARTNETT:

Q If 95 percent of trans people opposed your methods, do you think that they would make sense to continue suggesting them for trans people?

MR. BROOKS: Objection --

THE WITNESS: What was the --

MR. BROOKS: -- lack of foundation, calls for speculation.

THE WITNESS: What was the last part of your sentence?

BY MS. HARTNETT:

Q I'm just trying to ask you if -- like, say, assuming 95 percent of trans people opposed your methods, would you have concern for continuing to promote them?

MR. BROOKS: Objection.

THE WITNESS: To promote my methods?

BY MS. HARTNETT:

Q Towards --

MR. BROOKS: Objection.

BY MS. HARTNETT:

Q -- trans people.

[248]

A My method of -- of informed consent and my method of -- of being thoughtful and considerate about -- about -- about the sources and the consequences?

I don't believe that -- that a person thinks -- misunderstands my position would make me give up my position. If you show me that -- that my position is not tenable in a -- in a -- in a -- in a strong scientific basis, I'm certainly able to change.

The fact that public opinion, in some commun- -- some sectors of the community, you know, think -- misunderstand me and -- and don't really know what I'm saying, you see, that -- that wouldn't make me give it up.

And I don't know how you could assume that 95 percent of people, you see. I don't know -- you're just presuming things.

Q Are you opposed to civil rights for transgender people?

A Absolutely not. I am not --

Q Do you understand --

A I am not --

Q Sorry?

A -- opposed to civil rights for transsexual people.

[249]

Q Do you know that your opinion in this case is being used to support excluding an 11-year-old transgender girl from a middle school track team that wants her to play on it?

MR. BROOKS: Objection.

MR. TRYON: Objection.

MR. BROOKS: Foundation.

THE WITNESS: I already told you I don't know the details of this particular case, the B.P.J.

BY MS. HARTNETT:

Q I know. And I'm going to tell you that your opinion is being used by some of the defendants in this case to seek to deny an 11-year-old transgender girl from playing on a girls' cross-country and track team where her school otherwise would be willing to have her play, with the support of her parents and family.

MR. BROOKS: Objection.

There's no question pending, so far as I understand.

BY MS. HARTNETT:

Q Do you know that that's what your opinion is being used for in this case?

MR. BROOKS: Objection.

THE WITNESS: I am not aware.

[250]

BY MS. HARTNETT:

Q Do you object to your opinion being used to deny an 11-year-old girl the ability to run on a track team at her middle school in West Virginia when she's already otherwise socially transitioning and is supported by her family and her school?

MR. BROOKS: Objection; mischaracterizes the witness's opinions.

THE WITNESS: I've heard the objection that you're -- you're mischaracterizing my opinion.

I -- I don't understand.

My opinion has to do with the things I've testified to. I did not testify to anything about an 11-year-old girl.

And what you are telling me about, I trust you're telling me the truth.

I actually don't think about -- when I think about civil rights, I am thinking much more about, I think, older people, you know, housing, educational discrimination in colleges and things like that, vocation, right to vote.

You will have to -- it's a -- it's a new thing for me to even think about the civil rights of a six-year-old or a seven-year-old or an eight-year-old.

[251]

BY MS. HARTNETT:

Q Well, your -- I'll help you. Your opinion was also submitted in the case of Lindsay Hecox, a college student who was seeking to run consistent with her identity, gender identity, on her college cross-country and track team.

A Yes.

Q You're aware that your -- your testimony was submitted in support of prohibiting her from running on the team?

MR. BROOKS: Objection; mischaracterizes that case.

THE WITNESS: Again, my testimony --

MS. HARTNETT: I'm counsel of record in that case, and I can tell you that I'm accurately characterizing the case, which is that Dr. Levine's declaration was submitted in support of a motion to ban -- to -- to uphold a statute that would not permit Lindsay Hecox to run, consistent with her gender identity, on a college sports team. And I'm asking him, in light of his statement that he does not oppose transgender civil rights, how he can reconcile that with having his testimony used in this manner.

MR. BROOKS: Objection; argumentative.

[252]

The witness has explained that his opinions are about science.

MS. HARTNETT: Please stop testifying.

MR. BROOKS: Please stop arguing.

BY MS. HARTNETT:

Q Dr. Levine, how can you reconcile -- (Simultaneous speaking.)

MR. BROOKS: This is not a debate. This is a deposition.

MS. HARTNETT: And this -- you're not the witness, either. I'd like to ask Dr. Levine and get an answer as to how he can reconcile having his testimony be filed to oppose the participation of a college student on her college team consistent with her gender identity.

THE WITNESS: I don't find it easy to reconcile -- this is just part of some of the great conflict embedded in -- in -- my -- my knowledge is about science. And I do recognize that people interpret what I say in various ways and -- but I don't think I'm responsible for how that is interpreted. I'm just making statements based on my knowledge, based on my clinical experience. And I am uncomfortable, at times, with various aspects of what people make of -- of what I have said.

[253]

I -- I am uncomfortable, to some extent, by how the lawyers have used some of my -- you know, at times. And I am certainly uncomfortable at how the trans community has used some of what they think I stand for.

I'm trying to be clear what I -- what I think and what I stand for. And I am somewhat uncomfortable, at times, about many things, including this, but --

BY MS. HARTNETT:

Q Do you understand that you're being paid as an expert witness in both the Hecox case and in this case by the defendants in order to submit testimony that will be used against the participation of the transgender students?

MR. TRYON: Objection.

THE WITNESS: I don't think I fully understand that. I don't think -- I don't think that's -- I -- I guess the answer to the question is I don't fully understand it.

BY MS. HARTNETT:

Q Okay. Because I -- I'm -- I'm genuinely perplexed because you've said that you're supporting transgender civil rights and you wish for a time where there's less discrimination and that -- yet your submission is not being submitted in a neutral manner **[254]** in this case; it's being submitted in support of the side of the case that's seeking to defend the exclusion of the transgender student.

And so we don't need to belabor the point, but I'm just trying to -- I'm happy to tell you that. And if you have something you would like to say on the record as to how you can reconcile the use of your testimony for that, with the views you've expressed in this deposition about seeking to make the world better for transgender people, I would appreciate your chance to respond to that.

MR. BROOKS: Objection; mischaracterizes --

MR. TRYON: Objection.

MR. BROOKS: -- testimony and is outside the scope of this witness's expert opinions.

THE WITNESS: Well, I thank you for pointing that out. I will think about it more.

MS. HARTNETT: Thank you. I think we can take a break now.

THE VIDEOGRAPHER: We are off the record at 4:38 p.m.

(Recess.)

THE VIDEOGRAPHER: We are on the record at 4:55 p.m.

MS. HARTNETT: Thank you.

[255]

BY MS. HARTNETT:

Q Hi, Dr. Levine. We discussed the SEGM organization earlier. Do you recall that?

A I do.

Q And you described it as an evidence-based organization; correct?

A Yes. That's the title, yes.

Q And you view them as an organization that strictly adheres to the facts; correct?

A Well, facts are interpreted, but, yes, they have a basis in facts.

Q In January, you earlier, in the deposition, mentioned that you did a podcast; correct?

A I did.

Q And that podcast was with two of the lead advisors of SEGM; is that right?

A I don't think they're the lead advisors. They're -- they were members of the psychotherapy group. I don't -- I don't -- I wouldn't describe them as lead advisors to SEGM, no.

Q Okay. They're -- are they affiliated with SEGM in some way?

A They're members of SEGM, yeah.

Q And that would be Sasha Ayad and Stella **[256]** O'Malley; is that right?

A Yes.

Q Were the thoughts that you shared with them during that podcast all truthful?

A I hope so.

Q Okay. I'm just going to -- and I referenced, before we went on the record, uploading a few audio files. I've excerpted some excerpts from the talk you gave, which was, for the record, available at https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-Stephen -- S-T-E-P-H-E-N -- Levine, dated January 28th, 2022.

Dr. Levine, do you recall whether the podcast was -- the conversation you had with Ms. O'Malley and Ms. Ayad actually took place on January 28th?

A I think it did, yes.

Q Okay. So I'm going to just play for you an excerpt, and I'll ask you a question about it.

MS. HARTNETT: Could you please play Exhibit 89. (Exhibit 89 was marked for identification by the court reporter and is attached hereto.)

THE WITNESS: I'm not hearing anything.

THE VIDEOGRAPHER: Just -- just a moment. I believe he's working on it.

[257]

MR. REISBORD: Were you unable to hear that?

THE VIDEOGRAPHER: Correct.

MS. HARTNETT: We did not hear that.

MR. REISBORD: Let my try one more time.

(Video Clip Played.)

"In 1973" --

MR. REISBORD: Are you able to hear that?

MS. HARTNETT: Yes.

THE WITNESS: Yes.

MR. REISBORD: Okay.

(Video Clip Played.)

"In 1973, after 30 days in -- in practice, I was at a department of psychiatry and had a halftime private practice. I got a man who told me he was sitting in the backyard with a gun in his mouth, under his oak tree, and he decided either to kill himself" --

MS. HARTNETT: We can't hear it anymore.

(Video Clip Played.) –

"see a psychiatrist who used to be my supervisor a month ago, and my supervisor said, Well, there was an expert in human sexuality down at the university. Why don't you go see him?

And that was the beginning of my career working with people who wanted to change their sex.

You know, he almost killed himself at that **[258]** point in 1973."

BY MS. HARTNETT:

Q Dr. Levine, was that the patient that you were referring earlier to in the deposition?

A Yes.

Q Rutherford or Ruth; correct?

A Yes.

MS. HARTNETT: Could you play tab 40, please.

MR. REISBORD: Tab 40 would be Exhibit 90.

MS. HARTNETT: Oh, sorry, thanks.

(Exhibit 90 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"And -- and nine years later, he in fact did kill himself after he changed his gender and left his family and left his country and then returned back to live in America and just decided to end his life. So that was my introduction, my nine-year introduction, to adults who wanted to change their sex.

This was a highly accomplished man. He was the head of our county library system. He had a degree in divinity. And he was a joy to talk to. And he -- one day, about four years before he actually killed himself, he slashed his -- at his neck, and when he was admitted to the hospital, he -- he told me that I was **[259]** deficient as a therapist because I failed to investigate how angry he has been all of his life at his parents."

BY MS. HARTNETT:

Q Dr. Levine, is what was just played an accurate account of -- I'm sorry, is -- is what -- do you stand by the account that you provided to SEGM, as just played in that sequence?

MR. BROOKS: Objection to the description.

THE WITNESS: Are you asking if -- if -- if I said these things that you're recording --

BY MS. HARTNETT:

Q Yeah, thank you, I'll ask a better question. Is that what you said on the SEGM podcast earlier this year?

A I don't call this "the SEGM podcast." This is a --

Q I'm sorry.

A -- podcast of these two women who have a business in providing information to others who are interested. So I --

Q Okay.

A -- did say these things, as you -- as is obvious, I said these things.

[260]

Q And they were truthful; correct?

A Was I telling the truth? Yes --

Q Yes.

A -- I was -- I tell --

Q Okay.

A -- the truth.

Q Sorry, it's partially a formality of -- I'm just trying to confirm that what you were saying to them is also true today, and so that's why I'm asking you the question, but I won't refer to it as "the SEGM podcast."

MS. HARTNETT: Could you please play tab 41, Exhibit 91.

(Exhibit 91 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"It was quite an educational experience for me, both as a he and as a she, and -- and she and I wrote a paper in the

Archives of Sexual Behavior in 19-, I think, -83 called Increasingly Ruth: Towards an understanding of sex reassignment surgery.

And then in 1984, when he died, I wrote a letter to the editor about Ruth's suicide.

Q Dr. Levine, was that a recording of you speaking to the podcast earlier this year?

[261]

A Yes.

Q You mentioned that you wrote a letter to the editor after Ruth's death, and in that letter, you said that Ruth's unfortunate legacy to those who invested in her is psychologic injury due to her abandonment of them; is that correct?

A Would you repeat that? I don't recognize those words. Would you repeat them slowly?

Q I'm sorry. Ruth's unfortunate legacy to those who invested in her is psychologic injury due to her abandonment of them.

A Yes, that was --

Q Did you write that?

A Yes. I don't want to give you more information than you're asking for, but -- the answer to your question is yes.

Q Thank you.

MS. HARTNETT: Could you play tab -- Exhibit 92, please.

(Exhibit 92 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"So I've been accused of being very conservative on this issue and biased by -- by that **[262]** experience, and, in fact, I plead guilty. I am -- I -- I -- that was my introduction."

Female: "Yeah."

"And it -- and, unfortunately, it's not the only case of -- of people who have aspirations who think that their troubles as a person will disappear if -- if they change their gender presentation and change their bodies and -- and only to discover that life is not as easy as they imagined, and they didn't escape much.

So I plead guilty to being biased, and I think all of us have a kind of bias, and we ought to own it."

BY MS. HARTNETT:

Q Dr. Levine, were those your statements on the podcast earlier this year?

A Yes.

Q And were they your truthful statements?

A Yes.

MS. HARTNETT: Could you please play Exhibit 93.

MR. TRYON: This is Dave Tryon. I'm going to object to --

(Video Clip Played.)

"I have a Mas-" --

[263]

MR. TRYON: I'm going to object to to playing these excerpts without the full context.

MS. HARTNETT: And I will just say for the record that there is -- I think the -- the person that gave the

podcast knows the context, and I've given the web URL for anyone to look at the full context. There's not a written transcript online.

MR. TRYON: My objection stands.

MS. HARTNETT: Of course. Thank you. Could you play Exhibit 93, please.

(Exhibit 93 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"I have a Master's prepared person, just got out of her -- her internship, who told me how you're supposed to treat transgender people, and I was just astounded.

I gave a seminar two years ago to residents who told me -- residents in psychiatry -- who told me how trans people ought to be treated.

See, they had a chain in trust. Somebody taught them, and they believe it, the passion, they believe it. They have the zeal of the new -- of the convert to being a psychiatrist or being a counselor, whatever it is. And -- and -- and when I give them **[264]** facts, they think I'm an outlier or they think I'm an old fuddy-duddy, there's something wrong with me. They don't believe me.

Because the truth is that trans is normal, you see, and -- and that they can have highly successful lives, just like anybody else.

And it's not based on experience. It's certainly not based on any scientific scrutiny, you see.

And so what I'm really saying is that so many of the doctors just practice how they've been taught to practice. They -- they -- we -- we -- none of us have the brain power -- we take care of so many different things, we can't be

experts in -- in -- in the original train of -- that chain of trust at all, you see.

So of course we oversimplify everything. And, you know, there -- we rely on -- on a few skeptics like -- like the three of us."

BY MS. HARTNETT:

Q Dr. Levine, was that clip of you speaking on the podcast earlier this year?

A It is.

Q Was that your truthful statements?

MR. TRYON: Objection.

[265]

BY MS. HARTNETT:

Q Sorry?

A I said --

Q I --

A -- those things that you heard on the podcast, yes.

Q And were they your truthful statements?

A Yes.

MS. HARTNETT: Okay. Could you play Exhibit 94, please.

(Exhibit 94 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"And then three years later, there was the six standards of care that was almost word for word for what our group did except for one letter was necessary. That is, he wanted to make it easier to get transgender."

BY MS. HARTNETT:

Q Dr. Levine, was that you speaking on the podcast earlier this year?

A Yes. And it's my truthful statement.

Q Thank you. You used the term "get transgender" on that clip. I was just wondering what you mean by that.

[266]

A I think that was referring to hormones, access to hormones.

We used to have a standard that two independent individuals or one group committee were required to write a recommendation for hormones, and Dr. Richard Green, who was the head of the organization at the time, didn't like that at all. He was a strong advocate of immediate care. And he told me so, he didn't like it. And -- and he reconstituted -- accepted the fifth standards of care, and he formed a new committee with the -- you know, with the charge to get rid of that criteria for hormones.

Q Do you typically use the term "get transgender"?

A No. This was a spontaneous conversation. I don't -- it's a funny phrase. I don't know. It came out of my mouth. I don't know why. That's –

Q Okay.

A -- not my usual language.

But again, this was not a paper I was delivering that I, you know, worked on. This is something that happened rather spontaneously.

Q I understand.

MS. HARTNETT: Could you please play Exhibit 95.

[267]

(Exhibit 95 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"I think it's time for a re-examination of the wisdom of affirmative care. I'm not saying affirmative care doesn't help some people, but I'm not so sure how many people it harms."

BY MS. HARTNETT:

Q Dr. Levine, was that your truthful statement on the podcast earlier this year?

A It --

MR. TRYON: Same objection as before. Thank you. You may answer.

THE WITNESS: I -- it is my true statement. I'm still not sure what percentage of people are ultimately harmed and how to measure those harms and when to measure those harms.

MS. HARTNETT: Thank you. Could you play tab -- sorry -- Exhibit 96, please.

(Exhibit 96 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"The problem is that we do not have rigorous **[268]** follow-up studies of people who made the transition."

BY MS. HARTNETT:

Q Dr. Levine, is that your truthful statement made earlier this year?

MR. TRYON: Objection.

THE WITNESS: Yes.

MR. TRYON: I just want to place on the record evidence rule 106. Thank you. Go ahead and answer.

BY MS. HARTNETT:

Q Dr. Levine, do you agree that there is not rigorous follow-up studies of people who have made the transition?

A Yes. I believe I testimony -- I testified to that earlier today.

Q And for all of these statements that I've asked you about, do you stand by those statements, sitting here today?

A Number one, I have said those things, and I believe them to be essentially correct today, yes.

Q And, thank you, I'm asking only to -- in light of the objection, not to repeat my questions to you.

MS. HARTNETT: Could you please play Exhibit 97.

(Exhibit 97 was marked for identification **[269]** by the court reporter and is attached hereto.)

(Video Clip Played.)

"The people who come to me who are depressed, you know, those -- those -- after transition, those are just anecdotal reports. I have no idea what the -- what the denominator is, you see."

BY MS. HARTNETT:

Q Dr. Levine, do you agree with the statement that was just played?

A Yes.

MS. HARTNETT: Could you please play Exhibit 98.

(Exhibit 98 was marked for identification by the court reporter and is attached hereto.)

MR. TRYON: Counsel, before you play it --

MS. HARTNETT: Yes.

MR. TRYON: Counsel, will you just agree to give me a standing objection to these excerpts?

MS. HARTNETT: Yes.

MR. TRYON: Thank you.

(Video Clip Played.)

"And -- and because we don't know, because we don't know, I think we have to say why do we have all this enthusiasm, why do we have all this chain of trust passion that this is the best treatment. We don't know **[270]** is the best treatment, you see."

BY MS. HARTNETT:

Q Dr. Levine, do you agree with that statement that you made earlier this year?

A I do.

MS. HARTNETT: Could you please play Exhibit 99.

(Exhibit 99 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"Now, I want to quickly say that while I'm an advocate of someone who thinks or wants to be or considers themselves a transgendered person, I think they ought to have a psychotherapeutic approach before they make any -- any life-changing decisions, but I admit that I have no follow-up. This is not on the basis of randomized control study. I am in the same difficult position that the

affirmative care doctors are in, only I have more faith based upon a hundred years of doing psychotherapy as a tradition, you see, and they only have a few years, with no follow-up."

BY MS. HARTNETT:

Q Dr. Levine, is that your truthful statement?

A Yes.

MS. HARTNETT: Could you please play **[271]** Exhibit 100.

(Exhibit 100 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"So -- so what I'm saying is that in the early studies, the death rates from cancer and cardiovascular disease and -- and accidents were -- were elevated and what -- and what that really means is that the lifestyle things predispose them to physical diseases.

"So, you know, if you're a parent, you -- you -- you want to die -- you want to die before your children, you see.

"So for many -- for many of these kids, they're going to be sick.

"And I just saw a slide of the famous -- Jazz Jennings. Do you know that name?

Female: Yeah.

"Apparently Jazz Jennings was a very thin, very attractive person when she had surgery, and in the postoperative time, she's now grossly obese. She is -- I saw a picture of her. She is grossly obese.

"So, you know, this is one of the -- this is one of the things that never gets talked about, what are the physical

manifestations, what are the psychological manifestations, what are the outcomes."

[272]

BY MS. HARTNETT:

Q Dr. Levine, is that your truthful statement?

A Yes.

Q Is it your contention that Jazz Jennings is grossly obese because she had gender confirmation surgery?

A No. She became grossly obese after gender confirmation surgery. In addition, she had -- she had other problems as well, I think.

I only know that because Jazz Jennings is a public, you know, celebrity, so to speak, and people talk about her and people showed me pictures of her.

So I've never -- that's -- that's what I know.

Q But you've never met Jazz Jennings; correct?

A I have never met Jazz Jennings.

MS. HARTNETT: Could you play Exhibit 101, please.

(Exhibit 101 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"And the -- the affirmative care doctors like to blame all these comorbidities and the shortened lifespan on minority stress, and you would -- I think -- I think we recognize that it is stressful to be -- to belong to a sexual minority, but -- but **[273]** children who are cross-gender identified, who have separation anxiety and depression and so forth, they're not -- they're not having minority stress.

"And -- and the kids who -- you know, if you -- if you walk in -- if you walk in and see your postpartum depressed mom hanging from the rafters and then you decide three weeks later that you're going to change your gender, this is not minority stress."

BY MS. HARTNETT:

Q Dr. Levine, is that your truthful statement?

A Yes.

Q Are you aware of any example of an actual kid who walked in and saw their postpartum depressed mom hanging from the rafters and three weeks later decided to change gender?

A Absolutely.

Q Can you tell me what -- where is that example?

A I think that case was presented to me.

Q By whom?

A One of my staff. Or it was presented to me, you know, by somebody else. Occasionally, I supervise other people.

But that came -- that -- that came from a recent -- a recent January 20th case history that I heard.

[274]

It -- it has to do, you see, with not taking a history, giving people, very quickly, affirmative care and not appreciating the forces that might have shaped this -- that -- that may be very -- that may play out and may -- very difficult to have a happy, successful life as a trans person.

So I -- I can't give you the -- I can't tell you at the moment who told me that, but I can tell you I am not telling -- I am telling the truth. This is what I recently heard prior --

Q Was that as a -- sorry.

A Pardon me.

Q Was that -- was that an anecdote that came to you from somebody in your clinic?

A As I said before, it might have been someone in my clinic; it might have been some other professional who talked to me about that.

Q Do you know if the person at issue, the -- the -- that was seeking a transition, whether they had any signs of gender dysphoria prior to the mom hanging from the rafters?

A I think the implication was that they hadn't, but I don't remember enough details to -- I couldn't tell you the case history. That's the aspect of the case history that I recall.

[275]

Q Thank you.

MS. HARTNETT: Can you play Exhibit 102, please.

(Exhibit 102 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"Lots of girls have temporary eating disorders, and some of them end up overcoming it, but they overcome it sometimes by becoming vegetarians or vegans. So it's okay, and it's much better. It's much better than having an eating disorder."

BY MS. HARTNETT:

Q Dr. Levine, was that your truthful statement?

A Yes.

Q What point were you trying to make by drawing an analogy to eating disorders and vegetarians and vegans?

A I think you would have to play for me what preceded that, but off the top of my head today, two months after I made that statement, more than two months after I made that statement, I was probably making reference to the fact that among adolescent girls who declare themselves to be trans boys, a large percentage of them have a pre- -- a predeclaration eating disorder, that this is part of the -- the **[276]** psycho- -- the -- if we can agree that an eating disorder is a true problem and not just a dietary of something or other, the -- this evidence of the psychopathology that precedes transgender identification, the crystallization of a trans identification, eating disorder is just another way of self-harm where -- where one cannot live comfortably in the self as it is developing.

So that's probably what I was making reference to, the pre-crystallization of a transgender, the problems that are some- -- that are often seen in girls prior to their coming out as a trans boy.

Q Is it your view that you could correct the eating disorder and the person may stop identifying as transgender?

A Well, I think most eating dis- -- what I was saying -- I think you misunderstood -- is the -- the prelude to the eating disorder was transgender. I will say if you could help the person understand the motivation for the eating disorder and help her to come to grips with what she's doing is harmful to herself in the short and in the long run, then it wouldn't -- it may prevent -- it may help her to find another solution, for example, becoming a vegan or -- that would be a benign -- a less -- less problematic **[277]**

solution than having to become transgender, forget her eating disorder and focus on something else in a way that dominates her life.

So you -- you dominate your life by thinking that you're too fat when you're 93 pounds, and now you're domi- -- you give that up, and then you dominate your life because you're really a boy trapped in a girl's body and --

So I'm telling you, as a psychiatrist, life is complicated and histories are complicated and our ability to predict things is not very good, and I just want us to rely on science, as -- whatever the limitations of sciences are, I want to rely on science and not something shorter than science, you know, fervent, passionate beliefs, whatever.

Q So in that instance -- I'm just trying to make sure I understand -- your -- the idea would be that it's better to end up being vegan than transgender?

A If -- if you put it in that way, if you reduce everything to that simplicity, I guess the answer is it would be better to have a -- that would be a better supplementation of your original concerns about yourself and your body and the sexual meaning of your body than it is to repudiate your femininity entirely and try to remove your breasts surgically and take **[278]** hormones and so forth, yes.

MS. HARTNETT: Could you play Exhibit 103, please.

(Exhibit 103 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"It's your current sexual identity –

Female: Yeah.

-- "you see. I mean, I'm sure I've had identities -- I used to be a stamp collector, you know. I had an identity as a stamp collector. And I don't collect stamps anymore."

BY MS. HARTNETT:

Q Dr. Levine, are those your truthful statements?

A I was a stamp collector.

Q I was a baseball card collector.

Is being transgender like being a stamp collector?

A No.

MS. HARTNETT: Could you play tab -- Exhibit 104, please.

(Exhibit 104 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

[279]

"I think the doctor's responsibility is to diagnose this, understand the factors that is pushing the child in that direction and the family in that direction and to inform what -- the parents and the child of what is known and what is not known and what the alternative treatments are, and the parents and the child make the decision, not the doctor. The doctor does not have the data to make the decision."

BY MS. HARTNETT:

Q Dr. Levine, is that your truthful statements?

A That is, although I'm embarrassed, but I used the wrong -- I should have said "are" and not "is" in the first sentence.

Q I think I just did the same thing. I have one more excerpt to play.

MS. HARTNETT: Could you play Exhibit 105, please.

(Exhibit 105 was marked for identification by the court reporter and is attached hereto.)

(Video Clip Played.)

"So if I'm an expert in something, it's a very narrow topic I'm an expert in. Even though I'm a doctor and you -- somebody may think, well, he's a doctor; right? But the doctor doesn't know much about most things.

[280]

"And -- and there is the wisdom, I think, is the difference between demagoguery, which I think many affirmative care doctors are demagogues, and experts, many of whom are just uneasy about what is not known."

BY MS. HARTNETT:

Q Dr. Levine, were these your truthful statements from earlier this year?

A Yes.

Q Do you consider yourself to be a demagogue or an expert?

A I consider myself, on this issue of the scientific basis of -- of trans delivery -- care delivery, to be an expert in this very narrow field because my definition of an expert, knows the difference between what is known and what is not known, you see.

On many subjects that I have to work on every day as a psychiatrist, I -- I have -- I -- I'm not sure what -- the difference between what I know and what is known by more expert people in the field.

I seem to have enough to have credentials as a practicing doctor, but I'm not an expert in most things I take care of.

When it comes to the data about this matter of trans care, I feel I'm a relative expert, and I think I **[281]** have more perspective and more basis for that perspective than many people who have been taught how to take care of transgender people.

Q Do you believe Dr. Adkins is a demagogue?

A I don't know Dr. Adkins well enough to -- to make that decision. I don't want to be insulting at all to my colleagues, but if -- if Dr. Adkins believes this is genetically determined and if she believes that it's fixed and if she believes she's helping and she has evidence that she's helping people live happy lives for the next 40 years, I believe she is much more closer to my definition of a demagogue than, say, a person who can't distinguish between what she knows and what is known versus an expert.

But I don't want to pass judgment on her because, you know, I've just read her report, that's all.

Q How about Dr. Safer, would you have the same view there, that -- do you believe he's a demagogue, or you wouldn't want to pass judgment?

A You know, one of the ethical principles of being a doctor is to speak respectfully of one's colleagues.

I -- I would say, I just want to repeat, that most practicing doctors have a belief system that **[282]** they're working on the side of angels, and that's a different set of ideas than what science has already demonstrated.

So to the extent that people believe, passionately believe, that what they are doing is ensuring a -- a -- a

productive, successful, asymptomatic, fulfilling life and there's no evidence for it, well, I think they're not -- they shouldn't be certain about that.

And they're closer to an ordinary physician or a demagogue than they are to an expert.

Q Thank you. Could you just -- I have a -- hopefully, a couple of final questions about your expert report.

Could you pull that back up? That was Exhibit 87.

MR. BROOKS: Coming, coming.

BY MS. HARTNETT:

Q And I'm going to be just going to paragraph 81.

MR. BROOKS: Which is on.

MS. HARTNETT: It's on -- take your time, but page 31, paragraph 81.

MR. BROOKS: What heading are we under here?

MS. HARTNETT: You are under –

[283]

MR. BROOKS: I see it. I see the heading at the top of page 30. Is that the right heading? Am I missing anything --

MS. HARTNETT: Correct.

MR. BROOKS: -- or is that -- Under "Opinions and practices vary widely..." Okay. And then you said paragraph 81?

MS. HARTNETT: Right. And this is a paragraph about -- Dr. Levine is describing a Lichenstein article; is that correct?

MR. BROOKS: Let me just say, Dr. Levine, if you want to look at any paragraphs between the heading and this one, for context, you should feel free to, or if not -- if you don't feel the need, then you don't need to.

THE WITNESS: Okay.

BY MS. HARTNETT:

Q So this paragraph is talking about, in your words, the "loose standards" at Dr. Safer's clinics at Mount Sinai in Columbia; correct?

A Yes.

Q And do you say that he's -- I'm just reading from the first sentence, but you a say at least one **[284]** prominent clinic, quote, is quite openly admitting patients for even surgical transition who are not eligible under the criteria set out in WPATH's Standards of Care.

Do you see that?

A Yes. The last sentence, right.

Q Is it your understanding that patients were receiving care there without meeting the WPATH standards?

A WPATH standards are just one set of standards, and I guess Dr. Safer has a different set of standards.

I don't think that WPATH needs to be followed, you know. I don't think they're -- they are in fact the standards of care. They are just an organization that is providing some guidelines, which they call standards of care, but aren't true standards of care.

They're just guidelines from a professional organization that is -- that is an advocacy organization for -- for the treatment -- for affirmative treatment.

Q But are you aware that Mount Sinai went through the process of having those people satisfy the WPATH standards before they had surgery notwithstanding that they would have also met the other standards set forth by Sinai?

[285]

MR. BROOKS: Objection.

THE WITNESS: I'm -- I'm not deeply involved in the process of how Dr. Safer has done his work. This would be not an area of my expertise about -- about his criteria.

BY MS. HARTNETT:

Q I guess my question for you is whether you know, sitting here today, whether in fact Dr. Safer's center allowed patients to have surgery under what you call the "loose standards" without satisfying WPATH.

A Well, it was my understanding from the quoted study that -- that he was providing -- or giving permission for surgical care for people who may not have met the few criteria that -- that we have -- had organized in 2000- -- in, you know, the seventh edition.

Q Did you read the Lichtenstein article before citing it here?

A I must have read it, but it's probably one of hundreds of articles, and right now, I can't recall the details.

Q Thank you.

MS. HARTNETT: Could I take a -- go off -- I think I'm almost -- or -- done, if not done.

But could we go off the record briefly for me **[286]** to collect my nets and then hopefully we'll be done?

THE VIDEOGRAPHER: We are off the record at 5:34 p.m.

(Recess.)

THE VIDEOGRAPHER: We are on the record at 5:45 p.m.

MS. HARTNETT: Thank you, Dr. Levine. I have no further questions, but reserve the right to any recross if there's further questioning of you.

THE WITNESS: You're welcome.

MS. HARTNETT: Thank you.

MR. BROOKS: Speaking for the -- Roger Brooks, speaking for the intervenor, I have no questions for the witness.

MR. TRYON: This is Dave Tryon on behalf of the State of West Virginia.

Dr. Levine, thank you for your time.

I have no questions.

MS. MORGAN: This is Kelly Morgan on behalf of the West Virginia Board of Education and Superintendent Burch. I have no questions. Thank you.

MS. DENIKER: Dr. Levine, this is Susan Deniker, counsel for defendants Harrison County Board of Education and Superintendent Stutler, and I have no questions for you.

[287]

Thank you for your time.

THE WITNESS: You're welcome.

MS. ROGERS: Dr. Levine, this is Shannon Rogers on behalf of the West Virginia Secondary School Activities Commission. I have no questions either.

Thank you.

THE WITNESS: You're welcome.

MS. HARTNETT: Dr. Levine, thank you for your time.

THE VIDEOGRAPHER: Thank you.

We are off the record at 5:46 p.m., and this concludes today's testimony given by Stephen Levine, Dr. -- Dr. Stephen Levine.

The total number of media units was seven and will be retained by Veritext Legal Solutions.

Thank you.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

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MAXWELL KADEL, et al.,

Plaintiffs,

vs. Case No. 1:19-cv-272-LCB-LPA

DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, et al.,

Defendants.

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Video Deposition of
STEPHEN B. LEVINE, M.D.

September 10, 2021
9:05 a.m.

***

[23]

Q. Okay. And so then were there any external grants to research and publish about the treatment of children or adolescents --

A. No.

Q. -- with gender dysphoria? Okay. Is that a, "No," when I included the, "Gender dysphoria," as well?

A. That is a, no.

Q. Okay. Thank you. Okay. So on page 3 of your report -- actually, I'm sorry. It's going to be the bottom of page 4 and to the top of page 5. Your report lists your experience as an expert witness, which we talked about a little bit earlier. I just -- I'm wondering if you would confirm this is not an exhaustive list of your experience as an expert witness either via deposition or report.

A. I wouldn't want to testify that this is absolutely complete, given the fact that I don't keep a list compiled. This is kind of compiled retrospectively from memory and documents. And so this is the best I could have done on April of 2021 --

Q. Understood. Thank you. So --

A. -- you might find something else.

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[42]

Q. Was it --

A. -- in a commercial building where our clinic was. It was just, you know, a conference room in our clinic.

Q. And that was within -- was that within a business --

A. It was --

Q. -- a psychiatric practice?

A. I'm sorry. I interrupted you. It was within The Center For Marital Health, which was a business that I and two other people started and owned and ran. And in that business, we continued the same kind of work we did with the University minus the large number of trainees.

Q. You mentioned that after '93, you were not being paid by the University. Were you providing your clinical psychiatric professorship gratuitously?

A. Meaning without pay? Yes.

Q. Okay. Do you know if, after you moved the clinic away from Case Western Reserve, if Case Western Reserve University Medical School created a separate gender identity clinic?

[43]

A. Years later they did --

Q. Oh, sorry.

A. -- I would say, they created a separate clinic perhaps in 2017, 2016.

Q. Do you know the name of that clinic?

A. I don't think it's in the department of psychiatry. I think it's in the department of pediatrics. And the answer to your question is, no.

Q. Does The LGBTQ and Gender Care Program sound familiar?

A. No.

Q. But have you -- sorry. Have you evaluated any patients through that separate clinic that Case Western Reserve has?

A. No. Much to my dismay, that clinic was formed and maintained without any input from me, who I thought was one of the experts in the field.

Q. Do you know if they have psychiatrists, within that clinic?

A. I -- I'm not knowledgeable about the composition of that clinic. There is a very strong liaison between our department of

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[47]

What do you mean by, "This era"?

A. Before 1993.

Q. Okay. And what do you mean by, "Occasional"?

A. I would say that 95 percent of the patients that we saw were 16 and 17, 18 and up. We could debate what the word, "Child," means, but to me an 11-year-old is a child, even a 13-year-old is a child, especially when my children were 13. And so we -- in the first twenty years, transgender issues were primarily an older teenager and adult, mostly adult issues. In recent years, I would say, 12, 15 years, the number of adolescents appearing in gender clinics at our place and everywhere as far as I can see has increased exponentially, especially the number of teenage girls who are declaring themselves trans boys.

Q. So how many -- sorry. So the first twenty or so years, you said approximately 5 percent of all patients were children.

A. Were younger -- on the younger end of the spectrum --

Q. Right.

A. -- yes.

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[51]

it, you see? But at this moment -- this week, I have one patient that I see weekly, who is a transgender teen. My

staff -- if I can be presumptuous to call them, "My staff" -- our staff sees more.

Q. And thinking about the last year, approximately how many adult patients did you see -- and let's use your framing of, "Regular." So that could be one, for one followup visit or that could be for more -- how many adult patients did you see for treatment of gender dysphoria?

A. Approximately six.

Q. And using that same framing of, "Regular," how many children, so under age 11?

A. In the last year?

Q. Yes, yes. In the last year.

A. Zero.

Q. How many adolescents in regular treatment for gender dysphoria would you approximate you've seen in the last five years individually, exclusive of your supervision of other clinicians?

A. If you ask me the question in the last year, I would have told you five or six, **[52]** but since you ask it as a five-year period, I'm at a loss to tell you whether it's twelve or fifteen. I --

Q. An approximate is fine. Thank you.

A. -- let's just say a dozen with an asterisk, very approximate.

Q. And jumping a little bit more in terms of time. How about the last ten years?

A. Again, using the same asterisk, I would say, double it.

Q. Okay. And you said zero people under age 11, so children this last year. What about in the last five years?

A. Oh, two years ago, we had this charming little 6-year-old. One of my colleagues specializes in children and I get to hear about these cases. Occasionally I get to meet the parents, but I personally have not delivered a psychotherapeutic care or evaluation directly of a child with the exception of this one person that I was involved with.

Q. And that was this last year, you said?

A. That was -- I think it was probably **[53]** two, two and a half years ago.

Q. Oh, okay. And what kind of treatment -- I should say, have you referred any of those adolescent patients for additional treatment, besides psychotherapy, for the treatment of gender dysphoria?

A. Yes.

Q. And what kinds of treatment have you referred them for?

A. For endocrine treatment.

Q. Okay. And approximately what percentage of those adolescent patients have you referred for endocrine treatment?

A. Give me the timeframe of that question, please.

Q. Sure. So you said a few moments ago, in the last five years, you saw maybe, asterisk, 12 to 15 adolescent individually yourself. Of those 12 to 15, what would be the approximate percentage you referred for endocrine treatment?

A. I'm hesitating to answer the question, because some of those children have been taking testosterone or estrogen surreptitiously from their parents. And while **[54]** I didn't refer them for the treatment, I was seeing

them while they were taking the treatment. So if we're only talking about adolescent -- referrals of adolescents for hormones, I would say a very small percentage of those, say, I guess you would say 10 percent.

Q. Fair enough. Have you had yourself individually as a clinician, have you had any non-transgender children who you have made a referral for endocrine treatments related to other conditions?

A. No.

Q. Okay. So then zooming out 30,000 foot view of your 48-year career now, would you say overall, you have provided treatment -- that is, psychiatric treatment -- to mostly adults experiencing gender dysphoria, gender identity issues?

MR. KNEPPER: Objection, form.

A. I would say that throughout my career, we should divide my career into the first twenty years where mostly adults were seen by our team and myself. And then we ought to talk about the last ten or fifteen years **[55]** where the number of adults has diminished and the number of adolescents has increased dramatically.

Q. Okay. Thank you. So as a part of your private practice, do you write letters of authorization for endocrine treatments?

A. Yes.

Q. And do you write letters of authorization for gender affirming surgeries?

A. I have. I have not recently, because most of my patients are 13 or 15 or 16, you know.

Q. Okay. And I'm sorry. Just by, "Recent," when was the last time you wrote a letter of authorization for a gender affirming surgery for an adult?

A. Probably twelve months ago.

Q. Okay. And over the course of your career focusing on your treatment of adults experiencing gender identity issues, for what percentage of those patients would you estimate you wrote a letter of authorization for gender affirming surgery for?

MR. KNEPPER: Objection, form.

A. Again, I would like to put an **[56]** asterisk to whatever I answer this question as. I have not kept track of those figures. I have written -- I've written or cosigned letters for hormone treatments and for gender confirming surgeries for many people. There were more people in the '70s and '80s than in recent decades. In part as a reflection of my own evolution of understanding of these problems and in part it's a reflection of the demography of patients who are coming to see me. I really would not like to answer that question, only because I don't know if the word, "Fifteen," or the word, "Twenty-five," or the word, "Thirty-five," is more accurate --

Q. Understood.

A. -- but I can tell you, I have written letters, especially in the early years, for the things that you're making reference to.

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(Thereupon, Deposition Exhibit 2,
12/21/2020 Zoom Deposition of
Stephen B. Levine, M.D., was marked
for purposes of identification.)

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Q. Okay. For the record, I'm showing

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[66]

Q. Do you think as a general matter that it's good for patients who come to DELR for services related to gender dysphoria to be able to have insurance coverage of that care?

MR. KNEPPER: Objection, form. Beyond the scope.

A. Well, the people who come to DELR are generally coming for evaluation and psychotherapy services. And I believe it's very important that people have access to mental health care and that mental health care for many of our patients are not wealthy, affluent people. And the fees that even masters prepared people charge can become prohibitive. And so I think it's a very nice idea, the psychiatric services, mental health services evaluation and ongoing treatments, with or without medication, it would be nice to be able to cover those things, yes. I think that's a long answer, yes.

Q. Understood. And thinking about the treatment that you refer patients out for, the endocrine treatments in particular, do you think it is generally good if you provide authorization for that treatment that the **[67]** patient be able to afford it?

MR. KNEPPER: Objection, form.

A. May I say, of course?

Q. You may. You may say anything you would like.

A. Of course.

Q. Thank you. Well, anything you would like within reason.

If you make a letter of authorization for a patient for the treatment of gender dysphoria specifically related to a surgical treatment, do you think it is good that they be able to access that treatment that you've authorized?

MR. KNEPPER: Objection, form.

A. Not to be cagey, I want to talk about one word you just used in that sentence. I need you to understand that historically in our clinic for those 47 years, our clinics for 47 years, we are not in the business and we have never been in the business of recommending surgery or recommending hormones. We recommend a continued evaluation so that we -- the person can make up their mind how to proceed. It is not our knowledge base to know who's going to do better and who's going to do **[68]** worse and who is not going to have any difference at all with hormones or with surgery. So what we do is we say, we will write a letter of support for endocrine treatment or for hormones if this is what you want. And we say what our concerns are. We tell the endocrinologist and we tell the surgeon what our concerns are and that we see -- we have reservations about this, and these are our reservations, but the patient has decided this is what he or she wants to do. And so we write a letter of support, but I don't -- every time you use the word, "Recommendation," there's part of me that wants to say, no, we do not recommend. We have never recommended. We have not had the knowledge base. We have not had the clinical experience and the knowledge base to say, I'm a doctor. I know this field. This is what I recommend to make you better. We do not talk that way. We do not think that way. And so I may want to always put an asterisk to any sentence that you use the word, "Recommend." I need you to understand that that's where I'm coming from.

MR. CHARLES: Thank you, **[69]** Dr. Levine. Excuse me just a moment. Can you read back my question. I don't recall if I used, "Recommend." I thought I used, "Authorization." I just want to make sure.

(Record was read.)

MR. CHARLES: If we could just go off the record for a second.

VIDEOGRAPHER: Off the record 10:52.

(Discussion held off the record.)

VIDEOGRAPHER: On the record 10:53.

BY MR. CHARLES:

Q. Okay. Thank you for that clarification, Dr. Levine. I'll be more careful about using terminology more close to, "Authorization," rather than, "Recommendation," and I understand your distinction in your practice. So do you, though, think it's good, if you are authorizing a treatment, a patient has said, This is the treatment I would like, and you have done an evaluation and determined that you will write, as you said, a letter of support, do you then, as a practitioner, think it's good that they can access it, that they can afford it?

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[73]

concept of agency and being a doctor, I think is different than the implication of your question.

Q. Is the worrisomeness for a patient's future health, is that a reason to deny all medical care for gender dysphoria?

A. Absolutely not.

Q. Dr. Levine, I'd like to return back to, I believe it's Exhibit 2, the Claire deposition. And please, if you would turn to page 156.

A. I'm sorry. 150 what?

Q. Page 156. And beginning at line 10 on page 156, Dr. Levine, I'll read it, if you'll just follow along, please. Question: "Are you aware that this case concerns an insurance exclusion that is categorical at preventing" -- Skipping to line 15.
"-- hormones and surgery as a treatment for gender dysphoria?"
Answer: "I am aware that your plaintiffs are suing to get coverage for -- that is not provided by their particular insurance. I am aware of that."

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[84]

demonstrate their efficacy. This is the problem. This is the essence of the problem. This is, I think the essence of my testimony with you today. It's not whether I personally as a doctor would like this patient to have insurance to cover their hormones. It's about, is this the right thing to do for this person and can I help the person see clearly what the dangers are and what the benefits are. That's the issue for a doctor, for Stephen Levine as a doctor. I hope that's a cogent answer --

Q. It is --

A. -- to your question.

Q. -- it is cogent. Thank you. Given all of that, is that -- so you just explained, testified that there are complications, some lack of -- and I'm summarizing here, so I will confirm that this is an accurate summary of what you just shared, but I can't possibly

repeat all of that. Given all of those concerns that you have, is that a reason to deny all medical interventions to people with gender dysphoria?

MR. KNEPPER: Objection, form.

[85]

A. No, but that's not -- that's a separate question about insurance.

Q. Yes, it is a separate question. So now I'm asking: Are those concerns you raised justifications in your mind for denying medical interventions to all people with gender dysphoria?

MR. KNEPPER: Objection, form.

A. You know, I'm not advocating denying endocrine treatment or surgical treatment. I'm just saying that we as a medical profession need to walk the walk that we talk. We say as a principle of ethics that our interventions should be based upon the best current knowledge, it should be based on science. It should not be based on politics. It should not be based on fashion. It should not be based on civil rights considerations. They should be based on the kinds of studies that I just described to you with predetermined outcome majors that are agreed upon --

Q. Sorry?

A. -- period.

Q. I was --

A. I forgot to put the period.

[86]

Q. That's okay. Did you just say, Dr. Levine, you're not an expert in health insurance?

A. I am not an expert in health insurance.

Q. Okay. Or what insurance should or should not cover?

A. Yes.

Q. Do you recall what the insurance billing code typically is for psychotherapy for gender dysphoria? I know it's been a long time since you've accepted commercial insurance, so I'm not sure if the billing codes are the same, but do you recall --

A. The billing code is 90837.

Q. Okay. Is there a code that you're familiar with that is F64.0?

A. That's not a billing -- that's diagnostic code --

Q. Thank you.

A. -- there's a separate code for diagnosis and a separate code for procedure.

Q. I see. So F64.0 is a diagnostic code?

A. Yes.

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[91]

Q. Okay. Dr. Levine, in your report, you stated that you had not met with any of the plaintiffs in this case, correct?

A. Yes.

Q. Okay. And you have not interviewed any of the plaintiffs in this case, correct?

A. Correct.

Q. And so you are not offering any opinions about the plaintiffs in this case, correct?

A. Correct.

Q. Okay. And that would include the veracity of their experiences of gender dysphoria, correct?

A. Yes, correct.

Q. And that would not include the accuracy of their gender dysphoria diagnoses, correct?

A. Correct.

Q. Okay. You're not offering any opinions about their mental health histories?

[92]

A. Correct.

Q. Nor any of the affects of the gender affirming treatment they may have received?

A. Correct.

Q. Okay. Thank you. Let's return to your report. I don't know if you have that --

A. My report?

Q. Yes. You can put away that document in your hand. So if you would, please, turn to page 6 of your report. Okay. So on page 6, paragraph a. at the bottom of the page there, Dr. Levine. The report states that this is one of the opinions you're offering, which is, "Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable some individuals to 'pass' as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex." Did I read that correctly?

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[109]

methodology and are capable of critically reviewing the literature. So your statement is true on the most superficial level, but is totally incorrect when it comes to scientific standards of care for issuing guidelines for the medical profession. So I don't know how to answer the question. On the surface, the answer is, yes. And underneath the surface, the answer is, no.

Q. So the International Journal For Transgender Health is still a peer-reviewed source, though, right?

A. It's peer reviewed by people who make their living supporting transgender care.

Q. But it's still peer reviewed, right?

A. It's peer reviewed --

Q. And as for your --

A. -- I think it's peer reviewed.

Q. Okay. Understood. And as for your more conservative approach, can you cite to any studies or research that resulted in better outcomes than people who adhere strictly to the WPATH standards of care version 7?

A. No. This is part of the problem in

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[112]

evaluation leading to a therapeutic process, it seems prudent, given the fact that we are changing people's bodies, especially teenagers' bodies, and they are not of developmental sophistication yet that court systems or at least one court system thinks they're certainly too young to make these life-altering decisions. So people in SEGM

are biased in the direction of being conservative and providing psychotherapeutic evaluations of the child, of the teenager and of their parents, of their family systems to see if we can find a way to help them be informed about what is going -- what they think they want to do in their future.

Q. And so when you provide letters of authorization for hormones or for surgery, do you do so in accordance with the WPATH standards of care?

A. Yes. That is the standard, to provide a letter of recommendation.

Q. Okay. So turning back to your report, Dr. Levine. You can go ahead and put away the trial transcript there.

A. I'm sorry. Did you say, "Turning

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[114]

Q. Okay. So is a, "Hypothesis," an idea about why something happens, but doesn't provide evidence for why something is happening?

MR. KNEPPER: Objection, form.

A. A, "Hypothesis," generates the pursuit of evidence.

Q. Has social contagion as an explanation for increased cases of gender dysphoria been scientifically proven yet?

A. No. But when you seek -- when you see -- actually see patients and talk to them about their friends and hear about the influence of the Internet and the gurus on the Internet who tell 13 and 12-year-old children who are concerned about menses or concerned about breast development or concerned about their bodies changing and then they're told that they're transsexual by

somebody that they've never met that they talked to on the Internet, that would be social contagion or social education.

Or when you hear about a friend who declares themselves trans and then your patient six months later declares themselves trans, you **[115]** wonder about the -- the interpersonal, psychological link between best friends in young puberty, young years of puberty and how one can identify with one's friends and that would be a social contagion. Those are the kinds of ideas that people like me get when we sit with people week after week talking about their lives. You see, that's not science.

But that is clinician and this is the kind of thing that leads to intuition, clinical intuition and that's the source of the generation of the hypothesis. But we think as clinicians, when we hear -- I mean, I don't think I've ever seen a teenager trans person who hasn't been heavily involved and influenced by the Internet, for example, but I have not done studies to document that in a way that would be scientifically acceptable. There are other people who have. And I doubt very much if you'll ever find a clinician on any side of this issue, you see, who would say, oh, no most of my patients have never talked to anyone on the Internet about transgender. The Internet is just part of life today and -- but transgender teenagers spend **[116]** hours and hours of their time getting counseled or participating with the virtual trans community. That's a hypothesis.

Q. So no scientific citation?

A. When we use the word, "Scientific," in the best sense, yes, the answer to your question is, no scientific.

Q. Okay. No studies of citations you can point to today to support that hypothesis?

A. Oh, I think Lisa Littman's studies are in the literature and/or in press that documents this.

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(Thereupon, Deposition Exhibit 7, "Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria," Article, was marked for purposes of identification.)

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Q. Okay. For the record, please note I'm showing to Dr. Levine what has been marked as Exhibit 7. "Correction: Parent reports of adolescents and young adults perceived to show **[117]** signs of a rapid onset of gender dysphoria," by Lisa Littman published March 19, 2019. Have you seen this material before, Dr. Levine?

A. I've seen of it. I don't think I've read it.

Q. Okay. Were you aware that the Lisa Littman article had to be withdrawn, corrected and republished?

A. Yes.

Q. Okay. And were you aware that the initial article was based on a survey of parents --

A. Yes.

Q. -- of purportedly transgender children and the parents were recorded -- I'm sorry. Let me start over. Were you aware that the Littman article was based on a survey of parents who were recruited through some parent groups?

MR. KNEPPER: Objection, form.

A. I knew it was a survey of parents.

Q. Okay. And did you know there were no report-outs from the young adults of those parents in the article?

A. It was a report of parents'

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[122]

transitioning. However, it is...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." Did I read that correctly?

A. Yes, you did.

Q. All right. Your report also cites as support for the social contagion hypothesis to an article from Medscape.com written by Becky Mccall and Lisa Nainggolan as support for the social contagion theory. Is that correct?
I'm sorry. It's not going to be on this article, Doctor.

A. I don't know that article.

Q. Okay.

A. You haven't asked me a question about this. Did I misunderstand something?

Q. No, no. Sorry. We're just --

A. You haven't asked my opinions about that, yeah.

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(Thereupon, Deposition Exhibit 8, "Transgender Teens: Is the Tide Starting To Turn?" Article, was **[123]** marked for purposes of identification.)

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Q. Yeah. So, for the record, I'm showing Dr. Levine what has been marked as Exhibit 8. "Transgender Teens:

Is the Tide Starting To Turn?" by Becky McCall and Lisa Nainggolan, April 26, 2021. Dr. Levine, you said you have not reviewed this article before?

A. Which one are you referring to?

Q. I'm sorry. That one to your left.

A. This?

Q. Yes. Take your time.

A. Have I reviewed it, no. You know, I've seen the picture of Keira Bell. I've seen news reports of this in the past, but they were just news reports, yeah.

Q. Do you know if either of the authors of this article is a scientist?

A. I have no idea.

Q. Okay. Or a psychiatrist?

A. (Indicating.)

Q. I'm sorry. Could you make your responses verbal? I'm forgetting.

A. I have no idea.

[124]

Q. Okay. Thank you. Have either of them ever treated transgender children or adolescents?

A. I would have no idea.

Q. Okay. To your knowledge, is the information provided on Medscape.CA subject to peer review?

A. I don't know how Medscape works. I've heard there have been retractions, but I don't know how their peer reviewed is made. Perhaps people write in that, This is ridiculous what you've been teaching or what you've been

saying, but whether they're peer reviewed or not, I have no idea.

Q. So you probably -- I'm sorry. So do you know if this article has been published in a peer-reviewed journal to your knowledge?

A. "Transgender teens: Is the Tides" -- that article?

Q. Yes.

A. I don't know. I don't know this article. I don't know where it's from.

Q. Okay. So your report includes a quotation from this article. "The vast majority of youth now presenting with gender

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[128]

multi-continental set of observations from Europe, from Australia, from North America --

Q. Okay.

A. -- it almost doesn't even need citations it's so clinically apparent.

Q. Okay. But there's no citation in your report?

A. In my report, yes.

Q. Okay. So on page 18, going back to your report, at the bottom of page 18, you use a term, "Transgender Treatment Industry." Is this the first time you have used this term?

A. In this report?

Q. No.

A. You mean, did I ever use it in another report?

Q. Yeah, yeah.

A. I'm not sure. If this is -- if it's not the first, it might be the second.

Q. And where did the term originate?

A. I think it -- the term originated from Dwight Eisenhower at the end of his -- when he was leaving the presidency in 1952, he warned the people about the military industrial complex and that there was a very comfortable

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[131]

the methods we made reference to before, the efficacy of the treatment and the downsides of the treatment. But because WPATH is an advocacy organization and the scientific establishment of the efficacy of their treatments are not important to them, what they are doing is teaching young mental health professionals and medical professionals as a whole what their ideology is. They say it's scientifically established. I'm here to tell you to the extent that I understand science, it is not scientifically established. In a sense, there is an industry that has different elements that feed each other; that's the transgender treatment industry. I think if we put our heads together, we could find another term.

Q. So did you coin that phrase then?

A. No --

Q. Okay.

A. -- no.

Q. Have you seen it used before in any peer-reviewed articles?

A. Not in a peer-reviewed article. I've seen it used in these kind of expert **[132]** opinion -- (Indicating.)

Q. Okay.

A. -- I would -- you know, if I had time and I had a committee of people, I -- I would probably find a different term for it. But I don't mean it in a disparaging way. I mean that this is a group of compassionate people trying to help other people who actually believe that the science has established the best practices when in fact they're not well informed.

Q. Do you need a sip of water after that?

A. No. I'm just a long-winded guy. I want to add, if I may, that we should make a distinction between education and indoctrination. Education can be based on science. Indoctrination is based on preferred beliefs that, if you allow me to use this term again. The transgender treatment industry is heavy on indoctrination and has declared, if you look at the standards of care, if you don't believe these systems, you're not a competent -- you're not competent to take care of people. That of course is the height of

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[137]

A. No. Their gender dysphoria may be a product, you see, of these other things. For example, if you have someone who has been sexually abused by her stepfather and becomes a trans person in adolescents, we want to talk about the sexual abuse and the process between that person and what fears for the present and the future that has caused the child. And we're not attacking their trans identity. We're trying to help them understand where

they came from and what they're coping with and why they're so fearful or so distressed by their body changing.

Q. And their gender dysphoria could be separate and apart from that traumatic experience?

A. Theoretically it could be, yes.

Q. And if it persisted sufficiently enough, you would consider a letter of authorization for --

A. Yes.

Q. -- hormones?

A. Yes.

MR. KNEPPER: Objection, form.

Q. Okay. If you would, please, turn

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[151]

A. That is correct. And may I add that it's very, very difficult to understand. The natural question would be, how do you compare the general population with the trans people who did not have surgery with the trans people who did have surgery.

Q. Thank you, Dr. Levine. That's not my question, though. I just wanted to confirm that was not the control group. You mentioned this study later in your report, page 66 beginning at paragraph 74. Do you see that?

A. Um-hum.

Q. Okay. And basically that -- well, here, let me point you exactly. The sentence starts with, "Similarly," about halfway down the page, third sentence of that paragraph.

A. Um-hum.

Q. And, as you mentioned, you cite the Dhejne study and I believe -- or I should ask: Is the Denmark study you're referencing the study directly after it --

A. The Simonsen study.

Q. -- the Simonsen study?

A. Yes.

Q. Okay. So beginning with the Dhejne **[152]** study, do you think because that study showed that some people committed suicide after gender affirming surgery that no patient should be able to access gender affirming surgery?

MR. KNEPPER: Objection, form.

A. That would be illogical.

Q. Okay. Dr. Levine, I understand you said that would be illogical, but just to be clear. You're not recommending -- sorry. I'm not using that word. You're not saying that the fact that some people commit suicide following gender affirming surgery means that there should be a ban on access to that surgery. Is that right?

A. Not for that reason, no.

MR. KNEPPER: Objection, form.

Q. Not for that reason. Okay. Are you recommending that there would be bans on gender affirming surgery for any reason?

A. I think there are -- you know, I think most prudent people in this field, just to use the example of what you read out loud about the Finland study, a case-by-case basis. That's how doctor need to decide things, but there are many, many reasons to be cautious **[153]** fashion and to be very hesitant about going forward.

Q. But you're not recommending total bans on gender affirming surgery?

A. I'm not recommending total bans. I'm aware of the individual circumstances of individual people's lives and their commitment to transgender living. And I don't want to be draconian about this. I want to be compassionate about this.

Q. I understand. I appreciate that. I just want to make sure I'm understanding you correctly.

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(Thereupon, Deposition Exhibit 12, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," Article, was marked for purposes of identification.)

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Q. So for the record, I'm presenting to Dr. Levine what has been marked as Exhibit 12. "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment

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[156]

For the 22nd time today, did I read that correctly?

A. It's the 23rd time.

Q. Oh, okay.

A. Yes.

Q. I was hoping you weren't counting, but, okay. Did you testify earlier today that the limitation of the Dhejne study is that the controls were not transgender persons who had not undergone gender affirming surgery?

A. Yes.

MR. KNEPPER: Objection, form.

Q. Okay. You can set that aside, Dr. Levine.

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(Thereupon, Deposition Exhibit 13, 2017 "On Gender Dysphoria," Booklet From Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden, was marked for purposes of identification.)

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Q. For the record, Dr. Levine has an exhibit that has been marked as Exhibit 13. "On Gender Dysphoria," by Cecilia Dhejne from

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ideation in transgender people.

A. Well, you know about the Branstrom-Pachankis study and the criticism of the study --

Q. But I'm not talking about the study.

A. -- and part of the study demonstrated that it increased suicidal ideation and attempts in the first two and a half years after surgery, especially in the first year --

Q. Right. Is your testimony --

A. -- so I'm not testifying that. I thought you were asking me about this, which I need to comment on, because this is not an accurate depiction of my statement in the reference. (Indicating.)

Q. Well, that's not what I'm asking about, Dr. Levine.

A. Well, you're reading this and I'm misquoted here. So I don't want you to imply that she is accurately representing my views, because I did not say that gender affirming treatment in general should be stopped. I've never said that. This is an article about

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[173]

at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, gender dysphoria does not," continue, "through puberty." So there are some children who persist in their asserted gender identity through puberty, correct?

MR. KNEPPER: Objection, form.

A. Correct.

Q. And some who persist in wanting to transition via medical treatments?

MR. KNEPPER: Objection, form.

A. Yes. Some of the children have learned about medical treatments somewhere along the line and they feel instantly that this is for them.

Q. And then looking at paragraph 56, which is on page 41, so just the very next page on the bottom, the second sentence in that paragraph. "I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male...identity at some point during their teen

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[176]

transgender people is individual based, right?

A. Well, it's both --

MR. KNEPPER: Objection, form.

A. -- yes, that's partially true. And ideally that's true, but it's obviously not entirely true. It's why we're here, is it's categorically based.

Q. Let me rephrase that. You design treatment for your patients based on what that patient in front of you, what they need, what they want, what you determine -- sorry. Not what you determine, but what you might authorize?

MR. KNEPPER: Objection, form.

A. What the patient and I discern together.

Q. Thank you. Okay. Let's jump to, again, still in your report, page 68.

A. We've left 40 and 41? 68.

Q. Okay. Looking at the bottom of page 68, Dr. Levine, paragraph 78. It states, "Similarly, the American Psychological Association has stated because approach" --

A. Sorry.

Q. I apologize.

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[178]

Gender Nonconforming People (2015)." So is that lack of consensus that you discuss a justification to categorically ban social transition for children as a treatment for gender dysphoria?

MR. KNEPPER: Objection, form.

A. By, "Children," you mean 6 and 7 year olds?

Q. Those for whom medical intervention is not indicated.

A. Is that a reason to ban it?

Q. Correct, social transition.

MR. KNEPPER: Objection, form.

A. The reason to -- so let me qualify that. There's a, yes, answer, there's a reason to ban it. And the reason to ban it is both a developmental and an ethical reason. There have been eleven studies of these cross-gender identity children who are not socially transitioned and the vast majority of them de-transition by the time they're mid adolescents or older adolescents. They become homosexual individuals usually or bisexual individuals, but they are cis gender. So if we take a 6-year-old child and

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A. -- nor you didn't ask me to comment on that.

Q. It was related to what you had said before. So this is related but not related to what we just read. So you can put that aside.

A. Okay. But your next question was about puberty blocking hormones, which are not being used for 6-year-old's and 7-year-old's –

Q. Correct, yes, a separate group of people.

A. -- so we're on a different category.

Q. Yes.

A. Okay. So you asked me if I think puberty blocking hormones should be used on a case-by-case basis?

Q. Correct, yes.

A. I don't think so.

Q. So that is to say, there are no circumstances you would advocate for a total ban on that intervention?

MR. KNEPPER: Objection, form.

A. Number one, I've never seen a child where that has come up where I thought it was a good idea. In the cases I've seen, it was like **[185]** a treatment for the mother's pathology, not for the child. And it's like a warning sign, boy, be careful. You see, if you see one case like that, you wonder -- and it's so conspicuous, you wonder in the next case, if the same thing is going on in a more subtle way.

Is the child acting out the ambitions of the mother or the father? I just think prudence -- I think considering the child has not gone through puberty or has not gone far into puberty and puberty brings all kind of psychological, physical and social changes to a child and those changes lead to desistance in many, many children, to put them into a state where all their peers are developing physically and they're going to be poirot (phonetic).

And then most of those children have social anxiety problems and they avoid – they don't have friends, right. And this is going to make them even more different than their peers and it's gone to deprive them of the sexualization of their mind and the discovery of masturbation and the discovery of sexual desire for partners, you see. This is only going to increase the child's difference from **[186]** her peers or his peers and I don't think this is a prudent idea.

And if you wanted me to suggest a ban on anything, it would be a ban on using puberty blocking hormones, especially when the evaluation of those children are

focused on the gender dysphoria of the child and not on the background of the child and not on what's going on. So I think that's an answer to your question.

If we're going to use these drugs, if we're going to use social transformation of children, if we're going to use puberty blocking hormones, it should only be used in a carefully designed protocol. And follow up has to be guaranteed so in one year and in two years and in three years and before we start giving cross-gender hormones we have data --

Q. Sorry.

A. -- so the answer to your question is, I would consider banning puberty blocking hormones even for children who have been cross-gender identified for four years to give them a chance to desist, which is exactly what the Dutch protocol did, by the way.

[187]

Q. Sorry. So you just said you would ban -- you would recommend a ban on --

A. If --

MR. KNEPPER: Objection, form.

A. -- look, I'm a doctor. I'm not a policy maker --

Q. I understand, yes.

A. -- if you ask me my political opinion about, should we ban this, is that a reasonable thing, I think there's a very strong argument for banning puberty blocking hormones.

Q. Okay. And, right. So you're here as an expert offering an expert opinion. So are you separating that from -- like are you saying your political views that you would advocate for bans or are you saying your expert

opinion you're offering in this case is you would recommend ban?

MR. KNEPPER: Objection, form.

A. I would recommend ban. To what extent it's from my politics or from my being a parent or from my being a doctor, I don't know. I would recommend we not use puberty blocking hormones.

Q. In Claire, in this case that we

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Answer: "Where we had a healthy mother and father, an intact family who was psychologically informed and who has -- where a child has come out of toddlerhood acting consistently in a gender atypical fashion, and where the parents are not homophobic..."

Question: "The parents are not what kind of people?"

Answer: "Homophobic."

For the 27th time, did I read that correctly? Did I read that correctly?

A. Yes.

MR. CHARLES: Okay. All right. Let's go ahead and take a break for a few minutes.

VIDEOGRAPHER: Off the record 3:20.

(Recess taken.)

VIDEOGRAPHER: On the record 3:38.

BY MR. CHARLES:

Q. So, Dr. Levine, before the break, you were talking about 6 and 7 year olds and you mentioned there were

eleven studies. Can you identify which eleven studies from your report you're referring to?

A. Cantor, the reference Cantor lists **[192]** the eleven studies and these eleven studies have been done over probably thirty years.

Q. Okay. So Cantor was one review of eleven studies?

A. Cantor was a review of the eleven studies. I can't list to you the eleven individual studies. The latest one is written by Singh, S-i-n-g-h. It was published in April of 2021, in the Frontiers of Psychiatry. And that perhaps is the most comprehensive of them. And that's the one that confirms -- that's a study of boys and it confirmed that 12.2, I think percentage of them persisted over a thirteen-year period.

Q. So that was one -- that was the Singh study that came out. Is that same study mentioned in the Cantor review?

A. (Nodding.)

Q. Okay. And you said that established that 12.2 percent of prepubertal boys persisted into adolescents? Okay.

A. Yes. This harkens back to the ethical issue that I talked about before. You know, if you know that 88 percent of them are going to desist, why in the world

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identified 60,000 case reports world wide on the Internet. See Exposito-Campos..." --

A. That is an error, by the way.

Q. Sorry. Which part of that is an error?

A. That, "60,000," is my error. It 7 should say, "16,000."

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(Thereupon, Deposition Exhibit 17, "A Typology of Gender Detransition and Its Implications for Healthcare Providers," Article, was marked for purposes of identification.)

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Q. Okay. So for the record, I'm showing Dr. Levine what has been marked as Exhibit 17. "A Typology of Gender Detransition and Its Implications for Healthcare Providers," Pablo Exposito-Campos, 2021. Okay. Have you seen this study before, Dr. Levine?

A. Yes.

Q. Okay. So on page 1 of this report, about halfway through the very first paragraph in the introduction beginning with, "As a consequence." Do you see that there?

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[200]

important to note that this typology does not suggest two clear-cut categories, for a secondary detransition can lead to a primary detransition" -- oh, sorry. Let me start over. Sorry.

Okay. Let me start from a different place, Dr. Levine. The second sentence. "In r/detrans" --

And there's an HTTP address --

A. Okay.

Q. Okay. You see that.

-- "a subreddit for detransitioners to share their experiences with more than 16,000 members, one can find several stories of people who call their transgender status into question after stopping transitioning due to medical complications or feeling dissatisfied with their treatment results"?

Do you know what a, "Subreddit," is, Dr. Levine?

A. I believe it's just a division of a larger website where people, you know, with similar interests.

Q. Okay. Do you understand this sentence to be suggesting that all 16,000 of **[201]** those members have offered a story of detransition?

MR. KNEPPER: Objection, form.

A. I think -- I think it may be true that either they have offered a personal story or they're fascinated because of their own considerations of that story. They're thinking about it themselves, which would be in keeping with the idea that even people who have transitioned begin to doubt whether they made a wise decision and they're considering detransition. I'm not so sure it means that all 16,000. I would have no way of ascertaining that. You know, in my worry, I would lean towards most of them are seriously considering or have detransitioned. And in my skepticism, I would say I'm not sure whether it's 15,000 or 12,000 or 8,000.

Q. But you have no way to confirm that --

A. I have no way.

Q. -- if it's all of them or a few of them or three of them?

A. You're absolutely right. I have no way of confirming that.

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[225]

where hormones are safe and surgery is a good thing to do. If a person said that, you know, skeptically, I think that would disappoint certain patients, but how it was said and when it was said in response to what would either determine whether the person is engaged with the mental health professional or leaves the mental health professional. You know, all mental health professionals are not created equal.

Q. So it sounds like you're saying it could do harm to that patient?

MR. KNEPPER: Objection, form.

A. No, I'm not saying that. I'm saying it could be disappointing to that person. What that person did with the disappointment may prove harmful just because of that person or it may prove in fact beneficial.

Q. Are you satisfied -- let's orient this question around the patients you've seen in the last 12 months. Are you satisfied that those patients -- actually, sorry. Let me start over. Are you satisfied that the patients you have seen historically for whom **[226]** you provide letters of authorization for hormones give sufficiently informed consent?

MR. KNEPPER: Objection, form.

A. From my point of view, I did what I could to reach the standard of having the person internalize and think about, digest, dream about and come back and talk to me about it. That's all I can do. I can't guarantee that if I do what I do that it's going to change your mind or help you steer your ship in a slightly different angle --

Q. So --

A. -- so I would not write a letter of recommendation if I didn't feel like I did my part. And if the person indicated that they couldn't pay attention to me, I wouldn't write the letter.

MR. CHARLES: Understood.

Okay. John, finished.

MR. KNEPPER: You're finished?

MR. CHARLES: I mean, barring --

MR. KNEPPER: Barring --

MR. CHARLES: We can't tell the future.

MR. KNEPPER: I wasn't ready for

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[235]

history and current psychiatric diagnosis, it's more complicated than just the internet.

But we need to understand who these children are and how they're different from their peers and what we could possibly do to help them to have a better life. I know some of the conversation today was, we'll help them have a better life by giving them puberty blocking hormones, but that doesn't address -- I think it has a risk of harming them further. And it doesn't address the comorbid developmental challenges that these children face.

And I'm afraid -- and it's controversial, because I don't have the answer. I'm afraid there's a possibility we're making these children have a worse outcome. And until you can demonstrate to me in a very careful controlled study that separates the autistic from the non-autistic, you see? That separates the kids who come from a family that's intact from a family where there's a single parent.

Where you can separate the kids who were sexually abused from the kids who were not sexually abused. I'm not sure puberty blocking

[END OF EXHIBIT]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION
CASE NO. 4:20-cv-00020 – MW/MAF

JAMI CLAIRE, KATHRYN LANE and
AHMIR MURPHY,
Plaintiffs,
vs.
FLORIDA DEPARTMENT OF
MANAGEMENT SERVICES, et al,
Defendants.

[1]

ZOOMED DEPOSITION OF STEPHEN B. LEVINE, M.D.

Monday, December 21, 2020

9:30 a.m. – 2:51 p.m.

Via Zoom

Tallahassee, Florida 32308

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[29]

right?

A No, that is. I think -- we'll quibble 3 over the word only. If you use the word predominantly, I would say they are predominantly taking care of. They are a specialty clinic for the transgender.

Q So predominantly treating transgender people, but not 100 percent?

A That's my guess.

Q Okay. What sorts of treatments do you provide for your patients with gender dysphoria?

A Psychiatric evaluation of the patient and the family, the parents and the other siblings; psychotherapy to further the process of understanding this whole phenomenon; recommendations for hormones and occasionally recommendations for depending on the biologic sex of the patient, for genital or breast surgery.

Q How many patients have you recommended hormone therapy for?

A You mean over 47 years?

Q Le's start with the 47 years, yeah.

A I don't know. Can I give you a gross estimate?

Q Sure.

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to be directed to the surgeon.

Q Okay. If a surgeon told you I require a letter for this facial feminization surgery, are there circumstances under which you could see yourself providing a letter, not of recommendation but of authorization, for a person to receive this surgery from the surgeon?

A I could see myself under certain circumstances, if I understood the patient's motives and had a lot of time to discover and discuss this, the history and alternative approaches and wondering about the psychology of wanting this, I could see theoretically.

That's what I do, you know, as a psychiatrist; I am trying to investigate the meaning of the wish and the solution that the patient is hoping for, the problem the patient is hoping this would be a solution for.

And so I want to be able to consider this and have a respectful, mutual, slow dialogue that is slow, meaning multiple sessions, to consider the nuances of this because, you know, all of us have a self-concept of how handsome we are or pretty we are, and most everyone wants to get a little more handsome and a little more pretty and we are -- we

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[47]

Q Okay.

A I believe that if a surgeon is going to do this, he ought to know what I think -- what I know about the person's history and the person's intellectual capacities and the prices they paid for their gender dysphoria already.

For example, the loss of a family and no relations to children, or the inability to have a relationship, an intimate relationship with other people. I believe the surgeon needs to have an understanding of the person.

I don't have an understanding whatsoever of the techniques of surgery. You see? I am just a psychiatrist. And the psychiatrist -- and the surgeon has very little understanding of how a person got to be in his office. And I believe that the letters of recommendation should

capture the humanness of this person and the desperation of this person and the justification that the person uses and the hopes they have for this surgery. But that's Levine, you know.

Q I want to show you the WPATH Centers of Care section that discusses letters. This is Exhibit 7 which we are going to put on the screen.

(Exhibit 7 was marked for identification).

BY MR. TILLEY:

Q Let's go to page 27. It looks like the document page 27, it's .pdf page 33, Bates stamp 5 PL 0450524.

You see, Dr. Levine --

MS. COLES: Can you read that, Dr. Levine? It looks a little small on my computer.

THE WITNESS: I can read it. It says referral for surgery.

MS. COLES: Okay. Just making sure.

BY MR. TILLEY:

Q At the bottom, I am going to start there and then we'll go on to the following page. At the bottom it says, The recommended content of the referral letters for surgery is as follows: 1, the client's general identifying characteristics now we are continuing on to the next page -- number 2, results of the client's psychosocial assessment, including any diagnoses.

And then it goes on to 3, 4, 5, and 6.

Dr. Levine, can you just review those if you can read it and then let me know if you agree with those statements.

(Short pause.)

[49]

A I don't disagree with the statements, but each of those statements, of course, need to be operationalized by the letter writer. For example, the first one, identifying characteristics, oftentimes identifying characteristics would be like this is a 63-year-old Caucasian veterinarian. But there are many other identifying characteristics that might be included.

So you can interpret these things with terse statements or elaborate statements. I favor elaborate statements. For example, I would like to say a divorced father of four, or a roller derby official. I would like to identify him as much as a person as possible. But in the history of medicine, race, age, and nourishment passes for identifying information.

So the results of the psychosocial assessment, including any diagnosis. Psychosocial assessment would be the processes in his life history, including any current or past diagnoses, you see. So substance abuse might be a very important part of number 2.; and the duration. So if I am writing a letter, if I am one of two people who have been hired to write a letter for genital surgery, and I might have had three visits with the

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not inquiring about your medical history and your psychiatric history. But it may be psychologically beneficial to you and an M.D. may recommend that you do that. And that recommendation would be based on his or her knowledge that you are likely to suffer from seasonal affective disorder, and the treatment is bright lights and sunshine. And sunshine would be far superior because of

its luminescence, the number of lumens exposed, than bright lights.

BY MR. TILLEY:

Q Let's go back just briefly to WPATH. And I know you mentioned you have a more conservative approach. So let me ask you this.

Is it fair to say that if you personally believed that you would authorize hormones or surgery for someone with gender dysphoria, someone following the WPATH Standards of Care would also believe that?

A Yes.

Q Okay. Let's talk about insurance for a little bit. If you recommended that -- if you authorized some form of treatment for gender dysphoria, whether it be hormones or some form of surgery, would you expect that that treatment would be covered by your patient's insurance?

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offering an opinion on transgender people accessing sex-specific public places; is that right?

A No.

Q It's correct that that's not right?

A You mean like bathrooms, and so forth?

Q Right. You are not making an expert opinion in this case concerning sex-specific spaces; is that correct?

A That's right.

Q Okay. Let's go to page 13. You say that plaintiffs assert that the WPATH Standards of Care are widely accepted. Do you see that statement?

A Please tell me what paragraph it's in

Q Under heading number 4.

A Yes. Okay.

Q Do you disagree that the WPATH Standards of Care are widely accepted by the major medical and mental health associations?

A No.

Q Okay. You just think that they are wrong; is that correct?

A Yes, and widely accepted doesn't tell you 60 percent or 40 percent. It just says widely accepted.

Q Okay. Is it -- how would -- how would you

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[156]

You see?

So I am saying, please, let me talk to you about human beings here and how important having ongoing lifelong relations with one's children are and being a grandfather or grandmother, and being connected to a family of origin. I am not talking about categorical bans. I am talking about being smart.

BY MR. TILLEY:

Q Are you aware that this case concerns an insurance exclusion that is categorical at preventing

MS. COLES: Form.

BY MR. TILLEY:

Q -- hormones and surgery as a treatment for gender dysphoria?

MS. COLES: Form.

A I am aware that your plaintiffs are suing to get coverage for -- that is not provided by their particular insurance. I am aware of that.

BY MR. TILLEY:

Q Do you think that exclusion is appropriate?

MS. COLES: Form.

A I've already answered that question, **[157]** believe.

believe.

BY MR. TILLEY:

Q What is the answer?

A That it's a political decision that varies from state to state, and it belongs to the process of political science and the courts and not doctors.

Q And if you yourself were treating them and determined that they understood the risks and you thought the treatment would be psychologically beneficial and provided letters of authorization to them, you would want that treatment to be covered by insurance; is that correct?

MS. COLES: Form.

A I am an agent of the patient, I want what's best for the patient, and especially if the patient couldn't otherwise afford it, I would wish for my patient to have it, yes.

BY MR. TILLEY:

Q I know you said you are not about categorical bans, but let me ask you about minors again.

Would you support a categorical ban on access to puberty blockers to treat gender dysphoria?

MS. COLES: Form.

[END OF EXHIBIT]

TRANSGENDER POLICY

WVSSAC BOARD OF DIRECTORS

In the event a member school, or its governing authority, determines to permit transgender students to participate in interscholastic athletics, the WVSSAC has adopted the following policy to govern such participation:

I.

Definitions

Transgender Student - a student whose gender identity differs from the student's assigned sex at birth.

Gender Identity- a person's deeply-felt internal sense of being male or female.

II.

WVSSAC Transgender Student Policy

A Transgender Student shall be eligible to participate in interscholastic athletics in a manner consistent with a member school policy that meets the minimum standards designated by the WVSSAC Board of Directors policy.

The WVSSAC Board of Directors has designated the following as the minimum standards a member school must consider when determining whether a transgender student may participate in interscholastic athletics in a particular sport A separate determination shall be made by the member school for each sport in which the student seeks to participate.

1. The transgender student's school shall make the initial determination as to whether a student may participate in interscholastic athletics in a gender that does not match the gender assigned to him or her at birth. When determining whether a

transgender student is eligible to participate in interscholastic athletics in a manner consistent with the student's gender identity a member school must consider the following:

a. Whether the student is a "transgender student" as determined based upon applicable regulations and policies of the member school or its governing authority.

b. Whether the student meets all applicable academic and enrollment eligibility requirements.

c. Whether fair competition among high school teams would be impacted by the student's participation.

2. The determination of a student's gender assignment for interscholastic athletics shall remain in effect for the duration of the student's high school eligibility.

3. Any member school may appeal the eligibility of a transgender student on the grounds that the student's participation in interscholastic athletics would adversely affect competitive equity or safety of teammates or opposing players.

a. Any such appeal will be heard by the WVSSAC Board of Directors.

b. The identity of the student shall remain confidential. All discussion and documentation will be kept confidential and the proceedings will also be confidential unless the student and family make a specific request otherwise.

c. The WVSSAC Board of Directors will not consider whether the school has properly

determined the student's sex assignment. The board's deliberations will be limited to the question of whether the transgender student represents a threat to competitive equity or the safety of teammates **or** opposing players. Factors to be considered will include, but not be limited to, the age of the student; the athletic experience of the student; the degree to which the student presents a risk of harm to other competitors due to his or her strength, size, or speed; the nature of the sport; and the degree to which fair competition among high school teams would be impacted by the student's participation.