

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

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

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

CIRCLE CITY REPORTING  
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Indianapolis, IN 46204  
(317) 635-7857

**May 30, 2023**

**(1) Pages 2 - 5**

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

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

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1 report, things like that.  
2 Q Did you have a meeting or conversations  
3 specifically for the purpose of preparing you  
4 for today's deposition?  
5 A A brief meeting.  
6 Q When did that take place?  
7 A I think that was last Thursday morning, my time.  
8 Q Of course. Did you speak with anyone other than  
9 the attorneys for Indiana to prepare for today's  
10 deposition?  
11 A No.  
12 Q Did you review any documents in advance of  
13 today's deposition?  
14 A Yes.  
15 Q Which documents did you review?  
16 A The primary documents that I reviewed are listed  
17 on the front of my declaration. Do you want me  
18 to go through them? You'll have them in front  
19 of you, but I have them here if you need them.  
20 Q That was going to be my next question. Do you  
21 have any documents in front of you that you plan  
22 on referencing during the deposition?  
23 A I have my declaration.  
24 Q Okay. Is that the only document you have in  
25 front of you?

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1 A I was advised that that was the only document I  
2 was permitted.  
3 Q That's perfectly fine with me. I just want to  
4 make sure.  
5 The declaration that you have in front of  
6 you, does it have the attached exhibits, I think  
7 A through E?  
8 A Yes, A through E. The ones you just sent like  
9 10 minutes ago?  
10 Q The declaration that your attorneys provided to  
11 us have, I think, five attachments. The first  
12 was your CV and then the other four were medical  
13 records pertaining to each of the plaintiffs.  
14 Do you have those attachments in front of you?  
15 A No, I don't, no.  
16 Q And it sounds like you have received copies of  
17 several exhibits that I e-mailed to your  
18 attorneys a short while ago?  
19 A Yes, I received them about three minutes before  
20 this call.  
21 Q Okay. And is anyone else in the room with you?  
22 A No.  
23 Q And are you physically located in your home?  
24 A Yes, in my office, yes.  
25 Q Your home office?

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

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

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1 A Yes.  
 2 Q And it looks from your CV like you're employed  
 3 as a consultant presently?  
 4 A That's right.  
 5 Q And that's for a business called DK Consulting?  
 6 A Yes.  
 7 Q And I assume the DK is you?  
 8 A Yes.  
 9 Q Are you the -- I'm sorry, I talked over you.  
 10 A That's okay. I just said it's not very  
 11 original. No symbolism in that at all, yeah.  
 12 Q Are you the only employee of DK Consulting?  
 13 A I have an assistant, like an administrative  
 14 assistant.  
 15 Q Okay. Is that the only other employee?  
 16 A Yes.  
 17 Q And has this been your only employment since  
 18 2019?  
 19 A Yes.  
 20 Q And by "since 2019," I mean since you retired  
 21 from being a professor.  
 22 A That's right, yes.  
 23 Q Do you currently have any patient care  
 24 responsibility?  
 25 A I'm in full-time private practice, so yeah.

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

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<p>1 hours that I spend working. So, in my clinical</p> <p>2 hours, I would say at the moment two-thirds.</p> <p>3 Q And, I'm sorry, that was just a bad question</p> <p>4 then. About how many hours each week are you</p> <p>5 working as a clinician?</p> <p>6 A About 30.</p> <p>7 Q Okay. So about 20 hours or so each week you're</p> <p>8 treating or assessing patients for gender</p> <p>9 dysphoria?</p> <p>10 A Yes.</p> <p>11 Q And are all the patients with gender dysphoria</p> <p>12 that you see minors?</p> <p>13 A Yes, I specialize in minors.</p> <p>14 Q I'll come back to your clinical practice in just</p> <p>15 a little bit. It looks from your CV like you</p> <p>16 served as a professor at the University of</p> <p>17 Sydney in various capacities from 1988 through</p> <p>18 2019. Is that accurate?</p> <p>19 A That is.</p> <p>20 Q Your last position was as an honorary professor</p> <p>21 of psychology and a professor of music?</p> <p>22 A Yes.</p> <p>23 Q I'm just curious, but why music?</p> <p>24 A Sorry?</p> <p>25 Q I said I'm just curious, but why music?</p>	<p>1 me. And, for those years, I had two</p> <p>2 professorships that I had to juggle and get this</p> <p>3 search established. So I didn't do any</p> <p>4 undergraduate lecturing in that position. It</p> <p>5 was all as a director of research center and I</p> <p>6 was primarily supervising Ph.D. students but</p> <p>7 also doing a lot of research, applying for</p> <p>8 grants, writing papers, and so forth, yeah.</p> <p>9 Q Thank you. In your role as a professor of</p> <p>10 psychology or I guess before that a lecturer in</p> <p>11 psychology, were there specific subjects that</p> <p>12 you taught?</p> <p>13 A Yes, I was specifically hired for my expertise</p> <p>14 in developmental psychology and so I was</p> <p>15 primarily responsible for both the undergraduate</p> <p>16 and the postgraduate teaching in subjects like</p> <p>17 infant and child psychology, developmental</p> <p>18 psychology, developmental psychopathology. What</p> <p>19 else? Current issues in adolescent psychology,</p> <p>20 all those kinds of subjects, child and</p> <p>21 adolescent assessment.</p> <p>22 Q Of the psychology courses that you taught, did</p> <p>23 any of them concern treating gender dysphoria or</p> <p>24 providing gender-affirmative care?</p> <p>25 A There was no such thing when I started at the</p>
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<p>1 A Why music? It's a very long story and it's</p> <p>2 probably for another time, but I, you know --</p> <p>3 Q Let me ask you this because I couldn't tell from</p> <p>4 your CV. Is it teaching music or is it teaching</p> <p>5 the psychology of music or performance anxiety</p> <p>6 or what have you?</p> <p>7 A I established a research center at the Sydney</p> <p>8 Conservatorium of Music which is a faculty of</p> <p>9 the University of Sydney. So, when the Sydney</p> <p>10 Conservatorium of Music amalgamated with the</p> <p>11 university, it was a freestanding tertiary</p> <p>12 institution, and then there was a lot of</p> <p>13 legislative changes to reduce the number of</p> <p>14 tertiary institutions and the Sydney</p> <p>15 Conservatorium amalgamated with Sydney</p> <p>16 University and became a faculty, but we were a</p> <p>17 research-led university and it didn't have any</p> <p>18 research as a tertiary institution. It was</p> <p>19 primarily concerned with training young</p> <p>20 musicians.</p> <p>21 And they were looking for somebody who had</p> <p>22 research expertise and who knew about music and</p> <p>23 how the university structures ran, applying for</p> <p>24 research grants, setting up a research</p> <p>25 laboratory, so the magic finger was pointed at</p>	<p>1 university and there were no courses anywhere in</p> <p>2 Australia because the incidence and prevalence</p> <p>3 of that condition was estimated to be minutely</p> <p>4 small and we, therefore, focused on the much</p> <p>5 more prevalent conditions that children present</p> <p>6 with in childhood. So it wasn't on the radar.</p> <p>7 Let me put it that way.</p> <p>8 Q Did you teach any courses about that subject</p> <p>9 toward the end of your career with the</p> <p>10 University of Sydney?</p> <p>11 A No. Towards the end of my career as a</p> <p>12 professor, I was primarily supervising Ph.D.</p> <p>13 students and executing research grants,</p> <p>14 conducting research, and generally organizing</p> <p>15 the research program that I've described before.</p> <p>16 Q Have you taken any courses pertaining to gender</p> <p>17 dysphoria?</p> <p>18 A Well, there aren't any formal courses even now</p> <p>19 that I'm aware of in Australia and I would have</p> <p>20 to vet them very carefully before I book any of</p> <p>21 those courses because Australia has</p> <p>22 unquestioningly, and without due thought and</p> <p>23 consideration, adopted what we call here as</p> <p>24 gender ideology and as soon as I see the</p> <p>25 contents of the description of gender ideology,</p>



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1 I become, you know, quite twitchy and disturbed  
2 by the scientifically fallacious information  
3 that's being propagated, particularly in our  
4 entrance primary and secondary schools.  
5 So I have engaged in a very detailed  
6 undertaking to educate myself based on my  
7 thorough training and many, many years of  
8 clinical experience developing my own model and  
9 my own clinical practice approach to these young  
10 people.  
11 Q In the middle of your answer there you used the  
12 phrase "what we call here as gender ideology,"  
13 and I'm just curious who "we" is in that  
14 sentence.  
15 A Well, it's generally referred to in that way in  
16 the media and media who are somewhat less than  
17 supportive of things like gender-affirming care,  
18 for example, and all the new lexicon, the new  
19 terminology, you know, that's being propagated  
20 by the machinery of the trans advocates.  
21 Q Okay. And I asked if you had taken any courses  
22 pertaining to gender dysphoria and maybe I  
23 didn't ask the question in the right way. Other  
24 than your personal investigation and review of  
25 the literature and certain materials, do you

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1 have any professional training specific to  
2 gender dysphoria or its treatment?  
3 A As I explained, there are no such courses.  
4 People have just adopted practices from  
5 overseas. And, I mean, there are courses within  
6 courses, so, for example, in cultural studies  
7 there's a subcourse called gender and sexuality  
8 and within that course they would cover the  
9 discourses, the current discourses, but it's  
10 more in the area of sociology or critical  
11 studies. And my field is psychology so there's  
12 not really any intersection unless I choose to  
13 read some literature in that field, but there's  
14 no such discrete course as gender-affirming  
15 care.  
16 Q Okay. During your time as a professor for, if  
17 I'm doing the math right, 30, 31 years, did you  
18 have patient care responsibilities at the same  
19 time?  
20 A Yes, I had rights to private practice throughout  
21 my academic career.  
22 Q And about how many hours each week were you  
23 seeing patients? And I'm sure --  
24 A About 10.  
25 Q Okay. And was that more or less consistent

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1 throughout your time teaching?  
2 A Yeah. I mean, it varied according to, you know,  
3 circumstances, but, on average, I would say that  
4 would be about right.  
5 Q So, prior to your time in private practice  
6 following your tenure with the University of  
7 Sydney, were any of the patients that you saw  
8 diagnosed with gender dysphoria?  
9 A Do you mean when I was at the university?  
10 Q Yes. I'm sorry.  
11 A No. I only kind of became involved in about  
12 2019 when a colleague of mine, who is an  
13 adolescent psychiatrist, called me and said a  
14 few psychiatrists are getting referrals of these  
15 young children who are gender dysphoric and  
16 wanting to transgender and none of them had very  
17 much experience with child and adolescent  
18 psychology or psychiatry. And he asked me if I  
19 would review a couple of cases that he had been  
20 referred and have a case conference, a peer  
21 consultation. And it was from that point that I  
22 started to take on cases myself and to really  
23 intensively educate myself about what was going  
24 on and what was happening in this field, so it's  
25 really been for the last coming into five years.

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1 Q And do you remember what time of the year in  
2 2019 you left the University of Sydney?  
3 A July.  
4 Q So would it be after that time that you began  
5 looking into gender dysphoria?  
6 A Yes.  
7 Q Okay. And then it looks from your CV like from  
8 '86 through '87 you were a psychologist in  
9 private practice?  
10 A Yes, I was.  
11 Q During this time did you see or treat any  
12 patients with gender dysphoria?  
13 A No. I might say that they didn't exist in  
14 Australia in 1986/'87.  
15 Q Okay. Then I want to, if it's okay, just  
16 briefly focus on your clinical experience after  
17 you left the University of Sydney where you've  
18 been seeing patients and looking into gender  
19 dysphoria. Is that okay?  
20 A Yeah.  
21 Q Approximately how many patients with gender  
22 dysphoria or gender identity issues did you see  
23 over this period or have you seen over this  
24 period?  
25 MR. FISHER: I'm going to object to the

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1 form of that question. It's unclear whether  
2 those are two separate categories or you're  
3 conflating them together?  
4 MR. ROSE: That's a perfectly fair  
5 objection and if Tom had not called me, I would  
6 have rephrased it myself.  
7 Q How many patients diagnosed with gender  
8 dysphoria have you seen since you left the  
9 University of Sydney, more or less?  
10 A Well, it depends on whether you're talking about  
11 seeing them for assessment or seeing them for  
12 therapy. If I just counted the young people  
13 that I had seen for assessment, it would be in  
14 the vicinity of 150 to 180, and, of those, I  
15 would have taken probably 50 to 60 into  
16 long-term therapy.  
17 Q And pretend I know almost nothing about the  
18 practice of psychology, but what is, I guess,  
19 the assessment? A patient gets referred to you  
20 from some source and what happens then when  
21 you're assessing them?  
22 A Well, I always meet with the parents first and I  
23 get a full developmental history because there's  
24 a great deal of dispute about onset and I want  
25 to get a very clear picture from the parents

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1 about when their child first expressed ideas  
2 about being transgender and so forth. So I do a  
3 very careful historical overview of their  
4 developmental milestones. I also want to  
5 understand how they're performing at school. I  
6 also want to review any of the previous  
7 assessments that they've had for intellectual  
8 ability, any intellectual disabilities, learning  
9 disabilities, have they had an assessment for  
10 autism spectrum disorder, ADHD, have they ever  
11 been diagnosed with depression and anxiety, are  
12 they on any medications. So that is quite an  
13 extended interview with the parents.  
14 And during that time I'm also assessing the  
15 marital and parental dynamic so I'm looking for  
16 power imbalances in the marital diet, I'm  
17 looking for whether there's a lack of respectful  
18 interactions between the parents, and I'm also  
19 looking for whether there's any disagreement  
20 about how they should proceed with their child.  
21 And quite often you'll see one parent who is  
22 more supportive of allowing the transition and  
23 another parent who is not approving. So all of  
24 these things are extremely important.  
25 And then I will see the child on his or her

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1 own and that might go from one to three sessions  
2 depending on what I'm exploring with the child  
3 and what I think is happening in terms of this  
4 child's life.  
5 After that assessment of the child, I meet  
6 again with the parents and I give them an  
7 overview of my opinion and how we should proceed  
8 or how I recommend that the family proceed.  
9 Q Just a couple of questions about that.  
10 MR. FISHER: Gavin, I'm sorry to interrupt  
11 you. I just want to alert you. Because you're  
12 sharing your screen, when people are sending you  
13 text messages they're popping up on my screen.  
14 I'm doing my best to ignore them and not look at  
15 them, but I noticed at least one of them was  
16 from Chase so I thought I'd better alert you  
17 because probably you don't want me to see those.  
18 MR. ROSE: I appreciate that. Thank you.  
19 Can we go off the record for just a second?  
20 (A discussion was held off the record.)  
21 QUESTIONS BY GAVIN M. ROSE:  
22 Q Okay. Doctor, you just explained the assessment  
23 process when you see a patient for the first  
24 time for gender dysphoria, and my question to  
25 you is going to be whether there is an age range

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1 of the children that you assess.  
2 A I've seen children as young as three to four and  
3 I usually -- I have seen some young adults in  
4 their 20s, but the majority are under 18 years  
5 of age or around. You know, I've seen quite a  
6 few like 17, 18-year-olds.  
7 Q Would you say the majority are in their  
8 adolescence?  
9 A Yes, I would.  
10 Q Approximately how many children preadolescence  
11 have you assessed for gender dysphoria?  
12 A I think it would be less than a quarter of the  
13 presentations.  
14 Q So, if I'm doing the math, maybe 30-ish?  
15 A Yeah. I mean, it depends on whether you count  
16 the peripubertal children, you know, the 11 and  
17 12-year-olds because some children are reaching  
18 puberty at younger than average ages. So a  
19 child might be pubertal at 10 and so it would be  
20 a question of whether you would count that child  
21 as a child or as an emerging adolescent, so it  
22 gets a little bit gray if you wanted to strictly  
23 categorize them. The majority, I would say,  
24 would be between 10 and 18.  
25 Q Okay. And of the 150 to 180 patients you've

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1 assessed, how do you decide which ones will

2 become the 50 or 60 that you accept for

3 longer-term treatment?

4 A I make an assessment about whether the young

5 person is capable of entering into a

6 psychotherapeutic process. That's one

7 criterion.

8 Another is whether it is more (inaudible)

9 to work directly with the parents and, quite

10 often, I will choose to do that in the first

11 instance. So I will meet with the parents more

12 regularly than the child and I will -- I suppose

13 the word is coach, you know, coach them about

14 parenting and how to manage, you know, the

15 child's behavior generally and how to manage the

16 statements or, you know, gender sort of related

17 issues, so that's another way that I work.

18 And, in some cases, I'll work with the

19 family, usually the young person and the parents

20 together. In most cases I don't include

21 siblings. If I do do family therapy, it's just

22 with the identified child.

23 So I have a very broad perspective on the

24 kinds of interventions that I undertake and

25 they're based on very careful assessment of the

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1 dynamics of the family, the capacity to engage

2 in particular psychotherapeutic processes, and

3 that involves a capacity for insight and

4 reflective function. And, you know, if not, I

5 step it down to psychoeducation, behavioral

6 management. But I do find that an open

7 exploratory psychodynamic/psychotherapy approach

8 is more effective if it's suitable for that

9 young person and the family.

10 Q And you began that answering by saying that one

11 of the things you look at in determining whether

12 to accept a patient for longer-term treatment is

13 whether they're capable of entering into the

14 psychotherapeutic relationship or possibly the

15 process. What type of patient is not capable of

16 doing that?

17 A Well, you have to be very careful about young

18 people with autism spectrum disorder. In the

19 early days and even now, I did take some of

20 those into individual therapy because they were

21 extremely distressed young people. And, because

22 of their cognitive rigidity, cognitive

23 immaturity, their literal interpretation of the

24 world, and some of them display quite

25 obsessional features in both their behavior and

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1 their thinking, you come to a point where it

2 does not seem to be the best intervention for

3 that type of young person and so I seek other

4 methods, usually primarily working intensively

5 with the parents.

6 Q And when you assess a patient are you attempting

7 to -- are they coming to you with a diagnosis or

8 are you attempting to diagnose them?

9 A I'm not primarily focused -- I presume you're

10 meaning a diagnosis of gender dysphoria?

11 Q Sure.

12 A Yeah. The parent will usually tell me in the

13 first assessment interview what their child is

14 saying and doing with respect to gender and what

15 their demands are and expectations. When I see

16 the child, I'll ask them why they've come to see

17 me, what is their understanding of why they've

18 visited with me today, and I usually take the

19 assessment from that point. And you would be

20 amazed at how many of them don't start with

21 gender.

22 Q How many minor patients have you diagnosed with

23 gender dysphoria, if any?

24 A I think one.

25 Q And how old was that patient?

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1 A Four.

2 Q And when you diagnosed that patient with gender

3 dysphoria, what diagnostic criteria did you use?

4 A Well, I mean, the only acceptable one in current

5 situation is DSM-5 that you will see from my

6 declaration that I have great concerns about the

7 DSM-5 as do a large number of my colleagues.

8 Q Are those the criteria that you used in

9 diagnosing that one patient, though?

10 A I look at those criteria, but I primarily am

11 concerned with the behavior of the child.

12 Q What, if any, criteria other than the DSM-5 did

13 you consult in diagnosing that patient?

14 A I look at their general adaptation, whether

15 they're meeting developmental milestones,

16 whether they're capable of expressing an

17 independent idea about themselves because quite

18 often there are subtle communication dynamics

19 happening between parents and children, and, you

20 know, I mean, of course, the simplest one is

21 that mother speaks for the child and that's why

22 it's important to spend some time with the child

23 alone. And, often, because I do a lot of work

24 for the family court in Australia and for the

25 Office of the Department of Public Prosecutions



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1 where there are allegations of child sexual  
2 abuse, they're really, really, you know, very  
3 damaging custody disputes and so on.  
4 Q I'm sorry for interrupting, but I was going to  
5 ask: Did the tools or criteria that you used in  
6 addition to the DSM-5, do they come from any  
7 publication? Are they written down anywhere?  
8 A Well, they come from the development psychology  
9 literature and also the literature on dynamic  
10 psychotherapy.  
11 Q But there's no specific one page, two-page list  
12 of criteria that you can point me to for these?  
13 A Well, I have been a coauthor of two clinical  
14 guides for the management of children with  
15 gender dysphoria. One of them was an  
16 international consortium that I contributed a  
17 very significant portion of that document. I've  
18 also contributed in a major way to the clinical  
19 guide published by the National Association of  
20 Practicing Psychiatrists, and I've also written  
21 some therapeutic treatment guides for clinicians  
22 that I've presented at meetings and conferences  
23 for consideration.  
24 Q You described this one patient that you  
25 diagnosed with gender dysphoria. Were any of

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1 the other patients that you saw for gender  
2 dysphoria diagnosed with gender dysphoria by  
3 another professional?  
4 A By and large, my practice involves what's called  
5 tertiary referral, so a lot of these young  
6 people come to me when the parents have been  
7 horrified by what's been going on in the gender  
8 clinics.  
9 So one of the typical ways that it happens  
10 is that the child declares him or herself  
11 transgender. The mother takes the child to the  
12 general practitioner. That's the family  
13 treating doctor. The doctors will then refer  
14 these children to either gender-affirming  
15 (inaudible) pediatricians or to the gender  
16 clinics. And once you're on that, as the  
17 Swedish call it, the "trans train," there's  
18 almost only one stop and that's transition.  
19 And, so, when the parents go to these  
20 establishments, they're actually excluded from  
21 the process. They're being made to wait  
22 outside. If the parent wants to contribute  
23 their perceptions of their child and their  
24 worries about their child and maybe transition  
25 isn't the right thing for them, they're taken

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1 off and told that they're the problem and to get  
2 out of the child's way. And, you know, as soon  
3 as this child starts the transition process, all  
4 of these serious psychological problems up to  
5 and including self harm and school refusal and,  
6 you know, the old standards of depression and  
7 anxiety, they're all going to magically  
8 disappear if you start pumping the child with  
9 puberty blockers and cross-sex hormones.  
10 Q I'm sorry, Doctor.  
11 A I'll finish my answer.  
12 Q I'm sorry, Doctor. You've actually gone well  
13 beyond the question that I've asked so I'd like  
14 to turn back to the question that I asked which  
15 is: Other than the one patient that you  
16 diagnosed with gender dysphoria, had any of the  
17 other patients that you've seen for gender  
18 dysphoria been diagnosed with that condition by  
19 some other professional?  
20 A Well, I was about to finish my answer when you  
21 cut me off. So the answer is yes and I'm  
22 telling you the root by which they've been  
23 diagnosed after maybe one half-hour session by  
24 the gender clinic.  
25 Q And the reason I ask that question is I'm trying

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1 to hone down on, I guess, whether you believe  
2 that you have only had one patient with an  
3 accurate diagnosis of gender dysphoria or  
4 whether you believe you've had a number of  
5 patients with an accurate diagnosis of gender  
6 dysphoria.  
7 A Well, I was attempting to answer that question  
8 in your previous question which is I am a  
9 tertiary referral source. So the parents who  
10 become horrified at what's going on at the  
11 gender clinics are the people who are most  
12 likely to come to see me so they're already  
13 convinced that the diagnosis of gender dysphoria  
14 is inaccurate and inappropriate for their child,  
15 and, so, that would be the patient group that I  
16 see. I'm not seeing the captured parents.  
17 They're staying at the gender clinics.  
18 Q Okay. And, other than that one patient that you  
19 diagnosed with gender dysphoria, did you agree  
20 with the assessment of the parents that every  
21 other patient you saw for gender dysphoria had  
22 been inaccurately or inappropriately diagnosed  
23 with that condition?  
24 A I don't make definitive statements of that kind  
25 until I've worked with the parents and with the

Page 34

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

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

14 A I don't confirm the diagnosis.

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

17 A Of course.

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

22 A Yes.

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

Page 35

1 A Zero.

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

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

11 Q And do you continue to see that patient?

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

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

17 A Yes.

18 Q And were those subsequently discontinued?

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

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

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

12 A No, I've seen three or four.

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

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

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

Page 37

1 patients have you seen who are taking puberty  
2 blockers?

3 A Probably not many, two or three.

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

6 A Well, I did attempt to, yes.

7 Q Attempt but did not ultimately?

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

11 Q Why did it foreclose any further discussion?

12 A Well, they found the magic solution.

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

19 A Yes.

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

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

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1 and followed them for 20 years, 88% of them  
2 desisted by like adulthood and I think it was  
3 60% identified as gay young men. And I  
4 communicated that developmental trajectory to  
5 the parents and said that they needed to  
6 exercise extreme caution in allowing the child  
7 to follow his natural developmental trajectory  
8 and that any social transition or prescription  
9 of puberty blockade would derail that  
10 developmental trajectory.  
11 Q And, I'm sorry, how are you defining social  
12 transition?  
13 A Where the child changes his or her names or  
14 pronouns. They start to dress in the  
15 stereotypically style of the opposite sex where  
16 they grow their hair long or cut their hair  
17 short, that kind of thing.  
18 Q When you have a patient that presents to you as  
19 transgender, do you use particular pronouns in  
20 referring to that person?  
21 A I avoid pronouns altogether because I'm having  
22 first person conversation with a young person  
23 and I do not use --  
24 Q Well, you talk about the patient with their  
25 parents, though; right?

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1 A Not often, no. I usually separate the  
2 consultations with parents and children.  
3 Q I'm so sorry for the misunderstanding, Doctor.  
4 I did not mean you talk about the patient with  
5 the parents in the same room. I meant you have  
6 a separate conversation with the parents about  
7 the patient; correct?  
8 A Yes.  
9 Q And when you're speaking to the parent do you  
10 use pronouns to refer to the child?  
11 A I follow the parent and, in the majority of the  
12 cases that I see, the parent is insisting on the  
13 child's birth name and natal pronouns.  
14 Q Are there cases where the parent has referred to  
15 their child using their non-natal pronouns?  
16 A Yes, I had one last night and, I mean, it wasn't  
17 her first session. I've seen her before and she  
18 is now using her daughter's preferred name and  
19 masculine pronouns. And I have discussed that  
20 with her, you know, why is she doing that and  
21 how does she think it's helping her child, and I  
22 then seek permission from the parent to call the  
23 child by his or her given name and pronouns.  
24 Q And I assume your medical records use the sex  
25 the child was assigned at birth when they have

Page 40

1 to?  
2 A Yes. I need to do that for clinical purposes  
3 because I need to get a picture in my own mind,  
4 a template of this child, and quite often I have  
5 to do file reviews and case reviews and you will  
6 notice in my declaration that I have referred to  
7 these four young people using pronouns of their  
8 natal sex and their given name except in one  
9 case where the given name has been expunged  
10 completely, but that is my clinical practice.  
11 Q Okay. Doctor, in your CV, which should still be  
12 in front of you, Page 2 lists your membership in  
13 various professional organizations; is that  
14 correct?  
15 A Yeah.  
16 Q And I assume you remain a member of each of the  
17 organizations you list here?  
18 A No, I said that I -- well, in my CV, obviously,  
19 it doesn't say that, but somewhere I said, I  
20 think it was in the bio, you know, preceding  
21 this, I was a member or eligible for membership  
22 if I let the membership lapse and in some cases  
23 I have let the membership lapse because the fees  
24 are ridiculous and you have to be very  
25 selective.

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1 Q Okay. Of the professional societies you list on  
2 your CV, which of these societies or  
3 organizations do you remain a member?  
4 A Only the Australian Psychological Society, but I  
5 have at one time or another been members -- oh,  
6 and the International Association of Relational  
7 Psychoanalytic Psychotherapy. Oh, and I'm a  
8 member of the Australian Dispute Resolution  
9 Association, yeah.  
10 Q And when was the last time you were a member of  
11 the American -- or an international affiliate,  
12 it looks like, of the American Psychological  
13 Association?  
14 A I let those go after I left the university.  
15 Q So 2019 or so?  
16 A Yeah.  
17 Q Is that because the university was paying your  
18 membership dues?  
19 A Oh, no. No, we have to pay our own membership  
20 dues.  
21 Q Why did you let your membership lapse then?  
22 A There's just so much available on the Internet  
23 now. It just wasn't value for money. I mean,  
24 the Australian Psychological Society, the fees  
25 are \$1,000 a year and you just have to be

Page 42

1 selective.

2 Q And what does it mean to be an international

3 affiliate of the American Psychological

4 Association? I just don't know what that means.

5 A That means that if you're not American, you

6 can't be a full member.

7 Q Gotcha. Other than the organizations that you

8 list here on Page 2 of your CV, are you

9 currently a member of any other professional

10 organizations?

11 A Yes, I'm a council member of the University of

12 Sydney Association of Professors and I'm a

13 council member of the Australian Association of

14 University Professors. I'm a member of the

15 Society for Evidence-Based Gender Medicine.

16 Q And if I refer to that organization just as

17 SEGM, S-E-G-M, you'll know what I mean?

18 A I will.

19 Q How did you become a member of SEGM?

20 A I was invited.

21 Q By whom?

22 A There were two founding directors and I think

23 one of them is Australian and he put my name up

24 to the American cofounder and they invited me

25 together.

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1 Q And when did you first become a member?

2 A I'd say maybe three to four years ago.

3 Q Have you ever held a leadership position with

4 the organization?

5 A No, I avoid administration and hierarchies and,

6 you know, political positions like the plague.

7 I'm a clinician, I'm a researcher, I'm a writer,

8 and I don't have time for that and I'm not

9 interested in that, yeah.

10 Q Have you ever been compensated by SEGM for any

11 reason?

12 A Yes, I have been on one occasion.

13 Q I assume this was for giving a talk or

14 presentation to a meeting?

15 A I wrote some extensive material for their

16 clinical guide.

17 Q I'm sorry, I missed a word there. Wrote some

18 what material?

19 A Extensively. I wrote some very long documents

20 for them when we were putting together the

21 clinical guide and it was an honorarium. I

22 didn't ask for payment, but they appreciated the

23 amount of time and effort that I devoted to

24 that. And I was perfectly prepared to do it

25 voluntarily so it was just a gesture rather than

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1 -- it wasn't a contract. It was an honorarium.

2 Q Does SEGM hold meetings or conferences?

3 A Yes.

4 Q How often?

5 A I believe about once a month there's a Zoom

6 meeting and from time to time, you know, people

7 get together in person but it's very difficult

8 when you're in Australia. You have to be very

9 selective where you travel.

10 Q Do you have to be invited to become a member?

11 A I believe so.

12 Q Are you aware that statements by SEGM have been

13 cited in support of a formal opinion in Texas

14 that took the position that the provision of

15 certain gender-affirming care to a minor

16 constitutes child abuse?

17 A Yes.

18 MR. FISHER: I was just gonna object. I

19 wasn't sure what formal opinion. Could you

20 maybe --

21 MR. ROSE: I can state for the record, Tom,

22 but when Attorney General Paxton issued his

23 formal opinion declaring the provision of

24 certain care to be child abuse under Texas law

25 he cited SEGM, I think, a couple times.

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1 MR. FISHER: Paxton did, okay. Thank you.

2 MR. ROSE: And I didn't see a point to

3 bring that up and I apologize, bringing the

4 actual document up.

5 Q And I guess my question to you, Doctor, is

6 whether you believe that providing

7 gender-affirming care to minors in the form of

8 puberty blockers or hormones constitutes child

9 abuse.

10 A I would prefer to avoid a motive language. I do

11 believe it's very poor medicine to derail a

12 child's natural developmental trajectory

13 precipitously when the drugs that have been

14 prescribed have known demonstrated (inaudible)

15 to the human body.

16 Now, child abuse in this country, and I'm

17 sure in yours, carries with it a legal

18 definition and so I don't think it's helpful to

19 use a motive language when trying to discuss the

20 best treatment and management of young people

21 who are declaring themselves gender dysphoric.

22 Q And, I'm sorry, Doctor, I would know the answer

23 to this question if you were a psychologist in

24 America. As a psychologist in Australia, are

25 you authorized to prescribe medications?



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1 A No.  
2 Q Are you a member of any advocacy or political  
3 organizations?  
4 A No.  
5 Q Have you been in the past?  
6 A You mean advocacy for gender-affirming care?  
7 Q I meant in general and we can narrow it down  
8 from there.  
9 A No, I'm not a member of any political party.  
10 I'm not a member of any religious organization.  
11 I'm not a member of any gender or  
12 sexuality-based organization. I am a completely  
13 free agent.  
14 Q Okay. My understanding is that you have  
15 testified before several legislatures and other  
16 decision-making bodies concerning transgender  
17 persons or the provision of gender-affirming  
18 care; correct?  
19 A Well, only one formally in America and that was  
20 in Alabama.  
21 Q And I'll do that one first. Do you mean that  
22 you played a role in the Alabama bill similar to  
23 Indiana's before that bill was passed?  
24 A Yes.  
25 Q You, I assume, submitted written comments

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

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

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

Page 50

1 A Yeah.

2 Q And I assume these are cases where a court in

3 Australia, for one reason or another, wants a

4 child to be evaluated; is that fair?

5 A Yes, and they can also be referred for

6 court-mandated therapy.

7 Q In your responsibilities for court-referred

8 clients, did any of the issues arising from that

9 concern gender dysphoria?

10 A No, because the work that I've done for courts

11 related to gender dysphoria have been written

12 review and literature review and clinical

13 practice documents, so these court-referred

14 clients are usually to do with parental

15 capacity, custody, time with, and, you know, any

16 assessment that would make it necessary for the

17 child or the family to enter into a therapeutic

18 process.

19 Q Okay.

20 A I'll say no to that in terms of gender

21 dysphoria. This work, more or less, preceded my

22 work on gender issues.

23 Q Okay. And then Page 4 of your CV indicates that

24 you also consult for the Tribunal of the

25 Catholic Church; correct?

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1 A I have, yeah.

2 Q Is that something you currently do?

3 A The last case I did was probably about a year

4 ago, maybe more, but I have been doing it for a

5 very long time but I've kinda pulled back

6 because I've just got too much work in other

7 areas.

8 Q And, just very briefly, what did your

9 consultancy for the church or does it entail

10 when they refer something to you?

11 A Usually cases of marriage where one party is --

12 one or both parties is seeking an annulment of

13 the marriage, and it's a very arcane system and

14 it actually behaves very much like a court of

15 law. There's a defender of the faith and a

16 defender of the couple so it's quite

17 adversarial, it can be, and, extraordinarily,

18 the Catholic Church will sometimes find that

19 there are no grounds for annulment. And usually

20 people who go and seek annulments, they're

21 devout Catholics and they wanted to remarry in

22 the Catholic Church, but they can't remarry in

23 the Catholic Church. They can only have a civil

24 marriage unless their previous marriage has been

25 annulled, and so they're the people who seek

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1 annulments.

2 So I do a marriage assessment and I see the

3 couple and, you know, I do all the normal things

4 that I would normally do as a psychological

5 assessment of these couples to assist them and

6 support them in -- you know, it's usually a very

7 fraught and stressful time for these couples.

8 Q Okay. And then I'm going to scroll through this

9 real quick. And, I'm sorry, Doctor, did you say

10 that you have a copy of your CV in front of you?

11 A No, I don't, no.

12 Q Okay. Then I will scroll through real quick.

13 I'm going to scroll through Pages 5 through 8 of

14 your CV real quick, and my question to you is

15 going to be whether this, as it purports to, the

16 articles, reports, presentations that you have

17 given specifically concerning gender

18 dysphoria-related issues is going to be my

19 question. Spoiler alert.

20 Look through to the bottom there. Is that

21 an accurate description of what you identify in

22 Pages 5 through 8?

23 A Yeah, pretty much.

24 Q Okay. The very last entry under that subheading

25 related to gender dysphoria appears to be a

Page 53

1 radio interview that you gave in 2015. Do you

2 see that?

3 A Yes.

4 Q I've read the transcript to this interview.

5 It's my assumption it was mistakenly placed

6 here, but I will just ask you. Did this

7 interview specifically concern gender dysphoria

8 or any issues related to it?

9 A I'm sorry about that. Let me just turn my phone

10 off. It is misplaced, I'm afraid to say,

11 because the date of 2015 is prior to my work in

12 the gender dysphoria area, so I apologize for

13 that error.

14 Q That was my assumption. I just wanted to make

15 sure the record reflected that. And if that's

16 the only error you make in a 14-page CV, you

17 have done quite well for yourself.

18 Okay. The date you've given for when you

19 started focusing on gender-related issues of

20 2019 you've indicated, more or less, coincides

21 with when you left the University of Sydney.

22 I'm wondering, first and foremost, why you left

23 the University of Sydney.

24 A Well, after 31 years, I'd had enough and I was

25 wanting to get back into clinical work and the

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1 tertiary system in this country is somewhat less  
2 than conducive to genuine academic work. It's  
3 just turned into a corporate bazaar and I no  
4 longer felt the affinity that I've always felt  
5 for academic life and my academic institution in  
6 particular, but it was time for a change.  
7 I wanted to work clinically and I wanted to  
8 be free to express my firmly-held positions on  
9 certain topics. And you, no doubt, are very  
10 aware that there have been several academics  
11 around the world who have been sacked from the  
12 universities for expressing a contrary view, but  
13 that didn't motivate me. I have to be very  
14 clear about that because I hadn't really written  
15 or published anything or even formed my opinions  
16 firmly in 2019, but I did note with interest how  
17 other academics were being treated around the  
18 world if they dared to express a contrary view  
19 and I wouldn't find that acceptable.  
20 Q Was there anything specific at the University of  
21 Sydney that indicated to you you would not be  
22 allowed to express your opinions related to  
23 gender dysphoria?  
24 A Oh, absolutely. You just had to look at the new  
25 policies and, you know, colleagues using -- you

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1 know, you can see our names up here on the Zoom  
2 and suddenly putting in preferred pronouns and  
3 there were all sorts of indications that, you  
4 know, the opinions were only going one way and  
5 there was no room for academic debate, but I do  
6 stress that that was not a motivator for me  
7 personally.  
8 Q Okay. I'm going to scroll back up to Page 5 of  
9 your CV. Toward the bottom of the page is an  
10 article with the lead author R. D'Angelo that  
11 you coauthored titled One Size Does Not Fit All.  
12 Do you see that?  
13 A Yeah.  
14 Q Other than this publication, have any of your  
15 writings concerning gender dysphoria or its  
16 treatment been published in any peer-reviewed  
17 journals?  
18 A No, not at this point.  
19 Q But this D'Angelo article was published in a  
20 peer-reviewed journal?  
21 A Yes, it was.  
22 Q And it's my understanding from looking at the  
23 article that it's a direct response to an  
24 article that had been published by Jack Turban  
25 and others?

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1 A Correct.  
2 Q Pages 7 through 8 of your CV identify keynote  
3 and invited presentations and podcasts that you  
4 have given pertaining to gender dysphoria. Do  
5 you see that?  
6 A Yes.  
7 Q Is this a complete list of the presentations  
8 that you have given concerning gender dysphoria?  
9 A Look, it might not be complete. I, you know,  
10 was under extreme time pressure to get all the  
11 materials prepared for this deposition and I did  
12 focus very much on the content, you know,  
13 reviewing the literature, writing, and then I  
14 had to focus an enormous amount of attention on  
15 doing the case file reviews of the four  
16 plaintiffs so it may not be an exhaustive list.  
17 Q Is it fair to say that you intended it as an  
18 exhaustive list but there might have been some  
19 presentations that simply slipped your mind as  
20 you were preparing this?  
21 A Quite possibly, yes.  
22 Q Are there any presentations that you  
23 intentionally left off?  
24 A No.  
25 Q Okay. First of all, we've been going for about

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1 an hour and a half. Are you still good to go  
2 for a while?  
3 A Yes, I'm fine.  
4 MR. ROSE: Please, if anyone needs a break,  
5 feel free to speak up, but, as I say, I'm more  
6 than happy to keep talking as long as anyone  
7 will let me.  
8 THE WITNESS: I just wonder if I could have  
9 a one-minute adjournment. I'll be back in one  
10 minute.  
11 MR. ROSE: That's perfectly fine.  
12 (A recess was taken.)  
13 DIRECT EXAMINATION CONTINUING,  
14 QUESTIONS BY GAVIN M. ROSE:  
15 Q My understanding is that you have been retained  
16 by the State of Indiana to offer expert  
17 testimony in this case. Is that your  
18 understanding as well?  
19 A Yes.  
20 Q And you understand that this litigation  
21 generally challenges a complete ban on providing  
22 certain gender-affirming care to minors  
23 diagnosed with gender dysphoria?  
24 A Yes.  
25 Q In order to become involved in this case, did

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1 you reach out to Indiana or did Indiana or its  
2 attorneys contact you?  
3 A The latter.  
4 Q And you're being compensated at an hourly rate  
5 of \$400 U.S.?  
6 A Yes.  
7 Q Do you know approximately how many hours you've  
8 devoted to this case so far?  
9 A I've kept a running total, but it's well over  
10 100. Well over, yeah.  
11 Q How does the hourly rate of \$400 compare with  
12 the rate that you charge to clients for  
13 psychotherapy?  
14 A It's extremely generous.  
15 Q What is your hourly rate to provide  
16 psychotherapy?  
17 A I work on a sliding scale so people who are in  
18 financial hardship I work for what's called the  
19 Medicare rebate, which is the amount that is  
20 covered by the nationalized healthcare cover in  
21 Australia, and for people who own planes, boats,  
22 and tennis courts I charge about, depending,  
23 250.  
24 Q I'm sorry, did you say 350? 250?  
25 A 250. And that's a lot less in American dollars

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1 because our Australian dollar is only worth  
2 about \$.68 to your dollar at the moment.  
3 Q And that's what I was going to ask. That's in  
4 Australian dollars?  
5 A Yeah. Yeah.  
6 Q Okay. At the outset of this deposition you  
7 indicated that you had your expert declaration  
8 in front of you?  
9 A Yes.  
10 Q Is that still the case?  
11 A Yes, it is.  
12 Q Okay. I'm going to share my screen just very  
13 quickly right now and pull up what I marked as  
14 Exhibit 2. And I assume that you recognize this  
15 as the expert declaration you have submitted?  
16 A Yes.  
17 Q And I will tell you at the outset that I did not  
18 include any of the attachments that your  
19 attorneys provided to us. If it's okay with  
20 you, I am going to stop the share of this and  
21 both you and I can reference our hard copies and  
22 I assume that will be much quicker than me  
23 scrolling up and down through this. Is that  
24 okay?  
25 A That's okay.

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1 Q Okay. Did you draft your declaration yourself?  
2 A Yes.  
3 Q Did anyone other than you draft any portion of  
4 it?  
5 A No.  
6 Q Did anyone other than Indiana's attorneys review  
7 or comment on it before you finalized it?  
8 A No.  
9 Q Have you conferred with any other professionals  
10 about this litigation?  
11 A No.  
12 Q Are you familiar with -- and by familiar, I just  
13 mean do you know who they are. Are you familiar  
14 with the other individuals that Indiana has  
15 designated as expert witnesses in this case?  
16 A No, I don't think I am. I haven't been  
17 specifically advised, no.  
18 Q And my only question to you is whether you have  
19 conferred with any of them about this case.  
20 A No.  
21 Q Okay. I'm pulling up just very quickly what I  
22 have marked as Exhibit 3. Do you see that?  
23 A Yes.  
24 Q Have you seen this document before?  
25 A Yes.

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



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

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

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

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

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1 know as Eknes-Tucker?

2 A I'll take your word for that.

3 Q Okay. Doctor, I am ready to move into slightly

4 more substantive matters. Thank you for your

5 patience as I went through that.

6 I want to be perfectly clear from the

7 outset. Do you consider gender dysphoria to be

8 a valid medical diagnosis?

9 A No.

10 Q Are there any circumstances under which you

11 believe a patient may accurately be diagnosed

12 with gender dysphoria?

13 A Let me put it this way. I think there is a

14 phenomenon that one could describe as gender

15 dysphoria, but the diagnostic process is what

16 I'm referring to as lacking validity. So, in

17 answer to your first question -- could you just

18 repeat your first question about gender

19 dysphoria?

20 Q My first question was whether you consider

21 gender dysphoria to be a valid diagnosis.

22 A Diagnosis, no. I have major diagnostic concerns

23 with the way in which gender dysphoria is being

24 diagnosed, but I'm not challenging the existence

25 of a phenomenon, a clinical phenomenon, that can

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1 be described as gender dysphoria.

2 Q What does that mean, a clinical phenomenon?

3 A Well, you know, if a patient comes to you and

4 says, "Look, I've got very low mood, I'm not

5 sleeping, I've lost my appetite, I've got no

6 motivation," you'll say, "Well, you know, that

7 sounds like a depressive process," and I need to

8 explore that further with the patient.

9 Similarly, with gender dysphoria, you know,

10 children will come with their narrative about

11 I've always wanted to be a boy and I've always

12 wanted to play with boy things and, in the

13 extreme cases, they want to cut off their sexual

14 organs and so forth. So, of course, one has to

15 be alert to the possibility that there is a

16 clinical process in which the child is

17 uncomfortable in his or her own body and that

18 needs to be explored.

19 Q Do you believe that there are any circumstances

20 under which a child who presents with that

21 clinical phenomenon should be allowed to receive

22 puberty blockers or gender-affirming hormones?

23 A Under almost no circumstances would I think that

24 is a valid approach to take.

25 Q You qualify that with "almost no." What are the

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1 circumstances where you think that might be a

2 valid approach?

3 A Well, if you look at the historical literature

4 and, you know, the amount of writing that

5 occurred, you know, pre sort of 2005 to '10,

6 this was a vanishingly rare diagnosis,

7 vanishingly rare. For example, some of the

8 population figures given for the prevalence of

9 gender dysphoria pre the common era of gender

10 dysphoria, let's put it that way, Sweden was

11 reporting one in one million. The DSM-5

12 reported 1 in 27,000 females and one in 10,000

13 males. So, you know, these figures are

14 extremely low so I'm not going to be absolutist

15 and say there is no circumstance under which

16 it's not an appropriate diagnosis, but the

17 degree to which it's being diagnosed today is of

18 great clinical concern.

19 Q And, Doctor, my question was: How would a child

20 have to present to you for you to believe it to

21 be appropriate for that child to receive puberty

22 blockers or gender-affirming hormones or is that

23 just off the table entirely?

24 A It's very close to being off the table.

25 Q How about for adults? Do you think adults

Page 69

1 should have the ability to receive

2 gender-affirming hormones or even

3 gender-affirming surgery?

4 A Under very special circumstances. Under the

5 original treatment protocol for an adult seeking

6 transgender surgery was that they had to live in

7 their chosen sex for two years and undergo

8 intensive psychotherapy before they would be

9 cleared for surgery. None of those safeguards

10 are in place for young people.

11 Q If they were in place, would you believe it

12 would be appropriate for them to receive this

13 sort of gender-affirming care?

14 A In vanishingly rare cases.

15 Q And can you imagine a child who presents who has

16 consistently over a number of years presented as

17 a sex different than the birth sex who has been

18 in therapy for years and who is presenting with

19 no comorbidities and a certain level of

20 distress, can you imagine yourself thinking it

21 appropriate for that person to receive

22 gender-affirming medications?

23 A I don't think such a person exists.

24 Q Okay. I want to turn, at long last, to social

25 contagion and your description of social

Page 70

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

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

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1 A Did you say 108?  
2 Q 108 on Page 55.  
3 A Yes.  
4 Q Are you there?  
5 A Yes, I am.  
6 Q And in that paragraph you describe a "core group  
7 of 'actual' cases," I assume of gender  
8 dysphoria. Do you see that?  
9 A Yes.  
10 Q And by "core group of 'actual' cases," you meant  
11 actual cases of gender dysphoria?  
12 A Yes.  
13 Q And it appears to me that you're indicating in  
14 this paragraph that social contagion may affect  
15 some "actual cases" of gender dysphoria but may  
16 also affect some other, I assume, nonactual  
17 cases. Is that a fair statement?  
18 A Yes, that's a fair statement.  
19 Q And how does the social contagion affect the  
20 actual cases?  
21 A Well, it's the disinhibition effect that if --  
22 you see, I'm trying to cover all my bases here  
23 because all of the literature that I've read,  
24 all the epidemiological literature available on  
25 gender dysphoria, will identify a case. It

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1 might be 1 in 84,000. It might be 1 in 1  
2 million. It might be 1 in "twenty-two hundred  
3 and fourteen thousand." There's data predating  
4 2010 that shows, you know, very consistently  
5 that there are cases but they're vanishingly  
6 rare. It wouldn't even qualify for -- well, an  
7 orphan diagnosis qualifies because --  
8 Q Let me stop you there because I think you've  
9 gone well beyond the --  
10 MR. FISHER: Gavin, let her finish the  
11 answer, please. You keep doing this. You gotta  
12 let her answer. She's trying to provide you an  
13 answer.  
14 MR. ROSE: I think she keeps stepping well  
15 beyond my questions, Tom.  
16 A I'm sorry. I'll be very specific. It's okay.  
17 It's okay. The answer is: Yes, there are some  
18 actual cases. We don't know how many. And of  
19 those actual cases, the current (inaudible) of  
20 transgender affirming everything would help that  
21 vanishingly rare case who had not yet enacted or  
22 done anything about their genuine gender  
23 dysphoria to come forward for treatment.  
24 Q And I think you referred to that at the outset  
25 as a disinhibition effect. Is that fair?

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

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1 something that can have a social contagion  
2 effect?  
3 A Absolutely. Particularly as they're universally  
4 full of misinformation.  
5 Q What if a person is simply subjected to a book  
6 with a transgender protagonist, can that have a  
7 social contagion effect?  
8 A Yes, it can. The Internet site Anime was  
9 recently boasting that it now had 279 characters  
10 that were known cisgender.  
11 Q Do you know how many cisgender characters it  
12 has?  
13 A Half a dozen.  
14 Q And the Internet site Anime, is that anime.com?  
15 A I presume.  
16 Q You know throughout your declaration that in  
17 recent years there have been significant  
18 increases in persons identifying as transgender  
19 or in seeking care from gender clinics. I  
20 assume you agree that's a fair summary?  
21 A Yeah.  
22 Q I assume you agree that there are other factors  
23 in addition to social contagion that might also  
24 cause an increase in persons identifying as  
25 transgender?

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

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



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

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

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1 Q Sorry, I will repeat the question. Are you  
2 aware of any peer-reviewed studies at all that  
3 attempted to systematically study whether social  
4 contagion has led to increases in transgender  
5 identification?  
6 A Well, Jack Turban actually claims that he's  
7 systematically and emphatically disconfirmed  
8 social contagion, but, given that I only deal  
9 with robust scientific literature that uses a  
10 scientific method, I will say no because his  
11 study does not fall into that category.  
12 Q Are you aware of any peer-reviewed studies at  
13 all that attempted to determine what proportion  
14 of the increase in transgender identification  
15 over recent years can be attributed to social  
16 contagion?  
17 A I have stated at the outlet that my conclusions  
18 are inferential and deductual. I looked at  
19 social contagions in a range of other adolescent  
20 psychopathologies and the same mechanisms and  
21 the same dynamics and the same upward swings in  
22 prevalence have occurred in at least six  
23 adolescent psychopathologies that have been  
24 systematically studied. Now, there's no will to  
25 systematically study social contagion and gender

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

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1 A Yes, it's a yes.  
2 Q Okay. I'm going to pull up for you real quick  
3 what I have marked as Exhibit 5. And do you see  
4 that in front of you?  
5 A Yes.  
6 Q Beginning in -- and you can go there if you  
7 want, but in Paragraph 81 of your declaration  
8 you describe an article that was written by  
9 Dr. Littman who we mentioned.  
10 A Yes.  
11 Q And I understand that there was ultimately a  
12 correction to that article, but you recognize  
13 what I have in front of you as the original  
14 article that Dr. Littman authored?  
15 A Yes.  
16 Q And both you and Dr. Littman discuss  
17 "rapid-onset gender dysphoria"; correct?  
18 A Yes.  
19 Q Prior to Dr. Littman's article in 2018, are you  
20 aware of any professional literature that used  
21 that term?  
22 A No.  
23 Q Is rapid-onset gender dysphoria a diagnosis  
24 listed in the DSM-5 or its text revision?  
25 A No.

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

Page 84

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

Page 85

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

Page 86

1 there is in brackets. The quote is  
2 "unsupportive of transition" and the "gender" is  
3 taken from context.  
4 Q One of the websites that Dr. Littman indicates  
5 the survey was posted to is called Youth Trans  
6 Critical Professionals. Are you familiar with  
7 that website?  
8 A Yes.  
9 Q Have you ever visited it?  
10 A I tend not to spend a lot of time visiting  
11 websites.  
12 Q Have you ever visited it?  
13 A I've clicked to it.  
14 Q The reason I ask is that if you go right now,  
15 you pick up a language saying that the website  
16 is now private and it cannot be accessed, and  
17 I'm wondering if you were aware of that.  
18 A No.  
19 Q Okay. And you understand that Dr. Littman  
20 directed her survey toward the parents of  
21 transgender youth, not the youth themselves;  
22 right?  
23 A Yes.  
24 Q When you provide psychotherapy to one of your  
25 patients, are there any circumstances at all

Page 87

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

Page 88

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

Page 89

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

Page 90

1 issues with, and am I correct that this is that  
2 study?  
3 A Yes, it is.  
4 Q This was published in a journal called  
5 Pediatrics?  
6 A Yeah.  
7 Q And that's a peer-reviewed journal; correct?  
8 A Let's just say they have a peer-review process  
9 that has been degraded in recent times.  
10 Q Has the process itself changed to your  
11 knowledge?  
12 A No, the process is still the same.  
13 Q If it had not been for the article's publication  
14 of Dr. Turban's article or others like it, would  
15 you believe that the peer-review process of  
16 Pediatrics had been degraded in recent years?  
17 A I would have to judge that article by article,  
18 but it's astounding to me that some of the  
19 papers that I see published on the subject have  
20 actually got through a peer-review process if it  
21 was truly anonymized and objective.  
22 Q I understand that you might take issue with some  
23 of the data or the source of the data, but you  
24 understand that Dr. Turban and others analyzed  
25 data from several states that was collected by

Page 91

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

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

Page 93

1 you will need to look at it for this series of  
2 questions, but I certainly invite you to if it  
3 would be useful to you. In this paragraph --  
4 A Sorry for interrupting. It's very hard. I've  
5 got a visual impairment and it's very hard for  
6 me to go from screen to page, back and forward,  
7 and I'm just wondering if you would be able to  
8 quickly put that up on the screen for me.  
9 Q I can certainly do that. I can't promise it  
10 will be quickly, but I can certainly do that.  
11 A Okay.  
12 Q Do you see that in front of you?  
13 A Yeah.  
14 Q It's Paragraph 87 of your declaration; correct?  
15 A Yes.  
16 Q And I'm not going to get into precise numbers,  
17 but it sounds here like you're describing, I  
18 guess, differences in the share of persons  
19 identifying as transgender between adolescents  
20 and younger children over several decades; is  
21 that fair?  
22 A Yes.  
23 Q I think you say that prior to 2000, children age  
24 3 to 12 years identifying as transgender greatly  
25 outnumbered adolescents?



Page 94

1 A Yes.

2 Q And my understanding of your report is that you

3 believe the increase in the percentage of

4 adolescents identifying as transgender is

5 because that group, and particularly persons

6 assigned female at birth in that group, are

7 particularly susceptible to social contagion; is

8 that fair?

9 A Yes.

10 Q Is it fair to say that you think that social

11 contagion played a minimal role before the year

12 2000 in causing persons to identify as

13 transgender?

14 A Yes.

15 Q Is there an age at which you think persons

16 assigned female at birth have matured enough

17 that they're less likely to be susceptible to

18 social contagion?

19 A Could I register my disagreement with the phrase

20 "assigned female at birth"? Could you, please,

21 just say "a natal female" because sex is not

22 assigned at birth. Sex is determined at

23 conception by the presence of X and Y

24 chromosomes. It is not assigned at birth, so I

25 would appreciate if you could just use the

Page 95

1 phrase "a natal female" or "a natal male."

2 Q Why don't I just state for the record that when

3 I use the phrase "assigned female at birth," I

4 am referring to what you would refer to as a

5 "natal female," okay?

6 A But I don't want any more documents than

7 necessary to reflect flawed and fallacious

8 scientifically-lacking gender ideology of which

9 the phrase "assigned female at birth" is a major

10 contributor.

11 Q Do you understand what I mean when I say

12 "assigned female at birth"?

13 A I understand what you mean, but you're

14 expressing it incorrectly.

15 MR. FISHER: I'm concerned along these

16 lines that it's gonna end up putting words in

17 her mouth that she doesn't want, and I think

18 that that's probably part of her concern, too.

19 MR. ROSE: Well, she can certainly answer

20 however she feels comfortable, but I am going to

21 use the verbiage with which I feel comfortable.

22 Q And, as I stated for the record, when I use the

23 phrase "assigned female at birth," I'm referring

24 to what you would refer to as "a natal female."

25 Is that fair?

Page 96

1 A Yes.

2 Q Okay. The question that precipitated this was

3 whether there is an age at which you believe

4 that persons assigned female at birth have

5 matured enough that they are less susceptible to

6 social contagion?

7 A There's a clear set of studies that shows that

8 susceptibility decreases with increasing age and

9 cognitive maturity, so children are more

10 susceptible, in general -- we're talking in

11 population figures here but there's a lot of,

12 you know, variation at an individual basis, but,

13 statistically, in general, at a population

14 level, children tend to be more susceptible than

15 young adolescents; young adolescents tend to be

16 more susceptible than older adolescents; and

17 older adolescents tend to be more susceptible

18 than young adults, onwards.

19 So there's not a cut-off. There's not, you

20 know, 15 is the cut-off at which you're

21 susceptible and then after 15 you're not

22 susceptible. It's a gradient rather than

23 categorical, but that, from a statistical

24 perspective, is what the findings have been.

25 Q And I apologize for repeating you. I really

Page 97

1 just think I missed a word. It sounded like you

2 were saying that children are the most

3 susceptible, young adolescents next, older

4 adolescents next, and adults are the less

5 susceptible; is that fair?

6 A From a population statistically, a generalized

7 perspective, yes.

8 Q I understand there may be variants with

9 particular individuals; correct?

10 A Well, one variation that has been noted is that

11 children who are securely attached to their

12 parents are less susceptible compared with

13 children who were not securely attached and that

14 could occur anywhere from early childhood to

15 late adolescence, so there's very important

16 modifiers of that statement.

17 Q I had asked the initial question about whether

18 there was an age at which persons assigned

19 female at birth are mature enough, and you gave

20 me that hierarchy and that's perfectly fine. I

21 assume the same hierarchy exists for persons

22 assigned male at birth?

23 A The natal males, yes, the same hierarchy exists.

24 Q And we were talking in general, but as it

25 relates to the social contagion effect of

Page 98

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

Page 99

1 decreases following negative media coverage; is  
2 that fair?  
3 A That's fair.  
4 Q And the study you cite concerning the negative  
5 media coverage is the Indremo, the Swedish study  
6 from 2020?  
7 A Yes.  
8 Q I'm flipping over to Exhibit 9 now. And do you  
9 see that in front of you?  
10 A Yes, I do.  
11 Q And I assume that you recognize this as the  
12 Indremo and others study?  
13 A I know where you're going with this and it's a  
14 question of emphasis, but the results are the  
15 results. Indremo is trying to present it as,  
16 you know, let's get all the media coverage  
17 positive, but his study is, in fact, a perfect  
18 example of social contagion. Negative coverages  
19 reduces clinic numbers and positive coverage  
20 increases them and so it's really quite a robust  
21 demonstration of social contagion.  
22 Q I'm sorry, Doctor, my question was literally  
23 just do you recognize Exhibit 9, the Indremo  
24 study that you cite?  
25 A Yes, I do. I do recognize it, but I was

Page 100

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

Page 101

1 referrals?  
2 A Say that again. Sorry.  
3 Q You understand, don't you, that for both the  
4 positive media event and the first of the  
5 negative media events the study actually found  
6 virtually no change in the number of referrals  
7 to gender clinics following the media coverage;  
8 correct?  
9 A It's been some time since I've read the details  
10 of the article. It's just not my memory of it.  
11 I thought -- let me just see that conclusion.  
12 Q I've moved you down to the results section. Do  
13 you see that on the --  
14 A Yeah.  
15 Q And you agree that the majority of this section  
16 describes the changes in referrals following the  
17 second negative media event; correct?  
18 A Okay. So we're looking at time-specific  
19 changes. So in the three months following the  
20 event, referrals decreased by 25% overall, by  
21 32% for individuals being natal females, and by  
22 25% for those aged 13 to 18.  
23 Q And you understand that those statistics that  
24 you just recounted relate to the changes in  
25 referrals following the second negative media

Page 102

1 event; correct?

2 A Yeah. Yeah.

3 Q Do you see the last line of the results section

4 that says for the other two media events no

5 changes in referral counts or time trends were

6 observed?

7 A Yes, I do see that and I actually forgotten that

8 part of it.

9 Q Is it fair to say that in your expert report you

10 only described one of the three events studied

11 in the Indremo study?

12 A I was reporting the three-month follow-up data,

13 so I'd have to go back and just revisit that.

14 Q Okay. Then flipping back to your expert report

15 still on Paragraph 84, the last sentence of that

16 paragraph after you talk about the Indremo study

17 says, "On the contrary, increased positive media

18 coverage of trans issues resulted in an increase

19 in referrals to gender clinics." Do you see

20 that?

21 A Yeah.

22 Q The study you cite for that is Pang and others?

23 A Yes.

24 Q And, just for the record, I think you cite the

25 same study earlier in your report for a similar

Page 103

1 proposition.

2 A Yes.

3 Q Just proving to you that I read the entire

4 thing.

5 A I'm very impressed.

6 Q I was gonna say I could write my memoirs three

7 times over and end the night with your report

8 here.

9 Okay. I'm flipping over to Exhibit 10.

10 And, again, my first question to you is whether

11 you recognize this as the Pang report that you

12 cite.

13 A Yes.

14 Q And I will just tell you the page numbers on

15 this exhibit do not line up with page numbers

16 that you cited elsewhere in your report simply

17 because of where I got it from, I assume.

18 Okay. My understanding is that Dr. Pang

19 and others studied referral rates to gender

20 clinics in Australia and the UK following media

21 coverage related to transgender issues. Is that

22 your understanding?

23 A Yes.

24 Q Okay. I'm going to flip over to the PDF Page 5

25 where I have highlighted a portion beginning

Page 104

1 with "The search strategy." You don't need to

2 do so out loud, but can you read the highlighted

3 portion to yourself?

4 A Yes, I'm familiar with it, yes.

5 Q And this describes the search criteria or terms

6 that Pang and others used to find media items to

7 study in their report?

8 A Yes.

9 Q And you agree that these criteria included any

10 media coverage that contained the words gender,

11 transgender, or gender dysphoria as well as

12 child or adolescent; correct?

13 A Yes.

14 Q If there had been stories in the UK or Australia

15 during the relevant time period similar to the

16 negative media events that were covered in the

17 Indremo study, do you agree that they would

18 almost certainly have fallen within the search

19 criteria?

20 A It would only be a surmise, but it's likely.

21 Q It would have been very difficult to write about

22 that without using the words transgender and

23 either child or adolescent; right?

24 A Sure.

25 Q Okay. I'm going to scroll down to Page 9. And

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1 at the bottom of that carry-over paragraph at

2 the top, Pang and others write, "Testing whether

3 negative media coverage is associated with

4 reduced referral rates (and conversely whether

5 positive coverage is associated with increased

6 referral rates) would thus be a useful next

7 step." Did I read this correctly?

8 A Yes.

9 Q Would it surprise you to learn that this is the

10 only sentence in the entire study where media

11 coverage is referred to as either negative or

12 positive?

13 A Could you go back up to the top of the article?

14 Q Tell me where to stop.

15 A I just want to see the abstract. Okay. Keep

16 going. Okay. Just stop there. Come back down

17 actually. No, go up.

18 Q Sorry.

19 A There. Stop there. Okay. And you're saying

20 that he's talked about media coverage generally

21 as opposed to positive or negative media

22 coverage.

23 Q And do you agree with that?

24 A What in particular?

25 Q Do you agree that the study authors are talking

Page 106

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

Page 107

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

Page 108

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

Page 109

1 the United Kingdom and from Australia; correct?  
2 A Yeah.  
3 Q And, for much of this data, the citation is  
4 provide is to either Kenny, DT 2021 or Kenny, DT  
5 2022. Do you see that?  
6 A Yep.  
7 Q And these citations are obviously you; correct?  
8 A They're obviously me, yes.  
9 Q And are they referencing something that has been  
10 published or simply data that you've collected?  
11 A Well, it's been published on my website, but the  
12 figures were provided by the gender clinics and  
13 I converted them from either text or tabular  
14 form into a graph.  
15 Q Has this data been published in any  
16 peer-reviewed journal?  
17 A I think similar data has been used in  
18 peer-reviewed publications. (Inaudible) had to  
19 have used similar data to have done his study.  
20 Q Your chart wherein you reference both referrals  
21 to gender clinics in the UK and Australia  
22 provides under it that Australian data was  
23 provided by "gender clinics under freedom of  
24 information applications." Do you see that?  
25 A Yeah.



Page 110

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

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

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

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1 increased referrals were primarily in three  
2 states, Western Australia, Queensland, and  
3 Victoria. Do I have that right?  
4 A Yes.  
5 Q I assume on your chart WA is Western Australia?  
6 A That's right.  
7 Q And VIC is Victoria?  
8 A Yes.  
9 Q And QLD is Queensland?  
10 A Yes.  
11 Q My understanding is that Melbourne is the  
12 largest city in Victoria. Do I have that right?  
13 A Sydney is the largest.  
14 Q I'm sorry. Is Sydney not in New South Wales?  
15 A Sydney is in New South Wales.  
16 Q Sorry. I said Victoria. Is Melbourne the  
17 largest city in Victoria?  
18 A Oh, I see what you mean. , it is, yes.  
19 Q Okay. I'm sorry. I have to admit my knowledge  
20 of Australian geography is less than yours so I  
21 would've been happy to be told I was wrong  
22 there.  
23 A Well, my knowledge of your 51 states is very  
24 sparse in my mind as well, so we're even.  
25 Q We're somewhere between Los Angeles and New

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1 York. That's all you need to know.  
2 A Okay.  
3 Q Certainly that's all people in either Los  
4 Angeles or New York care about.  
5 Okay. My understanding, and please tell me  
6 if I'm wrong, is that the first health clinic  
7 catering solely to the needs of transgender  
8 persons or gender diverse persons in Melbourne  
9 was opened in 2016. Is that your understanding  
10 as well?  
11 MR. FISHER: I'm gonna object just because  
12 there's lack of definition behind those  
13 descriptions you just provided.  
14 Q And you can answer the question, Doctor.  
15 A I was just going to say a plane was flying  
16 overhead and I missed the substantive issue in  
17 your question.  
18 Q Sure. My understanding is that the first health  
19 clinic in Melbourne catering solely to  
20 transgender and gender diverse persons opened in  
21 2016. Is that your understanding as well?  
22 MR. FISHER: Same objection. You can  
23 answer.  
24 A I couldn't give you the precise year, so, if you  
25 have researched the question and found that it

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

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1 available to young people in WA experiencing  
2 problems with their gender identity."  
3 Is it your understanding that the gender  
4 identity service opened in Western Australia in  
5 2015?  
6 A Yes.  
7 Q And I assume that that's the largest gender  
8 clinic in Western Australia?  
9 A Yes.  
10 Q And then Exhibit 12 is another printout that  
11 I've taken from the website of the Government of  
12 Queensland wherein the article they published  
13 has someone saying that there was no  
14 multidisciplinary gender service in Queensland  
15 before the establishment of the gender clinic at  
16 Children's Health Queensland in 2017. And my  
17 question to you is: Is it your understanding  
18 that the gender clinic at Children's Health  
19 Queensland first opened in 2017?  
20 A Yes.  
21 Q Okay. In Paragraph 105 of your declaration,  
22 which spans two pages, but do you see the top of  
23 Paragraph 105 there?  
24 A Yes. Yep.  
25 Q And you provide a citation here to Tegg, 2022,

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1 personal communication?  
2 A Yep.  
3 Q And I assume that the citation is to something  
4 that was just relayed to you by whoever Tegg is?  
5 A Yes.  
6 Q And Tegg, I assume, is Simon Tegg?  
7 A Yes.  
8 Q And are you aware that Mr. Tegg is part of a  
9 group called Fully Informed?  
10 A Yes.  
11 Q Are you aware that that group has played an  
12 active role in advocating in favor of policies  
13 in New Zealand that would prevent children from  
14 accessing gender-affirming medications?  
15 A Of course.  
16 Q To your knowledge, has the data you received  
17 from Mr. Tegg been published in any peer-review  
18 journal?  
19 A Not to my knowledge.  
20 Q Okay. I'm going to scroll down just as an  
21 example to Paragraph 107. Do you see that  
22 there?  
23 A Yeah.  
24 Q The citation that you provide at the end of that  
25 paragraph is to a -- your guess is as good as

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1 mine on the pronunciation -- Respaut & Terhune,  
2 2022; correct?  
3 A Yep.  
4 Q This article here, Respaut & Terhune, is it  
5 published in a peer-review journal?  
6 A I'd have to look at the reference.  
7 Q I will just tell you that I found it and your  
8 references are at the end of your declaration,  
9 but Respaut & Terhune are actually reporters for  
10 Reuters. Does that refresh your recollection?  
11 A Well, I have quoted some journalistic pieces  
12 from reputable journals, yes, because they have  
13 access to information that's very difficult for  
14 people, you know, to obtain by any other means,  
15 so I have done that on a couple of occasions.  
16 Q And when you have relied on media stories for  
17 the information you provide in your expert  
18 report, you provide the citation in roughly that  
19 format, right, just the author and the year?  
20 A Yeah. Yeah. That is the accepted APA  
21 referencing convention.  
22 Q Is it fair to say that there are several other  
23 citations that you provide in your expert report  
24 that are just media stories?  
25 A There's a small handful out of 200 plus

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

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1 A No, because in this study Turban conflates  
2 transgender with gender diverse and that's a  
3 fatal flaw for any study to do that.  
4 Q Okay. And I apologize, that wasn't the portion  
5 that I was trying to focus on and that's just my  
6 verbiage, but you're relying on Dr. Turban's  
7 study to discuss the detransition rates. Is  
8 that a fair summary?  
9 A Not detransition rates generally but the  
10 detransition rates that he reports in that  
11 study.  
12 Q Okay. Do you understand that Dr. Turban's  
13 article did not just seek to collect data on the  
14 rate of so-called detransition but also sought  
15 to analyze why persons detransitioned?  
16 A I don't think he's capable of psychoanalyzing  
17 anything and I don't necessarily think he  
18 claimed to do so.  
19 Q Do you understand that the report itself  
20 purports to provide data on why persons  
21 detransitioned?  
22 A Yes.  
23 Q Do you understand that the data set that he  
24 relied on was of people who currently identify  
25 or identified at the time of the article as

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1 transgender?  
2 A Or gender diverse.  
3 Q Or gender diverse. I'm sorry. You understand  
4 that; correct?  
5 A Yes.  
6 Q So every person in the article who had  
7 "detransitioned" subsequently retransitioned.  
8 Is that your understanding of what the article  
9 purports to report?  
10 A It's very difficult to work out exactly what it  
11 purports to report.  
12 Q Okay. Well, you're relying on the article to  
13 talk about detransition rate and my question to  
14 you was whether you were aware that everyone in  
15 the article subsequently retransitioned;  
16 correct?  
17 A I'm not sure I'm aware of that now only because  
18 it's been some time since I read the paper.  
19 Q The article speaks for itself so if you're not  
20 aware of it, that's perfectly fine and I don't  
21 have to prolong the issue.  
22 Are you aware that the article also  
23 classified the reasons for "detransition" --  
24 A Yes.  
25 Q -- as either -- I'm sorry, I wasn't done with

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

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

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1 published in 2021. Do I have that correct?  
2 A Yeah.  
3 Q I understand that there is significant, I guess,  
4 elaboration in your expert declaration, but is  
5 it fair to say that many of the opinions you  
6 express in your expert declaration are also  
7 expressed in this article Exhibit 14?  
8 A Yes.  
9 Q And my understanding is that this article was  
10 published in a collection of articles by various  
11 Australian professionals. Do I have that right?  
12 A Yes.  
13 Q And the collection was devoted to the  
14 "transgendering" of children and adolescents; is  
15 that right?  
16 A Yeah.  
17 Q Was your article published anywhere else?  
18 A Not at this point, no.  
19 Q Has it been published -- I'm sorry, I was  
20 confused by your response. By "not at this  
21 point," do you mean not currently or do you mean  
22 not at the time that it was published in the  
23 collection of articles?  
24 A No to both questions.  
25 Q Okay. My understanding is that the article

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1 collection was edited and published by a  
2 sociologist in Australia named Geoffrey  
3 Holloway. Do I have that right?  
4 A Yes.  
5 Q Were you compensated for writing or submitting  
6 your article?  
7 A No.  
8 Q Okay. I'm pulling up Exhibit 15 and I will just  
9 tell you before we get into this that I have not  
10 taken the entire publication. What I have here,  
11 I think, is the cover page, the table of  
12 contents, and the editorial that appears as  
13 Section 1 to the publication. Do you recognize  
14 this as those portions of that collection in  
15 which your article appear?  
16 A Yes.  
17 Q The editorial that appears indicates that one of  
18 the key objectives of the publication was "to  
19 promote the campaign for a national, public  
20 inquiry into the transgendering of children and  
21 adolescents." Do you see that?  
22 A Yes.  
23 Q Is that your understanding as one of the key  
24 objectives of the publication?  
25 A Yes.



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1 Q Is that one of the reasons that you submitted  
2 your article for inclusion?  
3 A Yes.  
4 Q What is the transgendering of children and  
5 adolescents?  
6 A The transgendering refers to a process of  
7 persuasion that children are "born in the wrong  
8 body," that their gender identity, however  
9 defined, does not align with their natal sex,  
10 and the transgendering is the process whereby  
11 medical professionals assist the child to bring  
12 their sexed body into line with their reported  
13 gender identity using means such as puberty  
14 blockade, cross-sex hormones, and sex  
15 reassignment surgery.  
16 Q In your declaration you refer on several  
17 occasions to the "trans activist lobby." You're  
18 familiar with that, I assume?  
19 A Yes.  
20 Q Is the transgendering of children and  
21 adolescents being accomplished or attempted by  
22 the trans activist lobby?  
23 A Absolutely.  
24 Q Is there anyone other than the trans activist  
25 lobby that is performing the transgendering of

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

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

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

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1 most of my colleagues have had the experience of  
2 putting a huge amount of work into a paper and  
3 not even get past the first round of reviews, so  
4 I haven't pursued that avenue of dissemination,  
5 but I do have over 200 international  
6 peer-reviewed journal articles. So I'm not  
7 incapable of reaching a bar for peer review, but  
8 it's almost impossible to get articles critical  
9 of the current transgender position past a peer  
10 review.  
11 Q Okay. I'm back in your declaration right now  
12 and I am going to bring up, I guess, the end of  
13 Paragraph 140 and the beginning of Paragraph  
14 141. Do you see that in front of you?  
15 A Yep, I do.  
16 Q It appears to me that Paragraph 140 ends with a  
17 quote from a British neurosurgeon about  
18 lobotomy; correct?  
19 A Yep.  
20 Q And then in Paragraph 141 you apply this quote  
21 to the practice of transgendering children and  
22 young people. Is that a fair summary?  
23 A That's a fair summary.  
24 Q And you have in that paragraph a statement that  
25 "These young people are also 'totally ruined as

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1 social human beings." I assume that by "These  
2 young people" there, you're referring to  
3 transgender persons?  
4 A I'm referring to young people who have had their  
5 bodies medically and surgically altered in a  
6 vain attempt to change their sex.  
7 Q What does it mean to be totally ruined as a  
8 social human being?  
9 A It means that one suffers, as I say later on in  
10 that paragraph, pervasive mistreatment and  
11 violence, severe economic hardship and  
12 instability, discrimination, significant  
13 negative physical and mental health impacts, and  
14 so forth.  
15 Q Do you believe that the plaintiff children in  
16 this case have been totaled ruined as social  
17 human beings?  
18 A I think they have suffered enormously. They're  
19 very vulnerable young people and, I mean,  
20 obviously, I wouldn't apply that phraseology to  
21 very young children, you know, who still have  
22 the opportunity to be rehabilitated if they  
23 received the right care rather than the  
24 one-size-fits-all care of gender affirmation for  
25 which, you know, they are, in all likelihood,

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1 not appropriate.  
2 Q Sorry. One second, please. I'm sorry, Doctor,  
3 my co-counsel heard something that I didn't hear  
4 and we're probably both wrong on one front or  
5 another.  
6 What role does whether or not a person has  
7 had gender-affirming surgery play in your  
8 determination as to whether they are totally  
9 ruined as social human beings?  
10 A What role does surgery play in ruining them? Is  
11 that what you're asking?  
12 Q Sure, let's start there.  
13 A Okay. It's a significant traumatic insult on  
14 the body to remove perfectly healthy organs, the  
15 result of which will impair their sexual  
16 function. Many of them suffer ongoing and  
17 significant medical complications including  
18 chronic pain, infection, fistulas, bleeding,  
19 and, you know, in the case of male to female,  
20 they have to constantly dilate which I'm told  
21 causes significant pain. Many of them are  
22 sexually dysfunctional or are not able to feel  
23 comfortable enough to expose their naked bodies  
24 to other people. So, to the extent that those  
25 situations have eventuated from sex reassignment

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1 surgery, the answer to your question would be  
2 yes.  
3 Q Do you believe that children who have been given  
4 access to gender-affirming medications, either  
5 puberty blockers or hormones, but have not had  
6 surgery, do you believe that they are totally  
7 ruined as social human beings?  
8 A I don't think it's fair that you characterize my  
9 view as everybody who's had gender-affirming  
10 care of some kind or another are totally ruined  
11 human beings because it depends on the age of  
12 the child, it depends on the nature of the  
13 treatment, what age it was commenced at, and,  
14 you know, the kind of support they got and what  
15 was the final outcome, but if your question was  
16 about puberty blockade -- is that correct? Were  
17 they totally ruined human beings?  
18 Q I said puberty blockers or gender-affirming  
19 hormones, but if you have different --  
20 A Okay.  
21 Q -- for the two, please --  
22 A Well, some of the adverse effects of puberty  
23 blockade are -- I mean, I'm sure I'm not going  
24 to be able to include everything right at this  
25 moment, but the ones that come to mind are

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1 questions of future fertility, bone density and  
2 bone grown and their final height. It carries  
3 significant risks of weight gain and there are a  
4 significant number of children who report  
5 headaches and hot flashes and, more recently, a  
6 phenomenon called pseudotumor cerebri which, if  
7 not treated promptly, may cause blindness.  
8 So this drug is not safe and, in some  
9 respects, it's not reversible because what it,  
10 in fact, does is delay puberty including the  
11 growth of the sexual organs, and if the child  
12 remains on puberty blockers for longer than two  
13 years, the growth of their sexual organs may not  
14 return to what they would have been had they  
15 been allowed to mature without puberty blockade.  
16 The other thing that happens with puberty  
17 blockade is, of course, their peers are going  
18 through puberty and so all of the factors that  
19 made them feel different and gender dysphoric in  
20 the first place are often exacerbated because  
21 they remain in a prepubertal state while what  
22 used to be their best friends and peers are all  
23 moving into the next stage of development which  
24 is sexual maturation. So there are the possible  
25 problems caused by puberty blockade.

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1 So, if we move on to the cross-sex  
2 hormones, some of the problems with prescribing  
3 testosterone to women are, of course, well,  
4 first of all, the suppression of menses, the  
5 permanent infertility, and ovarian uterine  
6 atrophy that occurs with longer-term use often  
7 necessitating the removal of a young woman's  
8 uterus and ovaries because they atrophy and  
9 cause enormous pain. Then we have clitoral  
10 discomfort, vaginal atrophy which, of course,  
11 makes sexual intercourse very difficult. They  
12 often have cyst formation on the ovaries, pelvic  
13 pain, a condition called polycythemia which  
14 means that they develop too many red blood cells  
15 which carry medical risks. There's increased  
16 dyslipidemia, acne, oily skin. Some of them  
17 develop hypertension, some of them develop Type  
18 2 diabetes, mood swings, increased frustration  
19 and anger and aggression, a risk for deep vein  
20 thrombosis.  
21 That's what I can think of at the moment.  
22 I'm sure there are more, but, you know, these  
23 drugs are touted as being, you know, oh, wow,  
24 this is really going to get you what you want,  
25 but these issues are skated over, at best.

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1 So, if we move to the adverse effects of  
2 estrogen on males, we see things like, again,  
3 deep vein thrombosis, high triglycerides. Some  
4 of them will get hyperprolactinemia which means  
5 they will start to have discharge from their  
6 nipples. They can develop a condition called  
7 hyperkalemia which is excessive potassium which  
8 can really upset the metabolic balance in the  
9 body which can affect the heart. Again, Type 2  
10 diabetes, hypertension, weight gain.  
11 Yeah, these drugs are dangerous drugs.  
12 They're synthetic dangerous drugs to be pumping  
13 into young children and adolescents.  
14 Q And, just to be clear, Doctor --  
15 A I beg your pardon.  
16 Q I'm sorry, I didn't mean to cut you off there.  
17 I thought you were done.  
18 A Well, I'm sure I've missed something, but that  
19 will have to do for now.  
20 Q And, just to be clear, Doctor, you're not a  
21 medical doctor, are you?  
22 A I'm not.  
23 Q In your CV you make reference to what appears to  
24 me to be a two-part podcast called The Medical  
25 Scam of the Century. Do you know what I'm

Page 137

1 talking about?  
2 A I do know what you're talking about.  
3 Q Is it fair to say that you consider the  
4 "transgendering of children and adolescents" to  
5 be the medical scam of the century?  
6 A Yes.  
7 Q You're familiar, I assume, with the Australian  
8 Psychological Society; correct?  
9 A Of course.  
10 Q And, I'm sorry, I just forget. Is this one of  
11 the organizations you're still a member of or is  
12 it something --  
13 A Yes, it is. Yes, I'm still a member.  
14 Q And you're aware that this organization has  
15 published an information sheet recommending  
16 mental health practices that affirm transgender  
17 people's experiences?  
18 A Yes.  
19 Q And I'm pulling up Exhibit 16 for you. Do you  
20 see that in front of you?  
21 A Yes.  
22 Q You recognize this as that information sheet?  
23 A Yes, I do.  
24 Q And you understand that, along with this, the  
25 same organization published a one-page summary

Page 138

1 of its information sheet; correct?

2 A I do.

3 Q And I'm pulling up Exhibit 17. And you

4 recognize this as that summary; correct?

5 A Correct.

6 Q You previously mentioned the Royal Children's

7 Hospital in Melbourne; correct?

8 A Yes.

9 Q And my understanding is this is the largest

10 children's hospital in Melbourne?

11 A Yes, it is.

12 Q Is it the largest one in Australia? I just

13 don't know.

14 A No, there's the Westmead Children's Hospital and

15 the Prince of Whales Children's Hospital in New

16 South Wales.

17 Q But you're aware that it has published treatment

18 guidelines for the treatment of transgender and

19 gender diverse children and adolescents;

20 correct?

21 A Yes.

22 Q And what's the relationship, if you know,

23 between The Royal Children's Hospital and

24 AusPATH?

25 A Well, the director of the gender service at The

Page 139

1 Royal Children's Hospital is one of the

2 coauthors of AusPATH.

3 Q I'm pulling up for you what I have marked as

4 Exhibit 18. Do you see that in front of you?

5 A Yes, I do.

6 Q You recognize these as the treatment guidelines

7 that have been published by AusPATH for the

8 treatment of transgender and gender diverse

9 children and adolescents?

10 A Yes.

11 Q And these are the treatment guidelines that you

12 reference in your declaration occasionally as

13 the AusPATH guidelines?

14 A Yes.

15 Q And my understanding is that this is the

16 Australian body similar to WPATH?

17 A Yes.

18 Q We just briefly touched on this, but in your

19 declaration you repeatedly describe the

20 influence of the trans activist lobby and I'm

21 wondering -- and maybe I asked you this or

22 something close to this, but I'm wondering who,

23 in your estimation, comprises the trans activist

24 lobby.

25 A Look, I think in a footnote I said I'm using it

Page 140

1 as a summary term for the vast network of

2 individuals and organizations who are

3 propagating gender-affirming care.

4 Q Do you believe that the trans activist lobby has

5 a leader or a leadership structure?

6 A The trans activist lobby, which is my summary

7 term so that I don't have to list multiple

8 individuals and organizations, is an open system

9 network so it's got many, many influencers and

10 many networks and subnetworks that have, you

11 know, been -- it's been a very, very effective

12 marketing machine.

13 So it's got very great many modes, you

14 know, that can attract children, so we've got

15 TikTok, we've got Insta -- Instagram not so

16 much. What are the others? I'm having a mental

17 block about these websites, but there's many of

18 them that spend a great deal of time, you know,

19 attracting young people to these sites and, you

20 know, talking to them in very positive terms

21 about transgenering and they can be whatever

22 gender they like. And it often attracts young

23 children who are marginalized and who are

24 looking for a group, looking to belong, looking

25 to be important and special.

Page 141

1 And, yeah, so it's not any one individual,

2 but I did do a social network diagram for what's

3 going on in Australia and the network consists

4 of politicians, sadly the Australian Human

5 Rights Commission, the Commissioner for Children

6 and Young People, the eSafety Commissioner.

7 They're all singing the same song and there's no

8 capacity to (inaudible) the unanimous kind of

9 voice about gender-affirming care.

10 So, you know, I'm not being extremist or,

11 you know, it's not a conspiracy theory to call

12 it a trans lobby. It's a summary term for

13 what's happening in society currently and it's

14 very, very concerning.

15 Q And the deep dive that you said you took -- and

16 I'm sorry if I'm putting words into your mouth

17 -- into persons in power in Australia, it's my

18 understanding that that is available on your

19 website?

20 A What particularly?

21 Q I'm sorry, I will pull that up at the next break

22 and make sure we're talking about the same

23 thing.

24 I assume you believe that the trans

25 activist lobby is global and not limited to



Page 142

1 Australia; right?

2 A Oh, absolutely.

3 Q And The Royal Children's Hospital in Melbourne

4 is a member of the lobby?

5 A Look, I don't want you to put that kind of

6 notion into my mouth. I'm not kind of reifying

7 the transgender lobby as some, you know, star

8 chamber organization that's infiltrating the

9 world, but The Royal Children's Hospital acts as

10 a major harbor of this open social network

11 disseminating misinformation and advocating for

12 gender-affirming care very strongly, both

13 politically and in the courts. These are facts.

14 They're not part of a conspiracy theory.

15 The Australian standards of care have been

16 strongly influenced by the WPATH guidelines and

17 the WPATH guidelines have been strongly

18 influenced, so there's this mutual kind of

19 network of social influence to the point that

20 you would call it brute think because if you

21 have a look at the early documents like the

22 standards of care, you'll see the same authors

23 across different guidelines and standards of

24 care. So we've got Henriette van de Waal and

25 Peggy Cohen-Kettenis from the Amsterdam Clinic

Page 143

1 who were authors of the 2006 Dutch protocol and

2 we see their names appear repeatedly on these

3 standards of care compilations over the last few

4 years as well as the Endocrine Society. And

5 there are other names as well that keep coming

6 up like Louie Myer (phonetic) and so forth.

7 So there is this group think that has

8 developed around the guidelines including the

9 Australian Psychological Society. It's one

10 voice speaking and there's no room for doubt.

11 And, so, there is this collective

12 rationalization of thinking where there's a lot

13 of -- you know, there's no admission of any

14 other alternative point of view. They don't

15 survey the alternatives and every time an

16 alternative is offered like social contagion or

17 like the fact that many of these gender diverse

18 children will grow up to be gay adults if left

19 alone. They don't admit any other possible way

20 of helping and managing these young people, so

21 they do not appraise properly the risks of their

22 own preferred solution which is gender-affirming

23 care. They scoff at the idea of the

24 reversibility of some of their treatments. They

25 selectively choose information and they have

Page 144

1 this err of invulnerability that if you belong

2 to this group of gender-affirming care,

3 clinicians, politicians, teachers, et cetera,

4 then we have the truth. We have the absolute

5 truth. And all I'm saying, people outside of

6 that network are saying: Please think about

7 alternatives, please think about possible harm,

8 please think about irreversibility. And it's

9 not happening.

10 Q Is it fair to say that you believe that the

11 American Medical Association has been improperly

12 influenced by the trans activist lobby?

13 A Yes.

14 Q Is it fair to say that you believe the American

15 Psychiatric Association has been improperly

16 influenced?

17 A Yes.

18 Q How about the American Psychological

19 Association?

20 A Look, I've put a big list in my declaration and

21 if you have a look at all of their position

22 statements, there's very little variation, you

23 know, between them and it's --

24 Q I'm sorry, Doctor. We're gonna be here all

25 night if you don't just answer the question.

Page 145

1 A Okay.

2 Q The question was whether you believe the

3 American Psychological Association has been

4 improperly influenced by the trans activist --

5 A Yes.

6 Q And the same for the Endocrine Society?

7 A Yes.

8 Q Earlier in your deposition I showed you what was

9 Exhibit 8, the statement by the CAAPS

10 organization that had been signed by a couple

11 dozen other organizations. Do you remember that

12 document?

13 A Yes, I do.

14 Q Is it fair to say that you believe that each of

15 those organizations has been improperly

16 influenced by the trans activist lobby?

17 A Well, they're part of it so they influence each

18 other. It's a bidirectional influence.

19 Q And the various Australian state governments

20 that have passed bans on conversion therapy,

21 have they been improperly influenced by the

22 trans activist lobby?

23 A Well, I mean, I'm afraid I have to seriously

24 question their intellectual capacity to put a

25 bill like the banning of conversion therapy into

Page 146

1 parliament. It's an extremely poorly-worded  
2 document and it's unlikely to catch anyone in  
3 its net, but what it has done is scare off  
4 therapists from treating these children in any  
5 way whatsoever. So now there is an extreme  
6 shortage of skilled child and adolescent  
7 therapists to help these young people because  
8 almost no one wants to touch this patient group  
9 because of that legislation.  
10 Q You understand, I assume, that a federal judge  
11 in the Alabama case where you submitted an  
12 expert report issued an injunction against the  
13 statute banning certain types of  
14 gender-affirming care for minors; correct?  
15 A Issued an injunction against gender-affirming  
16 care?  
17 Q I'm sorry, that's lawyer talk. Issued an order  
18 for preventing the statute from taking effect.  
19 A Yes.  
20 Q Is it your position that that judge was  
21 improperly influenced by the trans activist  
22 lobby?  
23 A I don't have an opinion on that.  
24 Q I'm pulling up for you what I have marked as  
25 Exhibit 19. Do you see that document in front

Page 147

1 of you?  
2 A Yes.  
3 Q I assume you're familiar with this?  
4 A Yes.  
5 Q These are the informed consent standards that  
6 AusPATH has promulgated for gender-affirming  
7 hormone therapy?  
8 A Yeah.  
9 Q I'm popping Exhibit 18 back up for you and my  
10 question to you is whether you use any portion  
11 of this document, the AusPATH treatment  
12 guidelines, when you provide therapy to  
13 transgender persons or persons who identify as  
14 transgender.  
15 A Was your question: Is there any part of the  
16 document that says children should have therapy?  
17 Q My question was whether there's any portion of  
18 this document that you rely on when treating a  
19 patient who walks through your door.  
20 A No.  
21 Q And is the same true for Exhibit 19, the  
22 informed consent standards?  
23 A There are more general informed consent  
24 standards that every practicing clinician must  
25 adhere to, but the gender-affirming therapists

Page 148

1 don't even adhere to their own standards of  
2 informed consent and most of them don't even  
3 understand what constitutes informed consent.  
4 MR. ROSE: Off the record for a sec.  
5 (A discussion was held off the record.)  
6 Q Doctor, you ready to power forward?  
7 A Sure.  
8 Q Chapter 2 of your declaration -- excuse me. You  
9 have a separate what you call chapter of your  
10 declaration that specifically concerns the named  
11 plaintiffs in this case; is that fair?  
12 A Yeah.  
13 MR. ROSE: And, Tom, before we plow  
14 forward, just a matter of housekeeping. We want  
15 to make sure that Exhibits B, C, D, and E of the  
16 doctor's declaration as well as I think they  
17 will be Exhibits 20 and 21 of this deposition  
18 and any testimony about those are maintained as  
19 confidential. I assume that's not an issue and  
20 we can obviously figure out how that needs to  
21 work for the Court?  
22 MR. FISHER: Right. Agreed. No objection  
23 to that.  
24 Q Okay, Doctor. Just very generally, have you  
25 personally evaluated any of the plaintiffs?

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1 A As stated in my report, no, I haven't.  
2 Q Have you interviewed them at any time?  
3 A No.  
4 Q Have you interviewed any of their parents?  
5 A No.  
6 Q Have you ever communicated in any fashion with  
7 either them or their parents?  
8 A No.  
9 Q Have you ever communicated about the plaintiffs  
10 with any professional who has evaluated or  
11 treated any of them?  
12 A No.  
13 Q It's fair to say that your opinions about them  
14 come exclusively from a review of the medical  
15 records that you were provided; is that correct?  
16 A As stated in my report.  
17 Q Sorry. That's a yes?  
18 A Yes.  
19 Q Do you have an understanding as to whether each  
20 of the plaintiffs received mental health therapy  
21 before seeking or being prescribed either  
22 puberty blockers or gender-affirming hormones?  
23 A Did you say do I have an understanding?  
24 Q Do you understand whether the plaintiffs  
25 received mental health therapy before seeking or

Page 150

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

Page 151

1 A Yes.  
2 Q And you speculate in the footnote that it's  
3 unclear whether the doctor meant dysphoric or  
4 dysmorphic or was --  
5 A Yes.  
6 Q -- using the terms interchangeably; is that  
7 correct?  
8 A Yes.  
9 Q I assume you understand that gender dysphoria  
10 and body dysmorphic disorder are two entirely  
11 separate diagnoses; right?  
12 A They're not two entirely separate diagnoses, but  
13 they have different emphases.  
14 Q And they're listed separately in the DSM;  
15 correct?  
16 A Yes.  
17 Q Do you have an understanding that persons with  
18 diabetes are more likely to develop an eating  
19 disorder that might lead to body dysmorphia?  
20 A Yes.  
21 Q So do you agree that for a doctor managing a  
22 patient's diabetes whether a patient displays  
23 dysmorphic features might be particularly  
24 noteworthy?  
25 A Yes.

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1 Q But you still think the diabetes doctor, despite  
2 using the phrase "dysmorphic features," might  
3 have been intending to reference K.C.'s gender  
4 dysphoria?  
5 A Well, he then goes on to say "sweet transgender  
6 girl," so it's ambiguous.  
7 Q Okay. I'm going to scroll down to Paragraph  
8 229. Do you see that in front of you?  
9 A Yes. Yes.  
10 Q You're describing here an assessment of M.W.  
11 that you indicate took place on January 4th,  
12 2022. Is that a fair statement?  
13 A Yes.  
14 Q My review of the medical records, I'll just tell  
15 you, does not reveal anything from January 4th  
16 but does indicate that M.W. had an initial  
17 evaluation at Riley Gender Health Connect on  
18 April 14th, 4/14/22. Is it possible that you  
19 simply got the dates wrong?  
20 A Well, given that I had to scroll through  
21 literally thousands of pages on Notepad  
22 formatting, it is possible I got the date wrong.  
23 And, also, Americans reverse the date and month  
24 and it may have occurred for one of those two  
25 reasons.

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1 Q I understand that and I'm not blaming you. And,  
2 for the record, I did go through other portions  
3 of your declaration to see whether you were  
4 adopting the American style of month/day or  
5 whether you were not. I'm certainly not blaming  
6 you.  
7 In your report of this encounter you  
8 indicate that M.W. was neutral about certain  
9 secondary sexual characteristics, satisfied with  
10 other things, and also neutral about  
11 characteristics such as hair, voice, and general  
12 appearance. I understand that I'm not quoting  
13 everything, but you see the language I'm  
14 referencing; right?  
15 A Yes. Yes.  
16 Q And you underlined "voice"; right?  
17 A Uh-huh.  
18 Q Sorry. Yes?  
19 A Yes.  
20 Q Why did you underline "voice"?  
21 A Because voice is one of the characteristics  
22 around which young people claim extreme  
23 dysphoria.  
24 Q So is it fair to say that you underlined "voice"  
25 because you thought M.W. being neutral about

Page 154

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

Page 155

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

Page 156

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

Page 157

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



Page 158

1 A Correct.

2 Q I'm going to scroll up on the same document then

3 to the top of Page 2 where it says that M.W.

4 "Reports feeling significant dysphoria related

5 to chest, voice, and menstrual periods." Do you

6 see that?

7 A Yep.

8 Q And do you still think it was accurate for you

9 to report that M.W. is neutral about his voice?

10 A From the documents that were in front of me, I

11 reported that accurately.

12 Q This is part of the same document, Doctor.

13 A Look, I would like you to have a look at the

14 Notepad files that I was sent. They were

15 disjointed. They didn't necessarily even follow

16 one sentence continuing on the next line.

17 Sometimes I had to scroll down several lines to

18 get the end of a sentence. I was under extreme

19 time pressure. I was given some medical records

20 two days before I had to file my report. I was

21 up all night for three nights in a row trying to

22 complete the work.

23 But, even under all of those circumstances,

24 even if a young child reports dysphoria in

25 relation to chest, voice, and menstrual periods,

Page 159

1 I do not jump to the conclusion that this child

2 is suitable for gender-affirmation care.

3 Q And the circumstances you described about your

4 difficulties reviewing the medical records, I

5 assume that applies to the medical records of

6 all four plaintiffs?

7 A Well, most of them were given to me in that

8 format, in Notepad format.

9 Q Is that a yes?

10 A Yes.

11 Q Okay.

12 A But I didn't just rely on those medical records.

13 I also was given the declarations of the parents

14 and I had the parent reports from their lawyers

15 as well, so it was multiple sources of

16 information.

17 Q I'm back in Paragraph 229 of your declaration.

18 In the middle of this paragraph you say "there

19 is no evidence of a marked incongruence between

20 M.W.'s experienced/expressed gender and (all)

21 primary and/or secondary sex characteristics."

22 Do you see the language that I have just quoted?

23 A Yeah.

24 Q Why is "all" in parentheses?

25 A Because, generally speaking, the child would

Page 160

1 need to express a global dissatisfaction with

2 their body overall. I mean, you know, quite

3 often children will not like something about

4 themselves. I don't like my hips or I don't

5 like my shoulders. That doesn't make them

6 either body dysmorphic or gender dysphoric.

7 So, perhaps, it would've been better to put

8 "most" rather than "all," but I was just drawing

9 that point so that people wouldn't misconstrue

10 that one dissatisfaction or a few

11 dissatisfactions would meet criteria.

12 Q Let me put it this way, Doctor. Is "all" in

13 parentheses because the rest of that sentence is

14 a direct quote from the DSM-5 criteria for

15 gender dysphoria?

16 A Yes, it is. I am quoting from the criteria from

17 DSM.

18 Q So you added the word "all" to the criteria?

19 A Well, I probably did add it, yes, for emphasis.

20 Q Okay. Doctor, I was reading an interview that's

21 linked from your website to a website called

22 xxxkidernet.com. Are you familiar with the

23 interview that I'm referencing?

24 A Yep.

25 Q And I don't have it up in front of me, but I did

Page 161

1 copy this quote. And I'm going to read this

2 quote to you and then the questions I'm going to

3 ask is going to be whether you recall making

4 this statement and whether it is an accurate

5 statement of your beliefs.

6 You were quoted as saying, "Transgender

7 advocates state that in transgenderism -- the

8 belief/assumption that one has been born in the

9 wrong body -- the body must be aligned to one's

10 gender belief, not one's belief to one's

11 biological body. They assume that the mind is

12 correct in its perceptions and beliefs and the

13 body is diseased and must be treated."

14 Do you recall making that statement or

15 something similar to it?

16 A Yes.

17 Q And is what I quoted an accurate statement of

18 your beliefs?

19 A Yes.

20 Q When you provide psychotherapy to a transgender

21 patient or a patient identifying as transgender,

22 is one of your methods to attempt to align their

23 belief to their biological body?

24 A This is a grave misunderstanding of the process

25 of exploratory psychodynamic psychotherapy. I

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

8 And what I find in the majority of cases is  
9 that after the first few sessions the child just  
10 stops talking about gender dysphoria and wanting  
11 to transition and we start talking about their  
12 emotional distress and pain in relationship to  
13 what is happening in their primary attachment  
14 relationships and also other issues that are of  
15 great concern to them such as bullying and  
16 discrimination, isolation, loneliness, a fear of  
17 not meeting expectations. Many of them have  
18 very deeply entrenched self-punishment, internalized  
19 self-punishment that need to be dealt with and  
20 often we have to deal with how they manage their  
21 emotional distress through self harm.

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

Page 163

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

3 Q Okay.

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

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

9 A Uh-huh.

10 Q Sorry. ?

11 A Yes.

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

13 A I understand. I understand.

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

17 A Yes.

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

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

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

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

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1 trying to talk.

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

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

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

7 A Right.

8 Q Is this better for you?

9 A Yes. Thank you. Yes.

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

14 A Yes, it was, yes.

15 Q Did you give it in person, online?

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

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

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

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

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1 Association of Practicing Psychiatrists?

2 A Oh, that's highly likely, yes.

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

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

7 Q But the nation of Australia?

8 A The nation of Australia.

9 Q I assumed by how practicing was spelled.

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

13 A Yes.

14 Q Did you create the PowerPoint yourself?

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

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

24 A Yes.

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

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

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

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

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

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

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

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

25 But, in reality, it carries 18 months jail

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

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

11 A Yes.

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

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

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

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

5 A Yes, I do. Yes.

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

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

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

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1 A Yes, I do, yes.

2 Q What did you mean by that?

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

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

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

25 And that was my summary way of saying



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1 becoming transgender is not beautiful. In other  
2 words, it's not la dolce vita, the beautiful  
3 life that people envisage/fantasize about  
4 because their previous life was so difficult and  
5 in some cases traumatic. So it was part of a  
6 whole kind of complex constellation of factors  
7 that I had been talking about previously.  
8 MR. FISHER: I don't have any further  
9 questions.  
10 MR. ROSE: Just another hour, hour and a  
11 half maybe, Doctor. Doctor, it's 11 o'clock at  
12 night here. My boss is in my office and I have  
13 been told that if I ask you a single question, I  
14 will be fired on the spot, so I have no further  
15 questions.  
16 MR. FISHER: We'll take signature.  
17 AND FURTHER THE DEPONENT SAITH NOT.  
18  
19  
20  
21  
22  
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25

\_\_\_\_\_  
PROFESSOR DIANNA T. KENNY

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1 STATE OF INDIANA )  
2 ) SS:  
3 COUNTY OF HAMILTON )  
4 I, Brandy L. Bradley, RPR, a Notary Public in  
5 and for the County of Hamilton, State of Indiana at  
6 large, do hereby certify that PROFESSOR DIANNA  
7 T. KENNY, the deponent herein, was by me first duly  
8 sworn to tell the truth, the whole truth, and nothing  
9 but the truth in the above-captioned cause;  
10 That the foregoing deposition was taken on  
11 behalf of the Plaintiffs at the remote location of  
12 the witness, Sydney, New South Whales, Australia, on  
13 the 30th day of May, 2023, pursuant to the Applicable  
14 Rules;  
15 That said deposition was taken down in  
16 stenograph notes and afterwards reduced to  
17 typewriting under my direction, and that the  
18 typewritten transcript is a true record of the  
19 testimony given by said deponent, and thereafter  
20 presented to said deponent for his/her signature;  
21 That the parties were represented by their  
22 aforementioned counsel.  
23 I do further certify that I am a disinterested  
24 person in this cause of action; that I am not a  
25 relative or attorney of either party, or otherwise  
interested in the event of this action, and am not in

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1 the employ of the attorneys for either party.  
2 IN WITNESS WHEREOF, I have hereunto set my hand  
3 and affixed my notarial seal this \_\_\_\_ day of  
4 \_\_\_\_\_, 2023.  
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\_\_\_\_\_  
Brandy L. Bradley, RPR

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

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1 (Originating Party)  
2 Gaym M. Rose  
3 ACLU of Indiana  
4 1031 W. Washington Street  
5 Indianapolis, IN 46202  
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NOTICE OF DEPOSITION FILING  
UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF INDIANA  
INDIANAPOLIS DIVISION  
NO. 1:23-cv-00595-JPH-KMB  
K.C., et al., )  
Plaintiff(s), )  
-vs- )  
THE INDIVIDUAL MEMBERS OF THE )  
MEDICAL LICENSING BOARD OF )  
INDIANA, in their official )  
capacities, et al., )  
Defendant(s). )

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

-----  
(Date received by Circle City Reporting)  
CIRCLE CITY REPORTING  
135 N. Pennsylvania Street  
Suite 1720  
Indianapolis, IN 46204  
(317) 635-7857

	165:11	30:6;75:23	<b>advocating (3)</b>	<b>Alabama (8)</b>
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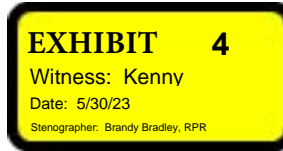
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## **Change or Suppression (Conversion) Practices Prohibition Act 2021**

**No.        of 2021**

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## No. of 2021

**The Parliament of Victoria enacts:**

## Division 1—General

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



Change or Suppression (Conversion) Practices Prohibition Act 2021  
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Part 1—Preliminary

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- (i) promote understanding of the prohibition on change or suppression practices under this Act and matters relating generally to change or suppression practices; and
- (ii) consider and resolve reports of change or suppression practices; and
- (iii) investigate serious or systemic change or suppression practices; and
- (c) to prohibit engaging in change or suppression practices, including through creating offences in relation to engaging in change or suppression practices and certain related activities; and
- (d) to amend the definitions of *sexual orientation* and *gender identity* in the **Equal Opportunity Act 2010**; and
- (e) to include sex characteristics as a protected attribute under the **Equal Opportunity Act 2010**; and
- (f) to make consequential amendments to certain Acts.

## 2 Commencement

- (1) Subject to subsection (2), this Act comes into operation on a day or days to be proclaimed.
- (2) If a provision of this Act does not come into operation within the period of 12 months beginning on the day on which this Act receives the Royal Assent, it comes into operation on the day after the end of that period.

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**3 Objects of this Act**

- (1) The objects of this Act are—
    - (a) to eliminate so far as possible the occurrence of change or suppression practices in Victoria; and
    - (b) to further promote and protect the rights set out in the Charter of Human Rights and Responsibilities; and
    - (c) to ensure that all people, regardless of sexual orientation or gender identity, feel welcome and valued in Victoria and are able to live authentically and with pride.
  - (2) In enacting this Act, it is the intention of the Parliament—
    - (a) to denounce and give statutory recognition to the serious harm caused by change or suppression practices; and
    - (b) to affirm that a person's sexual orientation or gender identity is not broken and in need of fixing; and
    - (c) to affirm that no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming; and
    - (d) to affirm that change or suppression practices are deceptive and harmful both to the person subject to the change or suppression practices and to the community as a whole.
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#### 4 Definitions

In this Act—

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

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

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

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

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

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

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

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

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

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

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

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

***enforceable undertaking*** means an undertaking accepted under section 43;

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

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

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

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

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

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

***investigation*** means an investigation under section 34;

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

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

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

- (a) is based in or outside Australia; or
- (b) is part of a larger organisation;

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

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

***produce*** includes permit access to;

***protected information*** has the meaning given by section 50;

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

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

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

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

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

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**5 Meaning of *change or suppression practice***

- (1) In this Act, a ***change or suppression practice*** means a practice or conduct directed towards a person, whether with or without the person's consent—
- (a) on the basis of the person's sexual orientation or gender identity; and
  - (b) for the purpose of—
    - (i) changing or suppressing the sexual orientation or gender identity of the person; or
    - (ii) inducing the person to change or suppress their sexual orientation or gender identity.
- (2) For the purposes of subsection (1), a practice or conduct is not a change or suppression practice if it—
- (a) is supportive of or affirms a person's gender identity or sexual orientation including, but not limited to, a practice or conduct for the purposes of—
    - (i) assisting a person who is undergoing a gender transition; or
    - (ii) assisting a person who is considering undergoing a gender transition; or
    - (iii) assisting a person to express their gender identity; or
    - (iv) providing acceptance, support or understanding of a person; or
    - (v) facilitating a person's coping skills, social support or identity exploration and development; or
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- (b) is a practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—
  - (i) to provide a health service; or
  - (ii) to comply with the legal or professional obligations of the health service provider.
- (3) For the purposes of subsection (1), a practice includes, but is not limited to the following—
  - (a) providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy;
  - (b) carrying out a religious practice, including but not limited to, a prayer based practice, a deliverance practice or an exorcism;
  - (c) giving a person a referral for the purposes of a change or suppression practice being directed towards the person.
- (4) For the purposes of subsection (1), a practice or conduct may be directed towards a person remotely (including online) or in person.

**6 Act binds the Crown**

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

**7 Contravention does not create civil or criminal liability**

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

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**8 Extra-territorial application**

- (1) This section applies if—
  - (a) a person engages in conduct outside, or partly outside, Victoria; and
  - (b) there is a real and substantial link between the conduct and Victoria.
- (2) This Act has effect in relation to the conduct as if it had been engaged in wholly within Victoria.
- (3) For the purposes of subsection (1), there is a real and substantial link with Victoria if—
  - (a) a significant part of the conduct occurs in Victoria; or
  - (b) the conduct occurred wholly outside Victoria, but the effects of the conduct occurred wholly or partly in Victoria.

**Division 2—Change or suppression practices are prohibited**

**9 General prohibition on change or suppression practices**

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

**Note**

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



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Part 2—Offences relating to change or suppression practices

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**Part 2—Offences relating to change or  
suppression practices**

**Division 1—Offences**

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

- (1) A person (**A**) commits an offence if—
- (a) A intentionally engages in a change or suppression practice directed towards another person (**B**); and
  - (b) the change or suppression practice causes serious injury to B; and
  - (c) A is negligent as to whether engaging in the change or suppression practice will cause serious injury to B.

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

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

- (2) A person (**A**) commits an offence if—
- (a) A intentionally engages in change or suppression practices directed towards another person (**B**); and
  - (b) any or all of the change or suppression practices, considered as a group, cause serious injury to B; and

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

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

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

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

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

- (a) A intentionally engages in a change or suppression practice directed towards another person (**B**); and
- (b) the change or suppression practice causes injury to B; and
- (c) A is negligent as to whether engaging in the change or suppression practice will cause injury to B.

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

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

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

- (a) A intentionally engages in change or suppression practices directed towards another person (**B**); and
- (b) any or all of the change or suppression practices, considered as a group, cause injury to B; and

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

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

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

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

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

- (a) A takes another person (**B**) from Victoria, or arranges for B to be taken from Victoria; and
- (b) A intends that a change or suppression practice directed towards B will be engaged in outside Victoria (whether by A or another person); and
- (c) a change or suppression practice directed towards B is engaged in outside Victoria; and
- (d) the change or suppression practice causes injury to B; and
- (e) A is negligent as to whether the change or suppression practice will cause injury to B.

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

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

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

- (a) A takes another person (**B**) from Victoria, or arranges for B to be taken from Victoria; and
- (b) A intends that change or suppression practices directed towards B will be engaged in outside Victoria (whether by A or another person); and
- (c) change or suppression practices directed towards B are engaged in outside Victoria; and
- (d) any or all of the change or suppression practices, considered as a group, cause injury to B; and
- (e) A is negligent as to whether any or all of the change or suppression practices, considered as a group, will cause injury to B.

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

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

**13 Offence of advertising a change or suppression practice**

(1) A person commits an offence if—

- (a) the person publishes or displays, or authorises the publication or display of, an advertisement or other notice; and
  - (b) the advertisement or other notice indicates, or could reasonably be understood as indicating, that the person or any other person intends to engage in one or more change or suppression practices, other than
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for the purposes of warning of the harm caused by such practices.

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

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

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

**14 Production of documents relating to advertising offence**

- (1) For the purpose of proceedings under section 13, the Commission may, by written notice, require any person to produce any documents specified in the notice to the Commission.
- (2) A person must not refuse, without reasonable excuse, to produce a document referred to in subsection (1) to the Commission.

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

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

**Division 2—General matters relating to offences against this Part**

**15 Corporate criminal responsibility for offence against this Part**

- (1) For the purposes of a proceeding against a body corporate for an offence against this Part, the following must also be attributed to the body corporate—
- (a) relevant conduct engaged in by an associate of the body corporate;
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- (b) knowledge of an associate of the body corporate;
- (c) intention—
  - (i) of the body corporate's board of directors; or
  - (ii) of an officer of the body corporate; or
  - (iii) of any other associate of the body corporate if a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the formation of that intention.
- (2) If an officer of a body corporate engages in conduct that constitutes an offence against this Part, the body corporate must be taken to have also engaged in conduct constituting the offence, and may be proceeded against and found guilty of the offence whether or not the officer has been proceeded against or found guilty of that offence.
- (3) In a proceeding against a body corporate for an offence against this Part brought in reliance on subsection (2), it is a defence to the charge for the body corporate to prove that it exercised due diligence to prevent the conduct engaged in by the officer.

**16 Who may bring proceedings for an offence under section 13**

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

- (a) the Commission; or
  - (b) a police officer; or
  - (c) a person who is authorised to do so, either generally or in a particular case, by the Commission.
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## **Part 3—Civil response scheme**

### **Division 1—Functions and powers of Commission**

#### **17 Functions and powers of Commission**

- (1) The Commission has the following functions—
    - (a) to develop and provide education in relation to change or suppression practices;
    - (b) to receive reports about change or suppression practices from any person;
    - (c) to request further information regarding reports of change or suppression practices from persons who make a report and persons or organisations alleged to be engaging in change or suppression practices;
    - (d) to determine appropriate responses to reports on the basis of information provided and the wishes of persons affected where those persons are involved in making reports;
    - (e) to offer education to persons and organisations engaged in change or suppression practices;
    - (f) to establish processes for facilitating an outcome in relation to matters in certain reports that meet the needs of persons affected by change or suppression practices;
    - (g) to focus on ensuring that persons affected by change or suppression practices receive support by directing them to appropriate support services;
    - (h) to support persons who are or may be victims of criminal offences under this Act to voluntarily report these to police.
  - (2) The Commission has all the powers necessary to enable it to perform its functions.
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**18 Functions of Commission—educative function**

- (1) The Commission must—
  - (a) establish and undertake information and education programs in relation to change or suppression practices; and
  - (b) promote and advance the objects of this Act and be an advocate for this Act.
- (2) The Commission must undertake programs to disseminate information and educate the public with respect to—
  - (a) the objects of this Act; and
  - (b) any other matters relevant to the provisions of this Act.

**19 Functions of Commission—research function**

- (1) The Commission may undertake research into any matter arising from, or incidental to, the operation of this Act that it considers would advance the objects of this Act.
- (2) The Commission may collect and analyse information and data relevant to the operation and objects of this Act.

**20 Commission may report on educative or research functions**

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



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**21 Functions of Commission—receiving reports and facilitating outcomes**

The Commission must—

- (a) receive reports under section 24 from persons affected by change or suppression practices (or persons acting on their behalf), or other persons; and
- (b) establish policies and issue procedures and directions on the manner in which such reports should be dealt with; and
- (c) in the case of a reports made by persons affected by change or suppression practices (or persons acting on their behalf), establish policies and procedures for the facilitation of an outcome in relation to the matters in the report.

**22 Staff of Commission**

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

**23 Delegation**

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

**Note**

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

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**Division 2—Reporting change or suppression practices to Commission**

**24 Reporting change or suppression practices**

- (1) A person affected by a change or suppression practice, or any other person, may make a report to the Commission in relation to an alleged change or suppression practice.
- (2) A report must be in the prescribed form (if any).

**25 Principles for responding to reports**

The principles for the Commission responding to reports are—

- (a) a response should be provided to the person who made the report; and
- (b) a response should be informed by the needs and wishes of persons affected by change or suppression practices; and
- (c) a response should be appropriate to the report; and
- (d) a response should be fair to all persons; and
- (e) a response should be consistent with the objects of this Act.

**26 Commission may request more information**

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

**27 Consideration of reports**

- (1) This section applies if, in considering a report, the Commission is satisfied that a person or organisation is engaging in, or has engaged in, a change or suppression practice.
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- (2) In responding to the report, the Commission must as far as practicable have regard to the following matters, to the extent that information about the matters is reasonably available to the Commission—
- (a) the wishes of the person or persons affected by the change or suppression practice;
  - (b) whether the change or suppression practice was a one-off event or a pattern of behaviour;
  - (c) the number of people affected by the change or suppression practice;
  - (d) the nature and extent of the harm caused by the change or suppression practice;
  - (e) any steps taken by a person or organisation to stop engaging in the change or suppression practice or to address the harms caused by the change or suppression practice.

**28 Responding to reports**

- (1) The Commission, after considering a report, may do one or more of the following—
- (a) offer targeted education to persons or organisations reported to have engaged in change or suppression practices;
  - (b) in the case of reports made by persons affected by a change or suppression practice, offer facilitation of an outcome in relation to the matters in the report;
  - (c) refer the report to another person or body under section 29;
  - (d) decline to respond to the report in accordance with section 30.
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- (2) Participation in facilitation of an outcome in relation to matters in a report is voluntary.

**29 Referral of reports**

- (1) Subject to subsection (3), if the Commission considers that a report relates to conduct that would be more adequately dealt with by another person or body, the Commission may refer the report to the other person or body.
- (2) The persons or bodies to which the Commission may refer a report include, but are not limited to, the following—
- (a) the Health Complaints Commissioner;
  - (b) the Australian Health Practitioner Regulation Agency;
  - (c) the Ombudsman;
  - (d) Victoria Police.
- (3) The Commission must not refer a report under subsection (1) without the consent of the person affected by the change or suppression practice to which the report relates, unless required to do so by a law dealing with mandatory reporting.

**30 Discretion to decline to respond to report**

The Commission may decline to respond to a report if—

- (a) the report refers to persons or organisations who can no longer be located; or
  - (b) the report relates to conduct in respect of which sufficient information is no longer available; or
  - (c) the report relates to conduct that has been adequately dealt with in another forum or would be more appropriately dealt with in another forum; or
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- (d) having regard to all the circumstances, the Commission considers it is not appropriate to respond to the report.

**31 Withdrawal from facilitation of an outcome**

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

**32 Agreements resulting from facilitation**

- (1) This section applies if, after the Commission facilitates an outcome in relation to a matter in a report, the persons engaged in the facilitation (the *parties*) reach agreement with respect to any of the matters.
  - (2) Any party may request that a written record of agreement be prepared by the parties or the Commission.
  - (3) A request must be made within 30 days after the agreement is reached.
  - (4) If a record of agreement is prepared by the Commission following a request under subsection (2)—
    - (a) the record of agreement must be signed by or on behalf of each party; and
    - (b) the Commission must certify the record of agreement.
  - (5) If a record of agreement is prepared by the parties following a request under subsection (2)—
    - (a) the record of agreement must be signed by or on behalf of each party; and
    - (b) on the request of a party, the Commission may certify the record of agreement.
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- (6) If the Commission certifies a record of agreement under subsection (4)(b) or (5)(b), the Commission must give each party a copy of the signed and certified record of agreement.
- (7) The refusal of the Commission to certify a record of agreement does not affect the validity of the agreement.

**33 Registration of agreements**

- (1) Any party to an agreement reached under section 32 may, after notifying each other party in writing, lodge a copy of the signed and certified record of agreement with the Tribunal for registration.
  - (2) Subject to subsection (3), the Tribunal must register the record of agreement and give a certified copy of the registered record of agreement to each party.
  - (3) If the Tribunal, constituted by a presidential member, considers that it may not be practicable to enforce, or to supervise compliance with, a record of agreement or part of a record of agreement, the Tribunal—
    - (a) in the case of a record of agreement, may refuse to register the record of agreement; or
    - (b) in the case of a part of a record of agreement, may refuse to register the part of the record of agreement that it considers may not be practicable to enforce, or to supervise compliance with.
  - (4) On registration, a registered record of agreement or a registered part of a record of agreement—
    - (a) is taken to be an order of the Tribunal in accordance with its terms; and
    - (b) may be enforced accordingly.
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- (5) The refusal of the Tribunal to register a record of agreement or any part of a record of agreement does not affect the validity of the agreement.

### **Division 3—Investigations**

#### **34 When investigation may be conducted**

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

- (a) that raises an issue that is serious in nature or indicates change or suppression practices that are systemic or persisting; and
- (b) that indicates a possible contravention of this Act; and
- (c) that relates to a class or group of persons; and
- (d) that would advance the objects of this Act.

#### **35 Commission to conduct investigation as it considers fit**

- (1) Subject to this Division, the Commission may conduct an investigation in the manner it considers fit.
- (2) In conducting an investigation, the Commission is bound by the principles of natural justice, unless otherwise expressly provided in this Division.

#### **36 Power to compel provision of information and production of documents**

- (1) If the Commission reasonably believes that—
    - (a) a person is in possession of information or a document that is relevant to an investigation; and
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(b) the information or document is necessary for the conduct of the investigation—

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

- (2) A notice referred to in subsection (1) must specify that the person must do either or both of the following within a reasonable period specified in the notice, or on a reasonable date and at a reasonable time specified in the notice—
- (a) give the Commission a document containing information required by the notice;
  - (b) produce to the Commission the documents specified in the notice.
- (3) A document referred to in subsection (2)(a) must be signed by the person or, in the case of a notice served on a body corporate, an officer of the body corporate.
- (4) If a document is produced to the Commission in accordance with a notice under this section, the Commission may—
- (a) take possession of the document; and
  - (b) make copies of the document or take extracts from the document; and
  - (c) retain possession of the document for as long as is necessary for the purposes of the investigation to which the document relates.
- (5) The Commission must allow a document retained under this section to be inspected, at all reasonable times, by any person who would be entitled to inspect the document if it were not in the possession of the Commission.
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**37 Power to compel attendance**

- (1) The Commission by written notice may require a person to attend before the Commission, at a reasonable time and place, to answer questions if the Commission reasonably believes that—
  - (a) the person has information that is relevant to an investigation; and
  - (b) the information is necessary for the conduct of the investigation.
- (2) A person who is required under this section to attend before the Commission—
  - (a) is entitled to be paid a reasonable sum for the person's attendance; and
  - (b) is entitled to have a legal or personal representative present.

**38 Compliance with notice requiring attendance or production of documents**

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

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

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

**39 Protection against self-incrimination**

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

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**40 Disclosure of identity of persons who give information or documents**

- (1) This section applies to a person who has given or who will give evidence, information or documents to the Commission as part of an investigation, whether or not the person is compelled to do so under section 36 or 37.
- (2) The Commission may give directions prohibiting the disclosure of the identity of the person, or prohibiting the disclosure of information that would be reasonably likely to identify the person, if the Commission considers that preservation of the person's anonymity is necessary—
  - (a) to protect the person's security of employment, privacy or any right protected by the **Charter of Human Rights and Responsibilities Act 2006**; or
  - (b) to protect the person from victimisation.

**41 Publication of evidence, information or documents**

- (1) The Commission may give directions prohibiting or limiting the publication of—
    - (a) any evidence given before the Commission or any information given to the Commission as part of an investigation; or
    - (b) the contents of any document produced to the Commission as part of an investigation.
  - (2) Subsection (1) applies whether or not a person was compelled to give the evidence or produce the information or document under section 36 or 37.
  - (3) In deciding whether or not to give a direction under subsection (1), the Commission must have regard to the need to prevent such of the following as are relevant to the circumstances—
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- (a) prejudice to the relations between the Government and the Commonwealth Government or between the Government and the Government of another State or a Territory;
- (b) the disclosure of deliberations or decisions of the Cabinet, or of a Committee of the Cabinet;
- (c) prejudice to the proper functioning of the Government;
- (d) the disclosure, or the ascertaining by a person, of the existence or identity of a confidential source of information in relation to the enforcement of the criminal law;
- (e) the endangering of the life or physical or psychological safety of any person;
- (f) prejudice to the proper enforcement of the law or the protection of public safety;
- (g) the disclosure of information the disclosure of which is prohibited, absolutely or subject to qualifications, by or under another Act;
- (h) the unreasonable disclosure of the personal affairs of any person or organisation;
- (i) the unreasonable disclosure of confidential commercial information.

**42 Outcome of an investigation**

- (1) After conducting an investigation, the Commission may take any action it considers fit.
  - (2) Without limiting subsection (1), the Commission may do any of the following—
    - (a) take no further action;
    - (b) enter into an agreement with a person about action required to comply with this Act;
-

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- (c) accept an enforceable undertaking;
- (d) issue a compliance notice to a person.

## **Division 4—Remedies**

### **43 Enforceable undertakings**

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

### **44 Register of enforceable undertakings**

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

### **45 Compliance notices**

- (1) If, following an investigation, the Commission believes that a change or suppression practice has occurred or is occurring, the Commission may issue a compliance notice to a person who is wholly or partly responsible for the change or suppression practice.
  - (2) A compliance notice must set out the following—
    - (a) the basis for the Commission's belief that a change or suppression practice has occurred or is occurring;
    - (b) the provisions of this Act (if any) that the Commission believes the person has contravened;
    - (c) the date by which the person must take or refrain from taking specified actions in relation to the change or suppression practice;
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- (d) the further action that the Commission may take if the person does not take or refrain from taking specified actions;
  - (e) that the person may apply to the Tribunal for review of the issuing of the notice or any term of the notice.
- (3) A person may, within 28 days of receiving the compliance notice, apply to the Tribunal for a review of the issuing of the compliance notice or of any term of the compliance notice.

**46 Failure to comply with enforceable undertaking or compliance notice**

- (1) This section applies if—
- (a) the Commission has accepted an enforceable undertaking from a person; or
  - (b) the Commission has issued a compliance notice to a person.
- (2) If the person fails to comply with the enforceable undertaking or the compliance notice—
- (a) the Commission may apply to the Tribunal to enforce the undertaking or the notice; and
  - (b) the Tribunal may make an order requiring the person to comply with the undertaking or notice.

**Note**

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

**47 Vicarious liability**

- (1) For the purposes of this Part, if a natural person engages in a change or suppression practice in the course of employment (including as a volunteer) or while acting as an agent—
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- (a) subject to subsection (2), both the natural person, and the employer or principal, as the case requires, are taken to have engaged in the change or suppression practice; and
- (b) the person towards whom the change or suppression practice was directed or another person may make a report under section 24 in respect of—
  - (i) the natural person; or
  - (ii) the employer or principal; or
  - (iii) both the natural person and the employer or principal.
- (2) The employer or principal is not taken to have engaged in the change or suppression practice if the employer or principal proves, on the balance of probabilities, that the employer or principal took reasonable precautions to prevent the natural person engaging in a change or suppression practice.

**48 Who may bring proceedings for an offence under this Part**

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

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

**49 Reports etc. that relate to organisations**

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

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- (a) the Commission may request information under section 26 from the president, secretary or other similar officer of the organisation; and
- (b) the Commission may offer targeted education to the president, secretary or other similar officer of the organisation; and
- (c) the president, secretary or other similar officer of the organisation may be a party to facilitation of an outcome for the purposes of Division 2 of this Part.

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Part 4—General matters

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## **Part 4—General matters**

### **Division 1—Secrecy**

#### **50 Definition**

In this Division—

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

- (a) in the course of performing functions or duties or exercising powers under this Act; or
- (b) as a result of another person performing functions or duties or exercising powers under this Act.

#### **51 Secrecy**

- (1) This section applies to a person who is or has been—
    - (a) the Commissioner; or
    - (b) a member of the staff of the Commission referred to in section 22;
    - (c) a person (other than a person referred to in paragraph (b)) acting under the authority of the Commission or the Commissioner.
  - (2) A person to whom this section applies must not, either directly or indirectly, make a record of, disclose or communicate protected information to any person unless —
    - (a) it is necessary to do so for the purposes of, or in connection with, the performance of a function or duty or the exercise of a power under this Act; or
-

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- (b) it is necessary to do so to prevent a credible and imminent threat of harm to one or more persons; or
- (c) it is necessary to do so to comply with a mandatory reporting obligation; or
- (d) the disclosure, communication or production is to a court in accordance with section 52; or
- (e) the information is already in the public domain; or
- (f) the information does not identify any person or organisation; or
- (g) all persons or organisations identified by the information have consented to the disclosure of the information.

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

**52 Disclosure to courts**

- (1) Subject to this section, a person to whom section 51 applies must not be required—
    - (a) to produce in a court any document containing protected information; or
    - (b) to disclose or communicate protected information to a court.
  - (2) Subsection (1) does not prevent a person to whom section 51 applies disclosing or communicating protected information or producing in a court any document containing protected information if the disclosure, communication or production —
    - (a) is necessary for the purposes of, or for a prosecution under or arising out of, this Part; or
    - (b) is required by an order of a court for the purposes of a criminal proceeding; or
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- (c) is with the consent of the person or organisation to whose affairs the information relates.

**Division 2—Provisions relating to certain proceedings**

**53 Commission not to prejudice certain proceedings or investigations**

- (1) The Commission must not perform the functions or duties or exercise the powers of the Commission under this Act in a manner that would prejudice any—
  - (a) criminal proceedings or criminal investigations; or
  - (b) investigations by the IBAC or the Victorian Inspectorate.
- (2) For the purposes of ensuring compliance with subsection (1), the Commission may consult any of the following—
  - (a) the Director of Public Prosecutions;
  - (b) the Chief Commissioner of Police;
  - (c) the IBAC;
  - (d) the Victorian Inspectorate.

**54 Person bringing proceedings presumed to be authorised to do so**

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

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**55 Commission may assist in proceedings as amicus curiae**

- (1) The Commission may assist a court or tribunal as amicus curiae in the following proceedings, with the leave of the court or tribunal—
  - (a) proceedings in which the Commission considers that the orders sought, or likely to be sought, may significantly affect the rights relating to change or suppression practices in relation to persons who are not parties to the proceedings;
  - (b) proceedings that, in the opinion of the Commission, have significant implications for the administration of this Act;
  - (c) proceedings where the Commission is satisfied that it would be in the public interest for the Commission to assist the court or tribunal as amicus curiae.

**Division 3—Annual report and review of Act**

**56 Annual report**

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

**57 Review of this Act**

- (1) The Attorney-General must ensure that an independent review of the operation and effectiveness of this Act commences 2 years after the commencement of this Act and is completed within 6 months.
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- (2) The Attorney-General must ensure that the review is conducted by a person who, in the opinion of the Attorney-General, possesses appropriate qualifications and expertise related to change or suppression practices.
- (3) The person conducting the review must consider the following—
  - (a) whether the criminal offences contained in this Act are effective;
  - (b) whether the civil response scheme is effective, including whether broader investigation and enforcement powers are required;
  - (c) whether a redress scheme should be developed.
- (4) A person who undertakes the review must give the Attorney-General a written report of the review as soon as practicable after completing the review.
- (5) The Attorney-General must cause a copy of the review to be laid before each House of the Parliament within 15 sitting days of that House after receiving the written report.

## **Division 4—Regulations**

### **58 Regulations**

- (1) The Governor in Council may make regulations for or with respect to the following matters—
    - (a) forms to be used for the purposes of this Act;
    - (b) any other matter or thing required or permitted by this Act to be prescribed or necessary to be prescribed to give effect to this Act.
  - (2) Regulations made under this Act—
    - (a) may be of limited or general application; and
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- (b) may differ according to differences in time, place or circumstance; and
- (c) may confer powers or impose duties in connection with the regulations on any specified person or specified class of persons; and
- (d) may apply, adopt or incorporate, with or without modification, any matter contained in any document, code, standard, rule, specification or method formulated, issued, prescribed or published by any person—
  - (i) wholly or partially or as amended by the regulations; or
  - (ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or
  - (iii) as formulated, issued, prescribed or published from time to time.

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

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

### **Division 1—Amendment of definitions**

#### **59 Definitions**

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

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

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

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

- (a) genitalia and other sexual and reproductive parts of the person's anatomy; and
  - (b) the person's chromosomes, genes, hormones, and secondary physical features that emerge as a result of puberty;"
- (3) In section 4(1) of the **Equal Opportunity Act 2010**, for the definition of *sexual orientation* substitute—
- "sexual orientation* means a person's emotional, affectional and sexual attraction to, or intimate or sexual relations with, persons of
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Part 5—Amendment of definitions in the Equal Opportunity Act 2010

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

**60 Attributes**

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

"(oa) sex characteristics;".

**Division 2—Transitional provisions**

**61 New Division inserted**

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

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

**197 Definitions**

In this Division—

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

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

**198 Conduct, disputes and investigations  
before commencement day**

(1) This section applies to—

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

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

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- (b) a dispute brought to the Commission before the commencement day that had not ended before the commencement day; and
  - (c) an investigation of the Commission that had not been finally determined before the commencement day.
- (2) The old Act continues to apply in relation to the conduct, dispute or investigation, as the case requires, as if the amendments made by Part 5 of the **Change or Suppression (Conversion) Practices Prohibition Act 2021** had not been made."



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Part 6—Consequential amendment of Acts

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**Part 6—Consequential amendment of Acts**

**Division 1—Amendment of the Equal Opportunity  
Act 2010**

**62 Obstructing Commission**

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

**63 False or misleading information**

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

**Division 2—Amendment of the Family Violence  
Protection Act 2008**

**64 Meaning of *emotional or psychological abuse***

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

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

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Part 6—Consequential amendment of Acts

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

#### **65 Meaning of *harassment***

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

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

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Part 7—Repeal of amending Parts

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## **Part 7—Repeal of amending Parts**

### **66 Repeal of amending Parts**

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

#### **Note**

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

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Endnotes

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## Endnotes

### 1 General information

See [www.legislation.vic.gov.au](http://www.legislation.vic.gov.au) for Victorian Bills, Acts and current authorised versions of legislation and up-to-date legislative information.

<sup>†</sup> *Minister's second reading speech—*

*Legislative Assembly:*

*Legislative Council:*

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

## CORRECTION

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

Lisa Littman

## Notice of republication

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

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

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

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

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



## OPEN ACCESS

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

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

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

### **Expanded discussion of qualitative analyses**

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



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

### Clarification of study design, methods, and related limitations

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

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

### Updated Information about recruitment

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

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

## Parental approaches to gender dysphoria and views on medical interventions

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

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

## Expanded discussion about limitations and biases

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

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

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

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

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

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

## Clarification of Fig 1

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

## Discussion of the ICD-11 change from “gender dysphoria” to “gender incongruence”

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

## Supporting information

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

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**EXHIBIT 8**

Witness: Kenny

Date: 5/30/23

Stenographer: Brandy Bradley, RPR

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# Coalition for the Advancement & Application of Psychological Science

## **CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD)**

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

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

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

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

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

### **Signatories:**

American Psychological Association (APA)

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

Society for a Science of Clinical Psychology (SSCP)

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

Society of Behavioral Medicine (SBM)

Society for the Psychological Study of Social Issues (SPSSI)

Association for Behavioral & Cognitive Therapies (ABCT)

National Association of School Psychologists

Council of University Directors of Clinical Psychology (CUDCP) Board

Asian American Psychological Association (AAPA)

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

MSU Research Consortium on Gender-based Violence

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

American Psychological Association, Division 22 Rehabilitation Psychology

New York Association of School Psychologists (NYASP)

Society for Community Research and Action (SCRA)

Society for the Study of School Psychology (SSSP)

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

Society of Personality and Social Psychology

Association for University and College Counseling Center Directors (AUCCCD)

Psychologists' Association of Alberta

Saint Louis University, Clinical Psychology Program

American Psychology-Law Society; Division 41 of APA

Michigan State University, Department of Psychology, Clinical Science Area

Psychologists in Public Service, American Psychological Association, Division 18

American Psychiatric Association

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

Society for Research in Child Development

National Association of Psychological Research and Graduation Programs

Council on Social Work Education

Stony Brook University, Clinical Psychology Program

Michigan State University Twin Registry (MSUTR)

Society of Counseling Psychology, Division 17, American Psychological Association

National Latinx Psychological Association (NLPA)

Anxiety and Depression Association of America

The Society of Clinical Psychology, APA Division 12

American Group Psychotherapy Association

University of Miami Department of Psychology

Portuguese Psychologists Association

Diverse Sexualities Research and Education institute

National Association of Social Workers

Puerto Rico Psychology Association

Association for Psychological Science

Connecticut Psychological Association

Howard Brown Health

American Association for Marriage and Family Therapy

British Columbia Psychological Association

World Professional Association for Transgender Health (WPATH)

Associations for Psychologists in Academic Health Centers

Nebraska Psychological Association

GLMA: Health Professionals Advancing LGBTQ Equality

Michigan Psychological Association

Arizona Psychological Association

New Hampshire Mental Health Counselors Association

Florida Psychological Association

Minnesota Association for Marriage and Family Therapy (MAMFT)

AIP— Italian Association of Psychology

Manitoba Psychological Society

Georgia Psychological Association

Vermont Psychological Association

Illinois Psychological Association

Delaware Psychological Association

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**EXHIBIT 22**

Witness: Kenny

Date: 5/30/23

Stenographer: Brandy Bradley, RPR

# PSYCHOTHERAPY FOR TRANSGENDER DECLARING ADOLESCENTS

**Dianna Kenny PhD MAPsS MAPA**

Professor of psychology (rtd), The University of Sydney  
Society for Evidence-based Gender Medicine

15 November 2021

## Four distinct groups

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

# Intake assessment



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





## TRANSITION, SELF HARM AND SUICIDALITY

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

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

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

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

## Mechanisms of social contagion

### ◦ Peer contagion

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



## Social contagion

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

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

## Mechanisms of social contagion

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



## Social contagion

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

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

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

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

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

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



## Family Constellation

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

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



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

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

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

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

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

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

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

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

## Sexual orientation

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



# ROMANTIC AND SEXUAL RELATIONSHIPS

## Majority of young GD adolescents

- (i) **have had no sexual experience (crushes from a distance, hand holding and kissing)**
- (ii) **disdain genital sex as “gross”**
- (iii) **are indifferent to loss of sexual function, fertility**
- (iv) **are confused about the nature of “trans” relationships e.g.,**

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



Anime character against a pansexual flag



## Case example: Artem, aged 15

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

### Of himself:

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

### Of his mother, Artem said:

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

### Of his father, Artem said:

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

## Internalized homophobia

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

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



## Conclusions



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





## CURRENT CONCEPTS IN GENDER AFFIRMING SURGERY FOR WOMEN IN TRANSITION

ONLINE EVENT

March 11th & 12th, 2021

### TRANSGENDER HEALTH

Moderated by Prof. Loren S. Schechter



**Transgender rights**  
**Dr. Jamison Green**



**Gender incongruence**  
**Prof. Christina Richards**



**Social acceptance**  
**Prof. Joz Motmans**



**Hormonal treatment**  
**Prof. Guy T'Sjoen**

### GENITAL SURGERY

Moderated by Dr. Marci L. Bowers



**Vaginoplasty: what is new?**  
**Prof. Stan Monstrey**



**20 years of surgery**  
**Dr. Iván Mañero**



**Montreal vaginoplasty**  
**Dr. Pierre Brassard**



**Failed vaginoplasty**  
**Prof. Miroslav Djordjevic**

### FACIAL SURGERY

Moderated by Drs. Shane Morrison & Devin Coon



**FGCS – state of the art**  
**Dr. Daniel Simon**



**Forehead and hairline**  
**Dr. Luis Capitán**



**Upper face feminization**  
**Dr. Christopher Inglefield**



**Rhinoplasty and lip lift**  
**Dr. Raúl J. Bellinga**



**Lower jaw contouring**  
**Dr. Javier G. Santamaría**



**Expectations in FGCS**  
**Dr. Jens U. Berli**

# Conclusions

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



TRANSITION could be

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

