

**IN THE UNITED STATES DISTRICT COURT FOR  
THE DISTRICT OF COLUMBIA**

ALISHEA KINGDOM, *et al.*, individually  
and on behalf of all others similarly situated,

*Plaintiffs,*

v.

DONALD J. TRUMP, et al.,

*Defendants.*

Civil Action No. 1:25-cv-00691-RCL

**DECLARATION OF LESLIE COOPER IN SUPPORT OF PLAINTIFFS' MOTION FOR  
AN UPDATED PRELIMINARY INJUNCTION AND TO STAY AGENCY ACTION**

I, Leslie Cooper, declare pursuant to 28 U.S.C. § 1746 that:

1. I am an attorney with the American Civil Liberties Union, attorneys of record for Plaintiffs in this action.

2. I submit this declaration in support of Plaintiffs' Motion for an Updated Preliminary Injunction and to Stay Agency Action. I have personal knowledge of the facts set forth in this declaration, and if I were called as a witness, I could and would testify competently to them.

3. I am counsel for Plaintiffs in *Keohane v. Dixon*, in the Northern District Court of Florida, case no. 4:24-cv-00434. In *Keohane v. Dixon*, Dr. Kristopher Kaliebe was deposed in that case on December 15, 2025.

4. Attached hereto as Exhibit A to my declaration is a true and correct copy of excerpts from the Deposition of Kristopher Kaliebe taken in *Keohane v. Dixon*, Case No. 4:24-cv-00434.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 29, 2026

*/s/ Leslie Cooper*

Leslie Cooper

# Exhibit A

1 couple of things. There are some things that I  
2 would have added to my new C.V.

3 Q Okay. So, the date on this report, if we  
4 can scroll back to the date page with the signature  
5 on page 69 of the PDF, is October 6th. October 6th.

6 I'm going to focus in on the topic of  
7 gender dysphoria. Have you added any publications  
8 on gender dysphoria since October, 2020 -- oh,  
9 October 6th, 2025?

10 A Yes. I think the most relevant publication  
11 was the Department of Health and Human Services,  
12 gender dysphoria report, which I was a coauthor on.

13 Q Okay. Anything else?

14 A In terms of just publications?

15 Q Just publications relating to gender  
16 dysphoria or transgender people.

17 A I don't know if my Obstacles To Progress  
18 article is on that C.V., but I'm guessing that it  
19 is. So, I believe -- I believe that the HHS report  
20 would be the only other addition.

21 Q Okay. So, you mentioned you've been a  
22 psychiatrist since I think you said 1999; is that  
23 right?

24 A I graduated in medical school in '99.

25 Q Okay. And when did you say you became a

1 psychiatrist?

2 A Well, I think most people would consider  
3 you to be a psychiatrist when you finish your first  
4 residency. So, I would -- I went -- I did general  
5 psychiatry for three years, and then I went into  
6 child. So, I went from general to child in 2002.

7 Q Okay.

8 A And then by some people's measures you're  
9 only fully minted in your profession when you're  
10 done with your fellowships. So, I finished my child  
11 psychiatry fellowship in 2004, and my forensic  
12 psychiatry fellowship in 2005. So, that was when my  
13 training ended.

14 Q Okay. And can you give an estimate of the  
15 number of patients that you've seen in your career  
16 for anything?

17 A Well, that's a good question, and it's  
18 difficult to estimate because we usually don't, you  
19 know, keep track, but I can -- I know that in my  
20 clinic in -- at the St. Charles Community Health  
21 Center, we did a chart review just before I left,  
22 and I average seeing 14 patients a day, per clinic  
23 day when I worked there, and I was at that clinic  
24 for 11 years, and I was two days a week for about  
25 half a day, and one day a week for half. So, I

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1 mean, I think those are all individual patients  
2 encounters. So, you know, some people -- obviously  
3 many of them were seen multiple times. Throughout  
4 all of my career I'd probably guess -- I mean,  
5 definitely over 10,000 patients.

6 Q Okay.

7 A It's probably closer to double that, I  
8 think would be a rough estimate in my head, but I --  
9 you know, that's probably a rough estimate, 20,000.

10 Q Okay. Thank you.

11 And can you give a rough estimate of  
12 pediatric versus adult patients among the patients  
13 you've seen over your career?

14 A Yes. I would probably estimate an 80/20 --

15 Q Uh-huh.

16 A -- split. Maybe -- or a quarter, 25/75. I  
17 think maybe more recently I've seen a higher  
18 percentage of adults. So, it may be now 25/75.

19 Q Okay. And I saw from your C.V. you have  
20 worked in juvenile correction settings; is that  
21 correct?

22 A Yes.

23 Q Have you worked ever in adult correction  
24 settings?

25 A Yes.

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1 Q Where was that?

2 A So, during my training I worked at the --  
3 at a correctional center in Louisiana when I was  
4 doing my forensic psychiatry fellowship. As part of  
5 correct -- forensic fellowships there's a  
6 requirement to train in correctional settings.

7 Q Uh-huh.

8 A And then I also worked for the Orleans  
9 Parish Prison, and during that time I was -- on two  
10 -- and really sort of two sort of separate  
11 occasions. First when I was living in Louisiana I  
12 did some coverage for -- at some other correctional  
13 facilities that they were contracted with. I  
14 remember Hunt was one of them. I don't know, you  
15 know, how this was -- I don't even think this is  
16 reflected on my C.V. because I was -- it was just a  
17 period of months of, you know, coverage sort of,  
18 because they ran out of --

19 Q Uh-huh.

20 A -- psychiatrists I guess to cover the  
21 facility.

22 And then somewhere again around 2018 or '19  
23 I was contacted -- I was also Orleans Parish -- I  
24 was contracted again with Orleans Parish Prison.  
25 So, I --

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1 but it has been typically through the places that I  
2 was employed with, like LSU Health Science Center or  
3 the University of South Florida. I have had some  
4 work outside, but it's usually contract work. So, I  
5 don't have a regular individual private practice.

6 Q Uh-huh.

7 A And nor have I ever had an individual  
8 private practice.

9 Q When you say, contract work, what does that  
10 mean? What kind of -- who was contracted?

11 A Correction -- some of my correctional work  
12 has been contract work.

13 Q Okay.

14 A So, that is not sort of flowing through.  
15 Like when you work at a university, you sometimes  
16 are not fully employed with them or you do something  
17 outside of the university.

18 Q Uh-huh.

19 A So, that's what I mean by contract work,  
20 that it just was work that I was doing independent  
21 of the university that I was also employed with at  
22 the time.

23 Q Uh-huh. Okay. So, now I've been asking  
24 you general questions about your work as a  
25 psychiatrist. I want to focus in on the patients

1 with gender dysphoria at this point.

2 Okay. And I've seen some of your past  
3 testimony, where you were asked about estimates, and  
4 I think the last time you testified was I -- it  
5 appears to be the -- I think the Cano case about a  
6 year ago; is that right?

7 A Yeah. As far as I recall, that was the  
8 last time I've testified in these matters, yeah.

9 Q Okay. So, sitting here today, December  
10 15th, 2025, what -- approximately how many patients  
11 with gender dysphoria have you seen in your career?

12 A Well, I think, you know, as I mentioned in  
13 the Cano case, the number was in the 20s, probably  
14 -- maybe it's more like 30 at this point --

15 Q Uh-huh.

16 A -- because I have -- currently have  
17 patients with gender dysphoria. So, that would --  
18 that would probably be -- I mean, 30 I think would  
19 be a fair estimate.

20 Q Okay. And of the patients you've seen  
21 approximately 30 patients with gender dysphoria, how  
22 many were adults versus pediatric cases?

23 A Yeah. Well, I'd say the majority would be  
24 pediatric cases. I've had some that have aged into  
25 adulthood while being seen --

1 Q Uh-huh.

2 A -- so, you know, they would be -- they  
3 would be young adults, and legally they're adults.  
4 And then there are patients in my outpatient  
5 resident clinic with gender dysphoria. So, there's  
6 probably, you know, a half dozen in that -- in that  
7 clinic or that I've seen in the -- in that clinic.  
8 So, that's a -- so, maybe there's -- for 18 years  
9 and over I'm guessing somewhere it would be like six  
10 or eight patients.

11 Q Okay. And of the 30 or so patients you've  
12 seen with gender dysphoria, how many have been in  
13 carceral settings?

14 A I would guess that that's a dozen --

15 Q Okay.

16 A -- perhaps even -- perhaps more than that,  
17 but maybe 15. Once again, you know, I'm sorry, you  
18 don't track things over time. And, so --

19 Q Uh-huh. So, about -- you think a dozen to  
20 15, nearly half of your 30 or so gender dysphoria  
21 patients have been in carceral settings?

22 A Yeah, that would be right.

23 Q Okay. And just to help clarify, and I can  
24 show you, if you need, at the time of your Cano  
25 deposition a year ago, I believe you said you had

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1 five patients with gender dysphoria you treated in a  
2 carceral setting. So, does that -- does that still  
3 sound about right? Do you think you had about ten  
4 more or eight more in the past year?

5 A Yeah. I mean, perhaps -- perhaps it is a  
6 -- yeah. I mean, my guess right now was more like  
7 12 or 15, I'm thinking, but I have had -- certainly  
8 have had at least five patients with gender  
9 dysphoria in the last year.

10 Q In the carceral settings?

11 A In those settings, yeah.

12 Q Okay. And of the dozen or 15 patients with  
13 gender dysphoria that you've seen in the carceral  
14 setting -- carceral setting, how many were adults  
15 versus minors?

16 A Well, the vast majority would have been  
17 under 18 because I -- since I'm working in juvenile  
18 correctional centers, people at those centers do age  
19 into -- you can be in a juvenile center up to age 21  
20 really. So, I believe -- there's at least two that  
21 aged in or were 18 at the time of treatment.

22 Q Okay. Understanding that at least two were  
23 -- turned 18 while being treated, of the dozen to 15  
24 patients with gender dysphoria that you've seen in  
25 carceral settings, were they all in juvenile

1 settings or were some of those dozen to 15 in adult  
2 settings?

3 A Right now I'm only working in juvenile  
4 correctional centers, so --

5 Q Okay.

6 A -- those are in juvenile settings.

7 Q So, all 12 to 15 were in juvenile settings?

8 A Correct. I don't remember -- as far as I  
9 remember, I don't remember seeing gender dysphoria  
10 in adult settings.

11 Q In adult carceral settings?

12 A Adult corrections, yes.

13 Q Okay. So, I want to now -- I was just  
14 focusing on the carceral settings. Now, I want to  
15 focus in on adult care that you've --

16 A Uh-huh.

17 Q I think you said -- well, actually I'm not  
18 sure I asked you this yet.

19 To save you time, I'm checking my notes.

20 Oh, I think you testified about six or  
21 eight of the -- about 30 patients with gender  
22 dysphoria were 18 or over; correct?

23 A Yes.

24 Q Okay. So, focusing in on that group of six  
25 or eight adults with gender dysphoria you've

1 treated, can you tell me what settings you saw them  
2 in?

3 A We just talked about some of them have --  
4 are 18, yet in juvenile corrections. And then  
5 there's an adult general psychiatry clinic that I  
6 work at. And then I work at Tampa General Hospital  
7 covering the hospital on the -- on the weekends.

8 Q Uh-huh.

9 A Right now those are the settings that I'm  
10 working in.

11 Q So, we're talking about six to eight  
12 adults. Can we break it down, how many you saw at  
13 the adult clinic? And is that the USF Clinic?

14 A Yes.

15 Q How many do you see there of the six to  
16 eight?

17 A I'd say the vast majority, so it's probably  
18 six or so then.

19 Q Okay. And then how many did you see at  
20 Tampa General of the six to eight?

21 A I would say that there's been two patient  
22 encounters. That's coverage. So, this is on-call  
23 coverage.

24 Q And that's counted in your six to eight  
25 patients you've seen who are adults with gender

1 dysphoria?

2 A Yes.

3 Q Okay. And then -- so, that gets you -- if  
4 there's about six at the USF Clinic, and about two  
5 in your Tampa General on-call coverage, is that --  
6 that's all of them?

7 A Yes.

8 Q Okay. And in the on-call coverage, that --  
9 would that just be one visit when you're on-call,  
10 and somebody needs to see a psychiatrist, and you  
11 see them that one time?

12 A Yeah, that's coverage at a major hospital,  
13 so it's what's called a consultation liaison  
14 service.

15 Q Uh-huh.

16 A So, you would either be covering someone  
17 that's already been seen by the service or it would  
18 be a new admission to the emergency room or someone  
19 on the floors of the -- of the hospital.

20 Q I see. Would that be a one-time --

21 A Yes. It would be, yes.

22 Q Okay. And at USF -- at the USF Adult  
23 Clinic where you said you saw about six adult  
24 patients with gender dysphoria, what is the nature  
25 of that clinical relationship? Is that more ongoing

1 or can you tell me a little about that?

2 A Yes. So, that's a resident clinic where  
3 you cover any sort of -- any incoming patients from  
4 the community that have just sort of wound up at  
5 that clinic by whatever referral system that they  
6 got there. So, it's a general full-service  
7 psychiatry clinic run by residents with attending  
8 supervision.

9 Q And, I'm sorry, did you say resident clinic  
10 or residential clinic?

11 A It's a resident, resident --

12 Q So, run by residents?

13 A The trainee -- yes. The trainees, and I  
14 supervise, and the patients are seen by the  
15 trainees.

16 Q Uh-huh. So, the six adult patients with  
17 gender dysphoria who you've seen at that clinic were  
18 being seen by residents who you supervised; is that  
19 correct?

20 A So, depending -- yes. The -- correct.

21 Q Okay. And is that ongoing treatment where  
22 someone comes in for weekly treatment or how often  
23 would they be with the clinic?

24 A So, it typically is ongoing treatment. So,  
25 there -- they can be longstanding patients. Some

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1 people stay in treatment for longer, some people are  
2 there for a shorter amount of time, but it could be  
3 years, it could be months --

4 Q Uh-huh.

5 A -- but it is typically not a one-time deal.

6 Q And of these six patients, adult patients  
7 with gender dysphoria that were at the USF Clinic,  
8 were all of them seen by residents or did you --  
9 were some of them your patients?

10 A Yes, we -- those are all seen at that  
11 clinic, and are seen by residents with my  
12 supervision.

13 Q And as the supervisor of the residents at  
14 that clinic who are providing treatment, do you meet  
15 with the patient as well?

16 A Yes. If they're a new admit or they're on  
17 -- depending on their insurance, that I would have  
18 to have a meeting with them if they're Medicaid or  
19 Medicare. If they have private insurance, then it  
20 may be that they're only seen by me during their  
21 initial visit. So, depending on the type of  
22 insurance I may see them every single time or they  
23 may be just seen by me initially, and then the  
24 resident follows up with them --

25 Q Uh-huh.

1           A    -- and presents the case to me, and then  
2    I --

3           Q    Okay.  So, of those six, were you involved  
4    in the initial evaluations of all of them or just  
5    some of them?

6           A    It would just -- it would depend.  Just  
7    some of them.  It sort of depends, did they show up  
8    to the clinic or are they new to the resident at the  
9    time --

10          Q    Uh-huh.

11          A    -- the year starts or are they already --  
12    have ongoing treatment, and it's just sort of being  
13    taken over, it could be either way.

14          Q    I see.  And of those six adult patients  
15    with gender dysphoria at the USF clinic that you  
16    referred to, how many did you provide therapy to  
17    yourself?

18          A    Those patients I have not provided direct  
19    -- well, when you say, therapy to, I -- you know, at  
20    that psychiatry clinic it is sort of a general  
21    psychiatry clinic.  So, I don't think therapy would  
22    be the ideal sort of description of what it is.

23          Q    Okay.

24          A    So, they're seen for, you know, holistic  
25    mental health care, and medication management, and

1 therapy, depending on what's needed. So, it's a --  
2 it is not a, quote, unquote, therapy clinic, where  
3 therapy is the emphasis of what we provide. We  
4 provide it, if needed, and -- but maybe -- or maybe  
5 not providing therapy, if not needed, if that's --  
6 if you understand.

7 Q So, would treatment be a better word than  
8 treatment --

9 A Yes.

10 Q -- if I asked that question again?

11 A Yes. Treatment would make more sense, yes.

12 Q Okay. And just to be clear, treatment  
13 could include medication; is that right?

14 A Yes.

15 Q Yes. And it could include therapy, if it  
16 was indicated?

17 A Yes.

18 Q What other treatments? I just want to make  
19 sure I understand the full range.

20 A You know, when you evaluate someone's  
21 mental health needs, there's many different possible  
22 things that you could provide to them.

23 Psychotherapy is typically seen as an in-depth  
24 exploration of a set of challenges or problems that  
25 a person wants to come in and specifically work on,

1 fit into psychotherapy and medication management in  
2 my type of clinics, and how I train the residents.

3 So, I just want to be clear that, yes,  
4 sometimes the words psychotherapy or medication  
5 management don't really, you know, cover everything  
6 we do.

7 Q Got you. And, so, at the USF Adult Clinic,  
8 is there a particular population or a particular set  
9 of issues that the clinic draws?

10 A No, it's a general clinic. So, we would  
11 just get whatever range of individuals from the  
12 community get to -- get referred to us.

13 Q Uh-huh.

14 A So, we take all type -- different types of  
15 problems.

16 Q Okay. And, so, going back to the six adult  
17 patients with gender dysphoria you referenced at the  
18 clinic, at USF, did you directly provide treatment  
19 of any kind to any of those six adults?

20 A Yes, in that I directly assessed or have  
21 seen them in person, and with the resident and, you  
22 know, came up with the treatment plan, so --

23 Q How many of them?

24 A Probably -- say probably two-thirds were  
25 seen, at least seen individually by me at either the

1 first time that I saw them, and then they were  
2 followed up or were -- their -- depending on their  
3 insurance they may need to be followed every time.

4 Q Uh-huh. So, were any of these six people  
5 you provided therapy to, psychotherapy?

6 A No, I would not be the psychotherapy  
7 provider in that case.

8 Q Okay. Would that be a resident?

9 A Yes. If that -- if a patient requires  
10 psychotherapy in the clinic, it would come through  
11 the resident.

12 Q Did any of those six patients require  
13 psychotherapy in the clinic?

14 A None of those six patients were coming to  
15 the clinic for psychotherapy or following up  
16 officially for psychotherapy. So, we were providing  
17 psychosocial supports and other types of assistance,  
18 but not what I would say traditional psychotherapy.

19 Q Uh-huh. For any of the six?

20 A Correct.

21 Q Correct. Okay. Did you see any of the --  
22 strike that.

23 You said you were involved in the  
24 assessment and treatment planning for about  
25 two-thirds of that group of six. Did you see any

1 one of the group of six more than once?

2 A Yes. So, many of them are ongoing patients  
3 that we're seeing month to month or -- or sometimes  
4 less often, it really depends on the acuity of the  
5 patient, what's going on, how often the resident or  
6 I feel they need to follow up with us, and how  
7 stable they are.

8 Q Uh-huh.

9 A So, yeah, they're ongoing -- that group is  
10 mostly ongoing treatment cases.

11 Q And -- but -- and maybe my question wasn't  
12 clear.

13 Were they seen more than once by you, Dr.  
14 Kaliebe, or as opposed to by residents and others?

15 A Yeah, I would say half of them would be  
16 ones that I see because of insurance reasons or, you  
17 know -- so, they have to follow up with me --

18 Q Okay.

19 A -- in addition to the resident.

20 Q Uh-huh. All right. Since this is a pretty  
21 small number of people, we can probably get a little  
22 more granular.

23 Of the six, were any of them coming to  
24 treatment for gender dysphoria?

25 A Well, how do you mean? How do you mean?

1 Q Well, so, maybe there's a different  
2 language you use in your field.

3 Do you talk about presenting conditions, is  
4 that an appropriate term?

5 A Yeah, I mean, I think if we're asking about  
6 what is -- what are their present -- I guess you  
7 could say presenting conditions or what are the, you  
8 know, problems or challenges that we're treating  
9 them for. If they're diagnosed with gender  
10 dysphoria, that's part of their overall picture, and  
11 would be part of our, you know, biopsychosocial  
12 assessment and treatment approach.

13 Q Uh-huh. And can you say what kind of  
14 presenting conditions these six adults came with?

15 A What other -- are you asking -- could you  
16 -- I'm not sure what you're asking.

17 Q Sure. So, of the six adults who have  
18 gender dysphoria that you referred to seeing at the  
19 USF Clinic, what kinds of presenting conditions did  
20 they come with?

21 MR. STEELY: Object.

22 A Presenting -- well, I mean, gender  
23 dysphoria would be a presenting condition.

24 BY MS. COOPER:

25 Q Uh-huh.

1 A Are you saying, what, in addition to gender  
2 dysphoria? I mean, I guess --

3 Q Yeah.

4 A -- we've already established that they have  
5 gender dysphoria.

6 Q Yes.

7 A So, that's one treatment.

8 You're saying what in addition to the  
9 gender dysphoria --

10 Q Yes.

11 A -- presenting treatment? Well,  
12 co-morbidities would include autism, psychosis,  
13 anxiety disorders, depressive disorders, personality  
14 disorders. I think within those that -- that range  
15 would be the ones that I have seen.

16 Q Uh-huh. But you mentioned none of those  
17 people are coming for psychotherapy at the clinic?

18 A They -- none of them were engaged in  
19 psychotherapy with us at the clinic. Some of them  
20 have therapists, but they may go to an individual  
21 therapist outside of the clinic.

22 Q Uh-huh. Okay. Of the six adult patients,  
23 you mentioned that about half because of their  
24 insurance you would see more often than just the one  
25 evaluation; correct?

1 A Correct.

2 Q Yeah. So, the other half you would just do  
3 the evaluation, and the treatment planning, but then  
4 the resident would be the one seeing them going  
5 forward?

6 A Yes.

7 Q Okay. So, for the half that you -- so,  
8 that would be about three that you saw more often.  
9 How long did you see those patients?

10 A Well, it would -- are you asking how many  
11 visits have you seen or are you asking how long have  
12 you spent per visit or -- I'm not sure what you're  
13 asking.

14 Q Sure. Well, let's start with how many  
15 visits.

16 A Uh-huh. Well, some patients would be  
17 ongoing. So, there may be a patient that -- you  
18 know, so some maybe I've seen three or four times,  
19 and they're in the process of continuing follow up.  
20 So, in terms of the ongoing -- and some have come to  
21 the clinic, and now, you know, I'm not sure -- you  
22 never really know in our business if they're coming  
23 back to the clinic. So, you've seen people, they're  
24 scheduled, you know, I haven't really scheduled.  
25 There's lots of residents. I don't know, you know,

1 are people really going to be seen again? Are they  
2 going to continue to follow up?

3 And then year to year if you are the  
4 supervisor for a case, they don't necessarily come  
5 back to your clinic. So, you may be someone's  
6 treatment provider for a year, and then they move on  
7 to a different, you know, attending supervisor  
8 because they get a new resident. You know, some  
9 residents keep patients for two years, that would  
10 probably be the -- be the maximum in our clinic.

11 So, some patients may have come and gone,  
12 and I saw them on -- you know, depending on how much  
13 they're following up, four occasions during the  
14 year. Some that would probably be the typical  
15 number, but maybe it would be more, six, if they're  
16 coming every two months. It would be 12 if they  
17 come every month, but I would say most of our  
18 patients are more like one to two months. So, I  
19 would say it's like six times a year would be a more  
20 -- depending on their acuity level, some are -- come  
21 more frequently than that. And then some are  
22 relatively stable, and are only seen every three  
23 months, so that would be four times.

24 Q So, understanding that every patient has a  
25 different routine based on their needs. For the --

1 I want to focus in on the patients with gender  
2 dysphoria.

3 So, you said there were about six, and half  
4 -- about half or three or so you've seen more than  
5 just at the evaluation time. Can you tell me how  
6 many times you've seen each of those three patients?

7 A I'm trying to -- you know. So, I would  
8 guess something about five times -- you know, three  
9 times for two of them, five times for one would be  
10 my -- would be my guess, something like that.

11 Q So, would -- so, just to put that together.  
12 For the three, somewhere between three and five  
13 times each?

14 A Yeah. And we're speaking only of the ones  
15 that need to follow up with me or that I've seen.

16 Q Yes.

17 A Okay. Yeah. Uh-huh.

18 Q Yes. Got you. And you anticipated my next  
19 question.

20 Of the other three or so who were seen by  
21 residents, how long are they being seen or how many  
22 visits have they had?

23 A I mean, there's -- there's some that have  
24 been -- had had more visits, and have been ongoing.  
25 So, some have been a higher number than that. I

1 would say maybe one that was more like eight or ten  
2 visits, and then two that were more like four, five  
3 visits.

4 Q Okay. And none of these six, though --  
5 just I want to make sure I didn't get confused.

6 None of these six were receiving  
7 psychotherapy from you or the residents at the  
8 clinic at USF; right?

9 A No, I would say that's not right. I think  
10 that there were of the -- of the patients who are --  
11 have been seen by the residents, that there are  
12 patients who did receive some psychotherapy from the  
13 residents. So, I do have some residents --  
14 supervision of residents who were seeing patients  
15 for psychotherapy.

16 Q Okay. So, of the group of six adults with  
17 gender dysphoria seen by the clinic, of the three  
18 that were seen by residents, some of those folks  
19 were receiving psychotherapy by the residents?

20 A These two patients that I remember did --  
21 were receiving psychotherapy from the resident.

22 Q Okay. And that would be -- do you recall  
23 -- well, you said of the three seen by residents,  
24 you estimated one of those patients was seen maybe  
25 eight to ten visits, and the other two about four to

1 five.

2 Do you recall whether the patients  
3 receiving psychotherapy were receiving it for four  
4 to five visits or eight to ten visits?

5 A Yes, sometimes the cases that you're -- you  
6 take over a resident, and they've already seen the  
7 patient, and, so, like at least one of the cases  
8 that I'm thinking of, the resident had a different  
9 supervisor the year before, and then I took over as  
10 a supervisor, and they continued with me, you know.  
11 So, they had already seen the patient a number of  
12 times --

13 Q Uh-huh.

14 A -- for psychotherapy, and medication  
15 management, and all of that, and then continued with  
16 me. So, I don't want to give the impression that  
17 the patient was only seen less times overall than  
18 they were seen, but in my supervisory capacity those  
19 were the numbers that I was giving you, if you -- if  
20 that makes sense.

21 Q It does.

22 Thank you for clarifying.

23 Okay. So, of these six adults with gender  
24 dysphoria that you referenced seen by the -- at the  
25 USF clinic, you have not provided psychotherapy to

1 any of those individuals; correct?

2 I didn't hear.

3 A I said, correct. You said to me directly  
4 provided psychotherapy --

5 Q Yes.

6 A -- yes, correct.

7 Q Okay. Got you. And then the other adult  
8 with gender dysphoria you mentioned were two people  
9 who you saw on-call at Tampa General; right?

10 A Correct.

11 Q But that was one visit --

12 A Correct.

13 Q -- for each?

14 A Yes.

15 Q Okay. So, switching gears from your adult  
16 patients, and focusing in on the pediatric patients  
17 or minors. By my math, you saw about 30 patients  
18 with gender dysphoria, and you said about six or  
19 eight were over 18, that would be 32 -- sorry, 22 or  
20 24 were minors; does that sound about right?

21 A Yes. Yeah. I mean, I'm getting a little  
22 confused with these numbers, so --

23 Q Yeah.

24 A Sorry, you know, I'm having trouble.

25 Q Yeah. Let me ask again.

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1 A I --

2 Q Let's make sure we're clear.

3 So, we have about -- you mentioned about 30  
4 patients that you've seen with gender dysphoria, and  
5 I believe you said about six or eight were 18 or  
6 older, and the rest were pediatric; does that -- did  
7 I get that right?

8 A Yeah. I'm kind of -- so, we're -- well, we  
9 would add the ones that we saw that we just  
10 discussed who were seen in the adult clinic, and  
11 then we would add the ones who were 18 at the time  
12 in the child -- seen in juvenile corrections, but  
13 were over 18. So, there's at least a couple in that  
14 -- in that category.

15 Q All right. And I want to make sure I'm  
16 clear. So, the total number, whether you -- when  
17 you don't try to tease out ages, it's about 30 is  
18 what you said; right?

19 A Uh-huh.

20 Q And then I get that somebody might be in a  
21 pediatric setting, but could be 18 or 19; right?

22 A Yeah.

23 Q Okay. So, when you were giving me the  
24 number of six to eight were adults, the ones you saw  
25 at the USF -- the six or so you saw at the USF

1 on the record is, yeah, I had a colleague ask me  
2 about, you know, the ability to consent for a young  
3 person, you know, considering puberty blockers.

4 Q Uh-huh.

5 A So, that -- I think I previously have  
6 testified regarding that. So, I also had that. But  
7 it was not a psychotherapy question, it was just a  
8 different question about care of a youth who would  
9 potentially, you know, go on to some medical  
10 therapies.

11 Q Uh-huh. Okay. But those -- that was the  
12 -- those three would be the examples of formal  
13 consults you had?

14 A Correct. Yes.

15 Q Okay. So, of the patients with gender  
16 dysphoria you saw at the juvenile corrections  
17 facilities or the USF Pediatric Clinic, were you  
18 providing psychotherapy to any of those youths?

19 A Yes. So, in juvenile corrections,  
20 depending on the setting, sometimes I'm in places  
21 where I, you know, spend more hours, and I'm able to  
22 do psychotherapy with certain patients. So, there  
23 were a number of patients who I've worked on in  
24 psychotherapy with gender-related distress or gender  
25 dysphoria diagnosis.

1 Q Uh-huh. And of those I think we said  
2 roughly 22 to 24 youths who -- with gender dysphoria  
3 that you've seen, approximately how many did you  
4 provide psychotherapy to?

5 A Well, to broadly speak I would say at least  
6 -- I would say a half dozen of the -- of the youth  
7 in corrections that I would -- that I provided  
8 psychotherapy for.

9 Q Uh-huh. And at USF, at the gender -- yeah,  
10 at the -- sorry, the pediatric clinic there?

11 A No, this is -- yeah, that's all in juvenile  
12 corrections, what I just said. And then I have one,  
13 you know, juvenile patient at USF that I had ongoing  
14 psychotherapy with.

15 Q Okay. So, just to be clear. When I asked  
16 how many of the juvenile patients with gender  
17 dysphoria you provided psychotherapy to, it was  
18 about a half dozen of youth and corrections, and one  
19 patients at USF Pediatric Clinic?

20 A Yeah.

21 Q Okay.

22 A Yes.

23 Q Thank you.

24 And what's the longest that you've spent --  
25 let me ask it differently.

1           What was sort of the longest  
2           psychotherapeutic relationship you've had with any  
3           of these seven or so youths with gender dysphoria?

4           A     The facility, Tampa Residential, which was  
5           where I'm spending the most clinical hours up until  
6           about two years ago, maybe a year and a half ago,  
7           maybe it was a year or so, they changed from a --  
8           they changed the level of facility. So, up until  
9           this change they were what in Florida would call a  
10          level eight facility, which was a minimum nine month  
11          stay. And then if things went not ideally, you  
12          could end up staying longer. So, you know, we were  
13          hoping to get the kids in and out by nine months,  
14          but if they don't do their work or get in trouble or  
15          whatever it could be longer.

16          So, I know in those patients in that  
17          facility, the nine months would be sort of your  
18          expected amount of time that they would be under my  
19          care, and that I'd be working with them. And, so,  
20          that would be the -- that would be some of them were  
21          in that facility.

22          Q     So, the half dozen or so youths with gender  
23          dysphoria you provided psychotherapy to in juvenile  
24          corrections, it would be nine months?

25          A     Nine months for some, six months for some.

1 you know, all sorts of other problems, trauma  
2 reactions. So, you know, like I said, it's  
3 difficult to disentangle what would be the primary  
4 treatment, so, the primary treatment target.

5 Q Okay. Let's take a break now. We've been  
6 going a little -- about an hour.

7 Is five minutes okay or do you need a  
8 little bit more?

9 A Five is fine with me.

10 Q All right. See you back at -- in five  
11 minutes.

12 Thank you.

13 (Thereupon, a recess was had at 10:38 a.m.;  
14 whereupon, we reconvened at 10:43 a.m.)

15 MS. COOPER: All right. We can go back on.

16 BY MS. COOPER:

17 Q One thing about your pediatric patients  
18 that I think I forgot to ask.

19 You had mentioned that of the 30 patients,  
20 I think we did the math, that about 22 to 24 were  
21 minors; correct?

22 A (No verbal response. The deponent nods his  
23 head up and down.)

24 Q Correct? Can you answer out loud?

25 A Yes.

1 Q You've been doing great. One nod there.

2 And then of those minors, you said about a  
3 dozen to 15 were in the juvenile corrections  
4 context; right?

5 A Yes.

6 Q Yes. Okay. And, so, that would mean about  
7 -- you know, the remainder eight, nine, somewhere in  
8 there would have been at Silver, the Silver Clinic  
9 at USF?

10 A Yes, although I'm not totally sure that  
11 that may not be a slight underestimate, I don't want  
12 to be -- so, if -- as we break down those numbers,  
13 the amounts seen at Silver, maybe that's a little --  
14 but it's in the ballpark, yes.

15 Q Okay. Great.

16 MS. COOPER: Sarah, if we can put up tab  
17 three, please, at page -- well, let's start at  
18 the cover page.

19 I'm going to -- we will be marking this as  
20 Exhibit 2, which -- I will be identifying it I  
21 should say as Exhibit 2, not marking.

22 (Plaintiffs' Exhibit Number 2 was  
23 identified and will be marked after the  
24 deposition is completed and/or received.)

25 BY MS. COOPER:

1 Q This is going to be a transcript of your  
2 deposition in the Dekker case.

3 And I'll ask you a few questions as soon as  
4 we have that up.

5 Okay. Can you see that or do we need to  
6 make it a little bigger?

7 A I can see it.

8 Q Okay. Let's see the date.

9 Does this look like your --

10 MS. COOPER: Scroll down a little bit just  
11 to see it.

12 MS. COOPER:

13 Q -- the deposition that you gave in the  
14 Dekker case?

15 A Yes.

16 Q Okay.

17 MS. COOPER: And scrolling back up to the  
18 top page. This was -- scroll down a little bit.

19 BY MS. COOPER:

20 Q We see the date there, March 20th, 2023;  
21 correct?

22 A Yes.

23 Q Okay. And just for the purpose -- for the  
24 court reporter, I think when you say, yes, sometimes  
25 you're saying it very softly.

1           A    It would depend on the context. I think  
2           there's some context where I'd feel it would be more  
3           appropriate to avoid just using -- I mean, you don't  
4           have to address someone by their, you know, name if  
5           they're in a -- but there -- there are times when I  
6           feel like it would be appropriate, and, yes, I would  
7           use the -- the name that they prefer, and the  
8           pronoun they prefer, but I think that's a clinical  
9           decision based on a patient in front of you.

10          Q    Okay.

11                MS. COOPER: If we can put up what we've  
12                identified as Exhibit 1 again, the expert report  
13                of Dr. Kaliebe. And I'd like to look at page 6.

14          BY MS. COOPER:

15          Q    Okay. There's -- paragraph 19 says, my  
16                recent publications related to gender dysphoria  
17                include.

18                MS. COOPER: And if you could scroll down  
19                slowly so Dr. Kaliebe can just -- oh, actually  
20                we can see them all; right? Almost.

21          BY MS. COOPER:

22          Q    So, these are all publications you've  
23                written about gender dysphoria; correct?

24          A    Correct.

25          Q    And you say recent ones, you had previous

1 publications on gender dysphoria as well?

2 A No, those are the -- those are the -- in  
3 medical journals, those are the only ones.

4 Q Okay. And the only thing since is the HHS  
5 report -- and I understand that's not a medical  
6 journal, but that's a publication that came out  
7 since this report; correct?

8 A Correct. Yeah. The finalized peer review  
9 article -- version is published.

10 Q Okay. And looking at the first one,  
11 Adolescent Onset Gender Dysphoria, Our Perspective,  
12 AACAP News, that's the American Academy of Child and  
13 Adolescent Psychiatry News --

14 A Correct.

15 Q -- is that right?

16 A Yes.

17 Q And this -- this was an opinion piece that  
18 you provided?

19 A Correct.

20 Q Okay. The next one, A Reply to Legal,  
21 Mental Health, and Societal Considerations Related  
22 to Gender Identity and Transexualism, Letter to the  
23 Editor, Journal of the American Academy of  
24 Psychiatry and the Law. That is a letter to the  
25 editor that you wrote?

1 A Correct.

2 Q Okay. And the following one is also a  
3 letter to the editor?

4 A Correct.

5 Q Okay. The question about the last one,  
6 Kozlowska, et al., including you, Obstacles To  
7 Progress and Pediatric Gender Medicine, European  
8 Journal of Developmental Psychiatry, was that a peer  
9 reviewed article?

10 A Yes.

11 Q And the -- this was a reviewed article that  
12 you wrote?

13 A Correct. I was a co-author on it.

14 Q Uh-huh.

15 A But, yes, I believe -- the journals title  
16 articles under different things for different  
17 journals. So, I'm not sure exactly what the  
18 official type of -- or category that the journal put  
19 it in, but I think a reviewed article would be --

20 Q Uh-huh.

21 A -- that probably would, you know, fairly  
22 suffice to describe it.

23 Q Okay. So, is this your only peer reviewed  
24 publication on gender dysphoria that's published in  
25 a scientific journal?

1 A The letters to the editor of the Journal of  
2 the American Academy of Psychiatry and Law are peer  
3 reviewed, they don't just publish a letter to an  
4 editor. You have --

5 Q Okay.

6 A -- to be reviewed to get into those. So,  
7 those are also considered peer reviewed articles.

8 Q Okay. So, let me ask it differently then.  
9 The Kozlowska, et. al., is that the only peer  
10 reviewed study or review that you've published in a  
11 peer reviewed journal?

12 A Yes.

13 Q Yes. Okay. And Kozlowska is about  
14 pediatric general medicine, as the title indicates;  
15 is that correct?

16 A It does. It covers a lot of issues that  
17 are important with -- for adult gender medicine  
18 also, but it is focused on pediatric gender  
19 medicine.

20 Q Uh-huh. Okay. So, have you -- oh, strike  
21 that.

22 Have you conducted any original research on  
23 gender dysphoria or transgender people?

24 A No.

25 Q Okay.

1 MS. COOPER: We can take down that, the  
2 exhibit for now.

3 BY MS. COOPER:

4 Q When did you first begin reading the  
5 literature, the scientific literature on gender  
6 dysphoria?

7 A Well, I think that to describe my evolution  
8 of knowledge regarding what we're currently calling  
9 gender dysphoria, you have to go back to my  
10 education, you know, even in medical school, and in  
11 residency which, you know, included different names  
12 for similar or if not exactly the same  
13 presentations. So, there was gender identity  
14 disorder. And during residency and adult  
15 psychiatry, and then in child psychiatry, and in  
16 forensic psychiatry you cover disorders of sexuality  
17 or sexual-related disorders or -- you know. So,  
18 depending on what the different organization or, you  
19 know, ICD versus DMS --

20 Q We're breaking up a little bit.

21 Is that -- is that --

22 A Am I back? Can you hear me okay?

23 MR. STEELY: I can hear you just fine.

24 MS. COOPER: Oops.

25 A Okay. Well, I'll keep talking if people

1 patients most of the time.

2 Q Okay. Let me -- let me -- thank you for  
3 that breakdown.

4 So, are you aware of any studies or  
5 evidence showing that adults with gender dysphoria  
6 are likely to overcome their gender dysphoria, more  
7 likely to overcome it if they are not able to  
8 socially transition?

9 A I didn't think that the matter has been  
10 studied. So, yeah, I don't think we have data one  
11 way or another on that.

12 Q Okay. And when you say that providing  
13 accommodations for social transition may enhance a  
14 patient's reluctance to receive psychotherapy, do  
15 you have -- is there evidence showing that people  
16 are unlikely to receive psychotherapy if they're  
17 able to socially transition?

18 MR. STEELY: Objection.

19 A Well, I think that all of this -- that  
20 question comes down to this really interesting  
21 dilemma that we have. If you have institutional  
22 support for the idea that mostly we should be going  
23 along with, and accommodating your, you know, cross  
24 sex ideas, then that will be helpful to you versus  
25 if an institution says, well, I think it's better

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1 environments people are in, the -- you know, it  
2 becomes then sort of frowned upon, and perhaps going  
3 against how people feel they should be treated to  
4 then, you know, engage in psychotherapy, right. So,  
5 there is a lot of stigmatization of psychotherapy  
6 within the professional community that -- like those  
7 -- like WPATH, and within those who follow that type  
8 of approach.

9 And, so, I think it happens, and I think it  
10 can make -- that it does make a difference with  
11 regard to engagement, what sort of stance, you know,  
12 institutions and mental health providers take  
13 regarding these things.

14 So, no, we don't have a lot of data on it,  
15 but I think it is reasonable to think that the --  
16 the willingness of an engagement for those with  
17 gender dysphoria, which is often difficult to get  
18 this special population to engage in substantial,  
19 you know, psychotherapy treatment can be underlined.

20 Q We don't have any data; right? It's not  
21 just that we don't have a lot of data --

22 A Uh-huh.

23 Q -- we don't have any data showing that --

24 A Uh-huh.

25 Q -- social transition makes people less

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1 likely to pursue psychotherapy; is that correct?

2 A Yes, it hasn't -- it hasn't been adequately  
3 studied, but I would say in my -- in my  
4 experience --

5 Q Okay.

6 A -- this -- this is a patient population  
7 that generally is reluctant to engage in  
8 psychotherapy.

9 Q And your understanding is that people who  
10 follow the WPATH standards are reluctant to provide  
11 therapy to their patients, and suggestions?

12 A Yeah, they're reluctant to provide what I  
13 would call, you know, high quality psychotherapy  
14 because there's a tension between saying that  
15 hormones and surgeries are the solution to your  
16 gender-related distress, and psychotherapy is the  
17 solution to your gender-related distress.

18 Q Uh-huh.

19 A So, those who are sort of more  
20 enthusiastically advocating for hormones and  
21 surgeries tend to be downplaying psychotherapy.

22 Q But you don't know how most providers are  
23 providing care, those who you would call affirming  
24 providers; right?

25 A I do know that I've been following the

1 dysphoria?

2 A Not that I -- not that I'm not aware of.

3 Q Okay. And I want to make sure I understand  
4 your view. Are you saying psychotherapy ought to be  
5 the exclusive treatment? I understand you -- well,  
6 let me -- let me rephrase.

7 I understand you say it should be the  
8 primary treatment. Is it your view it should be the  
9 exclusive treatment as well for gender dysphoria?

10 MR. STEELY: Object to form.

11 A Are you asking me about in correctional  
12 environments or --

13 BY MS. COOPER:

14 Q I'm asking in --

15 A -- in general?

16 Q Let me ask generally in the community.

17 A I do believe it should be the first line  
18 approach, and the primary approach. I don't --

19 Q Uh-huh.

20 A So, that's what I'm saying, it should be  
21 the first approach, and the primary approach.

22 Q But it should not necessarily be the  
23 exclusive approach in the community, psychotherapy?

24 A Correct.

25 Q Okay. But in the correctional environment

1 you believe psychotherapy should be the exclusive  
2 approach to gender dysphoria?

3 A Well, I believe as I've detailed in my  
4 report that I'm a -- I am -- I think that we can  
5 accept that certain exceptions are made to  
6 psychotherapy only, you know, especially under  
7 circumstances where someone has already presented in  
8 treatment.

9 Q Okay. And there are no studies, right,  
10 that demonstrate the effectiveness of psychotherapy  
11 alone to treat gender dysphoria; right?

12 A There are no studies demonstrating the --  
13 basically no studies demonstrate the effectiveness  
14 or ineffectiveness. It's not been studied.

15 Q Okay. So, is it your view that  
16 psychotherapy is effective at treating other mental  
17 health conditions, you believe they can be effective  
18 to alleviate gender dysphoria?

19 A Yes, I mean, in part I think the proven  
20 track record of helping individuals with all sorts  
21 of distress would include a very high likelihood  
22 that it would help individuals with gender-related  
23 distress. I don't see any reason why gender-related  
24 distress should be exceptionalized.

25 Q Uh-huh. Uh-huh. But there -- at this

1 point there's not evidence looking at that; is that  
2 correct?

3 A Basically one way or another there's not  
4 evidence, yes.

5 Q Uh-huh. Okay. And you cite an article by  
6 Hakeem about psychotherapy; right?

7 A Correct.

8 Q Yeah. Now, Hakeem is not suggesting that  
9 psychotherapy should be the exclusive treatment for  
10 gender dysphoria; right?

11 A Well, I would think -- I guess you would  
12 have to ask Dr. Hakeem about that. I don't believe,  
13 but I'm not a hundred percent sure what he  
14 recommends.

15 Q Well, in the article they recognize that  
16 homotherapy and gender conforming surgeries can be  
17 helpful for gender dysphoria; right?

18 A The article -- yeah, I'm not sure if his  
19 viewpoint has evolved since that time, but --

20 Q Uh-huh.

21 A -- yeah.

22 Q But in that article that's what he said?

23 A Yes.

24 Q Okay. Of your -- I think we said -- you  
25 said six to eight adult patients who you've treated

1 or had residents treat who have gender dysphoria,  
2 did any of those patients of their gender dysphoria  
3 resolve through psychotherapy?

4 A Well, I'm not aware of the outcome of some  
5 of the patients if they're no longer in the clinic.  
6 So, I don't know. And some already have ongoing  
7 treatment, and I would -- some have been medically  
8 treated already. So, none -- none have exclusively  
9 used psychotherapy as an approach. So, I -- so, no,  
10 I don't think that that's the case.

11 Q You say none of the six to eight patient  
12 --- adult patients with gender dysphoria that you or  
13 your residents have seen use psychotherapy as the  
14 exclusive approach?

15 A You asked about the adult patients?

16 Q Yes. Yes.

17 A Oh.

18 Q Is that correct?

19 A Correct. Correct.

20 Q Okay. Now, in your reports you offer  
21 various assertions about WPATH and WPATH's Standards  
22 of Care 8 based on documents from a WPATH production  
23 in a lawsuit in Alabama called Boe V. Marshall;  
24 right?

25 A Yeah, I mean, there's many lines of

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1 Q Uh-huh. And significant psychological  
2 distress for some inmates?

3 A Yes, I think especially in the short-term  
4 when they're -- when policies are changed, and  
5 someone is used to a certain policy. I think that's  
6 true with, you know, commentary policies much less  
7 something more, you know, impactful to inmates.

8 Q So, you don't disagree, I take it then that  
9 for someone with gender dysphoria the inability to  
10 socially transition and present to the world  
11 consistent with their gender identity, that that can  
12 help for some people improve their mental health?

13 MR. STEELY: Object to form.

14 A Well, I think it's a complex tradeoff that  
15 we're -- that we're contemplating individuals with  
16 gender dysphoria because the social transition I  
17 think for a large group of them would serve them to  
18 feel pleased and better, you know, in the short run,  
19 but may not help them in the long run, right. So, I  
20 mean, obviously this is an area that we need more  
21 study of how to get people to, you know, come to  
22 peace with their bodies that they have, but you can  
23 see that that would be a positive if someone was not  
24 upset about the body that they have, and exactly  
25 what institutional policies and other approaches

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1 lead to someone, you know, having less distress is a  
2 -- you know, a question that obviously we've been  
3 talking about it's a plus.

4 BY MS. COOPER:

5 Q So, in your view the goal for treatment of  
6 gender dysphoria is -- still should be helping  
7 people come to peace with the body they have?

8 A Well, I think, as we mentioned, there's a  
9 number of potential psychotherapeutic or other goals  
10 that you could, you know, reach with a patient, but  
11 I do think that at least some component of treatment  
12 would be to reduce gender dysphoria, that's a  
13 psychiatric disorder.

14 Q Uh-huh.

15 A So, if we can reduce that, that would be  
16 good.

17 Q Yeah. But at the moment we don't know if  
18 there's -- there's no evidence indicating whether  
19 psychotherapy can help reduce that dysphoria;  
20 correct?

21 A Uh-huh. Yes. But there's also very  
22 limited evidence on social transition.

23 Q Uh-huh.

24 A So, yes, there's a number and -- and the  
25 potential that there's some tradeoff that's high

1 iatrogenic or, you know, induced harm from  
2 continuing with the -- you know, with the social  
3 transition rather than working to accept the body  
4 that they have.

5 Q Even though we don't have any evidence that  
6 psychotherapy can help people come to accept the  
7 body that they have?

8 A Well, we have --

9 MR. STEELY: Object to form.

10 A We do have good evidence that in other  
11 disorders that they can. So, the evidence for  
12 something like a body dysmorphic disorder, CPT  
13 protocols are very effective. So, we -- and  
14 sebopsoriasis actually help also in that case. So,  
15 there's a number of other disorders where we do work  
16 with people to help accept their body, and work with  
17 the body, and get over body-related distress.

18 So, I think there is a good amount of  
19 evidence. And when you're talking about  
20 evidence-based medicine, especially in situations  
21 where the -- there's a lack of study in the  
22 particular disorder or problem that you're facing,  
23 then you look at all evidence, right. So, there's  
24 uncertain evidence regarding gender dysphoria of how  
25 to approach it, I think it's perfectly reasonable to