1 IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
2 CENTRAL DIVISION

3 DYLAN BRANDT, et al.,

4 Plaintiffs,
v. No. 4:21CV00450 JM
5
November 28, 2022
6 Little Rock, Arkansas
8:57 AM
7 LESLIE RUTLEDGE, et al.,

8 Defendants.

9 **TRANSCRIPT OF BENCH TRIAL - VOLUME 5**
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
10 UNITED STATES DISTRICT JUDGE

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23 *Proceedings reported by machine stenography. Transcript prepared utilizing computer-aided transcription.*

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1 (Proceedings continuing in open court at 8:57 AM.)
2 THE COURT: Are y'all ready?
3 MR. JACOBS: Your Honor, Defendants are ready to
4 call, I guess, our next witness, not our first witness. One
5 thing I wanted to check in on. So Dr. Regnerus is prepared to
6 testify remotely tomorrow, and I wanted to ask at what time the
7 Court could begin tomorrow with the hope that it could begin I
8 guess as early as we can make it happen. Because Dr. Regnerus
9 is testifying late in the evening from where he's located, so
10 just to avoid him having to run into testifying in the wee
11 hours of the early morning, if we could start as early as we
12 can. I recognize that --
13 THE COURT: I expect this will likely make everybody
14 cringe, but courthouse opens at 7:30.
15 MR. JACOBS: Could we -- I think he'd be available
16 to start at like 8:00.
17 THE COURT: That's fine. That would give everybody
18 time to get in the building and get settled and we could make
19 sure stuff is up.
20 MR. JACOBS: Okay. That's all the preliminary
21 matters that we have.
22 THE COURT: So with an asterisk, you've got my
23 entire week. What are your thoughts on how long you're going
24 to take?
25 MR. JACOBS: Our witnesses will be done Thursday and

1 we'll rest on Thursday.
2 THE COURT: I've got two sentencings, one at 1:00
3 and one at 2:00 on Wednesday. Those usually last 30 minutes,
4 so we're probably going to work a little later into lunch on
5 Wednesday.
6 MR. JACOBS: That won't be a problem, Your Honor.
7 THE COURT: And then it looks like I've got a lunch
8 hearing on the 1st. Okay. That's what is on my schedule other
9 than you guys. So are we ready to jump back in?
10 MR. JACOBS: We're ready, Your Honor. Defendants
11 will call Dr. Stephen Levine.
12 THE COURT: Sir, if you could come on the far side
13 of that silver rail. Good morning.
14 **STEPHEN LEVINE, DEFENDANTS' WITNESS, DULY SWORN**
15 DIRECT EXAMINATION
16 BY MR. CANTRELL:
17 Q Good morning, Dr. Levine.
18 A Good morning.
19 Q Can you state your name and spell it for the record.
20 A Stephen, S-t-e-p-h-e-n, Barrett, B-a-r-r-e-t-t, Levine,
21 L-e-v-i-n-e.
22 Q Thank you. Dr. Levine, can you tell us what academic and
23 clinical positions that you currently hold?
24 A I am clinical professor of psychiatry at Case Western
25 Reserve University. I'm a staff psychiatrist in a group

1 private practice outside the university at this point.
2 Q How long have you held those positions?
3 A Well, I started at Case Western Reserve in my residency
4 in 1970. I became assistant professor in 1973 and full
5 professor in 1986, I think perhaps 1984, and I've been seeing
6 patients throughout that time.
7 Q Dr. Levine, I'll ask you to speak a little bit more
8 directly into that microphone if you will. Dr. Levine, do you
9 have a CV?
10 A I do.
11 Q Okay.
12 Your Honor, may I approach?
13 THE COURT: Sure.
14 BY MR. CANTRELL:
15 Q Dr. Levine, if you will, I've handed you a binder. If
16 you would, turn to tab number one which should be Exhibit No.
17 1. Do you recognize this as your CV?
18 A I do.
19 Q Does your CV contain a listing of your publications and
20 other professional activities?
21 A It does.
22 Q Do you have any subsequent publications that are not
23 listed on your CV?
24 A I'm sure I do. On March 17th of this year, I published
25 with two colleagues a paper called *Reconsidering Informed*

1 *Consent for Transgender Identified Children, Adolescents and*
2 *Young Adults*. That article had four invited commentaries, and
3 subsequently my coauthors and I wrote two separate responses to
4 those commentaries. So in addition, there's an article coming
5 out in press on this topic of gender dysphoria. So probably
6 there are four or five different additional papers that are not
7 listed in this.
8 Q Are you aware of any impact that your Reconsidering
9 Informed Consent article has had?
10 A I'm sorry?
11 Q Are you aware of any impact that --
12 A Oh, as of yesterday morning, that article was downloaded
13 45,870 times throughout the world which means that it's in the
14 top 5 percent of articles read in all branches of science and
15 it is the number one article most often downloaded from the
16 individual journal that it was published in. So that article
17 has had widespread dissemination across the world.
18 Q Dr. Levine, can you tell us about your history and
19 experience treating patients with gender-related psychological
20 conditions?
21 A In 1974, a colleague and I in Cleveland started the first
22 gender identity clinic in Ohio and we've been seeing patients
23 in one form or another in one iteration of that clinic or
24 another since that time. We lost count in 1989, I think. We
25 had 325 patients that we had seen over those years from 1974 to

1 1989, and we continued -- after I left the university, we
2 continued our gender identity clinic under a different name.
3 And so in the early years, almost all the patients were adults.
4 Some of them were older teenagers, 20 years old, 19 years old,
5 but most of them were adults. And in recent years, the vast
6 majority of patients that we have seen are young people,
7 adolescents primarily, and sometimes parents bring in younger
8 children to us.
9 I should say that gender identity disorders are only one
10 aspect of my clinical interest. Over the years, I've been
11 interested in all things involved humans and sexuality. So
12 I've been involved with sexual dysfunction, marital
13 relationships as well as general psychiatric problems of adults
14 and teenagers.
15 Q Dr. Levine, have you previously supported your adult
16 patients' efforts to obtain medical interventions for gender
17 dysphoria?
18 A Yes. In those years, early years when almost all of our
19 patients were adults, many of them requested and obtained
20 hormones. And some of them requested and obtained various
21 forms of surgery.
22 Q I'll ask a similar question for minors. In the past,
23 have you supported patients' efforts to obtain medical
24 interventions for gender dysphoria for minors?
25 A Well, I think of minors as in two categories, prepubertal

1 minors and postpubertal minors, and so we have certainly
2 evaluated and offered psychotherapy services to families of
3 children who were prepubertal. And we have occasionally done
4 that, I mean not -- I'm sorry, but for adolescents or
5 postpubertal children, we have on occasion given cross-sex
6 hormones. We have never administered in any of our clinics
7 puberty-blocking hormones.
8 Q Dr. Levine, have you formed conclusions concerning the
9 safety and efficacy of treatment of minors with gender-related
10 psychological conditions?
11 A Well, many of the adolescents that we see have associated
12 psychiatric conditions. Our experience is pretty typical
13 across the world. So we have attempted to both assess those
14 conditions and consider with the families and the patients what
15 can be done about those things. That's a psychological
16 approach of prolonged assessment and psychotherapy and trying
17 to address the underlying problems. On occasion, we have
18 supported the idea that when a child is old enough, which in
19 our state is usually 18, if they still would like to have
20 hormones, I have personally written letters supporting that
21 process.
22 Q That's once they reach 18 do I understand?
23 A Yes. Or yes.
24 Q So does that represent a shift in your view?
25 THE COURT: Doctor, let me interrupt you for a

1 minute because you were talking about adolescents when you
2 spoke, and then he -- Mr. Cantrell asked you about over 18.
3 That's not jiving in my head.
4 THE WITNESS: Well, I think of adolescents, Your
5 Honor, as things that end in teen, and psychologically
6 adolescents we generally think ends at 20, 21. So a 19 year
7 old is an adolescent to me. The age of majority for medical
8 consent in Ohio, I think, is 18.
9 THE COURT: Got it. So the problem I'm having with
10 figuring out what your opinion is is your definition of
11 adolescent is straddling the age of majority in Arkansas, so
12 you're talking about post-pubescent as an adolescent that would
13 range from, I don't know, what was your number? We'll just
14 pick a number.
15 THE WITNESS: Well, the vast majority of the
16 patients that we see that are what I call postpubertal are far
17 less than 18.
18 THE COURT: I understand. That's what I'm trying to
19 decide. You were mentioning adolescents in your opinion just
20 now, and Mr. Cantrell said are we talking about anybody over
21 18. I'm having trouble deciding how far or the scope of your
22 opinion, because you said adolescents, he's saying adults.
23 There's a overlap between 18 and 19 for adolescent adults which
24 I'm having to wrap my head around a little bit. Not that I
25 don't agree with you, that there's some people who are over 18

1 that act like what I consider adolescents, but what I need to
2 focus in on is what is the scope of your opinion. Are we
3 talking about adults or are we talking about people who are
4 under 18?
5 THE WITNESS: I will try to confine my use of the
6 word "adolescent" to those 17 and younger.
7 THE COURT: Thank you. That'll help me.
8 BY MR. CANTRELL:
9 Q Dr. Levine, if I can just summarize what I think your
10 testimony is, and please let me know if this is correct. That
11 you do not currently recommend medical treatments for patients
12 who are under the age of 18?
13 A Correct.
14 Q Can you broadly outline the information that you have
15 considered in coming to that conclusion?
16 A Well, I've been following the psychiatric or I've been
17 following the literature of gender dysphoria since 1973, and so
18 my opinions are based on what is published in the literature
19 and a critical evaluation of what is published in the
20 literature and, of course, my accumulated experience since 1973
21 and 1974 with these patients.
22 Q And in forming your conclusions, did you rely on sources
23 of information that are widely used in your field?
24 A Yes, the papers that I mentioned, the paper that has been
25 downloaded across the world so often, it was a critical

1 evaluation of the two papers that are most widely used by the
2 organizations that support the medicalization or affirmative
3 care of adolescents. So I've certainly used the data that are
4 the basis of affirmative care. Affirmative care being perhaps
5 a euphemism or way we talk about medicalization of teenagers
6 with hormones and surgery.
7 MR. JACOBS: And, Your Honor, if the plaintiffs will
8 not be interested in voir diring the witness, I'll forego any
9 further investigation into Dr. Levine's qualifications.
10 THE COURT: Okay. That's fine. Doctor, I've got
11 one more question. Mr. Cantrell said that you don't currently
12 recommend medical treatments for patients who are under the age
13 of 18. Medical treatments in my opinion would include any
14 hormones or any medicine at all. Can you tell me what you mean
15 by recommending any medical treatment for patients under 18?
16 THE WITNESS: I was speaking in a very narrow sense,
17 Your Honor, of puberty-blocking hormones and cross-sex
18 hormones. So if it's a biologic male, we generally, we do not
19 now prescribe estrogens for that trans identified person. And
20 if it's a biologic female, we don't generally prescribe
21 testosterone for 17, 16 year olds, 15 year olds. But we give
22 insulin. I mean, I don't give insulin, but --
23 THE COURT: I understand that you prescribe, but may
24 not inject. But I'd understood your description of your
25 clinical practice to include some medical treatment for people

1 under the age of 17.
2 THE WITNESS: And as a psychiatrist, I treat for
3 anxiety and depression and psychosis and substance abuse.
4 THE COURT: Right. That's why I was having again a
5 little disconnect with the scope of the comment, but I'm on
6 track now. Thank you.
7 THE WITNESS: Could I just ask if I could have a
8 water?
9 THE COURT: Sure.
10 BY MR. CANTRELL:
11 Q So Dr. Levine, just to try to tie a bow on it and to
12 summarize what you've said that you do not support or recommend
13 puberty blockers or cross-sex hormones for patients under 18
14 with gender identity related conditions; is that correct?
15 A That's what I said, yes.
16 Q Okay, thank you. Dr. Levine, can you tell us what is
17 gender dysphoria and why does it matter how we treat
18 adolescents with gender dysphoria?
19 A Well, gender dysphoria refers to the incongruence between
20 one's identity as -- one's gender identity as being different
21 than the sex of the body. Depending on the criteria --
22 depending on the nosology or the classification systems that
23 are being used in America, the DSM-5-TR is a classification
24 system that requires and defines gender dysphoria as distress
25 over the incongruence between one's current gender sense of

1 self and one's body and often is associated with the desire to
2 have the secondary sex characteristics and to portray -- of the
3 opposite sex, and to portray one's self in society as a member
4 of the opposite sex.
5 Gender dysphoria implies and requires, according to that
6 diagnosis, distress or perhaps we should call that a kind of
7 suffering. But there is another classification system used in
8 Europe called the ICD-11 now, and it does not require the
9 presence of distress, it just requires the aspiration to live
10 as a member of the opposite sex. This is all complicated not
11 only by the fact that we have two different classification
12 systems in the world to define gender, to define this problem,
13 but also the fact that the form of gender identity variations
14 that are showing up in the last ten years have gone from the
15 previous distress over not being a member of the opposite sex
16 to defining one's self broadly as either having we call
17 nonbinary, that is I'm neither male nor female, I am a
18 combination of male and female or I'm neither male nor female.
19 And that's evolving.
20 It's been an interesting thing to watch in the last ten
21 years, the rapid evolution of the sense of an atypical gender
22 identity, but generally in America we refer to gender dysphoria
23 as a distressful condition where there's a mismatch between the
24 biologic sex and its sexual characteristics and one's sense of
25 gender identity. That is, my body and I don't match.

1 Q Dr. Levine, can you tell us how -- can you explain how we
2 treat minors with gender dysphoria shapes their chances of
3 living a happy and healthy life?
4 A So the real issue here is the consequences of gender
5 change. When I use the term "affirmative care", I'm referring
6 to giving cross-sex puberty-blocking hormones, cross-sex
7 hormones in various surgeries, removal of the breast, removal
8 of the testes, removal of the penis and of the ovaries, of the
9 uterus and so forth. So the consequences of these affirmative
10 medical treatments in adolescents are going to be a consequence
11 for the rest of that person's life. And so when 13 year olds
12 and 14 year olds say that I never want to have children, I
13 can't possibly live in this body, they are predicting or
14 they're asking for, and the medical profession, that is
15 affirmative, is cooperating with sterilizing them, with giving
16 them characteristics of the opposite sex which will affect
17 every aspect of their life in adult life.
18 And what we're talking about is cooperating with a
19 passionate view that a 13, 14, 15, 16 year old or sometimes
20 even younger has about their future, and they really have very
21 little concept of what their future holds. So we think that
22 there needs to be a lifelong perspective about the consequences
23 of gender change in adolescents and even earlier of younger
24 minors. So what I'm saying is that based upon my clinical
25 experience that the treatment of adolescents and younger people

1 with gender dysphoria needs to have a lifelong perspective, we
2 need to be thinking about what we know about adults with
3 transgender identities and what medical and psychological and
4 social problems they have before we start administering
5 hormones to 15 year olds.
6 Q Dr. Levine, can you just tell us briefly what is it that
7 is known about adults who have gone down that road?
8 A Well, every public health study of transgender
9 communities of adults recognizes that they are disadvantaged in
10 terms of healthcare, they have more substance abuse, they have
11 shortened life expectancies, they have more vocational
12 problems, they're on disability more often than the general
13 population, and trans communities are often looking for
14 continued psychiatric care and at rates that are higher than a
15 general population. And the sad part is that even after --
16 there's evidence that even after total -- doing everything that
17 doctors and surgeons can do for people, they still have a
18 higher suicide rate than the general population.
19 So if you look at all cause mortality, if you look at
20 completed suicides, if you look at the incidence of cancer, of
21 heart disease, all these things are higher in the adult trans
22 communities. And the ironic thing is that all the articles
23 that specify these things are urging more trans care, which is
24 a very hard thing for me to get my head around when we see that
25 the profile of the health and the social problems of adult

1 trans communities are so problematic and then we have a group
2 of people who are arguing for giving younger people -- putting
3 them on a pathway to join that community of problems. And so
4 I'm looking -- I'm one of the people who say wait a second, one
5 of the things we need to think about when we're considering
6 giving hormones and reinforcing and supporting the idea that
7 you can live a happy, successful life as a trans person is to
8 look at the lives of adults who are trans.
9 I'm not talking about picking out one person who's
10 successful or five people who are successful but look at the
11 public health data. The public health data which has been
12 published in very reputable journals all recognize that the
13 trans community is a problematic community in terms of public
14 health parameters. And this has been known probably for at
15 least ten years. So what we have here is this idea that we
16 have advocates who are saying let's full speed ahead, take
17 every child who says that they're trans or nonbinary and let's
18 support them and tell them that they can have a happy,
19 successful life, we'll remove their sexual organs, we'll cause
20 sterility for them, we'll change their social patterns of
21 intimate relationships and at the same time we know that
22 marriage rates and sexual dysfunction and even physical health
23 parameters are all problematic, that is, the risk of problems
24 are far greater in the trans communities in adult life.
25 So this is part of the basis of my worry, my public

1 health worry about what we're doing to young people.
2 Q Dr. Levine, do you care for your transgender patients?
3 Do you have care and concern for your transgender identifying
4 patients?
5 A Yes. I actually think that the things I'm talking about
6 is in their best interest for them to consider what they're
7 doing from a long term life cycle perspective. I've heard 15,
8 16-year-old patients tell me that won't happen to me. How they
9 can be sure that won't happen to me. One of the patients who
10 said don't worry, I'm very smart, Dr. Levine, that won't happen
11 to me is now deceased at age 18 from fentanyl overdose. And
12 when I was seeing him, this person wasn't using anything but
13 marijuana, but he went to college as a transsexual and couldn't
14 get a roommate so they assigned him a roommate of another
15 transsexual person but only two trans persons in the college
16 and they didn't get along and he transferred schools. And he
17 went to a new school and he made three overdoses and the third
18 one was fatal.
19 So I know there are people who do well as trans people at
20 least for a long period of time. And I'm not saying every
21 trans person is problematic, believe me, I'm not, but in
22 thinking about the fate of the patients who are coming to see
23 me in teenage years, I'm aware of the adult trans people I've
24 taken care of for 30 years. And so I'm worried and so I am in
25 my view caring for these people. I'm caring for their long

1 term interests. I'm caring for their human potential. I'm
2 caring for them as people.
3 Q Dr. Levine, can you tell us -- shifting gears slightly,
4 can you tell us what changes have been observed to the number
5 of patients presenting with pubertal onset dysphoria compared
6 with early childhood onset dysphoria in the past 10 to 15
7 years?
8 A Well, there has been a dramatic and poorly explained
9 rapid increase in the incidence of people who are transgender
10 identified. The Tavistock Clinic took care of -- in 2005,
11 2006, the Tavistock Clinic, I think, had in one year, nine, and
12 over the course of five years, about 50 people from the UK and
13 then about 12 years later, they had 2750 some people. In other
14 words, there has been a dramatic increase in the request for
15 trans-related affirmative services, or at least psychiatric
16 evaluations over the course of 10 or 15 years. It used to be
17 in the previous century and the early part of this century, it
18 used to be there were 3.5 biologic males who wanted to be
19 females for every biologic female who wanted to be males.
20 And today the vast -- the typical person presenting for
21 help as a biologic female who wants to be or labels herself a
22 trans male in some clinics, it's seven females, biologic
23 females to biologic males to every one biologic male now. So
24 the overall incidence is much closer now to one to one because
25 of the rapid increase both in males who want to be females and

1 in females who want to be males. But the explanation for this
2 is something we can only speculate about.
3 But there has been a dramatic change in the number of
4 girls who were never cross-gender identified as children, and
5 that is in grade school who around puberty get this idea that
6 they would prefer to be a male. And that's been happening in
7 Australia and in Europe and in North America and I believe in
8 Asia as well.
9 Q Can you tell us how these rapid demographic shifts bear
10 on the question of whether gender dysphoria is socially or
11 culturally influenced?
12 A Well, I believe the biology doesn't change that much in
13 15 years. Our genes and how they operate, the program for the
14 human life cycle doesn't change that much, and I don't think
15 that the distress of children or pubertal children is that
16 different. What is different is the social interpretations of
17 what it means to be distressed around puberty about one's body,
18 about one's bodily functions and about one's roles that they
19 see that older people have. And so children are redefining
20 their sense of self in terms of this trans ideology today and
21 their beliefs that many of them believe that this is
22 biological, it has nothing to do with what they're going
23 through as 12 and 13, 14 year olds.
24 And it just doesn't make scientific sense that we
25 suddenly have a change, suddenly biology is rearing its head in

1 dictating a trans identity. As many people have come to
2 realize that teenagers and now especially during COVID when
3 teenagers were at home have spent a great deal of time on the
4 internet and we believe that the internet has many
5 opportunities to learn about trans life, and we think this has
6 been an influence on the rising incidence of transgender
7 identities.
8 But I can say that while I could go on and speculate
9 about why there has been this increase, I don't really think
10 that science can tell you why. We can speculate and various
11 people have various speculations. Some people think it's a
12 social contagion from the internet, other people think it's a
13 social contagion from friends, close relationships, especially
14 among girls who have a friend who's trans. Some people think
15 that it's a retreat from adverse life experiences and family
16 disruptions and inability to like both parents or love both
17 parents, but these are all speculations, and I doubt since
18 there are so many people involved with this that we would find
19 one explanation that would explain everything.
20 We need to understand that in mental health work and
21 trying to grasp what happens to people who become who they
22 become and why, that we can't ever find one explanation for
23 things. Things are multifactorial, so I think this phenomenon
24 must be multifactorial as well, but it is a dramatic worldwide
25 change in how young people are identifying. And they're not

1 identifying as transsexuals like they were in 1990, for
2 example. The majority of them are identifying in something
3 that they call nonbinary. They're neither male nor female,
4 they're somewhere in between and they recognize that they're
5 evolving. And I like the term "gender fluid" because it talks
6 about the processes of becoming.
7 Now, as we know from general psychology, adolescence is a
8 period of time where there are dramatic changes between puberty
9 and the end of adolescence, we'll call that 18 for our
10 purposes. There are dramatic changes in many aspects of
11 identity, and gender identity is just one aspect of that change
12 from youth or childhood to the end of adolescence. The
13 great -- the leaders in this field like Erik Erikson have said
14 that one of the tasks of adolescence was to clarify sexual
15 identity.
16 And sexual identity today is known to include three
17 aspects: Gender identity, which we're discussing today;
18 orientation, which we haven't mentioned yet, that is whether
19 I'm homosexually attracted or heterosexually attracted or
20 bisexually attracted, and what I call the intention component,
21 that is what interests me sexually in what I do with my
22 partners, whether I'm just conventional or whether I'm a little
23 on the kinky side or sadomasochistic side, for example. So
24 those are the aspects of identity that are known to evolve in
25 all human beings as we go from say 11 or 12 to 18 and if you

1 will, older, 21 or even older.
2 Q Dr. Levine, what's the state of the evidence concerning
3 the existence of a brain structure that causes gender
4 dysphoria?
5 A Well, there's been a lot of speculation over the years
6 whether this is biological, and if it's biological, is it in
7 hormones, is it something caused by prenatal hormones, and for
8 years that has been investigated. We've never made any
9 progress to demonstrate that it's a hormonal phenomenon, so the
10 next thing was, is it a brain structure. And the most recent
11 article on this which was published in 2021 from an Italian
12 group summarized the state of being that there's nothing
13 specific about the brain that can be said to be the cause or
14 the antecedent of gender dysphoria.
15 And all the studies are complicated by the fact that many
16 of them with patients who were already on hormones and hormones
17 themselves may have caused brain abnormalities, and one can't
18 distinguish changes in the brain that may be due to homosexual
19 orientation from changes in the brain that may be due to either
20 the treatment of or the presence of a gender dysphoria.
21 So it's inconclusive. And I think -- I've been in trials
22 where the other expert witness has testified that this is a
23 brain structure problem, and even though the data by the people
24 who are experts in this cannot conclude that, there are
25 individual studies that suggest that possibly this is true, but

1 these are older studies that the MRI -- there's newer
2 technology that comes out all the time, but the most recent
3 studies which were published in 2019 and again last year, are
4 very conservative in their conclusions, so I would say that as
5 of today, we have no right to think that this is -- that the
6 brain structures of transgender identifying teenagers are
7 distinctly different and we cannot say this is the prelude, the
8 neurophysiologic or neuroanatomical prelude to future gender
9 identity -- gender dysphoria.
10 We have to separate preferred ideas and speculations from
11 what science knows. Science does not know that there's a brain
12 structure that causes either in males or females a transgender
13 identity or gender dysphoria or gender incongruence, depending
14 on which classification system you prefer.
15 Q So we've discussed some of the social influences that may
16 affect gender dysphoria. Can you talk a little more
17 specifically about what social factors influence pubertal onset
18 gender dysphoria, for example?
19 A I think exposure to the internet and transgender sites, I
20 think early life bonding difficulties. Transgender identities
21 are much more common in foster children, for example, than in
22 non-foster children, children in home. I'm sorry. I think I
23 lost my place. Would you repeat your question?
24 Q Sure. I was asking about social factors that influence
25 pubertal onset gender dysphoria.

1 A By social, we want to separate things that are in society
2 as a whole, celebrities, fashion. Clothing fashion has become
3 the -- Madison Avenue picks up on these kind of things and so
4 clothing styles, entertainment in the media, and what is taught
5 at schools, these are all part of the environment of the child
6 that is called social, but also determinative social force are
7 the social forces within the family. And so when there are
8 disruptive bonds between mother and child and father and child,
9 when there is violence in the home, when there is sexual abuse
10 in the home, these are all social factors that we can separate
11 from the psychological impact of those social factors, you see.
12 The best we can do is to list the megasocial factors, the
13 media, fashion industry, the entertainment industry, what's in
14 the paper, social movements, political movements that are going
15 on, the celebration, the celebration of a trans life as a
16 diverse life and as a part of an ideology of including more and
17 more people in the right to have a full life without
18 discrimination. How that impacts on the brain of a developing
19 child, none of us are sure.
20 Then there are the social factors that involve the bonds
21 between parents, the things that go on in the family, that
22 which is admirable and that which is not admirable in one's
23 parents and grandparents and aunts and uncles and so forth.
24 And we have the child's understanding of what it means to be a
25 male and what it means to be a female, you see. These are all

1 factors that are outside the child but they impinge upon the
2 child. And none of us, none of us know exactly how those
3 things are going to influence in any individual child, but the
4 fact that they're there and the fact that we have an explosion
5 of incidence of transgender identity across the world must mean
6 that some of the things that are happening around us in the big
7 system, not the family system, must be interacting with the
8 things that are happening in the family system to produce the
9 psychological changes that are somewhat unpredictable. I
10 should say are always somewhat unpredictable for your child and
11 my child.
12 Q And what can you tell us about differences in
13 susceptibility to social influences as between boys and girls?
14 A Well, I can only suspect that it must be more difficult
15 in today's age when in the larger social influences where
16 there's been so much emphasis, and rightly so, on how women's
17 lives have been constrained by societal concepts and in the
18 last 20, 30 years, women have developed all new -- there are
19 many new opportunities for women to do what they're able to do
20 and what they want to do and many of these kids I think have
21 seen the fact that women have been discriminated against and
22 women have been held back by social concepts, and so girls --
23 girls going into puberty not liking their bodies and the body's
24 physiologic functions for a while and seeing the social
25 discrimination or the barriers that women have may in fact make

1 them more vulnerable to deciding that it's no good to be a
2 woman and it's better to be a man.
3 I'm speculating, you see. I think the answer to your
4 question always is going to be a speculation. Various people
5 who have studied this have said that it's not clear why girls
6 are more vulnerable these days to being trans. I wish I could
7 tell you definitively the answer to your question. I think
8 about that a lot, but I realize it's just Dr. Levine's
9 thinking. It's not science.
10 Q Dr. Levine, are you familiar with what has been called
11 the desistance studies?
12 A What was the first part of the question?
13 Q Are you familiar with what has been called the desistance
14 studies?
15 A Yes, I know about desistance.
16 Q Just to develop the question a bit, can you tell us about
17 those class of studies and the patient population that they
18 pertain to?
19 A Yes. Well, desistance has several meanings. The most
20 dramatic meaning of desistance is somebody who has identified
21 and lived as a trans person who decides to return to living in
22 consonance with their biologic sex. And the desistance as we
23 know it today is appearing, data are appearing about the rates
24 of desistance and the desistance studies of people -- well, I'm
25 sorry, I have to divide the answer to the question of

1 desistance of minors who have been identified as cross-gender
2 children or gender dysphoric children versus people who have
3 been treated for trans with affirmative care in adolescence.
4 So among the first group, that is the minors who are
5 cross-gender identified, the desistance studies, there have
6 been 11 desistance studies and each of the 11 studies have
7 shown that the majority of children who are cross-gender
8 identified who are not socially transitioned or given any
9 hormones and so forth, these children desist, the majority of
10 these people, by the time they're adolescents or at the end of
11 adolescence, the vast majority of these children have returned
12 to living a gender identity in keeping with their biologic sex.
13 But the second group of desistance studies involve the
14 people who have been given affirmative care, most of these
15 people are people who did not have a trans identity during
16 grade school years, and the couple of studies that are
17 available from the UK, within 16 months, 6.9 percent of kids
18 had desisted and another 3 percent looked like they were
19 desisting and yet another study showed people who got hormones
20 first at age 20, that up to 30 percent of them had desisted in
21 five years, that is, had returned to not taking hormones and
22 seemed to live again in their -- in a way that's consistent
23 with their biologic sex.
24 So what we're having now is a group of people -- and the
25 famous study about this is by Lisa Littman who recently

1 published accounts of 100 people who desisted and the stated
2 reasons for it. But the awareness of desistance is a
3 contraversion of the idea that I used to hear a lot of from
4 affirmative care advocates that gender identity is not only
5 biologic but it's immutable. That is, it's unchangeable, and
6 once a transgendered person, always a transgendered person. So
7 we have these desistance studies. We have these people who no
8 longer live that way.
9 I published a study a few years ago of a man that saw me
10 when he was a junior in college and he lived as a woman for 30
11 years and desisted and came back to see me 30 years later to
12 help return to living as a male. So anecdotally, that is,
13 individual doctors have these experiences with desistance, but
14 now we have studies that are beginning to show the rate of
15 desistance and we suspect that desistance is going to be much
16 more common in the future as we have exploded in the number and
17 the way we treat these teenagers without adequate assessment
18 and adequate attempt to provide them with help with some of the
19 problems that they're having.
20 Q Dr. Levine, you mentioned the 11 research studies that
21 indicated a high rate of desistance. Are you aware of attempts
22 to discount applicability of that research?
23 A Oh yes. The big issue in the attempt to discount that
24 research was that some of these kids that were cross-gender
25 identified were subthreshold for the diagnosis at the time was

1 called Gender Identity Disorder of children. And so the data
2 was reanalyzed and it still showed that the people who met the
3 criteria, all the diagnostic criteria that's called the DSM-IV
4 criteria in those days, they desisted at the rate of
5 67 percent, and the ones that were subthreshold desisted at the
6 rate of 93 percent. So it stands that the majority of children
7 who are cross-gender identified who are not socially
8 transitioned who are not encouraged in this will desist, that
9 is, will return to the fact that they are reasonably happy
10 living in their biologic sex.
11 Now, what you should know about all this is that studies
12 in the 1980s have demonstrated that gender atypical children
13 grow up at a far greater rate to be homosexual men or lesbian
14 women or bisexual adults. It's not that cross-gender identity
15 does not have a consequence, that is, it isn't a prelude to
16 something. The natural history of strong cross-gender identity
17 is to develop a homosexual or bisexual orientation in
18 adolescence and adult life. And so this leads to some concerns
19 that by medicalizing or socializing a 4 year old or 6 year old
20 or an 8 year old into the opposite gender presenting them the
21 opposite gender, what we're really doing is trying to get rid
22 of homosexual people, and that this does not seem right to many
23 of us.
24 The natural history of cross-gender identity is to
25 largely become a gay adolescent, a gay and lesbian adolescent.

1 And what we're doing is then if we medicalize them, if we give
2 them a diagnosis and put them on a track to socialize them in
3 school as the opposite gender and then give them
4 puberty-blocking hormones and then cross-sex hormones and then
5 take off their breasts or their penis and their scrotum and so
6 forth, what we're really doing here is interfering with the
7 natural development of homosexual orientation. And what we're
8 doing is putting them on a course that they're going to need
9 medical care and be more susceptible to medical illnesses
10 including benign -- some incurable things like gallbladder
11 disease and the need for surgery for gallstones.
12 So this whole idea of what I'd say premature
13 decision-making without understanding of the lifetime
14 consequences of this includes the not understanding that these
15 are likely to be homosexual children, young homosexual
16 adolescents and adults when they grow up. And what's wrong
17 with that. You see, why would we medicalize, why would we
18 change that natural evolution of cross-gender identifications
19 are a prelude, statistically significant prelude to adolescent
20 and adult orientation of homosexual nature.
21 Q Shifting gears here. Dr. Levine, let's talk about the
22 two primary treatment models for gender dysphoria. So can you
23 tell us what are the two primary models of therapy for
24 adolescents with gender dysphoria?
25 A The most -- there are two. One is a profound and

1 thorough psychiatric assessment that would lead to family and
2 individual psychotherapy and the other is the gender
3 affirmative model.
4 Q Tell us about the psychotherapeutic approach to minors
5 with gender-related psychiatric conditions.
6 A As I may have already mentioned, a vast majority of these
7 children and adolescents have recognizable problems with
8 anxiety, socialization, depression, ADD, and a very large
9 percentage of them are autistic or on the autistic spectrum
10 disorder. So some of them as well, some of the older ones like
11 15 year olds are already heavily using marijuana. And anyway,
12 if you look at any one of those things, the anxiety, the
13 depression, eating disorders, evidence of self-harm,
14 suicidality, substance abuse, autism, ADD, learning
15 disabilities, and so forth, all those things need some kind of
16 attention from a mental health professional.
17 When they have gender dysphoria along with those things,
18 there is this tendency to think all these things are going to
19 get better if we can transition the child. The child has this
20 passionate notion that they are trans and that they need and
21 want and fervently desire hormones and they can't possibly live
22 their life in their sex bodies. So the psychiatric or the
23 psychotherapeutic approach begins with a competent, slow
24 psychiatric assessment of all the associated problems and an
25 attempt to interest both the parents and the -- because we're

1 talking about minors here, the parents have to be involved,
2 both the child and the parents in cooperation with seeing what
3 we can do to understand how each of these problems got
4 manifested, what were the antecedents and what can we do about
5 it.
6 Now, as you know -- I'm sorry, you may not know, but the
7 incidence of childhood adversity among this group is very high,
8 so when they have been physically abused or sexually abused or
9 they've had disruptive -- disruptions between their mother and
10 their father and themselves and so forth, we tend to talk about
11 the child's development, help them understand what they feel,
12 give them words for what they feel and work through the events
13 that happened to them when they were younger from the point of
14 view of their now more mature 18, 14 year old, 15 year old
15 sensibilities, their understandings of life, so this process is
16 not an attempt to change their gender identity, it's an attempt
17 to help them with what we call comorbidities.
18 And I can tell you, Your Honor, that other psychiatric
19 problems that children face are all treated -- primarily the
20 first step are treated with an assessment and psychiatric
21 individual and family interactions. Gender dysphoria seems to
22 be the exception. If a child presents with gender dysphoria,
23 we bypass all that problem and sometimes within one hour, some
24 affirmative therapists are saying to the parents your child is
25 gender dysphoric and the treatment should be hormones or

1 socialization in the opposite gender. And this does not make
2 any sense to people who have practiced psychiatry for years and
3 understand that transgender people are human beings first.
4 They're not trans people first, they're humans first.
5 And when they have all these psychiatric challenges, they
6 deserve the standard psychiatric care which involves a thorough
7 assessment and opportunities to consider what lies behind this
8 anxiety, what lies behind this self-harm, what lies behind this
9 suicidality, these thinking and thoughts of suicide, why are
10 you depressed, what is the explanation of why you can't make
11 friends, why you're so unhappy as a person, why you're so
12 pessimistic. This is just what I consider to be and others
13 consider to be good psychiatric care.
14 Q Can you tell us how psychotherapy could be helpful with
15 respect to minors' perceptions of what it means to be a male or
16 what it means to be a female?
17 A Well, an 8 year old or a 12 year old's concept of what
18 the range of male -- of acceptable behavior for men, what
19 acceptable behaviors -- what behaviors are acceptable to be a
20 man is very limited in a young person. I've had many a patient
21 in the early years when I asked why do you want to be a woman
22 and the answer comes out to be something close to, well, I have
23 all these feelings and I want to express my feelings and my
24 sisters can express their feelings, but in my family, we can't
25 express our feelings if we're male. I'm not saying that that's

1 the explanation for all transgenderism. I'm just saying that
2 children have a very limited concept of the possibilities of
3 what they can be in the world.
4 We can be thoughtful, compassionate, noncompetitive, like
5 bright colors, like to sing and dance, be more interested in
6 theater and theology and still be a male. You see, I can wear
7 pink, I can be a male and wear pink. I can express myself in
8 fashion as a male anyway I want. I don't have to change my
9 body in order to express myself as a male. And an 8 year old
10 doesn't understand that. Even a 13 year old doesn't understand
11 that. And we can say the same things for girls, you see.
12 When I was growing up, when I think about the ideas that
13 I believed when I was a child, I believed that a girl could not
14 biologically learn how to throw a softball. That's what I
15 believed as growing up in my society. And just look at what
16 has happened in the course of a generation or a lifetime where
17 our concepts of what a woman can be and what a man can be has
18 changed so dramatically. It takes time to understand these
19 things. We don't get this when we're 4 and we're 6 and we're
20 8. We don't even get it sometimes when we're 25.
21 So psychotherapy is an opportunity to have a conversation
22 of trust in a place that's safe with somebody who's
23 compassionate and thoughtful and interested in the welfare of
24 that particular child, you see. And that is not how
25 affirmative care works. Affirmative care says psychotherapy

1 only should be supportive of the transgender identity and
2 should be cheerleading for the opportunity to go forward as in
3 this changed way, and minimizes all the dangers or doesn't even
4 discuss the dangers. So psychotherapy is really a process of
5 getting to know the child in a position of trust and
6 confidentiality, of helping the parents understand what science
7 knows about the pros and cons, the benefits and the risks, and
8 eventually to help the child talk about his own concerns about
9 this, you see. This is what has been, in some of our writings,
10 referred to as true informed consent.
11 Informed consent requires time to appreciate the risks
12 and the aspirational benefits that risks, you see, the harms
13 and what we know about adult trans communities and their social
14 problems. So that has to be conveyed to the parents and that
15 has to be conveyed to the child or the child has to come to
16 grips with his own or her own fears about what they're
17 undertaking. You see, when a 15 year old says I have no fears,
18 this won't happen to me, these harms cannot -- I'll get a good
19 surgeon. You see, human beings are ambivalent about
20 everything. I think we need to understand that. There's more
21 ambivalence about things -- we're ambivalent about our husbands
22 and our wives. We're ambivalent about our children. We have
23 mixed feelings about everything.
24 And the idea that a 15 year old has no ambivalence about
25 this is an indication either, one, they're lying to us; two,

1 they're lying to themselves; or three, they have not lived long
2 enough to appreciate the complexity of the struggle it means to
3 be a human being, which is there are mixed feelings about
4 almost everything we do. There are mixed feelings about my
5 wonderful profession of being a doctor. I'm sure those lawyers
6 in this room have mixed feelings about being a lawyer. You
7 see, it's just in the nature. It's what psychiatry has learned
8 about the nature of human life is that we're conflicted. We
9 struggle.
10 Q Let me ask you about body discomfort. How can
11 psychotherapy help with body discomfort?
12 A Well, we have a body, it has characteristics, it's kind
13 of the universal thing that we struggle with our
14 characteristics of our body. We're too tall or we're too
15 short, we're too thin or we're too heavy. This organ is big or
16 too small. We talk about these things, you see, but in dealing
17 with and creating a trustful environment in which a child or
18 teenager can tell us over time what he or she thinks and feels
19 and we accept it and understand it and process it, many times
20 people's attitudes change about their body parts. In
21 psychiatry we have this diagnosis called body dysmorphic
22 disorder. It's a problem when one particular body part is the
23 source of great distress.
24 But gender dysphoria, when it meets criteria, when people
25 meet criteria, it's not simply about one body part, it's about

1 the body parts that designate them as a member of their
2 biologic sex. So we're not talking just about the shape and
3 size of the breasts, we're talking about the presence of the
4 breasts, for example, in a trans male teenager. So when we're
5 talking about all those other issues that I mentioned
6 previously, sometimes there are attitudes toward those body
7 parts and toward the sex body begins to modify and they come to
8 accept the fact that they are a male or a female and they have
9 to find some way of living within that body without doing harm
10 to that body.
11 So I can't tell you -- there's no technology for doing
12 that, like step one, step two, step three, you see. It is a
13 process of a trusting conversation over time where a child can
14 express their thoughts and feelings about their -- about every
15 aspect of their lives, and some of that conversation involves
16 their discomfort with their sex body parts. I don't think I
17 can tell you more specifically than that.
18 Q Can you tell us about any experience you have with
19 patients who maybe fail to realize that they're not unique with
20 respect to body discomfort?
21 A Yes. You know, I think all of us in the room can
22 understand, can remember going through puberty and the
23 discomforts we had with our bodies, our bodily selves, and some
24 of us had discomforts with some of the character traits we had.
25 We weren't courageous enough, for example, or we weren't strong

1 enough or we weren't pretty enough, or we weren't smart enough,
2 we weren't athletic enough. All these things that when we're
3 going through puberty are exaggerated but they're private,
4 they're subjected privacies that we don't talk very often to
5 our peers about or to our parents about so we think it's
6 unique.
7 The discovery of the pleasures of genital touching, for
8 example, which is a universal phenomenon is an extremely
9 private phenomenon, so we as 7th graders and 6th graders and
10 5th graders, we think it's unique to us. When, in fact, it's
11 going on in every chair in every classroom we sit in, you see.
12 So the trusted process of psychotherapy is a process where
13 these things can be discussed, and so generally speaking, this
14 is a very helpful thing for human beings. And it doesn't,
15 quote, cure this or that by some technology, it's about a
16 trusted human relationship that allows the sense of self to be
17 better understood, you see. And it keeps people from believing
18 they're the only ones who are discomforted by menstruation, for
19 example, or their breast size, or how their mother has been
20 demeaned by their father.
21 Q Can you explain how psychotherapy can help, for example,
22 with coping or resilience skills?
23 A Well, the processes I've just talked about, the child
24 gets more awareness of what he or she feels, has words for what
25 he or she feels, and begins to process the feelings that they

1 have and they gain confidence in talking, they gain confidence
2 in how they view themselves, you see. And they sometimes get
3 courage to do things that they were afraid to do before. This
4 sometimes is referred to as the process of gaining resilience
5 and coping better with all things that are coming down the pike
6 for them in life.
7 So psychotherapy helps people mature. It helps people
8 understand themselves and by nature it helps them understand
9 others, and in this process, they can then make decisions that
10 are better informed.
11 Q Can you tell us -- explain whether the psychotherapeutic
12 approach, is this the same thing that is called conversion
13 therapy or reparative therapy or are these different things?
14 A Well, Mr. Cantrell, this whole field of gender medicine
15 is so politicized that in order to prevent the processes that
16 I've just described, these processes have been pejoratively
17 relabeled as either reparative therapy or conversion therapy,
18 and the politics of this is such that is so powerful that
19 people like to do things like I do, that is, psychotherapists
20 have been frightened to be called a conversion therapist
21 because conversion therapy is some kind of attempt to change
22 people's gender identity.
23 Historically it's based on psychiatry's misadventure when
24 before 1974, psychiatry thought that homosexuality was some
25 kind of psychopathologic state and they devised treatments to

1 cure homosexuality which, of course, all failed, and became --
2 the term "conversion therapy" arose from that history of
3 psychiatry, and mostly in the 20th century, but that term has
4 just been applied by people who were involved in affirmative
5 care as conversion therapy. This is so bad -- this is so bad
6 and this came about in large part because the Standards of Care
7 that WPATH issued ten years ago or more said that psychiatric
8 assessment did not have to be done, all they had to do was
9 affirm the presence of gender identity disorder and that
10 psychotherapy was not the treatment for gender dysphoria, the
11 psychotherapy should only be supportive of the transition.
12 So before we knew it, all kinds of -- anyone who wanted
13 to talk in the way that I've been describing to you was
14 referred to as conversion therapy. And there have been laws
15 passed in various municipalities preventing conversion therapy.
16 But it's been a great unscientific leap by using the term
17 "conversion therapy" for what I'm talking about, from
18 conversion therapy of trying to cure homosexual people of their
19 homosexual desire.
20 Now, you need to understand that in the United States,
21 this politicization of psychotherapy as an approach to gender
22 identified -- cross-gender identified children and adolescents,
23 in the United States, conversion therapy is what is thrown at
24 people like me. We're called anti-trans people and conversion
25 therapists. But in Europe and Sweden and Finland and the UK,

1 in France, psychotherapy is the most recent recommended --
2 first approach recommendation to the treatment of gender
3 atypical youth. It's only in America that we talk about
4 conversion therapy and people like me are attacked as
5 conversion therapists.
6 I'm not a conversion therapist when I'm trying to convert
7 someone from depression to not being depressed or from an
8 anxious person to being a confident person, from a substance
9 abusing person to being a sober person, you see, but I'm
10 attacked as a conversion therapist when I'm trying to do
11 psychotherapy with a family and a child who's thinking about
12 changing their gender presentation. It makes no sense in some
13 larger way. It's politics, politics, politics. And it's part
14 of trying to suppress any attempt, any attempt to give people a
15 wider choice so that when they're older they can make an
16 informed decision about how they want to live.
17 Q So you've talked about how psychotherapy can help a
18 person, a patient recognize how things may change as they
19 mature, as they gain life experience. Can you say a little bit
20 more about how that is different from conversion therapy?
21 A I think conversion therapy thinks that the person, you
22 cannot be a trans person, it's a terrible thing to be, you're
23 immoral to do that. That's not how psychotherapy works.
24 That's not how psychotherapy works at all. Psychotherapy works
25 by listening to the patient's narrative of their lives, by,

1 over time, developing a trustful environment, a trust, and a
2 confidential environment where the child can share increasingly
3 over time his or her subjective experiences and raises
4 questions about the sources of their problems which often are
5 self-harm, low self-esteem, poor socialization, being very
6 anxious about numerous things, and frequently trying to get
7 them out of a state of depression.
8 It's not attack on their current gender identity. It's
9 an attempt to establish a relationship where their subjective
10 lives can be shared with another hopefully informed mature
11 person who's kind and compassionate and knowledgeable about
12 what distorts, for example, physical abuse and sexual abuse and
13 being sold as a sexual slave, so to speak. I mean, I've had
14 patients who at age 4 have been farmed out for money for sexual
15 purposes.
16 So psychotherapy is mischaracterized by affirmative care
17 people and the word that they use is conversion, but it's like
18 they have no understanding really of what good psychotherapy
19 consists of. And it is not an attack on the gender identity of
20 the patient. It is trying to understand the development of the
21 person and what explains the numerous symptoms that they have.
22 Q So we've been talking about the psychotherapeutic
23 approach. I'm going to switch over and talk more specifically
24 about what you've called the gender affirmative approach. Can
25 you just briefly tell the Court what is the medicalized

1 approach, how it differs from the psychotherapeutic approach?
2 A Well, when a child, an adolescent says that they are
3 transgender, whatever word they use, numerous words that could
4 fall under that umbrella like I'm gender binary, I'm gender
5 fluid, I'm pan gender, I'm agender, the therapist reviews
6 ideally the criteria for gender dysphoria or gender
7 incongruence and is not interested in how the person got to
8 that identity state, but what to do to support that identity
9 state. And so the things to support would be to explain how
10 they may proceed. They may present themselves in school in a
11 different way.
12 They can cut their hair short if they're a girl, they can
13 wear boys' clothing, they can wear girls' clothing. I'm trying
14 to jump between the biologic male and the biologic female, be
15 confusing. And so there are -- there are just a limited ways
16 of medical support or affirmative care. One is to socially
17 transition, that would include clothing and name, name change
18 and so forth. And then depending on the age, it would be
19 puberty-blocking hormones, cross-gender hormones, removal of
20 the breasts. That's usually the first surgery that's done in
21 the youngest of people is bilateral mastectomies for trans
22 identified male teenagers.
23 The usual genital surgeries to get rid of the penis and
24 the scrotum are not typically done before age 18. So it's just
25 the sequence of social transition, various forms of hormones

1 and various forms of surgery. And the surgeries not only are
2 breasts and genital surgery, but for many times, there's facial
3 feminization surgery, there's surgery on the larynx trying to
4 make the voice more -- higher in the registers for biologic
5 males who are trans females, and there are numerous other
6 cosmetic things that may be done. But the psychotherapy that
7 WPATH recommends as part of medical affirmative treatment is
8 supportive therapy.
9 It's not investigating the things that I've talked about.
10 It's not investigating the influence of childhood adversities.
11 It's to support the presentation of the self, the new self, and
12 to be optimistic about and make suggestions to deal with
13 whatever ongoing medical psychiatric problems that may exist.
14 The truth is that in all medical care, especially in the United
15 States, in all medical care, we do what we do, the surgeon does
16 the surgery, the endocrinologist does the hormones, and then we
17 basically lose sight of the patient.
18 So we don't really know what happens to those people over
19 time. That's one of the reasons why studies are so important.
20 So medicalization therapy is pretty simple therapy. It is
21 staged therapy. This stage, this stage, this stage, this
22 stage, goodbye. Have a nice life.
23 Q So in view of that and in view of the current state of
24 the evidence, can you explain what are the fundamental problems
25 with prescribing hormones and surgery to minors for

1 gender-related psychological issues?
2 A Well, we don't have any follow-up studies on what happens
3 to these teenagers who are given hormones. They're often given
4 hormones by pediatric endocrinologists and the child gets to be
5 20, 25, 30, and the pediatric endocrinologist turns them over
6 to someone else. And because medical care is there's nothing
7 compelling a patient to come back to a doctor, you see. If the
8 patient doesn't like the doctor, they don't come back. What we
9 really need in this field is to know what the consequences of
10 affirmative care are prospectively. The research that needs to
11 be done is much more sophisticated than it ever has been done
12 in order to answer the questions that we have. I'm sorry, I
13 think I've lost your original question.
14 Q Let me ask this question. Can you tell us what is the
15 evidence that gender dysphoria is cured or ameliorated by
16 hormones or surgery?
17 A Gender dysphoria, you recall, is a distress about not
18 having the full characteristics of the opposite sex, and gender
19 dysphoria from the doctor's point of view is ameliorated by
20 giving them what they want, that is cross-sex hormones. They
21 really don't know whether, for example, if you give
22 testosterone to a biologic girl and they don't really know
23 whether the gender dysphoria disappears. If you take off the
24 breasts of a gender dysphoric male, they still have female
25 genitals so they live with the social appearance or the

1 appearance of the chest and female genitalia. So the
2 incongruence of the body continues, you see, and the idea that
3 surgery, for example, taking -- changing -- what we call
4 vaginoplasty, creating a vagina, female appearing genitals from
5 a biologic male in a trans female, many of those people are
6 still gender dysphoric, they don't feel like they're feminine
7 enough.
8 Their bodies are tall or masculine in some ways, many of
9 them want to have a facial feminization surgery, so the quest
10 to increasingly feminize over time would indicate to people
11 like me that gender dysphoria persists, you see, that you're
12 putting this child on a pathway where they're always going to
13 be a little concerned that they're not feminine enough or
14 they're not masculine enough. And then when it comes to
15 intimate relationships, you see, it's a particular problem for
16 trans people.
17 The number of people who are interested in forming an
18 intimate romantic relationship with a trans person is limited
19 compared to cis-gendered people. And the post surgical
20 problems include sexual dysfunction, and the post hormonal
21 problems include sexual dysfunction. These things are not
22 discussed widely. Sex is a very difficult thing for people to
23 talk about in general conversation. So when we're thinking
24 about the long term follow-up of hormone treatment, we really
25 mean the long term follow-up. When we are talking about the

1 consequences or the harms, we need to specify what harms we're
2 talking about and people need to know in order to be informed
3 going into this treatment what these harms and what these
4 consequences are.
5 And my point or our point has been that informed consent
6 for trans children and their families has been woefully
7 inadequate because it's left out the long term uncertainties,
8 you see, it's uncertain because we haven't done the studies.
9 We only have cross sectional looks at the adult communities and
10 their problems and we only have the immediate and the one-year,
11 two-year follow-ups of the surgical complications of genital
12 surgery and breast surgery. So these are the harms and the
13 uncertainties about the harms that parents need to be informed
14 about which they're not being informed about.
15 Q Would that include, for example, the evidence of long
16 term impact on quality of life measures, is that what you're
17 getting at?
18 A For example, I can't remember the specific citation, but
19 a recent study I read said the quality -- one questionnaire of
20 quality of life showed that post surgically the general
21 psychological quality of life was improved from the
22 pre-surgical time but the quality of health, the physical
23 health dimensions were worse, and that's because even though in
24 informed consent, people are advertising that hormones and
25 surgery are safe and effective, but when you look at 30 percent

1 reoperation rates, it doesn't seem very effective to me. So
2 the health concerns of people post surgically are often
3 problematic and that gives rise to, well, I'm glad I had the
4 surgery because I'm now more of a man or more of a woman, but I
5 don't feel so healthy, I got this problem or that problem.
6 THE COURT: Mr. Cantrell, I'm going to interrupt you
7 and take a short break and give Karen a break and me as well.
8 Let's be in recess until 10:50. You can step down, Dr. Levine.
9 (Recess from 10:34 AM until 10:50 AM.)
10 BY MR. CANTRELL:
11 Q Dr. Levine, welcome back.
12 A Thank you.
13 Q So before the break we were talking about the
14 gender-affirmative or medicalized approach to adolescent gender
15 dysphoria. I want to continue with that. Can you tell the
16 Court -- I want to talk about some of the psychosocial risks of
17 the medicalized approach. So can you explain to the Court some
18 of the psychosocial risks pertaining to friendships that
19 transgender identifying patients tend to have as they grow
20 older?
21 A It's hard to know. On a rate basis, I can tell you from
22 my clinical experience that the transgender identified teenager
23 often counts among their only friends to be other gender binary
24 or trans identified friends. That begins to evolve because
25 before a child is transgender identified, he or she may have a

1 range of friends that no one -- the issue of sexual identity is
2 not part of that friendship, it's only the sex is part of the
3 friendship. The sex of the body. Girls being with girls and
4 boys with boys.
5 But as the identification gets socialized, the friendship
6 patterns tend to change and there's a lot of support among the
7 trans people and, in fact, in my clinical experience, most of
8 the early romantic relationships between trans people among
9 trans adolescents is with -- the romantic relationship is with
10 another trans identified person. So a trans male would have a
11 romantic relationship with another trans male and then think of
12 themselves as sort of gay. Or the trans female would have a
13 romantic relationship, a sexual relationship with another trans
14 female.
15 There's a lot of support for trans people from the
16 internet, and so some of the friendship patterns that I've
17 witnessed are virtual patterns, so someone in Ohio has a really
18 good friend in Texas and they talk every day in Texas but it's
19 a trans identified person. If we go back, if I could -- just a
20 little aspect of your question about puberty-blocking hormones
21 and the psychosocial effects of puberty-blocking hormones.
22 Puberty-blocking hormones are being given at a time when their
23 age mates are undergoing puberty and are changing. They're
24 growing taller, they're growing secondary sex characteristics,
25 they're starting menstruation and ejaculation, and they're

1 having sexual attractions to one another, and they're learning
2 from these painful experiences. Whereas the child that's kept
3 in a prepubertal state by hormones who often feels in part
4 because of a high incidence of autism, they're having
5 friendship patterns, friendship problems in the first place,
6 some of those autistic kids, they are not changing
7 biologically, and that has social, psychosocial implications
8 for their peers.
9 So if they're kept on these hormones for a couple years,
10 three years, sometimes four years, they remain looking like a
11 10 year old where everyone else is 14, 15 years old, you see,
12 and are having patterns. So the psychosocial implications of
13 puberty-blocking hormones can be I'm even further isolated,
14 therefore I'm further depressed, you see. Because in
15 adolescence, one of the key factors in happiness of adolescence
16 is their social connections with their peers. And so if we
17 give kids, if we give them this medical treatment, there's a
18 tendency for them to be even more socially isolated, and
19 therefore more anxious and more depressed.
20 Q Can you talk about the psychosocial risks of this
21 medicalized approach as it pertains to a person coming to
22 realize the meaning of permanent sterility?
23 A During adolescence, I don't think it's a big issue at
24 all. I think relative infertility or permanent sterility -- I
25 make a distinction between those two terms by the way. When

1 you take out the uterus and the ovaries or you remove the
2 testes, we're permanently sterilizing people, but infertility
3 is a relative thing so that if someone just takes hormones and
4 wants to have a baby, someone takes testosterone, retains their
5 uterus and their ovaries and they choose ten years later that
6 they would like to have a baby, they can stop their
7 testosterone, they're relatively infertile, they're not
8 sterile. But once you remove their uterus, they're sterile.
9 You understand those distinctions?
10 Q Uh-huh.
11 A So the issue about sterility is not -- or infertility is
12 not seemingly germane to the 15 year old, to the 16 year old,
13 to the 17 year old. But as time goes on and interpersonal
14 relationships are characterized by things that people in their
15 20s are concerned with, career, stable relationships, love,
16 sexual pleasure, reproduction, all the sudden a child who at 15
17 wasn't concerned about this, it sort of comes into focus, I
18 can't have a child. And that may have meaning for my partner
19 who wants to have a child, you see, and it may have meaning for
20 me because oh, my god, I can't have a child. Or if I can't
21 have a child by stopping my testosterone, I can't breast feed
22 this child because I don't have any breasts anymore because I
23 was eager to get rid of them when I was 14 years old.
24 So when I talked earlier about a life cycle perspective,
25 this is one of the implications of that. That these events,

1 these medical events, these surgical events, they have meaning,
2 but the meaning does not appear for years later, and then they
3 have a different life trajectory, you see, which may not
4 displease everyone. Lots of people don't have children, but
5 many people want to have children. Even those who don't want
6 to have children like the idea that they can have children if
7 they chose in the future. But that option is gone for people
8 who have been surgically fixed, whatever.
9 Q Can you say a little bit more, briefly, about the
10 psychological life tasks that are faced by a 20, 30, 40 year
11 old as opposed to an 18 year old or younger?
12 A The life tasks of a 20 year old is to find one's
13 identity, is to find one's vocation, one's vocational pathway,
14 it's to find someone to love or to be loved or to choose to
15 have a life without permanent connection. So it has to do with
16 the fixity that one is settled with who I am in terms of sexual
17 identity, and the issue is what will I do in the world
18 vocationally, how will I identify vocationally, and where do I
19 stand in terms of my aspiration for romance and permanent,
20 stable, loving connection, because love has two faces.
21 I want to love somebody and I want to be loved by
22 somebody, and if I want to be married or I want to have a
23 stable relationship, that is, what are my chances of finding a
24 partner and what are my chances of staying with that partner
25 through thick and thin throughout the course of my life until

1 death do us part. So those are the three issues.
2 And then when we think about the endocrine treatment and
3 then the surgical treatment of trans teenagers, we need to
4 think about how that will impact on sexual identity continuing
5 or absent gender dysphoria, perfect happiness with my
6 transgender state and this body, how will this impact on my
7 vocational aspirations and my ability to actually get the jobs
8 that I seek, that I desire. And what would it mean in terms of
9 finding a stable relationship, a loving relationship, and the
10 creation of a family, and what are my aspirations to be a
11 parent.
12 So these are the things that the parents of 13 and 14
13 year olds and sometimes 8 year olds and 9 year olds have to
14 consider. We are not talking about will the child be happy at
15 age 9 because she is on puberty-blocking hormones. We're
16 talking about will this person be happy at age 29 with the new
17 state, a new biologic state, a new social state and new
18 opportunities. And, you know, I don't know how this fits in,
19 but when people are writing about the problems of trans people,
20 they talk about minority stress and the fact that trans people
21 are still the object of considerable discrimination and so this
22 is not a good thing.
23 We're not saying discrimination is a good thing, we're
24 saying quite the opposite, but the reality for parents facing a
25 decision shall I transition my child, shall I give my child

1 step one hormones, step two hormones, and step three surgery,
2 what does this mean for my child's future in terms of society's
3 attitudes toward trans people and whether there are
4 opportunities for it. I know there are very successful trans
5 people in many, many fields, you see, but it's the rate. It's
6 the rate of opportunity, not the fact that one or two or five
7 or ten or 10,000 break through. What about 100,000 who don't
8 break through because of discrimination?
9 So parents have to think about these things and doctors
10 need to be able to present these things to the families of
11 pediatric patients who are transgender. They need to think
12 about this. They may still decide to transition their child,
13 but they have to be able to have an opportunity to think about
14 this, the pros and the cons and the harms that are known and
15 the harms that may be unfolded in the future. It's really hard
16 for parents to think about the sexual lives of their children.
17 That's difficult for any parent.
18 And you see how is it that doctors talk about sexual
19 dysfunction, future sexual dysfunction to a parent of an 11
20 year old. It's a really tough discussion. Parents don't like
21 to think about this, but it's part of the reality of what
22 they're getting into, what they're helping their child to get
23 into.
24 Q Can you explain the evidence concerning whether a
25 medicalized approach to adolescent gender dysphoria reduces

1 suicide?
2 A The worst -- let's start with the worst thing to be said
3 to a parent. Would you rather have a trans daughter than visit
4 your son in the cemetery? This used to be frequently told to
5 parents. So I just want to begin there. The next thing I want
6 to say to you is the suicide rate of people who have completed
7 all the transgender treatments that medicine has to offer is
8 higher than the general population by a very large factor. The
9 third thing I want to say is that when we talk about suicide,
10 we need to discriminate between suicidal ideas, thoughts of
11 suicide, suicide attempts that are minor, scratching the self,
12 trying to hang one's self with the pants of your Levi's, you
13 see, from a serious suicide attempt that could be lethal under
14 certain circumstances, and actual completed suicide.
15 Suicide ideation is very common in trans teens. Suicide,
16 completed suicide in trans teens is just slightly greater than
17 the suicides of people with mental illness of the same age
18 group like schizophrenics, bipolar, substance abusing people.
19 The Tavistock Clinic analysis of suicide there found in the
20 course of, I think, a decade, a little more, of treatment, the
21 Tavistock clinic comes up because it has the most patients in
22 Europe and probably anywhere in the world. And in that study,
23 there were four completed suicides in, I think, I don't
24 remember, 12 years or 15 years, something. Two of them were on
25 the wait list waiting for treatment and two of them were in the

1 midst of hormonal treatment. So the actual completed suicide
2 rate among kids in treatment is relatively small. It's a rare
3 event, but suicidal thoughts are very common.
4 I would -- if we wanted a round number, there's about a
5 50 percent chance that a trans teenager has had thoughts of
6 suicide. And that's much higher than non trans kids. But you
7 see, we don't want -- we want to separate suicidal thoughts
8 from attempts at suicide that are serious and potentially
9 lethal from completed suicide. We can't just lump all those
10 things together. We need to be very discriminate in what we're
11 talking about.
12 Q So what would you say in response to the claim that the
13 medicalized approach will reduce the risk of suicide for
14 adolescents?
15 A I think show me the data that, in fact, that that's true.
16 It doesn't exist. The data doesn't exist. But the scare of
17 parents that their child will suicide and when parents are
18 perceived by their children to be resistent to transition for
19 their kid, suicidal ideation increases. So we need to think
20 about, those of us on the front lines, why is this person
21 suicidal? Are they suicidal because they are so pessimistic
22 about their parents' attitude supporting them? Are they
23 suicidal because they've been suicidal because they've been
24 depressed since they were 8 years old?
25 We need to understand why. And that's the job of the

1 psychotherapist, the psychologist, the mental health
2 professional. It's not simply to say, oh my god, we're going
3 to cure them of their suicidal potential by giving them
4 hormones. Giving them hormones, if that's what they want, will
5 make them feel better, you see, but it doesn't prevent them
6 being suicidal when they confront some other problem that they
7 have as a result of being trans. Their friendship patterns,
8 their social isolation, their not knowing what to do about
9 going to the prom, whatever.
10 Q When you say that giving hormones to an adolescent would
11 make them feel better, is that a short term or long term
12 effect?
13 A I think all the clinicians who give hormones will tell
14 you that they perceive that their patients are much happier now
15 that they're on hormones because they ask that question and the
16 patient looks happier. But these are all short term things.
17 If I want a train for Christmas and my parents can't afford it
18 and a train appears at Christmas time under my Christmas tree,
19 I'm going to be much happier for a short period of time. So
20 what we're saying is that when we're talking about the ability
21 to love the self, to protect the self, to not put one's self in
22 danger of harm, either harmed by others or self-harm like
23 suicide, there's really very little evidence that hormones in
24 the long run prevent suicide.
25 And as I've already said to you, we have data that shows

1 that people who have had the complete process have more
2 suicide. And I think an earlier study from Holland by several
3 thousand people who have been treated with hormones only and
4 not surgery, the suicide rate was also elevated. The death by
5 suicide was pretty high.
6 Suicide is a problem for trans people, but it's not a
7 problem immediately. It's a long term problem. If you look
8 ten years after the final surgery is done, that's when the
9 suicide rate begins to be more dramatically elevated. There is
10 suicide at every stage. Suicide is known to exist at every
11 stage in the medical transitional process, but the highest
12 level is ten years afterwards.
13 Q Ten years after?
14 A After the last surgery, the last genital surgery or
15 breast surgery.
16 Q So shifting to a different topic, I want to talk to you
17 about your history and experience with the World Professional
18 Association for Transgender Health. So please tell us about
19 your history and experience with WPATH.
20 A Because I was interested in all things sexual when I was
21 done with my psychiatric residency, I got interested in this
22 new phenomenon, at least in Cleveland it was a new phenomenon.
23 We called it transsexualism in those days. And there was a
24 professional organization called the Harry Benjamin
25 International Gender Dysphoria Association. And so they had

1 meetings and I attended those meetings probably from the early
2 '70s on, and I was chosen to be the chairman of the fifth
3 rendition of the Harry Benjamin Association's fifth version of
4 the Standards of Care. I was the chairman of that committee
5 including the seven other people. And in 1999, we issued the
6 Standards of Care. So I was a member of that.
7 I think in 2007, they changed their name to the World
8 Professional Association for Transgender Health, WPATH. So I
9 was quite aware, of course, being the chairman of that
10 committee that wrote the standard, the 21-page Standards of
11 Care, of how we actually made those recommendations that we
12 made. But I was aware as soon as we submitted those, the
13 president of the organization did not like the idea that our
14 collective wisdom required that two independent mental health
15 professionals needed to give an opinion that hormones were
16 indicated in this particular patient. He thought that was much
17 too conservative and he immediately reissued a new committee to
18 rewrite the sixth Standards of Care which came out three years
19 later.
20 In the meantime, I attended another meeting and I began
21 to realize that the powers that be in WPATH were not so
22 interested in understanding what this phenomenon was about and
23 what should we do for these people and what are the evidence
24 that what we're doing for these people are helping them. It
25 was much more politicized and it became a pro trans treatment

1 organization. And as I thought of myself as interested in all
2 things sexual, but in particular in gender identity, what we
3 called in those days gender identity disorders, I thought we
4 departed from the skeptical wanting to be helpful but trying to
5 understand it and learning about this phenomenon, we departed
6 from what I call the scientific approach to it, to a
7 politicized advocacy approach to it.
8 We were sure, that is, the organization was sure that
9 they were helping people, not harming people, and that we
10 should go full speed ahead in maximizing the access to
11 treatment, and at which time, I decided I no longer could be
12 part of it because they departed from what I believed was the
13 legitimate interest in learning about the phenomenon in trying
14 to discern how best to help people. They decided they knew
15 best how to help people without the evidence that they knew
16 best. And that was a political thing.
17 So the organization became -- now we just call it WPATH.
18 It became both -- they call themselves a scientific
19 organization, they call themselves a policy making
20 organization, and they call themselves an advocacy
21 organization. And those three things are incompatible.
22 Science is not advocacy. Science is answering a question. And
23 you can't even ask a question if you know the answer. And if
24 the answer is politically -- it's a political question, it's an
25 ideologic question. We were asking scientific questions and

1 they were responding politically, ideologically.
2 Q So how would you evaluate WPATH's claim to speak for the
3 psychiatric profession?
4 A WPATH speaks for the people who belong to WPATH. They
5 speak for the population of trans people who believe in the
6 civil rights of adults with transgenderism. They don't speak
7 for the doctors who take care of the inpatients when
8 transsexual people make suicide attempts that are put in the
9 hospital are so depressed they can't function. They don't
10 speak for the doctors who take care of them as outpatients.
11 They don't speak for the vast, vast majority of physicians who
12 encounter the healthcare issues of the trans people. But they
13 say they speak for the medical profession and they are very
14 successful politically.
15 WPATH is a very successful political organization because
16 they've convinced courts all over that they have the standards
17 of care, they have the knowledge and they have the science.
18 And what I am saying to you is that the decisions and the
19 policies that are made are declarative principles that they
20 declare principles. They're not based on science, they're
21 based on what they think would be helpful to facilitate the
22 lives of transgender people. We're all trying to facilitate
23 the lives of transgender people. That's the point.
24 Even people who are opposed to hormones for 14 year olds
25 are trying to facilitate the lives of transgender people.

1 We're not -- we seem to be on opposite positions, you see, but
2 all of us are concerned sincerely with how best to help people
3 who are transiently or permanently identified in teenage years
4 or in early years with their identity, preoccupied with their
5 identity. What we're saying is that all of us are concerned
6 about the long term outcome of these people. The health, the
7 mental health, the physical health, the social health, the
8 vocational health. And I just think WPATH has abandoned the
9 idea that skepticism is the scope of science. They don't
10 permit skepticism. They boo.
11 I was at a Galveston meeting and when someone said
12 something cautionary, people booed. This is not what happens
13 in American Cardiology Association and American -- this is not
14 how science works, you see. But in WPATH, that's how it works.
15 WPATH suppresses evidence to the contrary. And we've already
16 discussed conversion therapy, you see, which is an example of
17 suppression of ideas to the contrary.
18 So WPATH really is not taken seriously in Europe anymore.
19 Finland doesn't follow that. The UK doesn't follow that. I
20 actually think Germany is about not to follow it. So although
21 WPATH says world association, it really is much more of a
22 United States association these days, where most of the members
23 are from the United States anyway.
24 Q Earlier I believe you mentioned the psychiatrists who
25 treat patients who seek inpatient psychiatric care. And I just

1 want to follow up to make sure that I'm following what you
2 said. What's the relationship between those psychiatrists and
3 WPATH?
4 A Mr. Cantrell, you asked me if they stand for the medical
5 profession, they represent the medical profession. And I'm
6 saying that these people in WPATH aren't inpatient
7 psychiatrists, they don't take care of people when they make
8 suicide attempts or when they're depressed or when they're in
9 substance abuse treatments. Those people are identified --
10 those patients are identified as trans people. But the people
11 who take care of them and seeing them at their worst,
12 psychiatric inpatient is when a person is really decompensated,
13 those people aren't members of WPATH. And when they come to
14 see people like me because they're depressed after transition,
15 WPATH doesn't see -- the people who take care of patients when
16 they seek outpatient treatment or inpatient, they're not
17 members of WPATH.
18 Members of WPATH give hormones and they use surgery and
19 they're advocates, you see, they don't take care of the
20 consequences. And they say they stand for the medical
21 profession, but they say WPATH is really an effective public
22 relations. They have convinced courtrooms that they are the
23 standards of care and they represent medicine's best thinking.
24 And they don't represent medicine's best thinking to the
25 Europeans any longer because the Europeans started this and

1 they've seen the outcomes much more than America has seen the
2 outcomes.
3 Q We'll address that in a moment. Continuing with WPATH,
4 how would you evaluate the WPATH Guideline's concern for
5 uncovering the reason why a patient is experiencing gender
6 dysphoria?
7 A I don't think they're that interested in that subject. I
8 think they're interested in the diagnosis and how to support
9 the people in their transition. They're not interested in the
10 background factors, the adversities, the family dysfunction,
11 the disruptions in bonds, the sexual abuse or the autism.
12 Actually they kind of think that autism is no reason not to
13 proceed with transgender, not to be cautious about it. They're
14 just autistic people, they're just on the spectrum. But the
15 truth is that among the trans community, the people who go for
16 trans services, the incidence of autism and the people who are
17 requesting services is seven times higher than the incidence of
18 autism in the general population, and that's from -- that's
19 been demonstrated on three different continents, you see.
20 So there's something about neuro-atypical or autistic
21 people that predisposes them to think at some point in their
22 lives, usually in teenage years, that they could have a better
23 life and that they are, in fact, a trans person. We know that
24 autism, without gender dysphoria, is a considerable challenge
25 for families and for the individual autistic persons. In fact,

1 they have a higher suicide rate than the general population as
2 well. They have many more social problems. Some of them are
3 brilliant people and they make wonderful contributions, but
4 interpersonally and personally, the typical autistic person has
5 a lot of challenges that the rest of us don't have.
6 So they're not so interested in what presented, what
7 forces led to the crystallization of an identity as a trans
8 person, they're just interested in how to support these people
9 and to make sure that they get what they want and they get it
10 as soon as possible. And they believe these people live
11 happily ever after even though they have no data to show that.
12 In fact, there's data to show quite the opposite.
13 Q Earlier you were talking about the different versions of
14 the WPATH guidelines. Can you explain how WPATH's guidelines
15 have historically dealt with psychotherapy and how they have
16 changed since your involvement?
17 A Well, prior to the 7th version which I think was
18 published in 2011, psychiatric assessment was required. Even
19 psychotherapy was required. And in 2011, psychotherapy
20 assessment was referred to as gatekeeping. Gatekeeping was
21 used in a very negative fashion. It became a source of oh, my
22 god, you wouldn't want to be called a gatekeeper, you see. The
23 principle in medical ethics -- the first principle in medical
24 ethics is "above all, do no harm." There is another principle
25 -- and there are several principles in medical ethics. There

1 is one called "respect for patient autonomy." So in this -- in
2 the ethical conflict in taking care of trans people, the doctor
3 is caught between "above all, do no harm" and "respect what the
4 patient wants". The patient's autonomy, respect for autonomy.
5 It's one thing to understand that patients have a right
6 to choose or choose to have a recommended care or not choose to
7 have a recommended care when they're an adult. But I'm not so
8 sure that an 11 year old gets to choose the medical treatment
9 that he or she desires. And what WPATH did in the 7th edition
10 is it said the major principle to follow is "respect for
11 patient autonomy", not "above all, do no harm." Not always act
12 in the patient's best interest. That's the third principle,
13 you see.
14 So that reordering from the Standards of Care is that
15 give the patient what they want as opposed to you, doctor, your
16 job is to see to the patient's health, short term and long term
17 health, and above all, do not put this person in harm's way.
18 So how we negotiate, how doctors and psychologists negotiate
19 the clash between these ethical principles is one of the things
20 we're talking about here today but at the level of medical
21 ethics.
22 Q So shifting to a new topic, you've mentioned the European
23 countries, and I'd like to talk to you about the national
24 reviews that have been conducted there and elsewhere. So can
25 you explain generally what the national reviews are?

1 A Well, there generally is a standard when any medical
2 topic is reviewed that up to 30 percent of people who are on
3 the committee should work in the area and they're allowed to
4 earn their living by working in that area, but 70 percent of
5 these people -- of the people in the committee need to be from
6 outside the field but have expertise in science and in studies
7 and what we call methodologic studies or epidemiologic studies.
8 So these national reviews meet these criteria where they have
9 people who have expertise in reviewing the quality of science
10 that is published.
11 Now, all publications are not created equally, you must
12 understand scientifically. So the committees from Sweden and
13 England and UK and Finland, and there's one just recently
14 published from McMaster University in Canada, all these people
15 are -- they meet these criteria of being methodologists and
16 each of these independent reviews of puberty-blocking hormones
17 and cross-sex hormones for minors have said that the quality of
18 evidence was low or very low. Those are very scientifically
19 well recognized designations for puberty-blocking hormones.
20 The designation is very low quality for cross-sex
21 hormones, it's low quality, and both of those mean that
22 scientifically the chances of the expected benefits will not be
23 forthcoming. And each of those four reviews have said that we
24 cannot guarantee based on the nature of science that the harms
25 that these interventions will lead to don't outweigh the

1 benefits. That is, the benefits do not necessarily outweigh
2 the harms.
3 Independent groups have reached the same conclusion.
4 Even the Endocrine Society that advocates for the treatment of
5 hormones have acknowledged that the quality of scientific
6 evidence for puberty-blocking hormones' producing benefit is
7 very low quality, and of cross-sex hormones are low quality.
8 But nonetheless, they recommend that this is the center of
9 treatment of trans -- ought to be the center of treatment of
10 trans care. And so Sweden and the UK and Finland have all said
11 it isn't true, that treatment of choice should be
12 psychotherapeutic assessment and psychotherapeutic processes.
13 So the question is do we listen to science or do we
14 listen to advocates. Do we listen to politics that come and go
15 or do we listen to the grounded data that independent,
16 scientifically credentialed people have concluded and
17 generated. And I say if you pay attention as a doctor to the
18 ethical uncertainties that you have, the qualms that you have,
19 and then you pay attention to that and then you read the data
20 that these people are producing, this is the best we have, then
21 I think we ought to say do we believe in science or do we
22 believe in politics.
23 Q So how would one of these reviews of the literature
24 compare to a single peer reviewed study?
25 A Well, the things that we're talking about are looking at

1 all the studies that meet criteria, reasonable criteria to be
2 investigated. A peer review study, you know, I, for example,
3 write a paper and I send it to you, you're the editor of the
4 journal and you select up to three different people who are
5 experts in the field and you give me feedback on my paper and
6 then I change my paper or I don't change my paper and then the
7 paper is accepted or it's rejected, that's individual paper.
8 So these committees have taken all the papers in that
9 particular subject area, those two subject areas, for example,
10 and they've looked at them all and they've looked at them by
11 people who are expert in this. Now, I just give you one
12 example of one paper.
13 The American Journal of Psychiatry is one of the premier
14 journals in my field. In 2019, they published on line a paper
15 that looked at a Swedish experience with hormones and
16 surgeries. And the American Journal of Psychiatry sent this
17 paper to three different reviewers and the paper got accepted
18 and it was published on line in 2019. Immediately, 12
19 different authors authoring seven different letters to the
20 editor appeared in the journal's office saying this study's
21 conclusion meaning that we should have a stronger policy that
22 more people should have gender-affirming care including
23 surgery, those 12 people said the data in this study do not
24 support the conclusions.
25 So the editor of that journal then sent that journal to

1 two new independent separate from one another statisticians who
2 then wrote back to the editor that the data -- the conclusions
3 of that study have no relationship to the data that they
4 presented, that it was spun in some way, you see, so the letter
5 to the -- so the editor of that particular journal in August of
6 2020 had those original seven letters published, and the
7 authors of the original paper wrote a retraction to the study.
8 So I give you this as an example because you asked what
9 is the difference between the evaluation of an individual paper
10 that is submitted which the editor then sends to, quote,
11 experts, and if all the experts believe in affirmative care,
12 they think this is a good paper, but when people who are much
13 more oriented toward the science of it, that is, the data of it
14 and the relationship between the data and the conclusions, what
15 we get is a whole different conclusion.
16 And so we have a lot more respect for Sweden and Finland
17 and UK's process of getting a committee of experts to look at
18 all the studies on a particular topic and then rate the level
19 of science. And the rating of the level of science says that
20 the expected benefits that the advocates support may not be
21 delivered, they're likely not to be realized, and that the
22 harms seem to outweigh the benefits. That's the state of
23 science 2022.
24 Q You mentioned that a peer reviewed paper may have three
25 reviewers. Would the national reviews have three reviewers?

1 A No. They would have more.
2 Q Would you have any response to the claim that the changes
3 that have been made in Europe as a response to these reviews
4 bring the treatment there more in alignment with treatment in
5 the United States?
6 A I think I misheard your question.
7 Q Let me ask it again. So would you have any response to
8 the claim -- so there's a claim that changes in Europe in
9 response to these reviews that have been done actually bring
10 treatment there more in alignment with treatment as it's done
11 in the United States. Would you have any response?
12 A It's quite the opposite. It's quite the opposite.
13 United States seems to be -- in the last five, six years, we've
14 gone from a handful of gender clinics to over 70 clinics in the
15 United States delivering affirmative care. Most of these
16 clinics have their names -- have affirmative care in their
17 names. They're pro hormones and pro getting people into
18 surgery. We've had a rapid explosion because we've had a rapid
19 incidence of people requesting services all over the United
20 States. Those services are not psychotherapeutic even though
21 they say they do psychiatric evaluations. I've had countless
22 parents coming to me telling me that they took their kid to one
23 of these places and in an hour or two, they were recommending
24 hormones, you see.
25 So what Europe is saying, at least those four places in

1 Europe is saying is please wait, wait, wait, this is a
2 psychiatric problem, this is not a, quote, medical genetically
3 derived problem. This is a psychosocial developmental problem.
4 It should be treated with psychotherapeutic evaluation and care
5 and thoughtful care, not quick to the endocrinologist, not
6 quick to the breast surgeon, just because a child thinks in a
7 certain way.
8 So it's not that the United States is in tune with
9 Europe, it's been in tune with Holland and the Dutch studies.
10 Which I don't know if you'll ask me about those, the Dutch
11 studies are the two studies that the Standards of Care and the
12 Endocrine Society base their affirmative care on, and those
13 studies have a lot of methodologic problems. So no, the answer
14 to your question as far as I can see is United States is going
15 the opposite direction than where Europe that started this
16 process is going, opposite.
17 Q Let me ask you briefly about each of these reviews.
18 First look at the UK. Can you tell me about the reviews that
19 have taken place there?
20 A Well, they've been in a series. First there was a study
21 that tried to replicate the Dutch studies that failed to
22 replicate the finding of psychological improvement, and then
23 the National Health Service had a preliminary review. And then
24 just recently months ago, they decided to restructure the way
25 they delivered trans care in the United Kingdom. And there

1 used to be two clinics, the Portman Clinic and Tavistock
2 Clinic, that saw all those cases. Those are the clinics from
3 which the data we talked about before where they were small to
4 rising incidence of trans people were demonstrated.
5 It was very apparent that those people could not handle
6 all the requests and that they were -- they had too long a wait
7 list and so the UK then decided that we should not centralize
8 this, we should decentralize this, and people should in their
9 communities get care that begins with assessment and
10 psychotherapy. So the Portman Clinic and the Tavistock Clinic
11 as of March 2023 will no longer exist, or at least their gender
12 identity service will not exist any longer. And so UK has
13 backed off of assessment, hormones, surgery.
14 Q What can you tell us about the UK's conclusions
15 concerning their review of the safety and efficacy of medical
16 treatments for gender dysphoria on minors?
17 A Actually not to repeat, but it's just what I previously
18 said, that the low quality of evidence and the concern with the
19 unexplained rapid increase in the incidence of this problem and
20 the fact that there are now appearing from the UK evidence of
21 detransition of kids who are put on hormones in their teenage
22 years and who have had their breasts removed.
23 Q Can you tell me about the relationship between the
24 reviews that we've discussed in UK and the Cass Review?
25 A That is the Cass. They're the same.

1 Q Okay. Then moving to Sweden, can you tell us about the
2 review that took place there and their conclusions?
3 A Well, it's going to be a little repetitive, but Sweden
4 said that while we could go ahead and give hormones to
5 adolescents, they only can be given in a predesigned research
6 protocol that gave science a chance of getting the answer to
7 the question that just because someone was transgender
8 identified in youth does not mean that they have access to
9 this. They should have access to psychiatric care first, but
10 they recognized that there are families who believed that this
11 is the best treatment for their child, but those people need --
12 they can only get those treatments if it's part of a research
13 protocol. They didn't specify what the elements of that
14 research protocol would be, but they just said it would be a
15 research protocol. And the research protocol was -- I think is
16 going to be done at the Karolinska Institute, which is -- we
17 Americans know that as sort of the home of the Nobel Peace
18 Prize. The Nobel Prize. It's not just peace prize.
19 So Sweden, like Finland and like UK, have evaluated the
20 evidence and they all say let's pause about this. Some of them
21 said let's not pause completely but let's pause in general and
22 if we can't do it scientifically, we can't do it at all. And
23 that's a very powerful thing. You see, the big question is,
24 ethical question, we can feminize bodies and masculinize
25 bodies. The issue is, should we. And we say the question is a

1 scientific question. And it depends upon the outcome.
2 And what we've done is that we've done the feminization
3 and masculinization of bodies, but we haven't found out what
4 the outcomes are, and we are saying full speed ahead in America
5 with the unknown outcomes. So I go back to the question,
6 clearly we can masculinize and feminize bodies. The issue is,
7 is there scientific justification for doing this. And in order
8 to answer that question, we have to define the parameters that
9 we will use to justify doing it or not justify doing it. And
10 we haven't defined even the parameters, so this looms over all
11 of us. Should we, are we harming people, are we helping
12 people. And people here are not just the patients themselves
13 but the people connected to those patients. Which we generally
14 don't discuss in this field.
15 Q Let me also ask you about Finland. And thank you for
16 being aware and not being repetitive, but I do want to ask you
17 about Finland and your awareness of the review and what has
18 taken place there.
19 A Well, Finland, I think after Sweden said -- made
20 statements like the brain is known to develop into its most
21 mature form by mid 20s and in general, people do not have the
22 cognitive decision-making process, the ability to think clearly
23 about life changing events until that age, and so in general,
24 they recommended that we wait to give any hormones to patients
25 who are transgender identified until about that age, I think

1 they said 26 originally, 26. After that, they said whether the
2 person can make a good judgment or not, they certainly, they're
3 developed as best they're going to develop, so it's up to them
4 whatever they do.
5 But the state of Finland is still responsible for people
6 less than maturity, cognitive maturity. They also said, I
7 believe, that under certain circumstances, it might be
8 acceptable, but that needed to be run by a panel of experts,
9 but in general, Finland said, whoa, we have followed the Dutch
10 protocol and our impression of the outcomes in our Finnish
11 population is not very positive. Let's put a stop to this.
12 Q Can you explain how the United Kingdom, Sweden, and
13 Finland are better situated than we are here in the United
14 States due to the fact that there is a national health system
15 in those countries?
16 A Yes. We'll just take Sweden for example, is that every
17 medical encounter, every judicial encounter, every automobile
18 accident gets reported to a central databank, so when
19 scientists want to mine the data, they know everyone who's been
20 in an emergency room with a suicide attempt who's trans, they
21 have data about that. Everyone who's in a psychiatric
22 hospital, they know about that. Every suicide, they know
23 about, at least what's on the death certificate, you see. So
24 it is possible.
25 This is the basis of a classic study that was published

1 in 2011 that showed that the suicide rate in post operative
2 people was 19.1 times greater than two control groups of
3 Swedish people, you see. And it showed that the suicide rate
4 specifically among trans males was 40 times higher. And it
5 took about ten years for this data to develop. And they also
6 showed that the death rates from cancer and heart disease were
7 higher, and the number of automobile accidents was higher, and
8 the number of criminal charges were higher. They showed in
9 2011 that based on everyone who had sex reassignment surgery
10 over a 30-year period, this was the data, it was mined from
11 what you were talking about from the national collections of
12 data.
13 And the study I just mentioned to you from the American
14 Journal of Psychiatry also came from that data, you see. So
15 Sweden and Finland and Denmark and the UK, they have access to
16 data mining. We call it data mining of big data that we don't
17 have in the United States, we don't even have in Arkansas, in
18 Ohio, and Pennsylvania. The only data we have are through
19 insurance companies, and those are often -- United Healthcare
20 does all the states or many of the states. We have Medicare,
21 but most of the kids aren't on Medicare that we're talking
22 about. Some of them are on Medicaid.
23 Anyway, we in America, we do not have the opportunities
24 to collect data that your smaller European countries have. And
25 that's why most of the studies are coming from Europe, they're

1 not coming from the United States.
2 Q I also wanted to ask you about what has taken place in
3 France. Can you talk about the statement from France?
4 A I don't think France has had an independent review in the
5 same way that the other countries have had. I'm not certain
6 about this, Mr. Cantrell. But I know France has issued a
7 statement of caution of recommendation of psychotherapy or
8 psychiatric assessment and therapy as the first approach to
9 this and not hormones. But I'm not aware of a French blue
10 ribbon committee of scientists. I have a feeling it was based
11 upon the work of other countries, but I'm not certain.
12 Q So we've looked at the various reviews and talked about
13 various reviews. I want to talk a little bit about the studies
14 that have been done or could be done to increase the quality of
15 evidence, specifically controlled studies, and I'd like to ask
16 you whether controlled studies could ethically be done in this
17 area.
18 A This is an area of controversy. Many people think it's
19 impossible to ethically do controlled studies because everyone
20 knows that hormones and surgery are the best treatment for
21 trans teens. This concept that you can't do a controlled study
22 because you don't have what we call in science equipoise, that
23 is, we don't have a state of understanding that we don't know
24 what the best treatment approach is. If the doctors who do
25 affirmative care believe as they do this is the best approach,

1 they can't ethically inform people, they can't get people to
2 enter into a placebo controlled or a psychotherapy versus
3 medication controlled trial, you see.
4 But if you understand the science, you know that the
5 affirmative care doctors need to recognize that they don't
6 know. They've been doing this by fashion, they've been doing
7 this because they were told this is the treatment of choice,
8 they were told science has already established this, and,
9 therefore, equipoise can be done, but even if we don't do a
10 controlled study, if we do a controlled study, we need to ask
11 ourselves what controlled groups would we use. Would we use
12 affirmative care as we've already decided versus psychotherapy
13 only versus nothing, just letting development happen versus
14 merely supportive therapy.
15 I think that if we could convince scientists that we
16 don't know the right answer and then those people can convince
17 the parents and the child that we don't know the right answer
18 and they have to submit to let's say we're going to use three
19 groups, we're going to randomly assign you to three groups and
20 we're going to evaluate you at these time intervals using these
21 methods, then in five years and in ten years, we will not have
22 this kind of debate in the courtroom, we'll have the answer,
23 you see. And maybe it may very well be that the kids who get
24 affirmative care will be far superior in their psychological
25 developmental outcomes than the kids who get psychotherapy, but

1 it could be quite the opposite and it could be that the third
2 group for no treatment at all, most of them have desisted and
3 have gone on with their lives and those people did equal to or
4 better than either of the other two. We don't know.
5 The point is we don't know and, therefore, we can't have
6 equipoise. We can't have a multisite. And I say because we
7 need large numbers, it has to be not just people in Arkansas,
8 it has to be multisite with protocol that has been decided in
9 advance, not in retrospect. And we have to commit to following
10 every one of those people in each group. That's how science is
11 done, prospective science is done. That's expensive. That's
12 difficult. But it can be done.
13 Now, the other if you can't do a controlled study, then
14 you have to decide to do what we call a large group cohort
15 study where there's no control but everyone who enters into the
16 protocol like everyone who seeks assessment has to be followed,
17 not just the ones who got treatment, but the ones who didn't
18 get treatment, the ones who dropped out of treatment, we need
19 to know what happens to these people, but we can't do it if we
20 just take the people who continue in the treatment and don't
21 study the drop-outs from the treatment. And we need to include
22 the death rates of these groups. All these studies would have
23 death rates as one of the parameters, the secondary outcomes
24 that we study.
25 So when we do those kind of scientific studies, we

1 designate a primary set of outcomes. These are the most
2 important parameters we're going to study and these are the
3 secondary or the least important or the less important ones.
4 And what we really want to see is that the primary and the
5 secondary outcomes match. We don't know the answer, you see.
6 And I think to go back to what I said before, Mr. Cantrell and
7 Your Honor, we're all interested in maximizing the outcomes of
8 these kids, giving them the potential to develop fully without
9 obstacles.
10 We have to admit we don't know really which is best, but
11 we are saying given the fact that psychiatry has existed for
12 over 150 years and that we treat all other developmental
13 problems in our field with these processes of assessment and
14 treatment with or without medications and not hormonal
15 medications but other medications, we ought to treat trans
16 people like they're like the rest of us. They deserve
17 thoughtful, compassionate, scientifically informed care.
18 Q Let me --
19 THE COURT: We're going to break for lunch before
20 you ask him your next question. We're going to break till
21 1:00, so court will be in recess till then.
22 (Recess at 11:59 AM.)
23 REPORTER'S CERTIFICATE
24 I certify that the foregoing is a correct transcript of
proceedings in the above-entitled matter.
/s/ Karen Dellinger, RDR, CRR, CCR
25 ---------------------------------- Date: December 3, 2022
United States Court Reporter

1 (Proceedings commencing in open court at 1:03 p.m.)
2 BY MR. CANTRELL:
3 Q. Good afternoon, Dr. Levine.
4 A. Good afternoon again.
5 Q. I wanted to follow up with a couple of questions
6 related to what we were talking about before lunch.
7 First of all, I wanted to ask you about follow-up of
8 patients here in the United States. Can you tell us
9 whether -- is there any uniform standards of following
10 patients after medical procedures for gender dysphoria in
11 the United States?
12 A. Historically, we've asked patients that we've taken
13 care of to give us follow-up and to come tell us how
14 they're doing on an annual basis. That almost never
15 happens. I am -- I've read recommendations -- in fact, we
16 put it in the Standards of Care in 1999 that people should
17 be followed up extensively so that we could see the
18 outcomes. And as far as I can see, this has not happened.
19 And neither the Swedes or the Finns comment in their
20 report that, in 2015 in their previous review, when people
21 -- when they asked for follow-ups from the people who were
22 delivering the care, it was very apparent five years later
23 that they did not have systematic follow-ups.
24 If you're a surgical patient, the surgeon is done
25 with you when you're healed and you're functional. When

1 you're an endocrine patient, depending on the age of which
2 you specialize, you may follow a patient for the rest of
3 their lives or until they stop taking hormones or you pass
4 them on to an adult. So the follow-up is not consistent.
5 As we spoke earlier today, there's no central record
6 keeping in the United States so that we could
7 retrospectively look and see what happened to a cohort or
8 a group of people that were given hormones or surgery or
9 transition services, whatever.
10 So although it would be ideal that we would have
11 follow-up, I would say that 70 years after we -- after the
12 medical profession has been involved in the trans -- in
13 trans care, we really don't have excellent follow-up
14 studies of any of our interventions. Although, there are
15 hundreds of follow-up studies, they're not excellent,
16 they're not of high quality, they have very different
17 durations of follow-up and different means of following
18 up. And it's not what we would do if we did a
19 scientifically predesigned study where we would designate
20 how we're going to measure it and when we're going to
21 measure it and, as I said before, what would be the most
22 important or primary measurement outcomes and what would
23 be the secondary outcomes.
24 We're flying -- I wouldn't say we're flying blind
25 because all of us who take care of patients have clinical

1 exposure to individual patients, but loss to follow-up is
2 typically in the 50 to 70 percent range in any study.
3 Q. What is the -- what are some of the negative
4 consequences of such a high loss to follow-up?
5 A. You don't know if people are happy or miserable or
6 detransitioned or made suicide attempts or got admitted to
7 a psychiatric hospital or gotten married and --
8 THE COURT: Doctor, can you slow down a little
9 bit? My court reporter is trying to take down everything
10 you say. So continue. You just got on a roll there for a
11 minute.
12 THE WITNESS: It's me, Your Honor.
13 So when we don't know what happened, we don't know
14 what happened in a positive way and we don't know what
15 happened in a negative way and we don't know what happened
16 in a medical way, we don't know what happened in
17 vocational way, we don't know what happened in a social
18 way, and we certainly don't know about the subjective
19 aspect of how the patient experiences his or her gender at
20 the moment and how that has evolved.
21 These are all reasonable questions, but after 70
22 years we don't have the answers. And I don't think that,
23 given the fact that we don't have the answers, we should
24 assume it's all positive or it's all negative.
25 Knowing what we know about other human beings, we

1 should assume it's probably a mixture. Some do well
2 reasonably. Some do disastrous. Some do not so well and
3 not so bad. So very positive, very negative mix. And I
4 would expect, just speculating, mixed would be the most
5 common one.
6 BY MR. CANTRELL:
7 Q. I want to talk to you about the Dutch studies. Can
8 you tell us what the Dutch studies are and indicate how
9 they've been used and --
10 A. The Dutch have had a group of researcher -- clinician
11 researchers for many, many years and have done many
12 studies. Generally, they were the first and most
13 respected researchers in the field. When we refer to the
14 Dutch studies today and when WPATH refers to the Dutch
15 studies and when the Endocrine Society refers to the Dutch
16 studies, they're referring to a study of -- that was
17 published in 2011 and a follow-up study that was published
18 in 2014.
19 The first study was of the results of puberty
20 blocking, and the second study, the 2014 study, was the
21 results of the whole sequence of puberty blocking,
22 cross-sex hormone, surgery, and then between one and one
23 and a half years of follow-up of evaluation. So those are
24 the two studies that generally most references to the
25 Dutch group.

1 Q. Can you talk about how those studies have been used
2 and whether that use is appropriate?
3 A. Well, when the 2014 study showed that the children --
4 the 55 children who had undergone surgery and were
5 followed for up to a year and a half were thought to be
6 positive outcomes and that they had, quote, no gender
7 dysphoria any longer and were doing pretty well compared
8 to the general sense of what the Dutch community at that
9 time was, at that age group. That got scaled across the
10 world as evidence that trans-affirmative care is the best
11 treatment for trans-identified children. And that's when
12 we had an explosion starting in 2014 and '15 of the number
13 of people seeking care and the gradual beginning of
14 cross-gender clinics in the United States and elsewhere
15 for these people. This is the scientific basis of the
16 explosion of trans care in the United States, the 2014
17 Dutch study.
18 So you should know that in the original study there
19 were 197 people and I think 111 were thought to be
20 mentally reasonable enough to offer them cross -- puberty
21 blocking hormones. And 70 of them, actually, the families
22 agreed to be in the study. And then the 2014 study only
23 had a follow-up on 55 of the 70. The 15 dropouts of the
24 study included one death from surgery, had an infection,
25 complication that killed the person. And several dropped

1 out because of obesity and the development of diabetes.
2 And I think 11 of them -- among the 11, if I haven't
3 summarized, many of them just refused follow-up and
4 there's been no understanding of why they dropped out.
5 So you need to understand the scientific basis of the
6 scaling up of transgender care, affirmative medical and
7 restrictive care is the basis of one uncontrolled study
8 done in Holland that was finished in 2014.
9 There's an attempt today to do a follow-up of those
10 people that was just reported in a national meeting, and
11 they couldn't find 50 percent of the people. So that's --
12 so we don't know what the long-term follow-up would be.
13 Obviously, culture is interested. Everyone is
14 interested in what happened to those 55 people or, shall I
15 say, the 69 people who are still alive during the course
16 of -- from 2014 to today. We don't know what happened to
17 those people.
18 So the studies are -- they were widely embraced. And
19 today -- and I think it's only today that researchers are
20 aware of the limitations of that study, and there are
21 many.
22 Q. Can you tell us a little more specifically about the
23 limitations?
24 A. Well, number one, there was no control group. Number
25 two, only -- when I gave you those numbers, 197 or

1 whatever number -- maybe it was 197 to 111, the
2 differences were people who were thought to be not
3 mentally healthy enough or families not stable enough to
4 even consider giving them puberty blocking hormones. Then
5 when we went from 111 to 70, both the families generally
6 didn't think this was a good idea. So -- so number one.
7 Number two rather, they're not -- number one, it's
8 not a controlled study, so all these things could have
9 happened for reasons other than affirmative care.
10 They selected the healthiest of the children and the
11 healthiest of the families. So when you demonstrate, you
12 start with health and then you end up in health, and you
13 can't really say that the health that you see at the end
14 of the study is due to the fact that they had care.
15 So today we don't -- we don't insist that people not
16 have psychopathology. And so the idea that taking a group
17 -- a study that was based on the absence of medical health
18 problems and applying it to everyone who comes doesn't
19 make sense.
20 And even the authors of the study have said two years
21 ago that it's a little frightening that the world has
22 embraced their research, which was about children who were
23 cross-gender identifying from preschool and early school
24 and who got worse during puberty with their gender
25 dysphoria who were still healthy except for being

1 depressed over their gender dysphoria, and then applying
2 that study to those people to anyone didn't make any
3 sense. And the authors of the study said that. It's not
4 Dr. Levine who's saying that, you see. So that's one of
5 the problems with the study.
6 The other problem with the study is the Dutch made
7 sure that those kids had a lot of support and they dealt
8 with both their parents and the kids with whatever issues
9 were coming up in the families. So the Dutch concluded
10 that affirmative care was good for transgendered youth,
11 but, of course, they were giving two treatments at once.
12 They were giving psychotherapeutic treatment at the same
13 time they were giving medical treatment.
14 But, you see, that's not -- that's not is what is
15 promulgated to the world. What is promulgated to the
16 world is that hormones, social change, and surgery is what
17 creates these well-adjusted children.
18 The other limitation about this is that most of the
19 parameters of mental health that they measured were not
20 changed from the early measures. They didn't change at
21 all. And the ones that -- the psychological measures were
22 only available on 32 of the 55 people. So the
23 generalizations that the world has taken that this is
24 scientifically proven is based on things that the people
25 who believe that, they don't even know about what was in

1 that study, you see. So today we appreciate that.
2 And these other people who have reviewed this
3 recognize that the databases for this kind of treatment is
4 very limited. There was an attempt in England to
5 replicate the study. It failed to it. They took anyone
6 who -- they took anyone who was gender identifying and
7 gave them the treatment, and they could not demonstrate
8 any psychological benefit.
9 So the other problem with the study, which I'm going
10 to have trouble articulating so that everyone understands,
11 is that the claim that there was no gender dysphoria one
12 and a half years after the last surgery was based upon one
13 questionnaire. And the questionnaire was given -- say, if
14 you were biologic male, there were questions about how --
15 your sense of your maleness. Then when you were done and
16 you were a female, you were given the questionnaire for
17 the females. And so -- so by switching the
18 questionnaires, which has been a very big contentious
19 matter, even deVries, who is the senior author of the
20 paper, recognizes there was a limitation in the
21 questionnaire. And now they've devised a different
22 questionnaire that is more -- that is not sex oriented or,
23 you know, biologic sex oriented.
24 So all of these things combine, the lack of control,
25 the concomitant use of psychotherapy, selection bias for

1 the people were -- and families who were very healthy and
2 supportive, you see, all of these things enter and make --
3 do not apply to the average -- may be a presumption -- the
4 average person in Arkansas who is applying for help for
5 gender dysphoria who may be of a range of mental health
6 capacities and abilities and so forth and have a range of
7 families -- of family circumstances.
8 So listen, all science, no matter the study, has
9 limitations. Many of those limitations are not
10 appreciated for several years. It takes time to
11 appreciate the strengths and the limitations of study.
12 And in science, we don't rely on any one study. We rely
13 on studies done from different perspectives, all coming
14 together on a particular point. But see, in this field,
15 one study -- one study that had two parts has become the
16 sole foundation for the justification of a worldwide
17 phenomena.
18 Q. So let me follow up about the gender dysphoria scale.
19 Can you explain -- so you said there was a scale -- one
20 gender dysphoria scale for males, one gender dysphoria
21 scale for females. Can you explain more specifically how
22 patients were evaluated at baseline and then
23 subsequently --
24 A. They use the same scale. The scale was based on
25 biologic sex and based on -- at follow-up, the scale was

1 on the new -- they assumed they were a new gender, a new
2 -- in this case, we use the word synonymously, gender and
3 sex.
4 On the scale that I -- on the first scale, I hate it
5 when people refer to me as a boy. And then on a score of
6 one to five, yes, I have five. And then when you take the
7 female scale and you say, I hate it when people refer to
8 me as a girl. And there is -- it's not a five, it's a
9 one, you see. And, therefore, when they add up all of
10 those kind of 12 different questions, when they add up all
11 of those things, it looks like there is no gender
12 dysphoria.
13 Q. I want to talk to you now about informed consent.
14 Dr. Levine, you've written about informed consent. Can
15 you tell the Court what that is and what procedures
16 informed consent is required for?
17 A. Informed consent is both a legal and a ethical --
18 it's a legal obligation of the provider and it's an
19 ethical obligation within the medical and psychological
20 association. It is to recognize the nature of the problem
21 that's being treated, the alternative -- the treatment
22 recommendations and the alternative treatment and the
23 benefits expected from the treatment and the harms or the
24 negative consequences of the treatment both in the short
25 term and in the long term.

1 So it also asks the doctor to tell the parents and
2 the child about what is uncertain about the treatment.
3 So everything that we've been talking about this
4 morning and since we resumed this afternoon is related to
5 the informed consent process.
6 Children are not able to legally consent, but -- so
7 their parents have to consent. And I contend -- and I
8 should say we contend and so do the Dutch contend that the
9 informed consent begins in the process of a psychiatric
10 evaluation and it extends in the process of getting to
11 know the family and getting to know the patient in great
12 detail. So informed consent is not like going to the
13 hospital with pneumonia where you get an IV and
14 antibiotics and we don't have you sign anything. We just
15 assume -- informed consent is assumed and not required to
16 be written down in a legal way. But, clearly, the
17 administration of cross-gender hormone or puberty-blocking
18 hormones or the removal of healthy tissue requires a
19 written informed consent.
20 But my point, and not just my point, other people
21 believe that informed consent should be a process and not
22 signified by, here's a three-page paper with all the
23 risks, sign here, which I see I've seen done.
24 When I had surgery a few years ago, that's how my
25 informed consent was. It was done 20 minutes before I was

1 anesthetized. But I understand that's how things work in
2 the surgical thing. But here we're talking about
3 transforming the future of a child, and informed content
4 is not just making a diagnosis and asking the patient if
5 they want hormones. Informed consent is a process between
6 the provider and the parents and the child about the
7 benefits and the risks and the uncertainties, you see,
8 what is known and what is not known.
9 Now, what is not known is so vital here. Youth
10 think, a 14-year old, that taking hormones will make you
11 live happily ever after. But we doctors need to
12 understand what is the basis of happily ever after. And
13 when we don't have a basis for it, when we have an
14 awareness of, for example, the elevated suicide rates in
15 Sweden of after all of these interventions, we feel like
16 informed consent -- somebody in the family needs to know
17 about these things.
18 So we're not saying informed consent prevents going
19 ahead in America with these treatments. We think it's a
20 prerequisite for going ahead when the appropriate people,
21 the parents, with the assent -- not the consent, but the
22 assent of the child and the physician, they can go ahead,
23 but they have to have informed consent.
24 When informed consent is perfunctory or abbreviated
25 -- so abbreviated that there is no real true information

1 or appreciation, you see. What does a parent need to
2 think about when we're doing something that's going to
3 sterilize their child? They need to think about that.
4 they need to think about that for their child. They need
5 to think about that for themselves. They need to think
6 about that for their family. That doesn't mean they can't
7 go ahead. It just means they need to think about it.
8 They're responsible for making the decision, and it's a
9 weighty decision. And all of us agree it's a weighty
10 decision. We believe informed consent needs to bring the
11 weight, the seriousness of the moment, to people's
12 awareness and not do it naively.
13 Q. So does proper informed consent require multiple
14 sessions over time?
15 A. Yes. Yes. It's a process. It's not an event.
16 Q. Can you tell us how -- how the ethical principle "do
17 no harm" plays in to the informed consent process?
18 A. Please repeat that question.
19 Q. Can you tell us how the ethical principle of "do no
20 harm" -- "first, do no harm" plays into the informed
21 consent process?
22 A. Yes. Because of the uncertainties of the long-term
23 outcome and the evidence of the harms or the problems that
24 adult trans communities have, it is ethically required
25 because of, "above all, do no" harm, which is the primary

1 medical ethical principle. It's important to share that
2 with the parents.
3 You're putting this child -- now your child may be
4 different. Your child might be bright or may be more
5 charming, may be much more natural in his cross-gender
6 feelings and expressions and behaviors. This may not
7 happen to your child. But if we look at the general group
8 of people, these harms need to be appreciated.
9 Q. Is there any relationship between age of
10 sterilization and incidents of regret?
11 A. Sterilization used to mean basically tying the tubes
12 of young teenagers and people who were older teenagers.
13 And the obstetricians published several studies, maybe ten
14 years ago, showing that the younger the sterilization of
15 women took place, the greater the subsequent incidents of
16 regret. So that it was different if you're tying the
17 tubes of a 43-year old mother who's had three children and
18 tying the tubes of a 17-year old who says, I don't want to
19 have children.
20 Q. Is there an established standard among practitioners
21 for the process of obtaining informed consent for minors?
22 A. I don't think so. I think it varies from clinic to
23 clinic. I may vary from clinician to clinician, from
24 hospital to hospital, from state to state, country to
25 country. We actually think that would be great in the

1 future if an international committee would create such a
2 document.
3 Q. So earlier we talked about the increased rates of
4 transgender identification among youth. Has this increase
5 -- has this increase created pressure on practitioners to
6 rapidly evaluate youth and make recommendations?
7 A. All doctors are concerned today about the rapidity
8 with which they're forced to see patients. Efficiency is
9 the new corporate standard in medical care. So here I am
10 talking about a relationship between a family and a
11 patient and a doctor or a team of doctors that require
12 time and consideration by -- appropriate consideration.
13 There are many forces available in culture -- extent in
14 culture today acting on the medical profession to increase
15 their efficiency, to decrease the amount of time we spend
16 with patients. This is a little antithetical to informed
17 consent.
18 If you have a lot of patient to see, you don't have a
19 lot of time to spend with patients, and developing this
20 relationship is impossible. And it's not impossible
21 because of the doctor personally; it's impossible because
22 of the system in which the doctors operate. They pressure
23 them terribly to be efficient. And in gender dysphoria, I
24 think requires a thoughtful, slow, deliberative,
25 assessment process and therapeutic relationship process.

1 And, unfortunately, the numbers of people applying for
2 care to these new clinics and the number -- the small
3 numbers of staff and the absence of experienced
4 psychiatrics often forces -- makes all of this stuff -- I
5 use the term high through-put, rapidly processing people,
6 using -- getting higher numbers of people through,
7 generating lots of mastectomy for young women.
8 THE COURT: Doctor, are you referring to
9 Arkansas statistics or nationwide?
10 THE WITNESS: Nationwide.
11 BY MR. CANTRELL:
12 Q. Dr. Levine, can you tell us what the informed consent
13 model of care is and how that differs from informed
14 consent as you're discussing it now?
15 A. It's so interesting to me. In this field, there are
16 euphemisms. There are nice ways of saying things that are
17 not quite true. For example -- I'm going to get to your
18 answer.
19 For example, we don't talk about mastectomy in trans
20 care; we talk about top surgery. We don't talk about
21 penectomies and testicular removal; we talk about bottom
22 surgery, you see.
23 So in the 7th Edition of trans -- of the WPATH
24 Standards of Care, they talk about informed consent model.
25 That sound wonderful. What does that mean? Never

1 defined. And on that basis, when we took out the mental
2 health professional as a requirement, the gatekeeper --
3 when we got rid of the gatekeeper and we had informed
4 consent model, what that meant is autonomy was more
5 important that this, "above all, do no harm."
6 So as long as the patient made the diagnosis -- was
7 given the diagnosis and the patient wanted it, whether the
8 parents were involved or not, the patient had -- was
9 informed about the benefits and the risks, and that's the
10 informed consent model. And that Dr. Levine and
11 colleagues and others are saying, including the Dutch
12 themselves, that is not informed consent. Informed
13 consent is not a perfunctory signing of the document. It
14 is a process.
15 But you see that's the euphemism, the informed
16 consent model. We followed the informed consent model.
17 It really is based upon autonomy versus -- most important.
18 Q. So we talked about desistance. I want to talk to you
19 briefly about detransition. And can you tell us what
20 detransition is and what the evidence is concerning the
21 rate of detransition among patients seeking treatment?
22 A. Well, for a very long time, detransition or regret
23 was used sometimes synonymously. And post surgically
24 throughout the world, the advocates of care said the
25 regret rate was one to two percent most.

1 Detransition, to answer your question, in some sense
2 means, I lived as the opposite gender for a time and I've
3 decided this is not for me any longer and I'm going to
4 return to live in a world that's more constant -- or
5 congruent with my biologic sex. That is detransition.
6 So, you know, my patients who lived as a woman,
7 presented themselves as a woman, taking the hormones and
8 then stopped taking the hormones and returned to living as
9 a male are detransitioned. But if you have a very strong
10 identification with -- say, you're a male and you -- as a
11 teenager, you have a very strong identification as a
12 female and you live as a female and you're insisting that
13 you're a woman, I am a woman, and then ten years pass and
14 then you recognize, well, there's strong pieces of me
15 that's a man, I'm a man and I'm a woman. So your label
16 for yourself is not trans sexual anymore. You relatively
17 detransitioned to, well, I'm both or I'm neither or I'm a
18 special case.
19 That's generally not called transitioning --
20 detransitioning but that happens in the evolution over
21 time of the sense of self as one -- as one confronts
22 timing and life's issues, you see.
23 But detransition generally refers to people who are
24 on hormones who stop taking hormones and who were living
25 in the opposite gender role and who returned to letting

1 their hair grow longer, for example, if they're a biologic
2 female and dressing more either neutrally or as a woman
3 more feminine.
4 So it has different meanings and it's sometimes
5 confused with regret, detransition. And many people who
6 regret what they did are trapped in what they've done and
7 there's -- so they don't detransition, but they live
8 however they can and -- but if you ask them about their
9 current gender identity, it's different than their gender
10 identity at age 17.
11 If you ask any 17-year-old how they think about
12 themselves and then ask them 30 years later how they think
13 about themselves, we will smile and say, well, we've
14 evolved as people. As I said before, trans people are
15 basic human people. And all the things that are true
16 about the evolution of our sense of self for humans
17 include human trans people. It too evolves. And so
18 detransition can be extreme to return or it can be more
19 modest and a return toward but not completely.
20 We don't know the rates of the latter. About the
21 rates of the former, there's just been three studies
22 published in the last year and a half, two years that have
23 different rates up to 30 percent in 16 months or five
24 years. More studies are going to be appearing I expect in
25 the next five years. We had this -- we -- five years from

1 now, I -- I can give you much more -- I hope I can give
2 you much more data on that, more information.
3 Q. Based on the data that we have, does there appear to
4 be any movement in the rate of detransition?
5 A. Yes.
6 Q. What is that?
7 A. It's increasing I think, both anecdotally and in
8 terms of systematic looks at that. And, you know, the
9 much maligned work of Lisa Littman, much maligned by the
10 affirmative care people. She interviewed a hundred
11 detransitioners and found some very important information
12 in that people felt they had an inadequate psychiatric
13 evaluation, an inadequate process, and no one was
14 interested in what happened to them in a negative way when
15 they were children. They now see that their trans
16 identity was an escape from even thinking about the events
17 that happened to them as children.
18 In general, you didn't just -- one more thing. In
19 the first edition of the *Handbook of Clinical Sexuality*
20 *for Mental Health Professionals*, which I edited, I had
21 Freeman Faflin (phonetic spelling) who was an affirmative
22 care psychiatrist from Germany, write a chapter on
23 transgender phenomenon. This was in 2004.
24 He wrote about a patient that who subsequently became
25 a psychiatrist and who was his patient when he

1 transitioned -- when she transitioned to male. And then
2 when the training was finished and the patient came back
3 to Dr. Freeman Faflin, the patient said, I could not tell
4 you or I could not tell myself about my sexual abuse as a
5 child. I think that, if I knew that, if I would have
6 talked about that, I probably would not have transitioned.
7 That was in 2004 and that was in a textbook.
8 So we were -- Dr. Faflin was recognizing in 2004 the
9 possibility of that kind of detransition or that kind of
10 regret.
11 You need to understand, Dr. Faflin in 1991 published
12 a study that was a review of all of the surgical outcome
13 data. And in that study in 1991, it was used to
14 promulgate sex reassignment surgery, even though I think
15 more than half the people were lost to follow-up in the
16 studies that he reviewed.
17 So we all -- we've always been aware of this problem
18 intuitively. There's always been evidence of it. There's
19 always been concerned, and yet the field in the United
20 States has just ignored all of our concerns. And so we
21 practice now based on fashion and not based on science.
22 MR. CANTRELL: Your Honor, may I have one
23 moment?
24 THE COURT: Sure.
25 BY MR. CANTRELL:

1 Q. Dr. Levine, just one final question. Can you -- can
2 you tell the Court why, in your opinion, states across the
3 nation have felt the need to enact laws like the SAFE Act
4 in relation to the medical profession and what has taken
5 place in the past ten or so years here in the United
6 States?
7 MS. COOPER: Objection. Foundation to be giving
8 opinions about the basis for other states' legislation.
9 MR. CANTRELL: Your Honor --
10 MS. COOPER: -- speculation.
11 MR. CANTRELL: -- Dr. Levine is an expert and
12 he's an observer of the field and I think --
13 THE COURT: I'm not sure why it's relevant, but
14 I'm going to let him give his opinion.
15 THE WITNESS: Well --
16 THE COURT: Are you asking this witness to give
17 the legislative intent for states across the nation?
18 MR. CANTRELL: No, Your Honor.
19 THE COURT: That's how I read your question. It
20 says: Can you tell the Court why, in your opinion, states
21 across the nation have felt the need to enact these laws.
22 MR. CANTRELL: I'm asking Dr. Levine to talk
23 about the medical profession and --
24 THE COURT: That's a different question, Mr.
25 Cantrell. You're asking this witness to tell me why

1 legislators across the nation have decided to pass laws.
2 MR. CANTRELL: Okay. Let me --
3 THE COURT: I'm reading your question off the
4 real-time so.
5 MR. CANTRELL: I would like to rephrase the
6 question.
7 THE COURT: That would be great.
8 MR. CANTRELL: Thank you, Your Honor.
9 BY MR. CANTRELL:
10 Q. Dr. Levine, based on your expertise and your
11 awareness of the practices that have been put into effect
12 over the last ten to 15 years here in the United States,
13 is it -- is it any surprise to you that -- that states
14 have sought a need to enact laws such as the SAFE Act?
15 A. Mr. Cantrell and the Court, you don't know this, but
16 I'm a bit of a cynic about political things, and I notice
17 that the 16 or 17 states, including Ohio, that is
18 considering limiting doctors' ability to practice medicine
19 as determined by the medical profession. It seems that
20 it's a kind of a Republican talking points these days
21 versus a liberal democratic talking point. For example, I
22 do some work in Massachusetts, and they are very liberal
23 about this, they're very affirmative about this.
24 And so I believe in a larger sense, beyond the
25 politics about this, that there is a kind of profound

1 worry about what we're doing to children and to their
2 families, and that certain states are much more sensitive
3 to this because they tend to be much more religious in
4 their basis and in their beliefs. And there is a -- see,
5 I as a physician, talk about the ethics in its
6 relationship to science. But people who aren't in the
7 medicine but who have strong feelings about this talk
8 about this in terms of God and God made man and woman and
9 they shouldn't -- doctors shouldn't play around in that
10 area. So I think there is an element of religious values
11 being played out in various state legislators as well.
12 So when we look at this phenomenon as a social
13 phenomenon in a critical way, I think we need to think
14 about the cultural values that are represented through
15 state legislatures and the feeling that COVID, for
16 example, brought all of this skepticism about science, the
17 science of vaccination and the science of masking. And so
18 many people have developed a new skeptical, non --
19 untrusting view of the institutions that medicine
20 represents, including public health authorities, including
21 what the doctor says are recommended treatments.
22 So I think earlier this morning you asked me to talk
23 about the big social forces. This belongs -- your
24 question belongs to the big social forces that incorporate
25 religious values and political values. And there are

1 different -- obviously, there are different political
2 values just like there are different religious values, and
3 these are reflected somehow in ways I don't understand
4 through legislative bills that are being debated and
5 passed in various states.
6 Q. Let me ask you this. So is it necessary for a person
7 to have specifically religious values in order to oppose
8 gender transition?
9 THE COURT: We're way far afield, Mr. Cantrell.
10 MR. CANTRELL: Your Honor, I anticipate that
11 plaintiffs will attempt to use religious issues with
12 respect to --
13 THE COURT: If and when they do, we'll deal with
14 that. But this witness is not the one that's going to
15 talk about whether or not people can or can't oppose in a
16 general sense transgender treatment. That's not what he's
17 here to testify to.
18 MR. CANTRELL: Dr. Levine has a scientific view
19 and I believe that his testimony is that if --
20 THE COURT: That's not what you asked again, Mr.
21 Cantrell. I'm ruling on what your questions are. You
22 asked him, would somebody have to have a religious view to
23 oppose this. He's not here to testify about what the
24 average Joe may decide or the average legislator may
25 decide about transgender treatment. That's not what he's

1 here to tell me about to help me with this case.
2 MR. CANTRELL: Yes, Your Honor. I'm going to
3 take it back to the science if -- if Your Honor will
4 allow.
5 THE COURT: Okay. Let's get there.
6 MR. CANTRELL: Okay.
7 BY MR. CANTRELL:
8 Q. Dr. Levine, the views that you've expressed this
9 morning, are -- are they based on science or nonscientific
10 consideration?
11 A. I hope my views are based upon the combination of
12 review of the scientific literature and my own clinical
13 experience over 50 years.
14 Q. And so you would not -- you would not say that --
15 well, let me just pause.
16 MR. CANTRELL: If I may have one moment, Your
17 Honor.
18 THE COURT: Sure.
19 MR. CANTRELL: Pass the witness, Your Honor.
20 CROSS-EXAMINATION
21 BY MS. COOPER:
22 Q. Good afternoon, Dr. Levine. I'm Leslie Cooper.
23 We've met. I'm with the ACLU.
24 Dr. Levine, you're aware this trial began last month
25 and it's now resuming this week. Is that correct?

1 A. Yes.
2 Q. Have you reviewed any transcripts of the first week
3 of trial?
4 A. No.
5 Q. Has anyone spoken to you about the testimony that was
6 given during the first week of trial?
7 A. No.
8 Q. You've been a psychiatrist seeing patients, I believe
9 you said, since 1973. Is that correct?
10 A. I started my residency three years before and I saw
11 patients then, so officially as credentialed psychiatrist,
12 yes, 1973.
13 Q. And the overwhelming majority of your patients have
14 been adults.
15 A. Over the years, yes.
16 Q. Is that right, that the overwhelming majority have
17 been adults?
18 A. Yes.
19 Q. Is that a yes?
20 And you've estimated that you've seen about 50
21 minors, patients under 18, in your nearly 50-year career.
22 Is that correct?
23 A. Yeah. In a previous testimony, give can you give me
24 that number?
25 Q. I can show you.

1 THE COURT: Let's short cut. Is that true?
2 THE WITNESS: It's approximately true.
3 MS. COOPER: Thank you, Your Honor.
4 BY MS. COOPER:
5 Q. And you've testified that you've seen about six
6 prepubertal children in your career over 50-plus years.
7 A. Yes. That's probably approximately true, personally
8 seen.
9 THE COURT: What was the last part? I couldn't
10 hear you?
11 THE WITNESS: I'm sorry?
12 THE COURT: I didn't hear the last couple of
13 words. Did you say something --
14 THE WITNESS: That I personally have been
15 involved.
16 THE COURT: Thank you. You faded off. I
17 couldn't hear.
18 BY MS. COOPER:
19 Q. I believe you testified on direct that there are
20 about 70 gender clinics in the United States. Is that
21 right?
22 A. Yes.
23 Q. And you don't know how different practitioners or
24 clinics provide care, correct?
25 A. There are many, many practitioners. How would I

1 possibly know how they all provide care? I've been aware
2 of some instances of care, yes.
3 Q. So there are many practitioners and clinics about
4 which you don't know protocols --
5 A. Many.
6 Q. And you don't know how common it is for clinicians to
7 provide hormone therapy to minors without a careful
8 assessment of the child and their comorbidities. Is that
9 correct?
10 A. Well, I've been in touch with many parents from all
11 over the country who have indicated that to me. But in a
12 numerical sense with a denominator, I'm not aware. I
13 certainly have had many experience where I heard
14 complaints of -- about that.
15 Q. You don't know if it's a small minority, a majority,
16 or something in between?
17 A. I don't know that 38 percent do and 42 percent don't
18 or -- I don't have that kind of information.
19 Q. You wouldn't say whether it's a majority or a
20 minority.
21 A. Couldn't say.
22 Q. You don't have any knowledge about how gender
23 affirming medical care is provided to minors in Arkansas.
24 Is that correct?
25 A. That's correct.

1 Q. You don't know what kind of protocols doctors in
2 Arkansas follow when they treat minors with gender
3 dysphoria, do you?
4 A. I have no contact with doctors in Arkansas.
5 Q. So you don't know whether they thoroughly assess
6 patients, including their psychological comorbidities.
7 A. Ms. Cooper, doctors always will say they thoroughly
8 assess their patients. The question is, what constitutes
9 the thorough assessment and how long does that take.
10 So, you know, it may very well be that a hundred
11 percent of doctors in Arkansas think that they're doing a
12 thorough assessment.
13 Q. But you don't know how any of them do that
14 assessment, do you?
15 A. Nor do you.
16 Q. You don't know if the protocols used by doctors in
17 Arkansas treating gender dysphoric minors include
18 psychotherapy.
19 A. I don't know that they have a protocol and I don't
20 know that they would agree what psychotherapy is and I
21 don't know that they have credentials to do psychotherapy
22 because, you see, we've removed the need for a mental
23 health professional to be involved with this for the last
24 12 years. So many of these clinics have masters prepared
25 mental health professionals, often green people in terms

1 of experience, doing mental health assessment.
2 Q. You don't anything about who was doing mental health
3 assessments of minors in Arkansas, do you?
4 A. No, I don't.
5 Q. You don't know if doctors in Arkansas provide hormone
6 therapy after a one-hour visit as you've described here
7 and elsewhere.
8 A. I don't know for certain what percentage of doctors
9 do that.
10 Q. You don't know if any in Arkansas do, do you?
11 A. As I said before, neither do you.
12 Q. And you don't know if they explore -- the doctors in
13 Arkansas explore how patients come to identify as
14 transgender when seeing these patients?
15 A. It would follow from my answers that you're right
16 about that. I don't know whether they know about the
17 development of trans identity.
18 Q. You don't know anything about how Arkansas doctors
19 engage in the informed consent process before providing
20 hormone therapy to minors, do you?
21 A. No, I don't.
22 Q. You don't know how thorough it is and if it's a
23 process versus a one-time event, do you?
24 A. No, I don't.
25 Q. Do you know - you don't know how many, if any, top

1 surgeries are performed on minors in Arkansas, do you?
2 A. What was that question?
3 Q. You don't know how many, if any, top surgeries are
4 performed on minors with gender dysphoria in Arkansas, do
5 you?
6 A. No, I don't.
7 Q. And you've described what you call the affirming
8 model of care. Is it correct that you don't know if any
9 or how many doctors who treat patients with gender
10 dysphoria in Arkansas -- minors with gender dysphoria,
11 practice the way you've described the affirming model of
12 care, do you?
13 A. I'm not familiar with medical care in any division of
14 medicine in Arkansas. I am aware of general patterns.
15 And I guess the answer to your question is, I will always
16 be -- I'm unaware of anything related to Arkansas.
17 Q. You have treated patients with gender dysphoria,
18 correct?
19 A. Correct.
20 Q. You diagnosed patients with gender dysphoria -- or
21 actually let me ask that differently.
22 When you evaluate minors for gender dysphoria, what's
23 reported by the parents contributes to your assessment of
24 whether the patient has gender dysphoria. Is that
25 correct?

1 A. Of course.
2 Q. And when you diagnosis patients for other --
3 A. Excuse me. I didn't answer that correctly.
4 Q. I'm sorry.
5 A. What is reported by the parents tells me about when
6 the gender dysphoria appeared. It doesn't influence the
7 diagnosis. The diagnosis is actually made by the patient.
8 It's not really made by the doctor. The doctor writes it
9 down and makes the diagnosis in the shortest claim, but
10 its the patient's self report that leads to the diagnosis.
11 We have no objective appraisal for the diagnosis.
12 So parents tell us about the early years of a
13 person's life beyond when they could possibly tell us
14 about what happened in the first four years of their life.
15 They tell us about their gender expressions during grade
16 school and the onset of gender dysphoria.
17 So in that sense, I had to correct my answer.
18 Q. This contributes to your -- this information from
19 parents contributes to your assessment of whether someone
20 meets criteria for gender dysphoria, correct?
21 A. No.
22 Q. That's not your view?
23 You were deposed in this case, were you not, in May?
24 A. I don't think you and I are understanding each other.
25 I don't know if it's my fault.

1 Q. Can we turn to page 41 of the deposition?
2 MS. COOPER: Can we turn on the monitors? Thank
3 you.
4 MR. CANTRELL: Your Honor, I'd just ask if
5 counsel could clarify the question so that it's clear
6 whether or not they're speaking past one another.
7 THE COURT: Can you reask your last question?
8 BY MS. COOPER:
9 Q. When you meet with parents and learn information you
10 described getting from parents, does that contribute to
11 your assessment of whether somebody -- a minor patient
12 meets criteria for gender dysphoria?
13 A. What it meets is the age of onset of their parents'
14 presence of gender dysphoria. It doesn't determine the
15 diagnosis, per se, is what I've been saying to you.
16 When -- what you're quoting, you mentioned you meet
17 with the parents, too, does that contribute to your
18 assessment whether someone meets the criteria for gender
19 dysphoria, what's reported by the parents. And then I
20 say, of course.
21 Perhaps today I'm being more clear about that. What
22 I want to know from the parents is what happened early in
23 life, and what I want to know is what other developmental
24 challenges the child had in -- before the onset of gender
25 identity atypicality, you see. So to make the diagnosis

1 of rapid onset gender dysphoria versus lifelong gender
2 dysphoria, the parents -- the parents' view is vital, you
3 see.
4 But, you know, today most of the onset of the gender
5 dysphoria presents itself at first in adolescence, not at
6 age four. In that sense, you and I are talking past each
7 other.
8 Q. All right. If we can look at -- just to wrap this
9 question up for clarity, on page 41 -- can you see the
10 screen in front of you --
11 A. Yes.
12 Q. -- beginning on line 22. Question: Does your -- you
13 mentioned that you meet with the parents too. Does that
14 contribute to your assessment whether someone meets the
15 criteria for gender dysphoria, what's reported by the
16 parents.
17 Answer: Of course.
18 That was your testimony?
19 A. I thought I just explained what I meant by that.
20 Q. When you diagnosis patients for other conditions like
21 depression or bipolar disorder, do you rely on self-report
22 of patients?
23 A. And reports from the parents.
24 Q. Reliance on self-report from the patients and
25 information from parents is not unique to the diagnosis of

1 gender dysphoria, is it?
2 A. That's right. It's not unique.
3 Q. Diagnosing patients based on self-report and
4 information from families who know the -- people who know
5 the patient, that's how psychiatry works, isn't it?
6 A. Ideally.
7 Q. You were deposed this past March in a case called BPJ
8 in West Virginia. Do you remember that case involving
9 athletics?
10 A. Yes.
11 Q. I'd like to show you a passage from -- well, a
12 passage from your deposition in that case. Can we look at
13 paragraph 6, please?
14 Do you see that in front of you in paragraph 6? It
15 says, if you'll read along with me: In the course of my
16 five decades of practice treating patients -- I'm sorry.
17 This is not your deposition. Let me back up. I misspoke.
18 You remember giving a report in the BPJ case. Is
19 that right?
20 A. I vaguely remember.
21 Q. And is this your expert report?
22 A. I don't know. You just --
23 Q. Can we scroll through this front page just to show?
24 A. It's my signature, yes.
25 Q. So if we can turn back to paragraph 6. And I would

1 like you to read along with me. In the course of my five
2 decades of practice treating patients who suffer from
3 gender dysphoria, I have at one time or another
4 recommended or prescribed or supported social transition,
5 cross-sex hormones, and surgery for particular patients,
6 but only after extensive diagnostic and psychotherapeutic
7 work.
8 So you wrote this passage, correct?
9 A. Yes.
10 Q. And you have supported patients' social transition.
11 Is that correct?
12 A. This -- this paragraph or sentence doesn't give an
13 age group.
14 Q. Understood. But I'm just asking generally, you have
15 supported --
16 A. Many four-year-olds.
17 Q. Yes. Okay. You have counseled some parents to
18 support the transgender identification of their child,
19 haven't you?
20 A. I'm not sure that's true. Depending on what you mean
21 by child. Child -- a could be 25. That is a child of a
22 parent can be 25.
23 Q. You've counseled some parents to support their minor
24 child's social transition, haven't you?
25 A. I have on rare occasion, yes.

1 Q. And switching back to adults, you've written letters
2 of authorization for adults seeking gender-affirming
3 surgeries. Is that correct?
4 A. I have.
5 Q. And you've done that as recently as the past two
6 years.
7 A. I have.
8 Q. And you've also written letters authorizing hormone
9 therapy for adult patients with gender dysphoria.
10 A. I have.
11 Q. And these are letters they can take to the
12 endocrinologist. Is that right?
13 A. Yes.
14 Q. And you have written such letters approving hormone
15 therapy for minors under 18 in a few cases within the past
16 five years, haven't you?
17 A. I don't think in the past five years.
18 Q. Okay. Can we turn to Dr. Levine's deposition, page
19 78?
20 I would like you to read along with me starting on
21 line 3. So between you and Mrs. Novak, there have been a
22 handful of cases in the past, say, five years where you
23 have approved hormone therapy for minor. Is that right?
24 These are particularly fraught difficult
25 circumstances, yes.

1 A. Yes.
2 Q. Mrs. Novak is someone who works in your medical
3 practice -- or your psychiatry practice?
4 A. She's a younger colleague of mine.
5 Q. That was your testimony.
6 A. I'm sorry?
7 Q. That was your testimony that I read correctly.
8 A. Yes. I'm just not sure today whether it's five years
9 or six years now. And in generally, there have been a few
10 very fraught cases where we felt that this is a very
11 reasonable thing given the severity, the complexity of the
12 case, and that we would -- we, along with parents, would
13 hold our breath that this would be of help.
14 Q. And you have cosigned letters for hormone therapy for
15 minors written by Mrs. Novak, again, approving some minors
16 for hormone therapy. Is that right?
17 A. Yes, but this has not occurred very recently, Ms.
18 Cooper.
19 Q. You would not write a letter supporting hormone
20 therapy for a minor if you did not believe the patient had
21 gender dysphoria, correct?
22 A. Correct.
23 Q. And you would not write a letter approving a minor
24 for hormone therapy without first determining that they
25 had a longstanding, stable gender identity. Is that

1 correct?
2 A. Yes.
3 Q. You've served as an expert witness in a case called
4 Keohane -- I'll spell that. K-e-o-h-a-n-e -- in Florida
5 in 2017. Is that correct?
6 A. I did.
7 Q. And you were deposed in that case?
8 A. I was.
9 Q. I would like to show you a passage of your
10 deposition.
11 Can we put up the Keohane transcript page?
12 First, confirm this is the deposition. We have that
13 is this your deposition that you gave.
14 A. Yes.
15 Q. Let's go to page 59. And on line 10, if you will --
16 beginning on line 10, read along with me.
17 I recommend psychotherapy to people and so I don't
18 exactly follow the standards. The 7th Edition wants to
19 give adolescents hormones very quickly and we're much more
20 cautious. We will give adolescents --
21 THE COURT: Can you slow down?
22 MS. COOPER: I'm sorry.
23 BY MS. COOPER:
24 Q. I'll start that sentence again. The 7th Edition
25 wants to give adolescents hormone very quickly and we're

1 much more cautious. We will give adolescents hormones,
2 but not as quickly as the Standards of Care would like.
3 That was your testimony in Keohane.
4 A. I have to say yes.
5 Q. And just to clarify, the Standards of Care you're
6 referring to in the 7th Edition, is that the WPATH's
7 Standards of Care 7th Edition?
8 A. Yes.
9 Q. When you were deposed in May of this year in this
10 case, the Brandt case, you testified, did you not, that
11 going forward you have not made a decision to no longer
12 write letters approving hormone therapy for patients under
13 18 years of age.
14 A. Indulge me a minute. In the previous thing you put
15 up, my deposition of adolescents was not the definition I
16 gave to the Judge earlier this morning. It was my
17 definition of an adolescent is somebody 19 years of age.
18 And so if you reread that, it would include 18-year-olds
19 and 19-year-olds.
20 So would you repeat the last question you asked me?
21 Q. Sure. When you were deposed this past May in this
22 case in Arkansas, you testified that, going forward, you
23 have not made a decision to categorically not write
24 letters approving hormone therapy for patients under 18,
25 correct?

1 A. I don't remember saying that, but if you have that, I
2 trust you.
3 Q. Yeah. I think we want to put that in the record.
4 Can we look at deposition page 227?
5 And if you go to line 3, part way through beginning
6 with the words, "Have you made a decision." Are you with
7 me? It's highlight.
8 Have you made a decision to no longer consider
9 hormone therapy for anybody who has not reached their 18th
10 birthday since you provided those letters?
11 Answer: I've made a decision to be very cautious and
12 to put a period of time in therapy between me and the
13 letter.
14 You go on to say more, which you're welcome to read
15 if you would like, but I want to continue on to another
16 passage that picks up rather than taking the Court's time
17 reading a lot of discussion in between.
18 If we could turn to page 228, line 3. Let me know if
19 you want to review there.
20 MR. CANTRELL: Your Honor, I would like to just,
21 if we could, take a look at the intervening testimony,
22 glance at that.
23 MS. COOPER: Sure. We can post that.
24 Absolutely.
25 THE COURT: I thought you were in the

1 deposition, Mr. Cantrell, but go ahead.
2 BY MS. COOPER:
3 Q. Do you have that in front of you now, Doctor? If you
4 look at line 3 and read along with me.
5 So I'm not sure if that answers my question. Have
6 you made a decision to no longer provide letters?
7 Answer: Oh, I'm sorry. No, I haven't made that
8 decision.
9 Question: So would it be a case-by-case basis if
10 there were a patient that you felt it was appropriate for
11 you -- appropriate for, you would consider doing it, say,
12 a 17-year-old or a 16-year-old?
13 Mr. Cantrell: Object to form.
14 Answer: I don't have a -- yes. The answer to your
15 question is yes.
16 I'm not going to ask you if that was your testimony
17 again --
18 A. Thank you.
19 Q. -- since I see how you love those questions.
20 Now, today you testified that you would not recommend
21 hormone therapy for patients under 18. Do you mean you
22 would not generally recommend hormone therapy as a general
23 matter?
24 A. Yes.
25 Q. So there may be exceptional cases where you would

1 still consider it appropriate.
2 A. Yes. These are very fraught circumstances. I think
3 all of us all over the world recognize that we are under
4 very difficult circumstances sometimes. We don't know
5 what to do and we eventually go along with the patient's
6 sincere desire to try hormones.
7 Q. Now, you talked on direct about an article you wrote
8 called, *Reconsidering Informed Consent for*
9 *Trans-identified Children, Adolescents, and Young Adults.*
10 And I just want to ask you a couple of questions
11 about that article.
12 In this article, you recommend informed content
13 process that you think providers should undertake before
14 authorizing medical or surgical transition for minors,
15 correct?
16 A. Yes.
17 Q. I'd like to pull up a passage from that article to
18 show you. If we can look at page 2. And I have some
19 material highlighted. Actually, I would like you to skip
20 to -- sorry. I wasn't in front of the mic. I would like
21 to skip to the second highlighted paragraph.
22 A. I know what you're you talking about.
23 Q. We over highlighted. If you'll read along with me in
24 the second paragraph there.
25 Social transition, hormonal interventions, and

1 surgery have profound implications for the course of the
2 lives of young patients and their families. It is
3 incumbent upon professionals that these consequences be
4 thoroughly patiently clarified over time prior to
5 undertaking any element of transition.
6 The informed consent process does not preclude
7 transition; it merely educates the family about the state
8 of the science underpinning the decision to transition.
9 Social transition hormones and surgeries are unproven in a
10 strict scientific sense and, as such, to be ethical,
11 require a thorough and fully informed consent process.
12 So in your view, it is ethical to provide gender
13 affirming hormone therapy to minor patients if the doctors
14 engage in the thorough evaluation process you describe in
15 your article and the thorough informed consent process
16 that fully informs patients and their parents of the risks
17 as well as the state of science, right?
18 A. If you read on in that article, I raise the question
19 of what do the doctors actually know about the state of
20 science and the risk and what false beliefs or beliefs
21 that are not scientifically established that they have.
22 So that can they give informed consent is an issue. Can
23 they provide informed consent process is an issue if
24 they're not informed themselves, if they have false
25 assumptions; for example, that is biologically dictated,

1 that is immutable, that it cures suicidal ideation, and
2 that it makes everyone live happily ever after, you see.
3 So in order to understand that last -- the
4 second-last sentence there, it does not preclude
5 transition. It presumes that the doctor is knowledgeable.
6 And what it I have been saying is that all the doctors are
7 not equally knowledgeable about the state of science.
8 Q. But you're not saying that no doctors are
9 knowledgeable.
10 A. Of course I'm not saying that, Ms. Cooper.
11 Q. In that article that we're looking at here, you don't
12 say that gender-affirming medical care, specifically
13 hormone therapy or blockers or surgeries, should be
14 categorically prohibited for minors, do you?
15 A. No, I don't. This is -- that was not the topic of
16 this article.
17 Q. You testified that you would like to see an
18 international committee -- this was today. You testified
19 that you'd like to see an international committee
20 developed standards for informed consent to provide
21 gender-affirming medical care to adolescents. Is that
22 right?
23 A. Yes.
24 Q. So, you're not seeking to prohibit care, but to
25 ensure that patients have been thoroughly provided

1 information and take the time and patience to understand
2 it before making this monumental decision.
3 A. Ms. Cooper, when you say "patients," you need to ask
4 -- for me to agree to that, you have to add parents and
5 patients.
6 Q. Thank you. Let me ask it differently.
7 So you're not looking to prohibit care, but to ensure
8 that patients, and particularly their parents when they're
9 minors, have thorough information in order to be able to
10 adequately make that decision. Is that correct?
11 A. I am not motivated to prohibit care. I am motivated
12 to clarify the scientific basis upon which the care is
13 provided, and if the basis is inadequate, to let doctors
14 be cautious about this.
15 Q. And to inform families of this information as well.
16 A. And to inform -- to use their own ethical unease
17 about the wisdom of this in their informing patients and
18 parents about the state of science here and what is not
19 known, the uncertainties, and the risks of harms.
20 Q. And your view is that, if families are -- by
21 "families," I'm specifically focusing on parents -- are
22 fully informed about the risks and the state of the
23 science, the decision about whether to pursue hormone
24 therapy for adolescents -- minor adolescents should be
25 made by the parents, patient, and doctors. Is that

1 correct?
2 A. I would prefer that the doctors be extremely well
3 informed about the outcome of hormone treatments or the
4 lack of outcome of hormone treatments before they are
5 offering that as the first treatment or the second
6 treatment even of the child -- the child who is so --
7 who's transgendered.
8 Q. Assuming those doctors are informed as you've
9 described, is it your view that family -- if families are
10 fully informed about the risks and the state of the
11 science -- the science, sorry -- the decision about
12 whether to pursue hormone therapy for minors to be made by
13 the parents, patient, and doctors?
14 A. Yes. Assuming that the parents are informed about
15 the psychosocial consequences of transforming the body and
16 transforming -- and solidifying, making more certain about
17 the trans identity when, if left alone, the child would
18 have more years to have social and romantic experiences
19 upon which to make that decision that they want to live as
20 a trans person.
21 All of us intuitively have doubts about a
22 15-year-old's knowledge about her future or his future.
23 And we are just trying to give those -- that developmental
24 process of adolescence the chance to proceed before we do
25 something that changes the direction of that developmental

1 outcome.
2 I think people who are advocates of hormonal
3 intervention recognize that they are precluding a bunch of
4 possibilities for their patients because their patients
5 passionately want this, you see, and they're certain
6 nothing bad is going to happen to them, it's going to
7 improve their lives. But, you see, we doctors have a
8 knowledge that the 15-year-old patient and their families
9 may not have, and it's our responsibility to bring that
10 knowledge to bear in the informed consent process.
11 Q. Okay. To be clear, you have written an article about
12 what the informed consent process should look like in the
13 case of providing hormone therapy to minors with gender
14 dysphoria, correct?
15 A. That article talks about not so much what they should
16 do, but what the evidence shows. I have not written an
17 article and said, informed consent should have the
18 following 16 features. I've said, here are the barriers
19 to informed consent. And I think if you take out one
20 sentence or one paragraph without reading the whole
21 article, you miss the point.
22 Q. But it's not your testimony, is it, that informed
23 consent for minors to receive hormone therapy for gender
24 dysphoria is an impossibility, is it?
25 A. It's not only a possibility, it's happening all over

1 the country.
2 Q. But proper informed consent.
3 A. I don't know. We don't know. None of us know what
4 the informed consent is in Missouri and in this clinic in
5 Missouri versus that clinic in Missouri and this doctor in
6 Iowa versus that doctor in Iowa.
7 Q. Understanding you don't know how each doctor provides
8 care, is it your view that if families who are seeing a
9 well-informed doctor under your understanding of what that
10 means, are fully informed about the risks and the state of
11 the science, the decision about whether to pursue hormone
12 therapy for adolescents -- minor adolescents should be
13 made by the parents, patient, and doctor. Is that
14 correct?
15 A. It is my testimony that that team of well-informed
16 doctor, scientifically well-informed, parents that have a
17 respect for the doctor and have met with the doctor
18 numerous times, and the doctor who has a relationship with
19 the patient, and after that patient has had a process of
20 psychotherapy where these matters, their ambivalence, the
21 uncertainty, their eating disorders, and their self-harm
22 episodes, et cetera, have been thoroughly explored -- if
23 that team of doctors, patient, and parent want to do that,
24 that's what doctors do. We do that for cancer as well,
25 you know.

1 Q. And they are the people who should make that
2 decision?
3 A. I would prefer doctors make the decision, of course,
4 but I want doctors to be informed not by politics, which
5 they are, but by science, which they're not.
6 Q. I want to go back to -- again, we talked about the
7 BPJ case. I think we looked at your report there before.
8 I want to ask you a question about your deposition. You
9 were deposed in that case, correct, earlier this year?
10 A. Yes. I trust you.
11 Q. If we can put up the front of the BPJ deposition.
12 Does that look like your deposition? Does that look
13 like your deposition?
14 A. I'm sorry. I thought you were --
15 Q. Is that a yes?
16 A. Yes.
17 Q. That was in March of this year. Is that what it
18 says?
19 A. Yes.
20 Q. If you can look on page 133, and I'll ask you to read
21 along with me, starting on line 20, just the highlighted
22 passage.
23 There's an ethical responsibility, a professional
24 responsibility to teach the parents, teach the adult what
25 is known and what is not known. What they decide is their

1 business, it's their prog -- it's their prerogative, it's
2 their child, it's their seven-year-old. It's not my
3 seven-year-old, see. It's not your seven-year-old. It's
4 not your 14-year-old. It's theirs.
5 THE COURT: Ms. Cooper, slow down a little bit.
6 BY MS. COOPER:
7 Q. That was the end of the passage. So that was your
8 testimony in March, Dr. Levine?
9 A. Taken out of context, it is, yes.
10 Q. Some people -- excuse me. You agree, don't you, that
11 there are some people who benefit, including long term,
12 from gender-affirming medical treatments?
13 A. Yeah. Yes. I have seen people who are happy that
14 they have made the transition, yes.
15 Q. And I want to switch gears and focus a little bit on
16 the law at issue in this case. You have concerns about
17 the law, Act 626, with respect to minors who are already
18 receiving hormone therapy and doing well but would be
19 required to discontinue treatment if the law took effect.
20 Is that correct?
21 A. Yes.
22 Q. You have concerns about -- specifically, about youth
23 who have already been stabilized in their new gender
24 having to discontinue treatment.
25 A. Yes.

1 Q. I'm sorry. Yes?
2 A. Yes.
3 Q. You believe that for youth who are currently
4 receiving hormone therapy, requiring them to discontinue
5 treatment could create a psychological -- could create
6 psychological and physiological problems, correct?
7 A. Most certainly, I think it would be a psychological
8 challenge for those folks, whether physiologically or
9 cause a significant problem is not clear because,
10 depending on their age and depending on the original
11 maturation of their ovaries and testes, stopping estrogen
12 or stopping testosterone abruptly may cause brief periods
13 of thermo-regulatory -- what we call hot flashes.
14 But I think if a person's just had hormones, say,
15 starting at age 15 or 16, their gonads had matured enough,
16 that they would begin the secretion of progesterone and
17 estrogen for biologic girls and testosterone for boys.
18 But I think psychologically, it would be a shocking and
19 devastating thing for them.
20 There are lots of negative things that happen to all
21 of us in life that are shocking and devastating, and we
22 learn to cope with it. And what I said at the deposition
23 is that doctors are compassionate people generally and
24 they would find a way to be of help. And my concern with
25 the law as ti was originally written is that it seems to

1 leave out what you're talking about. And that I thought
2 that the Attorney General would be kind and compassionate
3 to those people. But I just thought the doctors would
4 take care of it, but the law left out that, and that was
5 my concern.
6 Q. So you would prefer for the law to have made
7 provisions for minors who were doing better or functioning
8 well with medical transition and want to continue
9 treatment, but you weren't consulted, right?
10 A. I was not consulted.
11 Q. But you would also prefer for the law to have made
12 those provisions. Is that right?
13 A. You know, I don't have credentials as a legislature,
14 Ms. Cooper. I don't understand the process. I'm just a
15 doctor and concerned about the welfare of individuals who
16 think one thing and are treated medically and are
17 encouraged to believe that they are something and that it
18 will never change and then the infrastructure of that
19 belief is pulled away from them. Of course, they're going
20 to have a psychological reaction that's going to be
21 anxiety prone and depressive prone and may even lead to
22 temporary suicidal ideation.
23 But I just think that if the law goes into effect and
24 the doctors can identify those people, they will respond
25 to those people knowing what's coming and make some

1 provisions for their care and perhaps even have some
2 relationship to the legislature to add additional law to
3 provide guidance for how to take care of these people.
4 But this is not my expertise.
5 Q. Just to clarify, can we look at page 170 of the
6 deposition, line 15?
7 Do you see where it's highlighted on line 15,
8 beginning of the highlighting the word, but, "but there
9 are kids."
10 But there are kid who I will presume with you that
11 there are children who are doing better or who are
12 functioning well in their new role and who want to
13 continuing. And I think solutions will be found. You
14 know, I would you prefer this law to have made provisions
15 already for that, but that wasn't in. I wasn't consulted.
16 I read that correctly?
17 A. As I told you many times in deposition, you are an
18 excellent reader.
19 Q. Thank you.
20 In your opinion, the law does have a problem now
21 regarding how to treat those minors who are already
22 receiving hormone therapy, correct?
23 A. It's a problem.
24 Q. And you believe that for families of minors who have
25 been on hormone therapy and are doing well, if the law

1 takes effect, they will have to find a solution like going
2 to another state for treatment, correct?
3 A. That would be one solution. I think the doctors in
4 the state will take care of it.
5 Q. By convincing the legislature to change the laws?
6 A. By convincing the legislature or having an
7 understanding with the Attorney General's office about
8 this special case or these cases or just privately taking
9 care of medical care in a private way that, you know, you
10 don't know about.
11 Q. Under the radar, you're saying.
12 A. Of course. Doctors function that way all the time.
13 Q. And you've testified that you hope that medical
14 professionals would approach the legislature to not put
15 doctors in harm's way if they are taking care of minor
16 patients that they've previously committed to treat with
17 gender-affirming medical care, correct?
18 A. I consider doctors to be a community resource. It's
19 taken years and years of development. The society has
20 invested in to create a doctor with skills in a particular
21 specialty area. And to punish the doctor and to -- by
22 removing him from medical practice, defining -- depriving
23 the community of that resource seems Draconian. And I
24 think it's intended to scare doctors not to be involved
25 with this, as opposed to, I'm going to put you in jail and

1 make you lose your license.
2 So I do have this bias about doctors. I have very
3 positive view of doctors and their good intention and
4 their role in society and I think of them as community
5 resources. And anything that challenges the community
6 resource, short of moral repugnant behavior or
7 incompetence, I think I don't like.
8 Q. You talked a little bit in directed about research
9 and the need for more research on gender-affirming medical
10 care for minors.
11 Would you agree that minors should be able to receive
12 gender-affirming medical care in the context of clinical
13 trials?
14 A. Oh, yes. I think that would be wonderful.
15 Q. If someone were to ask you your opinion about a law
16 like the Arkansas law in this case, you would favor an
17 exception to the law for participation in clinical trials,
18 correct?
19 A. Depending on what we mean about -- depending on the
20 scientific merit of the clinical trial.
21 Q. Assuming it was a robust clinical trial like the type
22 were you describing earlier.
23 A. Yes.
24 Q. You would favor an exception for that?
25 A. Yes, whether it's in Arkansas or Missouri or Ohio and

1 ideally in all three.
2 Q. Yeah. I think you testified earlier that -- in
3 response to a question about the research, you said in
4 five years, I could give you more data, I think was the
5 way you put it. But not data from Arkansas, right, if the
6 law goes into effect because that research wouldn't be
7 able to be conducted here?
8 A. I would be happy if it were five other states, five
9 other -- five years from now. I don't care what the state
10 is.
11 Q. You were in discussions with the Alabama Attorney
12 General's office about serving as an expert witness in the
13 case there challenging a ban on gender-affirming medical
14 care for minors, correct?
15 A. I did have a phone conversation, yes.
16 Q. You told them you had concerns about the Alabama law.
17 Is that right?
18 A. Yes.
19 Q. You were uncomfortable with the Alabama law.
20 A. I don't exactly remember what I was uncomfortable
21 with. I think it was about the punishment of doctors,
22 removing doctors' licenses.
23 Q. That was a concern to you.
24 A. I just explained it.
25 Q. I think you may have touched on this, but is it fair

1 to say, if doctors in Arkansas were to lose their licenses
2 for providing gender-affirming medical care to minors,
3 that would be a concern to you?
4 A. It would be a concern to me. As I remember the law,
5 it doesn't say, lose your license. It says, reporting you
6 to the state medical board for whatever you decide. I
7 doubt very much that the board would take away a doctor's
8 license.
9 Q. But if they did, that would be a concern to you?
10 A. That would be a concern probably to all doctors
11 everywhere.
12 Q. Now, when you were retained by the Arkansas Attorney
13 General's office to provide -- to serve as an expert
14 witness in this case, you understood you were being hired
15 to provide information about the state of the science in
16 the field. Is that correct?
17 A. Yes.
18 Q. You were not submitting an expert report in this case
19 to express your support for the law, correct?
20 A. Right. I was here to represent a balanced view of
21 the state of science.
22 Q. You mentioned you had some concerns about the law
23 already, correct?
24 A. Correct.
25 MR. CANTRELL: Your Honor -- I was going to

1 object on the basis of asked and answered. It's the third
2 time counsel has asked that particular question.
3 MS. COOPER: I think I'm through with that line
4 of questions.
5 THE WITNESS: Your Honor, can we have a bathroom
6 break?
7 THE COURT: Yep. Take about a 15-minute break.
8 The Court will be in recess to 20 until 3:00.
9 (A recess was taken at 2:40 p.m.)
10 * * * * *
11 REPORTER'S CERTIFICATE
12 I, Valarie D. Flora, FCRR, TX-CSR, AR-CCR, certify that
13 the foregoing is a correct transcript of proceedings in the
14 above-entitled matter.
15 Dated this the 5th day of December, 2022.
16 /s/ Valarie D. Flora, FCRR
17 -------------------------
18 United States Court Reporter
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1 (Proceedings continuing at 3:00 p.m.)
2 BY MS. COOPER:
3 Q. Dr. Levine, you submitted a report in opposition to our
4 plaintiffs' motion for preliminary injunction. Do you remember
5 doing that in this case?
6 A. In this case?
7 Q. In this case, yeah.
8 A. That's too legalese for me.
9 Q. Okay. Let's show you -- if you can put up the report or
10 the rebuttal.
11 If you can look at the document on the screen dated
12 July 9th, '21, or filed. On the top, it says, "July 9th, '21,
13 declaration of Stephen Levine." Is this a report that you
14 prepared in this case?
15 A. That was my original report.
16 Q. Okay. If you can look at page -- excuse me -- paragraph
17 35, and read along, the highlighted material.
18 "To my knowledge, there is no credible scientific evidence
19 beyond anecdotal reports that psychotherapy can enable a return
20 to male identification for genetically male boys, adolescents,
21 and men, or return to female identification for genetically
22 female girls, adolescents and women."
23 That's what you said in your report?
24 A. That's what I did say, yes.
25 Q. Okay. Now, you talked on direct about your clinical

1 experience, and you mentioned that most of your patients were
2 adult patients. It's correct that you've had only two patients
3 who have detransitioned after medically transitioning. Is that
4 correct?
5 A. That I'm aware of at the moment, yeah.
6 Q. Okay. And in your report in this case, you cited a paper
7 by Exposito-Campos about detransition. Correct?
8 A. Yes.
9 Q. And you noted that the Exposito-Campos review of
10 detransitioning claimed to have identified 16,000 entries in a
11 search of proliferating websites devoted to this topic. Is that
12 correct?
13 A. Detransitioning, yes.
14 Q. And, to be clear, this did not represent 16,000
15 detransitioners. Right?
16 A. It's not possible to know what percentage of them are
17 individual people who have detransitioned.
18 Q. That was a reference of the number of people participating
19 in these online groups. Is that right?
20 A. Right.
21 Q. Uh-huh. Okay. Now, you talked some during direct
22 testimony about detransition and studies looking at rates of
23 detransition. I just had a couple of questions about that. You
24 mentioned that there was a study that said that there was a rate
25 of about 30 percent of patients detransitioned.

1 A. Yes.
2 Q. Right? How was detransition defined in that study?
3 A. I think as stopping hormones.
4 Q. People may stop hormones without going back to reverting to
5 their biological sex. Correct?
6 A. Yeah. The study is about the rate, you see. It's not
7 about the details, right?
8 Q. Okay. And I would like to pull up a passage in your
9 rebuttal report in this case. Do you have that, paragraph 17?
10 If you can look at page 1, is this your rebuttal?
11 Oh, is this the same document? I'm sorry. It is the same
12 document.
13 This is your report you wrote in this case?
14 A. I trust you.
15 Q. It has your name on it. Right? Did you look at it? I
16 want to make sure we're on the same page.
17 A. A rebuttal declaration of Dr. Stephen Levine, M.D.
18 Q. Let's look at paragraph 17, please. I would like to have
19 you go down sort of towards the bottom, second-to-last line in
20 that paragraph, beginning with the word "according." And read
21 along with me.
22 It says, "According to a recent study from a UK adult
23 gender clinic, 6.9 percent of those treated with
24 gender-affirmative interventions detransitioned within 16 months
25 of starting treatment, and 3.4 percent had a pattern of care

1 suggestive of detransition, yielding a rate of probable
2 detransition in excess of 10 percent. Another 21.7 percent of
3 patients disengaged from gender clinics without completing their
4 treatment plan. While some of these individuals later reengaged
5 with the gender service, the authors concluded detransitioning
6 might be more frequent than previously reported."
7 That's a passage from your report. Correct?
8 A. Correct.
9 Q. Now, when you spoke earlier about 6.9 percent and about
10 3 percent suggestive of detransitioning, that was this study you
11 are talking about. Is that correct?
12 A. There was another study.
13 Q. That was another study that also --
14 A. That was a subsequent study. It was one where people were
15 placed on hormones around age 20, and five years later they had
16 a rate of detransition I think closer to 30 percent.
17 Q. Well, so that number of 30 percent -- because I'm looking
18 here in 21 percent plus 10 percent gets to be around 30 percent,
19 that's not your 30 percent number?
20 A. Is that the Boyd study or the Hall study?
21 So No. 9 is the Hall study. I'm sorry. No. 9 is the Boyd
22 study.
23 Q. Okay.
24 A. So, you know, my point is that these are early rate
25 studies. There will be more studies. The fact that

1 detransition occurs in various forms to various degrees should
2 not be denied any longer. The incidence of using this 1 or
3 2 percent of regret for the whole phenomenon of maybe a mistake
4 has been made somewhere along the line no longer is acceptable.
5 What we need to think is that with the rising number of people
6 getting hormones and the rising number of people saying they are
7 transgender and then the rising number of people getting access
8 to hormones, we should expect that some of those people, given
9 the ordinary ambivalence of the human soul, will change their
10 mind as they get older and detransition to various degrees.
11 These studies are just the first early reports.
12 Q. Understood. But my question has to do with the 30 percent
13 figure you gave. These studies don't show that 30 percent of
14 patients who were on treatment detransitioned. Isn't that
15 right?
16 A. I think -- yes, that's right. They are showing that
17 30 percent dropped out of treatment or were lost to the original
18 treatment plan.
19 Q. So, to be clear, they showed that 6.9 percent, what you
20 described here, 6.9 percent detransitioned, and another
21 3.4 percent had a pattern of care suggestive of detransition.
22 But separately, to get to the remainder, to get to that
23 30 percent are 21.7 percent who are just people who dropped out
24 of the program. Right?
25 A. And that's study No. 1. That's Hall.

1 Q. Just to clarify, we don't know if 21 percent of those
2 people detransitioned.
3 A. No. They may have gotten their care at a different
4 country.
5 Q. In fact, your own description says some of them reengaged
6 in the clinics in those 21 percent.
7 A. That was a quote.
8 Q. That was a quote. Okay. Tell me, so there's another study
9 that showed 30 percent detransitioned? Which one is that?
10 A. If you look down further to No. 9, reference No. 9 to Boyd,
11 that's a study of older people detransitioning.
12 Q. Okay.
13 A. My point, Ms. Cooper, is that people detransition. And we
14 shouldn't be surprised, and we shouldn't sell the public that
15 once a trans always a trans.
16 Q. I want to switch gears for now and ask you about a
17 presentation you gave at the American Psychiatric Association
18 this past May. Correct?
19 A. Correct.
20 Q. Yeah. You presented at an annual conference of the
21 American Psychiatric Association in a symposium on reexamining
22 the best practices for transgender youth. Is that correct?
23 A. That is very correct.
24 Q. And among your co-presenters were Ken Zucker. Correct?
25 A. Yes.

1 Q. And others were Lisa Marchiano and Sasha Ayad? Correct?
2 A. Yes.
3 THE COURT: Ms. Cooper, can you spell that last name?
4 MS. COOPER: I can. Ayad is A-y-a-d.
5 BY MS. COOPER:
6 Q. And all four of you who were on that panel are people who
7 have dissenting views from APA policies on trans healthcare.
8 Correct?
9 A. That's right.
10 Q. Okay. And the APA was aware that the four of you were
11 presenting ideas that were not in keeping with official policies
12 of the APA. Correct?
13 A. Yes. They made an announcement of that before we were
14 allowed to present. And they sent a special person to moderate
15 it. They didn't allow me, the chairman, to moderate it, but
16 they didn't tell me they were going to do that. They just
17 showed up three minutes before the symposium, yes.
18 Q. And while you were talking, the group in the audience was
19 polite, and no one interrupted. Is that correct?
20 A. While I --
21 Q. While you were presenting on the panel.
22 A. Yes. They were very polite until the presentation was --
23 the presentations were finished.
24 Q. Excuse me? Until the presentations were --
25 A. Finished.

1 THE COURT: Dr. Levine, as a psychiatrist, how did
2 that make you feel? No. I'm kidding.
3 THE WITNESS: I can answer that, Your Honor.
4 THE COURT: You don't have to answer it. I'm just
5 trying to shake things up a bit. Keep going.
6 THE WITNESS: You succeeded.
7 BY MS. COOPER:
8 Q. No one interrupted. Correct?
9 A. I'm sorry?
10 Q. No one interrupted the presentations. Correct?
11 A. The only interruption in the presentation was when I began
12 to speak to introduce the symposium, this woman appeared and
13 told me to wait a minute, she was going to make the first
14 comment.
15 Q. But there wasn't a disruption of the content of the
16 presentations?
17 A. That's right.
18 Q. We just mentioned Ken Zucker, who was on the panel with
19 you. Is it correct that he is called -- excuse me -- he is a
20 proponent of what some call watchful waiting for prepubertal
21 children?
22 A. That's not what he presented about.
23 Q. But your understanding is he's a proponent. I'm sorry if
24 that wasn't clear. Putting aside his presentation at the panel,
25 he is a person who supports watchful waiting for prepubertal

1 children with gender dysphoria. Correct?
2 A. He was one of the original people who I think coined the
3 term. But we would have to understand what watchful waiting
4 means.
5 Q. Uh-huh, yeah. He doesn't favor social transition for
6 prepubertal children. Is that correct?
7 A. I think so. I think that's correct.
8 Q. Dr. Zucker has provided puberty blockers to minors -- I'm
9 sorry -- to minors who are post-puberty adolescents. Correct?
10 A. I actually cannot testify with any certainty about how Dr.
11 Zucker practices and has practiced. You should know that Dr.
12 Zucker was the first and most well-known researcher on childhood
13 gender identity disorder and was formulating various ways of
14 evaluating and testing and treating these people.
15 Q. My question, though, is about his use of blockers. At the
16 symposium, he said that he sometimes provided blockers to
17 minors. Correct?
18 A. I don't remember if he said that at the symposium. If you
19 have evidence that he said it, then I trust you.
20 Q. Let's look at page 300 of the deposition. Let's look at
21 the question above just to give context.
22 "Question: And Ken Zucker, Lisa Ayad and Lisa Marchiano
23 are people you would describe as supporting a more cautious
24 approach with respect to providing hormone therapy to minors.
25 "Answer: As Dr. Zucker said during the symposium, you

1 know, he sometimes has to prescribe puberty blockers to
2 children. But certainly I think you summarized what all four of
3 us believe."
4 That was your testimony. Correct?
5 A. Back in that deposition, I remembered that. But today --
6 Q. You don't remember now. Okay. Understood.
7 I'm going to switch gears a bit. You prescribe medication
8 to patients for various psychiatric conditions like depression.
9 Right?
10 A. I already said I have, yes.
11 Q. And you've prescribed drugs to patients for off-label use.
12 Correct?
13 A. Generally not.
14 Q. There are times you have prescribed drugs for off-label
15 use. Correct?
16 A. I can't remember a moment at this moment, but it's likely
17 that I might have.
18 Q. Okay. Let's just put up page 249 of the deposition to
19 refresh your recollection perhaps. Do you have that in front of
20 you? Starting on line 8 -- do you have that?
21 A. I have it, yeah.
22 Q. "Question: Do you never prescribe off-label drugs, drugs
23 for off-label use?
24 "Mr. Cantrell: Object to form.
25 "Answer: Yes. There are times that I've prescribed drugs

1 for off-label use."
2 That was your testimony. Correct?
3 A. Oh, yes, yes. That was my testimony.
4 Q. Okay. Off-label drug use is very common in probably every
5 field of medicine. Correct?
6 A. Yes.
7 Q. Uh-huh. And the fact that a drug is being used off label
8 does not make the use experimental. Correct?
9 A. In some sense it is experimental. It's not approved.
10 There hasn't been evidence other than in a clinical fashion to
11 do it. It's not experimental in the same serious way we're
12 talking about using the various drugs for gender dysphoria off
13 label and perhaps experimental.
14 Q. You would agree, though, that the fact that a drug is being
15 used off label does not alone mean that it's experimental.
16 Correct?
17 A. I would agree with that.
18 Q. People in your field know the difference between articles
19 that are peer reviewed in a scientific journal and different
20 kinds of publications. Right?
21 A. Yes.
22 Q. Speaking generally about psychiatric conditions, you would
23 agree that because of the complexity of the human psyche and the
24 difficulty of running controlled experiments in this area,
25 substantial disagreements among professionals about the causes

1 of psychological disorders and about the appropriate therapeutic
2 responses are not unusual. Correct?
3 A. That's quite a mouthful.
4 Q. Would you like me to --
5 A. No, no. I understand. That's sort of a general
6 establishment that we don't know a great deal about the causes
7 of various diagnosable conditions and that different
8 professionals have different views about the causes or the
9 relative importance of causes. It is to some extent a Tower of
10 Babel.
11 Q. And that is true with respect to the appropriate
12 therapeutic responses to various psychiatric conditions, that
13 people may have different approaches to what's the appropriate
14 psychotherapeutic response?
15 A. Well, they address people by professional A are treated
16 with these drugs and professional B for these drugs. But on a
17 scientific basis, we know that A and B, there's no significant
18 difference, even though you as a doctor prefer this drug and I
19 as a doctor don't like that drug.
20 Q. You testified today that the WPATH Standards of Care no
21 longer require a mental health assessment prior to initiating
22 hormone therapy. Now, that's for adults. Right? You were
23 talking about adults, because there is a mental health
24 requirement for minors seeking gender-affirming hormone therapy.
25 Correct?

1 A. I hope so in the DSM -- I'm sorry -- in the Standards of
2 Care, eighth edition, yeah.
3 Q. Do you know?
4 A. I can't remember. I think -- see, these are words that I
5 read, but it's the translation of words into action is the
6 issue. And who is a mental health professional and what
7 credentials and what level of experience and what understanding
8 of this disorder do they have, and how much do they know about
9 the state of science? I mean, you have to ask yourself the
10 question in those 70 clinics who is providing the psychiatric
11 assessment. You know, it used to be the psychiatrist and Ph.D.
12 psychologists were the only credentialed. That's not true now.
13 Lesser educated people are credentialed. Now even nurse
14 practitioners are making the diagnoses and prescribing hormones.
15 Q. But you don't know how that is done at most of the clinics
16 across the country. You don't know if that's the case. Right?
17 A. I know it's in the case of some places.
18 Q. Again, going back to the WPATH Standards of Care 8, would
19 you disagree, or would you agree, I'll ask, that they require a
20 comprehensive psychosocial assessment for minors who are seeking
21 gender-affirming medical care?
22 A. Yes. That's exactly what I mean about the words versus the
23 behaviors and the credentials of those who can provide those
24 comprehensive things. You see, in order to be a credentialed
25 mental health professional in WPATH, you have to agree to

1 WPATH's principles.
2 Q. But, again, you don't know how most practitioners around
3 the country, how credentialed they are and how they provide
4 care.
5 A. Who in the world knows?
6 Q. But you don't.
7 A. I don't and you don't.
8 Q. Okay. Now, I want to switch gears and talk about some of
9 the European reports that you talked about. Let's start with
10 Finland. You talked about a report from Finland. Do you
11 remember talking about that? Okay. And you mentioned that a
12 committee of, I believe you said, blue ribbon experts put
13 together these international reports. Which were the experts
14 who were the blue ribbon experts who put together the Finnish
15 report?
16 A. Their names?
17 Q. Anything about them.
18 A. I don't know their names.
19 Q. Do you know anything about them?
20 A. Well, I know the head of this national program. I know
21 her, but I don't know her colleagues.
22 Q. And do you know what organization put that report out?
23 A. Well, it's called COHERE. Please don't ask me what the
24 COHERE stands for.
25 Q. How many experts were on that blue ribbon committee that

1 COHERE put together?
2 A. I don't know the specific number, but those committees
3 usually number six or more people.
4 Q. But you don't know about how many were on the Finnish --
5 A. I don't know.
6 Q. Could it have just been the one doctor?
7 A. No, no way.
8 Q. What do you know about their expertise in gender dysphoria
9 treatment?
10 A. Well, I would presume, as I testified before, that what we
11 call blue ribbon committees have some people on it who are
12 expert, but there's a limited number. And the majority of the
13 experts are people from various fields whose credentials have to
14 do with expertise in study evaluation.
15 Q. You presume that. But do you know if that happened in the
16 Finnish report?
17 A. No. But I've been on the Cochrane report, which is an
18 Irish group, with a large number of people.
19 Q. Yeah. But I'm asking about the Finnish report.
20 A. As I already said, I don't know the names and the
21 credentials of the specific people in that report. I have a
22 trust that you don't seem to share that those kind of national
23 reports are done with highly credentialed people and never one
24 person.
25 Q. Except the Cass report you talked about. Right?

1 A. The Cass report, Cass is the senior author of a committee
2 of people.
3 Q. How many people are on that committee?
4 A. I don't offhand know. You could look and see at her
5 report. It probably lists the people.
6 Q. Do you know anything about the expertise of the people on
7 the Cass report committee you say exists?
8 A. I would assume, just as I answered previously. You are
9 aware of the Dallon report, which reviewed all the standards of
10 care that were in existence. They published a report in April
11 of '21, so they reviewed all the various standards of care for
12 transgender.
13 Q. Are they part of the Cass report?
14 A. Pardon me?
15 Q. I'm asking about the Cass report.
16 A. No. The Dallon report was the one that reiterated the
17 standards of which -- upon which these things are judged. And
18 the concept of 30 percent comes from the Dallon report, and the
19 concept that these standards of care are supposed to be reissued
20 every five years comes -- these are the standards of these
21 high-level committees, you see.
22 Q. I think I understand where we may be talking at each other.
23 Is it your understanding these European reports you mentioned
24 are all clinical practice guidelines of the type that the Dallon
25 report talks about, including the Cass report, that that's a

1 clinical practice guideline?
2 A. Let me answer your question. It's my understanding that
3 this Finnish -- the Finnish, the Swedish and the UK report and
4 the McMasters report from McMasters University in Canada are all
5 populated by people who have expertise in evaluating studies and
6 that are limited. The numbers of people who are actually
7 involved in the field are limited.
8 Q. But your understanding is based on the Dallon report
9 recommending that that's how these things should be done -- I'm
10 sorry -- the Dallon paper about how clinical practice guidelines
11 should be created?
12 A. That's if you are looking for a reference that verifies
13 what I'm saying, I refer you to the Dallon report.
14 Q. So did the Dallon report --
15 A. I think the national -- like the National Health Service's
16 concern with how care is delivered throughout the United
17 Kingdom, so they have considerations that are far beyond what do
18 the people with Tavistock Clinic do. They are asking the
19 question what is the scientific basis for what the people at the
20 Tavistock Clinic do, and they think -- that's what the Swedish
21 report and the Finnish report, what is the scientific -- what is
22 the evidence that supports what we're doing in our country to
23 these young people?
24 Q. I understand that your questions about -- your testimony
25 about what these reports talk about. My question is going to

1 the basis of your statement that these three reports from
2 Finland, Sweden and UK, and now you've mentioned the university
3 report out of Canada, all were blue ribbon committees of
4 experts. The basis of your knowledge that these were experts on
5 those committees, where is that coming from? Is it coming from
6 the Dallon article recommending that that's a good practice in
7 writing reports and you are assuming that they followed that
8 practice?
9 A. It's coming from the history in medicine, not just in this,
10 that when the treatment for an individual condition is reviewed
11 by a major super organization like Medicare reviewing the
12 surgical reports for transgenderism that the people who are
13 reviewing 50 or a hundred reports have expertise. I don't know
14 the names of the people. I don't even know whether they are
15 from urology or gynecology or psychiatry. But those general
16 superordinate structures in societies, sometimes in nations,
17 like the Medicare reports here, they have what I call blue
18 ribbon people on it, people who have credentials to objectively
19 look at the state of science beyond the passion of
20 practitioners.
21 Q. And just to be clear, though, you don't know anything about
22 any of the specific people on these committees in any of these
23 countries.
24 MR. CANTRELL: Your Honor, I think we've beat this to
25 death.

1 THE COURT: Is that true, Doctor?
2 THE WITNESS: It is true.
3 BY MS. COOPER:
4 Q. Okay. Now, the French report, the French document that you
5 talk about, that's not a review of the literature. Right?
6 A. I'm sorry. Which one?
7 Q. The French application.
8 A. The French, I don't think -- I don't want to testify it's
9 based on a review.
10 Q. So you don't know if that was done by a blue ribbon
11 committee of experts?
12 A. I don't know who did it, just there was a national body in
13 France.
14 Q. Okay. Thank you. That helped clarify that. I want to go
15 back to some of these individual reports and just a few
16 questions. The Finnish report did not recommend banning
17 gender-affirming medical care for minors, did it?
18 A. I think in special cases they thought it could be
19 continued.
20 Q. In fact, it allowed puberty blockers on a case-by-case
21 basis after careful consideration. Isn't that what it says?
22 A. I think so.
23 Q. And it says in the Finnish report that hormone therapy
24 could be provided to minors based on a thorough case-by-case
25 consideration if it can be ascertained that the identity as the

1 other sex is of a permanent nature and causes severe dysphoria.
2 Is that correct?
3 A. Yes.
4 Q. Now --
5 A. Ms. Cooper, then how could a bunch of doctors know that a
6 nine year-old's gender identity is permanent? It only could be
7 based on the fact it has existed for three years.
8 Q. Is anybody providing hormone therapy -- cross-sex hormone
9 therapy to nine year-olds?
10 A. Yes, yes, yes.
11 Q. Cross-sex hormone therapy?
12 A. No, no.
13 Q. That's what we're talking about.
14 A. Puberty blocking hormones.
15 Q. This was about cross-sex hormone therapy.
16 A. Oh, I'm sorry.
17 Q. Yeah.
18 A. Even so, if somebody has consistent cross-gender
19 identification from 12 to 16, there's no guarantee that that
20 person will be cross-gender identified at 25.
21 Q. But that's what the Finnish report said, what I described.
22 A. Right. You see the limitations inherent even in policy.
23 Q. So, turning to the French report, just to be clear, they
24 did not recommend prohibiting gender-affirming medical care for
25 minors, did they?

1 A. I don't know.
2 Q. You don't know?
3 A. At this moment.
4 Q. Uh-huh. So you don't know if in France minors can receive
5 gender-affirming medical care to treat gender dysphoria?
6 A. I think this was a general recommendation rather than a
7 prohibition. And the recommendation was psychotherapy and
8 psychiatric evaluation first.
9 Q. Okay.
10 A. I think what we have in common here in all of these
11 countries we're talking about is the recommendation, the prudent
12 recommendation that psychiatric evaluation and attention to
13 associate a psychopathology and worry about both detransition
14 and the rapid rise in the number of people calling themselves
15 transgender calls for a different approach, not the preclusion
16 of individual cases getting a particular treatment, but, in
17 general, doctors of our country think psychotherapy first, not
18 hormones first, not transition first. That's what these things
19 have in common, whether I remember one phrase or another from
20 the report.
21 Q. And your assumption is in the U.S. doctors are doing
22 medical transition before psychotherapy?
23 A. Oh, yes.
24 Q. But you don't actually know how many doctors do that.
25 Right?

1 A. Like you, I don't know the exact number.
2 Q. But you don't know?
3 A. Yes.
4 Q. And just to go back to the French report, is it correct
5 that the report says that psychological support should be
6 provided, but in the event of persistent desire for transition,
7 a careful decision about medical treatment with hormone blockers
8 or hormones of the opposite sex within the framework of
9 multidisciplinary consultation meetings is considered?
10 A. You need to ask what multidiscipline consultation means.
11 Q. I'm asking, is it your understanding that that's what the
12 French document that you talked about earlier provides?
13 A. I presume you are accurately reading from the French
14 document. I have no reason to distrust you on that.
15 Q. Let's put it up so we don't have to wonder. Can you go to
16 the top so we can see the beginning of it? Is this the French
17 document you were talking about from the National Academy of
18 Medicine?
19 A. You translate very well.
20 Q. Thank you. If we look at the highlighted portion, if you
21 will read with me -- actually, let's look above, where it says
22 in bold, "The National Academy of Medicine draws the attention
23 of the medical community to the increasing demand for care in
24 the context of gender trans-identity in children and adolescents
25 and recommends: A psychological support as long as possible for

1 children and adolescents expressing a desire to transition and
2 their parents." I'm not sure about the last. Oh, psychological
3 support for their parents. I'm sorry. Let me read that again
4 because I confused myself, just for the record. "A
5 psychological support as long as possible for children and
6 adolescents expressing a desire to transition and their
7 parents." And, second, it says, "In the event of a persistent
8 desire for transition, a careful decision about medical
9 treatment with hormone blockers or hormones of the opposite sex
10 within the framework of multidisciplinary consultation
11 meetings." That's what the French report says. Correct?
12 A. Yes. Do you want to leave that on for a second?
13 Q. Do you want it?
14 A. Yes. Because I want to talk about it.
15 Q. I'll leave it up. On redirect, counsel can ask you about
16 it or put it up if he wants to.
17 I want to ask a few questions about the Swedish report that
18 you talked about. Is it correct that the Swedish report
19 provides that puberty blockers and hormone therapy can be
20 provided to minors in research settings and in exceptional
21 circumstances?
22 A. Yes.
23 Q. And these recommendations provide that criteria for
24 offering blockers and hormone therapy to treat minors with
25 gender dysphoria should link more closely to those used in the

1 Dutch protocol. Correct?
2 A. What was the first part of that question?
3 Q. These recommendations --
4 A. Yeah. I'm sorry. In certain cases they can do it like the
5 Dutch protocol did it. If that's what you mean, yeah.
6 Q. Okay.
7 A. You see, these national bodies are making exceptions for
8 special cases. That doesn't mean 60 percent of the cases. It
9 doesn't mean 40 percent of the cases. It means a very small
10 percentage of the cases.
11 Q. And so the Swedish report follows the Dutch protocol used
12 in the Dutch studies that you talked about earlier. Is that
13 right?
14 A. Yes. That's the sequence, you know.
15 Q. So just a few questions on the Cass report that we touched
16 on. Again, like the other European reports you talked about,
17 the Cass report did not recommend stopping endocrine treatment
18 for minors with gender dysphoria, did it?
19 A. No.
20 Q. Endocrine treatment is provided to minors in the UK to
21 treat gender dysphoria.
22 A. The Cass report also said what I've been saying all day,
23 that we should think that the first line of treatment is
24 psychological assessment and thorough approach to the
25 comorbidities. What it doesn't say is that nobody should ever

1 get these drugs.
2 Q. And you mentioned a report from Canada. Hormone therapy
3 and puberty blockers are not prohibited for minors in Canada,
4 are they?
5 A. No. This was done for the State of Florida. It was not
6 done by the Canadian National Service. But what it did was
7 reiterate the low quality of evidence for puberty blockers being
8 beneficial and for cross-gender hormones being beneficial or
9 them in sequence being beneficial. Based on international
10 standards, blue ribbon people, sophisticated people, every
11 review says that the scientific objective review of the evidence
12 supporting these treatments is of very low quality.
13 Q. I'm not asking about the quality of evidence. I'm asking
14 about the recommendations in the reports. That's what my
15 questions were focused on. And going back to the Canadian
16 report, do I understand from what you said earlier that that's a
17 report that was prepared to be used in litigation to support a
18 ban on treatment in Florida?
19 A. I don't know exactly why it was done. What I was trying to
20 help you not make a mistake in thinking, that it was part of
21 Canadian national policy. It was an academic center. That
22 place does reviews, does all kind of reviews. And somebody I
23 think from the State of Florida commissioned and paid for the
24 review. And the review said, and it was objectively done, the
25 same thing that the other reviews have said, low quality and

1 very low quality evidence and meaning that the risk of harm,
2 that the risk of harm exceeded the knowledge of the benefits.
3 Q. So just to be clear, in Canada there's not a prohibition on
4 treatment for minors with gender dysphoria?
5 A. As far as I know, there's no prohibition in Canada.
6 Q. And none of these countries we talked about, in other
7 words, Finland, Sweden, UK, Canada, France, none of them have
8 prohibited care like Arkansas has.
9 A. None of them have what?
10 Q. Have prohibited care like Arkansas has in its law. Let me
11 say it again if that wasn't clear. None of the countries you've
12 talked about: Finland, Sweden, UK, Canada or France, has
13 prohibited gender-affirming medical care for minors the way
14 Arkansas has in the law at issue in this case.
15 A. All those countries have used the medical profession and
16 the agents of the medical profession, the institutions within
17 the medical profession, to review the scientific evidence and
18 then to form policies based on that evidence. They have not
19 passed as far as I know laws prohibiting and punishing doctors.
20 Q. And those policies that they have passed do not recommend
21 banning care the way Arkansas does. Correct?
22 A. They said being prudent with special cases. As I pointed
23 out to you, my interpretation of special cases doesn't mean
24 50 percent or 60 percent or 40 percent. It's a small number of
25 cases.

1 Q. And all of those five countries you believe have said that,
2 just special cases?
3 A. For all the countries except, you know, Sweden said with
4 the exception of I think rare special cases, all of those cases
5 that are going to get treatment have to get treated within a
6 protocol.
7 Q. France didn't limit it to special cases, did it?
8 A. Well, when I asked you to put that up, I was going to point
9 out the vagueness of those words and what they had to translate,
10 those words.
11 Q. Well, we can put it back up because I want to go back to
12 that passage that said "in the event of a persistent desire for
13 transition, a careful decision about medical treatment with
14 hormone blockers or hormones of the opposite sex within the
15 framework of multidisciplinary consultation meetings," that's
16 what they described. Correct?
17 A. So the question is -- one of the questions about this
18 highlighted, these two sentences, is what does it mean, the
19 framework of multidisciplinary consultation meetings? Does it
20 mean with the nurse practitioner and the social worker and the
21 psychiatrist and the psychologist? Does it mean with the
22 endocrinologist? Does it mean with the surgeon, you see? Does
23 it mean with a committee of trans people themselves? What does
24 it mean? WPATH always talks about that as well, you see. What
25 I'm talking about, and I think what all of these national bodies

1 are talking about, is the recognition that there's something
2 amiss psychologically and developmentally in a large percentage
3 of trans-identified children and adults and that the right
4 professional needs to deal with it.
5 So when we talk about multidiscipline, what we're really
6 talking about, does the endocrinologist agree? Does the surgeon
7 agree? They are not talking about the psychologist and the
8 nurse practitioner. They are just taking one of those mental
9 health professionals. And you know how systems work where M.D.s
10 get, you know, they tend to be looked at as more expert than
11 lesser trained people. So that's one of the vagueness about
12 these two sentences that you've highlighted.
13 Q. And you brought France up as an example of a better course,
14 a better approach, I understood. Is that not your view anymore?
15 A. No. I bring it up because even France is saying a
16 psychological assessment should no longer be downgraded. Mental
17 health professionals, the implication to me is that mental
18 health professionals should not be viewed disparagingly as mere
19 gatekeepers, you see, that people need to be considered. Their
20 psychological state needs to be considered by people who have
21 the capacity to take a developmental history, to know what it
22 means and to try to arrange a conversation for a therapy or
23 medication and combinations of the above that might ameliorate
24 some of the suffering that is in within the soul, within the
25 person, within the personality of the patient or the family.

1 That's all. I don't know what you are trying to get me to say
2 here.
3 Q. I'm confused because you are saying that care in the United
4 States is leaving out the psychological evaluation and
5 treatment. But I think you agreed that the WPATH Standards of
6 Care 8 specifically requires a comprehensive psychosocial
7 evaluation before you would consider hormone treatment for
8 minors. Is it just your assumption nobody is following the
9 standards?
10 A. Ms. Cooper, these are words. Comprehensive psychiatric
11 evaluation. I mean, I work in a multidisciplinary multi-health
12 clinic. And I can tell you that the various levels of education
13 that passes for mental health professionals are quite different.
14 The concepts that people have in mental health are quite
15 different.
16 Q. Is that different in Europe than in the U.S.?
17 A. Oh, absolutely.
18 Q. So they are all qualified there, but here you are assuming
19 most are not, to provide the care?
20 A. No.
21 Q. I'm just trying to understand the distinction.
22 A. I'm not saying that at all. You and I are crossing each
23 other at a very high altitude.
24 Q. I understand your criticism of care here is that
25 practitioners are downgrading mental health evaluation and not

1 taking that into consideration in comorbidities, but in Europe
2 they are focusing on that. But when I pointed out that the
3 standards of care here actually require that, you said, well,
4 they don't really follow the standards.
5 A. Ms. Cooper, what I was trying to say to you, you can read
6 these wonderful words in the standards of care, but it turns out
7 the devil is in the details. The devil is how it's translated,
8 who is doing the psychiatric assessments, what mindset do they
9 have, what knowledge do they have, and how long do they have to
10 do it. Every clinic can say we do comprehensive care. Every
11 clinic will say we do these evaluations. But from the parents'
12 point of view or the educated parents' point of view, that is
13 not what is happening to their child frequently.
14 Q. For some families you've talked to.
15 A. Frequently.
16 Q. For some families you've talked to. Correct?
17 A. I'm sorry?
18 Q. For some families you've talked to.
19 A. Almost for all the families I've talked to.
20 Q. Which is a tiny amount, representing a very tiny amount of
21 the clinics around the country. Correct?
22 A. And I don't know what percentage of the clinics, but they
23 are from many states.
24 Q. I just have a few more questions. I want to go back to the
25 second study on detransition that you mentioned showing the

1 30 percent detransition rate.
2 A. The Boyd study?
3 Q. That was the one by Boyd. Thank you. We're going to put
4 that up so we can get clarity on that. Looking at a study
5 called "Care of Transgender Patients: A General Practice
6 Quality Improvement Approach" by Isabel Boyd, et al., that's the
7 study you are talking about?
8 A. That was I think a primary care study.
9 Q. Okay. You have the highlighted portion in front of you?
10 A. Yes.
11 Q. "3.2.4. Undesired Treatment Outcomes (stopping hormones,
12 abnormal blood test results, side effects and complications)."
13 It says here, "Nine patients had stopped hormone therapy, one
14 related to practice policy because they had not attended any GIC
15 follow-up (the patient has restarted since the audit). Thus,
16 eight patients had stopped hormones voluntarily (20 percent
17 stopping rate; six trans men, two trans women). These patients
18 had been on treatment for a mean of five years (range 17 months
19 to 10 years). Four trans men had comments in the record that
20 related to a change in gender identity or detransitioning (4 out
21 of 41, 9.8 percent) quote: Would like to gradually
22 detransition. No longer wish to live your life as a male. Has
23 decided to detransition. Feels comfortable having decided to
24 dress and appear more feminine. Feels it was a mistake
25 identifying as non-binary now, close quotes.

1 None of these patients had undergone any gender-related
2 surgery. They had presented at a mean of 18 years of age, taken
3 testosterone for a mean of 18 months and currently presented as
4 female (three) or non-binary (one). The other four patients who
5 had stopped hormones continued to present as trans (two women,
6 two men): One, who had experienced orchidectomy, had a record
7 of regret (no hormonal treatment currently, regrets gender
8 reassignment); one had a medical reason noted for stopping,
9 quote, problems with PV bleeding despite androgen; two had no
10 specific reason for stopping in their record, but it was
11 documented that they had stopped."
12 So I see a 20 percent stopping rate, but I don't see a
13 30 percent detransition rate anywhere in there. Is this the
14 study you are talking about?
15 A. Yes. But, you know, I haven't read this study since it
16 came out. And you've picked out one paragraph. And perhaps we
17 could sit down and read it together and figure out whether I'm
18 right or wrong. And if I'm wrong, I'm wrong by 10 percent. The
19 point is, Ms. Cooper, the detransition for various reasons
20 happens. If it happens in this clinic, we should assume it
21 happens in Arkansas and in Missouri and everywhere else. And
22 the idea that people think it's a mistake is one of the things
23 I've tried to talk about this morning. We can't be sure that a
24 14 or 15 or 17 year-old knows what his or her future is going to
25 be. And if they cannot be prudent, we have to be prudent. And

1 if the medical profession isn't prudent about this, isn't
2 careful, isn't aware of the limitations, I guess legislatures
3 make a decision.
4 So I'm just asking the medical profession to be prudent and
5 to know about the evolution of gender identity. Even after it's
6 been solid during adolescence for three years or four years, it
7 doesn't mean that when you are 23 you don't think differently.
8 We must be prudent, and we must protect people sometimes against
9 things that we have reason to believe that a majority of people
10 may come to regret. Now, you see the real question here is not
11 the Boyd study.
12 Q. Well, I do want to stay on the Boyd study for a minute. I
13 understand your point that detransition happens. And that is
14 not the question I want to -- I'm not arguing about that.
15 A. Good.
16 Q. I'm asking about this 30 percent number that you testified.
17 I understand now you may be not standing by that 30 percent
18 figure?
19 A. Yeah. Maybe I'm going back to 20 percent.
20 Q. Then, even the 20 percent you would agree is not a
21 representation of detransition, but it represents the number of
22 people who stop medical transition for various reasons, some
23 medical reasons and unknown reasons. Correct?
24 A. I don't think you are going to make compelling points in my
25 view by picking out one paragraph and not looking at the whole

1 thing.
2 Q. You used the number 30 percent, and this appears to be
3 where it came from, so I need to pick it apart.
4 A. I do not represent myself as infallible. And my
5 statements, I can't imagine every statement is verifiable that I
6 ever make in my life. I'm doing the best I can with my memory.
7 Q. Fair enough. It's not a memory test. Looking at it here
8 now, though, you would agree that this study does not even say
9 20 percent detransitioned. It says 20 percent stopped the
10 medical transition for various reasons.
11 A. Well, can you tell what the denominator here is?
12 Q. Well, 20 percent. Twenty is a percentage.
13 A. That requires a denominator. What number of people are we
14 talking about?
15 THE COURT: Twenty out of a hundred.
16 THE WITNESS: That's not --
17 BY MS. COOPER:
18 Q. 41 is the N. If you want to know the number, it's 41 I
19 think it says. Four out of 41 were the ones who --
20 A. Is 41 the denominator?
21 Q. 4 out of 41 detransitioned.
22 A. So nine of 41 people stopped their hormones. Is that what
23 you are saying? So we do that math. 9 of 41.
24 Q. Twenty percent stopped.
25 A. It's over 20 percent.

1 Q. Stopped hormones?
2 A. Yeah.
3 Q. I just want to be clear, though, that doesn't represent
4 detransition. It represents stopping hormones for a variety of
5 different reasons.
6 A. And I want to be clear. I want to be clear that you don't
7 know it doesn't represent detransition. It means stopping
8 hormones. Why does a person stop hormones?
9 Q. Well, it says right here problems with bleeding despite
10 androgen, and two had no specific reasons. You don't understand
11 people stopping hormones besides detransition?
12 A. What are you quizzically asking?
13 Q. Do you think the only reason somebody who is on hormone
14 therapy for gender dysphoria would stop treatment, that the only
15 reason would be because they detransitioned?
16 A. No. Some stop because they get hypertension. Some stop
17 because they get obese. Some stop because they get blood clots.
18 Some stop because their hemoglobin levels go way up and they are
19 threatened with stroke.
20 Q. But they may still maintain their trans identity. Correct?
21 A. And, of course, if that would happen to a person, that
22 would make them rethink everything.
23 Q. I think we can put this study aside, and just a couple of
24 questions. Prior to this case, you had never heard of Mark
25 Regnerus. Correct?

1 A. Mark who?
2 Q. Regnerus.
3 A. Regnerus?
4 Q. R-e-g-n-e-r-u-s. It sounds like you still may not know who
5 he is. Is that correct?
6 A. I don't remember who he is.
7 Q. And prior to this case, you didn't know who Patrick Lappert
8 is. Correct?
9 A. That name is more familiar, but I can't, yes.
10 Q. You don't know who he is?
11 A. I don't remember.
12 MS. COOPER: Just a moment, please.
13 Pass the witness.
14 REDIRECT EXAMINATION
15 BY MR. CANTRELL:
16 Q. Dr. Levine, do you still have the binder in front of you?
17 A. Yes.
18 Q. If you would, turn to tab 9. This should be the French
19 National Academy of Medicine document that Ms. Cooper was asking
20 you about earlier.
21 A. Yes. It's in front of me.
22 Q. And I want to direct your attention, if you can see here,
23 to the third paragraph.
24 A. Uh-huh.
25 Q. If you will read with me, it says, "Whatever the mechanisms

1 involved in the adolescent, overuse of social networks, greater
2 social acceptability, or example in the entourage, this
3 epidemic-like phenomenon results in the appearance of cases or
4 even clusters in the immediate surroundings. This primarily
5 social problem is based, in part, on a questioning of an
6 excessively dichotomous vision of gender identity by some young
7 people." Did I read that correctly?
8 A. You, too, read very well.
9 Q. Thank you. And moving down --
10 THE COURT: What's the question other than what you
11 read to him, Mr. Cantrell? Did you read it correctly is not
12 really a question of this witness.
13 MR. CANTRELL: Well, Your Honor --
14 THE COURT: I'm not going to let you read to him and
15 then ask him if you read that correctly like on
16 cross-examination. What is your question of this witness?
17 MR. CANTRELL: Well, Your Honor, Ms. Cooper read
18 several passages.
19 THE COURT: Right. But you don't just get to read to
20 me and ask him if you read that correctly. That's not a
21 question and is probably the definition of a leading question,
22 which I'm not going to go into now. But I'm not going to have
23 you just read parts of this to me and ask him "did I read that
24 correctly?" What's your question to this witness about this
25 material?

1 BY MR. CANTRELL:
2 Q. Okay. Dr. Levine, here's my question. Dr. Levine, Ms.
3 Cooper's line of questioning would give the impression that the
4 French National Academy of Medicine was not quite as concerned
5 as you had previously testified was the case. Do you have
6 anything in response to say?
7 A. Well, that paragraph, I think, telling you that the French
8 National Academy is concerned about the social origins of
9 this -- and they went on a limb and said what they thought some
10 of the social origins and social forces actually were. Given
11 the fact that the National Academy of Medicine of France thinks
12 that this is socially constructive for many of these children,
13 for the majority of these children, that they go on to urge
14 caution, they are also saying there may be some cases that
15 deserve or justify the use of hormones, but the social forces
16 that are shaping this in epidemic proportion makes people, makes
17 the doctors of France, should make the doctors of France prudent
18 and careful. That's all. That's what I understand that
19 paragraph to mean.
20 Q. Dr. Levine, is that further reflected when you look down to
21 the next-to-last paragraph on this page, where it's referring to
22 "a great medical caution must be taken in children and
23 adolescents, given the vulnerability, particularly
24 psychological, of this population and the many undesirable
25 effects, and even serious complications, that some of the

1 available therapies can cause"?
2 A. Yes. In answer to the previous question of Ms. Cooper, I
3 listed some of the serious medical complications. Those are
4 just the psychological complications. So I use the word
5 "prudent." The French translate their word for caution.
6 Prudent and caution to me are synonyms, you know. It also says
7 in that paragraph that Sweden has banned the use of hormone
8 blockers, which was different than what I was led to believe by
9 Ms. Cooper.
10 Q. Ms. Cooper also asked questions concerning, I believe, the
11 possibility of clinical trials taking place in Arkansas. Are
12 you familiar with any clinical trials that are taking place in
13 Arkansas or planned to take place in Arkansas?
14 A. I'm not familiar, nor have I heard of that. A clinical
15 trial, that has to be prospective. You know, to begin with
16 certain patients, put them in different groups and then follow
17 them for a number of designated years with predetermined outcome
18 measures and definitions of primary and secondary outcomes that
19 we're going to focus on when we evaluate the people and follow
20 up is a very expensive thing. It requires usually federal
21 funding or some big funding source like the Gates Foundation
22 that has billions of dollars. It's a lifelong project really
23 for the original investigators because you are going to have to
24 study people for ten years or more. Those are tough studies to
25 do. They are very expensive, but they are vital studies to do.

1 MR. CANTRELL: If I can have a moment, Your Honor.
2 THE COURT: You may.
3 MR. CANTRELL: Nothing further, Your Honor.
4 MS. COOPER: Your Honor, if I may do one question on
5 recross. If we can put up the French National Academy document
6 again.
7 RECROSS-EXAMINATION
8 BY MS. COOPER:
9 Q. I believe, Dr. Levine, you testified just now on redirect
10 that Sweden bans or that France in this National Academy of
11 Medicine document said that Sweden bans puberty blockers. But I
12 want you to read with me here the bottom full paragraph
13 highlighted -- thank you -- starting with "In this respect, it
14 is important to recall the recent decision (May 2021) of the
15 Karolinska University Hospital in Stockholm to ban the use of
16 hormone blockers." Is that what you were referring to?
17 A. Yes.
18 Q. So that's one hospital, right, not a Swedish national
19 policy, just to clarify.
20 A. That's the -- the Karolinska Institute is the premiere
21 hospital.
22 Q. Right.
23 A. The world-renowned hospital. And there must be a
24 relationship between the review board and this clinic because
25 they wanted all the research to be done at the Karolinska.

1 Q. I understand you are speculating about the connection
2 there. But the national review board of Sweden did not ban
3 blockers. Correct? We talked about that before.
4 A. If Karolinska blocked blockers and if Karolinska is the
5 primary site for the Swedish people to get gender-affirming
6 care --
7 Q. Is it your understanding that's the only place you could
8 get gender-affirming medical care if you are a minor in Sweden?
9 A. I'm not sure. Sweden is a small country compared to the
10 United States. Those countries tend to create clinics like the
11 Portman Clinic in the UK that funnel these patients to the
12 centers of excellence, the centers of study.
13 Q. But you don't know how it's done in Sweden?
14 A. I don't know for sure how it's done in Sweden. I do know
15 Sweden, we're very concerned about the suicide rates of their
16 transgender population. The last report I had, it was
17 3.5 percent higher than the general population.
18 Q. I lied. I have a second question, if that's okay, related
19 to the same topic. I would like to put up another document, the
20 Swedish national report that we have discussed. This is, for
21 reference, DX17. This is the Swedish report you were discussing
22 earlier. Correct?
23 A. The translation of it?
24 Q. The English translation. If we can scroll, if you can look
25 at the first highlighted paragraph with me. "To minimize the

1 risk that a young person with gender incongruence later will
2 regret a gender-affirming treatment, the NBHW deems that the
3 criteria for offering GnRH analog and gender-affirming hormones
4 should link more closely to those used in the Dutch protocol,
5 where the duration of gender incongruence over time is
6 emphasized. Accordingly, an early childhood onset of gender
7 incongruence, persistence of gender incongruence until puberty
8 and a marked psychological strain in response to a pubertal
9 development is among the recommended criteria."
10 I'm sorry. I'm reading the wrong paragraph.
11 Apologies. I'm going to read the highlighted second
12 paragraph. "To ensure that new knowledge is gathered, the NBHW
13 further deems that treatment with GnRH analogs and sex hormones
14 for young people should be provided within a research context,
15 which does not necessarily imply the use of randomized
16 controlled trials, RCTs. As in other healthcare areas where it
17 is difficult to conduct RCTs while retaining sufficient internal
18 validity, it is also important that other prospective study
19 designs are considered for ethical review and that register
20 studies are made possible. Until a research study is in place,
21 the NBHW deems that treatment with GnRH analogs and sex hormones
22 may be given in exceptional cases, in accordance with the
23 updated recommendations and criteria described in the
24 guidelines." This is the requirement or provision in the
25 Swedish national report. Correct?

1 A. Correct.
2 Q. Okay. Thank you. Nothing else.
3 MS. TEMPLIN: Judge, if you are ready to proceed to
4 the next witness, we would call Dr. Patrick Lappert.
5 THE COURT: Are we going to be able to finish that
6 witness before five o'clock?
7 MS. TEMPLIN: I could try and get through at least a
8 good chunk of mine. I don't know about cross.
9 THE COURT: We're starting at eight o'clock on another
10 witness, right, Mr. Jacobs?
11 MR. JACOBS: That is the plan, Your Honor. Can we
12 have a moment to chat about the schedule with Dr. Lappert?
13 THE COURT: Sure.
14 (Brief recess.)
15 MR. JACOBS: So given how late in the day we are, I
16 don't think there's any way we could finish with Dr. Lappert
17 today without going forever. So I think what we would propose
18 is to go ahead and adjourn for today, start with Regnerus
19 tomorrow in the a.m. I think, if we start close to 8 a.m., it's
20 very likely we could be done by like one or whenever the Court
21 wants to break for lunch. That may be ambitious, but I think
22 it's pretty close.
23 THE COURT: With Zoom?
24 MR. JACOBS: Yeah, with the Teams meeting and be done
25 with that. Then Dr. Lappert will go after Dr. Regnerus

1 tomorrow. So he's willing to change his travel.
2 THE COURT: How long do you anticipate him going?
3 MR. JACOBS: Dr. Lappert?
4 THE COURT: Yes. Witness two tomorrow after the Zoom,
5 because we're talking about going until one, taking a lunch
6 break, then we're at two.
7 MS. TEMPLIN: Your Honor, it's not going to take me
8 three hours with Dr. Lappert. I'm not sure how long plaintiffs
9 have planned on cross. I certainly from my end can anticipate
10 being done by five.
11 MR. JACOBS: If I had three hours with Dr. Regnerus, I
12 would be very surprised if I had that long with him. When I say
13 done by one, now that I'm thinking about it, I could probably
14 push that down to noon realistically maybe.
15 THE COURT: My point is, if y'all are done with this
16 witness at five tomorrow, then we're going into the following
17 day with him also. So checking with his availability tomorrow
18 does no good.
19 MS. TEMPLIN: No, Your Honor. I anticipate both sides
20 could possibly be done by five depending on the length of cross.
21 I certainly do not plan to spend three hours on direct
22 examination. From two, it would not take me until five to do
23 direct examination.
24 THE COURT: I misheard you. I thought you said you
25 would be done by five.

1 MS. TEMPLIN: Apologies.
2 MR. JACOBS: That's what we would suggest. Dr.
3 Lappert is willing to change around his travel to make that
4 work. I think we went a little bit longer with Dr. Levine than
5 we anticipated. We hoped to be able to do both today. So long
6 as the Court has tomorrow afternoon available, so long as
7 there's not any objections on that end, I think we could switch
8 those and get everything done.
9 THE COURT: The only thing I have in my week that's in
10 y'all's way is the one o'clock 30 minute and the two o'clock 30
11 minute on Wednesday, then the noon hour on Thursday.
12 MR. JACOBS: Neither of those will be problems on our
13 end, Your Honor. If that's acceptable to everybody, I think we
14 will proceed with Dr. Regnerus tomorrow when we get everything
15 set and then proceed with Dr. Lappert.
16 THE COURT: If we get both of them done tomorrow, how
17 late do you anticipate going on Thursday?
18 MR. JACOBS: On Thursday, Your Honor, it could be a
19 full day on Thursday. I just don't know whether it's going to
20 be sort of an early day out on Thursday or not at this point.
21 THE COURT: I'm just curious.
22 MR. JACOBS: Regardless of this, we'll still be
23 totally done on Thursday with our witnesses. That won't impact
24 this at all.
25 THE COURT: All right. Court is in recess until

1 eight o'clock tomorrow.

2 MR. JACOBS: Yes, Your Honor.

3 (Overnight recess at 4:19 p.m.)

4 REPORTER'S CERTIFICATE

5 I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

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7 /s/Elaine Hinson, RMR, CRR, CCR Date: December 4, 2022.
United States Court Reporter

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