IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

EXPERT REPORT OF KRISTOPHER KALIEBE, M.D.

Introduction

Pursuant to 28 U.S.C. 1746, I declare:

1. I have been asked by the defendants to discuss my membership in professional associations, and the relevant guidelines and policies concerning gender dysphoria in those associations. I have been asked to provide a review of the evidence base for treatments of gender dysphoria. I also have been asked to opine on the influence of activism and suppression of open inquiry which has distorted academic dialogue and made published research and expert recommendations untrustworthy with regard to gender dysphoria.

2. This report is entirely my own work product, and no one was consulted for this this report.

3. If called to testify in this matter, I will testify truthfully based on my personal experience and knowledge.

4. I am being compensated at an hourly rate of $400 per hour for my time preparing this declaration. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

Here I provide a summary of my major points:

a. While historical reports of gender dysphoria exist, it has been rare until the last two decades.

b. There is no consensus in the field regarding the treatment of gender dysphoria, nor is there an evidence-base sufficient to lead to any confident recommendations.

c. Multiple reviews of the evidence base regarding treatment of gender dysphoria indicate that the evidence for affirmative treatment is low-quality.

d. Small numbers of advocate physicians within medical organizations have been able to leverage moralized claims and low quality evidence in order to promote affirmative care for gender dysphoria.

e. Significant evidence points to a spread of ideology combined with technologically induced contagion effects leading the recent increase in gender dysphoria.

f. As American medical professional organizations have already endorsed the concept of affirmative care as evidence-based and ethical, they are no longer neutral with regards to the science and have instead entered into advocacy roles.

g. Much of the slogans and assumptions associated with affirmative care for gender dysphoria are conjecture, opinion or misinformation presenting as established fact.

h. Due to the highly politicized and ideological nature of the issue of gender dysphoria, there is limited rigorous scholarly dialogue within American professional medical organizations and medical journals.

Background

6. I am an associate professor at the University of South Florida in Tampa Florida. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry and Forensic Psychiatry. My clinical work has been primarily in University based clinics, Federally Qualified Health Centers and juvenile corrections.

7. I was awarded my medical degree in 1999, and subsequently completed general psychiatry, child and adolescent psychiatry and forensic psychiatry training. This training includes education in human biology, human sexuality, development, brain functioning, normal development and psychopathology. Gender dysphoria and gender dysphoria treatment were part of my professional training.

8. From 2005 to 2016 I was Assistant Professor at Louisiana State University Health Science Center – New Orleans. I was the program director of the LSU Child Psychiatry Fellowship for 2 years. Since 2016 I have been Associate Professor at the University of South Florida where my clinical roles which mainly include working with juvenile corrections, supporting primary care physicians through the Florida Medicaid Psychiatric Medication hotline and in a university child and adolescent psychiatry clinic. I cover at Tampa General Hospital and recently added an adult psychiatry resident clinic to my schedule. I also practice forensic psychiatry including child and adult cases, both within criminal and civil court.

9. As a supervising physician at the University of South Florida's Silver Child Development Center my role is to function as a clinical supervisor and instructor. Child psychiatry residents and general psychiatry residents serve as the primary patient evaluators and clinicians. I evaluate new patients directly, and after see patients directly as needed. I oversee the resident's work products and function as the physician of record. Within this clinic I evaluate and treat patients with gender dysphoria.

10. In addition to these direct clinical experiences, part of my scope of duties within the Silver Child Development Center is training residents regarding the treatment of patients, including patients with gender dysphoria.

11. Within the juvenile justice system I also evaluate and treat patients with gender dysphoria. I further have been consulted to provide a second opinion and coordinate care regarding a patient with gender dysphoria in the Louisiana juvenile correctional system.

12. In addition to direct clinical care, I am routinely consulted by colleagues. Within my work at the Florida Medicaid Psychiatric Hotline I have collaborated in the care of patients with gender dysphoria. My colleague consultation includes providing my opinion regarding would a youth be competent to consent as requested by an endocrinologist regarding a youth considering puberty blockers on

a path toward sex hormone treatment and potential surgeries. I have been consulted regarding psychotherapeutic approaches to young adult patients who detransitioned.

13. I have extensive teaching experience including medical students, general psychiatry residents, child and adolescent psychiatry fellows and forensic psychiatry fellows. I have years of extensive positive feedback from medical students and psychiatrist residents.

14. My approach to the practice of medicine includes utilizing and appreciating the amazing progress modern medicine has made. I practice and support conventional medicine, I have strongly advocated for the expansion of Federally Qualified Health Centers, along with improved collaboration of mental health with primary care (Kaliebe 2016, Kaliebe 2017).

15. My support of, and attempts to improve conventional medicine, is balanced by a healthy degree of caution. The history of medicine is filled with examples of the harms which can come with unproven, unnecessary, aggressive or counterproductive interventions. As such, I've presented twice at the Preventing Overdiagnosis conference.

16. I am involved with Integrative Medicine, focused mainly on the role of mind-body medicine, mindfulness, nutrition and exercise, along with how modern medicine has adopted approaches which underemphasize and at times neglect the basics of health. Another academic interest of mine is the tradeoffs and stress of

moving to primarily electronics based communications, especially on young people. (Kaliebe 2002, Gerwin 2018) I have a longstanding interest in how technology and the media intersect with society and culture, including the impacts of social media, recent increases in tribalism and the spread of misinformation.

17. With Paul Weigle, I co-edited the Child and Adolescent Psychiatric Clinics of North America *Youth Internet Habits and Mental Health* edition in 2018 with 16 chapters by invited experts on digital and mental health related issues. (Kaliebe 2018)

18. I am a member of the American Academy of Psychiatry and the American Psychiatric Association. I have been most active within the American Academy of Child and Adolescent Psychiatry (AACAP). I was awarded status as a Distinguished Fellow at AACAP in 2016. I first presented regarding the media at the 2004 AACAP annual conference, and have now presented at the annual conference 25 times. I served as co-chair of the Media Committee from 2013-2021. I served as the Liaison from AACAP to the American Academy of Pediatrics from 2016-2022. I was an author on their practice guidelines for telepsychiatry. I have also served AACAP in the state affiliates, for the Louisiana Council for Child Psychiatry I was secretary / treasurer for 4 years and served as president for 2 years.

19. I have a longstanding interest in psychotherapy. I have additional training in Cognitive Behavioral Therapy and trauma-focused therapies. I have been

providing psychotherapy and teaching psychotherapy to psychiatry trainees throughout my career. I currently routinely supervise psychiatry residents regarding psychotherapy with the USF residency program. I created and taught a Cognitive Behavioral Therapy practicum for LSU residents from 2007 to 2016. I was a member of the Association for Behavioral and Cognitive Therapies from 2004 to 2016.

20. I have been on the Best Doctors list annually since 2007.

21. I also practice and teach forensic psychiatry and have testified in deposition or trial in the following cases over the past four years:

a. Civil Testimony, retained by the defense:

   i. In the Interest of RW, LL, AP Minor Children January 28, 2020 Circuit Court of the 13th judicial circuit, Juvenile Division, Judge Lisa Campbell, Tampa FL

b. Civil Testimony, court appointed:

   i. February 28, 2020, Jeffrey Spivey, petitioner/father and Teresa Spivey N/K/A Teresa Cartwright, respondent/mother Case No.: 2016 DR0471's, Circuit Court of the 12th judicial circuit in and for Manatee County Florida. Judge Kevin Bruning

c. Civil Testimony, court appointed:

   i. Re: The Marriage of Robyn Cohen McCarthy and John McCarthy November 1, 2019 11th Judicial Circuit, Family Division, Dade County, Judge Jason Dimitris, Miami FL

d. Criminal Testimony, retained by the defense:

i. The State of Florida v. Bill Paul Marquardt December 19, 2019 5th Judicial Circuit, Sumner County, Florida, Judge William Hallman III, Bushnell Florida

ii. The State of Florida v. Bill Paul Marquardt August 24, 2022 5th Judicial Circuit, Sumner County, Florida, Judge Mary P. Hatcher Bushnell Florida

e. Civil Depositions, retained by the defense:

i. Z.M.L., a minor, through her parents and guardians, -vs- D.R. Horton, Inc., a foreign corporation authorized to do business in Florida, United States District Court, Middle Division of Florida, Tampa, May 6, 2021

ii. THE ESTATE of JEAN LINDOR, deceased minor, by and through the Personal Representative of the Estate, JAMES LACROIX and NOUSE ANDREE LACROIX, individually, Plaintiffs, v. BOS TRANSPORT, LLC, a Florida Limited Liability Company, and ORESTES ZAMORA FLEITES, individually, December 5th, 2022

f. Civil Depositions, retained by the plaintiff:

i. Carlton Collins, individually, and on behalf of his minor son, Connor Samuel Collins v. David R. Wallace, Sr., M.D. Louisiana's 14th judicial district, Civil Suit: 2019 – 4128 – D, March 4th, 2022

g. Criminal Deposition, retained by the defense:

i. State of Florida v. Justin Mitchell Pennell, 2020CF000159FAXWS, 6th Judicial Circuit of the State of Florida in and for Pasco County, March 11, 2022Since 2016

22. A list of my publications is attached to this report as Exhibit "A".

The abrupt rise in transgender and non-binary identification

23. The discussion regarding transgender care is in the context of an unexplained and remarkable rise in patients reporting gender dysphoria. During my medical school experience and 3 residencies, I never encountered a patient reporting symptoms of gender dysphoria. For eleven years, from 2005 to 2016, I had a busy psychiatry clinic with about 80% minors and 20% adult patients without a single patient expressing gender dysphoria.

24. During those eleven years, none of the hundreds of medical students or residents I supervised presented cases to me describing patients with gender dysphoria. None of my social work or psychologist colleagues ever asked for consultation or advice regarding how to clinically approach patients with gender dysphoria. Within the last year, on a single day, I have treated three adolescent patients diagnosed with gender dysphoria.

25. My experience is consistent with statistics indicating an abrupt rise in gender dysphoria and presentations to medical clinics for related services. When a new patient population emerges, it creates challenges for physicians to respond. In medicine, typically when such an abrupt change in patient populations occur, the subsequent scholarly literature would typically discuss and debate underlying causes of this phenomenon.

26. Never before has there been large cohorts of individuals seeking medical services to alter their secondary sex characteristics. There had been decades of extremely rare treatment which was at the time acknowledged as compassionate but experimental care. Yet the current patients expressing gender dysphoria represent primarily a new and distinct patient population, not a population which has historically existed.

27. As a psychiatrist, I have encountered many patients who are uncomfortable with their bodies. This discomfort and dissatisfaction is often comingled with anxiety and depression, along with various diagnoses which involve bodily discomfort including eating disorders or Body Dysmorphic Disorder.

28. I have observed bodily discomfort more often in females, and especially as girls enter puberty, which is consistent with the epidemiological literature. Puberty introduces significant challenges and risks to females as they receive more attention from males, including adult males, along with increased competition from peers. Puberty now comes much younger than for our ancestors, creating a greater mismatch between brain and body maturity.

29. While the exact number is unknown it can be said that the incidence of gender dysphoria in youth was previously rare. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders published in 2013 rated in adults at 2-14 per 100000 (American Psychiatric Association p454).

Referrals at the Tavistock clinic in England increased over 50 fold in just a decade from 2009 to 2019. (Tavistock & Portman, NAHS Foundation Trust, 2020).

30. Similar increases have been reported across much of the economically advanced countries in the world, many showing over 1000% rise in gender dysphoria over the last decades (Marianowicz-Szczygiel 2022). This phenomenon requires some explanation and any complex phenomenon likely has a multifactorial line of causation. Yet multiple lines of evidence point to direct social influences and online and social media contagion as a major contributors to this increase in gender dysphoria. Biological factors causing the increase of gender dysphoria, such as endocrine disrupting chemicals, are plausible but have not been explored in the scholarly literature.

31. The involvement of social spread is supported by Lisa Littman's work (Littman 2018). It is supported by the timing of the massive increase in gender dysphoria coinciding with the rise in social media and associated "influencers". It is supported by the largest rise in gender dysphoria occurring in vulnerable adolescent females. This is precisely the same population most susceptible to online contagions such as "functional" rapid onset tics disorders, suicidal behavior, non-suicidal self-harm and increase self-reported Dissociative Identity Disorder.

32. The influence of culture, medical theories and ideology on symptom production is long-standing and well known. Shorter detailed numerous examples

of how culture intersects with psychiatric illness from the Victorian to modern era (Shorter 1993). For a discussion of how psychopathology can spread among psychiatric disorders, see Horesh et al's recent article (Horesh 2022).

33. Humans evolved as a sexually dimorphic, ultra-social and cultural species. Culture has co-mingled with our evolution, because unlike other animals, learning from others enables our very survival. Humans acquire a considerable portion of our behaviors and viewpoints "by tapping into a large body of non-genetic information that has been filtered and accumulated over generations. This process, termed cumulative cultural evolution, creates a storehouse in the form of strategies, attentional biases, motivations, tastes, and cognitive heuristics that are necessary for us to accomplish even the basics of survival". (p 210 Henrich 2021).

34. Thus humans can't explain the rationale for much of our routines, habits and customs because they have been shaped over time, some for thousands of year, some more recently. This raises the possibility there is time tested wisdom in many of our cultural adaptations. Cumulative culture constantly changes, but the recent rate of change has been exponentially faster due to the explosion of technologies. The modern world is thus experiencing perhaps the largest generation gap in history. Today's children and adolescents are exposed to so much more than out grandparents.

35. In ancient evolutionary environments, copying others aided survival via the transmission of acquired knowledge about what areas are safe, how to make shelters or weapons, what berries or mushrooms are safe to eat, and what type of social behavior is acceptable within a group. Humans' brains are particularly adapted with exceptional abilities to notice and copy the behavior of others.

36. Transmission of culture occurs in part via humans naturally mimicking what we observe in others. Yet these same instincts that develop helpful behavioral norms also enable social contagions that co-mingle with mental and behavioral disorders. Long-standing scholarly consensus exists confirming that direct social contagion not only affects health such as cardiac disease (Christakis. 2013), but interacts with technology enabled spread of mental health problems. (Haltigan 2023)

37. This can be seen in relation to suicide contagion (Yıldız,2019), non-suicidal self-injury (Jarvi, 2013), contagion related to eating disorders such as anorexia (Allison 2014). Since the Covid 19 pandemic, there has been an explosive increase of young people displaying features of Dissociative Identity Disorder and movements similar to those seen in Tic Disorders such as Tourette's (Pringsheim 2021). A google scholar review shows a dozen articles linking rapid onset tic disorders to social media. Similar to other examples of social contagion, these sudden onset tic presentations tend to be comorbid with pre-existing mental illnesses and adolescent girls show themselves to be the most susceptible.

38. The phenomenon labeled Mass Social Media Induced Illness (Giedinghagen, 2022) shows us that at scale, users of social media can develop technology facilitated psychosomatic illness. Psychiatrists have seen an abrupt rise in patients presenting with a self-diagnosis (Rettew 2022).

39. Consistent with all this evidence, the spread of beliefs about gender identity, such that all individuals should consider and question their gender identity, appears quite plausibly capable of significantly increasing the incidence of gender dysphoria. This is especially true as traditional sources of knowledge about the world such as families, school, local culture and religion have been replaced by what children observe on electronic screens. Youth even form complex reciprocal relationships with their avatars (Szolin 2023).

40. In their February 25, 2022 press release "Medicine and gender transidentity in children and adolescents" the French National Academy of Medicine notes "Whatever the mechanisms involved in the adolescent – overuse of social networks, greater social acceptability, or example in the entourage - this epidemic-like phenomenon results in the appearance of cases or even clusters in the immediate surroundings". It continues "The vigilance of parents in response to their children's questions on transidentity or their malaise, underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development of young people and responsible, for a very important part, of the

growing sense of gender incongruence." Thus the French National Academy of Medicine has concluded that the "epidemic-like" rise in gender dysphoria is tied to social media.

41. Psychiatrists also believe social media has significantly contributed to the rise in gender dysphoria. Yet most child and adolescent psychiatrists admit to me they will not speak publicly on this subject due to how sensitive the topic is, and also fears of hostilities from activists along with condemnation and retribution from others within their universities or organizations.

42. My personal conversations align with recent polling. While I was on stage presenting at the October 2022 American Academy of Child and Adolescent Psychiatry annual conference, as part of the presentation, the audience was anonymously polled on a number of topics. When polled: *How often do you see teens who seem to be influenced by social media in regards to their sexual and/or gender identity?* 80 of 97 (82%) indicated social media was an influence s*omewhat often* or *very often*. To my knowledge, this is the first data confirming that the vast majority of a group of child and adolescent psychiatrists acknowledge social contagion is a major contributor to the rise in gender dysphoria.

43. A similar poll was conducted at the January 18, 2023, meeting of the Child & Adolescent Psychiatry Society of Greater Washington, all attendees were physician members. For the question *How often do you see teens who seem to be*

influenced by social media in regards to their sexual and/or gender identity? Of the 34 respondents, 47% indicated *Occasionally* and 35% indicated *Often*. So again 82% of these child and adolescent psychiatrists reported they see their patients gender identity is influenced by social media.

44. It is plausible and probable that ideological and social factors underlie the increase in gender dysphoria. This does not rule out other factors. Concern, open discussion and scholarly exploration of this data does not constitute bias, discrimination or transphobia. This area requires thoughtful analysis and further study.

Review of the Evidence Base for Treatments of Gender Dysphoria

45. Neither Gender dysphoria (GD) itself, nor what is the best psychotherapeutic or medical approach is well understood. My review of the research concludes that the evidence base for gender dysphoria treatments is mixed and generally low quality. Below I provide detail to this assessment.

46. The administration of sex hormones and performing of surgeries are medical interventions with substantial risks, and as these interventions target otherwise healthy tissue, a high degree of evidence is expected before such a life altering intervention. Until recently cross sex hormone and surgeries for gender dysphoria have been exceedingly rare, thus there exists nominal long term data. It is especially challenging to evaluate this evidence base due to changing definitions and

epidemiology. It is my opinion that insufficient data is available to make confident proclamation regarding the risks and benefits of treatments of gender dysphoria.

47. I have reviewed Drs. Brignardello-Peterson and Wiercioch's 2022 *Effects of gender affirming therapies in people with gender dysphoria: Evaluation of the best available evidence*. This report was compiled for the Florida Agency for Health Care Administration. This report utilized GRADE: Grading of recommendations, assessment, development, and evaluations. This is the most widely used method for appraising studies to be included in systematic reviews and guidelines. (Goldet 2013). Their review revealed that the quality of evidence supporting treatments is generally low. The conclusions rendered fit the data and are logically sound.

48. Drs. Brignardello-Peterson and Wiercioch's review is consistent with the Endocrine Society's own grading in their 2017 Clinical Practice Guidelines. The Endocrine Society also utilizes the GRADE system (Hembree 2017). In fact, the Endocrine Society 2017 Clinical Practice Guidelines only grade as moderate or high quality recommendations for assessment or education. All recommendations regarding treatment are graded as supported by very low-quality or low quality evidence.

49. Similar to the state of Florida, countries across the globe have responded to concerns about medical practice for gender dysphoria by conducting

reviews. After the reviews, each country changed their approach. Many of these countries, due in part to their smaller and better organized medical systems, have offered more comprehensive and structured treatment regimens for gender dysphoria. In addition, these treatment options in Nordic countries have been in place longer than they have been typically more available in the United States.

50. In Sweden, the National Board of Health and Welfare (NBHW) was commissioned by the Swedish government to update guidelines via its *Care of Children and Adolescents with Gender Dysphoria*. After this systematic review was published in 2022 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services, Sweden's NBHW recommended a move away from cross sex hormones. The authors conclude that risks currently outweighs the possible benefits and most patients will need psychotherapy and supports rather than medical care. The Swedish National Board of Health and Welfare reported the 3 main factors:

a. A lack of reliable scientific evidence concerning the safety and efficacy of treatments.
b. Increasing concerns about de-transition.
c. Uncertainty brought about by the extreme rise in those seeking care, especially females.

51. They further conclude that "Evidence for non-binary gender identity is lacking." and the evidence is limited for adults. They further report "Gender dysphoria rather than gender identity should determine access to care". The authors conclude the "For adolescent with gender incongruence NBHW deems that the risks of puberty suppressing treatment with GnRH -analogues and gender affirming hormonal treatment currently outweighs the possible benefits. Treatment should be offered only in exceptional cases."

52. Sweden has made these changes within a context of longstanding access to care for gender dysphoria and much of the available data regarding longer term outcomes. A 2011 article reviewed sex-reassigned patients in Sweden from 1973 to 2003 and showed increased risk for suicide attempts and inpatient psychiatric care. (Dhejne 2011). A recent article, initially published claiming positive mental health results, after Letters to the Editors, caused a correction (Bränström 2020). This article reviewed patients diagnosed with gender incongruence between 2005 and 2015. The reanalysis and multiple Letters to the Editor in the end led even the authors to conclude that the methodological shortcomings preclude any statement on the suitability of surgery in persons seeking treatment for gender noncongruence. The peer review issues exemplified by these events will be discussed later in this report.

53. Finland is another Nordic country with an organized medical system and longstanding availability of care for gender dysphoria. Finland's recent Recommendation of the Council for Choices in Health Care in Finland (PALKO / COHERE Finland) *Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors* concluded "The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders." The authors further report cross sex identification "even in extreme cases, generally disappears during puberty. In some cases it persists or intensifies."

54. The authors state "A lack of recognition of comorbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental. Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment. A young person's identity and personality development must be stable so that they can genuinely face and discuss their gender dysphoria, the significance of their own feelings, and the need for various treatment options." They conclude: "In light of available evidence, gender reassignment of minors is an experimental practice. Based on studies examining gender identity in minors, hormonal interventions may be considered before reaching adulthood in those with firmly established transgender identities, but it must be done with a great deal of caution, and no

irreversible treatment should be initiated. Information about the potential harms of hormone therapies is accumulating slowly and is not systematically reported."

55. In their 2021 Position statement, *Recognizing and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence*, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) provides an overview of Gender Dysphoria and highlights the importance of respecting an individual's gender identity.

56. This position statement indicates that "Comprehensive Assessment is critical." "Evidence and professional opinion is divided whether an affirmative approach should be taken in relation to treatment of transgender children or whether other options are more appropriate." They further reflect that "There is a paucity of quality evidence on the outcomes of those presenting with Gender Dysphoria."

57. The 2022 press release of the French National Academy of Medicine, *Medicine and gender transidentity in children and adolescents*, reporting that on the epidemic like increase and that "This primarily social problem is based, in part, on a questioning of an excessively dichotomous vision of gender identity by some young people." "Therefore, faced with a request for care for this reason, it is essential to provide, first of all, a medical and psychological support to these children or adolescents, but also to their parents, especially since there is no test to distinguish a "structural" gender dysphoria from transient dysphoria in adolescence.

Moreover, the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". It is therefore advisable to extend as much as possible the psychological support phase."

58. They further report "However, a great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause."

59. Similarly, The National Health Service of England commissioned the Cass Review to evaluate the safety and effectiveness of gender dysphoria care. The systematic review commissioned in the UK found the evidence for puberty blockers and cross-sex hormones to be of "very low certainty."

60. "The key limitation to identifying the effectiveness and safety of gender-affirming hormones for children and adolescents with gender dysphoria is the lack of reliable comparative studies. All the studies included in the evidence review are uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using modified GRADE. A fundamental limitation of all the uncontrolled studies included in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean. " The authors further noted that the studies have relatively short follow-up and studies with a longer follow-up are needed to determine the long-

term effect of gender-affirming hormones for children and adolescents with gender dysphoria.

61. The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose reports themselves to have a "mission is to promote evidence-based care, education, research, public policy, and respect in transgender health." WPATH has created their Stands of Care (SOC) documents which shares some features equivalent to what a medical organization would call a clinical practice guideline. These documents are referred to as the Standards of Care (SOC), the 2011 edition as SOC -7 and the 2022 version as SOC-8. The authors of SOC-8 state: "The overall goal of SOC-8 is to provide health care professionals (HCPs) with clinical guidance to assist TGD people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment."

62. Due to its recent release, a thorough systematic review of WPATH SOC-8 is not available. Dahlen et al provided a systematic review and quality assessment of international clinical practice guidelines for gender minority/trans people which included the review of WPATH SOC-7. They note that WPATH SOC7 "contains no list of key recommendations nor auditable quality standards." Among the principal findings was that WPATH SOC 7 cannot be considered 'gold

standard'. The WPATH review scored poorly on editorial independence, applicability, and rigor of development. The review scored better on scope, stakeholder involvement and clarity of presentation. The reviewers noted that WPATH and other international clinical practice guidelines tended to prioritize stakeholder involvement rather than methodological rigor.

63. Among the implications were that "Clinicians should be made aware that gender minority/trans health CPGs outside of HIV-related topics are linked to a weak evidence base" and that "Organizations producing guidelines and aspiring to higher-level quality could use more robust methods, handling of competing interests and quality assessment."

64. The Mayo Clinic Proceedings article, *Clinical Practice Guidelines: a Primer on Development and Dissemination*, (Murad 2017) highlights that "trustworthy clinical practice guidelines require a systematic review to select the best available evidence and should explicitly evaluate the quality of evidence". The authors' criteria for trustworthy guidelines include:

a. "Be based on explicit and transparent process that minimizes distortions, biases and conflicts of interest"

b. "Provide a clear explanation of the logical relationships between alternative care options and health outcomes"

c. “Provide ratings of the quality of evidence and the strength of the recommendations”

65. Despite the well-known methodological weakness to SOC 7, WPATHS created SOC 8 in a similar manner, again disregarding the conventions expected to create a trustworthy clinical practice guideline.

66. While SOC 8 is a large document and it is beyond the scope of this report to review completely, I must note 4 major concerns as a mental health professional.

a. SOC 8 makes no analysis of privileging gender affirmation over body affirmation. For clinicians and psychotherapist these trade-offs are fundamental concerns.

b. SOC 8 suggests consumer-driven medical and surgical interventions and deems these medically necessary without adequate supporting evidence.

c. SOC 8 normalizes self-mutilation via inclusion of “Eunichs” as just another non-binary category without any suggestion that these individual require mental health assessment prior to any consideration of chemical or surgical procedures.

d. SOC 8 downplays concerns related to de-transitioning.

67. Four final thoughts regarding the limited evidence for treatments for gender dysphoria. Firstly, advocates of gender affirming treatments point to short-term improvements observed in some studies. It is possible that much of these improvements are placebo effects. Placebo effects are positive changes based on expectations. Placebo effects are routinely seen in other treatments, such as pills for depression. Vulnerable youth expressing gender dysphoria may be especially susceptible to believe in remedies celebrated by online influencers or advocate physicians. The enthusiastic claims of effectiveness of gender affirming treatments in the press, by medical societies and expressed by advocates at high prestige institutions, would be expected to enhance placebo effects (Clayton 2022). This creation of false expectations has significant potential to cause harm.

68. The second concern is many proponents of early transition of youth with gender dysphoria point to what is known as the "Dutch Protocol". Yet a recent reviews display that while some call published reports regarding results of the Dutch Protocol reliable research, this "research", is in fact severely flawed (Biggs 2022). This is because the Dutch protocol selected out patients to assure only the most successful outcomes. The clinicians flipped the questionnaire, leaving it unclear if gender dysphoria was resolved. Lastly, concomitant psychotherapy confounds whether effects were from psychotherapy or the hormones and surgeries. Added to this, is that clinics in the United States do not follow the rigor of the

original studies, and as such the result are unlikely to be generalizable (Abbruzzese 2022).

69. The third problem regards Informed Consent. It is a concern of clinicians, as I have been asked about it by colleagues. It is curious that there has been minimal dialogue exploring the unanswered questions related to informed consent in medical journals. These matters are disputed in other journals (Latham 2022, Levine 2022). Medical organizations have come out strongly for affirmative care, supporting the opinion that minors have the emotional and cognitive development to be responsible for whatever consequence their teenage selves make. Yet when the question was mandatory life in prison in Miller V. Alabama, The American Academy of Child and Adolescent Psychiatry (with the American Medical Association) Amicus Curiae (2012. P2-3) claims: "Scientists have found that adolescents as a group, even at later stages of adolescence, are more likely than adults to engage in risky, impulsive, and sensation-seeking behavior. This is, in part, because they overvalue short-term benefits and rewards, and are less capable of controlling their impulses making them susceptible to acting in a reflexive rather than a planned voluntary manner. Adolescents are also more emotionally volatile and susceptible to stress and peer influences. In short, the average adolescent cannot be expected to act with the same control or foresight as a mature adult." It is thus my opinion that The American Academy of Child and Adolescent Psychiatry is so

politicized it cannot keep track of its own claims in Amicus Briefs which contradict each other. Unless this organization is willing to backpedal on its well substantiated and well documented arguments in the Miller v Alabama case, how can it basically argue the opposite when it comes to consent for irreversible treatment within the context of low quality evidence and significant risk of harm?

70. The fourth concern is most grave. A recent article in the New England Journal of Medicine tracked 315 youths undergoing 2 years of gender affirming hormones (Chen 2023). Within 315 hormone treated youth there were 2 completed suicides. Curiously, this remarkably high suicide rate is not explored in the article. By comparison, a recent review tracked the Gender Identity Development Service in England, Wales and Northern Ireland from 2010 to 2020 (Biggs 2022). This found 4 completed suicides of 15032 transgender patients over 10 years. As Gender Identity Development Service in these locations were overwhelmed with patients, only a small fraction were receiving gender affirming hormones. If these are compared the American hormone treatment group, it would be akin to a waitlist control. Thus the most recent research shows a much higher than expected rate of suicide in the condition of affirmative hormone treatment.

Lack of consensus regarding treatment of gender dysphoria

71. With rapidly growing cohorts of patients expressing novel symptoms clusters in an new area of medicine where a limited evidence base exist, differences

of opinion regarding clinical care for gender dysphoria are expected. It would be remarkable if there was uniformity of opinion. Furthermore, gender care is politicized, and opinions tend to cluster in a manner consistent with an influence of political ideology (Regnerus 2022).

72. Within this context of low quality evidence and divergent opinions, there are bound to be calls for reasonable clinical safeguards. There are also serious reservations regarding the effectiveness and concerns about the risks from affirmative treatment for Gender Dysphoria (Clayton 2022, Biggs 2022).

73. Much of the push for affirmative treatment for gender dysphoria treatment has come from professional organizations such as the Endocrine Society, American Academy of Pediatrics and the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Medical professional organizations are large bureaucracies which serve many functions. They are important components of our medical system and usually provide great services for the profession and the public.

74. Just as other parts of society, professional medical organizations are susceptible to tribal influences and politicization. Their influence and credibility can be misused in a harmful manner. I have directly observed, that over the last decade, but particularly the last 5 years these organizations have prioritized a politicized and narrow vision of social justice advocacy. While this has arisen from

good intentions, it has contributed to the creation and spread of misinformation regarding treatment of gender dysphoria. I will explain how this occurred.

75. I have directly observed that within these organizations, the members most enthusiastic about a certain type of medicine self-selected into "special interest groups" or committees. For instance, the psychopharmacology committee is filled with supporters of using psychopharmacology and the psychotherapy committee is populated by members enthusiastic about psychotherapy. Committees on gender and sexuality have been no exception. By participating in a committee, a small group of people can establish themselves as content experts within their organization.

76. Using committees as content experts usually works well, as it did during my eight years as co-chair within AACAP's media committee. ACCAP leadership utilized our input to make decisions about policy statements, clinical recommendations, public education or relevant legislation.

77. Over the recent years that gender clinics started to spread across America, gender medicine enthusiasts self-selected into these clinics and also into gender relevant committees. Most physicians are wary of the very concept that it can be beneficial to give cross sex hormones to still developing minors. Thus those who venture into medicalized gender care are already a select few who bring to this work certain viewpoints and aspirations. Just as with the psychopharmacology or

psychotherapy committee members, gender committee members have strong personal and professional investment in the success of their favored type of treatment. This created a well-intentioned but homogenous group of gender medicine supporters.

78. Without the knowledge of most members of a professional organization, as few as the dozen members in a committee can steer these organization's leadership to advocate for treatments or policy positions. Once medical organizations have come out with policy statements, clinical practice guidelines and press releases advocating strongly for a position, they have difficulty accepting they may have misstated evidence, advocated for unwise policy or otherwise caused harm.

79. For example, the highly influential 2018 Policy Statement from the American Academy of Pediatrics (AAP) (Rafferty 2018) contained many citation errors, overstatements and unfortunately mischaracterized the longstanding and well-regarded clinical approach of watchful waiting (Cantor 2020). This policy statement has been particularly detrimental to the scholarly exchange of ideas related to gender dysphoria treatments, as it used the prestige and trustworthiness of the AAP to privilege the concept of affirmative care and denigrate other treatment. It also increased momentum to enshrine social transition and access to

medical treatments in minors, whether or not these are prudent or evidence based approaches.

80. Medical and psychiatric journals editors are surely aware of their affiliated professional organization's policy statements and political advocacy. Since the Endocrine Society, American Academy of Pediatrics, American Psychiatric Association and American Academy of Child and Adolescent Psychiatry have been all openly involved in political advocacy in support of gender affirming care, in reality their journal are no longer are scientifically neutral. This politicization is reflected in the editors' actions as medical and psychiatric journals have recently attempted to consolidate favorable opinion toward gender affirming treatments for gender dysphoria rather than promoting open scholarly debate.

81. This is not just my theory, Michael Norko, the editor of the Journal of the American Academy of Psychiatry and the Law emailed to me in June 2022: "The Journal is an instrument of AAPL, and it is my responsibility as Editor to lead it in a direction that supports the efforts and goals of the parent organization."

82. Not surprisingly, skeptical voices have been difficult to find within any of the journals of the Endocrine Society, American Academy of Pediatrics, American Psychiatric Association or American Academy of Child and Adolescent Psychiatry. In fact, I have not found a single skeptical or even ideologically balanced article in any of these journals. Journal editors have a wide discretion to

choose what topics are covered in their journals by choosing what articles are sent for review, commentaries, clinical perspective, vetting Letters to the Editor guiding what is included in the book review column and setting policies.

83. The medical journal I follow most closely, The Journal of the American Academy of Child and Adolescent Psychiatry has only published articles seeking conformity of thought with gender ideology and affirmative care, and has not allowed actual scholarly dialogue to be voiced. Please see the commentaries (Dixon 20202), clinical perspectives (Turban 2017, Turban 2018), and book reviews (Suto 2021, Chilton 2021, Kim 2021).

84. The 2017 Turban article provided the perspectives of transgender and gender nonconforming youth and reading that viewpoint can certainly be valuable for clinicians. Yet most striking was the youth's ideological assertions, misunderstanding of the evidence and pleas for their physicians to believe suppositions such as ""Sexuality and gender are two different things. TOTALLY separate." and "Puberty blockers and cross-sex hormones can save my life." It also contained a pressure to join the movement: "Let me know that you are on my team." These youth somehow have gotten the impression there is no doubt regarding the safety and efficacy of hormones and surgery. They also have the belief that changing society is the solution to their mental health challenges: "If I am depressed or anxious, it's likely not because I have issues with my gender identity,

but because everyone else does." More striking was that that authors expressed agreement with the youths' ideology. The authors conclude: "Likely due to a combination of minority stress and dysphoria related to being 'trapped in the wrong body,' these young people are disproportionately burdened by depression, anxiety, and suicide attempts." The evidence actually points to youth who are depressed, anxious and suicidal are more like express gender dysphoria (Kaltiala 2020).

85. The Journal of the American Academy of Child and Adolescent Psychiatry even published a Commentary filled with misinformation which pressured researchers to adopt progressive gender theories to "become allies" (Dixon 2022). It is curious but revealing that the participants seemed uninterested in core unanswered questions such as why individuals experience themselves as nonbinary or transgender. Conversely, the youth and authors used the commentary to push researchers to adopt ideology and allyship. These pressures on scholars are antithetical to the scientific method and have been a corrupting force in much recent research and academic dialogue regarding sex and gender. This politicized, low quality scholarship has minimal credibility and is a prime example of how medical journals have prioritized advocacy and ideology over trustworthy science. With two child and adolescent psychiatric colleagues, in response to Dixon et al, we wrote a Letter to the Editor of the Journal of the American Academy of Child and

Adolescent Psychiatry. The journal editor refused to even send this letter out for review.

86. Not only are the articles one sided, the peer review process regarding gender medicine within medical journals has become dysfunctional. Many recent examples show how prominent medical journals ignore significant weakness in methods, allow erroneous conclusions and overstatement of the strength of the evidence when articles support affirmative care or related concepts (Bigg 2020, Deangelo 2021, Kalin 2020, Giovanelli R. 2022). As mentioned earlier, the Journal of the American Psychiatric Association published a study with an erroneous positive conclusion regarding gender surgeries in Sweden, prompting a flurry of letters to the editors and later revision (Bränström 2020).

87. In 2018 Lisa Littman published an article which revealed aspects of the rapid spread of gender dysphoria in adolescents. After this research was peer reviewed and published, the journal PLOS ONE had a re-editing of the publication with a commentary added. This showed a disregard for the typical rules of scientific discourse, and should be noted was not a corrections, as there was no finding of error, misconduct or faulty methods. As confirmed by the PLOS ONE re-review, Dr. Littman's research methods were unremarkable and comparable to other mental health research, and this was not a correction as claimed by activists. Various journals also published articles deriding Dr. Littman's work and she was personally

harassed by activists. Brown University also did not make any effort to defend her Dr. Littman from attacks on her freedom to pursue science. This antagonism of Dr. Littman was not about her methods, but rather that her data indicated that Gender Dysphoria was spreading in a pattern consistent with social influence. Dr. Littman's other heresy was revealing how many parents perceive the gender affirming approach is dysfunctional. (Littman 2018)

88. Similar dynamics are in place even in newsletters. A colleague related a difficult experience with editors of the American Academy of Psychiatry and the Law Newsletter. The editors would not permit him to describe in his article the actual problematic behaviors of youth who declared themselves to be transgender on his inpatient unit. This silencing of actual clinical situations undermine the exchange of ideas on how to best provide clinical care.

89. Thankfully, journals outside of medicine have not allied themselves to one viewpoint and are willing to embrace open scholarly dialogue (Abbruzzesse 2023, D' Angelo 2021).

The breakdown of scholarly dialogue

90. Open inquiry is the ability to ask questions and share ideas without risk of censure. It is fundamental to medical research and scientific progress. Within medicine the ability for constructive disagreement and the expression of divergent

opinions has withered with regards to questions of biological sex, gender and gender medicine.

91. Political and social pressures are not new to this line of research and clinical care and do not come from only one political pole or fraction of society. Yet especially within the last decade, academia, including academic medicine has become more tribal, moralizing and more likely to attempt to silence divergent opinions (Bindewald 2021).

92. I witnessed these dynamics personally at the American Psychiatric Association 2022 annual conference. At the Clinical Perspective *The Management of Adolescent Onset Transgender Identity: Should "Best Practices" Change* on May 24th 2022, the was a preamble. In a procedure I've never before seen at a conference, the representatives from American Psychiatric Association who were monitoring the event were asked by leadership to read a statement prior to presentation indicating the content of the presentation clashed with official proclamations of the organization. During this Clinical Perspectives four speakers presented convincing data and opined that they questioned the evidence based and logic supporting current affirmative psychotherapy and medicalized practice regarding the treatment of transgender youth. Most of the audience respectfully sat while enjoying the thoughtful presentation. Yet a small crowd in the audience was disruptive. There were many interruptions of the presentation by a member of the

crowd who repeatedly provided his input. During the question-and-answer session, a series "questions" were rather hostile ad-hominem statements towards the presenters. Only a tiny fraction of the questions actually responded to any of the evidence or viewpoints presented. I have never previously observed any comparable unprofessional behavior or hostility toward presenters in any medical or psychiatric conference.

93. Similarly, in 2018 Lisa Littman, MD presented her research data at American Academy of Child and Adolescent Psychiatry conference and received personal enmity which caused a colleague to remark he has never seen a presenter at a conference treated with such hostility. I did not attend live but later watched the presentation online and also heard the many demeaning and unprofessional comments directed toward Dr. Littman.

94. Members of APA and AACAP who attend meetings and observe scholars being condemned will certainly think twice before voicing their concerns. This polarization and moralization can create a "spiral of silence": an appearance of agreement because a small moralizing group dominates the discussion (Noelle-Neumann 1974). This is consistent with my experience as I have been told by a range of child psychiatrists, from very senior AACAP "life members" to residents in training that they are unwilling to openly express their viewpoint, but they do not see data or logic supporting gender affirming treatments.

95. The 2022 American Academy of Child and Adolescent Psychiatry conference featured at least 6 presentations related to gender dysphoria or transgender patients, none presenting new research. Yet a research Symposium was rejected which was to include a prominent international researcher, Dr. Littman, a clinician experienced in treating gender dysphoria and was to feature detransitioners. The AACAP program committee co-chair James McGough later indicated via a May 28th 2022 email this highly unusual rejection was in part due to "concerns" about the methods employed in several of the presentations and that detransitioners would be involved. It defies logic that the only time methods are an issue is when the results of the research raises questions about affirmative care. Furthermore, I am aware of a number of presentations which have been accepted with the condition of making a small adjustment. The detransitioners as discussants could have easily been replaced as their only role would be to ask questions after the research is presented.

96. Dr. McGough indicates he took these concerns seriously. He referred concerned parties to "Aron Janssen co-chair the AACAP committee charged with taking the lead on trans issues." Dr. McGough also noted that "Aron is also on the program committee". A program committee member "taking the lead on trans issues" would give Dr. Janssen significant power to support or suppress presentations. I have seen Dr. Janssen present twice and spoken with him. Though

we disagree, he is a thoughtful person and means well. Yet those concerned with free exchange of scholarly ideas should notice the words he chose in his 2021 "Perspectives" article (Janssen 2021) whereas he characterized legislative and political endeavors to limit medical care as "malicious changes" that "provide fodder to perpetuate discrimination, fear and exclusion." He specifically states: "It is our ethical responsibility to respond to this assault".

97. Dr. Janssen characterizes those arguing against gender affirmative care as making "an effort to oppress". This all makes clear he does not want open rigorous scholarly exchange that would raise substantial questions about the ethics and efficacy of gender affirming care. It is further my assessment that across medical organizations and medical journals those who are "taking the lead on trans issues" share Dr. Janssen perspective.

98. For those not familiar with the proceedings of medical conferences, research symposiums are eagerly sought out by the medical societies. The same program chair has commented to me personally that research symposiums are by far the easiest type of presentation to be accepted. For this same conference I also submitted, with two other physicians, for a Special Interest Group presentation which was to feature data on de-transitioning. This proposal obviously provided data which raised questions about affirmative care, it was also not accepted.

99. Despite unclear evidence and significant disagreement among psychiatrists regarding the treatment of gender dysphoria, medical professional organizations have enthusiastically conducted a public campaign to portray these treatments as evidence based. The organizations' political activism has important ramifications and creates a false impression that gender affirming treatment rests on strong and settled science. Two recent press releases provide examples. The September 28th 2022 American Academy of Pediatrics (AAP) press release regarding the State of Oklahoma condemnation of any limits on gender affirming health care. Defending scope of practice is typical for medical associations. Yet the press release frames these limits as discrimination based on gender identity, a moralized characterization of restrictions on care.

100. American Academy of Pediatrics' opposition to Oklahoma's limits on moral grounds (discrimination) fails to acknowledge ethical concerns regarding treatment of children with gender dysphoria including large scale potentially irreversible damage to minors. This is an example of two competing moral frameworks which both express valid concerns. As such, a more appropriate perspective from a medical organization would be a call for reasoned dialogue to evaluate the moral claims on each side, examine the logic and data behind these moral frameworks and treatments. It is not immoral to seek to find more cautious ways to care for and support those with gender dysphoria, or to seek a higher level

of evidence before allowing minors to make permanent decisions regarding altering their bodies.

101. Curiously, the AAP statement invokes parental rights, but without clarifying if the AAP supports the very likely majority, who do not want hormonal or surgical treatment for their child's gender dysphoria. This AAP statement misses an opportunity to show respect for those who disagree, which is an indication of how politicized the AAP organization has become.

102. The American Academy of Child and Adolescent Psychiatry (AACAP) made a number of similar statements regarding limits on care such as the March 1, 2022 statement which characterized actions in Texas as "attacks" which endanger young people. The statement curiously claims "Gender affirming care is informed by long-standing standards of care and by evidence-based clinical studies". How longstanding are we talking about, because gender dysphoria was previously so rare I went over 20 years from medical school through over the first decade of my career without a single patient reporting gender dysphoria. The first gender clinic in the United States just opened in 2007. It is reasonable for AACAP to defend scope of practice, oppose criminalization of physicians and call out inappropriate use of child protective services. Yet a medical professional organization overstating evidence and using divisive rhetoric reveals serious ideological and political influence which undermines it's own legitimacy.

103. Even more revealing is the American Academy of Child and Adolescent Psychiatry's (AACAP) March 18th, 2022 press release reveals their leadership's strident position by remarking on an education bill, outside psychiatrists' area of expertise. AACAP's statement used politicized derogatory phrasing by calling Florida's legislation the "Don't Say Gay or Trans" bill. The press release quotes the current president of AACAP who demonizes supporters of the bill as unconscionable and implies these supporters "target and harm" LGBTQ+ youth". The American Academy of Child and Adolescent Psychiatry's leadership moralizes the debate, uses polarizing language and does not engage in forthright discussion which must include skepticism, not just affirmation.

104. It should be noted the national organization offered my regional AACAP branch (in the Tampa area) the opportunity to sign on to "BRIEF OF AMICI CURIAE AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION". The Tampa regional organization refused to sign on.

105. While I have little direct experience with the Endocrine Society, my assessment is that many endocrinologists, and perhaps most, also believe their professional organization is also too strongly influenced by activist physicians.

Similar to AACAP and AAP, they take a polarized position and misstate the strength of the evidence regarding gender affirming care. In particular, the April 20th 2022 press release "Endocrine Society Opposes Florida Department of Health Policy on Gender Dysphoria Treatment for Children and Adolescents" reveals overstatements of the strength of evidence and the false appearance of consensus in the medical community. This statement mischaracterizes puberty delaying medication as a "safe, reversible and conservative approach." This statement claims that attempts to restrict care are based on politics, rather than acknowledging legitimate concerns. It is interesting that they cite the Endocrine Society's own clinical practice guidelines. As noted previously, the Endocrine Society's own guidelines themselves graded the supporting evidence as low or very low quality for their clinical recommendations.

106. These organizations portrayal of affirmative treatments for gender dysphoria as both effective and virtuous has had a chilling effect on scholarly dialogue regarding gender dysphoria in the medical community. This framework brands those who disagree regarding the evidence base as morally inferior and biased. Through mechanisms I will describe below, moralization has been counter-productive to developing trustworthy science and has contributed to the spread of misinformation regarding treatment approaches to gender dysphoria.

107. Prudent physicians generally avoid being part of a partisan and moralized debate, and do not want to be harassed by gender activists (Evans 2021). When anonymously polled, as cited above, physicians are free to provide their actual opinion and show their skepticism. Supporters of affirmative care could survey physicians to specifically test their hypothesis of broad based support. Why have they not conducted such a survey?

108. As mentioned earlier, the highly politicized dialogue regarding the issue of transgender care (Evans 2021) mirrors a larger phenomenon within the academic community. On many complex and divisive issues within academia, there has been a push from the progressive left demanding conformity of opinion with a narrow, highly moralized viewpoints (Bindewald 2021). The example of gender dysphoria shows that academic medicine has not been immune to this same phenomenon.

109. Pressures to make affirmative therapies the only treatment for gender dysphoria essentially push all parties involved to adopt a simple clear framework for gender dysphoria treatment. Yet simple and clear does not represent the reality or the evidence base. All- or-nothing rhetoric can be an effective technique to rally support around a cause. Yet the treatment of gender dysphoria has complex ethical, legal, social and clinical trade-offs.

110. This moralized framing of affirmative treatments for gender dysphoria encourages a cognitive shortcut known as attribution substitution. Attribution substitution is the process whereby a simple, related moral judgement is substituted for various conceptually complex decisions. This common cognitive bias causes humans to intuitively believe viewpoints which appear virtuous, especially ideas which seem widely held within their social group. Affirmative care does sound compassionate and supportive, and these minor semantic can have a surprising influence.

111. For comparison, the Covid-19 pandemic provided a clear parallel of how moralizing medical issues can lead to misinformation and poor decision making. Individuals' tribal associations were shown to often influence their viewpoint of lockdowns, masks and vaccines more than data. (Kerr 2021, Jiang 2021). Call for conformity meant that dissenting physicians, even academic titans like John Ioannidis, Jay Bhattacharya, and Scott Atlas were treated badly both online and within the medical community. These pressures against voicing skepticism distorted the professional dialogue. Respectful conflict of opinion and impersonal rigorous exchange would have likely reduced harms, such as education loss and mental health deterioration associated with prolonged American school closures during the pandemic (Dooley 2022).

112. Ideological homogeneity and group identity are risk factors for developing irrational beliefs and spreading misinformation. (Su 2022, Sun 2022, Macy 2018). This directly relates to attitudes about transgenderism and gender dysphoria treatments where ideological dogma has distorted scientific exploration. Those who dare to question the dogma are treated as heretics.

113. These dynamics are understandable. Many times within psychiatry and medicine we as practitioners face enormous suffering. Gender non-conforming patients do at times face harassment and discrimination. Patients expressing gender dysphoria have high rates of depression, anxiety and self-harm. All physicians and mental health professionals want to help. Those who started gender clinics hoped to relieve suffering. Yet in medicine false hope can cause suffering.

114. All humans, including physicians, tend to find arguments in favor of conclusions we want to believe, and this bias in known as motivated reasoning (Peters 2020). Supporters of gender affirming treatment want to believe they have found an ethical and evidence based solution. This motivated reasoning explains the strong divergence between the enthusiastic support for gender affirming treatments and the relatively weak evidence base.

115. Once a group, such as a gender committee, endorses a statement of belief, such as “gender affirmative care is life-saving”, the other psychiatrists in their professional organization who have not reviewed the facts tend not to question

it. Psychiatrists face a rapidly expanding evidence base across disorders, and we depend on specialization to lead us toward progress in our varied patient populations.

116. Especially if the "experts" assert a strong moral claim regarding a clinical approach, other members would assume it is based on strong evidence. This creates a group process whereas the leadership responds to show support and loyalty, and others tend to follow. Support of this moral claim becomes a marker of virtue and raises status within the group. Those who are skeptical tend to self-censor (a Spiral of Silence) rather than taking a risk of being called unethical. These dynamics, especially leaderships' endorsement, make opinions appear like facts within the group. Members of this group they never hear counter arguments or disconfirming data and become ever more confident.

117. Within such moralized environments education and intelligence offer limited protection from irrational beliefs. In fact, sophisticated language skills enable virtuosity in creating and promoting false narratives. These dynamics have happened many times before in medicine and it is my assessment this has occurred again with regards to affirmative treatments of gender dysphoria.

118. Contrary to popular belief, humans' emotional programing drives much of our cognitive processes. That is, we tend to create beliefs that go along with what we feel, rather than the other way around. This usually works well, but also causes

serious problems. In cognitive therapy it is known as “emotional reasoning”. Emotional reasoning helps explain opinion cascades, partisanship and group-think.

119. Our highly social nature and limited rationality demand that, in medicine and science, we create conditions which foster trustworthy data and minimize the creation and spread of misinformation. Recently, as shown, medical organizations and journals have prioritized advocacy, putting them at risk for producing and officially sanctifying misinformation.

120. A prescription for open exchange and deliberate consideration regarding gender dysphoria treatments should aspire to:

a. Solicit a diversity of perspectives.

b. Discuss the argument, rather than the person making the argument.

c. Clarify the methods, source of data and its limitations.

d. Use precise language rather than broad ideologies.

e. Discuss potential sources of bias, including those related to group affiliation.

f. Quickly acknowledge and correct mistakes.

121. This framework would depersonalize the search for truth and esteem empirical dialogue. Yet conflict is required to help us create a trustworthy scholarly dialogue regarding gender dysphoria. This has not occurred and as such claim that there is an evidence base supporting gender affirming treatments is not credible.

122. Complex ethical issues regarding treatment of gender dysphoria deserve attention. Yet pressures to accept affirmation treatment as being the most virtuous and only effective approach discourages good faith scholarly dialogue. Furthermore, the characterization of those who oppose gender affirming care as transphobic or hateful has been used to justify silencing scholars whose data or logic does not support the gender affirming approach. This occurred with Lisa Littman. Former sex researchers have left the field due to the harassment and intellectual bullying they had received (Soh 2021).

123. Thus we are in the curious situation where in private, but not in public, most psychiatrists will acknowledge their doubts regarding affirmative care. My personal interactions with many thoughtful well regarded psychiatrists display a full range of views. Most child and adolescent psychiatrists consider automatic affirmation inappropriate, even though many are willing to use affirmative approaches selectively. (Evans 2021). Most psychiatrists are willing to admit we don't have enough research to really know how to proceed.

124. Within medicine and academia we need to create space to allow input from those who hold the opinion that logic and the evidence base do not support medical interventions for gender dysphoria. We require a frank discussion of the moral issues involved, including moral hazards associated with medical treatments

for gender dysphoria. Currently, I see no evidence any of this scholarly dialogue happening.

125. Beyond hormones and surgeries, thus the costs and benefits of gender self-identification have not gone through academic inquiry with open rigorous academic review. Social affirmation can be considered a psychosocial treatment, and the recent push for adoption of social affirmation is an attempt at a grand social experiment. This is most concerning as it pertains to children. Statements of physician advocates and medical organizations are used to justify social affirmation, yet social affirmation of children seems more driven by ideology than thoughtful reflection. Throughout human history societies have grouped children by biological sex rather than gender identity. In fact, children naturally group themselves by biological sex (Maccoby 1998). Grouping children by biological sex requires tradeoffs but works well. As it has been standard practice throughout the world there has never been the need for literature to defend this practice. Yet abandoning this convention for the experiment of childhood gender self-identification appears imprudent on many grounds, not least of which is that it will likely be psychologically destabilizing for children and adolescents.

126. Social affirmation for children is portrayed as ethical, but to what degree it is ethical depends on how it will affect children's lives. No substantial evidence guides this movement to rewire a basic element of society. There is a

longstanding forensic psychiatric literature showing that children are suggestible (Ceci 2000). It is easy to see the widespread suggestions of the existence of multiple genders and each child should declare their gender will increase confusion and cross sex identification. This should be expected to increase the incidence of, and persistence of, gender dysphoria. It is thus reasonable to expect social affirmation can cause harm, especially for emotionally vulnerable and neurocognitively impaired youth.

127. Social affirmation of children's and adolescents' self-declared gender requires more research and discussion before the risks and benefits are fully explored(Zucker 2020). Until more is known, and more rigorous scholarly dialogue takes place, society and academic medicine should avoid pushing such a large scale social experiment.

Psychotherapy

128. Patients presenting with gender dysphoria have real symptoms, typically with other comorbid mental health disorders. These patients require validation and support. I recommend their mental health treatment start with psychosocial supports and psychotherapy (Schwartz 2021). In psychiatry, we typically refer to other providers such as social workers, psychologists and licensed clinical therapists who tend to provide the bulk of psychotherapy. Despite this, as

noted in my background, I have extensive experience with psychotherapy, and additional training beyond the majority of psychiatrists.

129. Quality psychotherapy includes the process of exploring patient life history, emotions, coping style and thought patterns. This includes validating how patients feel, but it also includes teaching patients to not be guided solely by their feelings. Psychotherapy involves getting patients to recognize their own thought patterns, disturbed emotions, and, when appropriate, includes challenging irrational, self-defeating and harmful beliefs.

130. There is not an evidence base to support strictly "affirmative" psychotherapy for gender dysphoria, where therapists actively agree with a patient's self-assessment. Automatically agreeing with patient viewpoints is a radical departure from traditional mental health treatments and psychotherapy. Psychiatrists do not "affirm" hopelessness in depression, delusions in schizophrenia or distorted body image in anorexia or body dysmorphic disorder. The similarities between body dysmorphic disorder and gender dysphoria, and the contrast in how they are approached, provide significant evidence of how ideological and political forces have influenced medical practice (Kohls 2022).

131. Is it, for example, sensible, compassionate or good medical practice to, for instance, soon after a sexual assault, to automatically agree with a teen's new

self-assigned gender label? What about when a 9 year old girl spontaneously says "I feel like I am a boy", do we immediately ask what boy name to call her(him)?

132. In psychotherapy with a patient with gender dysphoria, the therapist would not advise a patient to change a gender identity, but also should not "agree" that a patient is the opposite sex. It is surely reasonable and compassionate for a psychotherapist to prefer a patient no longer to suffer with gender dysphoria. It would be inappropriate for a mental health professional to prefer gender dysphoria to continue. Yet the false binary of affirmative psychotherapy versus conversion therapy for gender dysphoria is being used to push therapists from any consideration that acceptance of one's biological sex or resolution of gender dysphoria is a positive event.

133. This categorizing of quality psychotherapy as conversion therapy is a serious misunderstanding of the complexities of ethical and effective psychotherapy (Schwartz 2021, D' Angelo 2021). The term "conversion therapy" is often misused by the supporters of affirmative care as an attempt to devalue and pathologize approaches other than purely affirming a patient's gender self-identification (Griffin 2021, Evans 2020). The only conversation therapy which has ever been researched is the attempt to change, or convert, sexual orientation.

134. Sexual orientation, with rare exception, appears to arise from in utero or early life biological factors. Thus conversion therapy for sexual orientation is

ineffective, hostile and pathologizing to same sex attracted individuals. Decades ago conversation therapy was rejected by modern medicine and mental health. Conversion therapy is a historical reality within the United States, but accusations of conversation therapy have been used as a technique to change the discussion from a question of nuanced mental health care to all-or-nothing thinking regarding affirmation. During my entire career I have never once encountered a single mental health professional that has practiced conversion therapy for sexual orientation. Nor has a single patient ever described to me that they endured conversion therapy.

135. Gender identity is distinct from sexual orientation. Gender identity is often described as fluid, and as this implies, often changes over time, particularly in young people. This gender fluidity is also why it is inappropriate to affirm a declared gender identity in a child. Psychotherapists need space to ask questions about gender identity. Exploring gender identity is not conversion therapy.

136. Time-tested and widely effective psychotherapy approaches include supportive therapy or cognitive behavioral therapy. Cognitive behavioral therapy has proven effective for virtually every mental health condition it has been researched for, including the full range of anxiety disorders, depressive and mood disorders, disturbed anger, sleep disturbance and trauma reactions including Post Traumatic Stress Disorder. Due to the high levels of comorbidity of psychiatric disorders in patients with gender dysphoria, cognitive behavioral therapy could be

extremely helpful as the same approach and techniques have proven effective with so many problems including anxiety, depression and in reducing self-harm.

137. Any psychotherapy should aim to help individuals gain a deeper understanding of themselves, develop coping skills and provide a neutral, unbiased process. Beyond standard psychotherapies, more specific and nuanced approaches for gender dysphoria exist, such as Exploratory Therapy (https://genderexploratory.com/). This "talking therapy" allows time for exploration of mental health concerns without pushing an ideological or political agenda.

138. Advocates of affirmative treatment dismissal of other approaches can be especially harmful in the cases of gender dysphoria presenting in the context of severe pre-existing psychiatric illness. Psychotherapy could led to the resolution of these comorbid illnesses. I can provide three examples.

139. Trauma: There is longstanding psychiatric literature showing that exposure to sexual trauma can lead to changes in gender expression (Cosentino 1993), and this has also been revealed by recent research on detransitioners. (Littman 2021). A recent review on Dissociative Identity Disorder and co-occurring Gender Dysphoria showed frequent childhood sexual abuse (Soldati 2022).

140. A core feature of Post-Traumatic Stress Disorder (PTSD) is avoidance. Repeatedly patients have described to me their physical and emotional distress when they are exposed to trauma reminders. Thus, they frequently have difficulty engaging in psychotherapy for PTSD. Even if they participate, they often actively avoid discussing their trauma. This is unfortunate as trauma focused therapies such as Trauma Focused Cognitive Behavioral Therapy have an excellent evidence base.

141. The massive rise in expressions of gender dysphoria has been most pronounced in adolescent females. This is a population where assessment for, and treatment of trauma, should be a top priority. Furthermore, based on the link between sexual abuse and gender dysphoria seen in detransitioners, assessment and treatment of trauma symptoms should be prioritized. It is possible that for many patients the delivery of trauma based psychotherapy may cause the desistence of gender dysphoria, which in some cases could be considered a co-occurring disorder related to the trauma.

142. Another feature which links gender dysphoria to trauma is the well-known phenomenon of traumatized individuals feeling "cut off" or disconnected from their bodies (Van der Kolk, 1994). Van der Kolk and other prominent PTSD experts recommend mind-body techniques and experiential moving meditations such as yoga to help the body process trauma. These techniques help ground people in the physical world, mindfully experience their bodies and increase positive

physical sensations. While only small studies exist, yoga is being used with success in many settings including prisons and substance abuse facilities. Yoga and other somatic therapies should be studied as a component of comprehensive treatment for gender dysphoria.

Autism

143. Autism Spectrum Disorders are neurodevelopment disorders. People with Autism Spectrum Disorder by definition have problems with social communication and interaction along with restricted or repetitive behaviors or interests. People with Autism Spectrum Disorders are consistently shown to be at increased risk for developing gender dysphoria (Cooper 2022). One review found gender dysphoria to be over 4 times as likely in patients with Autism Spectrum Disorders (Hisle-Gorman et al., 2019). Another review found compared to typically developing control, autistic adults who endorsed the wish to be the opposite sex were found to have more mental health challenges, bullying, suicidal ideation and worse quality of life. They also had worse autism symptoms and more co-morbid disorders than autistic adults who did not report the wish to be the opposite sex.

144. Autistic people experiencing gender dysphoria are a complex patient cohort. There is limited evidence of how best to help and support this specific populations. Due to the neurocognitive limitations in patients with Autism Spectrum Disorders they may be more suggestible. Autistic patients struggle

socially and often spend large amounts of time online. Due to their rigid and obsessive thought patterns, if they develop gender dysphoria they can become fixated and preoccupied with receiving hormonal or surgical procedures, whether or not they understand the risks. Patients with Autism Spectrum Disorder can be incredibly insistent, single minded and determined. They also may have limited insight and minimal ability to anticipate the negative consequences of obtaining the object of their obsessions. Until more is known about the specific outcome related to this vulnerable population, caution with any clinical approach is warranted. Again, special psychotherapy approaches would likely be helpful in this population, but as of yet none have been studied.

Borderline Personality Disorder

145. Personality Disorders are enduring patterns of inner experience and behavior which deviates from expected and causes distress and impairment in functioning. The epidemiology of personality disorders in individuals with gender dysphoria is unknown and estimates vary (Furlong 2022). Many estimates have the population extremely increased, such as 50% of adults, but others show smaller increases. One review of emergency room visits of transgender patients diagnosed personality disorders at 4%, versus matched community sample of 1%. The hospitalized sample was at 5% versus 2% in controls (Lam 2021). Little scholarly

guidance exists regarding specific approaches related to the various personality disorders with comorbid gender dysphoria.

146. In Borderline Personality Disorder there is, by definition, an unstable sense of self, and this leads to frequent personality changes. This typically means sudden shifts in employment, relationship, sexual identity, frequent moves and changes in types of friends. Patients with Borderline Personality Disorder often have early life trauma and find many social environments invalidating. Patients with Borderline Personality Disorder have high levels of emotional dysregulation, self-harm and substance use. This population is extremely difficult to treat.

147. With an unstable sense of self being a feature of the disorder, this patient population seems an especially poor candidate for affirming treatments, especially irreversible treatments. There are two psychotherapeutic approaches which have shown significant success, the most established is Dialectical Behavioral Therapy (Gillespie 2022), but Mentalization Base Therapy (Vogt 2019) also has significant evidence as a successful approach.

148. Especially for a young person developing signs of Borderline Personality Disorder, starting these proven approaches as early as possible is their best chance of avoiding a life course which is full of emptiness, struggle and suffering. Again, in this patient population, a focus on gender affirming treatments as the solution to this constellation of serious mental health problems is extremely

problematic, and appears likely to cause harm if it delays access to evidenced based treatments.

Conclusion

149. It is scientific and medical consensus that patients with gender dysphoria typically also have a mix of anxiety, depression, self-harm, personality disorders, neurodevelopmental disorders and trauma related symptoms. Yet these mental health problems generally pre-date or co-occur with the development of gender dysphoria.

150. There is not a scientific or medical consensus that comorbid mental health disorders are due to "untreated" gender dysphoria. This claim does not match the data. These co-occurring mental health problems pre-date and are, for the most part, not caused by the gender dysphoria.

151. As reported in the Finnish review (PALKO / COHERE Finland 2020): "A lack of recognition of comorbid psychiatric disorders common among gender-dysphoric adolescents can also be detrimental. Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." The Finnish experience shows that "treating" the gender dysphoria with affirmative medications and surgeries does not resolve the patients' mental health disorders (Kaltiala 2020).

152. Claims of medical necessity for hormones and surgeries for minors can be refuted by the fact that all cohorts of previous children and adolescent throughout human history have never "needed" these procedures. The burden of proof is on those who proposed hormones and surgeries for minors to conduct long term studies and show these practices to be safe and effective. These are currently experimental approaches which seem highly intertwined with ideology. As detransitioners become more visible and relate their stories, it is clear that this ideology has distorted the practice of medicine, leading to harm.

153. The medical system has a long history of spurts of overdiagnosis and overtreatment. Many of our interventions such as frontal lobotomies were celebrated at the time. Eventually society sees the harm, pushes back and the medical profession eventually reforms.

154. Harmful and unnecessary interventions are especially likely to occur when patient desires are combined with financial incentives and the best of intentions. The American opiate epidemic was ushered in by "expert" physicians who proposed physicians need more compassion because "pain is the 5th vital sign" (Mandell 2016, Adams 2016). Too much compassion can cause harm.

155. Psychiatrist Anna Lembke, in her 2016 *Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop* discusses how susceptible to manipulations physicians can be. "Doctors are by and large

pleasers. They make it through the complex maze of schooling all the way to medical school by figuring out early what people want and providing it." (Lembke 2016 P 104) In this way, physicians tend to go along with patient narratives and over-treat.

156. Conditions resting on entirely subjective assessments like level of pain or gender identity have the most potential for harmful overtreatment. In both cases, patients can easily find out what symptoms to report to obtain the treatment they desire. In the current political climate, physicians feel the pressure to not be assailed as a "gatekeepers", even when logic and data tell them outside social pressures should not distort medical care.

157. Dr. Lembke discusses the modern phenomenon of illness as identity: "Illness identities offer a chance for community." "The adoption of illness identities is driven by the breakdown of traditional social roles. Illness provides a way to define the self in a rapidly changing and increasingly fragmented world. Furthermore, ill persons today are lionized as heroes because they fight a battle against overwhelming physical forces. In a world where the struggle for basic survival (food, clothing, shelter) has become largely irrelevant for most Americans, the ill person is among the last great warriors." (Lemke 2016 P 98)

158. What Lembke points out is critical to the debate regarding gender dysphoria treatments. Community is so important for all of us, but especially

adolescents. There is significant evidence that a lack of socialization, and social struggles are factors which put adolescents at risk for gender dysphoria.

159. Depression and anxiety in adolescents often relate to social struggles and these generally predate the emergence of gender dysphoria. Autism is primarily a social disorder. Many child psychiatrists have expressed to me their experience that patients expressing a transgender or non-binary orientation have tended to struggle socially prior to declaring this orientation.

160. Sweden, England and Finland have all reviewed the evidence and pressed pause. These are countries with medical systems that have better tracking, more organized care and compassionate attitudes toward gender non-conforming persons. As the Finish review stated (PALKO / COHERE Finland 2020): "The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders."

161. After reviews, all countries concluded that restricting care and emphasizing psychotherapy rather than hormones and surgery is the compassionate course. Affirmative treatments are not, in fact, medically necessary. This is true when it comes to the most grave concern of all, suicide. Based on long term data in Sweden, Gender Affirming treatment have not been shown to be life-saving. We do not have convening data that affirmative treatments reduce suicidality, and based

on recent data, we should be especially concerned that it could increase it(Chen 2023).

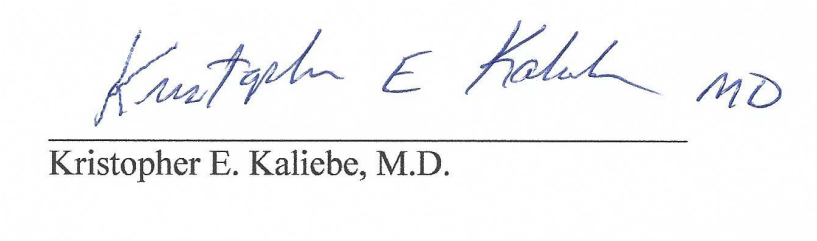
162. When claims are made that there exists a scientific and medical consensus supporting gender affirming care for gender dysphoria, this rests on the assertions of a small group of physicians who are already personally invested in this type of care. Those already providing hormones and surgeries have extremely powerful reasons to want to believe affirmative care is effective, and thus they are biased. I know psychiatrists involved in this type of care and they are smart, compassionate physicians. I have no doubt they have received significant positive feedback from patients and families. This is consistent with multiple studies showing short term benefit in mood and social dysphoria from affirming treatment.

163. Yet when the enthusiasm for affirming procedures is this celebratory, it is also clear that the detransitioners and other patients with less optimal outcomes will not return to these affirmative providers. We need controlled studies because gender clinics staff's personal experience is thus potentially biased toward the good responders they continue to see, without clear tracking of the rest. Short term positives responses can also be explained by placebo effects, especially under the current conditions where most gender clinics offer multidisciplinary teams providing support and therapy along with hormones and medical procedures.

164. For these many reasons the "gender experts" are not neutral observers. This is why long term controlled studies are needed. Just over two decades ago a previous group of "experts" minimized the risks of opiates when they proposed pain as the 5th vital sign. This turned out to be a large scale social disaster instigated in large part by the medical community. When aligned with economic and ideological forces, a small group of physicians can wield disproportionate influence. The modern medical system does make serious mistakes at scale. We should be taking a cautious approach and encouraging rigorous open scholarly dialogue where physicians who doubt the merits of affirmative gender care can speak freely without being attacked as immoral.

165. Gender roles will always exist, as humans are a sexually dimorphic species. Gender roles are not problems to be solved, but we do need to acknowledge the trade-offs. Much of the ideological and political activism is a reaction against a perception that gender roles are too rigid or stifling. Many young people want more ability to express themselves as they please, and it is agreed that we need to create space for all in our society. Yet the recent overall rise in depression, anxiety and self-harm supports that we are not meeting the needs of our youth. Yet in the debate regarding treatments for gender dysphoria, the medical system should still apply rules of evidence and proceed with caution.

I declare, pursuant to 28 U.S.C. s. 1746, under penalty of perjury that the foregoing is true and correct. Executed this 17th day of February, 2023.



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Attachment "A"

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Publications

Kaliebe, Kristopher and Adrian Sondheimer. "The media: Relationships to psychiatry and children." *Academic Psychiatry* 26.3 (2002): 205-215.

Kaliebe, Kristopher "Rules of thumb: three simple ideas for overcoming the complex problem of childhood obesity." *Journal of the American Academy of Child & Adolescent Psychiatry* 53.4 (2014): 385-387.

Kaliebe, Kristopher. "Dr Kaliebe Replies", Journal of the American Academy of Child & Adolescent Psychiatry, (2014) 53:10 1134.

Kaliebe, Kristopher "The Future of Psychiatric Collaboration in Federally Qualified Health Centers." *Psychiatric Services* (2016): appi-ps.

Kaliebe, Kristopher, and Josh Sanderson. "A Proposal for Postmodern Stress Disorder." The American journal of medicine 129.7 (2016): e79.

Osofsky, Howard J., Anthony Speier, Tonya Cross Hansel, John H. Wells II, **Kristopher E. Kaliebe**, and Nicole J. Savage. "Collaborative Health Care and Emerging Trends in a Community-Based Psychiatry Residency Model." *Academic Psychiatry* (2016): 1-8.

Yeh, Y. Y. and **K. Kaliebe**. "Impact of Nutrition on Neurocognition." *Southern medical journal* 109.8 (2016): 454.

K. Kaliebe Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. J Am Acad Child Adolesc Psychiatry. 56.11 (2017)

Kiss, R. and **Kaliebe, K**., Stress and Inflammation: New Perspectives on Major Depressive Disorder. JAACAP Connect, p.22. Winter 2020

Tamburello, A., Penn, J., Negron-Muñoz, R., & **Kaliebe, K**. (2023). Prescribing Psychotropic Medications for Justice-Involved Juveniles. Journal of Correctional Health Care.

Books, Textbook Chapters:

Weigle, P., **Kaliebe, K**., Dalope, K., Asamoah, T., & Shafi, R. M. A. (2021). 18 Digital Media Use in Transitional-Age Youth: Challenges and Opportunities. Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care, 357.

Invited Publications

"Telepsychiatry in Juvenile Justice Settings", **K Kaliebe**, J Heneghan, T Kim, Child and Adolescent Clinics of North America, 20 (2011) 113-123

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct; 56(10):875-893. Epub 2017 Jul 25. PMID: 28942810.

Kaliebe, Kristopher and Paul Weigle. "Child Psychiatry in the Age of the Internet." (2017). Child and Adolescent Psychiatric Clinics of North America, April 2018Volume 27, Issue 2, Pages xiii–xv

Gerwin, Roslyn L., **Kristopher Kaliebe,** and Monica Daigle. "The Interplay Between Digital Media Use and Development." Child and Adolescent Psychiatric Clinics 27.2 (2018): 345-355.

CURRICULUM VITAE

Kristopher Edward Kaliebe, MD

Associate Professor
University of South Florida, Morsani College of Medicine, Tampa Florida

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3515 E. Fletcher Avenue, MDC 14
Tampa FL 33613
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kkaliebe@usf.edu

Citizenship

United States

Education

Graduate/Medical: St. George's University
School of Medicine, Grenada, West Indies
Medical Doctor — January 1995- June 1999

Undergraduate: Columbia College,
Columbia University
New York, NY,
Bachelor of Arts, Biochemistry — September 1988-May 1992

Postgraduate Training

Clinical Fellowships:
Fellow, Forensic Psychiatry (PGY6)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2004 to June 2005

Fellow, Child and Adolescent Psychiatry (PGY 4-5)
Louisiana State University Medical Center
1542 Tulane Ave., New Orleans, LA 70112 — July 2002 to June 2004

Chief Resident in Child and Adolescent Psychiatry

- Acted as liaison between Child Psychiatry Fellows and Administration
- Coordinated with Program Director lecture and rotation schedules

July 2003 to June 2004

Residency:

Resident, Psychiatry (PGY 2-3)
University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 July 2000- June 2002

Internship: (PGY 1)
University of Medicine and Dentistry-
New Jersey Medical School
185 S Orange Ave, Newark, NJ 07103 July 1999- June 2000

Diplomate, American Board of Psychiatry and Neurology:

- Board Certification in General Psychiatry, awarded 2004, active
- Specialty Board Certification Child and Adolescent Psychiatry, awarded 2005, active
- Specialty Board Certification Forensic Psychiatry, awarded 2007, active

Awards, Honors, Honorary Society Memberships:

Department of Veterans Affairs Special Contribution Award for Clinical Service in Psychiatry
February 22, 2002

Outstanding Resident Award, Presented at the American Academy of Child and Adolescent Psychiatry, Miami, Florida,
October 17, 2003

Inducted into Berkeley Preparatory School Athletic Hall of Fame, Tampa, Florida,
November 7, 2003

Fellow, Louisiana State University Academy for the Advancement of Educational scholarship
October 2007 – 2016

Best Doctors, Louisiana in the subspecialty of Child and Adolescent Psychiatry
Awarded 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015 and 2016

Best Doctors, in Tampa Florida
2017, 2018, 2019, 2020, 2021, 2022

Awarded status as a Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry

July 6, 2016

Appointments:

Associate Professor, University of South Florida Medical School, Department of Psychiatry. September 2016 to present

- Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents and Child and Adolescent Psychiatry fellows who performed assessment, consultation, and treatment.

Tampa General Hospital Psychiatrist on Duty September 2016 to present

Manage the night, weekend and holiday clinical responsibilities of Tampa General Hospital including the over 1000 bed hospital and a 24-hour emergency room. Usually done in partnership with a psychiatric resident from the University of South Florida.

Facility Psychiatrist. Tampa Residential Facility September 2016 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system. Tampa Residential Facility is the most intensive level of mental health and substance abuse treatment, subcontracted to Truecore Solutions.

Facility Psychiatrist. Les Peters Academy Residential Facility

May 2017 to present

- Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted to Truecore Solutions.

Staff Psychiatrist, Orleans Parish Justice System March 2018 to July 2018

- Performed telepsychiatric evaluations and treatment in Orleans Parish Prison correctional system, subcontracted to Correct Care Solutions.

Facility Psychiatrist. Charles Britt Academy Residential Facility

November 2019 to July 2022

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Facility Psychiatrist. Columbus Youth Academy Residential Facility

June 2020 to present

•Performed psychiatric evaluations and treatment in Florida's juvenile correctional system, subcontracted by Sequel.

Louisiana State University Health Science Center Assistant Professor of Clinical Psychiatry July 2005 to June 2017

Louisiana State University Health Science Center Associate Professor of Clinical Psychiatry July 2016 - 2017

Mental Health Medical Director, St. Charles Community Health Center, Luling, Louisiana July 2005 to 2016

- Evaluated and treated a primarily Medicaid and underserved population of adult, child and adolescent patients in a Federally Qualified Health Care Center.

Coordinator for Child and Adolescent Integrated Mental and Behavioral Health Services, Louisiana Mental and Behavioral Health Capacity Project

September 2012 to July 2017

- Performed assessment, consultation, training, prevention, and education services to Federally Qualified Health Centers and community clinics in Coastal Louisiana.
- Evaluated and treat both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Back-up coverage, Louisiana Juvenile Justice System July 2016 to September 2022

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Wellpath (formerly Correct Care Solutions).
- Back up on call coverage for on-site psychiatrists
- As needed evaluated and treated remote video conferencing equipment (telehealth).

Staff Psychiatrist, Louisiana Juvenile Justice System July 2010 to July 2016

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system, subcontracted to Correct Care Solutions.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist on Duty October 2011 to July 2016
Children Hospital, Calhoun Campus. New Orleans, Louisiana

- Facilitated development of protocols and supervision regarding the training of Medical Students, General Psychiatry Residents and Child and Adolescent Psychiatric Fellows who utilize the Calhoun unit as primary training site for Child Psychiatry.
- Manage night and weekend clinical responsibilities for Children's Hospital emergency room and Inpatient Psychiatric Unit, including individually assessing all inpatients each weekend.

Staff Psychiatrist, Louisiana State University Juvenile Justice Program

July 2005 to August 2010

- Performed psychiatric evaluations and treatment in Louisiana's juvenile correctional system at Bridge City Center for Youth and Jetson Center for Youth.
- Evaluated and treated both on site and using remote video conferencing equipment (telehealth).

Staff Psychiatrist, Florida Parish Juvenile Detention Center,
July 2007 to August 2010

- Performed psychiatric evaluations and treatment using remote video conferencing equipment (telehealth).

Medical Officer on Duty July 2002 to July 2005
New Orleans Adolescent Hospital. New Orleans, Louisiana

• Managed clinical responsibilities of Crisis Intervention Services, a 24-hour emergency mental health response team serving families, children and adolescents from the Southeast Louisiana region.
• Managed two psychiatric inpatient units including a twenty bed adolescent and ten bed children's unit after hours on call.
• On call physician for Crisis Respite, a short term residential facility for children and adolescents located on hospital grounds.

Psychiatrist on Duty September 2003 to July 2005
New Orleans Veterans Administration Medical Center, New Orleans, Louisiana

- Managed clinical psychiatric responsibilities of a 450 bed hospital
- Managed clinical psychiatric responsibilities of a 27 bed inpatient psychiatric unit
- Managed clinical psychiatric responsibilities of 24-hour emergency room

Psychiatrist on Duty September 2001 to June 2002
New Jersey Medical Center Veterans Administration

- East Orange Medical Center, East Orange, NJ

Managed clinical psychiatric responsibilities of 24 hour emergency room along with a 295 bed hospital, 30 Nursing Home and 30 Domiciliary beds.

- Lyons Hospital, Lyons, NJ

Managed clinical psychiatric responsibilities of 356 bed hospital.

Teaching, Lecture

Undergraduate Medical Student

BMS6920.002, BMS6920.001 University of South Florida: Created five session elective: "Mind Body Medicine" Developed as part of University of South Florida medical school elective curriculum from 2017-current. Offered for up to 12 students as a credited elective including study guide, organizing readings, and experiential class learning.
2017 to present

At Louisiana State University Health Science Center New Orleans:

4 one-hour lectures instructing all Medical Students (MS2) in Child and Adolescent mental health during Psychiatry Basic Science block

February 2004 to February 2016

LSU Physical therapy
Annual 2 two-hour lectures on a range of mental health topics annually

2012 to 2016

LSU Public Health
Annual 2 hour lecture on psychopharmacology to incoming Masters Level students in Public Health

2012 to 2016

Graduate Medical Teaching

MEL 8602 C65 M: Child and Adolescent Psychiatry

Child and Adolescent Psychiatry Resident Teaching:

Arranged and co-instructed Forensics Lecture Series, bi-annually 10 lecture hours and 4 hours of individual lectures.

2016 to present.

Teach various topics within residency training. 1 lecture per year.

2016 to present.

University of South Florida General Psychiatry Residency:

Co-Produced elective track for 2 residents per year within University of South Florida Psychiatry Residency. Supervision of Integrative Psychiatry residents within the University of South Florida's Integrative Psychiatry Track, biweekly sessions utilizing curriculum from the Andrew Weil Center for Integrative Medicine**.**

July 2020- present

Forensic Psychiatry Resident Teaching:

Teach child and corrections related forensic topics within residency training. 4 lectures per year.

2018 to present.

LSUHSC New Orleans, General Psychiatry Resident Teaching

- Created and taught one hour weekly (44 weeks per year) Cognitive Behavioral Therapy practicum for PGY 3 residents

2007 to 2016

- One hour lecture on evolution and mood disorder each year for PGY3 residents
  2010 to 2016

LSUHSC New Orleans Child and Adolescent Psychiatry Resident Teaching

- One-hour didactic lectures on psychopharmacology for 8 weeks and cognitive behavior therapy for 4 weeks bi-annually
  2008-2016
- Organized and taught majority of the year-long bi-weekly one hour didactic program entitled Special Topics including a wide range of topics including development, forensic psychiatry, evolution, anthropology, nutrition, effects of technology, electronic media, sleep, exercise and physical activity, wellness and systems of care.
  2008 to 2016

LSU- Kenner Family Practice Residency:
Once yearly didactic lectures for 1 to 2 hours for Kenner Family Practice Residents
2009 to 2016

Created one session Mini-Course: "Optimizing Neurocognition through Nutrition." Developed and co-facilitated a module as part of Goldring Center for Culinary Medicine curriculum for medical students and other trainees with Annie Yeh, MD). Offered as a 1 credit elective for Tulane medical students including study guide, organizing readings, online webinar to be viewed prior to class, case studies during class and test.
2014

At Louisiana State University Health Science Center New Orleans: Core Clinical Psychiatry Rotation Lecture, 1 hour lecture presented to MS3 students every six weeks to 3rd year medical students covering Child Psychiatry Basics.
October 2003 to June 2005

At University of Medicine and Dentistry- New Jersey Medical School, Department of Psychiatry
• Lecture: "The Media and Psychiatry" for General Psychiatry Residents, created as part of the Culture and Psychiatry Seminar
August 2001 and 2002

Teaching, Supervisory

At University of South Florida, Tampa Florida:

Medical Student supervision

University of South Florida - 2017 to present
MEL 8109 L69 M

BCC 7154 002 M Psychiatry / Neurology Clerkship. Medical Students rotation through clinic one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic

Psychiatry Elective, 2 to 4 week Medical Student rotation through Child and Adolescent Psychiatry Silver Center Resident Clinic

Graduate Medical Education Supervision

Child and Adolescent Psychiatry Residency

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF Child and Adolescent Psychiatry residents who performed assessment, consultation, and treatment.

September 2016 to June 2021

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry correctional psychiatry with USF Child and Adolescent Psychiatry residents who observe clinical care in juvenile correctional facilities.

September 2016 to present

General Psychiatry Residency:

Supervise one afternoon weekly of outpatient Child and Adolescent Psychiatry Silver Center Resident Clinic with USF General Psychiatry Residents who performed assessment, consultation, and treatment.

September 2016 to present

Forensic Psychiatry Resident Teaching

Supervision of forensic psychiatry trainees within the University of South Florida forensic psychiatry training program**.** This includes review of resident competency evaluations along with co-evaluation of criminal defendants as individual cases arise.

2018 to present

At Louisiana State University Health Science Center New Orleans

LSU- Kenner Family Practice Residency:

- One month, once weekly half day mental health rotation at St Charles Community Health Center for all Kenner Family Practice Residents

  2008 to 2016

Clerkship/Residency Directorship:

Child and Adolescent Psychiatry Fellowship Training Director, Louisiana State University Medical Center. Oversaw and supervised resident physician training Managed administrative, evaluation and scheduling issues within the training program Collaborated with Louisiana State University psychiatric faculty to develop policies and procedures at various clinical site.

July 2010 to September 2012

Teaching Awards:

Association for Academic Psychiatry Honorary Fellow

October 2001- October 2002

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2006-2007 academic year

Louisiana State University Child and Adolescent Psychiatry Department Outstanding Teacher Award for the 2015-2016 academic year

Peer to Peer: Institutional Grand Rounds

"The Minds, They are a Changin' – An Overview and Update on MDMA and Psilocybin Grand Rounds University of South Florida Psychiatry Department, Tampa Florida

January 28 2022

"3 Simple Rules for Overcoming Obesity" University of South Florida Endocrinology Department, Tampa Florida

November 9, 2021

"A hard pill to swallow: psychotropic medications in foster care", University of South Florida, Department of Public Health, Tampa Florida

November 3, 2017

"Rules of Thumb: The importance of heuristic and cognitive biases in pediatric physical and mental health" Grand Rounds Children's Hospital, New Orleans

July 30, 2014,

Grand Rounds, Louisiana State University Department of Psychiatry, "Rules of Thumb, lifestyle interventions for mental health professionals." New Orleans, Louisiana

January 23, 2014

"Just say No, the Case against Stimulant Medication" Grand Rounds Children's Hospital, New Orleans, Louisiana

May 19th, 2010

"Violence: Neurobiology, Risk Assessment and Beyond", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

August 9, 2012

"Is ADHD a Nutritional Disorder", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 28, 2011

"Just say No, the Case Against Stimulant Medication", Grand Rounds Louisiana State University Department of Psychiatry, New Orleans, Louisiana

July 29th, 2010

Grand Rounds Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana "The Application of Darwinian Principles to Child Custody Evaluations", New Orleans, Louisiana

May 26th, 2005

"Attention Deficit Hyperactivity Disorder" Grand Rounds Department of Pediatrics, Louisiana State University School of Medicine, New Orleans, Louisiana

May 25th, 2005

"The Media, Our New Social World, How Should Pediatricians Respond?" Grand Rounds, Louisiana State University School of Medicine, Children's Hospital, New Orleans, Louisiana

June 2nd, 2004

"Attention Deficit Disorder" for Louisiana State University Health Science Center Juvenile Corrections Program Continuing Medical Education Presentation via telemedicine New Orleans, Louisiana

March 16th, 2004

"The Media, Relationships to Children and Psychiatry", Grand Rounds, Department of Psychiatry, Louisiana State University School of Medicine, New Orleans, Louisiana

June 4th, 2003

"The Media, Relationships to Children and Psychiatry", Grand Rounds, New Orleans Adolescent Hospital, New Orleans, Louisiana

March 28th 2003

Lectures by Invitation

"The Media, Relationships to Children and Psychiatry" Grand Rounds, University of West Virginia, Charleston, West Virginia, Department of Psychiatry and Behavioral Science

April 10th 2003

"The Media and Child and Adolescent Psychiatry –An Evolving Relationship" Chair and Presenter, Media Theatre, Annual Conference of the American Academy of Child and Adolescent Psychiatry

October 21st, 2004

"The Media, Our New Social World, How Should Health Care Professionals Respond?" Continuing Medical Education Presentation Snowshoe Mountain Retreat, Snowshoe Mountain, West Virginia

September 19th, 2004

"The Application of Darwinian Principles to Child Custody Evaluations" Grand Rounds Department of Psychiatry, University of South Florida, Tampa, Florida

October 31st, 2005

"The Evaluation and Treatment of Traumatized Children and Adolescents with ADHD" Web Cast Presentation and Grand Rounds sponsored by the National Center for Child Traumatic Stress Network's Rural Consortium, New Orleans, Louisiana

January 25th, 2007

"Behavioral Disorder or Traumatized Child?" Louisiana Federation of Families for Children's Mental Health, Children's Mental Health Conference, Houma Louisiana

May 9th, 2008

"Behavioral Disorder or Traumatized Child?" Grand Rounds Tulane University Department of Child Psychiatry, New Orleans, Louisiana

March 13th, 2009

"Brother's Little Helper: The Simpsons Satirizes Stimulant Medication as a Response to Childhood Behavior Problems" Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York Kristopher Kaliebe MD, K. Dalope, MD

October 30, 2010

"Violence Risk Assessment" Louisiana Psychiatric Medical Association Annual Meeting, New Orleans, LA

March 2, 2013,

"Telepsychiatry in Juvenile Justice Settings" part of "Telepsychiatry: Challenges and Successes Across Settings." Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Orlando FL

October 22, 2013

"What are they Missing, When Electronic Media Displaces Sleep, Academics and Exercise" part of **"**Identifying and Treating Internet-Related Mental Health Problems: An Evidence-Based Approach" Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, Toronto, Canada

October 24, 2014

"The Implications of the Pharmacological Treatment of Children" Michigan Drug Court Annual Conference, Lansing, Michigan

March 12, 2014

"Three rules to prevent and treat ADHD symptoms" as part of the Louisiana ADHD Symposium, organized by the Louisiana Department of Health and Hospitals ADHD Task Force, Baton Rouge, Louisiana

December 9, 2014

"Non-Pharmaceutical Interventions for ADHD", Invited Professorship: St George's University School of Medicine Complementary and Alternative Medicine Selective, St George's, Grenada, West Indies

August 28 – Sept. 3rd, 2014

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Diego, California

October 30, 2014

"The Management of Childhood Obesity" and "Disordered Eating in Children and Adolescents" Oregon Psychiatric Medical Association Conference, Portland, Oregon

February 27 and 28, 2015

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" National Alliance for the Mentally Ill Louisiana Annual Conference, New Orleans, Louisiana

April 17, 2015

"ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective" Preventing Overdiagnosis Conference, National Institutes of Health (NIH), Bethesda Maryland

September 2, 2015

"An alternative to diagnosis-based practice in pediatric mental health" Preventing Overdiagnosis Conference: National Institutes of Health NIH Bethesda Maryland

September 2, 2015

"Shell Shocked: Growing up in the Murder Capital of America". Discussant for Media Theatre, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Holly Peek, MD, Kristopher Kaliebe, MD San Antonio, Texas

October 29, 2015

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter,

Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, San Antonio, Texas

October 31, 2015

"What are they (we) Missing? When Electronic Media Displaces Sleep, Academics, and Exercise" Grand Rounds University of South Florida Psychiatry Department, Tampa Florida

November 12th, 2015

ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective, Louisiana Psychological Association, New Orleans, LA

May 20, 2016

"Rules of Thumb: 3 Simple Rules to Optimize Physical and Mental Health" Crohns and Colitis Association of America Regional Conference, New Orleans, LA,

June 12, 2016

"Evaluating and Assuring the Effective and Safe Use of Psychotropic Medications in Children" Webinar: National Council of Juvenile and Family Court Judges, with Judge Constance Cohen; Janie Huddleston and Dr. Joy Osofsky, Ph.D.

June 24, 2016,

"Psychotropic Medications 101: What Judges Need to Know for Effective Decision Making" Florida Child Protection Summit, with Melinda Sczepanski, Orlando FL

September 9, 2016

"Communicating With the Media and the Public as Child and Adolescent Psychiatrists Around Disaster and Highly Traumatic Events." Workshop, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Media Training Workshop, New York, New York

October 27, 2016

"Evolutionary Biology is a Basic Science for Child and Adolescent Psychiatry" Special Interest Group, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York

October 28, 2016

"Is War Ever Really Over? War-Affected Youth From Home to Host ountry", Discussant, Clinical Perspectives. Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, New York

October 28, 2016

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Melinda Sczepanski, Orlando, Florida

August 30, 2017

"Safe Use of Psychotropic Medications in Children." 2017 Safe Babies Court Teams Cross Sites Meeting, Fort Lauderdale, Florida

August 17, 2017

"Health Promotion in Pediatric Mental Health" Discussant, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 23, 2017

"New Technologies, New Laws, New Childhood" as part of "Clinical Guidelines for Navigating Media Use" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 24, 2017

"Screen Time and Childhood Behavior: Disruptive Influence or Easy Scapegoat" as part of "Caught in the Net, How Electronics effects Mental Illness" Chair and Presenter, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Washington, DC

October 26, 2017

"The Business of News, the Role of Child and Adolescent Psychiatrists in the Media, and Risk Communication." Member Services Forum, Annual meeting of the American Academy of Child and Adolescent Psychiatry: Washington, DC

October 27, 2017

"Caught in the net: a child psychiatrist's guide for navigating the internet age.", Workshop, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia

July 27, 2018

Chair, Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, "Caught in the Net: How Digital Media Shapes Mental Illnesses in Youth and How Psychiatrists Should Respond." Seattle, Washington

October 24, 2018

"Self-Care in the Child Welfare System" YMCA/Safe Children Coalition Conference, with Catarlyn Glenn, Sarasota Florida

April 18, 2019

"Psychotropic Medications 101: The pertinent essentials for all involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn, Orlando Florida

December 17, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness in Children and Adolescents", Annual Conference of the Florida Psychiatric Society, Tampa, Florida

September 21, 2019

"Effective Strategies for Higher Education and Beyond" Clinical Perspectives, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Mastering Information Flow for Transitional-Age Youth (TAY): as part of "Promoting Digital Citizenship in Transitional-Aged Youth (TAY) and College Students", Chicago, IL
October 19, 2019

"Caught in the Net: How Digital Media Interacts with Mental Illness", virtually presented at the Andrew Weil Center for Integrative Medicine, Tucson, Arizona
April 1, 2020

"A deeper dive into child and adolescent psychopharmacology for families and professionals involved in the child welfare system" Florida Child Protection Summit, with Catarlyn Glenn. Orlando, FL
September 3, 2020

"Screenagers: Next Chapter – How Online Behaviors Affect Depression and Anxiety Disorders in Adolescents", Media Theater (virtual) Annual meeting of the American Academy of Child and Adolescent Psychiatry
October 19, 2020.

"Helping Child Psychiatrists Navigate the Internet Age", "Career Focus: Setup Your Own Telepsychiatry Practice", "COVID-19 Related Psychiatric Issues"
Oasis Child and Adolescent Psychiatry Conference, Charleston, SC
May 17, 2021

"Conversation about health information, COVID, news, and related topics", discussant and breakout group leader, Digital Media and Mental Health Research Virtual Retreat
May 24th 2021

"The Social Dilemma: Helping Families Navigate the Pull, Pulse, and Power of Social Media", Media Theater, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 29, 2021

"Appealing Applications for Adolescent Mental Health: Social Media's Transformation During the COVID-19 Pandemic", Discussant, Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 25, 2021

"Angry Young Men, Common Threads in Different Types of Extremist Groups" as part of Political Extremism & Hate Group Recruitment of Adolescents", Clinical Perspective, Annual meeting of the American Academy of Child and Adolescent Psychiatry, Virtual
October 26, 2021

"Angry Young Men: Boys and Adolescent Males with Disruptive and Aggressive Behavior", "Nutritional Child Psychiatry" Oasis Child and Adolescent Psychiatry Conference, Charleston, SC

May 1st / 2nd, 2022

"Sexts, Lies & Videogames: Adolescent Boys, the Internet, & Mental Health" Chair and presenter on violence and young men: Clinical Perspective, Annual Meeting of the American Academy of Psychiatry Annual Meeting, New Orleans, LA

May 25, 2022

Clinical Activities or Innovation

Licensure:

Louisiana State Medical License, expires December 31st, 2022
Florida Medical License, expires January 31st, 2024

Federal DEA Controlled Substances License 12/31/2023
Louisiana license for Controlled Dangerous Substances expires 10/1/2022
Certification: ECFMG Certificate 0-573-532-9

Forensic Training:

Florida Forensic Examiner Training completed through the University of South Florida Department of Mental Health Law and Policy

August 15-17, 2019

Certifications in Psychotherapy:

Basic Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY

July 13, 2003

Advanced Practicum in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY

July 20, 2003

Associate Fellowship in Rational Emotive Behavior Therapy completed at the Albert Ellis Institute in New York, NY,

July 15, 2005

Accelerated Resolution Therapy, Basic Training

April 1-3, 2017

Accelerated Resolution Therapy, Enhanced Training

Sept 31, October 1, 2018

Accelerated Resolution Therapy, Advanced Training
October 2,3, 2018

American Association of Medical Colleges Medical Education Research Certificate
October 13th, 2010

Scholarly Activity

Funded block grants

Co-investigator on the Mental and Behavioral Health Capacity Project from September 2012 to June 2017

Unfunded research

Supervisor mentoring Medical Students:

University of South Florida IRB: Faculty Advisor Co Investigator May 2021

What is the impact of coronavirus confinement on Japanese college students' mental health? Ivana Radosavljevic STUDY002335

University of South Florida IRB: Faculty Advisor Co Investigator May 2021
Changes in college aged students' metabolic health due to Covid-19 confinement Matthew Udine, STUDY002341

PI as student supervisor, STUDY004118, IRB approved as Exempt Status, Palliative Care Patients' Attitudes & Openness to Psilocybin assisted Psychotherapy for Treatment of Existential Distress, Julia Wang

Journal Publications:

Peer Reviewed

Kaliebe, Kristopher and Adrian Sondheimer. "The media: Relationships to psychiatry and children." *Academic Psychiatry* 26.3 (2002): 205-215.

Kaliebe, Kristopher "Rules of thumb: three simple ideas for overcoming the complex problem of childhood obesity." *Journal of the American Academy of Child & Adolescent Psychiatry* 53.4 (2014): 385-387.

Kaliebe, Kristopher. "Dr Kaliebe Replies", Journal of the American Academy of Child & Adolescent Psychiatry, (2014) 53:10 1134.

Kaliebe, Kristopher "The Future of Psychiatric Collaboration in Federally Qualified Health Centers." *Psychiatric Services* (2016): appi-ps.

Kaliebe, Kristopher, and Josh Sanderson. "A Proposal for Postmodern Stress Disorder." The American journal of medicine 129.7 (2016): e79.

Osofsky, Howard J., Anthony Speier, Tonya Cross Hansel, John H. Wells II, **Kristopher E. Kaliebe**, and Nicole J. Savage. "Collaborative Health Care and Emerging Trends in a Community-Based Psychiatry Residency Model." *Academic Psychiatry* (2016): 1-8.

Yeh, Y. Y. and **K. Kaliebe**. "Impact of Nutrition on Neurocognition." *Southern medical journal* 109.8 (2016): 454.

K. Kaliebe Expanding Our Reach: Integrating Child and Adolescent Psychiatry Into Primary Care at Federally Qualified Health Centers. J Am Acad Child Adolesc Psychiatry. 56.11 (2017)

Kass, R. and **Kaliebe, K**., Stress and Inflammation: New Perspectives on Major Depressive Disorder. JAACAP Connect, p.22. Winter 2020

Case Reports, Technical Notes, Letters

Books, Textbook Chapters:

Weigle, P., Kaliebe, K., Dalope, K., Asamoah, T., & Shafi, R. M. A. (2021). 18 Digital Media Use in Transitional-Age Youth: Challenges and Opportunities. Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care, 357.

Papers in Press:

Accepted for publication: Prescribing Psychotropic Medications for Justice-Involved Juveniles, Journal of Correctional Health Care, A Tamburello, J Penn, R Negron-Muñoz, **K Kaliebe**

Invited Publications

"Telepsychiatry in Juvenile Justice Settings", **K Kaliebe**, J Heneghan, T Kim, Child and Adolescent Clinics of North America, 20 (2011) 113-123

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct; 56(10):875-893. Epub 2017 Jul 25. PMID: 28942810.

Kaliebe, Kristopher and Paul Weigle. "Child Psychiatry in the Age of the Internet." (2017). Child and Adolescent Psychiatric Clinics of North America, April 2018Volume 27, Issue 2, Pages xiii–xv

Gerwin, Roslyn L., **Kristopher Kaliebe,** and Monica Daigle. "The Interplay Between Digital Media Use and Development." Child and Adolescent Psychiatric Clinics 27.2 (2018): 345-355.

Other Research and Creative Achievements:

Poster Presentations:

"Collaborative Child and Adolescent Psychiatry within Primary Care Clinics in Coastal Louisiana" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, **Kristopher Kaliebe MD**, Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, San Antonio, TX

October 29, 2015

"Benefits of Integrating Young Child Psychiatric Services Into Primary Care Clinics in Underserved Communities" Poster, Annual meeting of the American Academy of Child and Adolescent Psychiatry, New York, NY Joy Osofsky, PhD; Howard Osofsky, MD, PhD; Lucy King, BA; Tonya Hansel, PhD, **Kristopher Kaliebe MD**

October 28, 2016

"Integrating child and adolescent psychiatry into community based primary care networks", Poster, International Association for Child and Adolescent Psychiatry and Allied Professions, Prague, Czechoslovakia **Kristopher Kaliebe MD**

July 25, 2018

" The Prevalence of the Adverse Childhood Experiences (ACE) in Florida Youth Referred to the Department of Juvenile Justice" Poster, Annual meeting of the American Academy of Psychiatry and the Law, Greg Iannuzzi, MD, Mark Greenwald, PhD**, Kristopher Kaliebe MD**

October 25, 2018

Other articles:

"LSU's *Breakfast Club* emphasizes education and recruitment into Child and Adolescent Psychiatry", American Academy of Child and Adolescent Psychiatry News,

January 2004

"Trix are for Kids!", American Academy of Child and Adolescent Psychiatry News,

May, 2013

Expanded Psychiatric Care Can Transform Federally Qualified Health Centers, American Psychiatric Association News,

..... Published online June 17, 2016

News Stories on Suicide, Fictional Content may Increase Risk for Contagion, Hansa Bhargava and **Kristopher Kaliebe**, American Academy of Pediatrics News, *Mastering the Media Column*,

Published online July 10, 2019

Webinars and creation of enduring materials:

Rules for Optimal Health, Webinar, University of South Florida Quality Parenting Initiative, Florida's Center for Child Welfare Information and Training Resources for Child Welfare Professionals*,* released
..... December 11, 2017

Florida's Center for Child Welfare Information and Training Resources, webinars series on pediatric mental health for child welfare professionals and caregivers, Kristopher Kaliebe with Catarolyn Johnson;
..... June 1, 8, 15, 22 and 29, 2020

"Don't just sit there- Adapt and Optimize in a post Covid world" University of South Florida Global Health Conversation Series, presented virtually
September 22, 2020

Service

Membership in Professional Organizations:

Member, American Academy of Child and Adolescent Psychiatry (AACAP),
2000 to present

AACAP Media Committee member
2003 –2021

C0-Chair, AACAP Media Committee
2013-2021

Media Committee Liaison to the Complementary and Integrative Medicine Committee of the AACAP
2012 to 2019

Liaison to the Committee on Communications and Media of the American Academy of Pediatrics, from American Academy of Child and Adolescent Psychiatry (AACAP)
2015 to present

Member Association for Behavioral and Cognitive Therapies
2004 – 2016

Member American Academy of Psychiatry and the Law
2004 to present

Member Zero to Three

2017 to 2021

Member Louisiana Council for Child Psychiatry (LCCP)
2003 to 2016

Louisiana Council for Child Psychiatry (LCCP)

Secretary-Treasurer
March 2010-March 2014

President
March 2014- June 2016

Member, American Psychiatric Association
2000 - 2012 , 2021 to present

LSUHSC Psychiatry Interest Group Faculty advisor
2008 to 2012

University of South Florida Medical School Integrative Medicine Student Interest Group faculty advisor
January 2020 to present

University of South Florida Medical School Mindfulness and Meditation in Medicine Group faculty advisor
January 2022 to present

University of South Florida Interdisciplinary (university wide) Psychedelics Interest Group faculty advisor
March 2022 to present

Editorial Posts and Activities:
Journal editorships, Reviewer

LSUHSC Institutional Review Board alternate reviewer 2008-2012

Safety Committee Member, Accelerated Resolution Therapy for Treatment of Complicated Grief in Senior Adults, University of South Florida
2017-19

Expert reviewer for *Adolescent Psychiatry* Thematic Special Issue: Coming of Age Online: Challenges of Treating the Internet Generation: (2), 4, 2014

Expert reviewer for *Academic Psychiatry* Media Column June 2018

Expert Reviewer for *Pediatrics* January 2021

Expert reviewer for *Academic Psychiatry* Media Column March 2022

Expert Reviewer for *Harvard Review of Psychiatry* May 2021

Co-editor: Kaliebe, Kristopher, and Paul Weigle. Youth Internet Habits and Mental Health, An Issue of Child and Adolescent Psychiatric Clinics of North America, E-Book. Vol. 27. No. 2. Elsevier Health Sciences. 2018

Member, Planning Committee for the Digital Media and Mental Health Research Retreat hosted by the nonprofit Children and Screens.
May 24th, 25th 2021.

Revised: October 2022