

# Exhibit 6

1 THE UNITED STATES DISTRICT COURT

2 EASTERN DISTRICT OF ARKANSAS

3 CENTRAL DIVISION

4 CASE NO. 4:21-CV-00450-JM

5 -----x

6 DYLAN BRANDT, by and through his

7 Mother, JOANNA BRANDT, et al.,

8 Plaintiffs,

9 V.

10 LESLIE RUTLEDGE, in her official

11 capacity as the Arkansas

12 Attorney General, et al.,

13 Defendants.

14 -----x

15 CONTAINS CONFIDENTIAL PORTIONS

16  
17 REMOTE/ORAL/WEB VIDEOCONFERENCE

18 VIDEOTAPED DEPOSITION OF

19 STEPHEN B. LEVINE, M.D.

20 May 26, 2022

21 9:20 a.m. CDT

22  
23  
24 Reported by:

25 Maureen Ratto, RPR, CCR

<p style="text-align: right;">Page 2</p> <p>1           * * *</p> <p>2</p> <p>3       Videotape deposition of Stephen B.</p> <p>4 Levine, M.D. held virtually via Zoom</p> <p>5 Teleconference, hosted from Veritext</p> <p>6 Legal Solutions, pursuant to notice,</p> <p>7 before Maureen Ratto, Certified Court</p> <p>8 Reporter, License No. XI01165,</p> <p>9 Registered Professional Reporter,</p> <p>10 License No. 817125, and Notary Public.</p> <p>11</p> <p>12           * * *</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p style="text-align: right;">Page 4</p> <p>1 A P P E A R A N C E S, continued:</p> <p>2 Co-counsel for Plaintiffs:</p> <p>3   GILL RAGON OWEN, PA</p> <p>4   425 West Capitol Avenue</p> <p>5   Little Rock, Arkansas 72201</p> <p>6   BY: BETH ECHOLS, ESQ.</p> <p>7       echols@gill-law.com</p> <p>8</p> <p>9 Counsel for the Defendants:</p> <p>10 SENIOR ASSISTANT ATTORNEY</p> <p>11 GENERAL, PUBLIC PROTECTION DIVISION</p> <p>12 OFFICE OF ARKANSAS ATTORNEY GENERAL</p> <p>13 323 Center Street</p> <p>14 Little Rock, Arkansas 72201</p> <p>15 BY: MICHAEL CANTRELL, ESQ.</p> <p>16       michael.cantrell@arkansasag.gov</p> <p>17   AMANDA LAND, ESQ.</p> <p>18       aland@arkansasag.gov</p> <p>19</p> <p>20 ALSO PRESENT:</p> <p>21 JASON ELY, Legal Video Specialist</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>
<p style="text-align: right;">Page 3</p> <p>1 A P P E A R A N C E S:</p> <p>2 Counsel for the Plaintiffs:</p> <p>3   SULLIVAN &amp; CROMWELL, LLP</p> <p>4   125 Broad Street</p> <p>5   New York, New York 10004</p> <p>6 BY: BRANDYN RODGERSON, ESQ.</p> <p>7       rodgersonb@sullcrom.com</p> <p>8   EMILY ARMBRUSTER, ESQ.</p> <p>9       armbrustere@sullcrom.com</p> <p>10   SOPHIA MATTHEWS, ESQ.</p> <p>11       matthewss@sullcrom.com</p> <p>12</p> <p>13 AMERICAN CIVIL LIBERTIES UNION</p> <p>14 125 Broad Street</p> <p>15 New York, New York 10004</p> <p>16 BY: LESLIE COOPER, ESQ.</p> <p>17       lcooper@aclu.org</p> <p>18   CHASE STRANGIO, ESQ.</p> <p>19       cstrangio@aclu.org</p> <p>20</p> <p>21 ACLU OF ARKANSAS</p> <p>22 904 West 2nd Street</p> <p>23 Little Rock, Arkansas 72201</p> <p>24 BY: GARY SULLIVAN, ESQ.</p> <p>25       gsullivan@aclu.org</p>	<p style="text-align: right;">Page 5</p> <p>1       VIDEOGRAPHER: Good morning.</p> <p>2   We are going on the record at 9:25</p> <p>3   a.m. on May 26th, 2022.</p> <p>4       This is Media Unit 1 of the</p> <p>5   video-recorded deposition of</p> <p>6   Dr. Stephen Levine taken by counsel</p> <p>7   for Plaintiff in the matter of</p> <p>8   Dylan Brandt, et al versus Leslie</p> <p>9   Rutledge, et al, filed in the</p> <p>10   United States District Court,</p> <p>11   Eastern District of Arkansas, Case</p> <p>12   No. 4:21-CV-00450-JM.</p> <p>13       Will counsel please identify</p> <p>14   themselves for the record?</p> <p>15       MS. COOPER: Leslie Cooper,</p> <p>16   from the ACLU for Plaintiffs</p> <p>17   appearing in New York.</p> <p>18       MR. STRANGIO: Chase Strangio,</p> <p>19   from the ACLU for Plaintiffs, also</p> <p>20   appearing in New York.</p> <p>21       MR. ROGERSON: Brandyn</p> <p>22   Rogerson, from Sullivan Cromwell</p> <p>23   for the Plaintiffs, appearing in</p> <p>24   New York.</p> <p>25       MS. ARMBRUSTER: Emily</p>

<p style="text-align: right;">Page 6</p> <p>1 Armbruster, from Sullivan &amp;  2 Cromwell, for the Plaintiffs.  3 MS. MATTHEWS: Sophia  4 Matthews, Sullivan &amp; Cromwell, for  5 the Plaintiffs in New York. And  6 I'm joined by one of our summer  7 associates.  8 VIDEOGRAPHER: Mr. Cantrell,  9 can we get your appearance here?  10 MS. ECHOLS: Beth Echols,  11 Bill Ragon Owen, for the  12 Plaintiffs, in Little Rock.  13 MR. CANTRELL: I'm Michael  14 Cantrell, with the Arkansas  15 Attorney General's Office, for the  16 Defendants.  17 VIDEOGRAPHER: The witness  18 will now be sworn in by the  19 reporter.  20 * * *  21 STEPHEN B. LEVINE, M.D., having been  22 first duly sworn according to law by  23 the Officer, testifies as follows:  24 DIRECT EXAMINATION BY MS. COOPER:  25 MS. COOPER: We did not hear</p>	<p style="text-align: right;">Page 8</p> <p>1 STEPHEN B. LEVINE, M.D.  2 one another. So if you can let me finish  3 my question before you begin to answer,  4 then even if you anticipate the end of my  5 question it makes for a much cleaner  6 record if you let me finish the question  7 and you then answer and I will do my best  8 to wait until you completed your answer  9 before asking another question. Okay?  10 A. Okay.  11 Q. And it's important because  12 your testimony needs to be typed, that  13 you answer verbally, so nods can't be  14 picked up by the court reporter and also  15 words like a-hum are hard to transcribe.  16 So just be mindful of that, please, okay?  17 A. Okay.  18 Q. If I ask a question that is  19 not clear to you or you need  20 clarification, please just ask and I will  21 try to ask the question in a clearer way.  22 But if you answer the question I will  23 assume that you've understood it. Okay?  24 A. Okay.  25 Q. And we will likely need to</p>
<p style="text-align: right;">Page 7</p> <p>1 STEPHEN B. LEVINE, M.D.  2 sound when Dr. Levine said "I do".  3 THE WITNESS: I do.  4 Q. Thank you. Good morning, Dr.  5 Levine.  6 I know we've met before but  7 it's been a very long time so I'll  8 reintroduce myself.  9 My name is Leslie Cooper and  10 I'm with the ACLU, counsel for  11 Plaintiffs, and I'll be taking your  12 deposition this morning or today.  13 So let's start out, just for  14 the record, can you please state your  15 full name?  16 A. Stephen Barrett Levine.  17 Q. So I know you've been deposed  18 a number of times before, but just so  19 we're clear, I'll go through the  20 groundrules so that we make sure we get a  21 clean record and the court reporter is  22 able to transcribe my questions and your  23 answers.  24 So first ground rule is let's  25 both do our best to avoid speaking over</p>	<p style="text-align: right;">Page 9</p> <p>1 STEPHEN B. LEVINE, M.D.  2 take some breaks during the course of the  3 day. I will certainly call some but if  4 there is any point which you need a break  5 just let me know and if I have a pending  6 question we'll just ask that you answer  7 that question and I'll try to find a good  8 breaking point, okay?  9 A. Okay.  10 Q. Is there anything that would  11 prevent you from providing competent or  12 complete and competent testimony today?  13 A. I can't think of anything.  14 Q. Okay. Is there any material  15 you're consulting in connection with your  16 deposition today, anything in front of  17 you?  18 A. Nothing is in front of me.  19 Q. Okay. Did you do anything to  20 prepare for the deposition today?  21 A. Yes.  22 Q. What did you do?  23 A. I reread my original expert  24 opinion report, I read some of the other  25 Plaintiffs' experts report, I reread my</p>

<p style="text-align: right;">Page 10</p> <p>1       STEPHEN B. LEVINE, M.D.  2 recent article on informed consent,  3 things like that.  4       It's hard for me to answer  5 that question explicitly because I'm  6 constantly reading things on this  7 subject.  8     Q.   You mention you read some of  9 the Plaintiffs' expert reports. Which  10 ones?  11    A.   I read part of Dr. Adkins'  12 report again and I read Dr. Anton Maria.  13    Q.   Is that it?  14    A.   I read a very brief report  15 from -- like a three-page report from I  16 think an endocrinologist. Hutchison was  17 it perhaps?  18    Q.   Did you read a report from  19 Dr. Karasic?  20    A.   I originally read Karasic's  21 report but I didn't do it in preparation  22 for today.  23    Q.   Okay. And what about  24 Dr. Turban's report?  25    A.   I didn't read that yesterday</p>	<p style="text-align: right;">Page 12</p> <p>1       STEPHEN B. LEVINE, M.D.  2       VIDEOGRAPHER: We're going  3 back on the record. The time is  4 9:59.  5     Q.   Thank you. When we left off I  6 was asking about anything you did to  7 prepare for the deposition. I just have  8 one last question about that.  9       Did you speak with anyone  10 other than counsel about your testimony  11 today?  12    A.   No.  13       MR. CANTRELL: Give us one  14 second. We had a technical issue.  15    A.   No.  16    Q.   I want to ask some questions  17 about your background as a psychiatrist  18 and your treatment of patients.  19       I understand you've been a  20 psychiatrist for quite some time. Can you  21 give me an idea of approximately how many  22 patients you've treated in your career?  23    A.   Well, if my career begins when  24 I was finished my residency, I have been  25 practicing psychiatry full-time since</p>
<p style="text-align: right;">Page 11</p> <p>1       STEPHEN B. LEVINE, M.D.  2 either, but I've read it in the past.  3     Q.   Okay. Did you meet with  4 counsel to prepare for your deposition?  5    A.   I did.  6     Q.   When did you do that?  7    A.   7:30 this morning.  8     Q.   Was that the only meeting that  9 you had to prepare?  10    A.   That's right.  11       MS. COOPER: I just want to  12 pause for a moment. We're having  13 some sound issues again.  14       Can we -- do we need to go off  15 the record to clear this up? It's  16 been fuzzy.  17       THE WITNESS: I spoke very  18 softly the last time.  19       MS. COOPER: Can we go off the  20 record? I think it's more than  21 that.  22       VIDEOGRAPHER: Off the record  23 at 9:32.  24       (Discussion is held off the  25 record.)</p>	<p style="text-align: right;">Page 13</p> <p>1       STEPHEN B. LEVINE, M.D.  2 1973, July 1st. I've never actually  3 counted up the numbers of patients I've  4 seen, but I work an average of 35 hours a  5 week with patients. So you multiply that  6 by four and then multiply that by 12 and  7 then multiply that by 49, I think you'll  8 have the answer. I'm not that good with  9 math anymore in my head.  10    Q.   All right. So sounds like  11 we're talking about potentially more than  12 a thousand patients. Does that sound  13 right?  14    A.   I trust your math.  15    Q.   Okay. And can you give me an  16 approximate number of patients you see  17 within a year? Is it the same math that  18 you just described, about 35 patient  19 hours a week with four days a week, 12  20 months a year?  21    A.   Five and a half days a week  22 for most of those years.  23    Q.   Okay. So say in the past year,  24 is that five and a half days a week?  25    A.   No. In the past year I've seen</p>

<p style="text-align: right;">Page 14</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- I've worked from ten a.m. to six p.m.  3 only five days a week, and most of those  4 hours are spent with patients.  5     Q.   Okay. In your practice, do I  6 understand right, most of your patients  7 are adults?  8     A.   Teenagers and adults.  9     Q.   And by teenager, do you mean  10 under 18 or would you include 18 and  11 19-year-olds in that?  12     A.   No. I see sometimes 15, 16,  13 17-year-olds.  14     Q.   And I believe you recently  15 testified that you've seen about 50  16 adolescent minor patients in your career.  17 Is that still about right?  18     A.   All these are guesstimates,  19 Ms. Cooper. I don't think I've changed my  20 estimate since the last deposition.  21     Q.   Okay. So it would be fair to  22 say the overwhelming majority of your  23 patients are adults and a small, much  24 smaller number are minors?  25     A.   That's correct.</p>	<p style="text-align: right;">Page 16</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Well, I run teaching  3 conferences and sometimes a child is  4 presented with a parent at a teaching  5 conference, so...  6     Q.   So, but of your patients that  7 you've seen and treated, there's about  8 six prepubertal children total, all of  9 whom were there for gender  10 identity-related issues?  11     A.   Yes.  12     Q.   So that's a good pivot to  13 focusing in on your treatment of patients  14 with gender dysphoria or gender  15 identity-related issues. And I know  16 you've been asked about that at a number  17 of depositions, so I just want to follow  18 up a little bit to make sure I have that  19 clear.  20       Can you give me an approximate  21 number of adult patients you've  22 personally treated in the past year that  23 have gender dysphoria?  24     A.   I am hesitating because of the  25 word "treatment" or "treated".</p>
<p style="text-align: right;">Page 15</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Speaking of prepubertal  3 children, I believe you most recently  4 that I saw testified that you've seen  5 about six prepubertal children. Is that  6 about right still?  7     A.   That's about right, still.  8     Q.   And that's for any condition?  9     A.   No. Those are all  10 gender-identified children.  11     Q.   Okay.  12     A.   I'm sorry. I hear about other  13 children, I mean children with other  14 problems, since adults often talk about  15 troubles with their children.  16     Q.   But as far as your own  17 patients, you've seen about six  18 prepubertal children and all of them had  19 gender identity-related issues; is that  20 right?  21     A.   That is right.  22     Q.   You didn't see prepubertal  23 children for other conditions?  24     A.   Not generally.  25     Q.   Ever?</p>	<p style="text-align: right;">Page 17</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Do you mean how many people  3 I've actually seen with a gender problem  4 versus somebody I'm actively regularly  5 trying to help with one problem or  6 another or do you mean all of the above?  7     Q.   Thank you. That's a good  8 question. Let's break it down.  9       So how many patients have you  10 seen in the past year who have had a  11 gender problem, I think is the language  12 you used?  13     A.   I would guess about ten.  14     Q.   And of those ten, how many  15 would you put in that other category of  16 regularly treating?  17     A.   Well, regularly treated  18 sometimes means regularly twice a year,  19 sometimes it means once a week, sometimes  20 it means someone coming for a three or  21 four hour consultation and there the  22 evaluation and the treatment get all  23 mixed up.  24       So I would say about the ten,  25 to use a concept of treatment of trying</p>

<p style="text-align: right;">Page 18</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to influence in one way or another,  3 clarify something, to be helpful to the  4 patient.  5       I've always tried to be  6 helpful. So I would say I've been  7 treating 100% of those people, but many  8 of them come for a one-time evaluation or  9 a followup.  10       So I think in the last year  11 probably most everyone I've seen has been  12 for a short-term intensive followup and  13 three or four of them may have been just  14 coming back every six months or three  15 months, something like that. Obviously, I  16 don't keep track of these numbers.  17     Q.   Understood. And when you say a  18 short-term intensive followup, is that  19 different than an evaluation?  20     A.   Well, it's someone I've  21 evaluated years before, you see.  22     Q.   And then they come back for  23 another evaluation several years later?  24     A.   No. They come back for  25 medication or some emotional issue</p>	<p style="text-align: right;">Page 20</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about your supervision of others, but  3 before we get to that. So I've just  4 asked you about in the past year.  5       Can you give me an  6 approximation of the number of patients  7 you've seen with gender dysphoria in the  8 past five years?  9     A.   I would say that I have  10 contacts with families or patients  11 directly with gender dysphoria about ten  12 times a year. And I don't think that has  13 changed much in the last five years.  14     Q.   And are some of those patients  15 people who -- let me rephrase that.  16       Do I correctly assume it's not  17 necessarily ten new patients each year,  18 that some of them are ongoing over a  19 course of more than one year?  20     A.   Some of them, yes.  21     Q.   Okay. And have patients with  22 gender dysphoria always been, you know, a  23 similar percentage of your practice,  24 these small numbers?  25     A.   They've never been the</p>
<p style="text-align: right;">Page 19</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they're having.  3     Q.   I see but -- I'm sorry. Go  4 ahead.  5     A.   Someone, some 40-year-old  6 trans person just had renal cancer and he  7 came to discuss -- she came to discuss  8 that process.  9     Q.   I see. So of the patients who  10 you were providing sort of ongoing  11 therapy for, would it be about three or  12 four in the past year who have had gender  13 dysphoria?  14     A.   Most of my work in the past  15 year has been supervising other people  16 who have had patients with gender  17 dysphoria.  18     Q.   I'll ask you about that. But  19 before we do that, of your own patients  20 is it about three or four that you've  21 seen that you're doing ongoing therapy  22 with in the past year?  23     A.   I think it would be closer to  24 two to three.  25     Q.   Okay. And I will be asking</p>	<p style="text-align: right;">Page 21</p> <p>1       STEPHEN B. LEVINE, M.D.  2 majority of my practice. It's varied from  3 year to year. You need to understand that  4 I used to be -- I started the first  5 gender identity clinic in Cleveland, Ohio  6 in 1974. And so in those days we were  7 keeping track of the numbers of people  8 and by 1989 we had -- I think we had 325  9 evaluations done and we stopped keeping  10 track when we stopped keeping track.  11       Would you repeat the question,  12 please? I don't think I answered it.  13     Q.   Well, no, thank you. I was  14 asking whether the -- whether gender  15 dysphoria patients have always been a  16 similar percentage of your entire patient  17 pool?  18     A.   My specialty from 1973 on was  19 human sexual problems, and gender  20 problems were just one of five or six  21 different categories of problems that  22 I've been involved with.  23       So I would say not more than  24 15% of my time over the course of my  25 career has been spent with gender</p>

<p style="text-align: right;">Page 22</p> <p>1       STEPHEN B. LEVINE, M.D.  2 problems. The rest of the time has been  3 spent with other ways that human beings  4 suffer sexually.  5     Q.   So let's turn to your  6 supervision of the work of others dealing  7 with gender issues.  8       Whose work do you supervise in  9 this area?  10    A.   I've always supervised all the  11 staff that has worked with me and so I've  12 always had a staff from 1973 on. So  13 basically, I've been the senior person  14 and on these -- so everyone who got  15 presented to our gender clinic eventually  16 got presented to me and many of the times  17 I've interviewed those people.  18       I now currently supervise six  19 people in the transgender team. Actually  20 someone just got added, so it would be  21 seven. And I also now supervise a  22 psychiatrist, child psychiatrist in New  23 York who calls me for supervision every  24 two weeks and we talk about her teenage  25 gender patients.</p>	<p style="text-align: right;">Page 24</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to gender dysphoria. And so I would say  3 -- are you asking for a number?  4     Q.   Yeah.  5     A.   I would say at any given time  6 there's probably a dozen people in our  7 practice with a gender identity issue.  8     Q.   The Transgender Team or -- the  9 Gender Diversity Team is the proper name  10 for it; is that correct?  11    A.   Yes.  12    Q.   Are they affiliated with any  13 other institution besides your private  14 practice?  15    A.   No.  16    Q.   Not with any university?  17    A.   No. I am but they are not.  18    Q.   And those folks who you  19 supervise who have seen about 12 patients  20 at any given time with gender identity  21 issues, are they a mixture of minors and  22 adults?  23    A.   Are you asking about the  24 patients or the staff?  25    Q.   The patients.</p>
<p style="text-align: right;">Page 23</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   So your staff at your  3 practice, you said there's seven people  4 on the trans team?  5     A.   Yes.  6     Q.   What is the trans team?  7     A.   We call it their Gender  8 Diversity Program. And so children,  9 teenagers and adults with these issues  10 present to our general outpatient mental  11 health practice.  12    Q.   And all seven providers in  13 that group see patients with gender  14 identity-related issues?  15    A.   Yes.  16    Q.   And approximately how many  17 patients with gender dysphoria has that  18 team seen in the past year, say?  19    A.   I don't -- I don't exactly  20 know, but they present cases to me at  21 this point once a month. It used to be a  22 little bit further -- I mean more often,  23 but in the last six months it's been once  24 a month. So almost every one of them has  25 patient or two who have some relationship</p>	<p style="text-align: right;">Page 25</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Yes.  3     Q.   And when you described these  4 other clinicians present a case to you  5 once a month, what does that mean, to  6 present a case?  7     A.   Well, they spend about 30  8 minutes telling us the story of their  9 patients and then the group of us discuss  10 the meaning of the story and we try to  11 help the therapist understand what is  12 going on a little more clearly and  13 sometimes we give guidance about what to  14 do next. That's what it means.  15    Q.   And do you have -- well, let  16 me ask it differently.  17       For all of the patients who  18 are being seen by these seven people on  19 the -- in the Gender Diversity Program,  20 do you have cases of every one of those  21 patients presented to you?  22    A.   Well, I have -- I have  23 clinicians of varying vintages of  24 experience and so perhaps the most  25 experienced person focuses mostly on</p>



<p style="text-align: right;">Page 26</p> <p>1       STEPHEN B. LEVINE, M.D.  2 children and young teenagers. I'm not so  3 sure she feels it's necessary to present.  4       In general, we ask our  5 professionals, our colleagues to present  6 cases that present problems for them,  7 either diagnostic problems or therapeutic  8 problems or ethical problems.  9       So the more experienced person  10 doesn't necessarily feel the need to  11 present to us. Generally speaking, we  12 encourage our staff when they're  13 uncomfortable with the processes that are  14 happening between them and their  15 patients, we ask them to present. That's  16 always been the case in our conferences.  17       You should understand that I  18 run two conferences a week and have done  19 that since 1977 for staff for these  20 purposes. When the professional is  21 uncomfortable for any reason in dealing  22 with a patient, we ask that person to  23 present to the staff.  24       While I am the leader of the  25 staff, many -- the rest of the staff is</p>	<p style="text-align: right;">Page 28</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you were to put together the other  3 patients in your practice who have gender  4 dysphoria-related issues, how many in a  5 year?  6       A. For the entire staff?  7       Q. Yeah.  8       A. I have no confidence in the  9 answer to that question. Since -- if  10 there are 12 at any given time, I would  11 imagine that over the course of a year  12 there may be as many as 20. Our patients  13 tend to stay, you see, so it may be 20,  14 25.  15       Come to think of it -- I'm  16 hesitating because for some reason within  17 the last year I ran some data on -- let  18 me back up.  19       My computer system that keeps  20 track of diagnoses only goes back to  21 2017. And I think we had 182 people with  22 a diagnosis, one of the gender identity  23 diagnoses. And I think there was  24 something like 60 that were my patients.  25 But, again, please, I'm not sure I</p>
<p style="text-align: right;">Page 27</p> <p>1       STEPHEN B. LEVINE, M.D.  2 present and so we have a group discussion  3 about what the issue is.  4       Q. And who was that experienced  5 person you mentioned who focuses on  6 children and younger teens?  7       A. Who is it?  8       Q. Yes. What is their name?  9       A. Her name is Anna Novak.  10       Q. She's the person in your  11 practice who sees the most minors with  12 gender dysphoria; is that correct?  13       A. I would say so, yes.  14       Q. You mentioned -- I'm just  15 trying to get a sense of the patients in  16 your practice.  17       You mentioned that at any  18 given time there's about 12 people,  19 patients in your practice who are dealing  20 with gender identity issues.  21       Can you tell me over the  22 course of a year how many patients that  23 would be?  24       You mentioned that for  25 yourself it might be about ten. But if</p>	<p style="text-align: right;">Page 29</p> <p>1       STEPHEN B. LEVINE, M.D.  2 remember these numbers correctly.  3       Q. Okay. Understood. And just  4 going back to the supervision and your  5 role in supervising the care of these  6 patients, do I understand correctly that  7 you hear about issues with these patients  8 only when the clinician has problems or  9 issues that they want to discuss with  10 others in the practice; is that right?  11       A. The therapist is asked to  12 clarify what question they would like the  13 conference to address. So that is the  14 ideal way the conference begins; I'm  15 having a problem with this aspect or that  16 aspect, so we then try to address that  17 aspect.  18       Q. So you are not necessarily  19 brought into the care decisions for all  20 of the patients with gender dysphoria  21 issues at your practice; is that right?  22       A. No. I am -- well, in some  23 sense, yes, I am talking about the care  24 and decisions that are made, but it's a  25 lot more subtle than I think your</p>

8 (Pages 26 - 29)

<p style="text-align: right;">Page 30</p> <p>1       STEPHEN B. LEVINE, M.D.  2 question implies.  3     Q.   But it wouldn't be for all  4 care decisions for all patients, it would  5 be -- only be for one that there is an  6 issue that the clinician wants to discuss  7 with the group; is that right?  8     A.   These are all credentialed  9 professionals. They make many many  10 decisions that they never consult anyone  11 about.  12     Q.   So focusing in now, I was  13 asking generally about patients with  14 gender dysphoria, sort of lumping  15 together adults and minors, and if we can  16 just focus in on minors now.  17       Of the I think you said  18 approximately ten people you've seen in  19 the past year, and I think you said two  20 to three in a recurring way, how many of  21 those gender dysphoria patients were  22 minors?  23     A.   A minor being somebody in the  24 teenage years?  25     Q.   Under 18.</p>	<p style="text-align: right;">Page 32</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the child or of the teenager, the  3 adolescent. So I don't know, you know,  4 how to answer your question. I don't  5 really consider the evaluation of a  6 teenager or adolescent complete without  7 an evaluation of their family  8 circumstances. And some of that  9 evaluation work is done without the  10 patient, the teenager present.  11       So I want you to understand  12 that I'm answering your question in terms  13 of that whole system, the family system,  14 not simply the 14-year-old.  15     Q.   Understood. So if the patient  16 is the 14-year-old I understand you would  17 likely see the patient as well as the  18 patient's parent and that would count as  19 one evaluation, right?  20     A.   Yes. And sometimes it's more  21 than one session with the parent.  22     Q.   But one -- sorry. That would  23 count at one minor patient who you were  24 treating?  25     A.   One family. I think about a</p>
<p style="text-align: right;">Page 31</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Yes. I would say the majority  3 of them in the past 12 months, have been  4 teenagers.  5     Q.   So again, that's about ten  6 total and two or three who you saw in a  7 regular way?  8     A.   Yes.  9     Q.   And then if we can expand that  10 to the past five years of the patients  11 that you've seen who have gender  12 dysphoria, can you give me an idea how  13 many are minors?  14     A.   I think you should multiply  15 times five of the answer I've previously  16 gave.  17     Q.   So would that be a total of  18 about 50 who you may have seen perhaps  19 once and 10 to 15 who you've seen in an  20 ongoing relationship; does that sound  21 right?  22     A.   Yes. Part of the -- part of my  23 hesitation here is I sometimes hear about  24 minors from their parents or I spend time  25 with parents as part of the evaluation of</p>	<p style="text-align: right;">Page 33</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient and a family as one.  3     Q.   Okay. So then in terms of the  4 number of minor patients, and including  5 their family, to estimate how many you've  6 seen in the past five years, does that  7 sound good?  8     A.   It would be -- I was just  9 clarifying the number 50 for you.  10     Q.   Okay. So that sounds about  11 right. In the past five years, and most  12 of them being a single evaluation, and 10  13 to 15 being ongoing treatment?  14     A.   Again, I want to use the word  15 guesstimate here.  16     Q.   A-hum. How many prepubertal  17 children with gender dysphoria have you  18 seen in the last year, if any?  19     A.   In the last year, prepubertal?  20 I think none.  21     Q.   And in the last five years  22 would that be the six you mentioned or  23 were they spread out over time?  24     A.   I don't think that I can  25 answer that question. I think -- you</p>

<p style="text-align: right;">Page 34</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know.  3     Q.   That's fine. You mentioned you  4 supervise a New York psychologist, I  5 think you said psychiatrist, a child  6 psychiatrist?  7     A.   A child psychiatrist.  8     Q.   What's their name?  9     A.   Pardon me?  10    Q.   What is that person's name?  11    A.   Must I answer that?  12       MR. CANTRELL: We can  13 designate information confidential.  14       MS. COOPER: We can  15 temporarily designate it  16 confidential and discuss that  17 later.  18    A.   Her name is Dr. Miriam  19 Goodman. I'm sorry. That's not right.  20 Grossman, Miriam Grossman.  21    Q.   And is that a common thing to  22 do in your field, to supervise somebody  23 from another practice somewhere?  24    A.   Oh, yes.  25    Q.   And I understand she pays you</p>	<p style="text-align: right;">Page 36</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I think she's primarily  3 interested in the forming a  4 psychotherapeutic relationship with these  5 people and talking about their  6 development and their motives and their  7 options. She is not an affirmative care  8 doctor. She is much more psychodynamic;  9 "I want to investigate this with the  10 patient" doctor.  11    Q.   Does she refer any of her  12 patients for hormone therapy?  13    A.   Some of her patients are on  14 hormone therapy. I don't -- I would guess  15 she's not the person to refer. She  16 doesn't discriminate against patients,  17 she doesn't try to stop them, she tries  18 to recognize that it's their option and  19 they need to consider their motives for  20 it and their fears about it and the  21 consequences of it.  22       MR. CANTRELL: Leslie, we will  23 designate the testimony about this  24 child psychiatrist as confidential.  25       MS. COOPER: All right. We can</p>
<p style="text-align: right;">Page 35</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for that supervision?  3     A.   She does, yes.  4     Q.   And that's a typical thing  5 that's done?  6     A.   Well, I don't know how  7 typical. You know, usually experienced  8 people don't want to pay for supervision,  9 but she read some of my papers and she  10 sought me out and we've been talking  11 every two weeks for probably six months,  12 maybe eight months.  13    Q.   And she treats patients with  14 gender dysphoria?  15    A.   Now her specialty is  16 adolescents with gender dysphoria.  17    Q.   And approximately how many  18 patients who are adolescents with gender  19 dysphoria does she see that you supervise  20 that care?  21    A.   I think she's probably talked  22 to me about six people.  23    Q.   Does she have a view about the  24 appropriateness of ever providing hormone  25 therapy for adolescents?</p>	<p style="text-align: right;">Page 37</p> <p>1       STEPHEN B. LEVINE, M.D.  2 review that later, but fine.  3     Q.   And I believe at a recent  4 deposition you mentioned that you  5 supervised another, I think a counselor  6 who was not part of your practice; is  7 that right? Was there a second person you  8 supervised, paid you for supervision?  9     A.   There is, but I don't recall  10 that that supervision was about a gender  11 -- well, it wasn't directly about a  12 gender case. Oftentimes, there are hidden  13 gender issues behind the presentation.  14    Q.   What is the name of that  15 counselor?  16    A.   Again, I'm not even sure I  17 remember her last name. Her first name is  18 Sherry.  19    Q.   And you don't remember her  20 last name?  21    A.   It's I think Katz.  22    Q.   Do you no longer supervise  23 her?  24    A.   She said she would get back to  25 me when she needed me and I haven't heard</p>

<p style="text-align: right;">Page 38</p> <p>1       STEPHEN B. LEVINE, M.D.  2 from her in about four months.  3     Q.   And she hasn't had any  4 patients with gender dysphoria issues  5 that she's discussed with you; is that  6 right?  7     A.   Well, she has a patient who  8 doesn't like sexual behavior with her  9 husband. And so part of that  10 investigation is helping her to know what  11 questions to ask involves the subtle  12 aspects of one's sexual identity.  13     Q.   Have you diagnosed any minor  14 patients with gender dysphoria?  15     A.   Ms. Cooper, patients come in  16 and tell the doctor that they have gender  17 dysphoria. This idea of diagnosing people  18 with gender dysphoria seems really formal  19 and physician-like. But the truth is  20 people come in and they tell you what  21 they have and that's -- they know the  22 diagnostic criteria for gender dysphoria.  23 And so the answer is yes, I have  24 diagnosed people with gender dysphoria,  25 but that really isn't such a difficult</p>	<p style="text-align: right;">Page 40</p> <p>1       STEPHEN B. LEVINE, M.D.  2 able to assess somebody for gender  3 dysphoria to be able to do that?  4     A.   I don't understand your  5 question but I forgot -- I didn't answer  6 your previous question completely.  7       Since 2006 I have supervised  8 the Gender Identity Team at the  9 Massachusetts Department of Corrections,  10 all of their inmates who have gender  11 dysphoria, so that's been 16 years. And  12 the supervision of those cases have been  13 ongoing and very numerous. I forgot that.  14       So the number of people I  15 supervise on the treatment of gender  16 dysphoria, these are adults, but they  17 number in the hundreds at this point. And  18 I'm sorry, I forgot that when you were  19 asking me the question.  20     Q.   Thank you.  21     A.   So would you repeat the last  22 question, please?  23     Q.   Sure. You had -- I had  24 previously asked you if you diagnosed any  25 patients with gender dysphoria and I</p>
<p style="text-align: right;">Page 39</p> <p>1       STEPHEN B. LEVINE, M.D.  2 process, since the patient tells you they  3 have it. And then you ask them a question  4 or two and then -- and then they meet  5 criteria generally.  6       Sometimes when they don't meet  7 criteria it's because they feel like they  8 have gender dysphoria for the last three  9 months and as you know that the criteria  10 is six months.  11     MR. CANTRELL: Leslie, just  12 for the record, I want it to be  13 clear that we were designating as  14 confidential the discussion of both  15 of the individuals who Dr. Levine  16 has supervised.  17     MS. COOPER: Outside of his  18 practice? Ms. Katz and Dr. Goodman,  19 that's who you are referring to,  20 right?  21     MR. CANTRELL: The two, the  22 two individuals, yes.  23     MS. COOPER: Okay.  24     Q.   So is it your view you don't  25 need to be a mental health provider to be</p>	<p style="text-align: right;">Page 41</p> <p>1       STEPHEN B. LEVINE, M.D.  2 believe you said yes, but that they  3 actually know themselves or diagnose  4 themselves.  5       Are you saying that one  6 doesn't need to be a mental health  7 provider to be able to assess whether  8 somebody has gender dysphoria?  9     A.   Well, I'm sure the primary  10 care physician, the nurse practitioner,  11 the cardiac surgeon, a physician, someone  12 who has a license, who has a credential  13 to make psychiatric diagnoses, which  14 would be any physician, could make a  15 diagnosis. But the diagnosis is based on  16 patient's self-report and to some extent  17 what the doctor or the licensee  18 perceives. And so one doesn't have to be  19 a mental health professional to make the  20 diagnosis. This is part of the problem,  21 you know.  22     Q.   Does your -- you mention that  23 you meet with the parents too. Does that  24 contribute to your assessment whether  25 somebody meets criteria for gender</p>

<p style="text-align: right;">Page 42</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria, what's reported by the  3 parents?  4     A.   Of course.  5     Q.   So you touched on -- I'm  6 sorry. You mention that if a patient  7 doesn't meet criteria it's usually  8 because it's just been three months and  9 the diagnostic criteria is six months.  10       Is that the only time you've  11 ever concluded that a patient did not  12 meet diagnostic criteria, is that the  13 length of time wasn't sufficient under --  14       MR. CANTRELL: Object to form.  15     A.   The purpose of a psychiatric  16 evaluation is to get a picture of the  17 person as a whole and not just the aspect  18 of that person's gender identity. And  19 oftentimes the diagnosis of a patient  20 carries much more serious concerns than  21 the gender identity issues or the sexual  22 identity or the orientation issues or the  23 paraphilic issues of the patients. It has  24 to do with their general mental health,  25 their depression, their suicidality,</p>	<p style="text-align: right;">Page 44</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Have you ever had patients,  3 adult or minors, who come to you because  4 maybe they already had a gender dysphoria  5 diagnosis, maybe they didn't, but their  6 goal is to get a diagnosis that -- and a  7 letter to be able to get hormone therapy?  8 Have you ever had patients like that?  9     A.   Oh, yes. Oh, yes.  10    Q.   Yes. And does that include  11 minors?  12    A.   Well, minors have asked for  13 that, yes. It includes minors.  14    Q.   Is it fair to assume that if a  15 minor has asked for that that you would  16 not provide a gender dysphoria diagnosis  17 if you did not think they met the  18 criteria?  19       MR. CANTRELL: Object to form.  20    A.   I think you better repeat that  21 question for me. There was something  22 about that question that seemed strange  23 to me.  24    Q.   Okay. Is it correct that if a  25 minor comes to you seeking a diagnosis</p>
<p style="text-align: right;">Page 43</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their self-harming, their anxiety states,  3 their social isolation, their autism,  4 their developmental physical activities,  5 their bedwetting, so forth.  6       So it's very important to  7 understand that I'm trying to get the  8 people I supervise to see the patient as  9 a whole, not just as a gendered person  10 because the treatment and the decisions  11 that ultimately are made by the family  12 has to do not simply with gender identity  13 but with how the person is doing in  14 general in the world. So that's the  15 answer to the question. It's much more  16 comprehensive.  17       Sometimes I make the diagnosis  18 that it's apparent that the person has  19 some kind of gender identity problem of  20 some duration. But I'm also very  21 sensitive to the other -- the other  22 emotional difficulties that they're  23 having at the same time or often what  24 preceded those; the diagnosis or the  25 crystallization of a trans identity.</p>	<p style="text-align: right;">Page 45</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and a letter for approval for hormone  3 therapy, that if you did not believe that  4 that minor had gender dysphoria and met  5 the diagnostic criteria you would not  6 give them that diagnosis; is that  7 correct?  8     A.   I would not write a letter in  9 support of hormone therapy if I didn't  10 believe that they had gender dysphoria.  11 Is that answer to your question?  12    Q.   It does answer. Thank you.  13       And have you ever had a  14 patient come in asking for a letter for  15 hormone therapy where you did not feel  16 they had gender dysphoria?  17    A.   Well, the patient tells me  18 that he or she has gender dysphoria. I  19 often see other issues and oftentimes  20 their parents see other issues.  21       So I generally don't meet a  22 person and write a letter for hormones. I  23 meet a person and I meet a person and I  24 meet a person and I meet a person and  25 then eventually I, if I feel it's in</p>

<p style="text-align: right;">Page 46</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their best interests and they understand  3 the pros and cons of this, and they  4 understand the nature of what is known  5 and what is not known, and they  6 understand what the problems are of adult  7 transsexual people, then I will sometimes  8 write a letter for them.  9     Q.   And are there people for whom  10 you would not write a letter, in -- let  11 me ask that in a clearer way.  12       Have there been people who  13 have sought a letter where you declined  14 to write a letter?  15     A.   Yes.  16     Q.   And were any of them  17 adolescents, minors?  18     A.   Well, actually the adolescent  19 tells me that they would like to take  20 hormones. They often don't tell me I want  21 a letter now. Adults have told me I want  22 a letter now, but teenagers generally  23 don't say those things to me. They say  24 they would like to have hormones or they  25 would like to have their genitals or</p>	<p style="text-align: right;">Page 48</p> <p>1       STEPHEN B. LEVINE, M.D.  2 adolescents tend to not be insistent on a  3 letter right now. But have you ever had  4 an adolescent patient at whatever point  5 in time, whether it was immediately or  6 into the therapeutic relationship, asked  7 for a letter and you did not feel it was  8 appropriate to provide that?  9     A.   You know, a person comes to  10 mind who was talking to me about getting  11 a letter from me eventually. Then in the  12 course of about six months of talking had  13 confessed to me that he is already taking  14 testosterone. And so I would not have  15 given that person a letter at that point,  16 in part, because that person had five  17 psychiatric hospitalizations by the time  18 he or she, depending on where they were  19 at the time, before they were 16 years of  20 age. But then at 17 surreptitiously was  21 taken testosterone but withheld that  22 information from me for a while.  23       So I guess the answer to your  24 question is there would be people with  25 gender dysphoria, claimed to have gender</p>
<p style="text-align: right;">Page 47</p> <p>1       STEPHEN B. LEVINE, M.D.  2 breasts redone and they agree to talk to  3 me over time. And sometimes -- well, I  4 could speak more directly to older people  5 who are very insistent, this is the only  6 thing they want from me and they don't  7 get the letter from me, they get the  8 letter sometimes from some of my staff,  9 but it's not exactly with my blessing.  10 But they're independent people and so I  11 have nothing to -- you know. It's their  12 clinical judgment.  13     Q.   Staying within the patients  14 who are minors, then do I understand  15 correctly that it's never been an  16 adolescent who has sought a letter that  17 you've declined to provide, only adults;  18 is that right?  19       MR. CANTRELL: Object to form.  20     A.   I -- again, I'm not grasping  21 your question.  22     Q.   Let me try to ask it  23 differently.  24       Has there ever been an  25 adolescent -- I understand that you say</p>	<p style="text-align: right;">Page 49</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria that I would not give a letter  3 for hormones at that point. I think  4 that's the answer to your question. Does  5 it seem like --  6     Q.   Yes. I think you've answered  7 my question. Thank you.  8       Have you ever had an  9 adolescent patient who you believed was  10 asserting a trans identity based on  11 social influence?  12     A.   Oh, yes.  13     Q.   Can you tell me about -- how  14 many times has that happened?  15     A.   Well, if you know anything  16 about -- and I'm sure you do -- about  17 adolescents and their involvement with  18 the internet and how teenagers going  19 through early puberty and having angst  20 about their body and their future body  21 and their degree of beauty or  22 handsomeness or masculinity or femininity  23 and how people spend what they do calling  24 "research" which means emersion in trans  25 websites and listening to trans guru and</p>

<p style="text-align: right;">Page 50</p> <p>1       STEPHEN B. LEVINE, M.D.  2 trans animae. So this is a very common  3 experience, I would say a universal  4 experience, in my clinical experience.  5       So that would be the cultural  6 influences of the typical trans teenager  7 that we hear about in our clinic. And as  8 far as I can see talking to colleagues  9 nationally and internationally, it's the  10 same thing.  11     Q.   And of those patients,  12 understanding that many of them look at a  13 lot of social media, did you believe any  14 of them were influenced to become  15 transgender or identify as transgender  16 who would not have otherwise --  17     MR. CANTRELL: Object to form.  18     Q.   -- except for social media?  19     A.   Well, in order to answer that  20 question I have to speculate. You're  21 really asking me; do I understand that  22 social media, cultural exposure,  23 education or miseducation or  24 indoctrination is an influence in some  25 teenager's new identification as a trans</p>	<p style="text-align: right;">Page 52</p> <p>1       STEPHEN B. LEVINE, M.D.  2 orientation and intention. And there  3 often are excursions into one or more  4 combinations of those three dimensions.  5 And so social media has helped many  6 people define themselves as, in some way,  7 as an atypical sexual identity before  8 they've had any social experience,  9 intimate experience, romantic experience  10 and even social experience with peers and  11 friendship patterns. So social media must  12 be considered as one of the developmental  13 influences on trans teenager gender  14 identity.  15     Q.   And you have supported  16 patients' social transition; is that  17 right?  18     A.   I -- yes.  19     Q.   And you've counseled some  20 parents to support the transgender  21 identification of their children?  22     A.   I've tried to at times, yes.  23     Q.   And looking at your patients  24 who have had gender dysphoria, have most  25 of them medically transitioned in some</p>
<p style="text-align: right;">Page 51</p> <p>1       STEPHEN B. LEVINE, M.D.  2 person? Then I would speculate yes.  3     Q.   And has there been any patient  4 you had who you felt that was what was  5 going on and did not diagnose them with  6 gender dysphoria as a result?  7     A.   That would not be a reason not  8 to diagnose them. That's a question about  9 where this came from or the developmental  10 influences on the patient's  11 crystallization of their identity as a  12 trans person.  13       You know, their identity  14 before they were a trans person have  15 oftentimes had -- they were something --  16 first they thought themselves to be  17 bisexual or lesbian or homosexual and  18 they were gay or not gay any longer or  19 not lesbian any longer. So you see that  20 adolescence is normally a change, a  21 change phenomenon over six, seven years.  22 And people assume different identities,  23 different dimensions of sexual identity.  24       There are three dimensions of  25 sexual identity; gender identity,</p>	<p style="text-align: right;">Page 53</p> <p>1       STEPHEN B. LEVINE, M.D.  2 way?  3     MR. CANTRELL: Object to form.  4     A.   I think you need to clarify  5 the question if you're only talking about  6 minors. Because if you're talking about  7 adults, the answer is very different.  8     Q.   All right. Let's break it  9 down. I think that's helpful.  10       Let's start with adults. Of  11 your adult gender dysphoria patients,  12 have most of them medically transitioned  13 in some way, either hormone therapy or  14 surgery or both?  15     A.   Yes. If I could just modify  16 "most", guessing, because some people  17 come to me thinking about it and then --  18 and some people come to me already on it  19 and some people I've written letters for  20 hormones for and surgery.  21     Q.   And of the patients, the adult  22 patients with gender dysphoria that you  23 have seen in the past year -- and I'm  24 trying to go back to find what your  25 estimate was of that number, I believe</p>

<p style="text-align: right;">Page 54</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you said about ten, but a smaller number  3 of whom you saw on a regular basis -- of  4 those patients, how many did not have any  5 medical transition?  6     A. I don't think in the past  7 year, I don't think in the past year I've  8 -- I've not seen anyone who was  9 contemplating medical transition but had  10 not transitioned. You know, I may have  11 been 18 months ago or 24 months ago, you  12 know, I can't -- I'm sorry. I think the  13 answer is probably zero or close to zero.  14     Q. And actually, now I'm  15 reviewing my notes, and I think, tell me  16 if I'm getting this right, that most of  17 your patients, when you said you had  18 about ten gender dysphoria patients in  19 the past year, two to three of whom were  20 on a recurring basis, that most of those  21 patients were minors; is that right?  22     A. Meaning, yeah, adolescents,  23 right.  24     Q. Under 18?  25     A. Yeah.</p>	<p style="text-align: right;">Page 56</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q. Okay.  3     A. And my brain does not work in  4 12-month intervals. So I've already  5 illustrated that I forgot a whole series  6 of work that I do in answering your  7 question. So your continuing to ask me  8 these numbers continues to make me feel  9 uncertain about my answers.  10    Q. All right. Let me try asking  11 it a different way.  12       Of the approximately ten or so  13 adolescent patients you've seen with  14 gender dysphoria, how many had medically  15 transitioned in some way?  16    A. Had medically transitioned? Is  17 that what you --  18    Q. Yes, medically.  19    A. Well, can I ask you if the  20 person who is surreptitiously taking  21 testosterone, would that be a medical  22 transition person?  23    Q. Sure. Let me ask it  24 differently.  25       Of the approximately ten</p>
<p style="text-align: right;">Page 55</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q. Okay. And so of those  3 adolescent patients, have most of those  4 patients also medically transitioned?  5     A. No. Most of them expressed the  6 desire to one day have medical transition  7 and most of their patients' parents are  8 horrified by it, about it and we were --  9 the teenager and I were talking.  10    Q. So of that ten that you've  11 seen altogether, and I know that's a  12 rough number because that includes  13 adults, is there any way to tease out, by  14 the way, just for clarity of our  15 conversations, of the approximately ten  16 people you've seen in the past year for  17 gender dysphoria, how many of them were  18 minors or under 18?  19    A. I think we already established  20 that they were mostly minors.  21    Q. Okay. But you can't say if it  22 was all?  23    A. You know, you're pursuing a  24 line of numerical questioning that I  25 already told you is a guess.</p>	<p style="text-align: right;">Page 57</p> <p>1       STEPHEN B. LEVINE, M.D.  2 adolescents you've seen with gender  3 dysphoria in the past year, how many of  4 them were taking hormone therapy, one way  5 or the other?  6     A. I think two.  7     Q. So one of them was the patient  8 you mentioned who was surreptitiously  9 taking testosterone; is that right?  10    A. Yes. But I think you should  11 understand that it is possible to get  12 hormones in ways that are not medically  13 approved and that this is one of the  14 great temptations that trans people have  15 when they're 15 and 16. And there is  16 another patient that was discovered to  17 have been trying to import estrogen from  18 China and it was discovered by his  19 parents. And it leaves me with the  20 feeling that even though some of the  21 people I've seen said they weren't on  22 hormones, there's at least the  23 possibility that they prematurely  24 transitioned without medical approval.  25       So this is just one of the</p>



<p style="text-align: right;">Page 58</p> <p>1       STEPHEN B. LEVINE, M.D.  2 great uncertainties we have in this field  3 about people telling the truth when they  4 go see a mental health professional with  5 this issue.  6     Q.   Okay. So did you have any, of  7 your ten or so adolescent patients you've  8 seen for gender dysphoria in the past  9 year, have medically approved hormone  10 therapy?  11    A.   Yes, one of them got hormones  12 got after 45 minutes with the first  13 doctor and I guess you would say that  14 that was medically approved.  15    Q.   So that was someone who saw  16 another doctor, got approved for hormones  17 by that other doctor and then saw you  18 later?  19    A.   Yes.  20    Q.   So of the ten or so  21 adolescents you've seen for gender  22 dysphoria, or who have had gender  23 dysphoria in the past year, you mentioned  24 one that you know of surreptitiously  25 receiving hormones, you know of one who</p>	<p style="text-align: right;">Page 60</p> <p>1       STEPHEN B. LEVINE, M.D.  2 taking hormone therapy but you don't know  3 for sure; is that right?  4     A.   Well, to my knowledge they're  5 not taking hormone therapy.  6     Q.   Okay.  7     A.   And one can never be sure  8 about any particular patient whether one  9 gets the whole truth.  10       Ms. Cooper, while you're  11 planning the next question can we take a  12 one minute break for mother nature?  13       MS. COOPER: Yes. Let's go off  14 the record.  15       VIDEOGRAPHER: Going off the  16 record. The time is 11:00.  17       (Recess is taken.)  18       VIDEOGRAPHER: Going back on  19 the record. The time is 11:06.  20     Q.   When we spoke earlier you  21 mentioned someone in your practice, I  22 think you said her name is Anna Novak; is  23 that right?  24     A.   N-o-v-a-k.  25     Q.   And is she a social worker?</p>
<p style="text-align: right;">Page 59</p> <p>1       STEPHEN B. LEVINE, M.D.  2 was approved in the 45 minute approval  3 process from another doctor.  4       Are there any others who you  5 know were receiving hormone therapy?  6     A.   Yes. And there was the one --  7 actually that person is sadly now  8 deceased -- who tried to import hormones  9 and I don't know whether the parents  10 discovered the first time or the second  11 time, and so I'm just not sure about that  12 particular person.  13       Oh, and I just -- I just --  14 again you're jogging my memory. There  15 was another person that went to the  16 University of Pittsburgh and had a  17 one-hour evaluation and was given a  18 testosterone prescription. So I forgot  19 about that. You see the longer you talk  20 to me the more I remember.  21     Q.   Good.  22     A.   So that would be I guess four  23 of people.  24     Q.   And of the other approximately  25 six, to your knowledge, they're not</p>	<p style="text-align: right;">Page 61</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   She's a Social Worker-S,  3 supervisor.  4     Q.   What does that mean?  5     A.   That means she's experienced  6 and has the license to supervise other  7 people in social work.  8     Q.   And is she I believe is the  9 person you said is most experienced in  10 your practice, of your staff, for the  11 treatment of adolescents with gender  12 dysphoria; is that right?  13     A.   No. In particular, with  14 children and young adults, yes. Well,  15 it's true what you said but I just want  16 to add also children.  17     Q.   A-hum. Is there anyone else on  18 your staff, besides yourself, that is  19 more experienced with adolescents with  20 gender dysphoria than Anna Novak?  21     A.   Nobody.  22     Q.   Okay.  23     A.   Although, most of the patients  24 we see these days are adolescents.  25     Q.   And she is able to make A</p>

<p style="text-align: right;">Page 62</p> <p>1       STEPHEN B. LEVINE, M.D.  2 diagnosis of gender dysphoria among her  3 patients where appropriate?  4     A.   Yes.  5     Q.   And is she able to recommend  6 treatment for those patients?  7     A.   Well, of course.  8     Q.   The fact that she's a social  9 worker doesn't preclude her from having  10 that ability to do that?  11       MR. CANTRELL: Object to form.  12     A.   Well, if there is a problem,  13 you know, she will present her case to  14 the group. But when she's seeing  15 children, the treatment is -- you know,  16 relates to the child's problems, the  17 family relationships. So she sees the  18 parents, she sees the child and when --  19 and that's true for her when her patient  20 is a teenager as well.  21       The treatment is to the extent  22 of the valuation and the  23 psychotherapeutic relationship, so she is  24 certainly able to recommend treatment.  25     Q.   And for any of her adolescent</p>	<p style="text-align: right;">Page 64</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   How many of those letters have  3 you co-signed for adolescent minor  4 patients?  5     A.   Very few. Over the course of  6 probably 20 years, a handful.  7       MS. COOPER: I'd like to mark  8 our first exhibit, which is tab 1.  9       (Exhibit Levine 1, Declaration  10 of Stephen B. Levine, MD, dated  11 February 23, 2022, was received and  12 marked on this date for  13 identification.)  14     Q.   We'll get to have some  15 practice with Exhibit Share. I'll let you  16 know when we have it uploaded.  17       THE WITNESS: What are we  18 doing?  19       MR. CANTRELL: She's marking  20 an exhibit and we're waiting for it  21 to be uploaded.  22       MS. COOPER: It should be  23 available now. You have to hit the  24 refresh button on your screen.  25       MR. CANTRELL: You can scroll</p>
<p style="text-align: right;">Page 63</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patients, have they been provided hormone  3 therapy?  4     A.   In recent years, no, from her  5 recommendation. I think some of the  6 families and some of the families then go  7 to another -- to an endocrinologist and  8 get the treatment. I'm not aware in the  9 last couple of years whether Mrs. Novak  10 has sent anyone for or recommended  11 hormone therapy treatment because I  12 generally sign letters with the therapist  13 for hormones and I don't recall her  14 bringing a letter to me. But we are doing  15 treatment, you understand, we're doing  16 treatment.  17     Q.   I understand. So you say in  18 the last few years you don't recall her  19 bringing a letter for hormone therapy for  20 a minor patient. Has she in the past?  21     A.   Yes.  22     Q.   And you've approved those  23 letters?  24     A.   I have signed, I've co-signed  25 a letter.</p>	<p style="text-align: right;">Page 65</p> <p>1       STEPHEN B. LEVINE, M.D.  2 up and down.  3       THE WITNESS: That's my expert  4 opinion report.  5     Q.   Dr. Levine, are you able to  6 see what's been marked as Exhibit 1?  7     A.   I can see it, yes.  8     Q.   And do you recognize this  9 document?  10     A.   I do.  11     Q.   Is this the declaration you  12 filed in the case BPJ in West Virginia?  13     A.   Yes.  14     Q.   And that was in February 2022,  15 according to the first page there; is  16 that right?  17     A.   Yes.  18     Q.   If you can scroll down to  19 paragraph 6 you'll see some highlighted  20 text there. Let me know when you've found  21 that.  22     A.   I have it.  23     Q.   Okay. I'm just going to read  24 and if you'll read along with me it says,  25 "In the course of my five decades of</p>

<p style="text-align: right;">Page 66</p> <p>1       STEPHEN B. LEVINE, M.D.  2 practice treating patients who suffered  3 from gender dysphoria I have at one time  4 or another recommended or prescribed or  5 supported social transition, cross-sex  6 hormones and surgery for particular  7 patients, but only after extensive  8 diagnostic and psychotherapeutic work."  9 Did I read that correctly?  10    A.   Yes.  11    Q.   Just a couple of questions  12 about terminology here.  13       When you say "prescribed", can  14 you tell me what you're referring to? Do  15 you mean actually writing prescriptions  16 or is something else?  17    A.   I mean writing a letter so the  18 endocrinologist can evaluate the  19 patient's physical status and make a  20 decision whether hormones are  21 contraindicated or not.  22    Q.   And when you say  23 "recommended", is that something  24 different?  25    A.   Different than what?</p>	<p style="text-align: right;">Page 68</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria, you need this treatment, it's  3 medically necessary.  4       So in a sense I've  5 recommended, I've gone along with, I've  6 said, well, if this is what you want to  7 do and I've assured myself, I've talked  8 to you about my concerns about this, and  9 I've agreed that if you go through  10 therapy and we think about this together,  11 and it's your decision, you have autonomy  12 about this, then I write a letter, I  13 recommend.  14       I don't recommend in the  15 former sense, I recommend in the latter  16 sense, that I've been with you for a long  17 time, and I respect your right to make  18 this decision.  19    Q.   Thank you. And I see in some  20 of your reports and depositions you've  21 used the word "approved" patients for  22 hormone therapy. Is that the same or do  23 you mean something different by that?  24    A.   No. You know, it's hard to --  25 it's efficient to use a word like</p>
<p style="text-align: right;">Page 67</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Than writing a letter for  3 somebody. I'm just trying to understand  4 what you mean by these terms.  5       Maybe there is no difference,  6 but I want to understand if there is a  7 meaningful difference when you say  8 "recommended", "prescribed" and you also  9 have the word "supported" in that  10 sentence, do those terms have different  11 meanings here?  12    A.   Well, I guess I'm hedging the  13 meanings of these words by using "or".  14    Q.   Okay.  15    A.   Really, what I really am  16 saying is that it's the patient's choice  17 at this point and I recognize that I've  18 done what I can to educate the person  19 about this and if the pattern wants to do  20 this, as the person does, then I write a  21 letter with my imprimatur as MD and  22 psychotherapist and experienced person in  23 the field.  24       It's not like I've seen the  25 person and I said, oh, you have gender</p>	<p style="text-align: right;">Page 69</p> <p>1       STEPHEN B. LEVINE, M.D.  2 "approved" or "recommended" or  3 "prescribed", without writing a paragraph  4 about the limitations of that.  5    Q.   But just to make sure I'm  6 understanding what you're referring to  7 when you would write a letter for  8 somebody after having a relationship with  9 them and determine that you've satisfied  10 yourself that you can write that letter  11 for them to take to an endocrinologist;  12 is that right?  13    A.   Yes.  14    Q.   Okay. You've also approved,  15 using the term in the same way, some of  16 your gender dysphoria patients, adult  17 patients that is for surgery; is that  18 right?  19    A.   Yes.  20    Q.   And when is the last time you  21 did that?  22    A.   Probably 16 months ago, 17, 18  23 months ago.  24       MS. COOPER: Okay. I'd like to  25 mark as the next exhibit what is</p>

<p style="text-align: right;">Page 70</p> <p>1       STEPHEN B. LEVINE, M.D.  2    tab 3.  3       We'll let you know when it's  4    uploaded. That's now available. Let  5    me know when you can see that.  6       (Exhibit Levine 2, excerpt of  7    the deposition of Stephen B.  8    Levine, MD re: Reiyn Keohane v.  9    Julie Jones was received and marked  10   on this date for identification.  11       THE WITNESS: It's a different  12   exhibit now?  13       MR. CANTRELL: Yes. It's a  14   different exhibit.  15    Q.   Are you able to see Exhibit 2,  16   Dr. Levine?  17    A.   I can see it, yes.  18    Q.   And do you recognize this as a  19   deposition you gave in the case of Reiyn  20   Keohane versus Julie Jones May of 2017?  21    A.   Actually, the last time I was  22   asked about this I didn't remember giving  23   a deposition. I only remembered being in  24   the courtroom at the trial but I presume,  25   I just don't remember the deposition.</p>	<p style="text-align: right;">Page 72</p> <p>1       STEPHEN B. LEVINE, M.D.  2    hormones very quickly and we are much  3    more cautious. We will give adolescents  4    hormones but not as quickly as the  5    Standards of Care would like."  6       Did I read that correctly?  7    A.   Umm.  8    Q.   Is that a yes?  9    A.   That is a yes. I'm trying not  10   to be funny.  11    Q.   Okay.  12    A.   I just want to compliment you  13   in your capacity to read.  14    Q.   Thank you so much.  15       So when you say there, just  16   for clarity, "I don't exactly follow the  17   Standards", do I understand correctly you  18   are referring to the WPATH Standards of  19   Care, 7th Edition?  20    A.   Yes, you are correct.  21    Q.   And when you say "we're much  22   more cautious" -- well, actually let me  23   ask it -- let me backup.  24       At the beginning of the  25   sentence you say in your "Center", is</p>
<p style="text-align: right;">Page 71</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   You remember being a witness  3   in that case; is that correct?  4    A.   Yes, I do.  5    Q.   Okay. If you could please  6   scroll down to page 59, and I think we've  7   only provided excerpts because we only  8   have one passage to show you. Okay?  9    A.   Yeah.  10   Q.   And I want to give you time to  11   read the surrounding text to make sure  12   that the context is clear to you. But do  13   you see that I've highlighted in blue  14   some text on page 59? Why don't you take  15   a moment to read the surrounding text,  16   including that and then we'll review it.  17       (Deponent reviews the  18   document.)  19    A.   Okay. I think I --  20   Q.   Okay. I'm just going to read  21   now the highlighted passage that says,  22   "And so in my Center I recommend  23   psychotherapy to people, so I don't  24   exactly follow the Standards. The 7th  25   Edition wants to give adolescents</p>	<p style="text-align: right;">Page 73</p> <p>1       STEPHEN B. LEVINE, M.D.  2    that your medical practice that you're  3   referring to?  4    A.   Repeat the last sentence. In  5   the what?  6    Q.   Sure. At the first passage  7   there -- I'm sorry -- the first sentence  8   there "And so in my Center". And I just  9   want to clarify, in your Center, is that  10   your medical practice?  11    A.   Yes.  12    Q.   Okay. And do I understand  13   correctly that you are saying that you,  14   in your practice, in your center are much  15   more cautious in terms of timing and when  16   you would give hormones to adolescents,  17   compared to what the WPATH Standards of  18   Care 7 says?  19    A.   Yes.  20    Q.   And just, again, going back to  21   terminology, the phrase "we will give  22   adolescents hormones", do you mean  23   approve or write a letter, as you  24   described before?  25    A.   Exactly.</p>

<p style="text-align: right;">Page 74</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   I think you mentioned a few  3 minutes ago that over the course of your  4 career or I guess -- strike that. I want  5 to be more precise.  6       I believe you testified over  7 the past 20 years or so you've approved  8 hormones for a handful of adolescents; is  9 that correct?  10    A.   Yes.  11    Q.   Okay. And when was the last  12 time you did that?  13    A.   In August 2020. The reason I  14 remember that is that in March 2021 this  15 person died and so it's fixed in my mind  16 these sequences.  17    Q.   And is this a patient who died  18 by suicide?  19    A.   Well, it's not clear. He died  20 of a heroin overdose and probably with  21 fentanyl, but when I was seeing him there  22 was no hint he was on heroin.  23       He only went on heroin when he  24 went to college and, as a trans person,  25 and couldn't find a roommate. And then</p>	<p style="text-align: right;">Page 76</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I'm not certain. If the answer  3 is affirmative, like one, two or three,  4 it certainly is an unusual thing.  5       I think our center is known to  6 be a place for people who want to think  7 about this when they have gender  8 dysphoria. We do occasionally see people,  9 they are not necessarily adolescents,  10 they could be 20, 21, 25, 26, 40, who  11 feel like they want to have, you know,  12 they know what they want. But what's  13 happened, in 19 -- I would say for 20  14 years in the Cleveland metropolitan area  15 we were the only show in town that had  16 expertise and interest in this problem.  17 But subsequently other places have arisen  18 and places associated with hospitals and  19 individuals who are, quote, "gender  20 specialists" in town. And so, generally  21 speaking, when adolescents want hormone  22 treatment and they have their parents  23 consent or they go somewhere else. So our  24 center these days selects people who want  25 a more thoughtful, conservative, careful,</p>
<p style="text-align: right;">Page 75</p> <p>1       STEPHEN B. LEVINE, M.D.  2 eventually found a trans roommate that he  3 didn't get along with, and then he didn't  4 study, this kid who was brilliant, and  5 then he left college and then started at  6 a new college and by the time he --  7 before he transferred to the new college  8 he, unknown to me and to his parents, he  9 was using heroin. And I think he had one  10 Narcon revival in his home before he died  11 in his dorm room at Ohio State.  12       So whether this is suicide or  13 just a product of bad judgment because of  14 his pain, his ongoing pain, and then he  15 died of a drug overdose, I'm not sure.  16    Q.   And when was the last time you  17 were asked to provide a letter for  18 hormone therapy for an adolescent? Was it  19 that patient?  20    A.   I think that was the last  21 time, yes.  22    Q.   And have any of the providers  23 that you supervise recommended or  24 approved anyone under 18 for hormone  25 therapy in the last five years?</p>	<p style="text-align: right;">Page 77</p> <p>1       STEPHEN B. LEVINE, M.D.  2 slow approach.  3       So I would say that my career  4 experience has to be divided into when we  5 were the only show in town and when we  6 became known as the place who is more  7 conservative.  8     Q.   I think you mentioned before  9 that Ms. Novak at least has approved some  10 minor patients for hormone therapy; is  11 that right?  12    A.   Yes. Yes.  13    Q.   And any other providers at  14 your center?  15    A.   We're just talking about  16 minors now?  17    Q.   Yes.  18    A.   I think I'm the one that sees  19 most of the minors, Mrs. Novak and  20 myself. Well, we have a child  21 psychiatrist who participates in the  22 evaluation of these adolescents, but  23 basically she doesn't do the  24 psychotherapy. She does sort of diagnosis  25 of anxiety and depression and autism and</p>

<p style="text-align: right;">Page 78</p> <p>1       STEPHEN B. LEVINE, M.D.  2 so forth.  3     Q.   So between you and Mrs. Novak  4 there have been a handful of cases in the  5 past, say, five years where you have  6 approved hormone therapy for minors; is  7 that right?  8     A.   These are particularly  9 fraught, difficult circumstances, yes.  10    Q.   Can you say what you mean by  11 that?  12    A.   Well, many of the people with  13 gender dysphoria have what others call  14 comorbid conditions. And sometimes we  15 have very disturbed people who are very  16 insistent and we don't seem to be able to  17 get anywhere in understanding their lives  18 with them until they get what they want,  19 so to speak.  20       So as I've said in some of my  21 publications, the ethical problems  22 involved with these patients are  23 sometimes very complicated and one has to  24 make decisions that one is uneasy about.  25       I, for one, am very sensitive</p>	<p style="text-align: right;">Page 80</p> <p>1       STEPHEN B. LEVINE, M.D.  2 treatment programs at three special  3 gender programs in Cleveland, when people  4 want hormones they often go to those  5 places and they get their hormones.  6 Those places don't often even ask us for  7 a letter of recommendation.  8       So the scene in my region is  9 perhaps different than the scene in  10 Little Rock or New York and so forth. And  11 -- that's all.  12    Q.   Have you ever written letters  13 of authorization for minor patients to --  14 minor patients with gender dysphoria to  15 receive puberty blockers?  16    A.   To what puberty blockers?  17    Q.   To receive puberty blockers.  18    A.   Never.  19    Q.   What about Mrs. Novak or  20 others in your practice?  21    A.   Never.  22    Q.   Have you ever written a letter  23 of authorization for any minor patient  24 for top surgery?  25    A.   Meaning less than 18?</p>
<p style="text-align: right;">Page 79</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to the long-term consequences of  3 medicalizing this problem because I'm  4 perhaps more aware of anyone in my unit  5 of the literature in this field. So I  6 find myself being ethically comfortable  7 talking with and not immediately giving  8 hormones to people immediately, meaning  9 quickly. I don't mean in 40 minutes or 60  10 minutes, I mean over a course of months.  11 So I think that's the answer to your  12 question.  13    Q.   Understood. But just in terms  14 of timeframe, I'm trying to get an  15 understanding, that I think you testified  16 both you and Mrs. Novak have approved  17 minor, some minor patients for hormone  18 therapy, and has that happened within the  19 past five years?  20    A.   What I'm saying -- I'm not  21 sure. I think -- I think it probably has  22 on rare occasion.  23       What you need to understand,  24 given the reputation that we have and the  25 availability of specialized gender</p>	<p style="text-align: right;">Page 81</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Yes.  3    A.   Never.  4    Q.   And what about others in your  5 practice?  6    A.   As far as I know, never.  7    Q.   And as patients come to you  8 now, going forward, current patients and  9 potentially new patients who are minors  10 with gender dysphoria, would you consider  11 writing a letter for them, if after that  12 careful, lengthy, exploratory period, you  13 felt it was appropriate?  14       MR. CANTRELL: Object to form.  15    A.   Ms. Cooper, as I said before,  16 I view gender dysphoria as one aspect of  17 a person's life, and I'm very sensitive  18 to finding other aspects of a person's  19 life, in particular, when they're  20 dysfunctional or highly symptomatic, as  21 some of the patients that we get to see  22 are, as most of the patients that we get  23 to see happen to be. So it's not a matter  24 of, here is the diagnosis, here is the  25 treatment. It's, here is the person who</p>

<p style="text-align: right;">Page 82</p> <p>1       STEPHEN B. LEVINE, M.D.  2 has gender dysphoria, who is autistic,  3 who is self-harming, who is not going to  4 school. And when I look at the whole  5 person I can't -- it's such a different  6 thing than what you're asking me.  7       You're asking me about when  8 gender dysphoria exists in a whole  9 person, do I recommend hormones or  10 surgery?  11     Q.   That is not what I meant to  12 ask you. So maybe I should clarify the  13 question.  14     A.   Thank you.  15     Q.   I understand from your  16 testimony that you have for some patients  17 written letters approving them for  18 hormone therapy.  19       I'm just trying to understand  20 whether that is something that you would  21 still consider at any point for future  22 patients? Or put another way, have you  23 taken that off the table and would no  24 longer consider that, regardless of the  25 circumstances?</p>	<p style="text-align: right;">Page 84</p> <p>1       STEPHEN B. LEVINE, M.D.  2 theoretically, if various factors were in  3 place, could see approving you said  4 someone who was 18 for hormone therapy.  5 Have you now ruled out for 17-year-olds  6 in the similar scenario you described?  7       MR. CANTRELL: Object to form.  8     A.   I haven't in an absolute sense  9 ruled out, but I am particularly inclined  10 to be wanting to delay the use of these  11 medications and certainly of surgeries  12 until I believe the person has had enough  13 maturity and enough life experience to  14 realize what the consequences of this  15 will be in the short term and in the  16 long-term.  17       So I am biased to provide  18 psychotherapeutic treatment as opposed to  19 hormonal treatment and I'm much quicker  20 to recommend psychotherapeutic treatment  21 than I am medical or surgical treatment  22 in minors, and in majors as well.  23     Q.   And by "majors", I assume you  24 mean adults, just for the record; is that  25 correct?</p>
<p style="text-align: right;">Page 83</p> <p>1       STEPHEN B. LEVINE, M.D.  2       MR. CANTRELL: Object to form.  3     A.   Those are two questions. So  4 I'll answer the first question.  5       On a theoretical basis, if I  6 had an opportunity to consider the whole  7 patient and the family and had an  8 opportunity to address the adversities in  9 the person's past and improve some  10 things, and if I thought that this person  11 was cognitively free enough from the  12 psychopathology to make an informed  13 decision and was 18-years-old, I could  14 theoretically say I will write a letter  15 in support of hormone therapy. That was  16 the answer to your first question.  17       That doesn't happen very  18 often. And as I already told you, the  19 last time I did that I've had to deal  20 with the parents grieving in my office.  21       Now, if you could repeat the  22 second question, I'll answer that.  23     Q.   Well, let's drop that one. I  24 want to follow up here.  25       Now, you mention that you</p>	<p style="text-align: right;">Page 85</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   For the record.  3     Q.   For the record.  4       So in the past when you have  5 approved people under 18 for hormone  6 therapy, had you determined that they had  7 the maturity to understand all the  8 implications that you were describing and  9 you made the judgment that it was  10 appropriate to author that letter?  11       MR. CANTRELL: Object to form.  12     A.   I don't think so. That's what  13 I mean, these things are ethically  14 fraught. One cannot be sure a  15 15-year-old, a 16-year-old, a 18-year-old  16 is mature enough. These are fraught --  17 these cause anguish in the souls of the  18 doctors. Or if they don't, I worry why  19 they don't.  20     Q.   When you've written letters  21 for adolescents in the past, did you  22 first determine that they had  23 long-standing stable -- a long-standing  24 stable gender identity?  25       MR. CANTRELL: Object to form.</p>

<p style="text-align: right;">Page 86</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A.   Yes. I would be very</p> <p>3 disinclined to write a letter for</p> <p>4 hormones if somebody had this for six</p> <p>5 months or seven months.</p> <p>6       MS. COOPER: Let's mark as</p> <p>7 Exhibit 3, tab 4, please.</p> <p>8       (Exhibit Levine 3, article re:</p> <p>9 Reconsidering Informed Consent</p> <p>10 written by Stephen B. Levine, MD,</p> <p>11 in the Journal of Sex &amp; Marital</p> <p>12 Therapy, was received and marked on</p> <p>13 this date for identification.)</p> <p>14 Q.   It should be available now.</p> <p>15 A.   Exhibit 3, I'll open 3?</p> <p>16 Q.   Yes. Let me know when you're</p> <p>17 able to see it.</p> <p>18 A.   I'm there.</p> <p>19 Q.   Do you recognize this</p> <p>20 document, Doctor?</p> <p>21 A.   I do.</p> <p>22 Q.   Is this your article</p> <p>23 Reconsidering Informed Consent for</p> <p>24 Trans-Identified Children, Adolescents</p> <p>25 and Young Adults?</p>	<p style="text-align: right;">Page 88</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       So when we socially transition</p> <p>3 a child or a teenager, that pretty much</p> <p>4 increases -- that increases their chance</p> <p>5 of getting medically transitioned in the</p> <p>6 future with all those consequences.</p> <p>7       So what I'm saying is parents</p> <p>8 need to be more fully understanding of</p> <p>9 what science knows and what science</p> <p>10 doesn't know, you see. And they need to</p> <p>11 understand what we're worried about with</p> <p>12 adults who have already made this</p> <p>13 transition and what the indicators of</p> <p>14 their dysfunction is as a group. So</p> <p>15 that's what informed consent, that's what</p> <p>16 this is about, you see.</p> <p>17       Are we, number one, evaluating</p> <p>18 these children correctly? Number two, do</p> <p>19 the doctors know the facts in this field?</p> <p>20 And three, are people being told what</p> <p>21 science knows and what science doesn't?</p> <p>22 And four, what -- do parents understand</p> <p>23 what the -- what the social, medical and</p> <p>24 psychological problems are of adults who</p> <p>25 have been well transitioned -- have been</p>
<p style="text-align: right;">Page 87</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A.   Yes, it is.</p> <p>3       Q.   And this was published in --</p> <p>4 this year, 2022, correct?</p> <p>5       A.   March 17th.</p> <p>6       Q.   I've read the article and as I</p> <p>7 understand it, and tell me if I'm getting</p> <p>8 this right, that you are recommending</p> <p>9 some specifics of an informed consent</p> <p>10 process that you think providers should</p> <p>11 undertake before authorizing hormone</p> <p>12 therapy for medical transition for</p> <p>13 minors; is that right?</p> <p>14 A.   And surgical transition, yes.</p> <p>15 Q.   Surgical transition. Okay.</p> <p>16 A.   And social transition.</p> <p>17 Q.   Okay. Thank you.</p> <p>18 A.   So let's be clear. To socially</p> <p>19 transition a person has enormous lifetime</p> <p>20 consequences. To add hormones as</p> <p>21 additional lifetime consequences and to</p> <p>22 remove bodily tissues that are healthy,</p> <p>23 have also have additional psychological</p> <p>24 consequences and parents need to</p> <p>25 understand all of the above.</p>	<p style="text-align: right;">Page 89</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 long transitioned. You see, that's what</p> <p>3 this article is about.</p> <p>4       Q.   Okay. And is it a description</p> <p>5 of the process for informed consent that</p> <p>6 you would apply with patients who are</p> <p>7 adolescents seeking social transition or</p> <p>8 medical transition?</p> <p>9       A.   I'm sorry. Would you repeat</p> <p>10 that, the first part?</p> <p>11       Q.   Sure. What you describe in</p> <p>12 this article, is it a process for</p> <p>13 obtaining informed consent that you would</p> <p>14 apply with patients who are minors</p> <p>15 seeking social transition or medical</p> <p>16 transition?</p> <p>17 A.   Yes. It would be a process</p> <p>18 with the parents and the minor. Yes,</p> <p>19 exactly.</p> <p>20 Q.   You anticipated my next</p> <p>21 question, whether that process includes</p> <p>22 the parents. So that's a "yes"?</p> <p>23 A.   The parents are the only</p> <p>24 people that can legally can give consent.</p> <p>25 Of course it has to involve the parents.</p>



<p style="text-align: right;">Page 90</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Right. And you would gauge,</p> <p>3 according to your recommendation in this</p> <p>4 article, gauge whether the minor</p> <p>5 comprehends all the information that</p> <p>6 you're providing them; is that right?</p> <p>7       MR. CANTRELL: Object to form.</p> <p>8     A.   To the extent that one can</p> <p>9 accurately assess whether a minor can, a</p> <p>10 13-year-old, a 14-year-old can appreciate</p> <p>11 a list of medical and psychosocial and</p> <p>12 psychosexual problems of being 30. You</p> <p>13 see, that's why we want to emphasize the</p> <p>14 parents, not the child.</p> <p>15       I don't really think the</p> <p>16 typical 14-year-old has the capacity.</p> <p>17 They have the passion; they have the</p> <p>18 zeal; they have the "I can't live without</p> <p>19 this" quality; they have the overvalued</p> <p>20 idea. They don't have the life</p> <p>21 experience to appreciate what this means.</p> <p>22     Q.   I see your coauthors listed</p> <p>23 here are E. Abbruzzese. Am I saying that</p> <p>24 right? I'm going to spell it for the</p> <p>25 court reporter Abbruzzese</p>	<p style="text-align: right;">Page 92</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 economist and a methodologist, she's an</p> <p>3 expert in analyzing material relating to</p> <p>4 health and she works for a health</p> <p>5 organization, but I don't think she's</p> <p>6 affiliated with a university, if that's</p> <p>7 what you're asking.</p> <p>8     Q.   No. I was just trying to</p> <p>9 understand her background. And what do</p> <p>10 you know about Julia Mason?</p> <p>11     A.   She's a pediatrician who has</p> <p>12 some experience with gender patients and</p> <p>13 conservative, "let's be thoughtful about</p> <p>14 this" approach. She doesn't -- I don't</p> <p>15 think she agrees with some of her</p> <p>16 colleagues in pediatrics who think social</p> <p>17 transition of six-year-olds is a good</p> <p>18 idea.</p> <p>19     Q.   And I understand that she's</p> <p>20 also affiliated with SEGM. Is it okay if</p> <p>21 I use those initials?</p> <p>22     A.   SEGM. I think we -- we call it</p> <p>23 SEGM.</p> <p>24     Q.   SEGM, happy to use that. Is</p> <p>25 she also affiliated with SEGM?</p>
<p style="text-align: right;">Page 91</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 A-b-b-r-u-z-z-e-s-e?</p> <p>3     A.   Yes.</p> <p>4     Q.   That's one. And the other is</p> <p>5 Julia W. Mason; is that correct, they're</p> <p>6 your coauthors of this paper? Okay.</p> <p>7     A.   Your reading skills continue</p> <p>8 to be excellent.</p> <p>9     Q.   Who is E. Abbruzzese?</p> <p>10    A.   Who is she?</p> <p>11    Q.   Well, does that person go by E</p> <p>12 or is that a full name?</p> <p>13    A.   She prefers to go by E.</p> <p>14    Q.   Okay. I see on this paper her</p> <p>15 affiliation listed is SEGM, the -- I'm</p> <p>16 going to say that wrong.</p> <p>17    A.   I'll say it for you.</p> <p>18    Q.   Say it for me. Thank you.</p> <p>19    A.   The Society For Evidence-Based</p> <p>20 Gender Medicine.</p> <p>21    Q.   That is the affiliation. Do</p> <p>22 you know if E. Abbruzzese is affiliated</p> <p>23 with any university or any other</p> <p>24 organization as well?</p> <p>25    A.   Well, she is -- she's a health</p>	<p style="text-align: right;">Page 93</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   I think she -- yes.</p> <p>3     Q.   How did you come to partner</p> <p>4 with these two authors on this paper?</p> <p>5     A.   People have read some of my</p> <p>6 writing and asked me to join. Sometimes I</p> <p>7 get invitations for this or that based on</p> <p>8 what people have read that I've written</p> <p>9 and E invited me to be part of a</p> <p>10 psychotherapy group of mental health</p> <p>11 professions who were looking at the</p> <p>12 possibility of alternate approaches to</p> <p>13 this because many of them have seen</p> <p>14 negative consequences in patients to</p> <p>15 transitions premature -- what they call</p> <p>16 premature transitions.</p> <p>17       So I joined a</p> <p>18 once-every-two-weeks, one-and-a-half-hour</p> <p>19 discussion on the internet with people</p> <p>20 from Australia and England and Ireland</p> <p>21 and Canada and various parts in the</p> <p>22 United States. And so we talked about --</p> <p>23 we were talking about these issues and</p> <p>24 talking about cases and talking about the</p> <p>25 difficulties in doing various forms of</p>

<p style="text-align: right;">Page 94</p> <p>1       STEPHEN B. LEVINE, M.D.  2 work and talking about the general trust  3 -- thrust of how science has been ignored  4 and a treatment fashion has taken over,  5 and there has been a political  6 indoctrination that's been amazingly  7 successful, and there's been a confusion  8 of medical science with political  9 concepts and civil rights.  10       So we got together to start  11 talking about these issues and people  12 were impressed that I have written of the  13 issues that they were talking about, so  14 they invited me to join the discussion.  15 And during those discussions it was  16 proposed, since I have had this interest  17 in informed consent and feeling like  18 there has been ethical problem in not  19 having the elements of informed consent,  20 that SEGM decided they would like me to  21 write a paper on this subject. And  22 starting I would say in January 2021 I  23 began writing a paper and SEGM actually  24 gave me a grant to, \$5,000, for the  25 effort to develop a paper.</p>	<p style="text-align: right;">Page 96</p> <p>1       STEPHEN B. LEVINE, M.D.  2 them I never heard back from them. But I  3 did write a letter authorizing a  4 mastectomy for a 26-year-old engaged  5 person, who is living together with her  6 fiancé, his fiancé.  7       Q. I believe you testified in  8 another case that you've written letters  9 for gender-dysphoric adults more than 50  10 times; is that right?  11       A. Over the course of a lifetime,  12 you know, I just use the word guesstimate  13 again to remind you of my previous  14 testimony.  15       In 1974, 1984 and 1994 the  16 field was very different. Our  17 understanding was very very different.  18 The situation, the landscape has changed  19 dramatically.  20       In the early years, in the  21 early decades we were dealing primarily  22 with adults and primarily with male  23 adults. But now the landscape, as you  24 well know, is a very different thing.  25       Q. But is that right, that you've</p>
<p style="text-align: right;">Page 95</p> <p>1       STEPHEN B. LEVINE, M.D.  2       That paper occupied me for, I  3 would say, 15 months of my time, and I  4 probably worked at the level of getting  5 \$2 an hour for the amount of time I spent  6 in developing this paper. So that's sort  7 of the background.  8       Q. Okay. Thank you. Have you  9 written letters of authorization for  10 adult gender dysphoria patients to get  11 gender-confirming surgeries?  12       A. I recently wrote a paper --  13 sorry. I wrote a letter of support most  14 recently for two people; one, the woman I  15 mentioned who developed renal cancer for  16 an orchiectomy, which she never went  17 through with, not because of the cancer  18 but for other reasons; and I wrote a  19 letter for a mastectomy to a 26-year-old  20 person who is engaged to a woman and I  21 had interviewed both the patient three  22 times and the fiancé. And I got a  23 promise from that person that I would see  24 them back three months after their  25 mastectomy. And despite my contacting</p>	<p style="text-align: right;">Page 97</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- does that sound about right, that  3 you've recommended or approved surgery at  4 least 50 times?  5       A. Well, if we could count it and  6 it turned out to be 36 or 61 it wouldn't  7 surprise me.  8       Q. Okay. Fair enough. So we've  9 talked about letters authorizing hormone  10 therapy. What do you say in these  11 letters?  12       A. What I say in these letters is  13 very different than what I've seen  14 recommended in these letters.  15       Q. What do you say?  16       A. I talk about the evaluation  17 that I've done, I talk about the person,  18 I talk about their strengths, their  19 weaknesses or their limitations, I talk  20 about their symptoms bearing, I talk  21 about their reasons for doing this, I  22 talk about my unease, if I have unease,  23 and I usually have unease. You see, so I  24 give a picture. So I've heard from  25 people that these are the most</p>

25 (Pages 94 - 97)

<p style="text-align: right;">Page 98</p> <p>1       STEPHEN B. LEVINE, M.D.  2 comprehensive and helpful letters I've  3 ever received from anybody.  4       I've written a book written by  5 -- published by the American Psychiatric  6 Association on transgender healthcare and  7 I saw the sample letters that people were  8 recommending and, basically; I have seen  9 this person and I think they're  10 cognitively prepared for this, they  11 understand the limitations and it's my  12 recommendation that they be given  13 hormones.  14       This is not the letter that I  15 have ever written or co-signed. The  16 letters that we write talk about the  17 elements of the evaluation and the whole  18 person and that we have discussed these  19 matters with the patient, and they're  20 usually a minimum of three page, two to  21 three page letter.  22     Q.   And do you say in the letters  23 that you believe that treatment is likely  24 to benefit the patient?  25     A.   No. I generally say that the</p>	<p style="text-align: right;">Page 100</p> <p>1       STEPHEN B. LEVINE, M.D.  2       The answer to your question, I  3 think in a briefer way, is that of course  4 I wouldn't write a letter thinking it's  5 going to harm them. I do -- I guess what  6 I said is sometimes I'm not sure it's  7 going to benefit them.  8     Q.   You mention some people are  9 lost to followup. Is that a common thing  10 in medical care in the United States?  11       MR. CANTRELL: Object to form.  12     A.   It's not a common thing in  13 ideal medical care, but it's certainly a  14 common thing in trans care.  15     Q.   So it's not a common thing  16 with your other kinds of patients who you  17 have for other conditions?  18     A.   Oh, I'm sure you can find  19 countless examples where there is a short  20 intervention with a patient and the  21 doctor never sees the patient again, of  22 course. But this is a chronic condition,  23 you know, gender dysphoria. It's not  24 really a curable condition for most  25 people. And if you recall the important</p>
<p style="text-align: right;">Page 99</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient believes that it's going to  3 benefit them and that we do not see any  4 reason to stand in the way of this and,  5 therefore, we are referring this patient  6 for hormone therapy.  7     Q.   Would you ever approve a  8 letter or do a letter if you felt that  9 treatment would be harmful to the person?  10    A.   If it was not going to benefit  11 the person, is that what you said?  12    Q.   I said would be harmful to the  13 person.  14    A.   Well, I have -- I can remember  15 a particular person, it was actually -- I  16 think it was for surgery, that we weren't  17 sure that this was going to help the  18 person, but we didn't know what else to  19 do for this person, and we outlined our  20 concerns about the mental state of this  21 person. So the person underwent surgery  22 and then we never heard back from them  23 again. It's the typical thing in the  24 United States, people are lost to  25 followup.</p>	<p style="text-align: right;">Page 101</p> <p>1       STEPHEN B. LEVINE, M.D.  2 study published by Sweden in 19 -- in  3 2011, the recommendation was for lifelong  4 psychiatric care. It's easy to make  5 recommendations like that. Those things  6 usually don't happen.  7     Q.   Just to go back then, when you  8 write these letters for patients with  9 gender dysphoria to approve hormone  10 treatment, you don't say whether or not  11 you think the treatment will be  12 beneficial to them?  13       MR. CANTRELL: Object to form.  14     A.   No. I say the patient wants  15 hormone treatment. I say that I've had an  16 opportunity to discuss hormone treatment  17 and his or her life in more detail; these  18 are things I know about this person; here  19 are the person's strengths, for example,  20 high intelligence; and here are the  21 person's limitations, chronic depression,  22 social isolation, anxiety states,  23 tendency to be dependent on marijuana;  24 and the patient and I have had a year,  25 year and a half of opportunities and I've</p>

<p style="text-align: right;">Page 102</p> <p>1       STEPHEN B. LEVINE, M.D.  2 met with them 23 times or 30 times or 18  3 times, and the person is now 18 years of  4 age and still persists in wanting to have  5 hormone surgery and I promised the person  6 that I would write a letter for them if  7 they cooperated with me to discuss this  8 and at great length and the patient has  9 met my criteria and she still wants to  10 take estrogen, and so I'm writing this  11 letter informing you that she has done  12 her psychiatric preliminary work and, no,  13 I'm not saying I think this is going to  14 benefit the person.  15     Q.   Are these letters needed  16 because some endocrinologist won't  17 provide the care without a letter from a  18 mental health provider?  19     A.   Well, that's not always true,  20 I'm sad to report. But generally  21 speaking, the people who say that they  22 follow the Standards of Care from WPATH  23 do require a mental health assessment.  24 They don't -- they don't really define  25 what that should be or how comprehensive</p>	<p style="text-align: right;">Page 104</p> <p>1       STEPHEN B. LEVINE, M.D.  2 other symptoms of mental illness.  3       So this is part of the ethical  4 problem, Ms. Cooper, that the surgeon  5 wants to assume that the ethics have been  6 worked out by the endocrinologist and the  7 endocrinologist wants to assume that the  8 ethics problem and the criteria have been  9 worked out by the mental health  10 professional.  11       So everyone is sort of passing  12 the buck here to the mental health  13 professional and that's why, you know,  14 very conservative people, like myself,  15 need to take time and thoughtfulness and  16 need to have a relationship with the  17 patient and the family and we need to  18 represent accurately what science knows  19 and what science doesn't know, and we  20 need to accurately represent what are the  21 problems, the well-known problems of the  22 marginalized, vulnerable, often substance  23 abusing, and chronically suicidal people  24 in adult life are. So that's my  25 long-winded answer to your question.</p>
<p style="text-align: right;">Page 103</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or how sophisticated, but they do want a  3 letter from a mental health professional.  4       The reason they want a letter  5 is they don't want to take ethical  6 responsibility for making this decision,  7 this is a fraught, difficult decision,  8 they want -- they want to say, well, the  9 psychiatrist or the social worker or the  10 mental health professional said it's  11 okay, therefore, I'm just doing this, and  12 I'm just going to assure myself that the  13 patient knows what the side-effects are  14 and knows when to call me or when to go  15 to the emergency room if this happens or  16 that happens, you see. But the ultimate  17 decision whether I should give hormones  18 or not is made by the mental health  19 professional. And as you may or may not  20 know, many endocrinologists have felt  21 very uneasy about this on an ethical  22 basis because they don't know whether  23 gender dysphoria is a mental illness or  24 not, even though some people say it's  25 not, because many of these people have</p>	<p style="text-align: right;">Page 105</p> <p>1       STEPHEN B. LEVINE, M.D.  2       MS. COOPER: This is a good  3 time for a break. Does this work as  4 a good lunch break time for folks?  5       MR. CANTRELL: Sure.  6       MS. COOPER: Let's go off the  7 record.  8       VIDEOGRAPHER: Going off the  9 record. The time is 12:05.  10       (Lunch recess is taken.)  11       VIDEOGRAPHER: Back on the  12 record. The time is 12:46.  13     Q.   I understand that for at least  14 some of your minor patients who have  15 gender dysphoria they're being treated  16 with psychotherapy alone, without, to  17 your knowledge, any hormone therapy,  18 correct?  19     A.   I think that's true for most  20 of them, yes.  21     Q.   And what is your approach to  22 psychotherapy to address gender dysphoria  23 with these patients?  24       MR. CANTRELL: Object to form.  25     A.   Would you like me to talk</p>

<p style="text-align: right;">Page 106</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about the general principles I think of  3 psychotherapy with patients? Is that what  4 the question is about?  5     Q. Fair enough. Let me ask it  6 differently.  7       Is it fair for me to assume  8 that based on your past testimony that at  9 least some of your minor patients with  10 gender dysphoria have comorbidities,  11 psychological comorbidities; is that  12 correct?  13     A. That's correct.  14     Q. Are there some who don't?  15     A. I don't think I met one yet.  16     Q. Over your career, you're  17 saying; is that right?  18     A. Yes.  19     Q. Are there people who have  20 gender dysphoria outside of your patient  21 pool who have gender dysphoria but don't  22 have comorbidities?  23     A. That depends on the evaluator.  24     Q. Okay. What I'm trying to  25 understand is what kind of psychotherapy</p>	<p style="text-align: right;">Page 108</p> <p>1       STEPHEN B. LEVINE, M.D.  2 don't have to change the gender identity  3 if we address the underlying processes,  4 whereby, the person decided that they  5 must be trans, if we can address their  6 social isolation, their uneasiness with  7 their body, the fact that they've been  8 sexual abused or something terrible has  9 happened in their family, we can deal  10 with those processes. We let the child  11 then decide over time, as they proceed  12 during adolescence, to try on various, as  13 most adolescents do have different  14 passions and sometimes the gender  15 dysphoria begins to fade away and they  16 develop a different identity, maybe a  17 lesbian identity or a gay male identity,  18 or they get interested in some other  19 topic entirely unrelated.  20       So the psychotherapy is; one,  21 an attempt to understand the motivations;  22 two, to understand the adversities and  23 the things that the person is troubling  24 with and to address those things; and  25 three, to recognize that this person is</p>
<p style="text-align: right;">Page 107</p> <p>1       STEPHEN B. LEVINE, M.D.  2 can address the gender dysphoria,  3 understanding there may be psychotherapy  4 needed to address other issues for other  5 patients, but how can psychotherapy  6 address the gender dysphoria?  7     A. That's an excellent question  8 and it probably requires an hour's answer  9 but I will try to be succinct.  10       One concept is that one's  11 identity is the product of other  12 processes. In other words, if I can use a  13 big word, it's a epiphenomena. And so  14 what we're interested in is the  15 antecedents to the crystallization of  16 this particular identity. And we're  17 interested in understanding the  18 developmental challenges that this child  19 has had from birth on or even during from  20 pregnancy on.  21       And so we try to address the  22 vulnerabilities that the child has and  23 help them deal with the underlying  24 challenges. Assuming that we don't have  25 to try to cure the gender identity, we</p>	<p style="text-align: right;">Page 109</p> <p>1       STEPHEN B. LEVINE, M.D.  2 more than their gender identity, and that  3 every human being is more complex than  4 their one aspect of their identity.  5       As you may know, Toni Morrison  6 has said there are hundreds of pieces of  7 me, when someone asked her. And there  8 are many pieces of your identity and my  9 identity and we try to introduce patients  10 to their richness, their complexity and  11 not to have them reduce everything in  12 their life to one thing.  13       In other words, we're  14 thoughtful and all this thoughtfulness  15 must depend upon a trusting relationship  16 between the patient, the family and the  17 doctor.  18       Now, one other thing that  19 happens in psychotherapy is what you --  20 the last exhibit you put up is the  21 informed consent process. So without  22 trying to proselytize, without trying to  23 warn or to scare, we just try to  24 represent what is known and what is not  25 known and to -- even though we recognize</p>

<p style="text-align: right;">Page 110</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that patients may be certain, most human  3 beings -- it's dangerous for most human  4 beings to be certain about anything. You  5 say, I'm certain I've fallen in love with  6 you and I'm going to marry you and I  7 can't live without you and two years  8 later after I married you I want to  9 divorce you. So we distrust certainty in  10 all human beings. So these are -- that's  11 my four-minute summary of my issues on  12 psychotherapy.  13       I also try to represent in the  14 process of that therapy what science  15 knows and these days, now that we have  16 countries that have said psychotherapy  17 ought to be the first approach because  18 the outcomes are not very clear when we  19 do medical, as the first approach, these  20 people need to know that.  21     Q.   Okay. Thank you. That was  22 helpful.  23       Of your gender dysphoria  24 patients who have been treated with  25 psychotherapy alone, whether adolescents</p>	<p style="text-align: right;">Page 112</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   And you're using the word  3 desist. Is this person you were talking  4 about, in the examples you're talking  5 about, prepubertal kids or are these  6 adolescents and adults?  7     A.   Adolescents. I've seen  8 prepubertal children desist as well.  9     Q.   So of your patients with  10 gender dysphoria how many who are  11 adolescents who are older have come to  12 identify with their natal sex?  13     A.   Have come to identify with  14 what?  15     Q.   That are natal sex, with  16 psychotherapy alone.  17     A.   I don't know.  18     Q.   How many that you are aware  19 of?  20     A.   How many am I aware? I'm aware  21 of a six-year-old who has desisted.  22     Q.   I'm talking adolescent and  23 older.  24     A.   Okay. I'm trying to think.  25 I've certainly reviewed case histories of</p>
<p style="text-align: right;">Page 111</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or adults, have any come to identify as  3 their natal sex?  4     A.   I think in late January of  5 this year parents came to me about their  6 15-year-old and we talked about their  7 concerns about announcement that he's a  8 trans woman and we -- the parents and I  9 talked about this and they came back to  10 see me about three weeks ago and their  11 son seems to be more comfortable being a  12 son now. And so, I've never seen their  13 son personally, I've done the parent  14 guidance.  15       So I think if you take my work  16 as both with parents alone, with kids  17 alone, with parents and kids together,  18 I've seen people desist and I've  19 certainly talked to other people,  20 colleagues who do psychotherapy that  21 they've seen people desist sometimes  22 before medical treatment and sometimes  23 during medical treatment and sadly  24 sometimes after medical surgical  25 treatment.</p>	<p style="text-align: right;">Page 113</p> <p>1       STEPHEN B. LEVINE, M.D.  2 people who have desisted.  3     Q.   Your patients, I'm asking.  4     A.   I know your question. I'm  5 just trying to review a lifetime of  6 experience.  7       Well, the one who comes to  8 mind who saw me first with his parents  9 who wouldn't come back because he said he  10 hated me and then he came back to me  11 three months later and said that what I  12 said during that initial evaluation has  13 haunted him and he hated me and now he  14 thinks I was right and he has returned to  15 living as a male. So that's one. I often  16 think about him.  17       I am dealing with another  18 child, teenager, who has moved a little  19 bit away from the trans world into the  20 sadomasochistic world and is experiencing  21 the pleasures of masochistic kink. I  22 have seen --  23     Q.   Before you move on, that  24 person no -- their gender identity is  25 different than it was?</p>

<p style="text-align: right;">Page 114</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I think -- I think the gender  3 identity is weakening about that, right.  4 And another person who -- the one that I  5 made mention to before, who had five  6 hospitalizations or four psychiatric  7 hospitalizations, who was taking  8 testosterone, I'm not sure that the  9 degree of certainty about the stability  10 of this gender identity seemed to be  11 weakening when I enabled this person to  12 psychotherapy to get his GED and then he  13 moved out of state to go to art school.  14 So I'm not -- I'm not exactly sure. I  15 can't say that's one who's desisted, but  16 I've watched this -- I've watched the  17 certainty become uncertainty, which I  18 consider to be a much more reasonable  19 human position, to be uncertain about  20 things, especially when one is an  21 adolescent.  22     Q.   What about adults, have you  23 had any adults come to identify with  24 their natal sex, your gender dysphoria  25 patients?</p>	<p style="text-align: right;">Page 116</p> <p>1       STEPHEN B. LEVINE, M.D.  2 feminine in their behavioral expressions.  3       It's really hard for me to  4 answer this because I don't see the world  5 simply as trans or non-trans. And I guess  6 I'm a student of the human psychology and  7 human psyche and I like to talk about  8 that every human being has a mosaic of  9 sexual identity identifications. We're  10 not what we appear, we are not  11 subjectively what we socially present  12 ourselves to be. And so I'm used to  13 talking about, say, just taking males,  14 for example, I'm used to talking about  15 feminine expressions and feminine  16 features in males and sometimes their  17 struggle or misunderstanding or lack of  18 understanding about the normality of  19 having a sexual identity mosaic of  20 masculine and feminine, gay and straight,  21 and kink and non-kinky aspirations,  22 sexual intentions.  23       So I can't really answer that  24 question because I don't see the world in  25 the terms that you're using.</p>
<p style="text-align: right;">Page 115</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I've seen prisoners reidentify  3 several times. I've seen the phenomenon  4 of trans in prison and bisexual and  5 straight out of prison.  6       Let me see about adults. I've  7 certainly seen adults who have thought --  8 who have come to me with this who are  9 terribly ambivalent and may have been  10 playing at this process, who then go back  11 into not playing, not expressing it.  12       You need to understand that  13 it's not a rare thing for people to have  14 a mosaic of combination of male and  15 female identifications in their psyche  16 and sometimes they give voice to or give  17 behavioral expression to the feminine and  18 sometimes to the masculine, and they have  19 considerable conflict about that. And  20 many adults who come to see me discuss  21 these things with me. So they're not  22 necessarily out as a trans person and  23 desist but they fluctuate between  24 masculine expressions or masculine  25 acceptance of their body and wishes to be</p>	<p style="text-align: right;">Page 117</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Are any of your patients who  3 have received hormone therapy, have you  4 seen benefits to their mental health as a  5 result of that treatment?  6     A.   Have I seen people benefit  7 from the results of my treatment?  8     Q.   From hormone therapy.  9     A.   I've seen people being very  10 happy instantly upon swallowing their  11 first treatment and for months, as  12 they're looking for breast development or  13 looking for oily skin and lowering of the  14 voice, they're immensely happy,  15 absolutely.  16       You know, in medicine,  17 especially in mental health medicine, we  18 have an enormous influence of the placebo  19 effect. Depressed people get a pill and  20 they start feeling better and the  21 question is, and why we do controlled  22 studies, is we try to separate the  23 placebo effect in the control group from  24 the true drug effect, you see.  25       So it's clearly, since we</p>

<p style="text-align: right;">Page 118</p> <p>1       STEPHEN B. LEVINE, M.D.  2 don't -- since we don't have any  3 controlled studies in this field of  4 taking hormones and so many people are so  5 much happier once they're getting  6 hormones because they wanted hormones for  7 years, for example, they're happy or  8 happier. The question is, are they  9 functioning better? Is there mental  10 health better a year later or six months  11 later or five years later?  12     Q.   That's my question for you. Do  13 you know whether any of your patients,  14 after six months or a year, five years,  15 their mental health was better after  16 taking hormones?  17     A.   Well, it depends what you mean  18 by mental health.  19     Q.   Whatever you meant when you  20 just said it.  21     A.   Well, if you mean are they  22 happy they're taking -- are they happy  23 taking hormones? Many are happy taking  24 hormones, they're happy with the  25 feminization, they're happy with the</p>	<p style="text-align: right;">Page 120</p> <p>1       STEPHEN B. LEVINE, M.D.  2 testified to, I've already told you this,  3 but in terms of their functional  4 capacities in the world there is not  5 evidence that that really improves them.  6       Now, I know some people are  7 improved but I also have seen patients  8 who take hormones and get terribly  9 depressed. You see, that's why we need  10 the science, because the doctors'  11 experience is so much heavily colored by  12 the last patient he's seen, you see. So  13 it's not focusing on the issue of, what  14 have you seen, Dr. Levine? It's what do  15 we know from the collective scientific  16 experience in this field. And that's why  17 we're having a contentious argument in  18 this courtroom, I mean in this issue,  19 because science tells us one thing and  20 people have other opinions. Doctors often  21 have other opinions from the science. And  22 as far as I can see, many of these  23 doctors don't know the science, they  24 don't --  25     Q.   When you say you've known --</p>
<p style="text-align: right;">Page 119</p> <p>1       STEPHEN B. LEVINE, M.D.  2 masculinization.  3     Q.   Do you think it relieved their  4 distress and anxiety for some patients?  5     A.   Well, you know, the U.K.,  6 Finland, Sweden, France have all tried to  7 -- and the Cochrane Reviews, they've all  8 tried to assess the answer to your  9 question, and it's not clear that these  10 people have better mental health after  11 taking hormones for a long period of  12 time.  13     Q.   I'm asking about your  14 patients, not the research. You're a  15 psychiatrist. Can you not evaluate their  16 mental health and whether it's improving  17 or deteriorating or staying the same?  18       MR. CANTRELL: Objection,  19 argumentative.  20     A.   Well, listen, I'm a  21 psychiatrist, I'm informed by the  22 science. Please, I think all doctors need  23 to be informed by the science. And I  24 certainly can evaluate certain aspects of  25 a person's life. And I've already</p>	<p style="text-align: right;">Page 121</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know some people have improved, how  3 do you know that?  4     A.   Because I see them, because  5 they liked the hormones, because they  6 like being feminized, for example, and  7 they like being masculinized, whether  8 they're still cutting themselves or still  9 not going to school or not working or  10 still getting depressed or if you talk to  11 -- if you talk to anyone who runs an  12 inpatient service, psychiatric service,  13 they're frequently getting people who are  14 trans identified who are on hormones who  15 are in there for depression or suicide  16 attempt and so forth. So, look, it's not  17 that if you give hormones and everyone is  18 guaranteed to be happy.  19     Q.   That's not my question. My  20 question is have any of your patients who  21 received mental health improvement as a  22 result of hormones? And as a psychiatrist  23 I thought psychiatrists could evaluate  24 the state of someone's mental health.  25       MR. CANTRELL: Object to form.</p>



<p style="text-align: right;">Page 122</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A. I have -- I have people who</p> <p>3 have been on hormones for years and who</p> <p>4 are functioning they think better.</p> <p>5       Now, I can just tell you since</p> <p>6 I'm psychiatrist seeing one patient, it's</p> <p>7 taken me three or four years to convince</p> <p>8 one person that he was worth more than he</p> <p>9 was getting paid for in his job and</p> <p>10 during all this time I've been giving him</p> <p>11 hormones and finally he went from getting</p> <p>12 \$30,000 a year in his job to a new job at</p> <p>13 \$90,000 and he's much happier at \$90,000</p> <p>14 than he is at 30,000. And if you're not</p> <p>15 careful you might have concluded it's the</p> <p>16 hormones that's making him happier, when</p> <p>17 I tell you it's the work that we have</p> <p>18 done to convince him that he's</p> <p>19 undervaluing himself because of his</p> <p>20 negative self views, you see.</p> <p>21       So if you ask me simply, have</p> <p>22 I had a patient who is better off on</p> <p>23 hormones than he was before he was on</p> <p>24 hormones, I would say yes. But whether</p> <p>25 it's to be attributed to hormones is an</p>	<p style="text-align: right;">Page 124</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 masculine and now that I'm treated with</p> <p>3 hormones I'm happier. But the question</p> <p>4 is, are they functioning better and are</p> <p>5 they mentally well? You see many times</p> <p>6 we tell ourselves the patient is improved</p> <p>7 but we don't tell ourselves the patient</p> <p>8 is healthy, they're just less depressed.</p> <p>9       Q. Are there any who are healthy</p> <p>10 who you believe that hormone therapy</p> <p>11 contributed to that?</p> <p>12       A. Well, I've certainly heard</p> <p>13 many accounts of people, sort of public</p> <p>14 figures who say that they are -- the</p> <p>15 hormones have really helped them</p> <p>16 considerably. So I believe -- I believe</p> <p>17 that's possible, yes. I don't get to see</p> <p>18 that that often myself, but I hear public</p> <p>19 pronouncements like that very frequently.</p> <p>20 People stand up at microphones sometimes</p> <p>21 and tell you how much better they are.</p> <p>22       Q. Have you seen that ever in</p> <p>23 your patients, that they are -- again,</p> <p>24 their mental health is better? I'm</p> <p>25 sorry. Was that a yes?</p>
<p style="text-align: right;">Page 123</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 entirely different question.</p> <p>3       Q. So you don't know whether --</p> <p>4 is it fair to say then you don't know</p> <p>5 whether hormones have helped any of your</p> <p>6 patients?</p> <p>7       A. It's fair to say many of my</p> <p>8 patients are happy taking hormones, and</p> <p>9 happiness is an improvement, you see.</p> <p>10 That doesn't mean they're not still</p> <p>11 depressed, it's that they're happier,</p> <p>12 they're happy with. They still may be</p> <p>13 anxious, they still may be smoking</p> <p>14 cigarettes, they still may be heavily</p> <p>15 using drugs, they still may be depressed</p> <p>16 but they say they're happier taking</p> <p>17 hormones.</p> <p>18       Q. Has hormones reduced any of</p> <p>19 those symptoms like anxiety and</p> <p>20 depression for any of your patients?</p> <p>21       A. Temporarily it does, yes, but</p> <p>22 that's probably the placebo effect. And</p> <p>23 then there is the effect of I always</p> <p>24 wanted to experiment, I've always had a</p> <p>25 mosaic that's heavily feminine or heavily</p>	<p style="text-align: right;">Page 125</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       A. No, that wasn't a yes. That</p> <p>3 was a non-answer. That was an I'm</p> <p>4 thinking.</p> <p>5       Q. Oh.</p> <p>6       A. Well, I'm thinking about a</p> <p>7 person who's happy expressing himself as</p> <p>8 a woman, but who is very unhappy because</p> <p>9 two of his three children won't talk to</p> <p>10 him.</p> <p>11       So you see we have to separate</p> <p>12 the happiness about gender expression</p> <p>13 from the general overall unhappiness or</p> <p>14 happiness of a person. And I don't expect</p> <p>15 hormones to take care of everything that</p> <p>16 ails a person, you see.</p> <p>17       That's one of the reasons why</p> <p>18 I caution young people that they are much</p> <p>19 more complicated and rich and varied and</p> <p>20 dimensional than simply gender identity.</p> <p>21 That's one of the reasons why I think all</p> <p>22 mental health professionals have to slow</p> <p>23 down and not rush to medicalize people.</p> <p>24       Q. When you said a few minutes</p> <p>25 ago you believe it's possible that</p>

<p style="text-align: right;">Page 126</p> <p>1       STEPHEN B. LEVINE, M.D.  2 hormone therapy can contribute to  3 positive mental health improvements but  4 it's not something you see very often, I  5 want to ask a couple of questions about  6 that.  7       Is that because you don't  8 generally get to follow the patients up  9 or is that because most of your patients  10 who get hormone therapy don't see a  11 benefit, in your experience?  12       MR. CANTRELL: Object to form.  13       A.   Well, what we suffer from in  14 this field and what I suffer from as a  15 doctor, is that we don't have followup  16 and we don't have systematic or systemic  17 long-term followup which is, of course,  18 what science requires to know to answer  19 these questions that you're getting at.  20       I think the answer to your  21 question is both, it's not either/or,  22 it's just both. You know, I'm a mental  23 health professional, when people feel  24 that they're happy -- people never come  25 to a mental health professional because</p>	<p style="text-align: right;">Page 128</p> <p>1       STEPHEN B. LEVINE, M.D.  2 gender-affirming medical care for minors,  3 and I wanted to ask, do you believe that  4 the risks of gender-affirming medical  5 care outweigh the benefits for all minors  6 with gender dysphoria?  7       A.   If you take out the word "all"  8 from that question it would be easier for  9 me to answer.  10       Would you mind rephrasing that  11 question without the word --  12       Q.   I think this is what -- yes. I  13 think I can.  14       Again, you've talked about the  15 risks and benefits of gender-affirming  16 medical care for minors and the need to  17 discuss that fully, right, with patients  18 and their families.  19       So my questions is, is it your  20 view that in every case of a minor with  21 gender dysphoria that the risks of that  22 medical treatment will outweigh the  23 benefits?  24       MR. CANTRELL: Object to form.  25       A.   Again, I think you put in a</p>
<p style="text-align: right;">Page 127</p> <p>1       STEPHEN B. LEVINE, M.D.  2 their life is going great. They come to  3 us in crisis, they come to us in despair,  4 they come to us in demoralization, they  5 come to us sometimes in sort of  6 life-threatening circumstances.  7       So, again, I'm working with  8 the whole person here and you're just  9 trying to, you see, cut off a little  10 piece of that whole person and ask a  11 little dimension of them.  12       Q.   Is it fair to say you're less  13 likely to hear about the success stories  14 because they're doing great and they  15 wouldn't have reason to come see you  16 again?  17       A.   That's right. Successful  18 people don't need to see me, successful  19 in that way. And if they went to another  20 doctor and they're getting hormones and  21 they're living happily ever after, they  22 don't come to visit Dr. Levine.  23       Q.   Now, you've talked about the  24 risks and benefits, you know, having to  25 look at the risks and benefits of</p>	<p style="text-align: right;">Page 129</p> <p>1       STEPHEN B. LEVINE, M.D.  2 phrase of three words there that make it  3 similar to "all". If I can rephrase -- I  4 don't know if I'm allowed --  5       Q.   Go ahead.  6       A.   It's not just Dr. Levine who  7 has estimated that the risks are  8 considerable and the benefits are  9 unclear. Independent reviews by people  10 who are capable of analyzing published  11 studies, and not all physicians or  12 Ph.D.'s are equally capable of analyzing  13 reports, independent reviews, two from  14 the U.K., one from Sweden, and one from  15 Finland, and I'm not sure whether France  16 did an independent review or just changed  17 their policy in February of this year,  18 but these countries who are much more  19 controlled and have much more information  20 than we do in United States with 50  21 separate states, these independent,  22 carefully -- carefully reviewed these  23 people who are skilled in looking at  24 methodologies, they have said that the  25 risks outweigh the benefits and have</p>

<p style="text-align: right;">Page 130</p> <p>1       STEPHEN B. LEVINE, M.D.  2 encouraged their country to no longer  3 create these rapid -- these many  4 treatments of choice or what used to be  5 called best practices for youth.  6       So it's not just a matter of  7 me, based on my clinical experience.  8 Although, my clinical experience is -- my  9 accumulated clinical experience does  10 cause me to be cautious. You need to  11 understand that I base a great deal -- I  12 take a great deal -- I give a great deal  13 of respect to commissions that have  14 independently assessed the data and found  15 the data to be lacking and the benefits  16 to be unclear in the long run, and the  17 risk in the long run to outweigh those  18 benefits.  19       And so that's how I answer  20 your question. Science has answered this  21 question as best that we can, given the  22 fact that it's May 2022. In June 2022 we  23 may have better information, which would  24 either support or make us change our  25 views. But based on today's knowledge,</p>	<p style="text-align: right;">Page 132</p> <p>1       STEPHEN B. LEVINE, M.D.  2 14-year-old or the removing the breasts  3 of a 14-year-old or 13-year-old, these  4 things have long-term risks for people  5 and for their families, and the fact that  6 there is one patient out of ten or one  7 patient out of thirty, you know, who  8 benefits from it and say the rest are  9 either unclear or they have -- they  10 regret. Public policy requires we not  11 look at a case alone but we look at a  12 series of cases and public policy should  13 rest upon what science knows. And that's  14 what I think you and I are discussing,  15 what does science know about this.  16       Q. My question --  17       A. You want to make this what Dr.  18 Levine believes, but Dr. Levine is trying  19 to represent here what science knows, you  20 see, and how many cases --  21       Q. I think we're getting far  22 afield. My question was not about public  23 policy.  24       The question was whether the  25 reason you would not agree that the</p>
<p style="text-align: right;">Page 131</p> <p>1       STEPHEN B. LEVINE, M.D.  2 especially informed by science, I would  3 say that the risks tend to outweigh the  4 benefits and now we have this whole  5 phenomenon of detransition of people who  6 have transitioned with the help of the  7 medical profession who are now saying, I  8 regret this or I'm detransitioning. And  9 you know that data as well as I do.  10       Q. Yes. So the problem with my  11 earlier question was the word "all" and  12 "that in every case."  13       So do I understand that your  14 testimony is that the benefits -- sorry  15 -- the risks of gender-affirming medical  16 care for minors tend to outweigh the  17 benefits, but that you would not agree  18 that that's true in every case?  19       MR. CANTRELL: Object to form.  20       A. When it comes to public policy  21 we can't let one case be the -- generate  22 public policy. If science has said that  23 the risks are exceeding the benefits, and  24 the risk includes tragedies and, for  25 example, permanent sterility of a</p>	<p style="text-align: right;">Page 133</p> <p>1       STEPHEN B. LEVINE, M.D.  2 benefit -- the risks outweigh the  3 benefits in all cases for all minors, was  4 because you didn't want to say that  5 that's true for every minor; is that  6 correct? I'm not asking you about public  7 policy.  8       MR. CANTRELL: Object to form.  9       A. I object that when you talk  10 about "all minors" --  11       Q. You can't agree --  12       A. If you want me to agree that  13 there is a case somewhere that may  14 benefit in the short run, and even in the  15 median-term run and possibly in the long  16 run who might be happy with a transition  17 that they've made, there must be patients  18 like that, of course. Of course there  19 are.  20       Q. Okay. That was my question.  21 And you talked about the European  22 countries determining that risks outweigh  23 the benefits. I believe perhaps you're  24 referring to the statement out of Sweden  25 when you reference that. Is that what</p>

<p style="text-align: right;">Page 134</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you had in mind?  3     A.   Did you say Sweden?  4     Q.   Yes.  5     A.   Yes. Sweden is one of them.  6     Q.   And tell me what other country  7 has said the risks outweigh the benefits,  8 have actually said that?  9     A.   Finland.  10    Q.   Finland said that?  11    A.   Yes.  12    Q.   Who else said that?  13    A.   I think the NICE report from  14 England and the Cass report and I'm  15 actually -- I'm actually a member of the  16 Cochrane Group who's evaluating these  17 subjects. But as the report is not out  18 yet I'm not permitted to talk about that.  19    Q.   And you're aware, right, that  20 in Finland, U.K., France and Sweden, that  21 they have not banned gender-affirming  22 care for minors, right?  23    A.   I'm aware that Sweden has said  24 that and Finland has said that they think  25 no one should have this treatment until</p>	<p style="text-align: right;">Page 136</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that they banned it. I think they've  3 recommended this. And to recommend  4 psychotherapy is to imply that  5 puberty-blocking hormones and cross-sex  6 hormones should not be the initial  7 approach to these kids.  8     Q.   So you are not aware then or  9 is it your understanding that Finland  10 allows minors to receive gender-affirming  11 medical care if the psychotherapy as a  12 first approach is not successful in  13 resolving the condition?  14    A.   I don't know.  15       MR. CANTRELL: Object to form.  16    A.   I'm not -- I don't know the  17 details of, like, how long they have to  18 have psychotherapy and what the  19 parameters of success would be. I think  20 it's a big policy statement if a  21 country -- if a country says this is how  22 we, as a country, are going to approach  23 this within our standardized universal  24 medical system, which is so different  25 than what we do in the United States, so</p>
<p style="text-align: right;">Page 135</p> <p>1       STEPHEN B. LEVINE, M.D.  2 about 26 and that -- and Sweden has said  3 minors can have gender-affirming care if  4 it's part of a scientific protocol, as  5 part of an experiment, what we would call  6 an IRB or government-approved experiment.  7 That's very different than, this is an  8 acceptable treatment for all kids that  9 claim to be gender dysphoric.  10    Q.   So you would agree with  11 Sweden's approach to allow the treatment  12 in the context of clinical trials but not  13 separately?  14    A.   Yes.  15    Q.   And -- sorry.  16    A.   I would agree.  17    Q.   And your understanding is that  18 Finland bans care for anyone under 26  19 gender-affirming medical care?  20       MR. CANTRELL: Object to form.  21    A.   My memory may not be correct,  22 but Finland has recommended that the  23 first approach to gender-dysphoric youth  24 should be a psychotherapeutic approach  25 and not a medical approach. I'm not sure</p>	<p style="text-align: right;">Page 137</p> <p>1       STEPHEN B. LEVINE, M.D.  2 different.  3     Q.   So it your understanding that  4 the U.K. does not allow gender-affirming  5 hormone therapy for minus?  6     A.   I know the U.K. did not go so  7 far as to disallow it but it's certainly  8 -- their recommendations have certainly  9 slowed the number of people getting it.  10       As you are well aware there  11 was -- there were two -- there was a  12 lawsuit that pretty much prohibited --  13 there was a lawsuit that the High Court  14 of London in I think 2019, December 17th,  15 said no one less than 16 could have  16 cross-sex hormone or puberty blockers and  17 anyone from 17, 16 or 17 had to have  18 court approval. And that was -- that  19 last part was reversed in 2020, I think  20 in September, where it said that doctors  21 had to decide, not courts.  22       I think the impact of the  23 first two decisions was that the rapid  24 use of puberty blockers and cross-sex  25 hormones diminished dramatically in the</p>

<p style="text-align: right;">Page 138</p> <p>1       STEPHEN B. LEVINE, M.D.  2 U.K.  3     Q.   Have you read the Cass report  4 out of the U.K.?  5     A.   I have in the past, yes.  6     Q.   Okay. And is it your  7 understanding that that report recommends  8 increasing access to gender-affirming  9 medical care for minors?  10       MR. CANTRELL: Object to form.  11     A.   I don't, I don't recall that.  12     Q.   Is it your understanding that  13 France is prohibiting gender-affirming  14 medical care for minors?  15     A.   No. It's my understanding that  16 France, in February, also recommended  17 psychotherapy as the first approach.  18     Q.   And that they would permit  19 gender-affirming medical care as an  20 alternative approach if psychotherapy is  21 not sufficient?  22       MR. CANTRELL: Object to form.  23     A.   I don't know that one way or  24 the other.  25     Q.   When we were talking about the</p>	<p style="text-align: right;">Page 140</p> <p>1       STEPHEN B. LEVINE, M.D.  2 to be boys when they go through puberty  3 and no one has fully explained this  4 tsunami of increased incidents, that the  5 medical professions' sort of best  6 practices approach to giving medical  7 treatment to all these people before we  8 understand the motivations, both the  9 social sources of the motivations and the  10 psychological sources of the motivations  11 in the person of the children, that this  12 has caused Sweden, Finmark -- Finland,  13 France and the U.K. and some elements in  14 the United States to have some caution  15 about what we're doing because we  16 recognize that adolescence is a time  17 that's a six-, seven-year process of  18 trying to define what one's identity is.  19 And one's identity at 13 is not the same  20 as one's identity as 15 or 16 or 20. And  21 so these are changeable phenomena. And  22 the idea that we're making permanent a  23 13-year-old or 14's gender identity by  24 medicalizing that identity, you see, and  25 supporting that identity, these countries</p>
<p style="text-align: right;">Page 139</p> <p>1       STEPHEN B. LEVINE, M.D.  2 risks and benefits, I got the sense from  3 what you're saying that you, your  4 understanding from the research is that  5 in the vast majority of cases that the  6 risks would outweigh the benefits of  7 care; is that right?  8     A.   I'll repeat.  9     Q.   Sure. I understood from your  10 past testimony that your view is that the  11 risks of gender-affirming medical care  12 for minors outweighs the benefits of such  13 care in the vast majority of cases?  14       MR. CANTRELL: Object to form.  15     A.   No, you misunderstood. I said  16 "I will repeat." I didn't ask you to  17 repeat. I'm sorry. We miscommunicated.  18     Q.   Oh.  19     A.   The scientific review of the  20 literature indicates that the long-term  21 benefits are unclear. There are  22 considerable concerns about the long-term  23 harms and as there has been an  24 increasing, a dramatic increase in the  25 number of girls assigned at birth wanting</p>	<p style="text-align: right;">Page 141</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and these scientific -- the scientific  3 scrutiny has said all this is a stop sign  4 for how we're taking care of people.  5       And so the risks are  6 uncertain, the detransition numbers are  7 increasing, the benefits have not been  8 demonstrated and, therefore, the risks  9 outweigh the benefits. That is what I  10 believe is science talking to you.  11     Q.   And you said the  12 detransitioning is increasing.  13       Are you aware of any data  14 comparing rates of detransition now to  15 some time in the past?  16     A.   No, but we're getting reports  17 of detransition. Do you know that March  18 12th of this year was National and  19 International Detransition Day?  20     Q.   I understand you have some  21 patients who have detransitioned; is that  22 correct?  23     A.   I have already testified to  24 that, right.  25     Q.   Detransition -- well, I don't</p>

<p style="text-align: right;">Page 142</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know if we did that today, but I know you  3 talked about desisted which I know may be  4 an overlap term.  5       Let me be clear. Have you had  6 patients detransition after having  7 received medical transition?  8     A.   I know of those people, yes.  9     Q.   And have any of them  10 retransitioned after detransitioning?  11    A.   Do you know that I wrote a  12 paper about one case?  13    Q.   I do. But I'm asking do you  14 know anyone who retransitioned after they  15 detransitioned?  16    A.   I've heard that that happens  17 sometimes, yes. The answer to your  18 question is I think I know of a prisoner  19 like that who detransitioned when  20 released and got readmitted to  21 incarceration and then returned to living  22 as a trans person. I wouldn't swear to  23 that. I'm not certain, in other words.  24    Q.   And your patients who  25 detransition, was it always because they</p>	<p style="text-align: right;">Page 144</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Okay. And did detransitioning  3 improve their mental health in these two  4 cases?  5     A.   Yes. Oh, yes.  6     Q.   I understand from your  7 writings and testimony, and tell me if  8 I'm not saying this correctly, that you  9 have concerns about I think what you've  10 called rapid affirmation, where doctors  11 prescribe medical transition too quickly.  12 Is that a fair statement?  13    A.   Yes. That's a fair statement.  14    Q.   And I understand from your  15 Reconsidering Informed Consent paper you  16 think it's important for clinicians to  17 take the time to really get to know the  18 patient and also to make sure to  19 thoroughly inform patients, and when  20 they're minors their parents, of the  21 risks associated with care and what is  22 known in the science; is that correct?  23    A.   That's correct, yes. It's also  24 correct that it's important for the  25 doctors to know, to actually know what</p>
<p style="text-align: right;">Page 143</p> <p>1       STEPHEN B. LEVINE, M.D.  2 came to identify with their natal sex or  3 were there other reasons?  4     A.   I'm sorry?  5     Q.   I can speak up.  6       Of your patients who  7 detransitioned, was it always due to them  8 coming to identify with their natal sex  9 or were there other reasons for the  10 medical detransition?  11    MR. CANTRELL: Objection.  12    A.   Two come to mind and they  13 detransitioned to reidentify with their  14 natal sex assigned at birth.  15    Q.   You've had two of your  16 patients detransition, is that what  17 you're saying?  18    A.   Yes.  19    Q.   Have you had just two or have  20 there been others?  21    A.   Well, that's one -- one I  22 wrote a paper about and one I already  23 talked to you about. And at the moment I  24 can't think of a third but, you know, I'm  25 slow to retrieve memories these days.</p>	<p style="text-align: right;">Page 145</p> <p>1       STEPHEN B. LEVINE, M.D.  2 science knows and to separate their  3 personal beliefs from what science knows.  4 I would have you add that to your  5 summary.  6     Q.   Okay. And is it your  7 understanding that all clinicians who are  8 providing care to minors with gender  9 dysphoria -- actually, me ask that  10 differently.  11       Is it your understanding that  12 all clinicians who are referring minors  13 for gender-affirming medical care or  14 providing themselves gender-affirming  15 medical care to minors, are doing it  16 without taking the time to do the  17 thorough evaluations and provide the  18 thorough information for informed  19 consent?  20    MR. CANTRELL: Object to form.  21    A.   Ms. Cooper, if you use the  22 word "all" in any one of your questions I  23 cannot answer it yes or no because I  24 object to the idea that the heterogeneity  25 of everything can be summarized as all or</p>

<p style="text-align: right;">Page 146</p> <p>1       STEPHEN B. LEVINE, M.D.  2 none.  3       Q. All right. Let me ask you a  4 question.  5       Is it true that -- is it your  6 understanding that a majority of  7 clinicians are providing care without  8 taking time to evaluate fully the  9 patients and thoroughly engage in the  10 informed consent process that you say is  11 important?  12       MR. CANTRELL: Object to form.  13       A. What I am saying in the  14 Reconsidering Informed Consent paper is  15 that these are the elements of informed  16 consent. I'm not sure how this  17 practitioner or this clinic does it  18 because there are 50 or more clinics in  19 the United States and many more clinics  20 around the world.  21       I'm trying to set the  22 standards for informed consent. I can't  23 make a judgment of whether it's 38% or  24 79%. I'm trying to articulate the  25 standards that would help somebody</p>	<p style="text-align: right;">Page 148</p> <p>1       STEPHEN B. LEVINE, M.D.  2 recommended having going on hormones.  3       So I have these experiences  4 and these experiences have helped me  5 write these two papers over the years  6 about informed consent. I'm not -- I'm  7 not testifying about all or none or  8 12.7%. I'm telling you, this is what I  9 think are the standards.  10       Now, I can tell you that as of  11 this morning 27,000 people downloaded  12 this article since March the 17th. So  13 it's not about my accusation in this  14 percentage of people. I'm trying to set  15 the standards. I'm trying to have it  16 based on science, and science is limited  17 here. And because it's limited we need  18 informed consent, and because we need  19 informed consent, it has to be honest,  20 and it has to separate the doctor's  21 belief from what science knows. So your  22 line of questioning somehow is -- is  23 missing my point.  24       Q. Do you have any knowledge  25 about how gender-affirming medical care</p>
<p style="text-align: right;">Page 147</p> <p>1       STEPHEN B. LEVINE, M.D.  2 ethically make the recommendation to a  3 family about this matter, period. These  4 are the ethical requirements, this paper  5 argues, for how to do this, considering  6 that science does not have the answer,  7 people -- doctors have to inform people  8 about the state of science, the state of  9 our knowledge, you see. And so I'm not  10 -- I can't answer your question by  11 majority, all or 12.6%.  12       I'm saying this paper  13 articulates what I hope will be the  14 standard for understanding informed  15 consent obligations for the individual  16 practitioner and, therefore, I hope it  17 will change how various institutions and  18 programs and individual doctors think  19 about this and approach their patients  20 and I hope it will change the process  21 whereby I won't have to have patients  22 come to see me saying, my son went to  23 this clinic and after one hour they said  24 this child is trans. They didn't know  25 the child is autistic, you see, and they</p>	<p style="text-align: right;">Page 149</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is provided to minors in Arkansas?  3       A. No, I'm not an expert. But I  4 don't think that there is any studies  5 going on in Arkansas, or least not that  6 I've heard of. And Arkansas, I think, has  7 a children's clinic and probably has  8 individual practitioners, but I don't  9 want to represent myself as very  10 knowledgeable about what's happening in  11 Arkansas. I think what's happening in  12 Arkansas is probably not that different  13 from what's happening elsewhere.  14       Q. You don't know what kind of  15 protocols the doctors there follow in  16 terms of providing this treatment to  17 minors?  18       A. No. I'm ignorant of that.  19       Q. Let's look again at what's  20 been marked as Exhibit 3, your  21 Reconsidering Informed Consent paper, and  22 if we can scroll down to page 2. Are you  23 there? There's some blue highlighted  24 text. Do you see that?  25       A. Yes, I'm there.</p>

<p style="text-align: right;">Page 150</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   I'm going to jump to the</p> <p>3 second paragraph that's highlighted. If</p> <p>4 you want to take a minute to</p> <p>5 contextualize where that is, I'll give</p> <p>6 you a moment to do that.</p> <p>7     A.   Okay.</p> <p>8     Q.   I want to read that second</p> <p>9 blue highlighted paragraph. Just follow</p> <p>10 with me. "Social transition, hormonal</p> <p>11 interventions and surgery have profound</p> <p>12 implications for the course of the lives</p> <p>13 of young patients and their families. It</p> <p>14 is incumbent upon professionals that</p> <p>15 these consequences be thoroughly,</p> <p>16 patiently clarified over time prior to</p> <p>17 undertaking any element of transition.</p> <p>18 The informed consent process does not</p> <p>19 preclude transition, it merely educates</p> <p>20 the family about the state of the science</p> <p>21 underpinning the decision to transition.</p> <p>22 Social transition, hormones and surgeries</p> <p>23 are unproven in the strict scientific</p> <p>24 sense and as such to be ethical require a</p> <p>25 thorough and fully informed consent</p>	<p style="text-align: right;">Page 152</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 have articulated.</p> <p>3       Many times doctors and systems</p> <p>4 think they are doing informed consent,</p> <p>5 but in our view they're not doing a</p> <p>6 thorough informed consent.</p> <p>7       For example, if somebody</p> <p>8 mentions to the family of a 13-year-old</p> <p>9 that they could do fertility preservation</p> <p>10 or we can take sperm and take eggs and</p> <p>11 save them and, therefore, we've covered</p> <p>12 the informed consent process about this</p> <p>13 sterilizing effect of surgery or</p> <p>14 hormones. I don't really think most</p> <p>15 families can consider what this means.</p> <p>16 And, for example, if the family is on the</p> <p>17 lower socioeconomic group and is on</p> <p>18 Medicaid, they're not going to be able to</p> <p>19 afford or maintain at 15 years of</p> <p>20 payments to a fertility -- to a freezer</p> <p>21 where these things are spent.</p> <p>22       So the issue really is, can a</p> <p>23 family understand what the doctor is</p> <p>24 talking about? And I've been familiar</p> <p>25 with what I consider to be perfunctory</p>
<p style="text-align: right;">Page 151</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 process."</p> <p>3       Okay. I'm not going to ask</p> <p>4 you if I read that right because I'm</p> <p>5 going to just assume that I did.</p> <p>6       A couple of questions about</p> <p>7 this. I want to make sure I understand.</p> <p>8 I think this is sort of a version of what</p> <p>9 you've been saying in the last few</p> <p>10 minutes. But do I understand correctly</p> <p>11 that in your view it is ethical to</p> <p>12 provide gender-affirming hormone therapy</p> <p>13 to minor patients if the doctors do</p> <p>14 engage in that thorough evaluation</p> <p>15 process you've described and do engage in</p> <p>16 that thorough informed consent process</p> <p>17 that fully informs patients and their</p> <p>18 parents of the risks and the state of the</p> <p>19 science? Is that a fair description of</p> <p>20 your view?</p> <p>21       MR. CANTRELL: Object to form.</p> <p>22     A.   The answer to your question is</p> <p>23 yes, presuming that the doctors actually</p> <p>24 do these things and whether they would</p> <p>25 meet the criteria that I and my coauthors</p>	<p style="text-align: right;">Page 153</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 informed consent processes.</p> <p>3       So the answer to your question</p> <p>4 is, if the doctor does the process over</p> <p>5 time, over a long period of time, and</p> <p>6 works with the parents to understand the</p> <p>7 implications of what we're talking about</p> <p>8 and the parents and the doctor all think</p> <p>9 that this circumstance with this family,</p> <p>10 with the absence of major</p> <p>11 psychopathology, or with the fact that</p> <p>12 there hasn't been sexual abuse of the</p> <p>13 child that the family is trying to cover</p> <p>14 up, you see, then I think yes, yes, we</p> <p>15 can do this. But I want to be careful</p> <p>16 because of the long-term consequences for</p> <p>17 everyone in the family, not just the</p> <p>18 patient.</p> <p>19       So if you force me I could say</p> <p>20 yes, I believe -- I wrote the paragraph,</p> <p>21 I believe in the paragraph, you see. But</p> <p>22 I want -- I'm urging caution and you are</p> <p>23 telling me that I am -- I am supporting,</p> <p>24 and you could give puberty blockers to</p> <p>25 kids if you did informed consent, and I'm</p>



<p style="text-align: right;">Page 154</p> <p>1       STEPHEN B. LEVINE, M.D.  2 saying, whoa, whoa, whoa. I'm saying the  3 standards for informed consent are very  4 high and I don't think they're being met  5 throughout the world. And you know this  6 has gone through peer review, this is not  7 just Levine's opinion.  8       Q. In this article then, I mean,  9 is it fair to say you're offering -- I  10 think you said you want this to be the  11 standard that practitioners follow what  12 you describe in this article; is that  13 right?  14       A. I'm saying that we have a  15 field called medical ethics. It's an  16 umbrella under which physicians need to  17 operate. So I am emphasizing the umbrella  18 here. That's what I'm saying. It's an  19 umbrella. It's a legal and it's an  20 ethical and it's a moral umbrella that  21 people should know what they're getting  22 into.  23       I think there is a long legal  24 precedent in the United States law that  25 says doctors just can't do anything, they</p>	<p style="text-align: right;">Page 156</p> <p>1       STEPHEN B. LEVINE, M.D.  2 standards and I think higher standard for  3 how care is provided to adolescents and  4 younger people with this diagnosis. Yes,  5 I'm trying to benefit those people.  6       Q. And in this article you don't  7 take the position that gender-affirming  8 -- let me ask it differently.  9       You don't argue in this  10 article that gender-affirming medical  11 care should be categorically prohibited  12 for minors, right?  13       A. No. I am saying that given the  14 uncertainties that science has clarified,  15 that it behooves the physician to; number  16 one, know what science has clarified; it  17 behooves the physician to separate his  18 personal beliefs, his personal passionate  19 beliefs from what science knows and to be  20 a trustworthy informer of the family over  21 time what is known and what is not known;  22 and what the implications are of social  23 transition, puberty-blocking hormones,  24 you know, cross-sex hormones and various  25 surgical interventions. And I think the</p>
<p style="text-align: right;">Page 155</p> <p>1       STEPHEN B. LEVINE, M.D.  2 need to teach the people what they're  3 about to do and get their consent. That's  4 been evolving in the law for, you know  5 better than I do, for decades.  6       I'm just reminding the world  7 of -- I'm sorry, I'm sounding very  8 narcissistic -- but my colleagues and I  9 are reminding the world of the standards  10 of informed consent and we're trying to  11 refine them and define them and we hope  12 to have an influence on being safe and  13 not harming people.  14       Q. Is it fair to say part of your  15 aim is to try to improve how care is  16 provided to minors with gender dysphoria  17 by writing this article?  18       A. Sorry. If you take your hand  19 away from your mouth --  20       Q. Sorry. I will try to speak  21 closer to the mic as well.  22       Through this article are you  23 trying to improve how care is provided to  24 minors with gender dysphoria?  25       A. I'm hoping to set the</p>	<p style="text-align: right;">Page 157</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctors, especially the pediatricians,  3 the doctors who are focused in pediatric  4 age groups need to pay attention to what  5 we know about adults with whom they've  6 had very little experiences. And after  7 they turn 18 pediatricians generally do  8 not get involved with people.  9       So the thing is that the  10 pediatric world tends to not be as  11 conversant with the adult world of the  12 trans people as they need to be in order  13 to inform parents of what the  14 implications are.  15       Q. So is it your view then if  16 parents are truly fully informed in the  17 way you say they need to be, that the  18 parents should be the ones to make the  19 decision about whether their adolescent  20 children undergo gender-affirming medical  21 care?  22       MR. CANTRELL: Object to form.  23       A. Gee, I thought I made these  24 things clear repeatedly already today.  25 But the parents have to give legal</p>

<p style="text-align: right;">Page 158</p> <p>1       STEPHEN B. LEVINE, M.D.  2 consent, the parents are in charge, you  3 see. Those views have to be taken into  4 consideration. The parents -- the ideal  5 set of parents knows the patient better  6 than the doctor will ever know the  7 patient, right?  8       The legal requirements for the  9 parents to make this decision are in  10 place because they have a brain  11 maturational process and life experience  12 process and fertility process, pregnancy  13 process, raising children process that  14 the child or the teen doesn't have. And  15 of course their judgment is crucial here.  16 But in order for them to make this very  17 difficult decision -- this is not an easy  18 decision for any parent, you see. In  19 order to make this decision, they have to  20 be informed.  21       And the problem is that many  22 of the doctors believe passionately, they  23 believe passionately in what they're  24 doing, but they don't know what science  25 says or they don't accept what science</p>	<p style="text-align: right;">Page 160</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is there to inform, not to recommend.  3       I think if it's truly an  4 informed consent, you see, the doctor  5 tells the facts and because things are  6 uncertain, the patient get -- that is the  7 unit patient, that is the parents and the  8 child, they get to decide based upon an  9 accurate set of facts, and the facts  10 include that we don't know about these  11 things, you see.  12       Now, I am different than  13 pediatricians. Pediatricians feel  14 obligated sometimes to recommend a  15 treatment, whereas, I feel the obligation  16 is to recommend the options and have --  17 to inform people of the options and help  18 the parents to decide which is best for  19 their family unit. It's different than  20 "the doctor recommends", you see. Now, I  21 think I'm different than many  22 pediatricians because I have that view.  23       MS. COOPER: How is everyone  24 doing in terms of breaking? This  25 looks like a fine time to break if</p>
<p style="text-align: right;">Page 159</p> <p>1       STEPHEN B. LEVINE, M.D.  2 says or they say, well, this study is BS,  3 you see. But that's what I think I've  4 been saying to you over an hour,  5 Ms. Cooper.  6       Q. Okay. And again, just  7 sometimes we need to get things clear for  8 the record.  9       Then assuming that the doctors  10 provide that full information that you've  11 described as necessary, is it your view  12 that the decision should be left with the  13 parents for the care of their minor child  14 with respect to gender-affirming medical  15 care?  16       MR. CANTRELL: Object to form.  17       A. In that individual case, if  18 the state allows this to happen, then it  19 is, yes, the answer is yes, the parents  20 and the child and the doctor, that's a  21 team, right, the parent, the child, the  22 doctor, that's a unit, that's a team and  23 sometimes the doctor is a set of  24 professionals, they are the team. And  25 what you may not know, I think the doctor</p>	<p style="text-align: right;">Page 161</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they need one or if you need to go  3 on.  4       THE WITNESS: My bladder would  5 like one minute.  6       MS. COOPER: Let's take a  7 break.  8       VIDEOGRAPHER: Going off the  9 record. The time is 1:51.  10       (Recess is taken.)  11       VIDEOGRAPHER: Back on the  12 record. The time is 2:02.  13       Q. Dr. Levine, is it right that  14 in this case you've been asked to provide  15 expert testimony about the state of the  16 scientific evidence about  17 gender-affirming medical care for minors?  18       A. Yes.  19       Q. And that's what you've  20 discussed in your reports in this case?  21       A. Well, you read the report.  22       Q. So that's a "yes"?  23       A. I hope it's a yes.  24       Q. Do you understand -- well, let  25 me ask you, have you ever read the</p>

<p style="text-align: right;">Page 162</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Arkansas law at issue in this case?  3     A.   I did, yes.  4     Q.   So you understand that the law  5 prohibits gender-affirming medical  6 interventions for minors which suffer  7 from gender dysphoria in all cases,  8 regardless of circumstances?  9       MR. CANTRELL: Object to form.  10    A.   I think that's what the law  11 says at this point in the history of the  12 law, yes.  13    Q.   Can you say what you mean by,  14 "at this point in the history of the  15 law?"  16    A.   Well, you know, if you  17 interpret the law as any doctor -- every  18 doctor has to stop prescribing hormones  19 to people who have been on hormones for  20 two years or three years, I really don't  21 think that's going to happen. I think the  22 law will be modified or that doctors will  23 get together and recommend a process  24 whereby people can be discontinued from  25 hormones.</p>	<p style="text-align: right;">Page 164</p> <p>1       STEPHEN B. LEVINE, M.D.  2 are currently on these treatments.  3       So that's a psychological and  4 medical problem that needs to be solved  5 if the law goes into effect. But I do  6 think the intent of the law is not so  7 much with the people who are currently  8 being treated, but the people who might  9 be treated after the law goes into  10 effect. That's my understanding.  11    Q.   Okay. When you talk about the  12 problem of the people who already are  13 17-year-olds and have been on hormone  14 therapy for a few years, do you think it  15 would be a problem to require them to  16 discontinue hormone therapy?  17       MR. CANTRELL: Object to form.  18    A.   I think there's a physiologic  19 problem and I think there's a  20 psychological problem and I think the  21 team of doctors that include, I hope  22 still, a mental health professional,  23 although I doubt if any of them have a  24 mental health professional, I think that  25 team of the endocrinologist or the</p>
<p style="text-align: right;">Page 163</p> <p>1       STEPHEN B. LEVINE, M.D.  2       I do think the writing of the  3 law was more about the future than it is  4 about the current situation and that the  5 current patients on hormones who are in  6 the process, say, 17-year-olds, 17 and a  7 half-year-olds, I don't think the law  8 will be literally interpreted for those  9 people as they will be interpreted for  10 the 13-year-old who comes with gender  11 dysphoria, who then would be offered in  12 Arkansas a different kind of approach.  13       I don't really think Arkansas  14 is trying to stop the treatment of kids  15 with gender dysphoria. I think they're  16 trying to stop the treatments with  17 scientifically unclear value and dangers  18 with children with gender dysphoria.  19       So as far as I understand, the  20 law says that we, we physicians in  21 Arkansas must desist from giving these  22 treatments, but I think doctors are going  23 to get together, and perhaps even with  24 the blessing or of another law in  25 Arkansas, to deal with the patients who</p>	<p style="text-align: right;">Page 165</p> <p>1       STEPHEN B. LEVINE, M.D.  2 primary care doctor or the pediatrician  3 and the mental health professional who's  4 been interested in gender dysphoria, will  5 have to get together and to think about  6 how best to do this, to live within the  7 law.  8       Now, if it's six months  9 before, you know, the person is 18,  10 they'll find some solution. And then if  11 the child is 16 and they're two years,  12 there will be a different kind of  13 solution to it. And so, it's not like the  14 medical profession can't respond to this  15 law, to live within the law and I don't  16 really think that the Attorney Generals  17 -- of the people in the Attorney  18 General's Office and the Prosecutor's  19 Office are going to be unsympathetic to  20 the situations that you and I are making  21 reference to.  22       The law, itself, you see, I  23 think is primarily about the future. But  24 it does have a problem now for what are  25 we going to do with these kids? And I</p>

<p style="text-align: right;">Page 166</p> <p>1       STEPHEN B. LEVINE, M.D.  2 trust the medical profession -- I trust  3 the medical profession to be sensitive to  4 the physical and the psychological and  5 the social needs of these children, and  6 they'll find a way.  7       Q. You talk about finding  8 solutions that stay within the confines  9 of the law. Do you mean find solutions  10 about how to detransition them in a way  11 that stays within the confines of the law  12 or to find a way to not detransition?  13       MR. CANTRELL: Object to form.  14       A. No. I don't imply it's going  15 to cause them to detransition. Gender  16 identity is a psychological thing. It  17 isn't dependent on taking hormones, you  18 see.  19       Q. Let me rephrase that question  20 then, understanding why that was  21 confusing.  22       When you were talking about  23 the medical community coming up with  24 solutions, do you mean solutions about  25 how to take them off of the hormone</p>	<p style="text-align: right;">Page 168</p> <p>1       STEPHEN B. LEVINE, M.D.  2 identity, which has been stable for four  3 years, is not going to disappear because  4 the child is not on hormones for six  5 months or can be on a lesser dose of  6 hormones, you see.  7       Now, spironolactone, for  8 example, is not a hormone, but it's  9 commonly used to suppress androgens and  10 to increase estrogen in the body. So  11 they'll figure out how to deal with this  12 if the law becomes the law, you see.  13       The doctors will work with the  14 law and they'll find a way. The law  15 doesn't apply to 18-year-olds. And so, I  16 just think the law, itself, is aimed at  17 preventing treatments that are not  18 scientifically established for young  19 people.  20       But this is a group that you  21 and I are now talking about that will be  22 -- will require some additional thinking,  23 which the law does not provide for at  24 this point. But I trust the medical  25 profession and their belief in if the</p>
<p style="text-align: right;">Page 167</p> <p>1       STEPHEN B. LEVINE, M.D.  2 therapy or solutions about how to not  3 take them off the hormone therapy? I'm  4 not sure what you meant by "solutions".  5       MR. CANTRELL: Object to form.  6       A. I'm saying that since medicine  7 ideally is on a case-by-case basis, the  8 team of physicians who are involved with  9 this, which I hope will be the endocrine  10 expert, and that may be the pediatrician,  11 him or herself, and the mental health  12 professional, and the team that has been  13 involved, let's say there's a children's  14 hospital that does this in Little Rock,  15 you know, those people will get together  16 and will think about this, both as a  17 policy; that is how we're going to  18 generally approach this and how we're  19 going to individually approach this for  20 this case versus that case, and they will  21 find a solution. And it is not -- it  22 doesn't necessarily mean detransitioning  23 the child. It may mean decreasing their  24 hormones or using something else or  25 reassuring the family that gender</p>	<p style="text-align: right;">Page 169</p> <p>1       STEPHEN B. LEVINE, M.D.  2 patient, in fact, is -- is doing better,  3 they may come to realize the person is  4 still not doing better and maybe the  5 treatment for the last three years hasn't  6 really amounted to an upgrade in  7 improvement, so the family and the  8 patient and the law sort of will be  9 cooperating to make an individual  10 decision that you may eventually call  11 detransition. But I don't know what that  12 will be, it's uncertain.  13       Q. If you have a 16-year-old  14 who's been on hormone therapy and by all  15 accounts the patient, parent and doctor  16 agree that has been a beneficial  17 treatment, and then the law goes into  18 effect tomorrow and the doctors can't  19 continue to provide hormone therapy for  20 two more years while the patient is a  21 minor, could that cause harm to that  22 minor, psychologically --  23       MR. CANTRELL: Object to form.  24       Q. -- physically?  25       A. Theoretically, it could cause</p>

<p style="text-align: right;">Page 170</p> <p>1       STEPHEN B. LEVINE, M.D.  2 distress. It would cause the family to  3 have to find a solution. It may be to go  4 to Kentucky or Missouri or Oklahoma or it  5 may, if it's a politically active family,  6 it may cause a conversation with the  7 legislature who will provide a secondary  8 bill, a bill that perhaps can pass very  9 quickly that only applies to those  10 16-year-olds, like those kids like you  11 are just making reference to, that would  12 be much more, you know, thoughtful about  13 how do we deal with the already  14 transitioned people who are doing well.  15       So if there are already  16 transitioned kids who are not doing well,  17 this may be, in fact, a benefit. But  18 there are kids who -- I will presume with  19 you that there are children who are doing  20 better or who are functioning well in  21 their new role and who want to continue,  22 and I think solutions will be found. You  23 know, I would prefer this law to have  24 made provisions already for that but that  25 wasn't in -- I wasn't consulted.</p>	<p style="text-align: right;">Page 172</p> <p>1       STEPHEN B. LEVINE, M.D.  2 banning new treatments.  3       Q.   And are some of those, the  4 ones that are considering it, like  5 Arkansas, banning continued care for  6 those already receiving treatment?  7       MR. CANTRELL: Object to form.  8       A.   I'm sorry. The two of you  9 heard that better than I did.  10      Q.   When you -- you mentioned you  11 had some concerns about what's going on  12 in other states. Are there proposals  13 you're concerned about that, like  14 Arkansas, would prohibit not just  15 forward-looking treatment for new  16 patients but treatment being continued  17 for those currently receiving  18 gender-affirming hormone therapy?  19      MR. CANTRELL: Object to form.  20      A.   What I'm saying is that the  21 social circumstances of children who are  22 gender dysphoric but haven't been  23 socialized into a new gender or haven't  24 been given one of the hormone treatments  25 is one set of issues. And what you are</p>
<p style="text-align: right;">Page 171</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Q.   And just to clarify, when you  3 say you would prefer that the law would  4 have made provisions already for that,  5 you mean, are you suggesting some kind of  6 a carveout for adolescents who are  7 already receiving gender-affirming  8 hormone therapy?  9       A.   I would have liked the law to  10 have talked about the present -- the  11 future treatments of this as of the time  12 the law was passed and recognizing the  13 social, psychological circumstances of  14 the children who already have been  15 stabilized in their new social gender,  16 their new gender, to think about those  17 kids. I don't think the law has thought  18 about those kids sufficiently. So I'm a  19 little concerned about that, and it's not  20 just in Arkansas, you know.  21      Q.   Where else are you concerned  22 about that?  23      A.   Well, as you know better than  24 I, other states are considering or have  25 -- you know, are considering similar</p>	<p style="text-align: right;">Page 173</p> <p>1       STEPHEN B. LEVINE, M.D.  2 raising appropriately is, what about the  3 children who already have spent years in  4 treatment, what are we to do about those  5 people? And I am trying to be kind and  6 understanding and compassionate about the  7 situations and those families.  8       I don't think this is a reason  9 to ban the law, so to speak. I think  10 it's a reason to think about those people  11 as a separate category of people, and to  12 be compassionate about them and  13 compassionate to the doctors and  14 compassionate to the parents, and to make  15 an individual -- to make -- as I already  16 said, I think there are two dimensions to  17 the response to that group of people;  18 one, is the teams of doctors who have  19 been involved with this need to get  20 together and think about what is  21 necessary in general for this group of  22 people; and then the individual doctors  23 taking care of this child and these set  24 of parents, you see, need to think about,  25 what are we going to do in this case? And</p>

<p style="text-align: right;">Page 174</p> <p>1       STEPHEN B. LEVINE, M.D.  2 I have more optimism that the good nature  3 of that process, the medical process,  4 they'll find solutions for this, you see.  5 And I hope one of the solutions will be  6 to approach the legislature to create --  7 to not put doctors in harm's way if they  8 -- if they're taking care of people who  9 they've previously committed to this  10 treatment.  11       If someone is taking four  12 years of an anti-cancer drug, and it's  13 now proven that this anti-cancer drug has  14 negative -- negative consequences, well,  15 the doctors can easily stop that, you  16 see. But here we're imposing -- we  17 recognize that if we stop the cancer  18 drug, there's a certain benefit to it and  19 there is a certain risk to it and the  20 doctors will modify that decision based  21 upon their understanding of the risks and  22 the benefits of the drug. What else can  23 we do?  24       So, you know, we want our  25 doctors to be preoccupied with the</p>	<p style="text-align: right;">Page 176</p> <p>1       STEPHEN B. LEVINE, M.D.  2 different what we're going to do with Tom  3 Burch. Am I clear? I think so.  4       Q.   So going back then to your  5 reports that discuss the scientific  6 evidence regarding gender-affirming  7 medical care for adolescents, by  8 submitting those reports in this case was  9 it your intention to express support for  10 banning gender-affirming medical care  11 across the board for minors?  12       MR. CANTRELL: Object to form.  13       A.   You are talking about this  14 article?  15       Q.   No. No. Sorry. Your reports  16 that you submitted in this case, your  17 expert reports, your declarations.  18       MR. CANTRELL: Object to form.  19       THE WITNESS: You want me to  20 answer this?  21       MR. CANTRELL: You can answer.  22       Q.   Actually, let me back up. I  23 don't want there to be confusion here.  24       You recall submitting expert  25 reports in this case, correct?</p>
<p style="text-align: right;">Page 175</p> <p>1       STEPHEN B. LEVINE, M.D.  2 welfare of the child, of our patients,  3 and I believe that doctors are  4 preoccupied with that. So we'll find a  5 way. We'll find a way. It's not just,  6 okay, it's going to stop and then doctors  7 are going to turn their back on these  8 people. I don't think that's going to  9 happen at all.  10       Q.   Now, in your view, would it be  11 best for an individual case-by-case  12 determination to be made for what to do  13 with each of those teens who is already  14 on gender-affirming medical care?  15       MR. CANTRELL: Object to form.  16       A.   You know, I've already  17 answered that question. I'll do it a  18 third time.  19       I think it will take two  20 forms; one, what are we going to do in  21 general about this problem because it's  22 new; and two, what are we going to do  23 about John Jones? They can be separate.  24 I mean, John Jones is going to fall  25 within the umbrella but it's going to be</p>	<p style="text-align: right;">Page 177</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A.   Of course.  3       Q.   Okay. And so my question  4 relates to those reports.  5       By submitting those reports in  6 this case was it your intention to  7 express support for banning  8 gender-affirming medical care across the  9 board for minors in Arkansas?  10       MR. CANTRELL: Object to form.  11       A.   I thought that the Attorney  12 General's Office hired me to give the  13 state -- to articulate the state of  14 science in this field. That's what I was  15 hired to do. I am not a proponent or an  16 opponent to this, to the law.  17       I have already told you my  18 concerns about the law. I'm not a  19 legislator, I'm not a politician, I don't  20 consider myself an expert in public state  21 policy, policy on state levels.  22       I do feel my expertise is in  23 my knowledge of the state of science in  24 this field, and I believe I'm being hired  25 to testify only to that.</p>

<p style="text-align: right;">Page 178</p> <p>1       STEPHEN B. LEVINE, M.D.  2       I don't present -- I don't  3 presume that I'm an expert in the wisdom  4 of the law. I hope I have a certain  5 degree of cogency and grasp of the state  6 of science, and that's what I believe  7 I've been hired to testify to. Is that an  8 answer to your question?  9       Q. I think it was. And from  10 earlier in the deposition we talked about  11 your articles Reconsidering Informed  12 Consent, and your views about how care  13 should be provided in this area. So I  14 just want to make sure I understand  15 correctly.  16       Is it your position, not that  17 care -- sorry. I'll start again. Is it  18 your position -- I'm sorry. I'm asking  19 this in a very awkward way.  20       Do I understand correctly that  21 it is not that you oppose ever providing  22 gender-affirming medical care to minors,  23 but that it should be done with a lot  24 more caution and according to standards  25 that you articulate in your revisiting</p>	<p style="text-align: right;">Page 180</p> <p>1       STEPHEN B. LEVINE, M.D.  2 position is scientifically and  3 personally, based on my experience, there  4 are considerable concerns, legitimate  5 concerns about the long-term implications  6 of what we're doing by medicalizing a  7 child's gender identity, you see, because  8 it makes -- it causes permanent damage.  9       Generally, "this above all, do  10 no harm" is the major medical principle  11 of ethics. And the penis is normal, the  12 breast tissue is normal, menstruation is  13 normal, you see, and interfering with  14 these things on the hope that the  15 long-term outcome will lead to mental  16 healthy, highly functional, loving  17 people. The hope. The science says,  18 well, what is the evidence that your hope  19 has been realized?  20       So my position is, as long as  21 you believe this, that it's an important  22 thing to do and there are things like  23 true transsexual people, which I'm not  24 sure exists, you see, then if you're  25 going to do these things, at least you</p>
<p style="text-align: right;">Page 179</p> <p>1       STEPHEN B. LEVINE, M.D.  2 informed consent article?  3       MR. CANTRELL: Object to form.  4       A. It's my position that there  5 are serious, serious concerns about the  6 wisdom of medicalizing gender identity in  7 a child and in an adolescent, and that the  8 evidence that this is beneficial to the  9 child, him or herself, and to the family  10 you see, in the long run and that it  11 improves the ability to function  12 socially, vocationally, educationally,  13 and sexually, these things are -- there  14 are indications that these things are not  15 health-promoting.  16       So given the state of science  17 I have concerns about the wisdom of this  18 and I hope that the doctors have the  19 concerns about the wisdom of this  20 treatment and apparently, the legislature  21 has concerns about the wisdom of these  22 treatments as well.  23       So if you understand my  24 testimony, I think you keep asking me  25 about, you know, what is my position? My</p>	<p style="text-align: right;">Page 181</p> <p>1       STEPHEN B. LEVINE, M.D.  2 should do it within the ethical framework  3 that this article discusses.  4       I don't know if I'm ever going  5 to be able to answer your question.  6       MS. COOPER: Can we mark  7 exhibit tab 17 as the next exhibit.  8       (Exhibit Levine 4, transcript  9 re: Presentation on Healthcare  10 Models For Transgender Adolescents,  11 dated March 12, 2020, was received  12 and marked on this date for  13 identification.)  14       Q. Okay. That should be up.  15       Dr. Levine, this is a  16 transcript of testimony from a  17 legislative hearing in Pennsylvania.  18       Do you recall testifying in  19 2020 at a legislative hearing in  20 Pennsylvania?  21       A. Yes, I do recall that.  22       Q. And am I right that that was  23 about state medical insurance coverage  24 for gender-affirming medical care for  25 minors? Is that the issue you were</p>

<p style="text-align: right;">Page 182</p> <p>1       STEPHEN B. LEVINE, M.D.  2 talking about?  3     A.   I think there was a health  4 subcommittee and they were trying to  5 decide whether Medicaid should cover  6 these treatments.  7     Q.   For minors; is that right?  8     A.   Yes, for minors.  9     Q.   Okay. If you could scroll down  10 with me to page 59, please.  11     A.   Okay. 59, yes. You didn't  12 highlight this page.  13     Q.   No. Sorry. Actually, let's go  14 to 58 because I want to make sure 57 --  15     A.   57?  16     Q.   Yes. If you could read,  17 there's an exchange between Dr. Levine  18 and Representative Cox where he asks a  19 question at the bottom of page 57. Do you  20 see that? Starting with, "If I might,  21 Mr. Chairman"?  22     A.   Yes. Okay. I'm there.  23     Q.   I just want to make sure you  24 can have the context. So why don't you  25 read there through page 59.</p>	<p style="text-align: right;">Page 184</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Okay. Just making sure we're  3 on the same page.  4       So at the top of 59 I want to  5 ask about a passage that says, "I'm not  6 asking the committee to outlaw sexual  7 assignment surgery, I'm not asking the  8 committee to outlaw the judicious use of  9 endocrine treatment, I'm just raising  10 questions for you about the wisdom of  11 encouraging puberty blocking, the way I  12 understand it happens in urban centers  13 that process many many kids, increasing  14 numbers of children." I'll stop there.  15       What did you mean by "the  16 judicious use of endocrine treatments"  17 there?  18     A.   Ms. Cooper, I know you're a  19 very intelligent person. And "judicious"  20 is a word you understand. So I'm a little  21 perplexed that you are asking me what I  22 meant by "the judicious use of endocrine  23 treatment."  24       I guess you mean, am I saying  25 that doctors need to be thoughtful, make</p>
<p style="text-align: right;">Page 183</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   I have now read to the top of  3 page 59. Do you want me to read through  4 59?  5     Q.   Yes, please.  6     A.   Okay.  7       (Deponent reviews the  8 document.)  9     A.   Okay.  10     Q.   So I wanted to ask you, this  11 was about whether to cover  12 gender-affirming medical care for minors  13 as part of the state Medicaid coverage?  14     A.   Well, Ms. Cooper, this is the  15 first time since March 12th, 2020 I read  16 those words, so you'll forgive whatever I  17 say next because I'm not exactly, you  18 know -- this was me two years ago and six  19 months ago. I've had a lot of experience  20 in the last 26 months. I've reviewed a  21 lot of data in the last 26 months.  22     Q.   But the topic you're talking  23 about is gender-affirming medical care  24 for minors, right?  25     A.   Right.</p>	<p style="text-align: right;">Page 185</p> <p>1       STEPHEN B. LEVINE, M.D.  2 good judgment? Yes, that's what I mean.  3       We've already spent a great  4 deal of time of what goes into judicious,  5 informed consent, based on science, based  6 on the families' education and ability to  7 comprehend, based on the psychopathology  8 of the family, the psychopathology of the  9 family, the psychopathology of what the  10 child has endured in life and is still  11 suffering from. That's what I mean by  12 judicious.  13       Now, I'm not saying that there  14 is no child that a therapist might  15 actually think it may not harm, it may  16 not help, but I think it's worth a try,  17 that would be judicious. That would be  18 judicious as of March 12th, 19 -- 2020.  19     Q.   Is it different now?  20     A.   I think it may be different  21 now that we've had additional reviews  22 about the risk/benefit ratios, but still  23 I would always want -- I would always  24 want the word judicious to modify what  25 doctors do.</p>



<p style="text-align: right;">Page 186</p> <p>1       STEPHEN B. LEVINE, M.D.  2       So I would never say -- I  3 mean, I'm not going to delete that word  4 and I don't think when you get medical  5 care you would want your doctor to be  6 non-judicious. So it's judicious.  7       Now, the question is, is it  8 really judicious to take a 13-year-old  9 and put them on hormones, say, puberty  10 blockers, and then a year later put them  11 on either testosterone or estrogen.  12 Today, given the science, it would  13 probably be even less judicious than it  14 was two years ago to do that. And again,  15 science is ever-changing, facts are  16 ever-evolving, and who knows what a year  17 from now we will know.  18       I don't think if we get new  19 knowledge it won't be from the United  20 States, it will be from other countries  21 who are more apt to be cautious and to do  22 studies like Sweden, for example.  23       Q.   You give the example of a  24 13-year-old, that maybe today it wouldn't  25 not be judicious to provide certain</p>	<p style="text-align: right;">Page 188</p> <p>1       STEPHEN B. LEVINE, M.D.  2 experiences and loving and falling in  3 love and having sexual experiences and  4 entering into a romantic relationship  5 with or without sex and understanding the  6 complexities of it, the nuances of it,  7 and to realize that I'm more than my  8 gender identity, and my body responds  9 with pleasure in ways that I didn't know  10 that I had before. That these things are  11 -- these things can change a child's  12 attitude towards the self, which is what  13 gender dysphoria is, you know, it's a  14 problem in one's attitude towards the  15 bodily self and the psychological self,  16 as represented in your own gender, your  17 concepts about your own gender.  18       So judicious also means the  19 judicious use of the doctor as a  20 maturational promoting agent, you see.  21 So much of the psychotherapy of these  22 children are -- is aimed at facilitating  23 maturation and not getting stuck on one  24 issue, you see.  25       So I think there the tradition</p>
<p style="text-align: right;">Page 187</p> <p>1       STEPHEN B. LEVINE, M.D.  2 medical transition treatment to a  3 13-year-old.  4       Could it in your view be  5 judicious in 2022 to ever provide hormone  6 therapy to a 16-year-old?  7       MR. CANTRELL: Object to form,  8 vague.  9       A.   Well, it wouldn't be judicious  10 if it was outlawed in the state. It  11 wouldn't be judicious to put the doctor  12 into some kind of jeopardy.  13       Q.   Let's put that aside. As a  14 medical question?  15       A.   As a medical question, if we  16 had a chance to do what Dr. Levine  17 suggests, not just today but in papers  18 I've written about understanding all the  19 things I've already said several times, I  20 think it is possible that there may be a  21 case or two that we could be planning for  22 ultimate endocrine treatment in the  23 future. I don't know that it has to  24 happen at 16, for example. I think at 16  25 it's possible to begin to have intimate</p>	<p style="text-align: right;">Page 189</p> <p>1       STEPHEN B. LEVINE, M.D.  2 of psychotherapy and the state of science  3 comes together to perform a powerful  4 argument that we should not be giving,  5 especially when there is high pressure on  6 institutions to process or have what I  7 call high throughput, move kids through  8 the system very quickly. I think that's  9 a very strong argument to not giving  10 hormones to the average 16-year-old who's  11 been identified for two years as a trans  12 person, you see. They can keep their  13 identity as a trans person, they can keep  14 that identity, but they need to have this  15 process that will help them participate  16 in the world as though they're a more  17 complicated person than just a trans  18 person.  19       So I think science and  20 psychology and the knowledge of  21 psychological development through  22 adolescence all come together to say  23 caution, caution, careful, don't harm  24 this kid, just because he wants this.  25       MS. COOPER: I'd like to mark</p>

<p style="text-align: right;">Page 190</p> <p>1       STEPHEN B. LEVINE, M.D.  2   tab 8 as the next exhibit.  3       (Exhibit Levine 5, transcript  4   of Stephen B. Levine, M.D. Monday,  5   December 21, 2020 re: Juli Claire  6   v. Florida Department of Management  7   Services was received and marked on  8   this date for identification.)  9   Q.   Exhibit 5 is now up. Are you  10 able to open the document?  11   A.   Did you ask me a question?  12   Q.   Can you see the document?  13   A.   Yes.  14   Q.   This is a transcript of a  15 deposition of you taken in the case  16 Claire against Florida Department of  17 Management Services. Do you recall being  18 deposed in that case?  19   A.   Vaguely.  20   Q.   Okay. According to the cover  21 page here that was in December of 2020;  22 is that correct?  23   A.   I trust the accuracy of that.  24   Q.   Can you please scroll down,  25 it's page 152 I put to point you to.</p>	<p style="text-align: right;">Page 192</p> <p>1       STEPHEN B. LEVINE, M.D.  2   Q.   I wanted to just ask you to  3 read with me, I'm going to read the  4 answer highlighted. You say "Because  5 categorical" -- actually, sorry. I'm  6 going to go up to the first prior answer,  7 "Listen, I'm going to answer all your  8 questions. I don't believe generally in  9 categorical bans of hormone treatment and  10 surgical treatment for individual  11 patients. Why is that? Because  12 categorical bans is an absolute thing and  13 I've already established that people have  14 different needs and I don't want to  15 deprive certain people, even though I  16 think it's a bad idea for other people.  17 That's what I take when you say  18 categorical bans."  19       And I understand this was a  20 case about adults that you were talking  21 about, so I don't want to confuse things.  22 But is that still your view in general,  23 about what you said there, that you don't  24 believe generally in categorical bans of  25 hormone therapy for certain patients?</p>
<p style="text-align: right;">Page 191</p> <p>1       STEPHEN B. LEVINE, M.D.  2   A.   152, I'm almost there. I'm  3 surprised. And you highlighted it.  4   Q.   All right. Let's -- I want to  5 make sure I give you time to read the  6 relevant context.  7       If you go to page 151, the  8 first question at the bottom I think is  9 the beginning of this question. If you  10 can read that through page 152.  11   A.   Where do you want me to begin?  12   Q.   Very bottom of page 151.  13   A.   "I am mindful of the time."  14   Q.   That's the question. Let's go  15 to the next page.  16   A.   Bates number.  17       (Deponent reviews the  18 document.)  19   A.   Where did you want me to stop,  20 with the highlight?  21   Q.   You can finish page 152. I  22 don't know if you need to read the  23 lawyer's objection. The end of your  24 testimony on that page.  25   A.   Okay.</p>	<p style="text-align: right;">Page 193</p> <p>1       STEPHEN B. LEVINE, M.D.  2       MR. CANTRELL: And just for  3 the record, the question beginning  4 where right before you started  5 reading, Leslie, says "Let's move  6 it to adults."  7       MS. COOPER: Yes. That's what  8 I was trying to clarify before,  9 perhaps not clearly.  10       MR. CANTRELL: Okay. I just  11 wanted to make sure we were clear  12 on that.  13       MS. COOPER: We're clear.  14       MR. CANTRELL: Okay.  15   A.   Ms. Cooper, I've been aware,  16 based on two recent studies, whose  17 prefaces have said it's unclear what the  18 mental health benefits are of sex  19 reassignment surgeries, they call it  20 sometimes gender-confirming or  21 gender-conforming surgeries. Two  22 studies by profound advocates of sex  23 assignment surgery began by saying it's  24 unclear, and I would add after 60 years  25 of doing these kind of surgeries, what</p>

<p style="text-align: right;">Page 194</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the mental health benefits of these  3 treatments, these surgical treatments  4 actually are.  5       Both of the studies -- one of  6 the studies, the most well known of the  7 studies is the Bränström-Panchankis Study  8 in the August American Journal of  9 Psychiatry, both of these studies have  10 been roundly attacked and the conclusions  11 of the study have been agreed upon by  12 others to not be based upon the data that  13 the study is purported to demonstrate.  14 And so the idea that the treatment of  15 adults is well established is -- is not  16 correct. The science is unclear even in  17 this arena of adults. And this is very  18 very relevant to the treatment of all  19 transgender people when, after 60 years  20 of experimenting or at least offering  21 these treatments, we can't be certain of  22 the mental health benefits and we are  23 aware of the high risk of suicides in  24 adults after the complete package of  25 medical treatment of the trans people. So</p>	<p style="text-align: right;">Page 196</p> <p>1       STEPHEN B. LEVINE, M.D.  2 I'm for informed consent and for people  3 whose brains are mature, as mature as  4 they're going to be. They get to decide,  5 you see.  6       So this was before, and I hold  7 the right to continue to evolve as a  8 professional in my understanding of  9 things. It's my right to mature as a  10 professional. It's my right to change my  11 mind and it's my right to phrase things  12 differently from every two years or every  13 two days, you see. Because, like  14 children, all adults mature, continue to  15 mature theoretically and professionals  16 mature.  17    Q.   So is your view no longer --  18 where you say, "I don't believe generally  19 in categorical bans on hormone treatment  20 or surgical treatment for individual  21 patients", is that no longer your view  22 after the new information you've learned  23 in the last two years?  24    A.   I'm not in favor of  25 categorical bans on surgery for</p>
<p style="text-align: right;">Page 195</p> <p>1       STEPHEN B. LEVINE, M.D.  2 in 2000 when I made this testimony I  3 didn't have access to those two studies.  4       So now I know that I'm even  5 more uncertain of the long-term wisdom of  6 doing these things with people just  7 because they want to. However, adults are  8 responsible, they're old enough to be  9 responsible for making decisions. And I  10 try to help them understand the data, but  11 if they still want to do this, they still  12 want to have their breasts removed or  13 they still want to have their  14 vaginoplasty, you see, if they understand  15 that their pleasure in masturbation, for  16 example, using their penis will disappear  17 and I can't guarantee they will be able  18 to have orgasm with masturbation or with  19 a partner when they female genitalia --  20 female-looking genitalia. Well, they get  21 to choose that, I don't get to ban that  22 for them, you see.  23       So I'm not exactly  24 categorically against things, as I've  25 testified I hope articulately already.</p>	<p style="text-align: right;">Page 197</p> <p>1       STEPHEN B. LEVINE, M.D.  2 transgender adults. I'm not in favor of  3 categorical bans. I'm just in favor of  4 the judicious -- of physicians doing  5 judicious decisionmaking based on correct  6 information. And I do think physicians  7 need not to disregard studies that they  8 don't happen to agree with because it is  9 not in keeping with their zeitgeist. So  10 maybe ask me that question again.  11    Q.   Well, I was asking whether  12 your opinion where you state here, "I  13 don't believe generally in categorical  14 bans of hormone treatment or surgical  15 treatment for individual patients",  16 whether that has changed?  17    A.   Well, actually I think it  18 makes more sense to categorically ban  19 puberty-blocking hormones in young people  20 than it does genital surgeries in  21 40-year-olds.  22    Q.   You would not at this point  23 favor categorical ban of hormone  24 treatment or surgical treatment for  25 adults for gender dysphoria?</p>

<p style="text-align: right;">Page 198</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   That's right.</p> <p>3     Q.   And you think it might make</p> <p>4 more sense to categorically ban puberty</p> <p>5 blockers for minors with gender</p> <p>6 dysphoria?</p> <p>7     A.   Right.</p> <p>8     Q.   And what about hormone</p> <p>9 treatment for minors with gender</p> <p>10 dysphoria?</p> <p>11    A.   I think it makes -- I think</p> <p>12 there is a very strong argument, which</p> <p>13 I've already tried to tell you the</p> <p>14 science has made, that this is -- the</p> <p>15 risks are too great to promote this as a</p> <p>16 standard treatment and certainly</p> <p>17 promoting this as a standard or what is</p> <p>18 called best practices, unquote -- quote</p> <p>19 best unquote practices.</p> <p>20       The idea that promoting this</p> <p>21 as the best practice is not only</p> <p>22 scientifically not correct, it's</p> <p>23 ethically not correct. And if it's</p> <p>24 ethically not correct, then it might not</p> <p>25 be legally correct.</p>	<p style="text-align: right;">Page 200</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 dysphoria, do I understand correctly that</p> <p>3 you would support the thorough informed</p> <p>4 consent process that you outlined in your</p> <p>5 article for that kind of treatment?</p> <p>6       MR. CANTRELL: Object to form,</p> <p>7 asked and answered.</p> <p>8     A.   I think I already expressed my</p> <p>9 ambivalence of categorical bans and I've</p> <p>10 already told you about the requirements</p> <p>11 for informed consent, but I think what I</p> <p>12 need to tell you now is that I believe</p> <p>13 that if doctors and parents and children</p> <p>14 knew, were given the facts on the ground,</p> <p>15 there probably would not be as much of a</p> <p>16 need for a law, you see, because I think</p> <p>17 the evidence suggests that the risk to</p> <p>18 this child is too great, and the</p> <p>19 consequence is not just for the child,</p> <p>20 the consequence is for the parent to have</p> <p>21 a mentally ill child or mentally ill</p> <p>22 adult is -- and that sometimes happens,</p> <p>23 you know, because we don't really pay</p> <p>24 attention to the underlying mental</p> <p>25 illness of the child. We say that all</p>
<p style="text-align: right;">Page 199</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   But putting aside the question</p> <p>3 of promoting hormone therapy as best</p> <p>4 practice, I'm just asking about</p> <p>5 categorically banning it for minors with</p> <p>6 gender dysphoria, are you in favor of</p> <p>7 that or does that fit into where you say</p> <p>8 -- let me ask it again.</p> <p>9       MR. CANTRELL: Object to form.</p> <p>10      MS. COOPER: I'm striking it.</p> <p>11    A.   Ms. Cooper, can I just ask you</p> <p>12 to face me when you --</p> <p>13    Q.   I'm sorry.</p> <p>14    A.   Because when your face is</p> <p>15 down, and I'm hard of hearing, I miss</p> <p>16 every third word.</p> <p>17    Q.   I'm sorry. Yeah, we don't</p> <p>18 want that.</p> <p>19       You talked about, for adult</p> <p>20 treatment, you're not favor in</p> <p>21 categorical bans you're for informed</p> <p>22 consent, I think is the way that you put</p> <p>23 it.</p> <p>24       And so my question is, for</p> <p>25 hormone therapy for minors with gender</p>	<p style="text-align: right;">Page 201</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 gender identities are normal but they</p> <p>3 have comorbidity. Their comorbidity may</p> <p>4 determine their mental illness at 22 and</p> <p>5 then for the parents they have a</p> <p>6 22-year-old child who is failing to</p> <p>7 launch and they may be happy taking</p> <p>8 hormones, you see, but they're not</p> <p>9 functioning very well.</p> <p>10      So what I'm saying is, we --</p> <p>11 it's not a matter of categorical bans</p> <p>12 alone, it's a matter of understanding</p> <p>13 what the profile of a child is and too</p> <p>14 many doctors have focused only on the</p> <p>15 gender dysphoria and they have believed</p> <p>16 that the best practice is hormones. And</p> <p>17 because they don't know the facts, people</p> <p>18 like state legislators are worrying about</p> <p>19 what they're doing to the next generation</p> <p>20 of children.</p> <p>21      And so that's where we are.</p> <p>22 And I don't know how to say this more</p> <p>23 clearly. You know, I think my attorney</p> <p>24 just said asked and answered. I think we</p> <p>25 could have said that three times already</p>

<p style="text-align: right;">Page 202</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or four times. This is a really fraught  3 area. All of us are concerned about this.  4     Q. I'm wondering, since you've  5 talked about -- you've got your article  6 about revisiting informed consent,  7 describing what I think you said would be  8 -- you feel is an appropriate standard to  9 be applied when considering  10 gender-affirming medical care for minors,  11 would in your view, if Arkansas passed a  12 law or regulation that required  13 clinicians to follow that kind of  14 rigorous process, would that be a better  15 choice than banning care across the board  16 no matter how that care is provided?  17       MR. CANTRELL: Object to form.  18     A. Maybe I'm getting too  19 fatigued. I don't think I grasped what  20 you were just asking me.  21     Q. Okay. So I understand from  22 your testimony that the concern you have  23 is providers not being cautious and  24 providing gender-affirming medical care  25 too quickly without thoroughly evaluating</p>	<p style="text-align: right;">Page 204</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctor's state of knowledge, not with  3 this doctor's state of belief --  4     Q. But a doctor -- sorry.  5     A. -- because beliefs are  6 determined not simply by scientific  7 knowledge, they're determined by many  8 other factors, including what someone  9 above them that they respect has taught  10 them, which may not be true at all, what  11 I like refer to as the chain of trust in  12 medical education. And we all have to  13 trust what we're taught, but we know the  14 soul of science is skepticism but we have  15 to learn so many things about so many  16 disorders that we just practically trust  17 what we're taught.  18       So I'm saying that people in  19 this arena often have strong beliefs that  20 they're on the side of angels and that  21 there's more benefit than there are harms  22 and that's not what science knows, and  23 they don't know that.  24       So what I'm saying is, when  25 you've asked that question you must</p>
<p style="text-align: right;">Page 203</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and getting to know the patients and  3 without thoroughly informing families of  4 everything you feel they need to know  5 about the risks and state of science,  6 that's a concern you've repeatedly  7 raised?  8     A. Can I stop you there?  9     Q. Yes.  10    A. Yes. That's right. But you  11 want to add one thing to your statement,  12 I'm also concerned that the doctors don't  13 know what the state of science is. So  14 their interactions with the patients,  15 meaning the family and the patient, are  16 based upon a positive view of the  17 potential of having a problem-free life  18 in the face of this child's history where  19 there are all these comorbidities. So if  20 the doctor does not know the facts on the  21 table circa May 26, 2022, then they can't  22 really give informed consent and if you  23 understand my article, which I think you  24 really do, these are the requirements for  25 informed consent. It begins with the</p>	<p style="text-align: right;">Page 205</p> <p>1       STEPHEN B. LEVINE, M.D.  2 include that the doctors need to know  3 what the truth is as scientifically  4 established, and that's whatever you said  5 accurate minus that point.  6     Q. So if the doctor knows what  7 the truth is, as you understand it, do  8 you believe a doctor could provide that  9 informed consent process to a family and  10 a family could choose to provide  11 gender-affirming medical care to a minor?  12       MR. CANTRELL: Object to form,  13 vague.  14     A. If there isn't a law  15 prohibiting it then I think, yes, under  16 certain circumstances. If a team of  17 doctors have had a thoughtful  18 deliberation process among themselves and  19 among the family, I think it's possible  20 to make this judicious decision. And  21 whether it would prove right or wrong,  22 the doctor may not know because it may  23 prove right in two months and be wrong in  24 two years. And so that's where science  25 comes in. We say, where is the long-term</p>

<p style="text-align: right;">Page 206</p> <p>1       STEPHEN B. LEVINE, M.D.  2 followup, folks? And the answer is, in  3 America we don't have any.  4       So we don't know whether this  5 judicious decision to say yes to hormones  6 has proven to be, in fact, judicious or  7 it may have been judicious then but  8 whether it's right in two years or five  9 years, we don't know. And you know if  10 this were your child you would want to  11 know what other people who went on  12 hormones five and ten years ago, how are  13 they doing? And the answer, if you ask  14 that to your doctor, for your child, the  15 doctor should say I don't know, I don't  16 know.  17    Q.   Could doctors have clinical  18 experience that would allow them to see  19 benefits to those kids in five years?  20    A.   Well, if it's a pediatrician  21 or pediatric endocrinologist who then  22 punts the child to an adult  23 endocrinologist or adult internist or  24 primary care doctor, they wouldn't know.  25 I mean, I've had -- I've talked to a</p>	<p style="text-align: right;">Page 208</p> <p>1       STEPHEN B. LEVINE, M.D.  2 expert is in the state of science.  3       It's not about support of a  4 law or against a law or whether an  5 insurance company should do this or  6 should not.  7    Q.   Let me ask you differently.  8 Have you testified about legislation that  9 bans gender-affirming medical care for  10 minors in any state?  11       MR. CANTRELL: Object to form.  12    A.   Have I testified in favor --  13    Q.   Have you testified in any  14 state legislative --  15    A.   No.  16    Q.   -- process?  17    A.   No. You have already seen my  18 Pennsylvania thing. I thought I was just  19 giving information. I wasn't testifying  20 for or against something.  21    Q.   You didn't testify in Alabama  22 about -- relating to a law about  23 gender-affirming medical care there?  24    A.   No.  25    Q.   Have you been asked to give</p>
<p style="text-align: right;">Page 207</p> <p>1       STEPHEN B. LEVINE, M.D.  2 doctor who thinks he's helping people  3 live long, happy, successful, vocational  4 and romantic lives and he's a child  5 psychiatrist who doesn't see kids after  6 17 or 18. So he just believes it. He just  7 believes it. Okay. What's the basis of  8 it? Well, I'm doing this, I have to  9 believe it, I believe it. But he's  10 teaching that to parents.  11    Q.   Have you ever been asked to  12 testify in support of a law banning  13 gender-affirming medical care for minors?  14       MR. CANTRELL: Object to form.  15    A.   I have been asked to give the  16 state of science in states that have --  17 are considering limiting insurance  18 coverages. And I don't know the answer  19 to your question of -- maybe in -- no one  20 has asked me to testify in favor of  21 banning a law. Everyone has asked me,  22 because I've been very clear with these  23 people, the only thing I'm relatively  24 knowledgeable about or what you would  25 called qualified as a Daubert qualified</p>	<p style="text-align: right;">Page 209</p> <p>1       STEPHEN B. LEVINE, M.D.  2 testimony related to a similar measure in  3 your state of Ohio?  4    A.   Yes, and I refused.  5    Q.   Why did you refuse?  6    A.   Because I'm not an expert in  7 these things. I think -- I refused  8 because this is what I know and I don't  9 want to be used for political -- I don't  10 want to be a pawn in political purposes.  11 These things are highly politicized. It  12 makes thinking very unclear.  13       I've come to learn that my  14 testimonies are public things that I  15 never imagined would be reading my expert  16 opinion reports, are reading my expert  17 opinion reports and calling me names  18 based on what they think. They call me  19 sometimes anti-trans or something. So I  20 don't want to be part of the public fray  21 but unfortunately I guess I am.  22    Q.   Do you think a law like  23 Arkansas, if it passed in Ohio, would be  24 beneficial to your minor patients with  25 gender dysphoria?</p>

<p style="text-align: right;">Page 210</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   If they pass this -- you say</p> <p>3 if they passed it in Ohio?</p> <p>4     Q.   Right.</p> <p>5     A.   Then I would say that it might</p> <p>6 be very beneficial for the future of</p> <p>7 trans-identified children in getting them</p> <p>8 what I consider to be reasonable</p> <p>9 appropriate care, because they have a</p> <p>10 psychological problem and they would then</p> <p>11 be treated like any other psychological</p> <p>12 problem by reviewing the patient's</p> <p>13 history and approaching the problems that</p> <p>14 the child has psychologically with or</p> <p>15 without some medication, like an</p> <p>16 antidepressant or anti-anxiety agent and</p> <p>17 we would have the same problem that you</p> <p>18 and I have discussed for 20 minutes about</p> <p>19 what to do with the children who already</p> <p>20 have been supported by the medical</p> <p>21 profession and I would urge then the Ohio</p> <p>22 legislature to have a bill that would</p> <p>23 take into consideration that which you</p> <p>24 and I have already discussed --</p> <p>25     Q.   So you wouldn't -- sorry.</p>	<p style="text-align: right;">Page 212</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 people the conservative treatment that</p> <p>3 might benefit them and then when they're</p> <p>4 older, if they want to do this, then</p> <p>5 they're responsible for themselves to do</p> <p>6 it.</p> <p>7       The state has an interest, I</p> <p>8 think, in protecting the vulnerable young</p> <p>9 and clearly, the transgendered</p> <p>10 populations are vulnerable people.</p> <p>11 They're not healthy people.</p> <p>12     Q.   So and in this case of</p> <p>13 gender-affirming hormone therapy for</p> <p>14 minors, you would prefer a categorical</p> <p>15 ban on care to an individual case-by-case</p> <p>16 determination with proper informed</p> <p>17 consent?</p> <p>18     A.   I would prefer that a higher</p> <p>19 quality mental health approach, first</p> <p>20 approach, be done with these children</p> <p>21 because I believe that if a high quality</p> <p>22 therapeutic process involving the</p> <p>23 children and the family process, that we</p> <p>24 would be able to help children find more</p> <p>25 comfort in how to live, than being</p>
<p style="text-align: right;">Page 211</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   -- benefiting from what we're</p> <p>3 talking about today.</p> <p>4     Q.   So if they did have a bill</p> <p>5 that they amended to say it doesn't apply</p> <p>6 to minors who are already currently</p> <p>7 receiving such treatment, you wouldn't</p> <p>8 have any concerns about that law, you</p> <p>9 think that would be in the best interests</p> <p>10 of minors with gender dysphoria in Ohio?</p> <p>11       MR. CANTRELL: Object to form.</p> <p>12     A.   You see, based on the</p> <p>13 assumption behind your question is that</p> <p>14 these treatments are really beneficial,</p> <p>15 that they're really helpful, that they</p> <p>16 cure many things and that they prevent</p> <p>17 suffering from depression and anxiety and</p> <p>18 substance abuse and suicidality, you see.</p> <p>19       That's what is behind your</p> <p>20 question, that there is something really</p> <p>21 positive about that. And these damn</p> <p>22 states that are trying to get rid of</p> <p>23 this, these are -- these are actions to</p> <p>24 harm people, you see. Whereas, I think</p> <p>25 they are actions trying to give these</p>	<p style="text-align: right;">Page 213</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 preoccupied solely with transforming</p> <p>3 their bodies.</p> <p>4       So all this business about</p> <p>5 categorical bans, I think because science</p> <p>6 is so uncertain and because other people</p> <p>7 feel profoundly, based on knowledge and</p> <p>8 intuition, that this is not a good thing</p> <p>9 to do to remove the breasts of 13- and</p> <p>10 14-year-old girls no matter what they</p> <p>11 say. We wouldn't take a 14-year-old who</p> <p>12 says, I don't ever want to have children</p> <p>13 and remove her ovaries. We wouldn't</p> <p>14 sterilize a 15-year-old girl or boy</p> <p>15 because they didn't -- they don't want to</p> <p>16 have children if that were cis. But we</p> <p>17 can somehow do that if they're trans and</p> <p>18 that doesn't make a lot of sense to many</p> <p>19 people.</p> <p>20     Q.   If somebody -- actually,</p> <p>21 strike that.</p> <p>22       MR. CANTRELL: Leslie, are we</p> <p>23 getting close a break?</p> <p>24       MS. COOPER: In a couple of</p> <p>25 minutes I think we can.</p>

<p style="text-align: right;">Page 214</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   So do I understand then that</p> <p>3 your view is that if a minor patient,</p> <p>4 their parents and their doctor agree that</p> <p>5 hormone therapy would be beneficial to</p> <p>6 the patient, and the family is provided a</p> <p>7 thorough informed consent process about</p> <p>8 the risks basis -- the risks and benefits</p> <p>9 of treatment and the state of the</p> <p>10 evidence, that the government should</p> <p>11 override that decision that the parents</p> <p>12 make?</p> <p>13       MR. CANTRELL: Object to form,</p> <p>14 asked and answered.</p> <p>15     A.   There is something about that</p> <p>16 long question that --</p> <p>17     Q.   Let me break it down.</p> <p>18     A.   -- I think you left something</p> <p>19 out.</p> <p>20     Q.   Maybe I did. Let me restate</p> <p>21 it. Thank you.</p> <p>22       So if a minor patient, their</p> <p>23 parents and their doctor agree that</p> <p>24 hormone therapy is appropriate for the</p> <p>25 patient, after the family is fully</p>	<p style="text-align: right;">Page 216</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 Swedish study from 2011 and the Bränström</p> <p>3 study in 2020 that demonstrated these</p> <p>4 problems with suicide, you see.</p> <p>5       So what happens is if we're</p> <p>6 going to inform the -- if the doctor or</p> <p>7 the pediatrician informs the patient</p> <p>8 about the benefits of hormones, you'll</p> <p>9 feel better, it will stabilize your</p> <p>10 sexual -- your gender identity, you see,</p> <p>11 your voice will get lower or you will</p> <p>12 grow breasts, and the risks are you'll</p> <p>13 get a blood clot or you'll weight gain or</p> <p>14 your blood counts will go up, you see,</p> <p>15 and your serum cholesterol will go up and</p> <p>16 your high triglycerides, they don't say</p> <p>17 these things will predispose you to death</p> <p>18 from cardiovascular disease, it's not a</p> <p>19 lifecycle -- it's not a lifecycle</p> <p>20 perspective. It's about the known medical</p> <p>21 effects of hormones. That's not informed</p> <p>22 consent, that's only a part of informed</p> <p>23 consent. And that's why I don't like how</p> <p>24 you phrased that sentence because it's</p> <p>25 about, oh, well, we talk about the risk</p>
<p style="text-align: right;">Page 215</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 informed about the risks and benefits of</p> <p>3 treatment, do you think the government</p> <p>4 should override that medical decision</p> <p>5 made by the parents?</p> <p>6       MR. CANTRELL: Same</p> <p>7 objections.</p> <p>8     A.   All right. The risk and</p> <p>9 benefits of treatment is what stopped me</p> <p>10 the first time because I happen to know</p> <p>11 that the risk of benefit treatment is</p> <p>12 that the benefits are not really written</p> <p>13 down, but the risks are thromboembolism,</p> <p>14 you know, weight gain, future</p> <p>15 cardiovascular disease, right. They're</p> <p>16 not talking about the risks that I'm</p> <p>17 talking about, you see. They're not</p> <p>18 talking about the long-term life course</p> <p>19 outcomes. They're not talking about the</p> <p>20 elevated suicide rate.</p> <p>21       I've never seen an informed</p> <p>22 consent that talked about the elevated</p> <p>23 suicide rate of adults who are fully</p> <p>24 transitioned. I've never -- I've never</p> <p>25 heard of a doctor talking about the</p>	<p style="text-align: right;">Page 217</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 and benefits of the treatment. You're not</p> <p>3 talking about the risk of the treatment</p> <p>4 because you don't have a lifetime</p> <p>5 perspective. And when you give -- when</p> <p>6 you give a 15-year-old hormones you're</p> <p>7 changing their life trajectory and you're</p> <p>8 shortening their lives.</p> <p>9     Q.   It sounds like you're of the</p> <p>10 view that these treatments can never be</p> <p>11 beneficial. So why did you write an</p> <p>12 article about how to approach it through</p> <p>13 informed consent rather than an article</p> <p>14 about banning the treatment?</p> <p>15       MR. CANTRELL: Object to form,</p> <p>16 argumentative.</p> <p>17     A.   I wrote an article to be</p> <p>18 helpful, to represent what doctors know</p> <p>19 and what doctors don't know. And I leave</p> <p>20 it to the medical profession and for</p> <p>21 anyone else who wants to read the</p> <p>22 article, like lawyers and legislatures,</p> <p>23 to think about the implications of this.</p> <p>24       I'm not -- I don't have the</p> <p>25 wisdom to ban everything. I don't know</p>



<p style="text-align: right;">Page 218</p> <p>1       STEPHEN B. LEVINE, M.D.  2 who benefits and who doesn't benefit. I  3 don't know the rate of unhappiness at  4 five years. I don't know -- I don't know  5 how society is to answer the question;  6 how many negative outcomes versus  7 positive outcomes would make us want to  8 continue or want to ban the treatment?  9       For example, if I ask you the  10 question, if you were a legislator or a  11 governor, if 15% of people are harmed and  12 50% are benefited and the rest, the 35%  13 are neutral, they don't know the answer,  14 would you ban it? And what happens if 60%  15 are harmed but 40 are helped, would you  16 ban it? You see, at what level? It's not  17 doctors who could decide this, you know,  18 it's legislatures or governors,  19 politicians can decide these things. But  20 you see as a doctor our medical  21 profession does not know what the actual  22 rate of harm is. And when these -- these  23 reviews in other countries have said it  24 looks like the risk of harm exceeds the  25 benefit, the benefits be cautious.</p>	<p style="text-align: right;">Page 220</p> <p>1       STEPHEN B. LEVINE, M.D.  2 take a pause and think about this.  3       I know lawyers have to win and  4 lose cases. But on a larger sense, I'm  5 trying to influence everyone to  6 understand what science is. And you guys  7 can fight it out.  8       Q.   Would you be comfortable if  9 every state in the country passed a law  10 banning gender-affirming medical care for  11 minors?  12       MR. CANTRELL: Object to form,  13 calls for speculation.  14       A.   You see, I think medical care  15 includes psychological care. So I don't  16 even think that your statement makes any  17 sense.  18       Q.   Let me rephrase the question.  19 Would you feel comfortable with a law  20 banning gender-affirming hormone therapy  21 for minors with gender dysphoria?  22       MR. CANTRELL: Same  23 objections.  24       A.   I would say based on what I  25 know today, that there would be a certain</p>
<p style="text-align: right;">Page 219</p> <p>1       STEPHEN B. LEVINE, M.D.  2       Now, in ten years we may know  3 that this treatment helps 83%, harms 10%  4 and 7% unclear. Well, if we -- if we knew  5 that 83% of people benefited, I would be  6 in favor of taking certain kids who met  7 certain criteria and putting them on this  8 path. But if it were reversed and only  9 13% were helped and 87% or 80% were  10 harmed, then I would say don't do this,  11 don't do this, please. I'm looking at --  12 we're talking about millions of people  13 here.  14       Q.   So given what we know how,  15 you're comfortable with your report being  16 used to help the state support and defend  17 a ban on care for minors --  18       MR. CANTRELL: Object to form.  19       Q.   -- ban on gender-affirming  20 medical care for minors?  21       MR. CANTRELL: Object to form.  22       A.   I believe my report is helping  23 you to think about the problem that  24 you're trying to defend. I believe I'm  25 helping everyone who reads the report to</p>	<p style="text-align: right;">Page 221</p> <p>1       STEPHEN B. LEVINE, M.D.  2 prudence to that and yet a certain  3 imprudence to that, and I don't know how  4 to balance those two things and I don't  5 really think, given what my -- what the  6 state of science has and where we are,  7 that it's up to us to make that decision.  8       I'm generally not -- I'm  9 generally not for statements like "all"  10 or "always" and "never". I've been a  11 doctor too long to know that even great  12 adversities today sometimes have good  13 outcomes and good things today have bad  14 outcomes.  15       So it's really hard for me to  16 take these kind of positions that I think  17 you're trying to box me into. So please,  18 please respect the complexity of my  19 views, at least as I experience them.  20       Q.   And just to wrap up and we can  21 take a break, is some of your discomfort  22 in answering these -- hold on. We're  23 having an audio problem message. Can you  24 hear me?  25       A.   I hear you fine.</p>

<p style="text-align: right;">Page 222</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Q.   Is your discomfort with the</p> <p>3 sort of "all" questions that as a general</p> <p>4 matter medical decisions would be made on</p> <p>5 a case-by-case basis as opposed to</p> <p>6 blanket rule about care?</p> <p>7       MR. CANTRELL: Object to form.</p> <p>8       A.   If I may go back to breast</p> <p>9 cancer for a minute, these case-by-case</p> <p>10 decisions are part of a larger umbrella</p> <p>11 of what science knows.</p> <p>12       So what science knows about</p> <p>13 the treatment of a particular form of</p> <p>14 breast cancer has to be modified because</p> <p>15 this woman with breast cancer or this man</p> <p>16 with breast cancer has an associated</p> <p>17 medical problem. So that treatment is on</p> <p>18 a case-by-case basis. But that's an</p> <p>19 exception to the umbrella of how we treat</p> <p>20 breast cancer. And that applies to</p> <p>21 everything. That applies to depression,</p> <p>22 that applies to schizophrenia, that</p> <p>23 applies to eczema.</p> <p>24       MS. COOPER: This would be a</p> <p>25 fine time to take a break. How much</p>	<p style="text-align: right;">Page 224</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 turned to the black market to try to</p> <p>3 access hormone therapy and you mentioned</p> <p>4 that that was a source of concern. Can</p> <p>5 you say why that was concerning or would</p> <p>6 be concerning?</p> <p>7       A.   Because the patient was lying</p> <p>8 to his parents and the patient had taken</p> <p>9 his 12-year-old sister and sort of</p> <p>10 colluded with her to keep this private</p> <p>11 and somehow he used her in this scheme</p> <p>12 and the parents were not only mad at the</p> <p>13 son for surreptitiously getting hormones</p> <p>14 from China, but of his younger, more</p> <p>15 naïve sister and putting her into a</p> <p>16 loyalty of conflict between the love for</p> <p>17 her parents and the love for her brother,</p> <p>18 and they found that to be morally</p> <p>19 reprehensible.</p> <p>20       Q.   Did you have any physical</p> <p>21 health concerns for your patients taking</p> <p>22 black market hormones?</p> <p>23       A.   Absolutely.</p> <p>24       Q.   Like?</p> <p>25       A.   One, that person is the person</p>
<p style="text-align: right;">Page 223</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 time would you like? Let's go out</p> <p>3 off the record.</p> <p>4       VIDEOGRAPHER: Going off the</p> <p>5 record. The time is 3:17.</p> <p>6       (Recess is taken.)</p> <p>7       VIDEOGRAPHER: Going back on</p> <p>8 the record. The time is 3:31.</p> <p>9       MS. COOPER: Can we go off?</p> <p>10 Sorry. I forgot to do something.</p> <p>11       VIDEOGRAPHER: Time is 3:32.</p> <p>12 We're off the record.</p> <p>13       (Discussion is held off the</p> <p>14 record.)</p> <p>15       VIDEOGRAPHER: Back on the</p> <p>16 record. The time is 3:32.</p> <p>17       Q.   Dr. Levine, do you think the</p> <p>18 Arkansas law were to go into effect that</p> <p>19 adolescents currently receiving care will</p> <p>20 find some way to get access to hormone</p> <p>21 therapy?</p> <p>22       MR. CANTRELL: Object to form.</p> <p>23       A.   I think some will.</p> <p>24       Q.   You mentioned earlier in the</p> <p>25 day at least one of your patients had</p>	<p style="text-align: right;">Page 225</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 who ultimately died of probably fentanyl.</p> <p>3       Q.   So is there --</p> <p>4       A.   So there is the naivete of the</p> <p>5 person who thinks I'm taking estrogen,</p> <p>6 I'm taking heroin, they think they know</p> <p>7 what they're taking and heroin -- I'm</p> <p>8 sorry -- words -- opioids are a perfect</p> <p>9 example of the dangers that society faces</p> <p>10 when we don't do science, when we just do</p> <p>11 what somebody or some group of people</p> <p>12 think is the best thing to do and we</p> <p>13 don't allow science to lead us. And now</p> <p>14 we have these incredible death rates from</p> <p>15 opioids throughout America, which is not</p> <p>16 abating, by the way.</p> <p>17       But this is a perfect example,</p> <p>18 I think, that all of us need to worry</p> <p>19 about when science does not lead</p> <p>20 therapeutics.</p> <p>21       Q.   Going back to hormone therapy,</p> <p>22 do you have any concerns that adolescents</p> <p>23 in Arkansas who are currently receiving</p> <p>24 hormone therapy under a doctor's care, if</p> <p>25 they had had to stop doing that because</p>

<p style="text-align: right;">Page 226</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the law took effect, would pursue  3 hormones from the black market?  4       MR. CANTRELL: Object to form,  5 calls for speculation.  6     A. I think some would get some  7 benefit from it because it would cause  8 them to rethink their situation and some  9 people would use black market and some  10 people would get a friend's oral  11 contraceptives, there will be all kinds  12 of ways of dealing with this and not all  13 necessarily bad and certainly not all  14 necessarily good.  15     Q. But using black market  16 hormones without a doctor's supervision,  17 is that necessarily bad?  18     A. Yes.  19     Q. We talked several hours ago I  20 think at this point about you and your  21 colleague, Ms. Novak, having written  22 letters of authorization for some minors  23 to receive gender-affirming hormone  24 therapy. I don't think I asked a followup  25 question. If you or Ms. Novak were --</p>	<p style="text-align: right;">Page 228</p> <p>1       STEPHEN B. LEVINE, M.D.  2 thinking that they're transgender.  3     Q. So I'm not sure if that  4 answers my question.  5       Have you made a decision to no  6 longer provide letters --  7     A. Oh, I'm sorry. No, I haven't  8 made that decision.  9     Q. So would it be a case-by-case  10 basis, if there were a patient that you  11 felt it was appropriate for you would  12 consider doing it, say, a 17-year-old or  13 16-year-old?  14       MR. CANTRELL: Object to form.  15     A. I don't have a -- yes. The  16 answer to your question is yes.  17     Q. Do you think it would be  18 beneficial to have clinical trials on the  19 safety and effectiveness of  20 gender-affirming medical care for minors?  21     A. Absolutely, yes.  22     Q. And does that mean you would  23 favor allowing minors to receive  24 treatment in the context of -- let me ask  25 you in a better way.</p>
<p style="text-align: right;">Page 227</p> <p>1       STEPHEN B. LEVINE, M.D.  2 well, let me ask it differently.  3       Have you made a decision to no  4 longer consider hormone therapy for  5 anybody who has not reached their 18th  6 birthday since you provided those  7 letters?  8     A. I've made a decision to be  9 very cautious and to put a period of time  10 in therapy between me and the letter.  11 That's the decision I've made. I've also  12 made the decision, based upon two parents  13 I've seen who wanted their child to be  14 given puberty blockers, that oftentimes  15 it is the mother who needs therapy rather  16 than the child.  17       So my policy, and I think and  18 my team, none of us are interested in  19 providing puberty-blocking hormones based  20 upon our limited experience with this.  21 And I think, generally speaking, we want  22 to have the evaluation psychotherapy  23 process, that I've already described to  24 you, as a matter of therapeutic approach  25 to children, adolescent children who are</p>	<p style="text-align: right;">Page 229</p> <p>1       STEPHEN B. LEVINE, M.D.  2       You would be supportive of  3 clinical trials that would, as I  4 understand it, necessarily mean that some  5 minors would be receiving  6 gender-affirming medical care as part of  7 those trials, correct?  8     A. I'm all in favor of a  9 national, multisite, carefully designed  10 study to answer the questions that we've  11 been struggling over for the last four  12 hours and 30 minutes. I have great  13 respect for the processes of science,  14 even though I know that science too has  15 limitations. But the limitations of  16 science are far less than the limitations  17 of individual doctors and their  18 passionate beliefs.  19     Q. So just to make sure I  20 understand it, a clinical trial  21 necessarily entails minor patients being  22 provided that treatment and then compared  23 to a control group that would not be  24 providing the hormone therapy, do I  25 understand that correctly?</p>

<p style="text-align: right;">Page 230</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   A clinical trial, it begins</p> <p>3 with a question and it -- it begins with</p> <p>4 a question and then it has a primary</p> <p>5 endpoint and then a set of secondary</p> <p>6 endpoints. And it has a means of</p> <p>7 evaluating those -- the primary and</p> <p>8 secondary endpoints that are agreed upon</p> <p>9 in advance, and in addition, it has a</p> <p>10 decision about when that -- those primary</p> <p>11 endpoints are going to be looked into,</p> <p>12 and when the secondary endpoints are</p> <p>13 going to be looked into, and there is an</p> <p>14 informed consent process to enter into</p> <p>15 the treatment process, and it has</p> <p>16 different groups, or what we call in</p> <p>17 methodology, different arms of the study,</p> <p>18 you see, and it often -- it sometimes has</p> <p>19 a placebo-controlled period, and then an</p> <p>20 arm where it divides into more placebo or</p> <p>21 this kind of treatment, and then this</p> <p>22 kind of treatment, you see.</p> <p>23       So I think in order to get the</p> <p>24 numbers that scientists would respect as</p> <p>25 having a robust what we call "N" or</p>	<p style="text-align: right;">Page 232</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 exception for minors who participate in</p> <p>3 clinical trials?</p> <p>4       MR. CANTRELL: Object to form.</p> <p>5     A.   I don't think that's what's in</p> <p>6 that law. I think if we had that study</p> <p>7 the prosecutors would bless that study.</p> <p>8     Q.   Right. So you think the law</p> <p>9 allows for those kind of clinical trials,</p> <p>10 that's your reading of the law?</p> <p>11    A.   I don't think in America --</p> <p>12 what I just said about the study is not</p> <p>13 an idea that is part of the dialogue of</p> <p>14 -- the culture war dialogue that's going</p> <p>15 on in America. It's much more a European</p> <p>16 concept. It's like science doesn't matter</p> <p>17 in this subject, it's only therapeutic</p> <p>18 fashion and it's only the passionate</p> <p>19 conviction of doctors that matter here.</p> <p>20       So I think that if we could --</p> <p>21 if on a national basis or on a multistate</p> <p>22 basis we could get together a group of</p> <p>23 research centers to do this, places like</p> <p>24 Arkansas would sign onto it and if we</p> <p>25 needed an exception -- if we needed a</p>
<p style="text-align: right;">Page 231</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 numbers we would have to have a</p> <p>3 multistate or multicenter study using the</p> <p>4 same protocol, approved by what's called</p> <p>5 an IRB, and that is a review body, to see</p> <p>6 to the efficacy of the study, the wisdom</p> <p>7 of the study and the morality of the</p> <p>8 study, the ethics of the study. I'm all</p> <p>9 in favor of that, because that's the way</p> <p>10 we advance, you see. And we also -- that</p> <p>11 study has to have a prolonged followup.</p> <p>12       So an individual place, you</p> <p>13 know, an individual child clinic can</p> <p>14 publish its results, but it can't do the</p> <p>15 same thing as a multisite study can do.</p> <p>16 And in the United States this is so</p> <p>17 cryingly necessary. And the trouble is</p> <p>18 the government has to fund this. These</p> <p>19 are very expensive things but it's</p> <p>20 certainly a worthy study to undertake.</p> <p>21 And yes, that is something I would be</p> <p>22 advocate, that's something I would</p> <p>23 advocate for.</p> <p>24     Q.   And are you aware that the</p> <p>25 Arkansas law in this case doesn't make an</p>	<p style="text-align: right;">Page 233</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 ruling from the Attorney General of this</p> <p>3 state or that state, I can't imagine the</p> <p>4 Attorney General would say no to a study.</p> <p>5 Because I think this law is saying you,</p> <p>6 doctors, are not studying this subject</p> <p>7 and, therefore, we're going to ban this</p> <p>8 because there is a lot of indications</p> <p>9 that we're harming our youth, you see.</p> <p>10 But if you give them the science and say</p> <p>11 we can restrict this, we can restrict the</p> <p>12 treatment to families who qualify for the</p> <p>13 protocol so we can answer the question in</p> <p>14 five years and it's going to take three,</p> <p>15 four, five years to begin the first step</p> <p>16 in answering the question, then I think</p> <p>17 probably whatever state you're talking</p> <p>18 about would be very susceptible, would be</p> <p>19 amenable to this.</p> <p>20       Now, I don't have a crystal</p> <p>21 ball and maybe I don't understand the</p> <p>22 politics of various states, obviously I</p> <p>23 don't, but that's my opinion or that's my</p> <p>24 speculation.</p> <p>25     Q.   So if you were involved or if</p>

<p style="text-align: right;">Page 234</p> <p>1       STEPHEN B. LEVINE, M.D.  2 somebody were to ask you about a law like  3 this would you favor having an exception  4 for participation in clinical trials?  5       MR. CANTRELL: Object to form.  6     A.   If -- if some legislator asked  7 me for my opinion I would be happy to  8 share a similar opinion that I just gave  9 you.  10       MS. COOPER: Okay. Let's mark  11 tab 10, please.  12       (Exhibit Levine 6, Declaration  13 of Dr. Stephen B. Levine, dated  14 July 2021, was received and marked  15 on this date for identification.)  16     A.   You're preparing a new  17 exhibit?  18     Q.   Yes. We'll let you know. Okay.  19 It's available now. If you can open  20 Exhibit 6.  21     A.   It's open.  22     Q.   Okay. Great. We're looking at  23 Exhibit 6. Do you recognize this  24 document?  25     A.   I do.</p>	<p style="text-align: right;">Page 236</p> <p>1       STEPHEN B. LEVINE, M.D.  2 identification for genetically male boys,  3 adolescents, and men or return to female  4 identification for genetically female  5 girls, adolescents, and women."  6       I know you wrote this about a  7 year ago. Is that still your view, is  8 that still correct?  9     A.   Well, there has been more  10 anecdotal evidence since that time but in  11 the strict scientific way, in the way  12 that you and I were just talking about, a  13 future study for medical intervention, we  14 still have the same paucity of  15 information, we have still only anecdotal  16 reports, even though some people collect  17 a series of cases in their anecdotal  18 reports but they still are scientifically  19 anecdotal only.  20       The field of psychotherapy  21 finds it more difficult to do controlled  22 studies but there have been controlled  23 studies than medication treatments.  24 Because medication treatments often have  25 to do with this drug versus various doses</p>
<p style="text-align: right;">Page 235</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Is this a declaration you  3 submitted in this case back in July of  4 '21?  5     A.   Yes.  6     Q.   If we can scroll all the way  7 down to paragraph 35, let me know when  8 you found that.  9     A.   I just bypassed it. 35.  10    Q.   Why don't you take a moment to  11 read the full paragraph. If you could  12 just read the paragraph.  13    A.   Sorry. Say that again?  14    Q.   If you could just read the  15 full paragraph.  16    A.   To myself, item 35? Just that  17 paragraph, right?  18    Q.   Just that paragraph. Have you  19 finished reading?  20    A.   I've read it.  21    Q.   I want to read together just  22 the first sentence, "To my knowledge,  23 there is no credible scientific evidence  24 beyond anecdotal reports that  25 psychotherapy can enable a return to male</p>	<p style="text-align: right;">Page 237</p> <p>1       STEPHEN B. LEVINE, M.D.  2 of drugs or drugs versus placebo. It's,  3 you know, hard to do placebo-controlled.  4       In psychotherapy studies  5 placebo controls are really weightless  6 placebo. But the answer is yes, it's  7 still -- actually, I wrote the same thing  8 in the article that was published six  9 weeks ago, so...  10    Q.   But it's not outdated, I just  11 wanted to check; is that right?  12    A.   Sorry. I didn't understand  13 your question.  14       MR. CANTRELL: We're having a  15 little bit of trouble understanding  16 you. I'm not sure what has  17 happened.  18       MS. COOPER: Okay. I'll try  19 again. So far so good?  20       THE WITNESS: As long as your  21 head is straight. You see when you  22 look down I have trouble.  23    Q.   I need a little podium.  24       So I just wanted to confirm  25 that, and I think you have, that the</p>

<p style="text-align: right;">Page 238</p> <p>1       STEPHEN B. LEVINE, M.D.  2 statement that there is no credible  3 scientific evidence beyond anecdotal  4 reports that psychotherapy can enable a  5 return to male identification for  6 genetically male boys, adolescents or men  7 or return to female identification for  8 genetically female girls, adolescents and  9 women, that that's still the state of the  10 science?  11     A.   Yes. I just came from a  12 symposium two days ago where two people  13 talked about their psychotherapy helping  14 people to desist, what we call desist or  15 detransition through psychotherapy. So  16 these are, again, anecdotal reports.  17 Basically psychiatry has a lot of those  18 anecdotal reports.  19     Q.   Who were those clinicians or  20 those that spoke about their experience?  21     A.   You want their names?  22     Q.   Yes, please.  23     A.   One was Sasha Ayad and the  24 other was Lisa Marchiano.  25       MS. COOPER: Can we mark as</p>	<p style="text-align: right;">Page 240</p> <p>1       STEPHEN B. LEVINE, M.D.  2     A.   Okay.  3     Q.   And in this paragraph -- well,  4 why don't you take a minute to read the  5 paragraph.  6     A.   Actually, I'm pretty familiar  7 with that.  8     Q.   Okay. Yes, we discussed  9 different types of scientific evidence,  10 correct?  11     A.   It's a hierarchy of the  12 trustworthy evidence, the risk or the  13 chances the evidence will prove to be  14 factually valid. In that sense it's a  15 hierarchy.  16     Q.   Understood. The anecdotal  17 evidence you described a few moments ago  18 regarding psychotherapy, helping patients  19 have a return to their natal gender  20 identity, is that -- does that fit within  21 B, a single case or a series of cases  22 what could be called anecdotal evidence?  23 Is that how you would describe that?  24     A.   Well, you see A and B are  25 pretty low. But at least when someone</p>
<p style="text-align: right;">Page 239</p> <p>1       STEPHEN B. LEVINE, M.D.  2 the next exhibit tab 6?  3       (Exhibit Levine 7, Declaration  4 of Stephen B. Levine, MD dated  5 December 9, 2021 was received and  6 marked on this date for  7 identification.)  8     Q.   You can refresh and it will be  9 there, Exhibit 7.  10     A.   It's not there yet.  11     Q.   So Exhibit 7, do you recognize  12 that as a declaration that you submitted  13 in this case -- I'm scrolling down to the  14 signature block, on page 93, December 9th  15 2021?  16     A.   I don't have the date in front  17 of me, but I trust you.  18     Q.   If you go to page 93 you can  19 see. I'm sorry, page 93 on the document.  20     A.   Oh, that's the date. That's  21 what you had me see.  22     Q.   I just wanted you to look at  23 that and understand what you're looking  24 at here. Now, I'd like you to go to  25 paragraph 88.</p>	<p style="text-align: right;">Page 241</p> <p>1       STEPHEN B. LEVINE, M.D.  2 publishes a case history, especially case  3 history that's not a paragraph but an  4 extended case history, where the readers  5 can understand the dynamic forces  6 involved in the patient's life, that's  7 much better than a person like me  8 pontificating, or a patient like one of  9 your Plaintiffs' experts pontificating  10 based on what they think exists in the  11 world.  12       So I know lay people don't  13 understand this, but they think he's an  14 expert, you know, he's a doctor, he's an  15 expert. But lay people often don't  16 understand the limitations of what  17 doctors know or experts know. But you  18 have a different sense of what expert  19 means in the law. You have to qualify to  20 be an expert in the law. But in terms of  21 reliability of information, a single case  22 history and even a series of case  23 histories, is still anecdotal evidence.  24     Q.   And that's the category that  25 the evidence you talked about regarding</p>

<p style="text-align: right;">Page 242</p> <p>1       STEPHEN B. LEVINE, M.D.  2 psychotherapy, allow return to --  3     A.   Well, it's also the same kind  4 of evidence that passionate believers in  5 the hormone therapy have, based on their  6 case experience, even if they write it  7 up, so to speak.  8     Q.   Well, I wasn't asking about  9 that. I'm just asking about your -- the  10 evidence you talked about regarding --  11 that you call anecdotal evidence about  12 returning to your natal -- having a  13 gender identity that matches your natal  14 sex, that is the level of evidence we  15 have at this point, correct?  16     A.   Are you talking about my case  17 history that I published?  18     Q.   No. I'm talking about the body  19 of existing scientific evidence showing  20 that psychotherapy can cause a return to  21 your gender identity that matches your  22 sex assigned at birth, is that limited to  23 --  24     A.   Yeah, sometimes that's called  25 --</p>	<p style="text-align: right;">Page 244</p> <p>1       STEPHEN B. LEVINE, M.D.  2 received hormone blocking --  3 puberty-blocking hormones. And based on  4 the results of those studies there was  5 total inconsistency from one study to  6 another about the results. There was --  7 there was no appreciation that along with  8 puberty blocking agents, other things  9 were being given to the patient, like  10 antidepressants, for example. There was  11 very little appreciation of the effects  12 of maturation and there was no control  13 group to effect -- to see how kids mature  14 between, say, 11 and 14. And so the  15 results of that cohort study, which is  16 higher than a case report because it's a  17 series of cases and multiple studies of a  18 series of cases from various centers, the  19 results were that, at best, the results  20 of puberty-blocking hormones were  21 inconclusive and they certainly didn't  22 demonstrate with scientific certainty  23 that puberty-blocking hormones were  24 beneficial.  25       So you can see that even if</p>
<p style="text-align: right;">Page 243</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   Let me finish the question,  3 I'm sorry, just for the record.  4       That would fall within under  5 B, a single case or series of cases what  6 could be called anecdotal evidence?  7     A.   Yes.  8     Q.   Okay. Now, you had started to  9 talk about the research we have on --  10 maybe not the research but the use of  11 hormone therapy to treat minors with  12 gender dysphoria.  13       Which categories of research  14 or evidence do we have that shows or  15 addresses -- let me ask that again. I  16 muddled it. I'm sorry.  17       What categories of your  18 categories A through G, that you conclude  19 here, do we have assessing  20 gender-affirming medical care for minors?  21     A.   Well, if you look at some of  22 the reviews for puberty-blocking  23 hormones, I think one of the reviews  24 looked at ten studies. These were cohort  25 studies, that is groups of people who</p>	<p style="text-align: right;">Page 245</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you go from up to a cohort study, but if  3 the cohort study doesn't have a control  4 group, I guess it's not really -- it's a  5 series of cases without a control group,  6 it really doesn't -- it doesn't give you  7 a lot of certainty that this is correct.  8       And you see, in our field of  9 transgender care, we don't have -- we  10 don't have E, and I'm not even sure -- we  11 don't have a cohort study with a serious  12 control group. And so we're really left  13 at the level somewhere B+ perhaps or C-,  14 because we don't have a control group.  15 This is still a low level, Ms. Cooper,  16 this is not -- this is not robust.  17     Q.   So you don't have cohort  18 studies, B?  19     A.   We don't have cohort studies  20 with control groups.  21     Q.   By B you meant cohort study  22 with control group, is that in the  23 definition of cohort study that would be  24 involved?  25     A.   Maybe I haven't stated that</p>

<p style="text-align: right;">Page 246</p> <p>1       STEPHEN B. LEVINE, M.D.  2 correctly. Maybe I should have said a  3 cohort study with a control group. But  4 that's generally -- you know, anything --  5 you see from A to -- A to D is just, it's  6 not robust. It's not -- it's not  7 powerful. And one study is not powerful.  8 We need multiple studies from various  9 times and various places from various  10 perspectives and we have that potential  11 in gender medicine. We have Australia and  12 Canada and Amsterdam and Sweden, we have  13 Boston, we have other cities throughout  14 America. This could be done. This could  15 be done. And it's not being done.  16       Anyway, that's not your  17 question, I guess, so ask your question.  18       Q.   It's fine. Now, double-blind  19 clinical trial, that couldn't be done,  20 right, for gender-affirming hormone  21 therapy, right? Could it be blinded? How  22 would that be possible?  23       A.   May I answer that question in  24 detail?  25       Q.   Let's get started and see.</p>	<p style="text-align: right;">Page 248</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A.   I presume you know,  3 Ms. Cooper, that I am a psychiatrist,  4 right?  5       Q.   I do.  6       A.   A psychiatrist. And you know  7 that psychotherapy, psychiatrists my age,  8 my vintage, have been trained in doing  9 therapy with people and some of it is  10 short-term and some of it is long-term.  11 And psychiatrist -- the psychotherapeutic  12 process in therapy has never really been  13 submitted to the rigors of randomized  14 controlled studies.  15       So of course the answer to  16 your question is that I do therapies that  17 are not based on randomized controls.  18       Q.   Do you treat patients with  19 medication?  20       A.   Oh, of course I treat patients  21 with medications, and the medications  22 that are FDA approved for certain  23 indications are the result -- the modern  24 ones, not the ones that were accepted 50  25 years ago, in practice 50 years ago --</p>
<p style="text-align: right;">Page 247</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A.   Well, it's going to take some  3 time. I don't know if you want me to take  4 all this time. I'll be happy to answer --  5       Q.   Let me ask a different  6 question. Do you think it could be  7 blinded?  8       A.   Yes.  9       Q.   Okay. That's fine.  10       Are there treatments that you  11 provide to patients -- well, let me ask  12 it differently.  13       Do you only provide treatments  14 to patients that have the benefit of  15 randomized controlled clinical trials?  16       MR. CANTRELL: Object to form,  17 vague.  18       Q.   Let me restate that. You're  19 right. It was vague.  20       Do you only provide treatments  21 to patients that are supported by  22 evidence that includes randomized  23 controlled clinical trials?  24       MR. CANTRELL: Same  25 objections.</p>	<p style="text-align: right;">Page 249</p> <p>1       STEPHEN B. LEVINE, M.D.  2 but the modern ones are all the process  3 of double-blind placebo triple trials,  4 the kinds of control trials that I  5 already described to you, multisite,  6 different cultures, different dose  7 toggles (sic) and so forth.  8       Q.   Do you never prescribe  9 off-label drugs, drugs for off-label use?  10       MR. CANTRELL: Object to form.  11       A.   Yes. There are times that I've  12 prescribed drugs for off-label use. That  13 is not the same as making me say that all  14 drugs off-label are equally judicious.  15       Q.   Understood. So in your view  16 the fact that a drug is being used for  17 off-label purpose doesn't, by itself,  18 mean it's an improper use of the drug?  19       A.   Does it mean what?  20       Q.   It doesn't, by itself, mean  21 that there is anything wrong with using  22 the drug for that purpose?  23       A.   If we want to use that gross  24 generalization that you made, of course  25 you're right.</p>



<p style="text-align: right;">Page 250</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Well, help inform me. Let me</p> <p>3 ask it more precisely.</p> <p>4       I think you just said you have</p> <p>5 used drugs for off-label uses; is that</p> <p>6 right?</p> <p>7     A.   I think you and I are</p> <p>8 misunderstanding each other at this</p> <p>9 point. Yes, I said that.</p> <p>10    Q.   Okay. I understand. I'm not</p> <p>11 talking about randomized controlled</p> <p>12 clinical trials. I'm just asking about</p> <p>13 off-label drug use.</p> <p>14    A.   Well, I think you know in</p> <p>15 medicine off-label drug use is very</p> <p>16 common in probably every field, including</p> <p>17 psychiatry. The wisdom of that depends</p> <p>18 on the drug and what's known about it,</p> <p>19 what the benefits and the risks are.</p> <p>20    Q.   Does the fact that a use of</p> <p>21 the drug is off-label necessarily mean</p> <p>22 it's an experimental use of the drug?</p> <p>23    A.   Just that alone does not mean</p> <p>24 it's experimental. It just means that it</p> <p>25 doesn't have the rigor of a scientific</p>	<p style="text-align: right;">Page 252</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 insomnia is a lot different than giving</p> <p>3 somebody a drug that stops their</p> <p>4 menstruation, for example. So we need to</p> <p>5 be judicious about not comparing apples</p> <p>6 to zebras.</p> <p>7     Q.   I want to switch topics and</p> <p>8 talk about the desistance literature.</p> <p>9       Do you know what I mean when I</p> <p>10 refer to the desistance literature?</p> <p>11    A.   The persistence literature, is</p> <p>12 that what you said?</p> <p>13    Q.   The desistance literature.</p> <p>14       MR. CANTRELL: Desistance.</p> <p>15    A.   Desistance, the desistance</p> <p>16 literature?</p> <p>17    Q.   Yes. Does that -- you</p> <p>18 understand what I'm referring to when I</p> <p>19 talk about that body of research?</p> <p>20    A.   Yes.</p> <p>21    Q.   I'm just making sure. I just</p> <p>22 have a few questions about that.</p> <p>23       Is it correct that these</p> <p>24 studies found that most prepubertal</p> <p>25 children who had been diagnosed with</p>
<p style="text-align: right;">Page 251</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 basis for its use.</p> <p>3       So if I use an off-label drug</p> <p>4 to get someone to go to sleep at night,</p> <p>5 because I have experience that the drug</p> <p>6 is helpful in 50% of the time that I give</p> <p>7 it approximately, and I don't really</p> <p>8 think much harm will come unless they</p> <p>9 have nightmares and then they won't use</p> <p>10 the drug again, that's a very different</p> <p>11 thing than using an off-label drug that's</p> <p>12 going to change the physiology of a</p> <p>13 person's life permanently or at least for</p> <p>14 a very long period of time.</p> <p>15    Q.   Okay.</p> <p>16    A.   So I know where you're going</p> <p>17 here, that hormones are used on an</p> <p>18 off-label basis and the FDA has not</p> <p>19 approved them, and they've never been</p> <p>20 treated to a randomized</p> <p>21 placebo-controlled trial. But of course,</p> <p>22 the implications of using a mild</p> <p>23 antidepressant that's soporific to help</p> <p>24 people to sleep that has not been</p> <p>25 approved for insomnia but is used for</p>	<p style="text-align: right;">Page 253</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 gender identity disorder, I believe, had</p> <p>3 desisted by puberty; is that correct?</p> <p>4     A.   If you and I are referring to</p> <p>5 the same body of studies, then that's</p> <p>6 correct. I'm not sure what studies you're</p> <p>7 referring to, but I am aware of a group</p> <p>8 of studies that have shown that under</p> <p>9 certain circumstances, non-intervention,</p> <p>10 that 11 of 11 studies have shown that</p> <p>11 children desist, the majority of children</p> <p>12 desist by the time they're somewhere in</p> <p>13 adolescence. Sometimes that's referred to</p> <p>14 puberty, but I really think it's later in</p> <p>15 adolescence, since puberty is a variable</p> <p>16 period of time.</p> <p>17    Q.   And a number of these studies</p> <p>18 were done by Ken Zucker; is that correct?</p> <p>19    A.   A number of studies?</p> <p>20    Q.   Some of these studies were</p> <p>21 done by Ken Zucker; is that correct?</p> <p>22    A.   Yes. Yes. He was one of the</p> <p>23 coauthors of several followup studies,</p> <p>24 yes.</p> <p>25    Q.   Did any of these studies show</p>

<p style="text-align: right;">Page 254</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that youth who continue to have gender  3 dysphoria in adolescence were likely to  4 desist?  5     A. I think the literature of  6 desistance about the people who begin  7 their gender identity, their transgender  8 identity in adolescence is really far  9 less clear and less developed than what  10 the cross-gender identified younger  11 children, that's what those 11 studies  12 referred to.  13     Q. I think my question maybe  14 wasn't clear because I meant to convey  15 something differently.  16       If you're talking about just  17 the population of people who had gender  18 dysphoria from early childhood, the  19 studies that looked at -- actually, let  20 me take that back.  21       For individuals who have  22 gender dysphoria from early childhood and  23 continue to have gender dysphoria after  24 puberty begins, is there any evidence  25 indicating a likelihood of desistance in</p>	<p style="text-align: right;">Page 256</p> <p>1       STEPHEN B. LEVINE, M.D.  2 has gender dysphoria, say, at age 14,  3 that that would be likely to desist?  4     A. Well, I happen to know of a  5 woman who had gender dysphoria, who now  6 has lived as a woman, a cis woman for  7 years and years and years. And the  8 reason she's sort of studied this subject  9 and is sort of an expert in this subject  10 is that she persisted when during your  11 adolescence for a while. And I happen to  12 know, which I think you probably are  13 aware of, the previous studies among --  14 among male-identified homosexual men,  15 that two-thirds of them have a history of  16 having very strong feminine  17 identifications when they were children.  18 And I don't know if they all had gender  19 dysphoria because when they were younger  20 we weren't really looking at that term,  21 we didn't even have this concept. But  22 feminine -- among homosexual adult males,  23 many of them recognize that they had a  24 long period of time when they wanted to  25 be a girl, and that they behaved in</p>
<p style="text-align: right;">Page 255</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that population of patients?  3     A. You mean if with childhood  4 onset gender dysphoria, we'll just take  5 those 11 studies and summarize them  6 inaccurately as, say, 22% persist, okay?  7 You're asking me, is there any evidence  8 that I'm aware of among those 22 kids who  9 persist, do any of those children  10 subsequently desist? Is that the question  11 you asked me?  12     Q. Let's start there, if you  13 could answer that question?  14     A. I don't know the answer to  15 that question. But I want to be clear,  16 that's what I thought you were asking.  17     Q. Okay.  18     A. So I'm asking you, was that  19 the question you were asking me?  20     Q. It wasn't exactly but I  21 understand that that's what you were  22 answering, so I will ask differently.  23       Are you aware of any evidence  24 indicating that somebody who has gender  25 dysphoria from early childhood and still</p>	<p style="text-align: right;">Page 257</p> <p>1       STEPHEN B. LEVINE, M.D.  2 feminine ways.  3       Now, most of these people, and  4 I can tell you from Richard Green's study  5 published in 1988, The Sissy Boy  6 Syndrome, I think the numbers were -- he  7 followed for 15 years 88 children who  8 were cross-gender identified. The sample  9 came from both New York and from  10 California, he actually worked in both  11 places bi-coastally. And 86 of those  12 children grew up to be non-cross-gender  13 identified, two of them declared  14 themselves to be transgender and I think  15 like a handful declared themselves to be  16 heterosexual, but the majority of those  17 cross-gender identified children grew up  18 to be homosexual in their orientation to  19 men, to their same cisgender people.  20       So that was the Richard Green  21 study from 1988, and I think that begins  22 to answer your question. But none of  23 those children were, you know, affirmed  24 socially trans, you know, no pediatrician  25 said you ought to live as a little girl,</p>

<p style="text-align: right;">Page 258</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know, and nobody was giving  3 puberty-blocking hormones.  4     Q. But they were first assessed  5 during pre-pubertal childhood, right, you  6 would agree?  7     A. They were all identified as  8 cross-gender identified little boys who  9 wanted to be little girls, yeah.  10    Q. So you mention there is a  11 woman you know who desisted after  12 adolescence and has been studying the  13 issue.  14       My question was, is there any  15 evidence that it's likely that people who  16 start experiencing gender dysphoria in  17 early childhood and continue to  18 experience it in early adolescence are  19 likely to desist, the way we have that  20 evidence about prepubertal kids?  21    A. I can only answer that  22 question tangentially.  23       You are aware that there are  24 increasing numbers of people who are  25 coming out of the woodwork saying that</p>	<p style="text-align: right;">Page 260</p> <p>1       STEPHEN B. LEVINE, M.D.  2 treatment, and another 20% were lost to  3 followup, some of whom may have come back  4 for treatment later. And there was a  5 second study by Boyd, et al, the first  6 one I mentioned is by Hall, and that's a  7 group of people who were started on  8 hormones on an average age of 20 and in a  9 five-year followup almost 30% of those  10 people had desisted.  11       So we're beginning to get  12 information about the rate of desistance  13 which in some people's language is the  14 rate of error, although, I'm not sure  15 that is the right language. It's the  16 error rate of making -- the patient  17 decides it was an error, even though some  18 of them say, well, it wasn't really -- I  19 don't want to do this anymore but I don't  20 regret having taken hormones for X years  21 because it's helped me decide who I am  22 and what I want to be now.  23       So you know these are very  24 difficult, complicated, nuanced kind of  25 distinctions that we're making about</p>
<p style="text-align: right;">Page 259</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they have detransitioned and many of  3 those children, many of those adults or  4 older people, older teenagers, many of  5 those kids -- I mean, I don't know what  6 proportion of those children were  7 cross-gender identified as children, many  8 of them probably were -- had onset of  9 transgender identities shortly after  10 puberty.  11       But I think the answer to your  12 question, in a tangential way, is I'm  13 aware that people detransition after  14 prolonged periods of time of medical  15 treatment or even just certain  16 non-medical but cross-gender identified  17 identities. But I can't -- I can tell you  18 about two recent studies that were  19 published and I became aware of them in  20 the beginning of this year, so it's not  21 in my report, they're both from the U.K.  22 and one of them was a 16-month followup  23 after being started on hormones and at 16  24 months there were a total of 10% of the  25 kids had desisted from their hormone</p>	<p style="text-align: right;">Page 261</p> <p>1       STEPHEN B. LEVINE, M.D.  2 regret and desistance and so forth.  3     Q. Can I ask you -- I think I  4 didn't hear, when you said the rate of  5 desistance in that second study you  6 mentioned by Boyd, what percentage was  7 that? I just didn't hear.  8     A. I think up to 30% of people  9 were no longer taking treatment with  10 hormones after five years.  11    Q. The connection busted up right  12 as you said that. Can you repeat it?  13    A. I said this is the Boyd, et al  14 study from the U.K. published in this  15 year, I think. And I forget the numbers  16 at this point, but actually it's quoted  17 in my paper, and the specific numbers are  18 in my paper. But my general recollection  19 is that there was a five-year followup.  20 The average age of entering -- of getting  21 hormones was 20 and by 25 there was a  22 large, very impressively large dropout  23 rate from hormone treatment. And the  24 authors stated that, given the  25 uncertainties about this, and the</p>

<p style="text-align: right;">Page 262</p> <p>1       STEPHEN B. LEVINE, M.D.  2 difficulties in following up people, it  3 may very well be that we have vastly  4 underestimated the number of people who  5 discontinue hormones just because we  6 don't have these careful followup  7 studies. I believe the Boyd, et al study  8 was basically getting hormones in primary  9 care settings.  10    Q.   And you believe it was a 30%  11 rate of desistance from the numbers they  12 had?  13    A.   I think, you know, I could  14 look it up on my paper, but that's what  15 --  16    Q.   That's okay. Is that right,  17 you don't remember?  18    A.   That's what I remember but,  19 you know, who knows what people remember  20 accurately.  21    Q.   Do you remember whether it was  22 a majority or a minority of the --  23    A.   No. It was about 30. It  24 wasn't 60. It was 30. Maybe it was 28-7,  25 you know.</p>	<p style="text-align: right;">Page 264</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for affirmative care of adolescence  3 actually consider it to be an  4 alternative. It's where there is  5 disagreement, you know.  6       And just to go back to the  7 earlier part of your question, watchful  8 waiting can mean sometimes do nothing but  9 followup the patient in three months or  10 six months, whatever, regularly, to see  11 how this works out, sometimes -- that  12 would be one form of watchful waiting.  13 The other form of watchful waiting would  14 be to take the parents in and talk to the  15 parents and leave the kid alone and then  16 help the parents deal with their  17 intrafamilial issues. The third form of  18 watchful waiting might be to not deal  19 with the child's gender identity, but to  20 deal only in a therapeutic process with  21 the other issues, the other developmental  22 challenges that the child has, but just  23 leave the gender identity alone with the  24 assumption that perhaps gender identity  25 is an epiphenomenon of some other</p>
<p style="text-align: right;">Page 263</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Are you familiar with the  3 watchful waiting approach to minors with  4 gender dysphoria?  5    A.   I know that term, yes.  6    Q.   And do you understand -- what  7 do you understand that term to mean?  8 Let's make sure we're on the same page.  9    A.   Well, I think -- I think you  10 know from my expert opinion. I describe  11 this in my report. So do you want me to  12 repeat that?  13    Q.   Fair enough. I don't need you  14 to do that.  15       As described in your report,  16 is that an approach that is recognized as  17 applying to prepubertal children with  18 gender dysphoria?  19    A.   Well, it depends on the  20 practitioner. Watchful waiting was  21 certainly a concept that began with the  22 child onset gender dysphoria realm. It  23 has been -- it's a concept that's applied  24 to adolescents as well, but it certainly  25 is not a concept of people who advocate</p>	<p style="text-align: right;">Page 265</p> <p>1       STEPHEN B. LEVINE, M.D.  2 underlying problem. And if we can deal  3 with the underlying problem, perhaps the  4 child can one day make a clearer decision  5 about how he or she wants to live his  6 gendered life.  7       So that's my understanding of  8 watchful waiting. So I said three, but  9 sometimes I say it as two versions, but I  10 made a third version for you today  11 because I wanted to emphasize sometimes  12 the child is not getting treated at all,  13 but the parents are getting treated. And  14 then sometimes the parent and the child  15 is treated, but we're not focusing on  16 gender, per se. Whereas, if you do  17 give -- you know, socialize a child,  18 you're certainly treating them for their  19 gender.  20    Q.   Just one moment, I'm going to  21 show you an exhibit.  22       Has Ken Zucker been a leading  23 proponent of watchful waiting in the  24 field?  25    A.   Ken Zucker recently told me he</p>

<p style="text-align: right;">Page 266</p> <p>1       STEPHEN B. LEVINE, M.D.  2 -- he thinks he coined the term and he  3 was embarrassed about it.  4     Q.   Why was he embarrassed?  5     A.   It wouldn't be a term he would  6 use today, I think would be my  7 speculation. When he said that, I said I  8 didn't think you actually coined the term  9 "watchful waiting", because he's a  10 psychologist and I'm a physician. And  11 watchful waiting is a term that I think  12 grew up in medicine and in surgery and it  13 has a great deal to do with men's  14 prostate cancer, and when it's mild  15 enough we say that we're going to watch  16 -- we're going to practice watchful  17 waiting, we're not going to have an  18 intervention, we're going to get a --  19 perhaps you're familiar with the PSA  20 test, we're going to do a digital exam  21 and a PSA test every six months. And  22 it's only if your PSA or you get a nodule  23 in your prostate that we will intervene  24 surgically or through radiation.  25       So that has a long tradition</p>	<p style="text-align: right;">Page 268</p> <p>1       STEPHEN B. LEVINE, M.D.  2 within a relatively short period may also  3 be a common outcome for post-pubertal  4 youths who exhibit recently described  5 'rapid onset gender disorder.' I observe  6 an increasingly vocal online community of  7 young women who have reclaimed a female  8 identity after claiming a male gender  9 identity at some point during their teen  10 years. A recent review of  11 detransitioning claimed to have  12 identified 16,000 entries in a search of  13 proliferating websites devoted to this  14 topic. However, data on outcomes for this  15 age group with and without therapeutic  16 interventions is not yet available to my  17 knowledge."  18       So a couple of questions. That  19 16,000 number, that's not 16,000 stories  20 of detransition, is it?  21     A.   No. Those are 16,000 people  22 that Dr. Exposito-Campos identified as  23 being members of various groups with that  24 title. That doesn't tell us that each of  25 those persons have detransitioned. They</p>
<p style="text-align: right;">Page 267</p> <p>1       STEPHEN B. LEVINE, M.D.  2 in prostate medicine, in the urology  3 field. And I wouldn't be surprised --  4 you know, in the leukemia field we have  5 certain kinds of slow-growing leukemic  6 processes that we just watch. And  7 certainly in probably every field we have  8 watchful waiting for one condition or  9 another.  10       Certainly in child psychology  11 there are situations where we watch and  12 we wait and see if people outgrow  13 whatever the issue is.  14     Q.   Let's go back to Exhibit 7,  15 you may have that up, paragraph 78.  16     A.   I didn't -- I didn't  17 understand any word you just said.  18     Q.   That's terrible. Exhibit 7, if  19 you could go back to Exhibit 7, paragraph  20 78.  21       I'll read it together since it  22 is just the highlighted paragraph. It  23 says, "Desistance, (a patient's willing  24 reacceptance of their biological sex  25 through normal developmental processes)</p>	<p style="text-align: right;">Page 269</p> <p>1       STEPHEN B. LEVINE, M.D.  2 could be parents of kids, they could be  3 kids who are thinking about  4 detransitioning, they could be people who  5 have detransitioned, but that's still a  6 large number. And it raises the question  7 for you and I to think about, is  8 detransition is an issue that needs to be  9 thought about very carefully because some  10 of those people who would detransition  11 might regret having undergone these  12 medical treatments or these psychological  13 adaptations.  14       So it's just another  15 indication that I would say to all of us,  16 let's be careful here, this could be a  17 dangerous thing.  18     Q.   That 16,000 number doesn't  19 tell you anything about the number of  20 stories of detransitioners that are  21 included there, is there? Does it?  22       Let me ask you differently.  23 The number 16,000 doesn't tell you  24 about how many detransitioners are in  25 that group, does it?</p>

<p style="text-align: right;">Page 270</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   I think I just said that.</p> <p>3     Q.   Okay. Just making sure we're</p> <p>4 clear.</p> <p>5       Let's go to paragraph 70 in</p> <p>6 the same Exhibit 7. Let me know you're</p> <p>7 there.</p> <p>8     A.   Yes.</p> <p>9     Q.   Why don't you just read the</p> <p>10 paragraph to yourself.</p> <p>11    A.   I read it.</p> <p>12    Q.   Looking at the last sentence</p> <p>13 of the paragraph that's highlighted it</p> <p>14 says, "Two separate valuations, one from</p> <p>15 Canada and one from U.K., reviewed</p> <p>16 WPATH's guidelines and found them</p> <p>17 untrustworthy." And you have there a</p> <p>18 footnote, number 43 that cites a study by</p> <p>19 S. Dahlen, et al and then another one</p> <p>20 after that it says see also</p> <p>21 <a href="https://genderreport.CA/bias-not-evidence">https://genderreport.CA/bias-not-evidence</a></p> <p>22 -dominate-standard-of-care.</p> <p>23    A.   That's right.</p> <p>24    Q.   I'd like to focus on the</p> <p>25 second one. I just had some questions</p>	<p style="text-align: right;">Page 272</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Let's take a look.</p> <p>3     A.   I don't have -- I have that</p> <p>4 article at home.</p> <p>5     Q.   We'll pull it up. Maybe let's</p> <p>6 mark that as Exhibit 8, please.</p> <p>7       (Exhibit Levine 8, Canadian</p> <p>8 Gender Report, dated October 1,</p> <p>9 2019 was received and marked on</p> <p>10 this date for identification.)</p> <p>11    A.   Shall I go to that?</p> <p>12    Q.   It's not quite there yet. All</p> <p>13 right. It's available now.</p> <p>14    A.   Oh, MacRichards not McFarland.</p> <p>15 Sorry.</p> <p>16    Q.   If you read with me, we're</p> <p>17 looking at Exhibit 8, which is just, for</p> <p>18 the record, a document with a heading</p> <p>19 Canadian Gender Report. And then on the</p> <p>20 bottom of the first page it says, "The</p> <p>21 following investigative report was</p> <p>22 contributed by @Lisa MacRichards (a</p> <p>23 pseudonym)." And then goes on to say,</p> <p>24 "Lisa MacRichards works at a Canadian</p> <p>25 hospital and holds a Master of Science</p>
<p style="text-align: right;">Page 271</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 about that.</p> <p>3       Is that the report from Canada</p> <p>4 that you were referring to?</p> <p>5     A.   Yes.</p> <p>6     Q.   And you've reviewed that</p> <p>7 report, I take it?</p> <p>8     A.   I've read that report, yes.</p> <p>9     Q.   Okay. Was it published by a</p> <p>10 scientific organization?</p> <p>11    A.   The author was a journalist</p> <p>12 and I don't think it was published by a</p> <p>13 scientific organization. But if you read</p> <p>14 that review, it's very cogent and it's</p> <p>15 not -- in a different language form it</p> <p>16 says much of the same thing as the</p> <p>17 Dahlen, et al study.</p> <p>18    Q.   Do you know anything about the</p> <p>19 author?</p> <p>20    A.   No.</p> <p>21    Q.   The author was anonymous,</p> <p>22 right?</p> <p>23    A.   No. No.</p> <p>24    Q.   No?</p> <p>25    A.   Her name is I think McFarland.</p>	<p style="text-align: right;">Page 273</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 degree from the University of British</p> <p>3 Columbia", and some other text.</p> <p>4       So do you not understand -- is</p> <p>5 Lisa MacRichards her real name? Did I</p> <p>6 read that wrong or misunderstand?</p> <p>7     A.   I presume this is the same</p> <p>8 thing. The one I have at home doesn't</p> <p>9 exactly look like this, but I presume</p> <p>10 it's the same.</p> <p>11    Q.   So by reading, do you</p> <p>12 understand that to mean that Lisa</p> <p>13 MacRichards is not her real name?</p> <p>14    A.   I didn't remember when I told</p> <p>15 you this initially that it wasn't her</p> <p>16 real name, but it probably says that in</p> <p>17 my report too.</p> <p>18    Q.   Does that give you any concern</p> <p>19 about relying on a report if somebody is</p> <p>20 publishing it anonymously?</p> <p>21    A.   Actually, the Dahlen report</p> <p>22 gives me no concerns. The Dahlen report</p> <p>23 is a group of, a team of methodologists</p> <p>24 from different field who are expert in</p> <p>25 reviewing standards of care.</p>

<p style="text-align: right;">Page 274</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   I understand, but I'm asking</p> <p>3     you about this one.</p> <p>4     A.   But you see, the -- there are</p> <p>5     other people who looked at and tried to</p> <p>6     live with and understand the Standards of</p> <p>7     Care and have found them wanting. And so</p> <p>8     I could have easily just given the Dahlen</p> <p>9     report, but I thought it would strengthen</p> <p>10    it a little bit if we see that someone</p> <p>11    else has thought about this from a</p> <p>12    different continent, also looking at</p> <p>13    this.</p> <p>14       I could probably give more</p> <p>15    examples of people who don't follow the</p> <p>16    Standards of Care but to me the most</p> <p>17    important thing is that this report,</p> <p>18    whatever its limitations are, that it's</p> <p>19    not a scientific peer-reviewed journal,</p> <p>20    so to speak, it just happens to say</p> <p>21    similar things as the peer-reviewed</p> <p>22    scientific report says.</p> <p>23       And so, I don't know why --</p> <p>24    whoever Lisa MacRichards really is -- I</p> <p>25    don't know why she wants to use a</p>	<p style="text-align: right;">Page 276</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Standards of Care on the 7th Edition are</p> <p>3     good enough, you see.</p> <p>4       So the fact that there's a</p> <p>5     Lisa MacRichards to me is not just a big</p> <p>6     deal.</p> <p>7     Q.   Okay. You mentioned you</p> <p>8     distinguish this from peer-reviewed</p> <p>9     academic settings.</p> <p>10       What does that mean to be a</p> <p>11    peer-reviewed academic study? I think</p> <p>12    that was the term you used.</p> <p>13    A.   You're asking me what does</p> <p>14    "peer-reviewed" mean?</p> <p>15    Q.   Yeah, what does that mean?</p> <p>16    A.   That means when a person --</p> <p>17    I'll use myself, for example -- when a</p> <p>18    person submits an article to a journal,</p> <p>19    that it's first read by the editor and if</p> <p>20    it is viewed to be a reasonable</p> <p>21    submission, the editor usually sends it</p> <p>22    out to three people who have some</p> <p>23    knowledge of the subject area, and those</p> <p>24    are called the peer reviewers. Hopefully,</p> <p>25    they're really peers and, hopefully, they</p>
<p style="text-align: right;">Page 275</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     pseudonym. In my experience when people</p> <p>3     work for clinics that do trans care they</p> <p>4     sometimes, and they're objecting to it,</p> <p>5     rather than quit their jobs, as many</p> <p>6     people at the Tavistock Clinic quit over</p> <p>7     many years, I think they lost 60</p> <p>8     psychologists over five or ten years</p> <p>9     because of the trans care. So they</p> <p>10    developed a pseudonym and they write --</p> <p>11    they do research and they write what they</p> <p>12    think. And I think that's probably what</p> <p>13    Lisa MacRichards -- maybe her real name</p> <p>14    is McFarland, I don't know. So that's</p> <p>15    what I think.</p> <p>16       So it does give me concern but</p> <p>17    it doesn't -- it wouldn't make me think</p> <p>18    that that disqualifies this idea. I</p> <p>19    think even the committee that's doing the</p> <p>20    WPATH standards have reasons to criticize</p> <p>21    the 7th Edition of the Standards of Care.</p> <p>22       So the idea that the Standards</p> <p>23    of Care are what God has said and this is</p> <p>24    the truth and this is science, even the</p> <p>25    people in WPATH don't think that the</p>	<p style="text-align: right;">Page 277</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     know something about the subject</p> <p>3     material. And then those people write a</p> <p>4     critique, which then the editor puts</p> <p>5     together. So there are usually three</p> <p>6     reviewers to a paper, then the author,</p> <p>7     myself, gets back after several months,</p> <p>8     sometimes after nine months or ten</p> <p>9     months, we get back three critiques,</p> <p>10    three evaluations, independent</p> <p>11    evaluations, anonymous evaluations, I</p> <p>12    don't know who's doing it, and they often</p> <p>13    have criticisms and suggestions.</p> <p>14       Now, they're asked to make a</p> <p>15    decision, and they independently make the</p> <p>16    following decision; reject; have major</p> <p>17    revision; have minor revision, those are</p> <p>18    the choices they're usually given. And if</p> <p>19    the paper is not rejected it is -- if the</p> <p>20    paper is rejected, the author gets</p> <p>21    reasons for the deficiencies of the study</p> <p>22    or whatever the paper is, and they may</p> <p>23    decide to send it to a different journal.</p> <p>24    But if it's major revision, then between</p> <p>25    the three reviewers and the editor</p>

<p style="text-align: right;">Page 278</p> <p>1       STEPHEN B. LEVINE, M.D.  2 they're told exactly what's wrong with  3 the paper, even though it has merit, and  4 how they can fix the paper. And if it has  5 minor revisions, a similar thing happens  6 there are less points and they're  7 relatively -- they don't go to the heart  8 of the matter but they are much more to  9 round out the article. And so that's peer  10 review.  11       So what happens is then I, as  12 the journal writer, as the manuscript  13 writer then responds to the reviewer and  14 we make changes, oftentimes we make  15 changes in track changes mode, so that  16 the reviewers and the editor can see what  17 we've changed and we have to justify the  18 changes. And sometimes we agree with the  19 reviewer and sometimes we disagree. And  20 if we disagree, we have to state why we  21 disagree.  22       So we send that back and then  23 the reviewers get that material from us,  24 from me, us, and they then decide to  25 reject, to have another major</p>	<p style="text-align: right;">Page 280</p> <p>1       STEPHEN B. LEVINE, M.D.  2 reviewer who believes in affirmative care  3 and you look at the Panchankis article,  4 you say, look what the authors say, look  5 what they found, it's just -- it confirms  6 what I believe about that. So they're not  7 very critical about it.  8       So the peer review does not  9 guarantee factualness, it's just a way we  10 have to increase the likelihood of being  11 correct, reasonable science.  12       In the Panchankis -- the  13 Bränström-Panchankis study is a beautiful  14 case in point, that there is something  15 wrong within this field that we can't be  16 critical of certain work that's  17 affirmative to trans care.  18       Now, you probably know that  19 there were seven letters to the editor  20 that were so, so correct in pointing out  21 the deficiencies that Dr. Kalin, the  22 editor, then sent this out to two  23 additional reviewers, this would be  24 reviewer four and reviewer five. And  25 those two people looked at this study and</p>
<p style="text-align: right;">Page 279</p> <p>1       STEPHEN B. LEVINE, M.D.  2 modification, to a minor modification or  3 acceptance.  4       And that's the process of peer  5 review, as I understand it, and as I have  6 experienced it in the 152-or-so articles  7 that I have published.  8       Q. Does publication in a journal  9 that uses the peer-review process, is  10 that considered more reliable scientific  11 evidence than material published  12 elsewhere?  13       MR. CANTRELL: Object to form.  14       A. I don't think I understand.  15 Can I repeat the question to see if I  16 understand?  17       Q. I'll ask it differently.  18       Does the peer-review process  19 help insure that the research is  20 reliable?  21       A. Well, as you can tell from the  22 Bränström Panchankis study, sometimes  23 egregious errors are not picked up by the  24 reviewers, you see.  25       The trouble is if you're a</p>	<p style="text-align: right;">Page 281</p> <p>1       STEPHEN B. LEVINE, M.D.  2 said that the results of this study, the  3 conclusions of the study could not be  4 based on the data that were presented,  5 and that led to Dr. Kalin publishing the  6 seven original letters, which I think  7 that were 12 authors, but the two  8 independent statistical authors, which  9 were not published, and Dr. Kalin wrote a  10 little article about the process and  11 about the concerns about the paper, and  12 then the two original authors were asked  13 to write a response to all this and they  14 wrote what some people call a retraction,  15 but when people are -- don't like that  16 term, they wrote that more research was  17 necessary in order to reach the  18 conclusions that we reached in this  19 paper, that our paper did not prove -- we  20 understand it did not prove our  21 conclusions.  22       Q. I want to ask about the  23 peer-review process.  24       A. I think I just explained it.  25       Q. You did. In your field or</p>



<p style="text-align: right;">Page 282</p> <p>1       STEPHEN B. LEVINE, M.D.  2 among scientists is it understood which  3 journals are the peer-reviewed journals  4 and which are not?  5     A.   Oh, all the journals are  6 peer-reviewed. There are newspapers  7 that -- you know, like there is something  8 called Psychiatric Times. Psychiatric  9 Times asks me sometimes to write an  10 article and they sometimes send it out to  11 someone else to say it's okay or the  12 editor says, oh, you have to write it  13 differently. That is not what I call peer  14 review. You know, the Psychiatric Times  15 doesn't want to get sued or lose  16 readership or something outrageous, so  17 they check with someone else. And if you  18 look closely they have a board, an  19 editorial board that they send those  20 papers to for a quick "okay". But it's  21 very different than peer-reviewed, as I  22 originally described, and which failed in  23 the process of Bränström and Panchankis.  24     Q.   People in your field know the  25 difference between peer-reviewed in a</p>	<p style="text-align: right;">Page 284</p> <p>1       STEPHEN B. LEVINE, M.D.  2 concerns about the rapidity of  3 affirmative care and the lack of  4 evidence. That's why they named it The  5 Society For Evidence-Based Gender  6 Medicine. It's not about medicine, in  7 particular, it's confined to this  8 particular topic.  9       So many -- you know, I don't  10 know if you consider me a scientist, but  11 so there are many people who, like me,  12 are interested in this, are clinically  13 involved and who are interested in  14 exploring the scientific basis of this  15 subject because we, from our clinical  16 work, have developed the kind of worry  17 about what we're doing to people.  18       So I don't know if you would  19 agree that this is a scientific  20 organization. You probably would think  21 that the American Psychiatric Association  22 is a scientific organization, and they  23 would like to think they're a scientific  24 organization, but other people know that  25 it's a trade organization as well, who</p>
<p style="text-align: right;">Page 283</p> <p>1       STEPHEN B. LEVINE, M.D.  2 scientific journal and different kinds of  3 publications?  4     A.   Yes, I hope so. I think I  5 answered your question, right?  6     Q.   You did. I'm going to switch  7 gears now.  8       I want to talk about SEGM, as  9 you called them, and you cited to a  10 publication, I believe in paragraph 8,  11 SEGM -- I'm going to back to your report,  12 I'm sorry, Exhibit 7.  13     A.   Exhibit 7?  14     Q.   Yes. I believe you cited in  15 paragraph 8 --  16     A.   Sorry. What paragraph are you  17 talking about?  18     Q.   Let's close that. I made a  19 mistake.  20       I want to understand a little  21 bit more about SEGM. Are they a  22 scientific organization?  23       MR. CANTRELL: Object to form.  24     A.   Well, it's a group of  25 clinicians and scientists who share</p>	<p style="text-align: right;">Page 285</p> <p>1       STEPHEN B. LEVINE, M.D.  2 then talks about science and presents  3 scientific studies.  4       So, you know, the question you  5 just asked needs to be examined closely,  6 and what you mean and what I mean and  7 what the culture means and how naïve all  8 of us can be about what is science and  9 what is not science.  10     Q.   Does SEGM have a position  11 about whether gender-affirming medical  12 care for minors should be prohibited  13 across the board?  14     A.   Should be prohibited across  15 the board? Actually, I don't think so. I  16 think what SEGM -- I don't know that  17 anyone can say what SEGM -- it has --  18 let's say it has 100 members. I don't  19 think there's a uniformity of belief  20 system among the hundred members, except  21 that there is reason to be skeptical  22 about what is going on and to be worried  23 about what is going on and to wonder  24 whether compassion lies in supporting or  25 not supporting these kind of</p>

<p style="text-align: right;">Page 286</p> <p>1       STEPHEN B. LEVINE, M.D.  2 interventions. There is a kind of  3 uncertainty and a uniformity of desire  4 for better study and better reasoning and  5 to separate advocacy from science.  6       That is what I think that  7 these people have in common, or I should  8 say we people since, you know, they paid  9 me money to write that article. So but I  10 don't think you're right if you are  11 asserting that SEGM is against all  12 care --  13     Q.   That's not what I'm asking.  14 I'm definitely not asserting. I'm asking.  15     A.   Well, it's my opinion that  16 they don't have a policy that they're  17 against all trans care for youth.  18       I think they are saying where  19 is the science? And when the science is  20 not there we ought to be cautious.  21 Please be cautious, world, please, is  22 probably what they would say.  23     Q.   Are you still involved with  24 SEGM?  25     A.   Not today, I mean, currently</p>	<p style="text-align: right;">Page 288</p> <p>1       STEPHEN B. LEVINE, M.D.  2 knowledge and the latest recommendations  3 that a group of people together, had put  4 together.  5       I just think that was an  6 extremely ambitious thing. And if you can  7 look at how many years delayed the WPATH  8 8th Standards of Care are, and it's  9 probably three years past due, how  10 difficult it is to formulate guidelines  11 in this controversial area.  12       So I don't know exactly what  13 happened because I'm not privileged to  14 the -- you know, I'm not a decisionmaker  15 or policy maker in SEGM. I was sometimes  16 used to participate in this process. But  17 we worked together on it and then  18 suddenly we weren't working on it  19 anymore. So I don't really know the  20 answer.  21     Q.   So was there even a framework  22 developed for what the guidelines would  23 look like?  24     A.   Well, SEGM was interested in  25 the psychotherapeutic approach and how to</p>
<p style="text-align: right;">Page 287</p> <p>1       STEPHEN B. LEVINE, M.D.  2 involved with SEGM? You know, because we  3 wrote an article, I sometimes write to my  4 second and third author and say, do you  5 know how many people have looked at this  6 lately? You know, there's 27,000.  7 That's in the top 1% of any article ever  8 written, and this article must be having  9 an impact everywhere.  10     Q.   I understood from a previous  11 deposition that you gave that you have  12 been on a committee to develop treatment  13 guidelines with SEGM. Is that still in  14 the works?  15     A.   No.  16     Q.   What happened with that?  17     A.   I think SEGM had too many  18 ideas. They didn't have the manpower,  19 the energy and the time to -- they were  20 going to publish -- they were going to  21 publish in some undisclosed --  22 unclarified form guidelines for primary  23 care physicians and guidelines for mental  24 health professionals where people could  25 get updates on the latest scientific</p>	<p style="text-align: right;">Page 289</p> <p>1       STEPHEN B. LEVINE, M.D.  2 guide mental health professionals, how to  3 think about doing psychotherapy. We first  4 had to say there are scientific  5 limitations and if we're going to have an  6 alternate treatment we're just not saying  7 whatever your past experience is, go to  8 psychotherapy because we don't know what  9 that was going to result in.  10       So what we were trying to do  11 was illustrate processes of therapy and  12 then principles of therapy. So this is  13 very hard to teach how to do  14 psychotherapy, Ms. Cooper, because  15 generally speaking, we want to -- we can  16 only give overriding, overarching  17 principles like, pay attention to the  18 quality of the relationship, or what  19 should you do about the name, what name  20 should you address the patient by? But  21 when you're lost -- when you have in a  22 private confidence psychotherapeutic  23 session you never know exactly what's  24 going to happen. We can't tell you what  25 to do in every circumstance.</p>

<p style="text-align: right;">Page 290</p> <p>1       STEPHEN B. LEVINE, M.D.  2       So generally we have to have a  3 certain faith system, in the power of a  4 good relationship, a trustworthy,  5 respectable relationship that illuminates  6 what people feel, what they've been  7 through and what they're conflicted about  8 and what they're worried about.  9       What all psychotherapists  10 share is the belief that that's a  11 maturation -- if you can meet those  12 criteria that's a maturation stimulating  13 process and we think that's important for  14 13, 15 and 17 and 27-year-olds who have  15 this psychological pain called gender  16 dysphoria. And we actually think it's not  17 different than if someone who didn't have  18 gender dysphoria, but had the pain of  19 anxiety or the pain of depression or the  20 pain of feeling that they're low status  21 in their peer group, you see, we would  22 want to do the same thing. And we, SEGM  23 people, or at least the psychotherapy  24 section of SEGM people were very  25 concerned, very concerned that somehow</p>	<p style="text-align: right;">Page 292</p> <p>1       STEPHEN B. LEVINE, M.D.  2 for transgender youth?  3       A. That's a nice paraphrase of  4 it, yes.  5       Q. Would you describe it  6 differently? I can't remember the exact  7 title.  8       A. It wasn't what you just said  9 but it's close enough.  10      Q. And who were your  11 co-presenters?  12      A. I mentioned two of them  13 already and the fourth one was Kenneth  14 Zucker.  15      Q. And the another two, was that  16 Sasha Ayad and Lisa Marchiano?  17      A. Yes.  18      Q. Well, was it a symposium? Did  19 I use the right word when I said that?  20      A. That's what the APA calls it.  21      Q. How big was the audience for  22 this program?  23      A. I'm sorry. What was that?  24      Q. How big was the audience for  25 this program?</p>
<p style="text-align: right;">Page 291</p> <p>1       STEPHEN B. LEVINE, M.D.  2 when a kid announces a trans identity he  3 or she is disqualified based on WPATH's  4 pronouncement in 2013, that he is  5 disqualified from needing this process,  6 which we think is ridiculous.  7       MS. COOPER: I was going to  8 suggest we take a break now. Can we  9 do that?  10      MR. CANTRELL: Okay.  11      MS. COOPER: Let's take five  12 minutes good?  13      MR. CANTRELL: Sure.  14      (Recess is taken.)  15      VIDEOGRAPHER: Going off the  16 record the time is 4:58.  17      (Recess is taken.)  18      VIDEOGRAPHER: Going back on  19 the record. The time is 5:15.  20      Q. Dr. Levine, did you present  21 this month at a symposium at the APA  22 conference?  23      A. Two days ago.  24      Q. Two days ago? And was that a  25 symposium on reexamining best practices</p>	<p style="text-align: right;">Page 293</p> <p>1       STEPHEN B. LEVINE, M.D.  2       A. Well, you know, I'm such a --  3 it was a big room. There were -- there  4 was 11 rows, there was approximately 100  5 people there.  6       Q. Okay. And was this part of a  7 larger conference where there was a  8 series of presentations on other issues  9 related to gender dysphoria?  10      A. Yes. This is the annual  11 American Psychiatric Association  12 conference and there were a few symposia  13 on gender issues, because the theme was  14 Social Determinants of Mental Health Or  15 Mental Illness. And the APA has gone out  16 of its way to specialize and to welcome  17 all forms of mental cultural diversity.  18 And that was the theme and this was just  19 one of perhaps 50 different symposia that  20 were held during a four-day period.  21      Q. So they were not all on gender  22 dysphoria-related issues but some were?  23      A. Most were not gender  24 dysphoria, but there were a handful of  25 papers relating to that.</p>

<p style="text-align: right;">Page 294</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   And just for clarity, I think</p> <p>3     you said it was the American Psychiatric</p> <p>4     Association conference; is that right? It</p> <p>5     wasn't the American Psychological</p> <p>6     Association?</p> <p>7     A.   Yes, you're right.</p> <p>8     Q.   I get confused with the APAs.</p> <p>9     Did -- excuse me. Let me back up.</p> <p>10       Sasha Ayad and Lisa Marchiano,</p> <p>11    are those both members of SEGM?</p> <p>12    A.   Yes.</p> <p>13    Q.   And Ken Zucker presented as</p> <p>14    well, you said?</p> <p>15    A.   Yes.</p> <p>16    Q.   And did any of these</p> <p>17    presenters, including yourself, suggest</p> <p>18    halting hormonal therapies to treat</p> <p>19    minors with gender dysphoria?</p> <p>20    A.   That didn't come up in the</p> <p>21    symposium.</p> <p>22    Q.   What did come up? What kind of</p> <p>23    recommendations were made?</p> <p>24    A.   Well, I spoke first for about</p> <p>25    eight minutes, and then Ken Zucker -- and</p>	<p style="text-align: right;">Page 296</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     trust -- you want me to talk about what I</p> <p>3     --</p> <p>4     Q.   Sure.</p> <p>5     A.   So I talked about the</p> <p>6     processes of people at high places,</p> <p>7     sometimes institutions, sometimes</p> <p>8     researchers, policymakers, creating a</p> <p>9     diagnosis and creating a treatment and</p> <p>10    the reason we do that is we're trying to</p> <p>11    -- we can recognize suffering based on</p> <p>12    people's patterns, and so we create</p> <p>13    diagnoses and we offer treatments.</p> <p>14    Hopefully some of those treatments are</p> <p>15    based on science, and then we trickle</p> <p>16    those things down to educators and</p> <p>17    educators, in turn, follow this chain of</p> <p>18    trust down to our students and mostly our</p> <p>19    students are medical students, our</p> <p>20    psychology students, our social work</p> <p>21    students that have some familiarity with</p> <p>22    the soul of science, which is skepticism,</p> <p>23    which says; show me what is the evidence</p> <p>24    for this.</p> <p>25       So this is the chain of trust</p>
<p style="text-align: right;">Page 295</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     I'll tell you what I spoke about if</p> <p>3     you're interested -- and Ken Zucker then</p> <p>4     talked about the evidence for the</p> <p>5     epidemiological shift towards -- across</p> <p>6     the world towards more children claiming</p> <p>7     an identity, a trans identity, but the</p> <p>8     predominance of female girls at birth,</p> <p>9     what you might call assigned-at-birth</p> <p>10    girls, and then Dr. Marchiano --</p> <p>11    Dr. Marchiano talked about the state of</p> <p>12    science in this field and the limitations</p> <p>13    of, for example, the DeVries study from</p> <p>14    what we call the Dutch protocol, which,</p> <p>15    you know, I wrote about in the paper and</p> <p>16    she talked about detransitioning and what</p> <p>17    that means. So she spoke for about 20</p> <p>18    minutes on those topics about the</p> <p>19    limitations of science in the field and</p> <p>20    then Sasha Ayad spoke for the last few</p> <p>21    minutes about what you and I have already</p> <p>22    made mention of, which is how to conceive</p> <p>23    of -- how to do therapies, the principles</p> <p>24    of psychotherapy for transgender youth</p> <p>25    and what I spoke about was the chain of</p>	<p style="text-align: right;">Page 297</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     that educates physicians, we'll just pick</p> <p>3     on physicians for a minute. And I said</p> <p>4     the chain of trust is never entirely</p> <p>5     trustworthy and sometimes the chain of</p> <p>6     trust is not trustworthy at all because</p> <p>7     science changes what is the truth or what</p> <p>8     is the therapy and what is the problem</p> <p>9     and what suffering we're going to</p> <p>10    associate, we're going to focus on.</p> <p>11       So I started out with the</p> <p>12    concept of a chain of trust is how</p> <p>13    medical education works. And I need to</p> <p>14    remind everybody that the chain of trust</p> <p>15    is never always trustworthy because</p> <p>16    today's facts are not tomorrow's facts.</p> <p>17       So then I talked about ten</p> <p>18    ideas that are -- I talked about the</p> <p>19    difference between affirmative treatment,</p> <p>20    which I don't have to tell you about, and</p> <p>21    alternate treatment, which I hope I'm</p> <p>22    beginning to tell you it exists, you see.</p> <p>23    So I made those distinctions. And then I</p> <p>24    gave a slide with ten ideas that many</p> <p>25    people who, in my experience, are in the</p>

<p style="text-align: right;">Page 298</p> <p>1       STEPHEN B. LEVINE, M.D.  2 affirmative treatment activity process,  3 they actually believe, for example, that  4 it is biologically determined, that it's  5 fixed for life or immutable and that the  6 treatments have already been proven to  7 decrease suicide and increase people's  8 social functioning. Anyway, I had ten  9 things that I believe I've heard and I've  10 read, which I don't believe science has  11 established.  12       So I talked about those ten  13 things. And then I talked about the rise  14 in what I like to call the transgender  15 treatment industry and saying that there  16 are now -- you know, there used to be  17 very few centers in the 1970s and 1980s,  18 there were very few little pockets of  19 clinical work and now there are over 50  20 centers in the United States that  21 specialize in affirmative care. In  22 Cleveland, for example, we have three of  23 them whose name tells you that they're  24 interested in affirmative care.  25       And so that's all I had to say</p>	<p style="text-align: right;">Page 300</p> <p>1       STEPHEN B. LEVINE, M.D.  2 hormone therapy to minors?  3       A. As Dr. Zucker said during the  4 symposium, you know, he sometimes have  5 prescribed puberty blockers to children  6 but certainly I think you summarize what  7 all four of us believe.  8       Q. Would you say that all four of  9 you would be considered dissenting views  10 in the APA world?  11       MR. CANTRELL: Object to form.  12       A. We have dissenting views from  13 the APA's positions, is that what you  14 mean?  15       Q. Well, let me ask it  16 differently.  17       Would you say all four of you  18 on the panel have views that are  19 considered dissenting from the views of  20 the major medical associations, including  21 the American Psychiatric Association?  22       MR. CANTRELL: Object to form,  23 vague.  24       A. Well, there are 28,000  25 psychiatrists in the APA, I think. So</p>
<p style="text-align: right;">Page 299</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and because I was really -- the basic --  3 that was my introductory way of saying,  4 isn't this a time for a paradigm shift?  5 Can we, based upon science, the  6 limitations of science, can we say that  7 this idea of affirmative care is proven  8 and is the best thing to do? Can we have  9 -- can we open our minds to the  10 possibility that the best practices are  11 not necessarily the best practices and we  12 need to be somewhat skeptical and could  13 we even imagine that we have another  14 paradigm shift?  15       And that was my introduction  16 to Dr. Zucker and Dr. Ayad -- Ms. Ayad  17 and Dr. Marchiano. And then we had  18 questions, I mean discussion. That was it  19 -- actually, it was supposed to be 90  20 minutes but it lasted I think almost 115  21 minutes.  22       Q. And Ken Zucker, Lisa Ayad and  23 Lisa Marchiano are people who you would  24 describe as supporting a more cautious  25 approach with respect to providing</p>	<p style="text-align: right;">Page 301</p> <p>1       STEPHEN B. LEVINE, M.D.  2 certainly I don't -- I mean, there are --  3 people in the audience came up to us and  4 say, gee, thank you for saying these  5 things, I didn't have the courage to say  6 these things, and there is so much worry  7 that people were going to be harmed,  8 their reputation would be harmed if they  9 express any dissenting view.  10       The APA, in 2010, in 2010  11 declared that there is no such thing as  12 an abnormal gender identity and was very  13 supportive of all this affirmative care.  14 And that was really before some of the  15 seminal studies have showed up.  16       So they had a political view  17 because the APA has made a terrible  18 mistake in this -- before 1973 when they  19 called homosexual people to be  20 psychopathology, that was a form of I  21 think they called it a psychopathic  22 personality disorder or something, I  23 don't remember exactly. But they were  24 extremely embarrassed about their  25 position that they maintained for years</p>

<p style="text-align: right;">Page 302</p> <p>1       STEPHEN B. LEVINE, M.D.  2 and years and years.  3       You know, all of us in  4 medicine are a little bit aware of  5 mistakes that we've made about social  6 issues. You know, the American  7 Psychiatric -- the American Medical  8 Association used to support eugenics.  9 And, of course, you and I have already  10 talked about the mistake of the opioid  11 crisis and I can go on and on, and so  12 could you, about the --  13     Q.   Maybe we can switch gears.  14     A.   -- about the misadventures.  15 But answer to your specific question, the  16 APA was aware that we were presenting  17 ideas that were not in keeping with the  18 official policies of the APA.  19       In fact, they made that  20 announcement and they asked people -- I  21 mean, they sent a special moderator to  22 our session, unbeknownst to me and I  23 didn't have any special monitor -- I  24 didn't see any APA monitors in any of the  25 other sessions I attended during -- you</p>	<p style="text-align: right;">Page 304</p> <p>1       STEPHEN B. LEVINE, M.D.  2     Q.   And you've not reviewed his  3 expert report in this case?  4     A.   If I have I don't remember it.  5     Q.   So you never heard of him  6 before?  7     A.   Given my memory, put a little  8 asterisk about that, please.  9     Q.   Let me ask it differently. Is  10 it someone you know who works in the area  11 of treatment for gender dysphoria?  12     A.   What is his first name?  13     Q.   Mark.  14     A.   No. Mark, no, I don't know  15 that person. At least at 5:30 I don't  16 know that person.  17     Q.   Do you know who Patrick  18 Lappert is?  19     A.   Patrick, last?  20     Q.   L-a-p-p-e-r-t.  21     A.   That name sounds more familiar  22 but I don't associate it with anything.  23 No, I don't know.  24     Q.   If I were to mention that he  25 also submitted an expert report for the</p>
<p style="text-align: right;">Page 303</p> <p>1       STEPHEN B. LEVINE, M.D.  2 know, during the days I was there, but  3 this woman appeared, who was the head of  4 the program, and she made a little  5 announcement that this was a respectful  6 institution and that people needed to be  7 -- talk nice, and the APA was aware that  8 some of the ideas expressed here were not  9 in keeping with the official policy of  10 the APA.  11       So while we were all talking  12 the group was extremely polite and nobody  13 interrupted and so forth and so on.  14     Q.   Switching gears, do you know  15 who Mark Regnerus is?  16     A.   Sorry. Who? Margaret?  17     Q.   Mark Regnerus.  18     A.   No, I don't know that name.  19     Q.   R-e-g-n-e-r-u-s. He is an  20 expert witness for the State of Arkansas  21 in this case. Does that help ring a  22 bell?  23     A.   R-e-g-n-u-s?  24     Q.   R-e-g-n-e-r-u-s.  25     A.   I don't know that name.</p>	<p style="text-align: right;">Page 305</p> <p>1       STEPHEN B. LEVINE, M.D.  2 State of Arkansas, would that help you  3 remember who he is?  4     A.   I don't remember reading an  5 expert report by Dr. Lappert. Is it Dr.  6 Lappert?  7     Q.   Yes. Okay. Do you know  8 Dr. Paul Hruz, H-r-u-z?  9     A.   Yes.  10     Q.   And do you know him  11 personally?  12     A.   I've met Dr. Hruz somewhere, I  13 think on another case.  14     Q.   Did you ever meet Dr. Hruz at  15 any professional conference?  16     A.   I don't think we go to the  17 same conferences.  18     Q.   Why is that?  19     A.   I'm a psychiatrist.  20     Q.   Gotcha. Is he someone you know  21 to be an expert in the field of gender  22 dysphoria, treatment of gender dysphoria  23 in adolescents?  24     A.   I know him to be a person who  25 has strong negative views about going</p>

<p style="text-align: right;">Page 306</p> <p>1       STEPHEN B. LEVINE, M.D.  2 ahead with hormone treatments without  3 adequate scientific foundation. That's  4 what I know of Dr. Hruz.  5     Q. Did you read his report that  6 he submitted in this case?  7     A. I think I probably did  8 somewhere, nine, ten months ago, yeah.  9     Q. Was there anything that he  10 opined that you disagreed with?  11       MR. CANTRELL: Object to form.  12     A. You may or may not know that  13 I've spent a lot of time editing reports.  14 I'm the senior editor of a major textbook  15 in sexual ideas, sexual health called  16 Handbook of Clinical Sexuality For Mental  17 Health Professionals.  18       And so I'm used very much to  19 taking experts and helping them write  20 more clearly and more succinctly and more  21 powerfully. And I often ask people, what  22 does this mean? Could you say that more  23 clearly?  24       So probably when I read other  25 experts' reports, and let's not pick on</p>	<p style="text-align: right;">Page 308</p> <p>1       STEPHEN B. LEVINE, M.D.  2 you know about Michael Biggs?  3     A. He's from the U.K. and he's  4 someone who has a great capacity to  5 analyze data and to recognize, you know,  6 reasonableness and he's someone who digs  7 into data in a far deeper way than most  8 human beings can do and don't have the  9 capacity to do.  10       So I've been very interested  11 in what he has said about various  12 articles, in particular, about  13 Dr. Turban's articles, which many of us  14 have enormous skepticism about, enormous  15 skepticism about.  16       So he recently published a  17 letter to the editor about suicide and  18 gender -- teens with gender dysphoria and  19 looked at the data from the Tavistock  20 Clinic and came up with a rate of suicide  21 that was surprisingly low, considering  22 all the claims that we have to give  23 hormones to kids because they're going to  24 kill themselves if they don't. And he  25 found that in looking at all the data</p>
<p style="text-align: right;">Page 307</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Dr. Hruz specifically, I could say that  3 about many of the expert reports on  4 either side, I wouldn't have said it  5 exactly that way. So I don't remember  6 right now whether I disagree with  7 something he said.  8       I certainly know that a few  9 experts have rebutted some of his  10 concepts. You know, some of your experts  11 don't think that I know what I'm talking  12 about either, or should I say more  13 respectfully, they disagree with  14 something I said.  15     Q. I mean, is there anything in  16 particular you have in mind where you say  17 our experts rebutted some of Dr. Hruz's  18 concepts?  19       MR. CANTRELL: Object to form.  20     A. I think in order to answer  21 that question I would have to read his  22 report again.  23     Q. All right. In your reports in  24 this case I saw some references to  25 publications by Michael Biggs. What do</p>	<p style="text-align: right;">Page 309</p> <p>1       STEPHEN B. LEVINE, M.D.  2 over the years that there were four known  3 suicides of people who registered to the  4 Tavistock Clinic over a ten-year period  5 and two of those kids were in treatment  6 with hormones and two of them were on the  7 waitlist. And he calculated the rates,  8 the suicide rate there and it was .03%,  9 which is so different than, you see, what  10 everyone is afraid of. Because people  11 have a hard time -- maybe if you're in  12 psychiatry you don't have a hard time  13 with this, but outside of psychiatry,  14 people, when they hear about suicidality,  15 they don't make these distinctions.  16     Q. I just want to interrupt  17 because I didn't mean to ask you about  18 Michael Biggs' work --  19     A. I'm sorry. I'm sorry.  20     Q. -- about his background.  21       So do you understand, is he a  22 doctor or psychiatrist?  23     A. No. He's not a psychiatrist,  24 he's not a MD. He has a Ph.D. in  25 Sociology.</p>

<p style="text-align: right;">Page 310</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Is he someone you consider to</p> <p>3 be an expert on treatment of gender</p> <p>4 dysphoria?</p> <p>5     A.   No. He's an expert on the</p> <p>6 analysis of data.</p> <p>7     Q.   And is he a member of SEGM?</p> <p>8     A.   I don't know.</p> <p>9     Q.   Do you know if he's opposed to</p> <p>10 any provision of gender-affirming medical</p> <p>11 care for minors?</p> <p>12    A.   I don't know.</p> <p>13    Q.   Switching gears, as a</p> <p>14 psychiatrist, is it fair to say you treat</p> <p>15 a range of mental health conditions in</p> <p>16 your patients?</p> <p>17    A.   Yes.</p> <p>18    Q.   Would that include depression?</p> <p>19    A.   Of course.</p> <p>20    Q.   Anxiety?</p> <p>21    A.   Of course.</p> <p>22    Q.   Bipolar disorder?</p> <p>23    A.   I'm sorry. What was that?</p> <p>24    Q.   Bipolar disorder.</p> <p>25    A.   Which kind of disorder.</p>	<p style="text-align: right;">Page 312</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   Occasionally -- I'm sorry.</p> <p>3 You reminded me, I can order blood tests</p> <p>4 and certainly -- and I take a medical</p> <p>5 history. Being a doctor it's important</p> <p>6 for me to take a medical history, in</p> <p>7 part, because I know what certain</p> <p>8 diseases mean, whereas, social workers</p> <p>9 may not know.</p> <p>10    Q.   So would a blood test be able</p> <p>11 to detect something like anxiety or</p> <p>12 depression?</p> <p>13    A.   Not a blood test, no.</p> <p>14    Q.   Any physiological tests?</p> <p>15    A.   Well, you can run an EKG and</p> <p>16 you can take a person's pulse, you can</p> <p>17 see their body shake. I mean, I have</p> <p>18 patients who shake in front of me. I</p> <p>19 don't need a blood test to see they're</p> <p>20 nervous, I can hear what they do when</p> <p>21 they're nervous, you know. So -- and when</p> <p>22 they're depressed, you know, there are</p> <p>23 certain -- their face looks depressed,</p> <p>24 their posture looks depressed, their</p> <p>25 attitudes looks depressed, their</p>
<p style="text-align: right;">Page 311</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   Bipolar.</p> <p>3       MR. CANTRELL: She's saying</p> <p>4 bipolar.</p> <p>5     A.   Oh, bipolar. Yes.</p> <p>6     Q.   Are there any -- strike that.</p> <p>7       When you are diagnosing</p> <p>8 patients with these conditions, do you</p> <p>9 rely on self-report of the patients?</p> <p>10    A.   Of course I do.</p> <p>11    Q.   Is there any other evidence</p> <p>12 you can look to to verify the evidence</p> <p>13 provided in the patient's self-report?</p> <p>14    A.   Yes.</p> <p>15    Q.   Can you tell me what kinds of</p> <p>16 things?</p> <p>17    A.   I can talk to a spouse, I</p> <p>18 could talk to a parent, I could do a</p> <p>19 psychological test, I could fill out a</p> <p>20 form and have them fill out a form, I can</p> <p>21 read their medical history, I can talk to</p> <p>22 the previous therapist. I think that's</p> <p>23 most of what I can do.</p> <p>24    Q.   Is there any kind of</p> <p>25 physiological verification?</p>	<p style="text-align: right;">Page 313</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 self-concepts sound depressed.</p> <p>3       So that's all part of the</p> <p>4 first thing a doctor does, first thing we</p> <p>5 learn in how to do physical diagnosis is</p> <p>6 to observe the patient. So we learn a lot</p> <p>7 by looking at the patient.</p> <p>8     Q.   Are there objective -- have</p> <p>9 you used the term objective and</p> <p>10 subjective to refer to methods of</p> <p>11 diagnosing a condition? Is that</p> <p>12 terminology you use?</p> <p>13    A.   Well, the patient talks about</p> <p>14 their subjectivity and we're interested,</p> <p>15 at least in psychiatry, we're interested</p> <p>16 in how they think and how they feel and</p> <p>17 how they suffer from what the problem is.</p> <p>18 And objectively we look at them and we</p> <p>19 hear how they speak and observe what they</p> <p>20 do with their bodies and their eyes and</p> <p>21 their posture while we're talking. We</p> <p>22 also can have these questionnaires or do</p> <p>23 psychological tests as a more objective</p> <p>24 appraisal.</p> <p>25       For example, when I do a</p>



<p style="text-align: right;">Page 314</p> <p>1       STEPHEN B. LEVINE, M.D.  2 forensic report for somebody who's  3 committed or is accused of a crime, I  4 always provide psychological testing to  5 verify my impressions or to see what I've  6 missed, so to speak. So there are things  7 that are objective and we gather  8 information that is patient narrative.  9 But, again, we also -- we're also being  10 paid what some of my patients call big  11 bucks, we get the big bucks for making  12 judgments about what the person says and  13 thinks and feels, and we sometimes  14 provide an alternate view of -- and then  15 we watch -- sometimes this is called an  16 interpretation -- and we watch the  17 patient's response to our alternate view,  18 and then we see that patient over time  19 and we see how our alternate view may  20 land on fertile ground and help a person  21 shift their subjectivity.  22       I mean, a lot of people say --  23 I don't mean to sound too proud about  24 this -- but a lot of people say, it was  25 so very helpful talking to you, Dr.</p>	<p style="text-align: right;">Page 316</p> <p>1       STEPHEN B. LEVINE, M.D.  2 paradoxes in psychiatry. We live with  3 paradoxes and contradictions.  4       It is -- you know, the APA  5 declared in 2010 that there is no such  6 thing as an abnormal gender identity, and  7 the policy from the DSM-IV was  8 inconsistent with that.  9       Now, the DSM-V has said, well,  10 gender identity, per se, is not an  11 abnormality, but if people are distressed  12 then they have a psychiatric diagnosis.  13       You see, if you are going to  14 ask me if I have issues with the DSM-V  15 diagnosis of gender dysphoria, you really  16 need to ask me if I have issues about  17 psychiatric diagnosis, in general, and  18 then we would have to talk about that at  19 great length. And you don't want me to  20 spend an hour talking about that. And  21 then we could get to the specifics about  22 gender dysphoria as a diagnosis and why  23 the DSM -- why the ICD-11 has went out of  24 its way to not make it a psychiatric  25 diagnosis, and how they think that that's</p>
<p style="text-align: right;">Page 315</p> <p>1       STEPHEN B. LEVINE, M.D.  2 Levine, you've really helped me today, I  3 feel much better leaving after 50 minutes  4 than I did when I walked in here. That's  5 why I get paid the big bucks, so to  6 speak, you know.  7       So I don't know if you want to  8 call this objective. I'm comfortable with  9 the subjectivity, the patient's  10 subjectivity and my subjectivity and the  11 relationship between the two of those  12 subjectivities.  13    Q.   Do you take issue with the DSM  14 diagnosis of gender dysphoria?  15       MR. CANTRELL: Object to form,  16       vague.  17    A.   What issue would you be  18 referring to?  19    Q.   Do you think that gender  20 dysphoria is appropriately considered a  21 psychiatric condition?  22    A.   Oh. Well, in the DSM-V there  23 is a psychiatric condition. In the  24 ICD-11 it is a condition that affects  25 sexual health. This is one of the great</p>	<p style="text-align: right;">Page 317</p> <p>1       STEPHEN B. LEVINE, M.D.  2 a major step forward, and which I think  3 it helps everyone deny the importance of  4 self-harm and suicidality and depression  5 and anxiety. Because that's something  6 separate from gender identity, you see.  7 It's a comorbidity. As though a person  8 can have six different diagnoses. I  9 laugh when I sometimes get patients who  10 come from others who gave six psychiatric  11 diagnoses, it's one person and they have  12 six different problems. And you see,  13 this is the diagnostic problem, this is  14 the diagnostic foolishness I think that  15 we have in separating things out. It's  16 just one person struggling with life, you  17 see.  18    Q.   Do you think that gender  19 dysphoria is diagnosed only based on  20 patient's self-report?  21       MR. CANTRELL: Object to form.  22    A.   By whom?  23    Q.   By the -- by you, by whoever  24 is doing --  25    A.   If you are asking about me</p>

<p style="text-align: right;">Page 318</p> <p>1       STEPHEN B. LEVINE, M.D.  2 versus -- you didn't ask about me. You  3 asked about, do I think gender dysphoria  4 is diagnosed by a patient's self-report?  5 Well, of course, it begins with patient's  6 self-report and it also requires a sense,  7 the doctor's sense of what is gender  8 dysphoria and where does it come from and  9 how long has it existed and who is this  10 person, you see, and is this person  11 mentally ill, apart from the gender  12 dysphoria problem, you see.  13       So you know, one can be  14 psychotic and have gender dysphoria or  15 one can be a little anxious and have  16 gender dysphoria, and those are different  17 kettles of fish.  18     Q.   And I think we talked about  19 this earlier, do you look to information  20 from the parents when diagnosing a minor  21 with gender dysphoria?  22     A.   Why, of course.  23     Q.   Is the reliance on self-report  24 from patients and information from family  25 members unique to the diagnosis of gender</p>	<p style="text-align: right;">Page 320</p> <p>1       STEPHEN B. LEVINE, M.D.  2 is, is that -- is the reliance on  3 patient's self-report and report from  4 family members unique in the psychiatric  5 field to the diagnosis of gender  6 dysphoria?  7       MR. CANTRELL: Object to form.  8     A.   Oh, I see. I see where you've  9 been going here.  10       Self-report is a very  11 important component in the diagnosis of  12 any psychiatric condition.  13       In the field of gender  14 dysphoria, in the beginning of the  15 history of the gender dysphoria we  16 recognized in the '70s and '80s that many  17 people lied to us because they read the  18 textbook description and they wanted  19 hormones, for example, and they gave us  20 textbook descriptions of their gender  21 dysphoria. So we trying to distinguish  22 in the '70s and '80s in adults between  23 people who had -- looking at men, for  24 example, men who evolved into trans  25 identities from transvestitic fetishism</p>
<p style="text-align: right;">Page 319</p> <p>1       STEPHEN B. LEVINE, M.D.  2 dysphoria?  3       MR. CANTRELL: Object to form.  4     A.   No.  5     Q.   Is that true of other  6 psychiatric conditions?  7     A.   Yes. For example, if somebody  8 is having cognitive troubles, and say,  9 oh, I'm not having any troubles, I just  10 got lost on the way home last night, I'd  11 be happy to talk to their spouse or their  12 son or their daughter or their other  13 doctor, whatever.  14       Of course, I mean, this is --  15 you know, this is standard medical stuff.  16 It doesn't require just being a  17 psychiatrist. The internist does the  18 same thing, the pediatrician does the  19 same thing, even the neurosurgeon does  20 the same thing.  21     Q.   Well, I'm asking because there  22 have been critiques by others that the  23 diagnosis of gender dysphoria is not  24 valid because it is only based on  25 patient's self-report. And my question</p>	<p style="text-align: right;">Page 321</p> <p>1       STEPHEN B. LEVINE, M.D.  2 or cross-married, heterosexual  3 cross-dressers from people who had what  4 we thought back then was true gender  5 dysphoria. We didn't call it gender  6 dysphoria in those days, true  7 transsexualism.  8       It turns out now that  9 children, teenagers spend so much time on  10 social media and so much time on trans  11 social media, and that there are people  12 telling teenagers what to tell the  13 doctor, that now we have the problem of;  14 do we believe the patient's subjective  15 report? Is there -- is the patient  16 telling us the truth as they experience  17 themselves or are they telling us what we  18 think we need to hear in order to  19 recommend affirmative care? And this is  20 one of the reasons why we need to have a  21 conservative, slow report to figure out  22 the truth because people lie to doctors  23 when they want something, and transgender  24 people are no exceptions to the human  25 potential to lie to doctors to achieve</p>


<p style="text-align: right;">Page 322</p> <p>1       STEPHEN B. LEVINE, M.D.  2 some goal that they have in mind. And so  3 doctors can't treat people like they're  4 liars, but they have to understand that  5 it may not be the whole truth.  6       So that when someone says it's  7 not valid because it's only self-report,  8 I think the substance of that claim is  9 that it may not always be true, just  10 self-report and, therefore, it's  11 important to get multiple sources of  12 information sometimes and it's important,  13 Levine would say it's important to know  14 that person over time because stories  15 change.  16    Q.   Are there other mental health  17 conditions that you can diagnose only  18 based on self-report and report from  19 others who know the patient?  20    A.   I think that's how it works.  21    Q.   That's how psychiatry works?  22    A.   Yes. I think the answer to  23 your question; are there other  24 conditions, the answer is simply yes. But  25 I'm so long-winded here.</p>	<p style="text-align: right;">Page 324</p> <p>1       STEPHEN B. LEVINE, M.D.  2 So I don't know -- he made mention of  3 several different issues he wanted to  4 talk to me about.  5       So I don't know -- I can just  6 report to you some somebody called me  7 about -- he called me a weak ago Friday,  8 tomorrow would be a week, last Friday he  9 called but I've been -- I was on my way  10 to the APA meeting.  11    Q.   What issues did he say he  12 wanted to talk about?  13    A.   He didn't say, but I presumed  14 it was something about trans world.  15 People don't ask me to be expert  16 witnesses about schizophrenia.  17    Q.   Do you think parents of a  18 minor on hormone therapy should be deemed  19 child abusers?  20       MR. CANTRELL: Object to form.  21    A.   That's sort of a -- let me see  22 if I got that question. Do I think the  23 parents who support a child being on  24 hormones should be accused of child  25 abuse?</p>
<p style="text-align: right;">Page 323</p> <p>1       STEPHEN B. LEVINE, M.D.  2    Q.   Are you familiar with the  3 decision in Texas to investigate families  4 of children who are -- actually, not  5 children. I'll start that again.  6       Are you aware of a decision in  7 Texas to deem gender-affirming medical  8 care for minors to be child abuse?  9    A.   I read the papers.  10   Q.   So you are aware of that from  11 the news; is that right?  12   A.   The dear Governor of Texas.  13   Q.   You are aware; is that  14 correct?  15   A.   I read the papers. I'm aware.  16 I don't know if I'm as aware as you are  17 but I'm aware somewhat of this idea.  18   Q.   Have you been asked to provide  19 expert testimony in litigation in Texas  20 over that policy?  21   A.   Actually, last week somebody  22 from the Attorney General's Office called  23 me and I said there is no possibility I  24 could talk to you until -- for another  25 couple of weeks because I'm so damn busy.</p>	<p style="text-align: right;">Page 325</p> <p>1       STEPHEN B. LEVINE, M.D.  2   Q.   Yes.  3   A.   Is that your question?  4   Q.   Yes.  5   A.   I would say that's sort of a  6 laughable idea.  7   Q.   Why do you say that?  8   A.   Because I've spent almost  9 seven hours to you explaining the answer  10 to that question.  11   Q.   Yeah, tell me how I missed it.  12       So it's a laughable idea  13 because you don't consider parents who  14 access gender-affirming medical care for  15 their minor children to be engaged in an  16 act of child abuse?  17   A.   I don't think they're  18 knowingly abusing their child. I think  19 they often are misinformed because of the  20 principles I outlined in our article. I  21 don't think they've been informed and I  22 don't think we should punish parents by  23 taking their child away. And I've, by  24 the way, seen that where social agencies  25 take children away, custody of children</p>

<p style="text-align: right;">Page 326</p> <p>1       STEPHEN B. LEVINE, M.D.  2 away from 14-year-old kids who object to,  3 you know, the use of affirmative care on  4 their 14-year-old.  5       The culture is somewhat  6 hyperbolic about this subject, you see,  7 and people need to calm down about this.  8 The Governor needs to calm down about  9 this, I mean the Governor of Texas. And  10 you know, these principles have something  11 to do with the election cycle. And I'm  12 talking about science here. And I'm not  13 an expert on election cycles, but I am a  14 citizen, you know, I do vote, I do make  15 up my mind about what happens in the  16 political sphere. But I really want you  17 to talk to me about what I know about  18 science.  19       If you're asking me about my  20 opinions about various political things,  21 I'll be happy to tell you, but I don't  22 think, you know, that's what you got me  23 here for. But maybe I don't understand  24 why you have me here.  25       Q. Do I take it from your answer</p>	<p style="text-align: right;">Page 328</p> <p>1       STEPHEN B. LEVINE, M.D.  2 law there and they said, well, thank you  3 very much, Dr. Levine, we'll get back to  4 you. So I haven't heard since that time  5 from them.  6       Q. What concerns did you explain  7 to them?  8       A. I don't remember the details  9 of the Alabama law, only that it made me  10 uncomfortable. I particularly -- I think  11 there was something like revocation of  12 licenses or ten years in prison,  13 something that I thought was Draconian. I  14 think there was -- I think they were  15 threatening to send doctors to prison.  16 And I'm aware that there are many  17 controversies in medicine. And it's only  18 in this area -- or in the abortion area  19 and this area that we have such passion  20 as a nation. And when we think about  21 taking a cultural resource like  22 physicians that communities depend upon  23 for their physical and mental health and  24 putting them in prison because they have  25 a different view some medical issue, I</p>
<p style="text-align: right;">Page 327</p> <p>1       STEPHEN B. LEVINE, M.D.  2 that if you were asked to serve as an  3 expert witness on behalf of the State of  4 Texas to help them defend their policy of  5 investigating parents for child abuse for  6 providing gender-affirming hormone  7 therapy that you would decline that?  8       MR. CANTRELL: Object to form.  9       A. Oh, yes.  10       Q. Was that an "oh, yes", did I  11 hear that right?  12       A. Yes. At this moment I would  13 decline that, if that's how they phrased  14 it, yeah.  15       Q. I can't remember if I asked  16 you this already. Have you been asked to  17 offer expert testimony in the case  18 involving the felony ban on  19 gender-affirming medical care in Alabama?  20       A. I was in discussions with the  21 Attorney General, one of the Assistant  22 Attorney Generals of Alabama, about a  23 month ago and I had a conference call and  24 I explained some of my concerns about  25 that, about what I understood to be the</p>	<p style="text-align: right;">Page 329</p> <p>1       STEPHEN B. LEVINE, M.D.  2 just think that's over the top.  3       Q. Are you aware that the  4 Arkansas law provides that doctors who  5 provide gender-affirming medical care to  6 minors would be deemed to be acting in  7 violation of medical ethics and could  8 have their licenses taken away by the  9 State Medical Board?  10       MR. CANTRELL: Object to form.  11       A. That is not -- that is not my  12 reading of the law. I do know that there  13 is a kind of threat of reporting to the  14 State Medical Board, but I don't really  15 think that law mandates the removal of  16 their medical license.  17       Q. A consequence of the law, if  18 that is what the law means, would that be  19 a concern of yours?  20       MR. CANTRELL: Object to form.  21       And Dr. Levine is not an attorney  22 so he, of course, can't answer  23 legal -- can't give a legal  24 opinion.  25       MS. COOPER: Of course.</p>

<p style="text-align: right;">Page 330</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     Q.   I'm not asking for your legal</p> <p>3     opinion. I'm asking if the state law does</p> <p>4     actually mean that some doctors could</p> <p>5     have their licenses taken away if they</p> <p>6     provide gender-affirming medical care to</p> <p>7     minors, would that cause you concern?</p> <p>8     A.   So, listen, you may not know</p> <p>9     this but the State Medical Board of Ohio</p> <p>10    has used me as an evaluator of doctors</p> <p>11    who have gotten into trouble over many</p> <p>12    years. They've used me since I would say</p> <p>13    1990, and they have me -- when people</p> <p>14    renew their licenses, they have to listen</p> <p>15    to a 20-minute talk by me. And that's in</p> <p>16    the last year, not for 30 years. They've</p> <p>17    used me for consultations for errant</p> <p>18    doctors.</p> <p>19       I've been witnessing for 30</p> <p>20    years how state medical boards operate,</p> <p>21    our state medical -- the Ohio State</p> <p>22    Medical Board operates. And so when</p> <p>23    doctors are accused of things they get a</p> <p>24    very careful evaluation.</p> <p>25       So just because the Arizona</p>	<p style="text-align: right;">Page 332</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     support a policy that would discipline</p> <p>3     doctors who provide this care by taking</p> <p>4     away their medical licenses?</p> <p>5       MR. CANTRELL: Object to form.</p> <p>6     A.   I'm actually not here to</p> <p>7     support policy, but to let science lead</p> <p>8     policy.</p> <p>9     Q.   You mentioned that there are</p> <p>10    others in your medical practice who</p> <p>11    provide care for minors with gender</p> <p>12    dysphoria.</p> <p>13       Are they aware of your</p> <p>14    participation in this case and other</p> <p>15    cases involving issues related to this</p> <p>16    treatment?</p> <p>17    A.   I'm sorry. Which group of</p> <p>18    people are you asking me about?</p> <p>19    Q.   The doctors in your -- the</p> <p>20    providers in your practices.</p> <p>21    A.   Yes. Yes. I think they may not</p> <p>22    be aware of Arkansas, per se, but they're</p> <p>23    aware that I do function as an expert</p> <p>24    witness in some states, sometimes.</p> <p>25    Q.   And is it your experience that</p>
<p style="text-align: right;">Page 331</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     law says something, words something that</p> <p>3     is vaguely threatening, it really doesn't</p> <p>4     mean that, practically speaking, that</p> <p>5     they will lose their license.</p> <p>6       I don't think the law remands</p> <p>7     or demands that the Arkansas State</p> <p>8     Medical Board removes their license. I</p> <p>9     think, if I remember reading it</p> <p>10    correctly, they could report them to the</p> <p>11    State Medical Board.</p> <p>12    Q.   I'm not asking your analysis</p> <p>13    of the statute. I am asking if doctors</p> <p>14    were to lose their licenses because they</p> <p>15    provided gender-affirming medical therapy</p> <p>16    to minors, would that be a concern to</p> <p>17    you?</p> <p>18       MR. CANTRELL: Object to form.</p> <p>19    A.   If we leave it as simply as</p> <p>20    you just said, it would be a concern to</p> <p>21    me. But I think what I was trying to tell</p> <p>22    you is it's more complicated, the</p> <p>23    process. The devil is in the details and</p> <p>24    not in the statement that you made.</p> <p>25    Q.   And fair to say you would not</p>	<p style="text-align: right;">Page 333</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     they agree with the opinions you have</p> <p>3     offered in these cases?</p> <p>4     A.   I don't think they know the</p> <p>5     opinions that I offer in these cases. I</p> <p>6     don't think any one of them have read any</p> <p>7     expert opinion report I ever wrote. I</p> <p>8     mean, if you look at the length of this</p> <p>9     report you got to be a lawyer to read</p> <p>10    this. No one else in their right mind</p> <p>11    would read these reports or maybe a</p> <p>12    parent would read this report.</p> <p>13    Q.   Would you agree there is</p> <p>14    disagreement among doctors and other</p> <p>15    healthcare providers about the</p> <p>16    appropriate way to treat adolescents with</p> <p>17    gender dysphoria?</p> <p>18       MR. CANTRELL: Object to form.</p> <p>19    A.   I think I must be getting</p> <p>20    tired because I'm having a hard time</p> <p>21    grasping what you're asking me. Would I</p> <p>22    agree to what?</p> <p>23    Q.   That there is -- I'll ask it</p> <p>24    again because maybe you didn't hear all</p> <p>25    of it.</p>

<p style="text-align: right;">Page 334</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2       Would you agree that among</p> <p>3 doctors and other healthcare providers</p> <p>4 there are diverse views about the</p> <p>5 appropriate treatment for gender</p> <p>6 dysphoria in adolescents?</p> <p>7     A.   Yes. I would agree to that.</p> <p>8     Q.   Some oppose the use of</p> <p>9 hormonal interventions to treat gender</p> <p>10 dysphoria and some support it; is that a</p> <p>11 fair statement?</p> <p>12    A.   Oh, I'm aware that, you know,</p> <p>13 your Plaintiffs' experts support it and</p> <p>14 they represent many people in those</p> <p>15 50-some units across America who are</p> <p>16 actively providing hormone treatment for</p> <p>17 teenagers. Yes, I'm aware.</p> <p>18    Q.   Are there other psychiatric</p> <p>19 conditions about which there is</p> <p>20 substantial disagreement in the field</p> <p>21 about the appropriate course of</p> <p>22 treatment?</p> <p>23    A.   Of course.</p> <p>24    Q.   Can you give me an example or</p> <p>25 two?</p>	<p style="text-align: right;">Page 336</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 hearts and revascularize the</p> <p>3 atherosclerotic blood vessels and there</p> <p>4 was a controversy and people couldn't</p> <p>5 decide. So people did a study and found</p> <p>6 out if you treat this medically you don't</p> <p>7 need to have open heart surgery. And</p> <p>8 then we further then had controversies</p> <p>9 about should we put a stent in rather</p> <p>10 than using medication.</p> <p>11       So medicine advances because</p> <p>12 there are disagreements. There are</p> <p>13 disagreements in psychiatry. There are</p> <p>14 disagreements in every field. You see,</p> <p>15 trans care is the only -- is the most</p> <p>16 controversial, most passionate thing. The</p> <p>17 passion comes from patients who want it</p> <p>18 and the passion comes from doctors who</p> <p>19 believe compassionately, wholeheartedly</p> <p>20 that this is helping them, and they don't</p> <p>21 want to know that the suicide rates after</p> <p>22 all they do, after all this treatment</p> <p>23 have not improved, you see.</p> <p>24       So controversy -- I want to</p> <p>25 teach people that controversy is how we</p>
<p style="text-align: right;">Page 335</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2     A.   Well, some people think that</p> <p>3 high-dose antipsychotic drugs are the</p> <p>4 treatment, lots of people disagree about</p> <p>5 which drugs to use. I wrote a book in</p> <p>6 2020 called Psychotherapeutic Approaches</p> <p>7 to Sexual Problems. And on the 10th and</p> <p>8 final chapter of the book I urged the</p> <p>9 readers to not run away from controversy</p> <p>10 but to embrace controversy and understand</p> <p>11 what the controversy is about and to</p> <p>12 recognize that the reason there is a</p> <p>13 controversy is that we don't have enough</p> <p>14 science to answer the question, and that</p> <p>15 would help us pay attention to subsequent</p> <p>16 studies to move us in the direction.</p> <p>17       You see, what's happened in</p> <p>18 this field is people got polarized and</p> <p>19 they try to cancel the opposing views out</p> <p>20 all the time. I say, embrace the</p> <p>21 controversy. Of course, there are</p> <p>22 controversies. That's how science</p> <p>23 advances, you see.</p> <p>24       There used to be controversies</p> <p>25 about whether you should open up the</p>	<p style="text-align: right;">Page 337</p> <p>1       STEPHEN B. LEVINE, M.D.</p> <p>2 advance knowledge and we -- we don't have</p> <p>3 to -- we have to acknowledge the</p> <p>4 controversy and we have to be balanced</p> <p>5 enough to understand the opposing points</p> <p>6 of view and then conceptualize how in the</p> <p>7 world -- or some of us have to</p> <p>8 conceptualize how in the world are we</p> <p>9 going to advance and get the answer to</p> <p>10 the contentious issue. But defining the</p> <p>11 contentious issue is the first step to</p> <p>12 progress.</p> <p>13       MS. COOPER: With that I can</p> <p>14 pass the witness.</p> <p>15       MR. CANTRELL: Okay. Let's</p> <p>16 take a short break.</p> <p>17       VIDEOGRAPHER: Going off the</p> <p>18 record. The time is 6:09.</p> <p>19       (Recess is taken.)</p> <p>20       VIDEOGRAPHER: Back on the</p> <p>21 record. The time is 6:21.</p> <p>22 CROSS-EXAMINATION BY MR. CANTRELL:</p> <p>23     Q.   Just one question, Dr. Levine.</p> <p>24       You discussed earlier a social</p> <p>25 worker in your clinic named Anna Novak.</p>

<p style="text-align: right;">Page 338</p> <p>1       STEPHEN B. LEVINE, M.D.  2       My only question is, what  3 capacity, what ability does she have to  4 approve minors for hormone therapy?  5       A. As a standalone person I don't  6 think she has any authority or legitimacy  7 or credentials to approve surgery or  8 hormones. She's a social worker. She's a  9 very competent person and she's very  10 experienced in this area and we depend  11 very much on Anna Novak to evaluate  12 families and parents and the life history  13 of children with this problem and to  14 enter into a substantial, ongoing  15 relationship. And if, in doing what we  16 have earlier said today is the process of  17 informed consent and having a growing  18 understanding of what the dynamics in the  19 family are, if the parents decide, having  20 recognized the various forms of treatment  21 options that are available, if the  22 parents decide that they would like to go  23 ahead with, say, cross-sex hormones then  24 Anna will write a letter to the -- she  25 will present it to me or to the group and</p>	<p style="text-align: right;">Page 340</p> <p>1       STEPHEN B. LEVINE, M.D.  2 child. And so we say, go ahead and give  3 them hormones and hopefully you'll follow  4 the patient and we'll follow the patient.  5       So I don't really like the  6 word that we recommended or Anna Novak  7 recommended or Anna Novak approved it.  8       What we're really saying is  9 that we've done what we can, to the best  10 of our ability with this family and they  11 have autonomy in decisionmaking about  12 this.  13       I think that's a lot different  14 than happens in many clinics, when you  15 hear about someone, and maybe this isn't  16 the modal experience, but it is certainly  17 a common enough experience that people  18 get -- I want testosterone and by the end  19 of the first visit they have a  20 prescription. Is that an answer?  21       MR. CANTRELL: That's an  22 answer, Dr. Levine. And with that,  23 we'll pass the witness. But we  24 will review and sign.  25       MS. COOPER: No more</p>
<p style="text-align: right;">Page 339</p> <p>1       STEPHEN B. LEVINE, M.D.  2 if there is a consensus agreement about  3 this, considering what we all know about  4 the situation, and we have no -- we have  5 no reason to believe that this is going  6 to be a disaster, even though we have no  7 reason to believe that there is going to  8 have a favorable outcome, we will write a  9 letter to the endocrinologist about our  10 understanding of this case and that we --  11 we give our permission for the -- not the  12 urologist, but the endocrinologist to  13 provide those hormones.  14       In that sense I think people  15 might say, well, don't you approve it?  16 But Anna Novak doesn't prove it. If  17 anyone approves it, it's my signature  18 with the MD degree that legitimizes the  19 -- it gives the endocrinologist not only  20 a great deal of information about the  21 patient and the family, it gives them the  22 idea that we have concerns, of course,  23 the parents are aware of our concerns,  24 and they have decided that this is in the  25 best interests of their family and their</p>	<p style="text-align: right;">Page 341</p> <p>1       STEPHEN B. LEVINE, M.D.  2 questions.  3       VIDEOGRAPHER: This concludes  4 the video deposition. The time is  5 6:25. Going off the record.  6       (The proceedings were  7 adjourned at 6:25 p.m.)  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25</p>

<p style="text-align: right;">Page 342</p> <p>1       C E R T I F I C A T E</p> <p>2       I, MAUREEN M. RATTO, a</p> <p>3 Registered Professional Reporter, do</p> <p>4 hereby certify that prior to the</p> <p>5 commencement of the examination,</p> <p>6 STEPHEN B. LEVINE, M.D. was sworn by me</p> <p>7 to testify the truth, the whole truth</p> <p>8 and nothing but the truth.</p> <p>9       I DO FURTHER CERTIFY that the</p> <p>10 foregoing is a true and accurate</p> <p>11 transcript of the proceedings as taken</p> <p>12 stenographically by and before me at</p> <p>13 the time, place and on the date</p> <p>14 hereinbefore set forth.</p> <p>15       I DO FURTHER CERTIFY that I am</p> <p>16 neither a relative nor employee nor</p> <p>17 attorney nor counsel of any of the</p> <p>18 parties to this action, and that I am</p> <p>19 neither a relative nor employee of such</p> <p>20 attorney or counsel, and that I am not</p> <p>21 financially interested in this action.</p> <p>22</p> <p>23 </p> <p>24       MAUREEN M. RATTO, RPR</p> <p>25       License No. 817125</p>	<p style="text-align: right;">Page 344</p> <p>1 Stephen B. Levine, M.D. Monday,</p> <p>2 December 21, 2020 re: Juli</p> <p>3 Claire v. Florida Department of</p> <p>4 Management Services</p> <p>5 Exhibit Levine 6, Declaration of 234</p> <p>6 Dr. Stephen B. Levine, dated</p> <p>7 July 2021</p> <p>8 Exhibit Levine 7, Declaration of 239</p> <p>9 Stephen B. Levine, MD dated</p> <p>10 December 9, 2021</p> <p>11 Exhibit Levine 8, Canadian 272</p> <p>12 Gender Report, dated October 1,</p> <p>13 2019</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>
<p style="text-align: right;">Page 343</p> <p>1       I N D E X</p> <p>2 WITNESS: STEPHEN B. LEVINE, M.D. 6</p> <p>3 DIRECT EXAMINATION BY MS. COOPER 6</p> <p>4 CROSS-EXAMINATION BY 337</p> <p>5 MR. CANTRELL</p> <p>6</p> <p>7       E X H I B I T S</p> <p>8 Exhibit Levine 1, Declaration of 64</p> <p>9 Stephen B. Levine, MD, dated</p> <p>10 February 23, 2022</p> <p>11 Exhibit Levine 2, excerpt of the 70</p> <p>12 deposition of Stephen B. Levine,</p> <p>13 MD re: Reilyn Keohane v. Julie</p> <p>14 Jones</p> <p>15 Exhibit Levine 3, article re: 86</p> <p>16 Reconsidering Informed Consent</p> <p>17 written by Stephen B. Levine,</p> <p>18 MD, in the Journal of Sex &amp;</p> <p>19 Marital Therapy</p> <p>20 Exhibit Levine 4, transcript re: 181</p> <p>21 Presentation on Healthcare</p> <p>22 Models For Transgender</p> <p>23 Adolescents, dated March 12,</p> <p>24 2020</p> <p>25 Exhibit Levine 5, transcript of 190</p>	<p style="text-align: right;">Page 345</p> <p>1 MICHAEL CANTRELL, ESQ.</p> <p>2 michael.cantrell@arkansasag.gov</p> <p>3       June 8, 2022</p> <p>4 RE: BRANDT, et al. vs. RUTLEDGE, et al.</p> <p>5 5/26/2022, Stephen B. Levine (#5163591)</p> <p>6 The above-referenced transcript is available for</p> <p>7 review.</p> <p>8 Within the applicable timeframe, the witness should</p> <p>9 read the testimony to verify its accuracy. If there are</p> <p>10 any changes, the witness should note those with the</p> <p>11 reason, on the attached Errata Sheet.</p> <p>12 The witness should sign the Acknowledgment of</p> <p>13 Deponent and Errata and return to the deposing attorney.</p> <p>14 Copies should be sent to all counsel, and to Veritext at</p> <p>15 erratas-cs@veritext.com.</p> <p>16</p> <p>17 Return completed errata within 30 days from</p> <p>18 receipt of testimony.</p> <p>19 If the witness fails to do so within the time</p> <p>20 allotted, the transcript may be used as if signed.</p> <p>21</p> <p>22       Yours,</p> <p>23       Veritext Legal Solutions</p> <p>24</p> <p>25</p>



<p style="text-align: right;">Page 346</p> <p>1 BRANDT, et al. vs. RUTLEDGE, et al.  2 5/26/2022 - Stephen B. Levine (#5163591)  3 E R R A T A S H E E T  4 PAGE____ LINE____ CHANGE____  5 _____  6 REASON_____  7 PAGE____ LINE____ CHANGE____  8 _____  9 REASON_____  10 PAGE____ LINE____ CHANGE____  11 _____  12 REASON_____  13 PAGE____ LINE____ CHANGE____  14 _____  15 REASON_____  16 PAGE____ LINE____ CHANGE____  17 _____  18 REASON_____  19 PAGE____ LINE____ CHANGE____  20 _____  21 REASON_____  22 _____  23 _____  24 Stephen B. Levine                      Date  25</p>	
<p style="text-align: right;">Page 347</p> <p>1 BRANDT, et al. vs. RUTLEDGE, et al.  2 5/26/2022 - Stephen B. Levine (#5163591)  3 ACKNOWLEDGEMENT OF DEPONENT  4 I, Stephen B. Levine, do hereby declare that I  5 have read the foregoing transcript, I have made any  6 corrections, additions, or changes I deemed necessary as  7 noted above to be appended hereto, and that the same is  8 a true, correct and complete transcript of the testimony  9 given by me.  10 _____  11 _____  12 Stephen B. Levine                      Date  13 *If notary is required  14 SUBSCRIBED AND SWORN TO BEFORE ME THIS  15 _____ DAY OF _____, 20____.  16 _____  17 _____  18 _____  19 NOTARY PUBLIC  20 _____  21 _____  22 _____  23 _____  24 _____  25</p>	

<b>&amp;</b>	<b>14</b> 32:14,16 90:10	168:15 207:6	216:3 335:6
<b>&amp;</b> 3:3 6:1,4 86:11	90:16 132:2,3	<b>181</b> 343:20	343:24 344:2
343:18	213:10,11 244:14	<b>182</b> 28:21	<b>2021</b> 74:14 94:22
<b>0</b>	256:2 326:2,4	<b>18th</b> 227:5	234:14 239:5,15
<b>00450</b> 1:4 5:12	<b>14's</b> 140:23	<b>19</b> 14:11 76:13	344:7,10
<b>03</b> 309:8	<b>15</b> 14:12 21:24	101:2 185:18	<b>2022</b> 1:20 5:3
<b>1</b>	31:19 33:13 57:15	<b>190</b> 343:25	64:11 65:14 87:4
<b>1</b> 5:4 64:8,9 65:6	85:15 95:3 111:6	<b>1970s</b> 298:17	130:22,22 187:5
272:8 287:7 343:8	140:20 152:19	<b>1973</b> 13:2 21:18	203:21 343:10
344:12	213:14 217:6	22:12 301:18	345:3
<b>10</b> 31:19 33:12	218:11 257:7	<b>1974</b> 21:6 96:15	<b>21</b> 76:10 190:5
219:3 234:11	290:14	<b>1977</b> 26:19	235:4 344:2
259:24	<b>151</b> 191:7,12	<b>1980s</b> 298:17	<b>22</b> 201:4,6 255:6,8
<b>100</b> 18:7 285:18	<b>152</b> 190:25 191:2	<b>1984</b> 96:15	<b>23</b> 64:11 102:2
293:4	191:10,21 279:6	<b>1988</b> 257:5,21	343:10
<b>10004</b> 3:5,15	<b>16</b> 14:12 40:11	<b>1989</b> 21:8	<b>234</b> 344:5
<b>10th</b> 335:7	48:19 57:15 69:22	<b>1990</b> 330:13	<b>239</b> 344:8
<b>11</b> 244:14 253:10	85:15 137:15,17	<b>1994</b> 96:15	<b>24</b> 54:11
253:10 254:11	140:20 165:11	<b>1:51</b> 161:9	<b>25</b> 28:14 76:10
255:5 293:4	169:13 170:10	<b>1st</b> 13:2	261:21
315:24 316:23	187:6,24,24	<b>2</b>	<b>26</b> 1:20 76:10
<b>115</b> 299:20	189:10 228:13	<b>2</b> 70:6,15 95:5	95:19 96:4 135:2
<b>11:00</b> 60:16	259:22,23	149:22 343:11	135:18 183:20,21
<b>11:06</b> 60:19	<b>16,000</b> 268:12,19	<b>20</b> 28:12,13 64:6	203:21
<b>12</b> 13:6,19 24:19	268:19,21 269:18	74:7 76:10,13	<b>26th</b> 5:3
27:18 28:10 31:3	269:23	140:20 210:18	<b>27</b> 290:14
56:4 181:11 224:9	<b>17</b> 14:13 48:20	260:2,8 261:21	<b>27,000</b> 148:11
281:7 343:23	69:22 84:5 137:17	295:17 330:15	287:6
<b>12.6</b> 147:11	137:17 163:6,6	347:15	<b>272</b> 344:11
<b>12.7</b> 148:8	164:13 181:7	<b>2000</b> 195:2	<b>28,000</b> 300:24
<b>125</b> 3:4,14	207:6 228:12	<b>2006</b> 40:7	<b>28-7</b> 262:24
<b>12:05</b> 105:9	290:14	<b>2010</b> 301:10,10	<b>2:02</b> 161:12
<b>12:46</b> 105:12	<b>17425</b> 342:23	316:5	<b>2nd</b> 3:22
<b>12th</b> 141:18	<b>17th</b> 87:5 137:14	<b>2011</b> 101:3 216:2	<b>3</b>
183:15 185:18	148:12	<b>2013</b> 291:4	<b>3</b> 70:2 86:7,8,15,15
<b>13</b> 90:10 132:3	<b>18</b> 14:10,10 30:25	<b>2017</b> 28:21 70:20	149:20 343:15
140:19,23 152:8	54:11,24 55:18	<b>2019</b> 137:14 272:9	<b>30</b> 25:7 90:12
163:10 186:8,24	69:22 75:24 80:25	344:13	102:2 229:12
187:3 213:9 219:9	83:13 84:4 85:5	<b>2020</b> 74:13 137:19	260:9 261:8
290:14	85:15 102:2,3	181:11,19 183:15	262:10,23,24
	157:7 165:9	185:18 190:5,21	330:16,19 345:17

<b>30,000</b> 122:12,14 <b>323</b> 4:13 <b>325</b> 21:8 <b>337</b> 343:4 <b>35</b> 13:4,18 218:12 235:7,9,16 <b>36</b> 97:6 <b>38</b> 146:23 <b>3:17</b> 223:5 <b>3:31</b> 223:8 <b>3:32</b> 223:11,16	184:4	<b>87</b> 219:9	324:25 325:16
	<b>5:15</b> 291:19	<b>88</b> 239:25 257:7	327:5
	<b>5:30</b> 304:15	<b>8th</b> 288:8	<b>abused</b> 108:8
<b>4</b> <b>4</b> 86:7 181:8 343:20 <b>40</b> 19:5 76:10 79:9 197:21 218:15 <b>425</b> 4:4 <b>43</b> 270:18 <b>45</b> 58:12 59:2 <b>49</b> 13:7 <b>4:21</b> 1:4 5:12 <b>4:58</b> 291:16	<b>6</b>	<b>9</b>	<b>abusers</b> 324:19
	<b>6</b> 65:19 234:12,20 234:23 239:2 343:2,3 344:5	<b>9</b> 239:5 344:10	<b>abusing</b> 104:23 325:18
	<b>60</b> 28:24 79:9 193:24 194:19 218:14 262:24 275:7	<b>90</b> 299:19	<b>academic</b> 276:9,11
<b>5</b> <b>5</b> 190:3,9 343:25 <b>5,000</b> 94:24 <b>5/26/2022</b> 345:5 346:2 347:2 <b>50</b> 14:15 31:18 33:9 96:9 97:4 129:20 146:18 218:12 248:24,25 251:6 293:19 298:19 315:3 334:15 <b>5163591</b> 345:5 346:2 347:2 <b>57</b> 182:14,15,19 <b>58</b> 182:14 <b>59</b> 71:6,14 182:10 182:11,25 183:3,4	<b>61</b> 97:6	<b>90,000</b> 122:13,13	<b>accept</b> 158:25
	<b>64</b> 343:8	<b>904</b> 3:22	<b>acceptable</b> 135:8
	<b>6:09</b> 337:18	<b>93</b> 239:14,18,19	<b>acceptance</b> 115:25 279:3
<b>7</b> <b>7</b> 73:18 219:4 239:3,9,11 267:14 267:18,19 270:6 283:12,13 344:8 <b>70</b> 270:5 343:11 <b>70s</b> 320:16,22 <b>72201</b> 3:23 4:5,14 <b>78</b> 267:15,20 <b>79</b> 146:24 <b>7:30</b> 11:7 <b>7th</b> 71:24 72:19 275:21 276:2	<b>6:21</b> 337:21	<b>9:20</b> 1:21	<b>accepted</b> 248:24
	<b>6:25</b> 341:5,7	<b>9:32</b> 11:23	<b>access</b> 138:8 195:3 223:20 224:3 325:14
	<b>7</b>	<b>9:59</b> 12:4	<b>accounts</b> 124:13 169:15
<b>8</b> <b>8</b> 190:2 272:6,7,17 283:10,15 344:11 345:3 <b>80</b> 219:9 <b>80s</b> 320:16,22 <b>817125</b> 2:10 342:25 <b>83</b> 219:3,5 <b>86</b> 257:11 343:15	<b>a</b>	<b>9th</b> 239:14	<b>accumulated</b> 130:9
	<b>a.m.</b> 1:21 5:3 14:2	<b>abating</b> 225:16	<b>accuracy</b> 190:23 345:9
	<b>abbruzzese</b> 90:23 90:25 91:9,22	<b>ability</b> 62:10 179:11 185:6 338:3 340:10	<b>accurate</b> 160:9 205:5 342:10
<b>8</b> <b>8</b> 190:2 272:6,7,17 283:10,15 344:11 345:3 <b>80</b> 219:9 <b>80s</b> 320:16,22 <b>817125</b> 2:10 342:25 <b>83</b> 219:3,5 <b>86</b> 257:11 343:15	<b>able</b> 7:22 40:2,3 41:7 44:7 61:25 62:5,24 65:5 70:15 78:16 86:17 152:18 181:5 190:10 195:17 212:24 312:10	<b>abnormal</b> 301:12 316:6	<b>accurately</b> 90:9 104:18,20 262:20
	<b>abnormality</b> 316:11	<b>abortion</b> 328:18	<b>accusation</b> 148:13
	<b>absence</b> 153:10	<b>absolute</b> 84:8 192:12	<b>accused</b> 314:3 324:24 330:23
<b>8</b> <b>8</b> 190:2 272:6,7,17 283:10,15 344:11 345:3 <b>80</b> 219:9 <b>80s</b> 320:16,22 <b>817125</b> 2:10 342:25 <b>83</b> 219:3,5 <b>86</b> 257:11 343:15	<b>absolutely</b> 117:15 224:23 228:21	<b>abuse</b> 153:12 211:18 323:8	<b>achieve</b> 321:25
			<b>acknowledge</b> 337:3
			<b>acknowledgement</b> 347:3
<b>8</b> <b>8</b> 190:2 272:6,7,17 283:10,15 344:11 345:3 <b>80</b> 219:9 <b>80s</b> 320:16,22 <b>817125</b> 2:10 342:25 <b>83</b> 219:3,5 <b>86</b> 257:11 343:15			<b>acknowledgment</b> 345:12
			<b>aclu</b> 3:21 5:16,19 7:10
			<b>aclu.org</b> 3:17,19 3:25
<b>8</b> <b>8</b> 190:2 272:6,7,17 283:10,15 344:11 345:3 <b>80</b> 219:9 <b>80s</b> 320:16,22 <b>817125</b> 2:10 342:25 <b>83</b> 219:3,5 <b>86</b> 257:11 343:15			<b>act</b> 325:16

<b>acting</b> 329:6 <b>action</b> 342:18,21 <b>actions</b> 211:23,25 <b>active</b> 170:5 <b>actively</b> 17:4 334:16 <b>activities</b> 43:4 <b>activity</b> 298:2 <b>actual</b> 218:21 <b>adaptations</b> 269:13 <b>add</b> 61:16 87:20 145:4 193:24 203:11 <b>added</b> 22:20 <b>addition</b> 230:9 <b>additional</b> 87:21 87:23 168:22 185:21 280:23 <b>additions</b> 347:6 <b>address</b> 29:13,16 83:8 105:22 107:2 107:4,6,21 108:3,5 108:24 289:20 <b>addresses</b> 243:15 <b>adequate</b> 306:3 <b>adjourned</b> 341:7 <b>adkins</b> 10:11 <b>adolescence</b> 51:20 108:12 140:16 189:22 253:13,15 254:3,8 256:11 258:12,18 264:2 <b>adolescent</b> 14:16 32:3,6 46:18 47:16,25 48:4 49:9 55:3 56:13 58:7 62:25 64:3 75:18 112:22 114:21 157:19 179:7 227:25	<b>adolescents</b> 35:16 35:18,25 46:17 48:2 49:17 54:22 57:2 58:21 61:11 61:19,24 71:25 72:3 73:16,22 74:8 76:9,21 77:22 85:21 86:24 89:7 108:13 110:25 112:6,7,11 156:3 171:6 176:7 181:10 223:19 225:22 236:3,5 238:6,8 263:24 305:23 333:16 334:6 343:23 <b>adult</b> 16:21 44:3 46:6 53:11,21 69:16 95:10 104:24 157:11 199:19 200:22 206:22,23 256:22 <b>adults</b> 14:7,8,23 15:14 23:9 24:22 30:15 40:16 46:21 47:17 53:7,10 55:13 61:14 84:24 86:25 88:12,24 96:9,22,23 111:2 112:6 114:22,23 115:6,7,20 157:5 192:20 193:6 194:15,17,24 195:7 196:14 197:2,25 215:23 259:3 320:22 <b>advance</b> 230:9 231:10 337:2,9 <b>advances</b> 335:23 336:11	<b>adversities</b> 83:8 108:22 221:12 <b>advocacy</b> 286:5 <b>advocate</b> 231:22 231:23 263:25 <b>advocates</b> 193:22 <b>affiliated</b> 24:12 91:22 92:6,20,25 <b>affiliation</b> 91:15 91:21 <b>affirmation</b> 144:10 <b>affirmative</b> 36:7 76:3 264:2 280:2 280:17 284:3 297:19 298:2,21 298:24 299:7 301:13 321:19 326:3 <b>affirmed</b> 257:23 <b>affirming</b> 128:2,4 128:15 131:15 134:21 135:3,19 136:10 137:4 138:8,13,19 139:11 145:13,14 148:25 151:12 156:7,10 157:20 159:14 161:17 162:5 171:7 172:18 175:14 176:6,10 177:8 178:22 181:24 183:12,23 202:10 202:24 205:11 207:13 208:9,23 212:13 219:19 220:10,20 226:23 228:20 229:6 243:20 246:20 285:11 310:10	323:7 325:14 327:6,19 329:5 330:6 331:15 <b>afford</b> 152:19 <b>afield</b> 132:22 <b>afraid</b> 309:10 <b>age</b> 48:20 102:4 157:4 248:7 256:2 260:8 261:20 268:15 <b>agencies</b> 325:24 <b>agent</b> 188:20 210:16 <b>agents</b> 244:8 <b>ago</b> 54:11,11 69:22 69:23 74:3 111:10 125:25 183:18,19 186:14 206:12 226:19 236:7 237:9 238:12 240:17 248:25,25 291:23,24 306:8 324:7 327:23 <b>agree</b> 47:2 131:17 132:25 133:11,12 135:10,16 169:16 197:8 214:4,23 258:6 278:18 284:19 333:2,13 333:22 334:2,7 <b>agreed</b> 68:9 194:11 230:8 <b>agreement</b> 339:2 <b>agrees</b> 92:15 <b>ahead</b> 19:4 129:5 306:2 338:23 340:2 <b>ails</b> 125:16 <b>aim</b> 155:15 <b>aimed</b> 168:16 188:22
--	--	---	---

<b>al</b> 1:7,12 5:8,9 260:5 261:13 262:7 270:19 271:17 345:4,4 346:1,1 347:1,1 <b>alabama</b> 208:21 327:19,22 328:9 <b>aland</b> 4:18 <b>allotted</b> 345:20 <b>allow</b> 135:11 137:4 206:18 225:13 242:2 <b>allowed</b> 129:4 <b>allowing</b> 228:23 <b>allows</b> 136:10 159:18 232:9 <b>alternate</b> 93:12 289:6 297:21 314:14,17,19 <b>alternative</b> 138:20 264:4 <b>altogether</b> 55:11 <b>amanda</b> 4:17 <b>amazingly</b> 94:6 <b>ambitious</b> 288:6 <b>ambivalence</b> 200:9 <b>ambivalent</b> 115:9 <b>amenable</b> 233:19 <b>amended</b> 211:5 <b>america</b> 206:3 225:15 232:11,15 246:14 334:15 <b>american</b> 3:13 98:5 194:8 284:21 293:11 294:3,5 300:21 302:6,7 <b>amount</b> 95:5 <b>amounted</b> 169:6 <b>amsterdam</b> 246:12	<b>analysis</b> 310:6 331:12 <b>analyze</b> 308:5 <b>analyzing</b> 92:3 129:10,12 <b>androgens</b> 168:9 <b>anecdotal</b> 235:24 236:10,15,17,19 238:3,16,18 240:16,22 241:23 242:11 243:6 <b>angels</b> 204:20 <b>angst</b> 49:19 <b>anguish</b> 85:17 <b>animae</b> 50:2 <b>anna</b> 27:9 60:22 61:20 337:25 338:11,24 339:16 340:6,7 <b>announcement</b> 111:7 302:20 303:5 <b>announces</b> 291:2 <b>annual</b> 293:10 <b>anonymous</b> 271:21 277:11 <b>anonymously</b> 273:20 <b>answer</b> 8:3,7,8,13 8:22 9:6 10:4 13:8 28:9 31:15 32:4 33:25 34:11 38:23 40:5 43:15 45:11 45:12 48:23 49:4 50:19 53:7 54:13 76:2 79:11 83:4 83:16,22 100:2 104:25 107:8 116:4,23 119:8 125:3 126:18,20 128:9 130:19	142:17 145:23 147:6,10 151:22 153:3 159:19 176:20,21 178:8 181:5 192:4,6,7 206:2,13 207:18 218:5,13 228:16 229:10 233:13 237:6 246:23 247:4 248:15 255:13,14 257:22 258:21 259:11 288:20 302:15 307:20 322:22,24 325:9 326:25 329:22 335:14 337:9 340:20,22 <b>answered</b> 21:12 49:6 130:20 175:17 200:7 201:24 214:14 283:5 <b>answering</b> 32:12 56:6 221:22 233:16 255:22 <b>answers</b> 7:23 56:9 228:4 <b>antecedents</b> 107:15 <b>anti</b> 174:12,13 209:19 210:16 <b>anticipate</b> 8:4 <b>anticipated</b> 89:20 <b>antidepressant</b> 210:16 251:23 <b>antidepressants</b> 244:10 <b>antipsychotic</b> 335:3 <b>anton</b> 10:12	<b>anxiety</b> 43:2 77:25 101:22 119:4 123:19 210:16 211:17 290:19 310:20 312:11 317:5 <b>anxious</b> 123:13 318:15 <b>anybody</b> 98:3 227:5 <b>anymore</b> 13:9 260:19 288:19 <b>anyway</b> 246:16 298:8 <b>apa</b> 291:21 292:20 293:15 300:10,25 301:10,17 302:16 302:18,24 303:7 303:10 316:4 324:10 <b>apa's</b> 300:13 <b>apart</b> 318:11 <b>apas</b> 294:8 <b>apparent</b> 43:18 <b>apparently</b> 179:20 <b>appear</b> 116:10 <b>appearance</b> 6:9 <b>appeared</b> 303:3 <b>appearing</b> 5:17,20 5:23 <b>appended</b> 347:7 <b>apples</b> 252:5 <b>applicable</b> 345:8 <b>applied</b> 202:9 263:23 <b>applies</b> 170:9 222:20,21,22,23 <b>apply</b> 89:6,14 168:15 211:5 <b>applying</b> 263:17
--	--	--	--

<b>appraisal</b> 313:24 <b>appreciate</b> 90:10 90:21 <b>appreciation</b> 244:7,11 <b>approach</b> 77:2 92:14 105:21 110:17,19 135:11 135:23,24,25 136:7,12,22 138:17,20 140:6 147:19 163:12 167:18,19 174:6 212:19,20 217:12 227:24 263:3,16 288:25 299:25 <b>approaches</b> 93:12 335:6 <b>approaching</b> 210:13 <b>appropriate</b> 48:8 62:3 81:13 85:10 202:8 210:9 214:24 228:11 333:16 334:5,21 <b>appropriately</b> 173:2 315:20 <b>appropriateness</b> 35:24 <b>approval</b> 45:2 57:24 59:2 137:18 <b>approve</b> 73:23 99:7 101:9 338:4 338:7 339:15 <b>approved</b> 57:13 58:9,14,16 59:2 63:22 68:21 69:2 69:14 74:7 75:24 77:9 78:6 79:16 85:5 97:3 135:6 231:4 248:22	251:19,25 340:7 <b>approves</b> 339:17 <b>approving</b> 82:17 84:3 <b>approximate</b> 13:16 16:20 <b>approximately</b> 12:21 23:16 30:18 35:17 55:15 56:12 56:25 59:24 251:7 293:4 <b>approximation</b> 20:6 <b>apt</b> 186:21 <b>area</b> 22:9 76:14 178:13 202:3 276:23 288:11 304:10 328:18,18 328:19 338:10 <b>arena</b> 194:17 204:19 <b>argue</b> 156:9 <b>argues</b> 147:5 <b>argument</b> 120:17 189:4,9 198:12 <b>argumentative</b> 119:19 217:16 <b>arisen</b> 76:17 <b>arizona</b> 330:25 <b>arkansas</b> 1:2,11 3:21,23 4:5,12,14 5:11 6:14 149:2,5 149:6,11,12 162:2 163:12,13,21,25 171:20 172:5,14 177:9 202:11 209:23 223:18 225:23 231:25 232:24 303:20 305:2 329:4 331:7 332:22	<b>arkansasag.gov</b> 4:16,18 345:2 <b>arm</b> 230:20 <b>armbruster</b> 3:8 5:25 6:1 <b>armbrustere</b> 3:9 <b>arms</b> 230:17 <b>art</b> 114:13 <b>article</b> 10:2 86:8 86:22 87:6 89:3 89:12 90:4 148:12 154:8,12 155:17 155:22 156:6,10 176:14 179:2 181:3 200:5 202:5 203:23 217:12,13 217:17,22 237:8 272:4 276:18 278:9 280:3 281:10 282:10 286:9 287:3,7,8 325:20 343:15 <b>articles</b> 178:11 279:6 308:12,13 <b>articulate</b> 146:24 177:13 178:25 <b>articulated</b> 152:2 <b>articulately</b> 195:25 <b>articulates</b> 147:13 <b>aside</b> 187:13 199:2 <b>asked</b> 16:16 20:4 29:11 40:24 44:12 44:15 48:6 70:22 75:17 93:6 109:7 161:14 200:7 201:24 204:25 207:11,15,20,21 208:25 214:14 226:24 234:6 255:11 277:14	281:12 285:5 302:20 318:3 323:18 327:2,15 327:16 <b>asking</b> 8:9 12:6 19:25 21:14 24:3 24:23 30:13 40:19 45:14 50:21 56:10 82:6,7 92:7 113:3 119:13 133:6 142:13 178:18 179:24 184:6,7,21 197:11 199:4 202:20 242:8,9 250:12 255:7,16 255:18,19 274:2 276:13 286:13,14 317:25 319:21 326:19 330:2,3 331:12,13 332:18 333:21 <b>asks</b> 182:18 282:9 <b>aspect</b> 29:15,16,17 42:17 81:16 109:4 <b>aspects</b> 38:12 81:18 119:24 <b>aspirations</b> 116:21 <b>asserting</b> 49:10 286:11,14 <b>assess</b> 40:2 41:7 90:9 119:8 <b>assessed</b> 130:14 258:4 <b>assessing</b> 243:19 <b>assessment</b> 41:24 102:23 <b>assigned</b> 139:25 143:14 242:22 295:9 <b>assignment</b> 184:7 193:23
--	---	--	--

<b>assistant</b> 4:10 327:21 <b>associate</b> 297:10 304:22 <b>associated</b> 76:18 144:21 222:16 <b>associates</b> 6:7 <b>association</b> 98:6 284:21 293:11 294:4,6 300:21 302:8 <b>associations</b> 300:20 <b>assume</b> 8:23 20:16 44:14 51:22 84:23 104:5,7 106:7 151:5 <b>assuming</b> 107:24 159:9 <b>assumption</b> 211:13 264:24 <b>assure</b> 103:12 <b>assured</b> 68:7 <b>asterisk</b> 304:8 <b>atherosclerotic</b> 336:3 <b>attached</b> 345:11 <b>attacked</b> 194:10 <b>attempt</b> 108:21 121:16 <b>attended</b> 302:25 <b>attention</b> 157:4 200:24 289:17 335:15 <b>attitude</b> 188:12,14 <b>attitudes</b> 312:25 <b>attorney</b> 1:12 4:10 4:12 6:15 165:16 165:17 177:11 201:23 233:2,4 323:22 327:21,22	329:21 342:17,20 345:13 <b>attributed</b> 122:25 <b>atypical</b> 52:7 <b>audience</b> 292:21 292:24 301:3 <b>audio</b> 221:23 <b>august</b> 74:13 194:8 <b>australia</b> 93:20 246:11 <b>author</b> 85:10 271:11,19,21 277:6,20 287:4 <b>authority</b> 338:6 <b>authorization</b> 80:13,23 95:9 226:22 <b>authorizing</b> 87:11 96:3 97:9 <b>authors</b> 93:4 261:24 280:4 281:7,8,12 <b>autism</b> 43:3 77:25 <b>autistic</b> 82:2 147:25 <b>autonomy</b> 68:11 340:11 <b>availability</b> 79:25 <b>available</b> 64:23 70:4 86:14 234:19 268:16 272:13 338:21 345:6 <b>avenue</b> 4:4 <b>average</b> 13:4 189:10 260:8 261:20 <b>avoid</b> 7:25 <b>aware</b> 63:8 79:4 112:18,20,20 134:19,23 136:8	137:10 141:13 193:15 194:23 231:24 253:7 255:8,23 256:13 258:23 259:13,19 302:4,16 303:7 323:6,10,13,15,16 323:17 328:16 329:3 332:13,22 332:23 334:12,17 339:23 <b>awkward</b> 178:19 <b>ayad</b> 238:23 292:16 294:10 295:20 299:16,16 299:22	78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1,10 87:1 88:1 89:1 90:1 91:1,2,2 92:1 93:1 94:1 95:1 96:1 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1 129:1 130:1 131:1 132:1 133:1 134:1 135:1 136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 149:1 150:1 151:1 152:1 153:1 154:1 155:1 156:1 157:1 158:1 159:1 160:1 161:1 162:1 163:1 164:1 165:1 166:1 167:1 168:1 169:1 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1 182:1 183:1 184:1 185:1 186:1 187:1 188:1 189:1 190:1,4 191:1 192:1 193:1 194:1 195:1 196:1 197:1 198:1 199:1
		<b>b</b>	
		<b>b</b> 1:19 2:3 6:21 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1,10 65:1 66:1 67:1 68:1 69:1 70:1,7 71:1 72:1 73:1 74:1 75:1 76:1 77:1	

200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 211:1 212:1 213:1 214:1 215:1 216:1 217:1 218:1 219:1 220:1 221:1 222:1 223:1 224:1 225:1 226:1 227:1 228:1 229:1 230:1 231:1 232:1 233:1 234:1,13 235:1 236:1 237:1 238:1 239:1,4 240:1,21,24 241:1 242:1 243:1,5 244:1 245:1,13,18 245:21 246:1 247:1 248:1 249:1 250:1 251:1 252:1 253:1 254:1 255:1 256:1 257:1 258:1 259:1 260:1 261:1 262:1 263:1 264:1 265:1 266:1 267:1 268:1 269:1 270:1 271:1 272:1 273:1 274:1 275:1 276:1 277:1 278:1 279:1 280:1 281:1 282:1 283:1 284:1 285:1 286:1 287:1 288:1 289:1 290:1 291:1 292:1 293:1 294:1 295:1 296:1 297:1 298:1 299:1 300:1 301:1 302:1 303:1 304:1 305:1 306:1 307:1 308:1 309:1 310:1 311:1 312:1 313:1 314:1 315:1	316:1 317:1 318:1 319:1 320:1 321:1 322:1 323:1 324:1 325:1 326:1 327:1 328:1 329:1 330:1 331:1 332:1 333:1 334:1 335:1 336:1 337:1 338:1 339:1 340:1 341:1 342:6 343:2,7,9,12,17 344:1,6,9 345:5 346:2,24 347:2,4 347:12 <b>back</b> 12:3 18:14 18:22,24 28:18,20 29:4 37:24 53:24 60:18 73:20 95:24 96:2 99:22 101:7 105:11 111:9 113:9,10 115:10 161:11 175:7 176:4,22 222:8 223:7,15 225:21 235:3 254:20 260:3 264:6 267:14,19 277:7,9 278:22 283:11 291:18 294:9 321:4 328:3 337:20 <b>background</b> 12:17 92:9 95:7 309:20 <b>backup</b> 72:23 <b>bad</b> 75:13 192:16 221:13 226:13,17 <b>balance</b> 221:4 <b>balanced</b> 337:4 <b>ball</b> 233:21 <b>ban</b> 173:9 195:21 197:18,23 198:4 212:15 217:25	218:8,14,16 219:17,19 233:7 327:18 <b>banned</b> 134:21 136:2 <b>banning</b> 172:2,5 176:10 177:7 199:5 202:15 207:12,21 217:14 220:10,20 <b>bans</b> 135:18 192:9 192:12,18,24 196:19,25 197:3 197:14 199:21 200:9 201:11 208:9 213:5 <b>barrett</b> 7:16 <b>base</b> 130:11 <b>based</b> 41:15 49:10 91:19 93:7 106:8 130:7,25 148:16 160:8 174:20 180:3 185:5,5,7 193:16 194:12 197:5 203:16 209:18 211:12 213:7 220:24 227:12,19 241:10 242:5 244:3 248:17 281:4 284:5 291:3 296:11,15 299:5 317:19 319:24 322:18 <b>basic</b> 299:2 <b>basically</b> 22:13 77:23 98:8 238:17 262:8 <b>basis</b> 54:3,20 83:5 103:22 167:7 207:7 214:8 222:5	222:18 228:10 232:21,22 251:2 251:18 284:14 <b>bates</b> 191:16 <b>bearing</b> 97:20 <b>beautiful</b> 280:13 <b>beauty</b> 49:21 <b>bedwetting</b> 43:5 <b>began</b> 94:23 193:23 263:21 <b>beginning</b> 72:24 191:9 193:3 259:20 260:11 297:22 320:14 <b>begins</b> 12:23 29:14 108:15 203:25 230:2,3 254:24 257:21 318:5 <b>behalf</b> 327:3 <b>behaved</b> 256:25 <b>behavior</b> 38:8 <b>behavioral</b> 115:17 116:2 <b>behooves</b> 156:15 156:17 <b>beings</b> 22:3 110:3 110:4,10 308:8 <b>belief</b> 148:21 168:25 204:3 285:19 290:10 <b>beliefs</b> 145:3 156:18,19 204:5 204:19 229:18 <b>believe</b> 14:14 15:3 37:3 41:2 45:3,10 50:13 53:25 61:8 74:6 84:12 96:7 98:23 124:10,16 124:16 125:25 128:3 133:23 141:10 153:20,21
---	--	--	---



158:22,23 175:3 177:24 178:6 180:21 192:8,24 196:18 197:13 200:12 205:8 207:9,9 212:21 219:22,24 253:2 262:7,10 280:6 283:10,14 298:3,9 298:10 300:7 321:14 336:19 339:5,7 <b>believed</b> 49:9 201:15 <b>believers</b> 242:4 <b>believes</b> 99:2 132:18 207:6,7 280:2 <b>bell</b> 303:22 <b>beneficial</b> 101:12 169:16 179:8 209:24 210:6 211:14 214:5 217:11 228:18 244:24 <b>benefit</b> 98:24 99:3 99:10 100:7 102:14 117:6 126:11 133:2,14 156:5 170:17 174:18 185:22 204:21 212:3 215:11 218:2,25 226:7 247:14 <b>benefited</b> 218:12 219:5 <b>benefiting</b> 211:2 <b>benefits</b> 117:4 127:24,25 128:5 128:15,23 129:8 129:25 130:15,18	131:4,14,17,23 132:8 133:3,23 134:7 139:2,6,12 139:21 141:7,9 174:22 193:18 194:2,22 206:19 214:8 215:2,9,12 216:8 217:2 218:2 218:25 250:19 <b>best</b> 7:25 8:7 46:2 130:5,21 140:5 160:18 165:6 175:11 198:18,19 198:21 199:3 201:16 211:9 225:12 244:19 291:25 299:8,10 299:11 339:25 340:9 <b>beth</b> 4:6 6:10 <b>better</b> 44:20 117:20 118:9,10 118:15 119:10 122:4,22 124:4,21 124:24 130:23 155:5 158:5 169:2 169:4 170:20 171:23 172:9 202:14 216:9 228:25 241:7 286:4,4 315:3 <b>beyond</b> 235:24 238:3 <b>bi</b> 257:11 <b>bias</b> 270:21 <b>biased</b> 84:17 <b>big</b> 107:13 136:20 276:5 292:21,24 293:3 314:10,11 315:5	<b>biggs</b> 307:25 308:2 309:18 <b>bill</b> 6:11 170:8,8 210:22 211:4 <b>biological</b> 267:24 <b>biologically</b> 298:4 <b>bipolar</b> 310:22,24 311:2,4,5 <b>birth</b> 107:19 139:25 143:14 242:22 295:8,9 <b>birthday</b> 227:6 <b>bisexual</b> 51:17 115:4 <b>bit</b> 16:18 23:22 113:19 237:15 274:10 283:21 302:4 <b>black</b> 224:2,22 226:3,9,15 <b>bladder</b> 161:4 <b>blanket</b> 222:6 <b>bless</b> 232:7 <b>blessing</b> 47:9 163:24 <b>blind</b> 246:18 249:3 <b>blinded</b> 246:21 247:7 <b>block</b> 239:14 <b>blockers</b> 80:15,16 80:17 137:16,24 153:24 186:10 198:5 227:14 300:5 <b>blocking</b> 136:5 156:23 184:11 197:19 227:19 243:22 244:2,3,8 244:20,23 258:3 <b>blood</b> 216:13,14 312:3,10,13,19	336:3 <b>blue</b> 71:13 149:23 150:9 <b>board</b> 176:11 177:9 202:15 282:18,19 285:13 285:15 329:9,14 330:9,22 331:8,11 <b>boards</b> 330:20 <b>bodies</b> 213:3 313:20 <b>bodily</b> 87:22 188:15 <b>body</b> 49:20,20 108:7 115:25 168:10 188:8 231:5 242:18 252:19 253:5 312:17 <b>book</b> 98:4 335:5,8 <b>boston</b> 246:13 <b>bottom</b> 182:19 191:8,12 272:20 <b>box</b> 221:17 <b>boy</b> 213:14 257:5 <b>boyd</b> 260:5 261:6 261:13 262:7 <b>boys</b> 140:2 236:2 238:6 258:8 <b>bpj</b> 65:12 <b>brain</b> 56:3 158:10 <b>brains</b> 196:3 <b>brandt</b> 1:6,7 5:8 345:4 346:1 347:1 <b>brandyn</b> 3:6 5:21 <b>break</b> 9:4 17:8 53:8 60:12 105:3 105:4 160:25 161:7 213:23 214:17 221:21 222:25 291:8
--	---	---	---

337:16 <b>breaking</b> 9:8 160:24 <b>breaks</b> 9:2 <b>breast</b> 117:12 180:12 222:8,14 222:15,16,20 <b>breasts</b> 47:2 132:2 195:12 213:9 216:12 <b>brief</b> 10:14 <b>briefe</b> 100:3 <b>brilliant</b> 75:4 <b>bringing</b> 63:14,19 <b>british</b> 273:2 <b>broad</b> 3:4,14 <b>brother</b> 224:17 <b>brought</b> 29:19 <b>bränström</b> 194:7 216:2 279:22 280:13 282:23 <b>bs</b> 159:2 <b>buck</b> 104:12 <b>bucks</b> 314:11,11 315:5 <b>burch</b> 176:3 <b>business</b> 213:4 <b>busted</b> 261:11 <b>busy</b> 323:25 <b>button</b> 64:24 <b>bypassed</b> 235:9	230:16,25 238:14 242:11 281:14 282:13 295:9,14 298:14 314:10 315:8 321:5 327:23 <b>called</b> 130:5 144:10 154:15 198:18 207:25 231:4 240:22 242:24 243:6 276:24 282:8 283:9 290:15 301:19,21 306:15 314:15 323:22 324:6,7,9 335:6 <b>calling</b> 49:23 209:17 <b>calls</b> 22:23 220:13 226:5 292:20 <b>calm</b> 326:7,8 <b>campos</b> 268:22 <b>canada</b> 93:21 246:12 270:15 271:3 <b>canadian</b> 272:7,19 272:24 344:11 <b>cancel</b> 335:19 <b>cancer</b> 19:6 95:15 95:17 174:12,13 174:17 222:9,14 222:15,16,20 266:14 <b>cantrell</b> 4:15 6:8 6:13,14 12:13 34:12 36:22 39:11 39:21 42:14 44:19 47:19 50:17 53:3 62:11 64:19,25 70:13 81:14 83:2 84:7 85:11,25	90:7 100:11 101:13 105:5,24 119:18 121:25 126:12 128:24 131:19 133:8 135:20 136:15 138:10,22 139:14 143:11 145:20 146:12 151:21 157:22 159:16 162:9 164:17 166:13 167:5 169:23 172:7,19 175:15 176:12,18 176:21 177:10 179:3 187:7 193:2 193:10,14 199:9 200:6 202:17 205:12 207:14 208:11 211:11 213:22 214:13 215:6 217:15 219:18,21 220:12 220:22 222:7 223:22 226:4 228:14 232:4 234:5 237:14 247:16,24 249:10 252:14 279:13 283:23 291:10,13 300:11,22 306:11 307:19 311:3 315:15 317:21 319:3 320:7 324:20 327:8 329:10,20 331:18 332:5 333:18 337:15,22 340:21 343:5 345:1 <b>capable</b> 129:10,12	<b>capacities</b> 120:4 <b>capacity</b> 1:11 72:13 90:16 308:4 308:9 338:3 <b>capitol</b> 4:4 <b>cardiac</b> 41:11 <b>cardiovascular</b> 215:15 216:18 <b>care</b> 29:5,19,23 30:4 35:20 36:7 41:10 72:5,19 73:18 100:10,13 100:14 101:4 102:17,22 125:15 128:2,5,16 131:16 134:22 135:3,18 135:19 136:11 138:9,14,19 139:7 139:11,13 141:4 144:21 145:8,13 145:15 146:7 148:25 155:15,23 156:3,11 157:21 159:13,15 161:17 165:2 172:5 173:23 174:8 175:14 176:7,10 177:8 178:12,17 178:22 181:24 183:12,23 186:5 202:10,15,16,24 205:11 206:24 207:13 208:9,23 210:9 212:15 219:17,20 220:10 220:14,15 222:6 223:19 225:24 228:20 229:6 243:20 245:9 262:9 264:2 270:22 273:25
<b>c</b>			
<b>c</b> 3:1 4:1 245:13 342:1,1 <b>calculated</b> 309:7 <b>california</b> 257:10 <b>call</b> 9:3 23:7 78:13 92:22 93:15 103:14 135:5 169:10 189:7 193:19 209:18			

274:7,16 275:3,9 275:21,23 276:2 280:2,17 284:3 285:12 286:12,17 287:23 288:8 298:21,24 299:7 301:13 310:11 321:19 323:8 325:14 326:3 327:19 329:5 330:6 332:3,11 336:15 <b>career</b> 12:22,23 14:16 21:25 74:4 77:3 106:16 <b>careful</b> 76:25 81:12 122:15 153:15 189:23 262:6 269:16 330:24 <b>carefully</b> 129:22 129:22 229:9 269:9 <b>carries</b> 42:20 <b>carveout</b> 171:6 <b>case</b> 1:4 5:11 25:4 25:6 26:16 37:12 62:13 65:12 70:19 71:3 96:8 112:25 128:20 131:12,18 131:21 132:11 133:13 142:12 159:17 161:14,20 162:2 167:7,7,20 167:20 173:25 175:11,11 176:8 176:16,25 177:6 187:21 190:15,18 192:20 212:12,15 212:15 222:5,5,9,9 222:18,18 228:9,9	231:25 235:3 239:13 240:21 241:2,2,4,21,22 242:6,16 243:5 244:16 280:14 303:21 304:3 305:13 306:6 307:24 327:17 332:14 339:10 <b>cases</b> 23:20 25:20 26:6 40:12 78:4 93:24 132:12,20 133:3 139:5,13 144:4 162:7 220:4 236:17 240:21 243:5 244:17,18 245:5 332:15 333:3,5 <b>cass</b> 134:14 138:3 <b>categorical</b> 192:5 192:9,12,18,24 196:19,25 197:3 197:13,23 199:21 200:9 201:11 212:14 213:5 <b>categorically</b> 156:11 195:24 197:18 198:4 199:5 <b>categories</b> 21:21 243:13,17,18 <b>category</b> 17:15 173:11 241:24 <b>cause</b> 85:17 130:10 166:15 169:21,25 170:2,6 226:7 242:20 330:7 <b>caused</b> 140:12 <b>causes</b> 180:8	<b>caution</b> 125:18 140:14 153:22 178:24 189:23,23 <b>cautious</b> 72:3,22 73:15 130:10 186:21 202:23 218:25 227:9 286:20,21 299:24 <b>ccr</b> 1:25 <b>cdt</b> 1:21 <b>center</b> 4:13 71:22 72:25 73:8,9,14 76:5,24 77:14 <b>centers</b> 184:12 232:23 244:18 298:17,20 <b>central</b> 1:3 <b>certain</b> 76:2 110:2 110:4,5 119:24 142:23 174:18,19 178:4 186:25 192:15,25 194:21 205:16 219:6,7 220:25 221:2 248:22 253:9 259:15 267:5 280:16 290:3 312:7,23 <b>certainly</b> 9:3 62:24 76:4 84:11 100:13 111:19 112:25 115:7 119:24 124:12 137:7,8 198:16 226:13 231:20 244:21 263:21,24 265:18 267:7,10 300:6 301:2 307:8 312:4 340:16 <b>certainty</b> 110:9 114:9,17 244:22	245:7 <b>certified</b> 2:7 <b>certify</b> 342:4,9,15 <b>chain</b> 204:11 295:25 296:17,25 297:4,5,12,14 <b>chairman</b> 182:21 <b>challenges</b> 107:18 107:24 264:22 <b>chance</b> 88:4 187:16 <b>chances</b> 240:13 <b>change</b> 51:20,21 108:2 130:24 147:17,20 188:11 196:10 251:12 322:15 346:4,7,10 346:13,16,19 <b>changeable</b> 140:21 <b>changed</b> 14:19 20:13 96:18 129:16 197:16 278:17 <b>changes</b> 278:14,15 278:15,18 297:7 345:10 347:6 <b>changing</b> 186:15 217:7 <b>chapter</b> 335:8 <b>charge</b> 158:2 <b>chase</b> 3:18 5:18 <b>check</b> 237:11 282:17 <b>child</b> 16:3 22:22 32:2 34:5,7 36:24 62:18 77:20 88:3 90:14 107:18,22 108:10 113:18 147:24,25 153:13 158:14 159:13,20 159:21 160:8
--	---	--	--

165:11 167:23 168:4 173:23 175:2 179:7,9 185:10,14 200:18 200:19,21,25 201:6,13 206:10 206:14,22 207:4 210:14 227:13,16 231:13 263:22 264:22 265:4,12 265:14,17 267:10 323:8 324:19,23 324:24 325:16,18 325:23 327:5 340:2 <b>child's</b> 62:16 180:7 188:11 203:18 264:19 <b>childhood</b> 254:18 254:22 255:3,25 258:5,17 <b>children</b> 15:3,5,10 15:13,13,15,18,23 16:8 23:8 26:2 27:6 33:17 52:21 61:14,16 62:15 86:24 88:18 112:8 125:9 140:11 157:20 158:13 163:18 166:5 170:19 171:14 172:21 173:3 184:14 188:22 196:14 200:13 201:20 210:7,19 212:20,23,24 213:12,16 227:25 227:25 252:25 253:11,11 254:11 255:9 256:17 257:7,12,17,23	259:3,6,7 263:17 295:6 300:5 321:9 323:4,5 325:15,25 325:25 338:13 <b>children's</b> 149:7 167:13 <b>china</b> 57:18 224:14 <b>choice</b> 67:16 130:4 202:15 <b>choices</b> 277:18 <b>cholesterol</b> 216:15 <b>choose</b> 195:21 205:10 <b>chronic</b> 100:22 101:21 <b>chronically</b> 104:23 <b>cigarettes</b> 123:14 <b>circa</b> 203:21 <b>circumstance</b> 153:9 289:25 <b>circumstances</b> 32:8 78:9 82:25 127:6 162:8 171:13 172:21 205:16 253:9 <b>cis</b> 213:16 256:6 <b>cisgender</b> 257:19 <b>cited</b> 283:9,14 <b>cites</b> 270:18 <b>cities</b> 246:13 <b>citizen</b> 326:14 <b>civil</b> 3:13 94:9 <b>claim</b> 135:9 322:8 <b>claimed</b> 48:25 268:11 <b>claiming</b> 268:8 295:6 <b>claims</b> 308:22	<b>claire</b> 190:5,16 344:3 <b>clarification</b> 8:20 <b>clarified</b> 150:16 156:14,16 <b>clarify</b> 18:3 29:12 53:4 73:9 82:12 171:2 193:8 <b>clarifying</b> 33:9 <b>clarity</b> 55:14 72:16 294:2 <b>clean</b> 7:21 <b>cleaner</b> 8:5 <b>clear</b> 7:19 8:19 11:15 16:19 39:13 71:12 74:19 87:18 110:18 119:9 142:5 157:24 159:7 176:3 193:11,13 207:22 254:9,14 255:15 270:4 <b>clearer</b> 8:21 46:11 265:4 <b>clearly</b> 25:12 117:25 193:9 201:23 212:9 306:20,23 <b>cleveland</b> 21:5 76:14 80:3 298:22 <b>clinic</b> 21:5 22:15 50:7 146:17 147:23 149:7 231:13 275:6 308:20 309:4 337:25 <b>clinical</b> 47:12 50:4 130:7,8,9 135:12 206:17 228:18 229:3,20 230:2 232:3,9 234:4	246:19 247:15,23 250:12 284:15 298:19 306:16 <b>clinically</b> 284:12 <b>clinician</b> 29:8 30:6 <b>clinicians</b> 25:4,23 144:16 145:7,12 146:7 202:13 238:19 283:25 <b>clinics</b> 146:18,19 275:3 340:14 <b>close</b> 54:13 213:23 283:18 292:9 <b>closely</b> 282:18 285:5 <b>closer</b> 19:23 155:21 <b>clot</b> 216:13 <b>coastally</b> 257:11 <b>coauthors</b> 90:22 91:6 151:25 253:23 <b>cochrane</b> 119:7 134:16 <b>cogency</b> 178:5 <b>cogent</b> 271:14 <b>cognitive</b> 319:8 <b>cognitively</b> 83:11 98:10 <b>cohort</b> 243:24 244:15 245:2,3,11 245:17,19,21,23 246:3 <b>coined</b> 266:2,8 <b>colleague</b> 226:21 <b>colleagues</b> 26:5 50:8 92:16 111:20 155:8 <b>collect</b> 236:16 <b>collective</b> 120:15
--	--	--	---

<b>college</b> 74:24 75:5 75:6,7 <b>colluded</b> 224:10 <b>colored</b> 120:11 <b>columbia</b> 273:3 <b>combination</b> 115:14 <b>combinations</b> 52:4 <b>come</b> 18:8,22,24 28:15 38:15,20 44:3 45:14 53:17 53:18 81:7 93:3 111:2 112:11,13 113:9 114:23 115:8,20 126:24 127:2,3,4,5,15,22 143:12 147:22 169:3 189:22 209:13 251:8 260:3 294:20,22 317:10 318:8 <b>comes</b> 44:25 48:9 113:7 131:20 163:10 189:3 205:25 336:17,18 <b>comfort</b> 212:25 <b>comfortable</b> 79:6 111:11 219:15 220:8,19 315:8 <b>coming</b> 17:20 18:14 143:8 166:23 258:25 <b>commencement</b> 342:5 <b>commissions</b> 130:13 <b>committed</b> 174:9 314:3 <b>committee</b> 184:6,8 275:19 287:12	<b>common</b> 34:21 50:2 100:9,12,14 100:15 250:16 268:3 286:7 340:17 <b>commonly</b> 168:9 <b>communities</b> 328:22 <b>community</b> 166:23 268:6 <b>comorbid</b> 78:14 <b>comorbidities</b> 106:10,11,22 203:19 <b>comorbidity</b> 201:3 201:3 317:7 <b>company</b> 208:5 <b>compared</b> 73:17 229:22 <b>comparing</b> 141:14 252:5 <b>compassion</b> 285:24 <b>compassionate</b> 173:6,12,13,14 <b>compassionately</b> 336:19 <b>competent</b> 9:11,12 338:9 <b>complete</b> 9:12 32:6 194:24 347:8 <b>completed</b> 8:8 345:17 <b>completely</b> 40:6 <b>complex</b> 109:3 <b>complexities</b> 188:6 <b>complexity</b> 109:10 221:18 <b>complicated</b> 78:23 125:19 189:17 260:24 331:22	<b>compliment</b> 72:12 <b>component</b> 320:11 <b>comprehend</b> 185:7 <b>comprehends</b> 90:5 <b>comprehensive</b> 43:16 98:2 102:25 <b>computer</b> 28:19 <b>conceive</b> 295:22 <b>concept</b> 17:25 107:10 232:16 256:21 263:21,23 263:25 297:12 <b>concepts</b> 94:9 188:17 307:10,18 313:2 <b>conceptualize</b> 337:6,8 <b>concern</b> 202:22 203:6 224:4 273:18 275:16 329:19 330:7 331:16,20 <b>concerned</b> 171:19 171:21 172:13 202:3 203:12 290:25,25 <b>concerning</b> 224:5 224:6 <b>concerns</b> 42:20 68:8 99:20 111:7 139:22 144:9 172:11 177:18 179:5,17,19,21 180:4,5 211:8 224:21 225:22 273:22 281:11 284:2 327:24 328:6 339:22,23 <b>conclude</b> 243:18	<b>concluded</b> 42:11 122:15 <b>concludes</b> 341:3 <b>conclusions</b> 194:10 281:3,18 281:21 <b>condition</b> 15:8 100:22,24 136:13 267:8 313:11 315:21,23,24 320:12 <b>conditions</b> 15:23 78:14 100:17 310:15 311:8 319:6 322:17,24 334:19 <b>conference</b> 16:5 29:13,14 291:22 293:7,12 294:4 305:15 327:23 <b>conferences</b> 16:3 26:16,18 305:17 <b>confessed</b> 48:13 <b>confidence</b> 28:8 289:22 <b>confidential</b> 1:15 34:13,16 36:24 39:14 <b>confined</b> 284:7 <b>confines</b> 166:8,11 <b>confirm</b> 237:24 <b>confirming</b> 95:11 193:20 <b>confirms</b> 280:5 <b>conflict</b> 115:19 224:16 <b>conflicted</b> 290:7 <b>conforming</b> 193:21 <b>confuse</b> 192:21
--	---	--	--

<b>confused</b> 294:8 <b>confusing</b> 166:21 <b>confusion</b> 94:7 176:23 <b>connection</b> 9:15 261:11 <b>cons</b> 46:3 <b>consensus</b> 339:2 <b>consent</b> 10:2 76:23 86:9,23 87:9 88:15 89:5,13,24 94:17,19 109:21 144:15 145:19 146:10,14,16,22 147:15 148:6,18 148:19 149:21 150:18,25 151:16 152:4,6,12 153:2 153:25 154:3 155:3,10 158:2 160:4 178:12 179:2 185:5 196:2 199:22 200:4,11 202:6 203:22,25 205:9 212:17 214:7 215:22 216:22,23 217:13 230:14 338:17 343:16 <b>consequence</b> 200:19,20 329:17 <b>consequences</b> 36:21 79:2 84:14 87:20,21,24 88:6 93:14 150:15 153:16 174:14 <b>conservative</b> 76:25 77:7 92:13 104:14 212:2 321:21	<b>consider</b> 32:5 36:19 81:10 82:21 82:24 83:6 114:18 152:15,25 177:20 210:8 227:4 228:12 264:3 284:10 310:2 325:13 <b>considerable</b> 115:19 129:8 139:22 180:4 <b>considerably</b> 124:16 <b>consideration</b> 158:4 210:23 <b>considered</b> 52:12 279:10 300:9,19 315:20 <b>considering</b> 147:5 171:24,25 172:4 202:9 207:17 308:21 339:3 <b>constantly</b> 10:6 <b>consult</b> 30:10 <b>consultation</b> 17:21 <b>consultations</b> 330:17 <b>consulted</b> 170:25 <b>consulting</b> 9:15 <b>contacting</b> 95:25 <b>contacts</b> 20:10 <b>contains</b> 1:15 <b>contemplating</b> 54:9 <b>contentious</b> 120:17 337:10,11 <b>context</b> 71:12 135:12 182:24 191:6 228:24 <b>contextualize</b> 150:5	<b>continent</b> 274:12 <b>continue</b> 91:7 169:19 170:21 196:7,14 218:8 254:2,23 258:17 <b>continued</b> 4:1 172:5,16 <b>continues</b> 56:8 <b>continuing</b> 56:7 <b>contraceptives</b> 226:11 <b>contradictions</b> 316:3 <b>contraindicated</b> 66:21 <b>contribute</b> 41:24 126:2 <b>contributed</b> 124:11 272:22 <b>control</b> 117:23 229:23 244:12 245:3,5,12,14,20 245:22 246:3 249:4 <b>controlled</b> 117:21 118:3 129:19 230:19 236:21,22 237:3 247:15,23 248:14 250:11 251:21 <b>controls</b> 237:5 248:17 <b>controversial</b> 288:11 336:16 <b>controversies</b> 328:17 335:22,24 336:8 <b>controversy</b> 335:9 335:10,11,13,21 336:4,24,25 337:4	<b>conversant</b> 157:11 <b>conversation</b> 170:6 <b>conversations</b> 55:15 <b>convey</b> 254:14 <b>conviction</b> 232:19 <b>convince</b> 122:7,18 <b>cooper</b> 3:16 5:15 5:15 6:24,25 7:9 11:11,19 14:19 34:14 36:25 38:15 39:17,23 60:10,13 64:7,22 69:24 81:15 86:6 104:4 105:2,6 145:21 159:5 160:23 161:6 181:6 183:14 184:18 189:25 193:7,13 193:15 199:10,11 213:24 222:24 223:9 234:10 237:18 238:25 245:15 248:3 289:14 291:7,11 329:25 337:13 340:25 343:3 <b>cooperated</b> 102:7 <b>cooperating</b> 169:9 <b>copies</b> 345:14 <b>correct</b> 14:25 24:10 27:12 44:24 45:7 71:3 72:20 74:9 84:25 87:4 91:5 105:18 106:12,13 133:6 135:21 141:22 144:22,23,24 176:25 190:22 194:16 197:5
--	--	---	--

198:22,23,24,25 229:7 236:8 240:10 242:15 245:7 252:23 253:3,6,18,21 280:11,20 323:14 347:8 <b>corrections</b> 40:9 347:6 <b>correctly</b> 20:16 29:2,6 47:15 66:9 72:6,17 73:13 88:18 144:8 151:10 178:15,20 200:2 229:25 246:2 331:10 <b>counsel</b> 3:2 4:2,9 5:6,13 7:10 11:4 12:10 342:17,20 345:14 <b>counseled</b> 52:19 <b>counselor</b> 37:5,15 <b>count</b> 32:18,23 97:5 <b>counted</b> 13:3 <b>countless</b> 100:19 <b>countries</b> 110:16 129:18 133:22 140:25 186:20 218:23 <b>country</b> 130:2 134:6 136:21,21 136:22 220:9 <b>counts</b> 216:14 <b>couple</b> 63:9 66:11 126:5 151:6 213:24 268:18 323:25 <b>courage</b> 301:5 <b>course</b> 9:2 20:19 21:24 27:22 28:11	42:4 48:12 62:7 64:5 65:25 74:3 79:10 89:25 96:11 100:3,22 126:17 133:18,18 150:12 158:15 177:2 215:18 248:15,20 249:24 251:21 302:9 310:19,21 311:10 318:5,22 319:14 329:22,25 334:21,23 335:21 339:22 <b>court</b> 1:1 2:7 5:10 7:21 8:14 90:25 137:13,18 <b>courtroom</b> 70:24 120:18 <b>courts</b> 137:21 <b>cover</b> 153:13 182:5 183:11 190:20 <b>coverage</b> 181:23 183:13 <b>coverages</b> 207:18 <b>covered</b> 152:11 <b>cox</b> 182:18 <b>create</b> 130:3 174:6 296:12 <b>creating</b> 296:8,9 <b>credential</b> 41:12 <b>credentialed</b> 30:8 <b>credentials</b> 338:7 <b>credible</b> 235:23 238:2 <b>crime</b> 314:3 <b>crisis</b> 127:3 302:11 <b>criteria</b> 38:22 39:5 39:7,9 41:25 42:7 42:9,12 44:18 45:5 102:9 104:8	151:25 219:7 290:12 <b>critical</b> 280:7,16 <b>criticisms</b> 277:13 <b>criticize</b> 275:20 <b>critique</b> 277:4 <b>critiques</b> 277:9 319:22 <b>cromwell</b> 3:3 5:22 6:2,4 <b>cross</b> 66:5 136:5 137:16,24 156:24 254:10 257:8,12 257:17 258:8 259:7,16 321:2,3 337:22 338:23 343:4 <b>crucial</b> 158:15 <b>cryingly</b> 231:17 <b>crystal</b> 233:20 <b>crystallization</b> 43:25 51:11 107:15 <b>cs</b> 345:15 <b>cstrangio</b> 3:19 <b>cultural</b> 50:5,22 293:17 328:21 <b>culture</b> 232:14 285:7 326:5 <b>cultures</b> 249:6 <b>curable</b> 100:24 <b>cure</b> 107:25 211:16 <b>current</b> 81:8 163:4 163:5 <b>currently</b> 22:18 164:2,7 172:17 211:6 223:19 225:23 286:25 <b>custody</b> 325:25	<b>cut</b> 127:9 <b>cutting</b> 121:8 <b>cv</b> 1:4 5:12 <b>cycle</b> 326:11 <b>cycles</b> 326:13
			<b>d</b>
			<b>d</b> 246:5 343:1 <b>dahlen</b> 270:19 271:17 273:21,22 274:8 <b>damage</b> 180:8 <b>damn</b> 211:21 323:25 <b>dangerous</b> 110:3 269:17 <b>dangers</b> 163:17 225:9 <b>data</b> 28:17 130:14 130:15 131:9 141:13 183:21 194:12 195:10 268:14 281:4 308:5,7,19,25 310:6 <b>date</b> 64:12 70:10 86:13 181:12 190:8 234:15 239:6,16,20 272:10 342:13 346:24 347:12 <b>dated</b> 64:10 181:11 234:13 239:4 272:8 343:9 343:23 344:6,9,12 <b>daubert</b> 207:25 <b>daughter</b> 319:12 <b>day</b> 9:3 55:6 141:19 223:25 265:4 293:20 347:15

<b>days</b> 13:19,21,24 14:3 21:6 61:24 76:24 110:15 143:25 196:13 238:12 291:23,24 303:2 321:6 345:17 <b>deal</b> 83:19 107:23 108:9 130:11,12 130:12 163:25 168:11 170:13 185:4 264:16,18 264:20 265:2 266:13 276:6 339:20 <b>dealing</b> 22:6 26:21 27:19 96:21 113:17 226:12 <b>dear</b> 323:12 <b>death</b> 216:17 225:14 <b>decades</b> 65:25 96:21 155:5 <b>deceased</b> 59:8 <b>december</b> 137:14 190:5,21 239:5,14 344:2,10 <b>decide</b> 108:11 137:21 160:8,18 182:5 196:4 218:17,19 260:21 277:23 278:24 336:5 338:19,22 <b>decided</b> 94:20 108:4 339:24 <b>decides</b> 260:17 <b>decision</b> 66:20 68:11,18 83:13 103:6,7,17 150:21 157:19 158:9,17 158:18,19 159:12	169:10 174:20 205:20 206:5 214:11 215:4 221:7 227:3,8,11 227:12 228:5,8 230:10 265:4 277:15,16 323:3,6 <b>decisionmaker</b> 288:14 <b>decisionmaking</b> 197:5 340:11 <b>decisions</b> 29:19,24 30:4,10 43:10 78:24 137:23 195:9 222:4,10 <b>declaration</b> 64:9 65:11 234:12 235:2 239:3,12 343:8 344:5,8 <b>declarations</b> 176:17 <b>declare</b> 347:4 <b>declared</b> 257:13 257:15 301:11 316:5 <b>decline</b> 327:7,13 <b>declined</b> 46:13 47:17 <b>decrease</b> 298:7 <b>decreasing</b> 167:23 <b>deem</b> 323:7 <b>deemed</b> 324:18 329:6 347:6 <b>deeper</b> 308:7 <b>defend</b> 219:16,24 327:4 <b>defendants</b> 1:13 4:9 6:16 <b>deficiencies</b> 277:21 280:21	<b>define</b> 52:6 102:24 140:18 155:11 <b>defining</b> 337:10 <b>definitely</b> 286:14 <b>definition</b> 245:23 <b>degree</b> 49:21 114:9 178:5 273:2 339:18 <b>delay</b> 84:10 <b>delayed</b> 288:7 <b>delete</b> 186:3 <b>deliberation</b> 205:18 <b>demands</b> 331:7 <b>demonstrate</b> 194:13 244:22 <b>demonstrated</b> 141:8 216:3 <b>demoralization</b> 127:4 <b>deny</b> 317:3 <b>department</b> 40:9 190:6,16 344:3 <b>depend</b> 109:15 328:22 338:10 <b>dependent</b> 101:23 166:17 <b>depending</b> 48:18 <b>depends</b> 106:23 118:17 250:17 263:19 <b>deponent</b> 71:17 183:7 191:17 345:13 347:3 <b>deposed</b> 7:17 190:18 <b>deposing</b> 345:13 <b>deposition</b> 1:18 2:3 5:5 7:12 9:16 9:20 11:4 12:7 14:20 37:4 70:7	70:19,23,25 178:10 190:15 287:11 341:4 343:12 <b>depositions</b> 16:17 68:20 <b>depressed</b> 117:19 120:9 121:10 123:11,15 124:8 312:22,23,24,25 313:2 <b>depression</b> 42:25 77:25 101:21 121:15 123:20 211:17 222:21 290:19 310:18 312:12 317:4 <b>deprive</b> 192:15 <b>describe</b> 89:11 154:12 240:23 263:10 292:5 299:24 <b>described</b> 13:18 25:3 73:24 84:6 151:15 159:11 227:23 240:17 249:5 263:15 268:4 282:22 <b>describing</b> 85:8 202:7 <b>description</b> 89:4 151:19 320:18 <b>descriptions</b> 320:20 <b>designate</b> 34:13,15 36:23 <b>designating</b> 39:13 <b>designed</b> 229:9 <b>desire</b> 55:6 286:3 <b>desist</b> 111:18,21 112:3,8 115:23
--	---	--	---



163:21 238:14,14 253:11,12 254:4 255:10 256:3 258:19 <b>desistance</b> 252:8 252:10,13,14,15 252:15 254:6,25 260:12 261:2,5 262:11 267:23 <b>desisted</b> 112:21 113:2 114:15 142:3 253:3 258:11 259:25 260:10 <b>despair</b> 127:3 <b>despite</b> 95:25 <b>detail</b> 101:17 246:24 <b>details</b> 136:17 328:8 331:23 <b>detect</b> 312:11 <b>deteriorating</b> 119:17 <b>determinants</b> 293:14 <b>determination</b> 175:12 212:16 <b>determine</b> 69:9 85:22 201:4 <b>determined</b> 85:6 204:6,7 298:4 <b>determining</b> 133:22 <b>detransition</b> 131:5 141:6,14,17,19,25 142:6,25 143:10 143:16 166:10,12 166:15 169:11 238:15 259:13 268:20 269:8,10	<b>detransitioned</b> 141:21 142:15,19 143:7,13 259:2 268:25 269:5 <b>detransitioners</b> 269:20,24 <b>detransitioning</b> 131:8 141:12 142:10 144:2 167:22 268:11 269:4 295:16 <b>develop</b> 94:25 108:16 287:12 <b>developed</b> 95:15 254:9 275:10 284:16 288:22 <b>developing</b> 95:6 <b>development</b> 36:6 117:12 189:21 <b>developmental</b> 43:4 51:9 52:12 107:18 264:21 267:25 <b>devil</b> 331:23 <b>devoted</b> 268:13 <b>devries</b> 295:13 <b>diagnose</b> 41:3 51:5 51:8 322:17 <b>diagnosed</b> 38:13 38:24 40:24 252:25 317:19 318:4 <b>diagnoses</b> 28:20 28:23 41:13 296:13 317:8,11 <b>diagnosing</b> 38:17 311:7 313:11 318:20 <b>diagnosis</b> 28:22 41:15,15,20 42:19 43:17,24 44:5,6,16	44:25 45:6 62:2 77:24 81:24 156:4 296:9 313:5 315:14 316:12,15 316:17,22,25 318:25 319:23 320:5,11 <b>diagnostic</b> 26:7 38:22 42:9,12 45:5 66:8 317:13 317:14 <b>dialogue</b> 232:13 232:14 <b>died</b> 74:15,17,19 75:10,15 225:2 <b>difference</b> 67:5,7 282:25 297:19 <b>different</b> 18:19 21:21 51:22,23 53:7 56:11 66:24 66:25 67:10 68:23 70:11,14 80:9 82:5 96:16,17,24 97:13 108:13,16 113:25 123:2 135:7 136:24 137:2 149:12 160:12,19,21 163:12 165:12 176:2 185:19,20 192:14 230:16,17 240:9 241:18 247:5 249:6,6 251:10 252:2 271:15 273:24 274:12 277:23 282:21 283:2 290:17 293:19 309:9 317:8,12 318:16 324:3 328:25 340:13	<b>differently</b> 25:16 47:23 56:24 106:6 145:10 156:8 196:12 208:7 227:2 247:12 254:15 255:22 269:22 279:17 282:13 292:6 300:16 304:9 <b>difficult</b> 38:25 78:9 103:7 158:17 236:21 260:24 288:10 <b>difficulties</b> 43:22 93:25 262:2 <b>digital</b> 266:20 <b>digs</b> 308:6 <b>dimension</b> 127:11 <b>dimensional</b> 125:20 <b>dimensions</b> 51:23 51:24 52:4 173:16 <b>diminished</b> 137:25 <b>direct</b> 6:24 343:3 <b>direction</b> 335:16 <b>directly</b> 20:11 37:11 47:4 <b>disagree</b> 278:19 278:20,21 307:6 307:13 335:4 <b>disagreed</b> 306:10 <b>disagreement</b> 264:5 333:14 334:20 <b>disagreements</b> 336:12,13,14 <b>disallow</b> 137:7 <b>disappear</b> 168:3 195:16 <b>disaster</b> 339:6
---	---	---	---

<b>discipline</b> 332:2 <b>discomfort</b> 221:21 222:2 <b>discontinue</b> 164:16 262:5 <b>discontinued</b> 162:24 <b>discovered</b> 57:16 57:18 59:10 <b>discriminate</b> 36:16 <b>discuss</b> 19:7,7 25:9 29:9 30:6 34:16 101:16 102:7 115:20 128:17 176:5 <b>discussed</b> 38:5 98:18 161:20 210:18,24 240:8 337:24 <b>discusses</b> 181:3 <b>discussing</b> 132:14 <b>discussion</b> 11:24 27:2 39:14 93:19 94:14 223:13 299:18 <b>discussions</b> 94:15 327:20 <b>disease</b> 215:15 216:18 <b>diseases</b> 312:8 <b>disinclined</b> 86:3 <b>disorder</b> 253:2 268:5 301:22 310:22,24,25 <b>disorders</b> 204:16 <b>disqualified</b> 291:3 291:5 <b>disqualifies</b> 275:18	<b>disregard</b> 197:7 <b>dissenting</b> 300:9 300:12,19 301:9 <b>distinctions</b> 260:25 297:23 309:15 <b>distinguish</b> 276:8 320:21 <b>distress</b> 119:4 170:2 <b>distressed</b> 316:11 <b>district</b> 1:1,2 5:10 5:11 <b>distrust</b> 110:9 <b>disturbed</b> 78:15 <b>diverse</b> 334:4 <b>diversity</b> 23:8 24:9 25:19 293:17 <b>divided</b> 77:4 <b>divides</b> 230:20 <b>division</b> 1:3 4:11 <b>divorce</b> 110:9 <b>doctor</b> 36:8,10 38:16 41:17 58:13 58:16,17 59:3 86:20 100:21 109:17 126:15 127:20 152:23 153:4,8 158:6 159:20,22,23,25 160:4,20 162:17 162:18 165:2 169:15 186:5 187:11 188:19 203:20 204:4 205:6,8,22 206:14 206:15,24 207:2 214:4,23 215:25 216:6 218:20 221:11 241:14 309:22 312:5	313:4 319:13 321:13 <b>doctor's</b> 148:20 204:2,3 225:24 226:16 318:7 <b>doctors</b> 85:18 88:19 119:22 120:10,20,23 137:20 144:10,25 147:7,18 149:15 151:13,23 152:3 154:25 157:2,3 158:22 159:9 162:22 163:22 164:21 168:13 169:18 173:13,18 173:22 174:7,15 174:20,25 175:3,6 179:18 184:25 185:25 200:13 201:14 203:12 205:2,17 206:17 217:18,19 218:17 229:17 232:19 233:6 241:17 321:22,25 322:3 328:15 329:4 330:4,10,18,23 331:13 332:3,19 333:14 334:3 336:18 <b>document</b> 65:9 71:18 86:20 183:8 190:10,12 191:18 234:24 239:19 272:18 <b>doing</b> 19:21 43:13 63:14,15 64:18 93:25 97:21 103:11 127:14 140:15 145:15	152:4,5 158:24 160:24 169:2,4 170:14,16,19 180:6 193:25 195:6 197:4 201:19 206:13 207:8 225:25 228:12 248:8 275:19 277:12 284:17 289:3 317:24 338:15 <b>dominate</b> 270:22 <b>dorm</b> 75:11 <b>dose</b> 168:5 249:6 335:3 <b>doses</b> 236:25 <b>double</b> 246:18 249:3 <b>doubt</b> 164:23 <b>downloaded</b> 148:11 <b>dozen</b> 24:6 <b>dr</b> 5:6 7:2,4 10:11 10:12,19,24 34:18 39:15,18 65:5 70:16 120:14 127:22 129:6 132:17,18 161:13 181:15 182:17 187:16 223:17 234:13 268:22 280:21 281:5,9 291:20 295:10,11 299:16,16,17 300:3 305:5,5,8,12 305:14 306:4 307:2,17 308:13 314:25 328:3 329:21 337:23 340:22 344:6
---	--	--	--

<p><b>draconian</b> 328:13</p> <p><b>dramatic</b> 139:24</p> <p><b>dramatically</b> 96:19 137:25</p> <p><b>dressers</b> 321:3</p> <p><b>drop</b> 83:23</p> <p><b>dropout</b> 261:22</p> <p><b>drug</b> 75:15 117:24 174:12,13,18,22 236:25 249:16,18 249:22 250:13,15 250:18,21,22 251:3,5,10,11 252:3</p> <p><b>drugs</b> 123:15 237:2,2 249:9,9,12 249:14 250:5 335:3,5</p> <p><b>dsm</b> 315:13,22 316:7,9,14,23</p> <p><b>due</b> 143:7 288:9</p> <p><b>duly</b> 6:22</p> <p><b>duration</b> 43:20</p> <p><b>dutch</b> 295:14</p> <p><b>dylan</b> 1:6 5:8</p> <p><b>dynamic</b> 241:5</p> <p><b>dynamics</b> 338:18</p> <p><b>dysfunction</b> 88:14</p> <p><b>dysfunctional</b> 81:20</p> <p><b>dysphoria</b> 16:14 16:23 19:13,17 20:7,11,22 21:15 23:17 24:2 27:12 28:4 29:20 30:14 30:21 31:12 33:17 35:14,16,19 38:4 38:14,17,18,22,24 39:8 40:3,11,16,25 41:8 42:2 44:4,16 45:4,10,16,18</p>	<p>48:25 49:2 51:6 52:24 53:11,22 54:18 55:17 56:14 57:3 58:8,22,23 61:12,20 62:2 66:3 68:2 69:16 76:8 78:13 80:14 81:10,16 82:2,8 95:10 100:23 101:9 103:23 105:15,22 106:10 106:20,21 107:2,6 108:15 110:23 112:10 114:24 128:6,21 145:9 155:16,24 162:7 163:11,15,18 165:4 188:13 197:25 198:6,10 199:6 200:2 201:15 209:25 211:10 220:21 243:12 254:3,18 254:22,23 255:4 255:25 256:2,5,19 258:16 263:4,18 263:22 290:16,18 293:9,22,24 294:19 304:11 305:22,22 308:18 310:4 315:14,20 316:15,22 317:19 318:3,8,12,14,16 318:21 319:2,23 320:6,14,15,21 321:5,6 332:12 333:17 334:6,10</p> <p><b>dysphoric</b> 96:9 135:9,23 172:22</p>	<p><b>e</b></p> <p><b>e</b> 3:1,1 4:1,1 90:23 91:2,2,9,11,13,22 93:9 245:10 303:19,19,23,24 303:24 304:20 342:1,1 343:1,7 346:3,3,3</p> <p><b>earlier</b> 60:20 131:11 178:10 223:24 264:7 318:19 337:24 338:16</p> <p><b>early</b> 49:19 96:20 96:21 254:18,22 255:25 258:17,18</p> <p><b>easier</b> 128:8</p> <p><b>easily</b> 174:15 274:8</p> <p><b>eastern</b> 1:2 5:11</p> <p><b>easy</b> 101:4 158:17</p> <p><b>echols</b> 4:6,7 6:10 6:10</p> <p><b>economist</b> 92:2</p> <p><b>eczema</b> 222:23</p> <p><b>editing</b> 306:13</p> <p><b>edition</b> 71:25 72:19 275:21 276:2</p> <p><b>editor</b> 276:19,21 277:4,25 278:16 280:19,22 282:12 306:14 308:17</p> <p><b>editorial</b> 282:19</p> <p><b>educate</b> 67:18</p> <p><b>educates</b> 150:19 297:2</p> <p><b>education</b> 50:23 185:6 204:12 297:13</p>	<p><b>educationally</b> 179:12</p> <p><b>educators</b> 296:16 296:17</p> <p><b>effect</b> 117:19,23 117:24 123:22,23 152:13 164:5,10 169:18 223:18 226:2 244:13</p> <p><b>effectiveness</b> 228:19</p> <p><b>effects</b> 103:13 216:21 244:11</p> <p><b>efficacy</b> 231:6</p> <p><b>efficient</b> 68:25</p> <p><b>effort</b> 94:25</p> <p><b>eggs</b> 152:10</p> <p><b>egregious</b> 279:23</p> <p><b>eight</b> 35:12 294:25</p> <p><b>either</b> 11:2 26:7 53:13 126:21 130:24 132:9 186:11 307:4,12</p> <p><b>ekg</b> 312:15</p> <p><b>election</b> 326:11,13</p> <p><b>element</b> 150:17</p> <p><b>elements</b> 94:19 98:17 140:13 146:15</p> <p><b>elevated</b> 215:20,22</p> <p><b>ely</b> 4:21</p> <p><b>embarrassed</b> 266:3,4 301:24</p> <p><b>embrace</b> 335:10 335:20</p> <p><b>emergency</b> 103:15</p> <p><b>emersion</b> 49:24</p> <p><b>emily</b> 3:8 5:25</p> <p><b>emotional</b> 18:25 43:22</p>
---	---	---	--

<b>emphasize</b> 90:13 265:11 <b>emphasizing</b> 154:17 <b>employee</b> 342:16 342:19 <b>enable</b> 235:25 238:4 <b>enabled</b> 114:11 <b>encourage</b> 26:12 <b>encouraged</b> 130:2 <b>encouraging</b> 184:11 <b>endocrine</b> 167:9 184:9,16,22 187:22 <b>endocrinologist</b> 10:16 63:7 66:18 69:11 102:16 104:6,7 164:25 206:21,23 339:9 339:12,19 <b>endocrinologists</b> 103:20 <b>endpoint</b> 230:5 <b>endpoints</b> 230:6,8 230:11,12 <b>endured</b> 185:10 <b>energy</b> 287:19 <b>engage</b> 146:9 151:14,15 <b>engaged</b> 95:20 96:4 325:15 <b>england</b> 93:20 134:14 <b>enormous</b> 87:19 117:18 308:14,14 <b>entails</b> 229:21 <b>enter</b> 230:14 338:14	<b>entering</b> 188:4 261:20 <b>entire</b> 21:16 28:6 <b>entirely</b> 108:19 123:2 297:4 <b>entries</b> 268:12 <b>epidemiological</b> 295:5 <b>epiphenomena</b> 107:13 <b>epiphenomenon</b> 264:25 <b>equally</b> 129:12 249:14 <b>errant</b> 330:17 <b>errata</b> 345:11,13 345:17 <b>erratas</b> 345:15 <b>error</b> 260:14,16,17 <b>errors</b> 279:23 <b>especially</b> 114:20 117:17 131:2 157:2 189:5 241:2 <b>esq</b> 3:6,8,10,16,18 3:24 4:6,15,17 345:1 <b>established</b> 55:19 168:18 192:13 194:15 205:4 298:11 <b>estimate</b> 14:20 33:5 53:25 <b>estimated</b> 129:7 <b>estrogen</b> 57:17 102:10 168:10 186:11 225:5 <b>et</b> 1:7,12 5:8,9 260:5 261:13 262:7 270:19 271:17 345:4,4 346:1,1 347:1,1	<b>ethical</b> 26:8 78:21 94:18 103:5,21 104:3 147:4 150:24 151:11 154:20 181:2 <b>ethically</b> 79:6 85:13 147:2 198:23,24 <b>ethics</b> 104:5,8 154:15 180:11 231:8 329:7 <b>eugenics</b> 302:8 <b>european</b> 133:21 232:15 <b>evaluate</b> 66:18 119:15,24 121:23 146:8 338:11 <b>evaluated</b> 18:21 <b>evaluating</b> 88:17 134:16 202:25 230:7 <b>evaluation</b> 17:22 18:8,19,23 31:25 32:5,7,9,19 33:12 42:16 59:17 77:22 97:16 98:17 113:12 151:14 227:22 330:24 <b>evaluations</b> 21:9 145:17 277:10,11 277:11 <b>evaluator</b> 106:23 330:10 <b>eventually</b> 22:15 45:25 48:11 75:2 169:10 <b>everybody</b> 297:14 <b>evidence</b> 91:19 120:5 161:16 176:6 179:8 180:18 200:17	214:10 235:23 236:10 238:3 240:9,12,13,17,22 241:23,25 242:4 242:10,11,14,19 243:6,14 247:22 254:24 255:7,23 258:15,20 270:21 279:11 284:4,5 295:4 296:23 311:11,12 <b>evolve</b> 196:7 <b>evolved</b> 320:24 <b>evolving</b> 155:4 186:16 <b>exact</b> 292:6 <b>exactly</b> 23:19 47:9 71:24 72:16 73:25 89:19 114:14 183:17 195:23 255:20 273:9 278:2 288:12 289:23 301:23 307:5 <b>exam</b> 266:20 <b>examination</b> 6:24 337:22 342:5 343:3,4 <b>examined</b> 285:5 <b>example</b> 101:19 116:14 118:7 121:6 131:25 152:7,16 168:8 186:22,23 187:24 195:16 218:9 225:9,17 244:10 252:4 276:17 295:13 298:3,22 313:25 319:7 320:19,24 334:24
--	---	---	---

<b>examples</b> 100:19 112:4 274:15 <b>exceeding</b> 131:23 <b>exceeds</b> 218:24 <b>excellent</b> 91:8 107:7 <b>exception</b> 222:19 232:2,25 234:3 <b>exceptions</b> 321:24 <b>excerpt</b> 70:6 343:11 <b>excerpts</b> 71:7 <b>exchange</b> 182:17 <b>excursions</b> 52:3 <b>excuse</b> 294:9 <b>exhibit</b> 64:8,9,15 64:20 65:6 69:25 70:6,12,14,15 86:7 86:8,15 109:20 149:20 181:7,7,8 190:2,3,9 234:12 234:17,20,23 239:2,3,9,11 265:21 267:14,18 267:19 268:4 270:6 272:6,7,17 283:12,13 343:8 343:11,15,20,25 344:5,8,11 <b>existed</b> 318:9 <b>existing</b> 242:19 <b>exists</b> 82:8 180:24 241:10 297:22 <b>expand</b> 31:9 <b>expect</b> 125:14 <b>expensive</b> 231:19 <b>experience</b> 25:24 50:3,4,4 52:8,9,9 52:10 77:4 84:13 90:21 92:12 113:6 120:11,16 126:11	130:7,8,9 158:11 180:3 183:19 206:18 221:19 227:20 238:20 242:6 251:5 258:18 275:2 289:7 297:25 321:16 332:25 340:16,17 <b>experienced</b> 25:25 26:9 27:4 35:7 61:5,9,19 67:22 279:6 338:10 <b>experiences</b> 148:3 148:4 157:6 188:2 188:3 <b>experiencing</b> 113:20 258:16 <b>experiment</b> 123:24 135:5,6 <b>experimental</b> 250:22,24 <b>experimenting</b> 194:20 <b>expert</b> 9:23 10:9 65:3 92:3 149:3 161:15 167:10 176:17,24 177:20 178:3 208:2 209:6 209:15,16 241:14 241:15,18,20 256:9 263:10 273:24 303:20 304:3,25 305:5,21 307:3 310:3,5 323:19 324:15 326:13 327:3,17 332:23 333:7 <b>expertise</b> 76:16 177:22	<b>experts</b> 9:25 241:9 241:17 306:19,25 307:9,10,17 334:13 <b>explain</b> 328:6 <b>explained</b> 140:3 281:24 327:24 <b>explaining</b> 325:9 <b>explicitly</b> 10:5 <b>exploratory</b> 81:12 <b>exploring</b> 284:14 <b>exposito</b> 268:22 <b>exposure</b> 50:22 <b>express</b> 176:9 177:7 301:9 <b>expressed</b> 55:5 200:8 303:8 <b>expressing</b> 115:11 125:7 <b>expression</b> 115:17 125:12 <b>expressions</b> 115:24 116:2,15 <b>extended</b> 241:4 <b>extensive</b> 66:7 <b>extent</b> 41:16 62:21 90:8 <b>extremely</b> 288:6 301:24 303:12 <b>eyes</b> 313:20	276:4 302:19 <b>factors</b> 84:2 204:8 <b>facts</b> 88:19 160:5,9 160:9 186:15 200:14 201:17 203:20 297:16,16 <b>factually</b> 240:14 <b>factualness</b> 280:9 <b>fade</b> 108:15 <b>failed</b> 282:22 <b>failing</b> 201:6 <b>fails</b> 345:19 <b>fair</b> 14:21 44:14 97:8 106:5,7 123:4,7 127:12 144:12,13 151:19 154:9 155:14 263:13 310:14 331:25 334:11 <b>faith</b> 290:3 <b>fall</b> 175:24 243:4 <b>fallen</b> 110:5 <b>falling</b> 188:2 <b>familiar</b> 152:24 240:6 263:2 266:19 304:21 323:2 <b>familiarity</b> 296:21 <b>families</b> 20:10 63:6,6 128:18 132:5 150:13 152:15 173:7 185:6 203:3 233:12 323:3 338:12 <b>family</b> 32:7,13,25 33:2,5 43:11 62:17 83:7 104:17 108:9 109:16 147:3 150:20 152:8,16,23 153:9
		<b>f</b>	
		<b>f</b> 342:1 <b>face</b> 199:12,14 203:18 312:23 <b>faces</b> 225:9 <b>facilitating</b> 188:22 <b>fact</b> 62:8 108:7 130:22 132:5 153:11 169:2 170:17 206:6 249:16 250:20	

153:13,17 156:20 160:19 167:25 169:7 170:2,5 179:9 185:8,9 203:15 205:9,10 205:19 212:23 214:6,25 318:24 320:4 338:19 339:21,25 340:10 <b>far</b> 15:16 50:8 81:6 120:22 132:21 137:7 163:19 229:16 237:19 254:8 308:7 <b>fashion</b> 94:4 232:18 <b>fatigued</b> 202:19 <b>favor</b> 196:24 197:2,3,23 199:6 199:20 207:20 208:12 219:6 228:23 229:8 231:9 234:3 <b>favorable</b> 339:8 <b>fda</b> 248:22 251:18 <b>fears</b> 36:20 <b>features</b> 116:16 <b>february</b> 64:11 65:14 129:17 138:16 343:10 <b>feel</b> 26:10 39:7 45:15,25 48:7 56:8 76:11 126:23 160:13,15 177:22 202:8 203:4 213:7 216:9 220:19 290:6 313:16 315:3 <b>feeling</b> 57:20 94:17 117:20	290:20 <b>feels</b> 26:3 314:13 <b>felony</b> 327:18 <b>felt</b> 51:4 81:13 99:8 103:20 228:11 <b>female</b> 115:15 195:19,20 236:3,4 238:7,8 268:7 295:8 <b>feminine</b> 115:17 116:2,15,15,20 123:25 256:16,22 257:2 <b>femininity</b> 49:22 <b>feminization</b> 118:25 <b>feminized</b> 121:6 <b>fentanyl</b> 74:21 225:2 <b>fertile</b> 314:20 <b>fertility</b> 152:9,20 158:12 <b>fetishism</b> 320:25 <b>fiancé</b> 95:22 96:6 96:6 <b>field</b> 34:22 58:2 67:23 79:5 88:19 96:16 118:3 120:16 126:14 154:15 177:14,24 236:20 245:8 250:16 265:24 267:3,4,7 273:24 280:15 281:25 282:24 295:12,19 305:21 320:5,13 334:20 335:18 336:14 <b>fight</b> 220:7	<b>figure</b> 168:11 321:21 <b>figures</b> 124:14 <b>filed</b> 5:9 65:12 <b>fill</b> 311:19,20 <b>final</b> 335:8 <b>finally</b> 122:11 <b>financially</b> 342:21 <b>find</b> 9:7 53:24 74:25 79:6 100:18 165:10 166:6,9,12 167:21 168:14 170:3 174:4 175:4 175:5 212:24 223:20 <b>finding</b> 81:18 166:7 <b>finds</b> 236:21 <b>fine</b> 34:3 37:2 160:25 221:25 222:25 246:18 247:9 <b>finish</b> 8:2,6 191:21 243:2 <b>finished</b> 12:24 235:19 <b>finland</b> 119:6 129:15 134:9,10 134:20,24 135:18 135:22 136:9 140:12 <b>finmark</b> 140:12 <b>first</b> 6:22 7:24 21:4 37:17 51:16 58:12 59:10 64:8 65:15 73:6,7 83:4 83:16 85:22 89:10 110:17,19 113:8 117:11 135:23 136:12 137:23 138:17 183:15	191:8 192:6 212:19 215:10 233:15 235:22 258:4 260:5 272:20 276:19 289:3 294:24 304:12 313:4,4 337:11 340:19 <b>fish</b> 318:17 <b>fit</b> 199:7 240:20 <b>five</b> 13:21,24 14:3 20:8,13 21:20 31:10,15 33:6,11 33:21 48:16 65:25 75:25 78:5 79:19 114:5 118:11,14 206:8,12,19 218:4 233:14,15 260:9 261:10,19 275:8 280:24 291:11 <b>fix</b> 278:4 <b>fixed</b> 74:15 298:5 <b>florida</b> 190:6,16 344:3 <b>fluctuate</b> 115:23 <b>focus</b> 30:16 270:24 297:10 <b>focused</b> 157:3 201:14 <b>focuses</b> 25:25 27:5 <b>focusing</b> 16:13 30:12 120:13 265:15 <b>folks</b> 24:18 105:4 206:2 <b>follow</b> 16:17 71:24 72:16 83:24 102:22 126:8 149:15 150:9 154:11 202:13 274:15 296:17
--	---	---	--

340:3,4 <b>followed</b> 257:7 <b>following</b> 262:2 272:21 277:16 <b>follows</b> 6:23 <b>followup</b> 18:9,12 18:18 99:25 100:9 126:15,17 206:2 226:24 231:11 253:23 259:22 260:3,9 261:19 262:6 264:9 <b>foolishness</b> 317:14 <b>footnote</b> 270:18 <b>force</b> 153:19 <b>forces</b> 241:5 <b>foregoing</b> 342:10 347:5 <b>forensic</b> 314:2 <b>forget</b> 261:15 <b>forgive</b> 183:16 <b>forgot</b> 40:5,13,18 56:5 59:18 223:10 <b>form</b> 42:14 44:19 47:19 50:17 53:3 62:11 81:14 83:2 84:7 85:11,25 90:7 100:11 101:13 105:24 121:25 126:12 128:24 131:19 133:8 135:20 136:15 138:10,22 139:14 145:20 146:12 151:21 157:22 159:16 162:9 164:17 166:13 167:5 169:23 172:7,19 175:15 176:12,18 177:10 179:3	187:7 199:9 200:6 202:17 205:12 207:14 208:11 211:11 214:13 217:15 219:18,21 220:12 222:7,13 223:22 226:4 228:14 232:4 234:5 247:16 249:10 264:12,13 264:17 271:15 279:13 283:23 287:22 300:11,22 301:20 306:11 307:19 311:20,20 315:15 317:21 319:3 320:7 324:20 327:8 329:10,20 331:18 332:5 333:18 <b>formal</b> 38:18 <b>former</b> 68:15 <b>forming</b> 36:3 <b>forms</b> 93:25 175:20 293:17 338:20 <b>formulate</b> 288:10 <b>forth</b> 43:5 78:2 80:10 121:16 249:7 261:2 303:13 342:14 <b>forward</b> 81:8 172:15 317:2 <b>found</b> 65:20 75:2 130:14 170:22 224:18 235:8 252:24 270:16 274:7 280:5 308:25 336:5 <b>foundation</b> 306:3	<b>four</b> 13:6,19 17:21 18:13 19:12,20 38:2 59:22 88:22 110:11 114:6 122:7 168:2 174:11 202:2 229:11 233:15 280:24 293:20 300:7,8,17 309:2 <b>fourth</b> 292:13 <b>framework</b> 181:2 288:21 <b>france</b> 119:6 129:15 134:20 138:13,16 140:13 <b>fraught</b> 78:9 85:14 85:16 103:7 202:2 <b>fray</b> 209:20 <b>free</b> 83:11 203:17 <b>freezer</b> 152:20 <b>frequently</b> 121:13 124:19 <b>friday</b> 324:7,8 <b>friend's</b> 226:10 <b>friendship</b> 52:11 <b>front</b> 9:16,18 239:16 312:18 <b>full</b> 7:15 12:25 91:12 159:10 235:11,15 <b>fully</b> 88:8 128:17 140:3 146:8 150:25 151:17 157:16 214:25 215:23 <b>function</b> 179:11 332:23 <b>functional</b> 120:3 180:16 <b>functioning</b> 118:9 122:4 124:4	170:20 201:9 298:8 <b>fund</b> 231:18 <b>funny</b> 72:10 <b>further</b> 23:22 336:8 342:9,15 <b>future</b> 49:20 82:21 88:6 163:3 165:23 171:11 187:23 210:6 215:14 236:13 <b>fuzzy</b> 11:16
<b>g</b>			
<b>g</b> 243:18 303:19,23 303:24 <b>gain</b> 215:14 216:13 <b>gary</b> 3:24 <b>gather</b> 314:7 <b>gauge</b> 90:2,4 <b>gay</b> 51:18,18 108:17 116:20 <b>gears</b> 283:7 302:13 303:14 310:13 <b>ged</b> 114:12 <b>gee</b> 157:23 301:4 <b>gender</b> 15:10,19 16:9,14,14,23 17:3 17:11 19:12,16 20:7,11,22 21:5,14 21:19,25 22:7,15 22:25 23:7,13,17 24:2,7,9,20 25:19 27:12,20 28:3,22 29:20 30:14,21 31:11 33:17 35:14 35:16,18 37:10,12 37:13 38:4,14,16 38:18,22,24 39:8 40:2,8,10,15,25			

41:8,25 42:18,21 43:12,19 44:4,16 45:4,10,16,18 48:25,25 51:6,25 52:13,24 53:11,22 54:18 55:17 56:14 57:2 58:8,21,22 61:11,20 62:2 66:3 67:25 69:16 76:7,19 78:13 79:25 80:3,14 81:10,16 82:2,8 85:24 91:20 92:12 95:10,11 96:9 100:23 101:9 103:23 105:15,22 106:10,20,21 107:2,6,25 108:2 108:14 109:2 110:23 112:10 113:24 114:2,10 114:24 125:12,20 128:2,4,6,15,21 131:15 134:21 135:3,9,19,23 136:10 137:4 138:8,13,19 139:11 140:23 145:8,13,14 148:25 151:12 155:16,24 156:7 156:10 157:20 159:14 161:17 162:5,7 163:10,15 163:18 165:4 166:15 167:25 171:7,15,16 172:18,22,23 175:14 176:6,10 177:8 178:22 179:6 180:7	181:24 183:12,23 188:8,13,16,17 193:20,21 197:25 198:5,9 199:6,25 201:2,15 202:10 202:24 205:11 207:13 208:9,23 209:25 211:10 212:13 216:10 219:19 220:10,20 220:21 226:23 228:20 229:6 240:19 242:13,21 243:12,20 246:11 246:20 253:2 254:2,7,10,17,22 254:23 255:4,24 256:2,5,18 257:8 257:12,17 258:8 258:16 259:7,16 263:4,18,22 264:19,23,24 265:16,19 268:5,8 272:8,19 284:5 285:11 290:15,18 293:9,13,21,23 294:19 301:12 304:11 305:21,22 308:18,18 310:3 310:10 315:14,19 316:6,10,15,22 317:6,18 318:3,7 318:11,14,16,21 318:25 319:23 320:5,13,15,20 321:4,5 323:7 325:14 327:6,19 329:5 330:6 331:15 332:11 333:17 334:5,9 344:12	<b>gendered</b> 43:9 265:6 <b>genderreport.ca</b> 270:21 <b>general</b> 1:12 4:11 4:12 23:10 26:4 42:24 43:14 94:2 106:2 125:13 173:21 175:21 192:22 222:3 233:2,4 261:18 316:17 327:21 <b>general's</b> 6:15 165:18 177:12 323:22 <b>generalization</b> 249:24 <b>generally</b> 15:24 26:11 30:13 39:5 45:21 46:22 63:12 76:20 98:25 102:20 126:8 157:7 167:18 180:9 192:8,24 196:18 197:13 221:8,9 227:21 246:4 289:15 290:2 <b>generals</b> 165:16 327:22 <b>generate</b> 131:21 <b>generation</b> 201:19 <b>genetically</b> 236:2 236:4 238:6,8 <b>genital</b> 197:20 <b>genitalia</b> 195:19 195:20 <b>genitals</b> 46:25 <b>getting</b> 48:10 54:16 87:7 88:5 95:4 118:5 121:10	121:13 122:9,11 126:19 127:20 132:21 137:9 141:16 154:21 188:23 202:18 203:2 210:7 213:23 224:13 261:20 262:8 265:12,13 333:19 <b>gill</b> 4:3,7 <b>girl</b> 213:14 256:25 257:25 <b>girls</b> 139:25 213:10 236:5 238:8 258:9 295:8 295:10 <b>give</b> 12:13,21 13:15 16:20 20:5 25:13 31:12 45:6 49:2 71:10,25 72:3 73:16,21 89:24 97:24 103:17 115:16,16 121:17 130:12 150:5 153:24 157:25 177:12 186:23 191:5 203:22 207:15 208:25 211:25 217:5,6 233:10 245:6 251:6 265:17 273:18 274:14 275:16 289:16 308:22 329:23 334:24 339:11 340:2 <b>given</b> 24:5,20 27:18 28:10 48:15 59:17 79:24 98:12 130:21 156:13 172:24 179:16
---	---	---	--



186:12 200:14 219:14 221:5 227:14 244:9 261:24 274:8 277:18 304:7 347:9 <b>gives</b> 273:22 339:19,21 <b>giving</b> 70:22 79:7 122:10 140:6 163:21 189:4,9 208:19 252:2 258:2 <b>go</b> 7:19 11:14,19 19:3 53:24 58:4 60:13 63:6 68:9 76:23 80:4 91:11 91:13 101:7 103:14 105:6 114:13 115:10 129:5 137:6 140:2 161:2 170:3 182:13 191:7,14 192:6 216:14,15 222:8 223:2,9,18 239:18,24 245:2 251:4 264:6 267:14,19 270:5 272:11 278:7 289:7 302:11 305:16 338:22 340:2 <b>goal</b> 44:6 322:2 <b>god</b> 275:23 <b>goes</b> 28:20 164:5,9 169:17 185:4 272:23 <b>going</b> 5:2 12:2 25:12 29:4 49:18 51:5 60:15,18 65:23 71:20 73:20	81:8 82:3 90:24 91:16 99:2,10,17 100:5,7 102:13 103:12 105:8 110:6 121:9 127:2 136:22 148:2 149:5 150:2 151:3 151:5 152:18 161:8 162:21 163:22 165:19,25 166:14 167:17,19 168:3 172:11 173:25 175:6,7,8 175:20,22,24,25 176:2,4 180:25 181:4 186:3 192:3 192:6,7 196:4 216:6 223:4,7 225:21 230:11,13 232:14 233:7,14 247:2 251:12,16 265:20 266:15,16 266:17,18,20 283:6,11 285:22 285:23 287:20,20 289:5,9,24 291:7 291:15,18 297:9 297:10 301:7 305:25 308:23 316:13 320:9 337:9,17 339:5,7 341:5 <b>good</b> 5:1 7:4 9:7 13:8 16:12 17:7 33:7 59:21 92:17 105:2,4 174:2 185:2 213:8 221:12,13 226:14 237:19 276:3 290:4 291:12	<b>goodman</b> 34:19 39:18 <b>gotcha</b> 305:20 <b>gotten</b> 330:11 <b>government</b> 135:6 214:10 215:3 231:18 <b>governor</b> 218:11 323:12 326:8,9 <b>governors</b> 218:18 <b>grant</b> 94:24 <b>grasp</b> 178:5 <b>grasped</b> 202:19 <b>grasping</b> 47:20 333:21 <b>great</b> 57:14 58:2 102:8 127:2,14 130:11,12,12 185:3 198:15 200:18 221:11 229:12 234:22 266:13 308:4 315:25 316:19 339:20 <b>green</b> 257:20 <b>green's</b> 257:4 <b>grew</b> 257:12,17 266:12 <b>grieving</b> 83:20 <b>gross</b> 249:23 <b>grossman</b> 34:20 34:20 <b>ground</b> 7:24 200:14 314:20 <b>groundrules</b> 7:20 <b>group</b> 23:13 25:9 27:2 30:7 62:14 88:14 93:10 117:23 134:16 152:17 168:20 173:17,21 225:11	229:23 232:22 244:13 245:4,5,12 245:14,22 246:3 253:7 260:7 268:15 269:25 273:23 283:24 288:3 290:21 303:12 332:17 338:25 <b>groups</b> 157:4 230:16 243:25 245:20 268:23 <b>grow</b> 216:12 <b>growing</b> 267:5 338:17 <b>gsullivan</b> 3:25 <b>guarantee</b> 195:17 280:9 <b>guaranteed</b> 121:18 <b>guess</b> 17:13 36:14 48:23 55:25 58:13 59:22 67:12 74:4 100:5 116:5 184:24 209:21 245:4 246:17 <b>guessing</b> 53:16 <b>guesstimate</b> 33:15 96:12 <b>guesstimates</b> 14:18 <b>guidance</b> 25:13 111:14 <b>guide</b> 289:2 <b>guidelines</b> 270:16 287:13,22,23 288:10,22 <b>guru</b> 49:25 <b>guys</b> 220:6
--	---	--	---

<b>h</b>	<b>happy</b> 92:24	125:22 126:3,23	<b>help</b> 17:5 25:11
<b>h</b> 305:8 343:7	117:10,14 118:7	126:25 144:3	99:17 107:23
346:3	118:22,22,23,24	164:22,24 165:3	131:6 146:25
<b>half</b> 13:21,24	118:25 121:18	167:11 179:15	160:17 185:16
93:18 101:25	123:8,12 125:7	182:3 193:18	189:15 195:10
163:7	126:24 133:16	194:2,22 212:19	212:24 219:16
<b>hall</b> 260:6	201:7 207:3 234:7	224:21 287:24	250:2 251:23
<b>halting</b> 294:18	247:4 319:11	289:2 293:14	264:16 279:19
<b>hand</b> 155:18	326:21	306:15,17 310:15	303:21 305:2
<b>handbook</b> 306:16	<b>hard</b> 8:15 10:4	315:25 322:16	314:20 327:4
<b>handful</b> 64:6 74:8	68:24 116:3	328:23	335:15
78:4 257:15	199:15 221:15	<b>healthcare</b> 98:6	<b>helped</b> 52:5 123:5
293:24	237:3 289:13	181:9 333:15	124:15 148:4
<b>handsomeness</b>	309:11,12 333:20	334:3 343:21	218:15 219:9
49:22	<b>harm</b> 100:5	<b>healthy</b> 87:22	260:21 315:2
<b>happen</b> 81:23	169:21 180:10	124:8,9 180:16	<b>helpful</b> 18:3,6 53:9
83:17 101:6	185:15 189:23	212:11	98:2 110:22
159:18 162:21	211:24 218:22,24	<b>hear</b> 6:25 15:12	211:15 217:18
175:9 187:24	251:8 317:4	29:7 31:23 50:7	251:6 314:25
197:8 215:10	<b>harm's</b> 174:7	124:18 127:13	<b>helping</b> 38:10
256:4,11 289:24	<b>harmed</b> 218:11,15	221:24,25 261:4,7	207:2 219:22,25
<b>happened</b> 49:14	219:10 301:7,8	309:14 312:20	238:13 240:18
76:13 79:18 108:9	<b>harmful</b> 99:9,12	313:19 321:18	306:19 336:20
237:17 287:16	<b>harming</b> 43:2 82:3	327:11 333:24	<b>helps</b> 219:3 317:3
288:13 335:17	155:13 233:9	340:15	<b>hereinbefore</b>
<b>happening</b> 26:14	<b>harms</b> 139:23	<b>heard</b> 37:25 96:2	342:14
149:10,11,13	204:21 219:3	97:24 99:22	<b>hereto</b> 347:7
<b>happens</b> 103:15	<b>hated</b> 113:10,13	124:12 142:16	<b>heroin</b> 74:20,22,23
103:16 109:19	<b>haunted</b> 113:13	149:6 172:9	75:9 225:6,7
142:16 184:12	<b>head</b> 13:9 237:21	215:25 298:9	<b>hesitating</b> 16:24
200:22 216:5	303:3	304:5 328:4	28:16
218:14 274:20	<b>heading</b> 272:18	<b>hearing</b> 181:17,19	<b>hesitation</b> 31:23
278:5,11 326:15	<b>health</b> 23:11 39:25	199:15	<b>heterogeneity</b>
340:14	41:6,19 42:24	<b>heart</b> 278:7 336:7	145:24
<b>happier</b> 118:5,8	58:4 91:25 92:4,4	<b>hearts</b> 336:2	<b>heterosexual</b>
122:13,16 123:11	93:10 102:18,23	<b>heavily</b> 120:11	257:16 321:2
123:16 124:3	103:3,10,18 104:9	123:14,25,25	<b>hidden</b> 37:12
<b>happily</b> 127:21	104:12 117:4,17	<b>hedging</b> 67:12	<b>hierarchy</b> 240:11
<b>happiness</b> 123:9	118:10,15,18	<b>held</b> 2:4 11:24	240:15
125:12,14	119:10,16 121:21	223:13 293:20	<b>high</b> 101:20
	121:24 124:24		137:13 154:4

189:5,7 194:23 212:21 216:16 296:6 335:3 <b>higher</b> 156:2 212:18 244:16 <b>highlight</b> 182:12 191:20 <b>highlighted</b> 65:19 71:13,21 149:23 150:3,9 191:3 192:4 267:22 270:13 <b>highly</b> 81:20 180:16 209:11 <b>hint</b> 74:22 <b>hired</b> 177:12,15,24 178:7 <b>histories</b> 112:25 241:23 <b>history</b> 162:11,14 203:18 210:13 241:2,3,4,22 242:17 256:15 311:21 312:5,6 320:15 338:12 <b>hit</b> 64:23 <b>hold</b> 196:6 221:22 <b>holds</b> 272:25 <b>home</b> 75:10 272:4 273:8 319:10 <b>homosexual</b> 51:17 256:14,22 257:18 301:19 <b>honest</b> 148:19 <b>hope</b> 147:13,16,20 155:11 161:23 164:21 167:9 174:5 178:4 179:18 180:14,17 180:18 195:25 283:4 297:21	<b>hopefully</b> 276:24 276:25 296:14 340:3 <b>hoping</b> 155:25 <b>hormonal</b> 84:19 150:10 294:18 334:9 <b>hormone</b> 35:24 36:12,14 44:7 45:2,9,15 53:13 57:4 58:9 59:5 60:2,5 63:2,11,19 68:22 75:18,24 76:21 77:10 78:6 79:17 82:18 83:15 84:4 85:5 87:11 97:9 99:6 101:9 101:15,16 102:5 105:17 117:3,8 124:10 126:2,10 137:5,16 151:12 164:13,16 166:25 167:3 168:8 169:14,19 171:8 172:18,24 187:5 192:9,25 196:19 197:14,23 198:8 199:3,25 212:13 214:5,24 220:20 223:20 224:3 225:21,24 226:23 227:4 229:24 242:5 243:11 244:2 246:20 259:25 261:23 300:2 306:2 324:18 327:6 334:16 338:4 <b>hormones</b> 45:22 46:20,24 49:3 53:20 57:12,22	58:11,16,25 59:8 63:13 66:6,20 72:2,4 73:16,22 74:8 79:8 80:4,5 82:9 86:4 87:20 98:13 103:17 118:4,6,6,16,23,24 119:11 120:8 121:5,14,17,22 122:3,11,16,23,24 122:25 123:5,8,17 123:18 124:3,15 125:15 127:20 136:5,6 137:25 148:2 150:22 152:14 156:23,24 162:18,19,25 163:5 166:17 167:24 168:4,6 186:9 189:10 197:19 201:8,16 206:5,12 216:8,21 217:6 224:13,22 226:3,16 227:19 243:23 244:3,20 244:23 251:17 258:3 259:23 260:8,20 261:10 261:21 262:5,8 308:23 309:6 320:19 324:24 338:8,23 339:13 340:3 <b>horrified</b> 55:8 <b>hospital</b> 167:14 272:25 <b>hospitalizations</b> 48:17 114:6,7 <b>hospitals</b> 76:18 <b>hosted</b> 2:5	<b>hour</b> 17:21 59:17 93:18 95:5 147:23 159:4 316:20 <b>hour's</b> 107:8 <b>hours</b> 13:4,19 14:4 226:19 229:12 325:9 <b>hruz</b> 305:8,12,14 306:4 307:2 <b>hruz's</b> 307:17 <b>https</b> 270:21 <b>hum</b> 8:15 33:16 61:17 <b>human</b> 21:19 22:3 109:3 110:2,3,10 114:19 116:6,7,8 308:8 321:24 <b>hundred</b> 285:20 <b>hundreds</b> 40:17 109:6 <b>husband</b> 38:9 <b>hutchison</b> 10:16 <b>hyperbolic</b> 326:6
<b>i</b>			
<b>icd</b> 315:24 316:23 <b>idea</b> 12:21 31:12 38:17 90:20 92:18 140:22 145:24 192:16 194:14 198:20 232:13 275:18,22 299:7 323:17 325:6,12 339:22 <b>ideal</b> 29:14 100:13 158:4 <b>ideally</b> 167:7 <b>ideas</b> 287:18 297:18,24 302:17 303:8 306:15 <b>identification</b> 50:25 52:21 64:13			

70:10 86:13 181:13 190:8 234:15 236:2,4 238:5,7 239:7 272:10 <b>identifications</b> 115:15 116:9 256:17 <b>identified</b> 15:10 86:24 121:14 189:11 210:7 254:10 256:14 257:8,13,17 258:7 258:8 259:7,16 268:12,22 <b>identify</b> 5:13 50:15 111:2 112:12,13 114:23 143:2,8 <b>identities</b> 51:22 201:2 259:9,17 320:25 <b>identity</b> 15:19 16:10,15 21:5 23:14 24:7,20 27:20 28:22 38:12 40:8 42:18,21,22 43:12,19,25 49:10 51:11,13,23,25,25 52:7,14 85:24 107:11,16,25 108:2,16,17,17 109:2,4,8,9 113:24 114:3,10 116:9,19 125:20 140:18,19 140:20,23,24,25 166:16 168:2 179:6 180:7 188:8 189:13,14 216:10 240:20 242:13,21 253:2 254:7,8	264:19,23,24 268:8,9 291:2 295:7,7 301:12 316:6,10 317:6 <b>ignorant</b> 149:18 <b>ignored</b> 94:3 <b>illness</b> 103:23 104:2 200:25 201:4 293:15 <b>illuminates</b> 290:5 <b>illustrate</b> 289:11 <b>illustrated</b> 56:5 <b>imagine</b> 28:11 233:3 299:13 <b>imagined</b> 209:15 <b>immediately</b> 48:5 79:7,8 <b>immensely</b> 117:14 <b>immutable</b> 298:5 <b>impact</b> 137:22 287:9 <b>implications</b> 85:8 150:12 153:7 156:22 157:14 180:5 217:23 251:22 <b>implies</b> 30:2 <b>imply</b> 136:4 166:14 <b>import</b> 57:17 59:8 <b>importance</b> 317:3 <b>important</b> 8:11 43:6 100:25 144:16,24 146:11 180:21 274:17 290:13 312:5 320:11 322:11,12 322:13 <b>imposing</b> 174:16 <b>impressed</b> 94:12	<b>impressions</b> 314:5 <b>impressively</b> 261:22 <b>imprimatur</b> 67:21 <b>improper</b> 249:18 <b>improve</b> 83:9 144:3 155:15,23 <b>improved</b> 120:7 121:2 124:6 336:23 <b>improvement</b> 121:21 123:9 169:7 <b>improvements</b> 126:3 <b>improves</b> 120:5 179:11 <b>improving</b> 119:16 <b>imprudence</b> 221:3 <b>inaccurately</b> 255:6 <b>incarceration</b> 142:21 <b>incidents</b> 140:4 <b>inclined</b> 84:9 <b>include</b> 14:10 44:10 160:10 164:21 205:2 310:18 <b>included</b> 269:21 <b>includes</b> 44:13 55:12 89:21 131:24 220:15 247:22 <b>including</b> 33:4 71:16 204:8 250:16 294:17 300:20 <b>inconclusive</b> 244:21	<b>inconsistency</b> 244:5 <b>inconsistent</b> 316:8 <b>increase</b> 139:24 168:10 280:10 298:7 <b>increased</b> 140:4 <b>increases</b> 88:4,4 <b>increasing</b> 138:8 139:24 141:7,12 184:13 258:24 <b>increasingly</b> 268:6 <b>incredible</b> 225:14 <b>incumbent</b> 150:14 <b>independent</b> 47:10 129:9,13,16,21 277:10 281:8 <b>independently</b> 130:14 277:15 <b>indicates</b> 139:20 <b>indicating</b> 254:25 255:24 <b>indication</b> 269:15 <b>indications</b> 179:14 233:8 248:23 <b>indicators</b> 88:13 <b>individual</b> 147:15 147:18 149:8 159:17 169:9 173:15,22 175:11 192:10 196:20 197:15 212:15 229:17 231:12,13 <b>individually</b> 167:19 <b>individuals</b> 39:15 39:22 76:19 254:21 <b>indoctrination</b> 50:24 94:6
--	---	---	---

<b>industry</b> 298:15 <b>influence</b> 18:2 49:11 50:24 117:18 155:12 220:5 <b>influenced</b> 50:14 <b>influences</b> 50:6 51:10 52:13 <b>inform</b> 144:19 147:7 157:13 160:2,17 216:6 250:2 <b>information</b> 34:13 48:22 90:5 129:19 130:23 145:18 159:10 196:22 197:6 208:19 236:15 241:21 260:12 314:8 318:19,24 322:12 339:20 <b>informed</b> 10:2 83:12 86:9,23 87:9 88:15 89:5 89:13 94:17,19 109:21 119:21,23 131:2 144:15 145:18 146:10,14 146:15,22 147:14 148:6,18,19 149:21 150:18,25 151:16 152:4,6,12 153:2,25 154:3 155:10 157:16 158:20 160:4 178:11 179:2 185:5 196:2 199:21 200:3,11 202:6 203:22,25 205:9 212:16 214:7 215:2,21	216:21,22 217:13 230:14 325:21 338:17 343:16 <b>informer</b> 156:20 <b>informing</b> 102:11 203:3 <b>informs</b> 151:17 216:7 <b>initial</b> 113:12 136:6 <b>initially</b> 273:15 <b>initials</b> 92:21 <b>inmates</b> 40:10 <b>inpatient</b> 121:12 <b>insistent</b> 47:5 48:2 78:16 <b>insomnia</b> 251:25 252:2 <b>instantly</b> 117:10 <b>institution</b> 24:13 303:6 <b>institutions</b> 147:17 189:6 296:7 <b>insurance</b> 181:23 207:17 208:5 <b>insure</b> 279:19 <b>intelligence</b> 101:20 <b>intelligent</b> 184:19 <b>intensive</b> 18:12,18 <b>intent</b> 164:6 <b>intention</b> 52:2 176:9 177:6 <b>intentions</b> 116:22 <b>interactions</b> 203:14 <b>interest</b> 76:16 94:16 212:7 <b>interested</b> 36:3 107:14,17 108:18 165:4 227:18	284:12,13 288:24 295:3 298:24 308:10 313:14,15 342:21 <b>interests</b> 46:2 211:9 339:25 <b>interfering</b> 180:13 <b>international</b> 141:19 <b>internationally</b> 50:9 <b>internet</b> 49:18 93:19 <b>internist</b> 206:23 319:17 <b>interpret</b> 162:17 <b>interpretation</b> 314:16 <b>interpreted</b> 163:8 163:9 <b>interrupt</b> 309:16 <b>interrupted</b> 303:13 <b>intervals</b> 56:4 <b>intervene</b> 266:23 <b>intervention</b> 100:20 236:13 253:9 266:18 <b>interventions</b> 150:11 156:25 162:6 268:16 286:2 334:9 <b>interviewed</b> 22:17 95:21 <b>intimate</b> 52:9 187:25 <b>intrafamilial</b> 264:17 <b>introduce</b> 109:9 <b>introduction</b> 299:15	<b>introductory</b> 299:3 <b>intuition</b> 213:8 <b>investigate</b> 36:9 323:3 <b>investigating</b> 327:5 <b>investigation</b> 38:10 <b>investigative</b> 272:21 <b>invitations</b> 93:7 <b>invited</b> 93:9 94:14 <b>involve</b> 89:25 <b>involved</b> 21:22 78:22 157:8 167:8 167:13 173:19 233:25 241:6 245:24 284:13 286:23 287:2 <b>involvement</b> 49:17 <b>involves</b> 38:11 <b>involving</b> 212:22 327:18 332:15 <b>irb</b> 135:6 231:5 <b>ireland</b> 93:20 <b>isolation</b> 43:3 101:22 108:6 <b>issue</b> 12:14 18:25 24:7 27:3 30:6 58:5 120:13,18 152:22 162:2 181:25 188:24 258:13 267:13 269:8 315:13,17 328:25 337:10,11 <b>issues</b> 11:13 15:19 16:10,15 22:7 23:9,14 24:21 27:20 28:4 29:7,9 29:21 37:13 38:4
---	--	---	---

42:21,22,23 45:19 45:20 93:23 94:11 94:13 107:4 110:11 172:25 264:17,21 293:8 293:13,22 302:6 316:14,16 324:3 324:11 332:15 <b>item</b> 235:16 <b>iv</b> 316:7	188:19 197:4,5 205:20 206:5,6,7 249:14 252:5 <b>juli</b> 190:5 344:2 <b>julia</b> 91:5 92:10 <b>julie</b> 70:9,20 343:13 <b>july</b> 13:2 234:14 235:3 344:7 <b>jump</b> 150:2 <b>june</b> 130:22 345:3 <b>justify</b> 278:17	184:13 189:7 206:19 207:5 219:6 244:13 255:8 258:20 259:5,25 269:2,3 308:23 309:5 326:2 <b>kill</b> 308:24 <b>kind</b> 43:19 106:25 149:14 163:12 165:12 171:5 173:5 187:12 193:25 200:5 202:13 221:16 230:21,22 232:9 242:3 260:24 284:16 285:25 286:2 294:22 310:25 311:24 329:13 <b>kinds</b> 100:16 226:11 249:4 267:5 283:2 311:15 <b>kink</b> 113:21 116:21 <b>kinky</b> 116:21 <b>knew</b> 200:14 219:4 <b>know</b> 7:6,17 9:5 16:15 20:22 23:20 32:3,3 34:2 35:6,7 38:10,21 39:9 41:3,21 47:11 48:9 49:15 51:13 54:10,12 55:11,23 58:24,25 59:5,9 60:2 62:13,15 64:16 65:20 68:24 70:3,5 76:11,12 81:6 86:16 88:10	88:19 91:22 92:10 96:12,24 99:18 100:23 101:18 103:20,22 104:13 104:19 109:5 110:20 112:17 113:4 117:16 118:13 119:5 120:6,15,23 121:2 121:3 123:3,4 126:18,22 127:24 129:4 131:9 132:7 132:15 136:14,16 137:6 138:23 141:17 142:2,2,3,8 142:11,14,18 143:24 144:17,25 144:25 147:24 149:14 154:5,21 155:4 156:16,24 157:5 158:6,24 159:25 160:10 162:16 165:9 167:15 169:11 170:12,23 171:20 171:23,25 174:24 175:16 179:25 181:4 183:18 184:18 186:17 187:23 188:9,13 191:22 195:4 200:23 201:17,22 201:23 203:2,4,13 203:20 204:13,23 205:2,22 206:4,9,9 206:11,15,16,24 207:18 209:8 215:10,14 217:18 217:19,25 218:3,4 218:4,13,17,21 219:2,14 220:3,25
<b>j</b>	<b>k</b>		
<b>january</b> 94:22 111:4 <b>jason</b> 4:21 <b>jeopardy</b> 187:12 <b>jm</b> 1:4 5:12 <b>joanna</b> 1:7 <b>job</b> 122:9,12,12 <b>jobs</b> 275:5 <b>jogging</b> 59:14 <b>john</b> 175:23,24 <b>join</b> 93:6 94:14 <b>joined</b> 6:6 93:17 <b>jones</b> 70:9,20 175:23,24 343:14 <b>journal</b> 86:11 194:8 274:19 276:18 277:23 278:12 279:8 283:2 343:18 <b>journalist</b> 271:11 <b>journals</b> 282:3,3,5 <b>judgment</b> 47:12 75:13 85:9 146:23 158:15 185:2 <b>judgments</b> 314:12 <b>judicious</b> 184:8,16 184:19,22 185:4 185:12,17,18,24 186:6,6,8,13,25 187:5,9,11 188:18	<b>k</b> 60:24 <b>kalin</b> 280:21 281:5 281:9 <b>karasic</b> 10:19 <b>karasic's</b> 10:20 <b>katz</b> 37:21 39:18 <b>keep</b> 18:16 179:24 189:12,13 224:10 <b>keeping</b> 21:7,9,10 197:9 302:17 303:9 <b>keeps</b> 28:19 <b>ken</b> 253:18,21 265:22,25 294:13 294:25 295:3 299:22 <b>kenneth</b> 292:13 <b>kentucky</b> 170:4 <b>keohane</b> 70:8,20 343:13 <b>kettles</b> 318:17 <b>kid</b> 75:4 189:24 264:15 291:2 <b>kids</b> 111:16,17 112:5 135:8 136:7 153:25 163:14 165:25 170:10,16 170:18 171:17,18		

221:3,11 225:6 229:14 231:13 234:18 235:7 236:6 237:3 241:12,14,17,17 246:4 247:3 248:2 248:6 250:14 251:16 252:9 255:14 256:4,12 256:18 257:23,24 258:2,11 259:5 260:23 262:13,19 262:25 263:5,10 264:5 265:17 267:4 270:6 271:18 274:23,25 275:14 277:2,12 280:18 282:7,14 282:24 284:9,10 284:18,24 285:4 285:16 286:8 287:2,5,6 288:12 288:14,19 289:8 289:23 293:2 295:15 298:16 300:4 302:3,6 303:2,14,18,25 304:10,14,16,17 304:23 305:7,10 305:20,24 306:4 306:12 307:8,10 307:11 308:2,5 310:8,9,12 312:7,9 312:21,22 315:6,7 316:4 318:13 319:15 322:13,19 323:16 324:2,5 326:3,10,14,17,22 329:12 330:8 333:4 334:12 336:21 339:3	<b>knowingly</b> 325:18 <b>knowledge</b> 59:25 60:4 105:17 130:25 147:9 148:24 177:23 186:19 189:20 204:2,7 213:7 235:22 268:17 276:23 288:2 337:2 <b>knowledgeable</b> 149:10 207:24 <b>known</b> 46:4,5 76:5 77:6 104:21 109:24,25 120:25 144:22 156:21,21 194:6 216:20 250:18 309:2 <b>knows</b> 88:9,21 103:13,14 104:18 110:15 132:13,19 145:2,3 148:21 156:19 158:5 186:16 204:22 205:6 222:11,12 262:19 <b>I</b> <b>I</b> 304:20 <b>label</b> 249:9,9,12 249:14,17 250:5 250:13,15,21 251:3,11,18 <b>lack</b> 116:17 284:3 <b>lacking</b> 130:15 <b>land</b> 4:17 314:20 <b>landscape</b> 96:18 96:23 <b>language</b> 17:11 260:13,15 271:15 <b>lappert</b> 304:18 305:5,6	<b>large</b> 261:22,22 269:6 <b>larger</b> 220:4 222:10 293:7 <b>lasted</b> 299:20 <b>late</b> 111:4 <b>lately</b> 287:6 <b>latest</b> 287:25 288:2 <b>laugh</b> 317:9 <b>laughable</b> 325:6 325:12 <b>launch</b> 201:7 <b>law</b> 6:22 154:24 155:4 162:2,4,10 162:12,15,17,22 163:3,7,20,24 164:5,6,9 165:7,15 165:15,22 166:9 166:11 168:12,12 168:14,14,16,23 169:8,17 170:23 171:3,9,12,17 173:9 177:16,18 178:4 200:16 202:12 205:14 207:12,21 208:4,4 208:22 209:22 211:8 220:9,19 223:18 226:2 231:25 232:6,8,10 233:5 234:2 241:19,20 328:2,9 329:4,12,15,17,18 330:3 331:2,6 <b>law.com</b> 4:7 <b>lawsuit</b> 137:12,13 <b>lawyer</b> 333:9 <b>lawyer's</b> 191:23 <b>lawyers</b> 217:22 220:3	<b>lay</b> 241:12,15 <b>lcooper</b> 3:17 <b>lead</b> 180:15 225:13,19 332:7 <b>leader</b> 26:24 <b>leading</b> 265:22 <b>learn</b> 204:15 209:13 313:5,6 <b>learned</b> 196:22 <b>leave</b> 217:19 264:15,23 331:19 <b>leaves</b> 57:19 <b>leaving</b> 315:3 <b>led</b> 281:5 <b>left</b> 12:5 75:5 159:12 214:18 245:12 <b>legal</b> 2:6 4:21 154:19,23 157:25 158:8 329:23,23 330:2 345:23 <b>legally</b> 89:24 198:25 <b>legislation</b> 208:8 <b>legislative</b> 181:17 181:19 208:14 <b>legislator</b> 177:19 218:10 234:6 <b>legislators</b> 201:18 <b>legislature</b> 170:7 174:6 179:20 210:22 <b>legislatures</b> 217:22 218:18 <b>legitimacy</b> 338:6 <b>legitimate</b> 180:4 <b>legitimizes</b> 339:18 <b>length</b> 42:13 102:8 316:19 333:8 <b>lengthy</b> 81:12
--	---	--	---

<b>lesbian</b> 51:17,19 108:17	15:1 16:1 17:1 18:1 19:1 20:1	131:1 132:1,18,18 133:1 134:1 135:1	244:1 245:1 246:1 247:1 248:1 249:1
<b>leslie</b> 1:10 3:16 5:8 5:15 7:9 36:22 39:11 193:5 213:22	21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1 29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1,15 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1,9,10 65:1,5 66:1 67:1 68:1 69:1 70:1,6,8 70:16 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1,8,10 87:1 88:1 89:1 90:1 91:1 92:1 93:1 94:1 95:1 96:1 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1,14 121:1 122:1 123:1 124:1 125:1 126:1 127:1 127:22 128:1 129:1,6 130:1	136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 149:1 150:1 151:1 152:1 153:1 154:1 155:1 156:1 157:1 158:1 159:1 160:1 161:1,13 162:1 163:1 164:1 165:1 166:1 167:1 168:1 169:1 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1,8,15 182:1,17 183:1 184:1 185:1 186:1 187:1,16 188:1 189:1 190:1,3,4 191:1 192:1 193:1 194:1 195:1 196:1 197:1 198:1 199:1 200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 211:1 212:1 213:1 214:1 215:1 216:1 217:1 218:1 219:1 220:1 221:1 222:1 223:1 223:17 224:1 225:1 226:1 227:1 228:1 229:1 230:1 231:1 232:1 233:1 234:1,12,13 235:1 236:1 237:1 238:1 239:1,3,4 240:1 241:1 242:1 243:1	250:1 251:1 252:1 253:1 254:1 255:1 256:1 257:1 258:1 259:1 260:1 261:1 262:1 263:1 264:1 265:1 266:1 267:1 268:1 269:1 270:1 271:1 272:1,7 273:1 274:1 275:1 276:1 277:1 278:1 279:1 280:1 281:1 282:1 283:1 284:1 285:1 286:1 287:1 288:1 289:1 290:1 291:1,20 292:1 293:1 294:1 295:1 296:1 297:1 298:1 299:1 300:1 301:1 302:1 303:1 304:1 305:1 306:1 307:1 308:1 309:1 310:1 311:1 312:1 313:1 314:1 315:1,2 316:1 317:1 318:1 319:1 320:1 321:1 322:1,13 323:1 324:1 325:1 326:1 327:1 328:1,3 329:1,21 330:1 331:1 332:1 333:1 334:1 335:1 336:1 337:1,23 338:1 339:1 340:1,22 341:1 342:6 343:2 343:8,9,11,12,15 343:17,20,25 344:1,5,6,8,9,11 345:5 346:2,24 347:2,4,12
<b>lesser</b> 168:5			
<b>letter</b> 44:7 45:2,8 45:14,22 46:8,10 46:13,14,21,22 47:7,8,16 48:3,7 48:11,15 49:2 63:14,19,25 66:17 67:2,21 68:12 69:7,10 73:23 75:17 80:7,22 81:11 83:14 85:10 86:3 95:13,19 96:3 98:14,21 99:8,8 100:4 102:6,11,17 103:3 103:4 227:10 308:17 338:24 339:9			
<b>letters</b> 53:19 63:12 63:23 64:2 80:12 82:17 85:20 95:9 96:8 97:9,11,12,14 98:2,7,16,22 101:8 102:15 226:22 227:7 228:6 280:19 281:6			
<b>leukemia</b> 267:4			
<b>leukemic</b> 267:5			
<b>level</b> 95:4 218:16 242:14 245:13,15			
<b>levels</b> 177:21			
<b>levine</b> 1:19 2:4 5:6 6:21 7:1,2,5,16 8:1 9:1 10:1 11:1 12:1 13:1 14:1			



<b>levine's</b> 154:7 <b>liars</b> 322:4 <b>liberties</b> 3:13 <b>license</b> 2:8,10 41:12 61:6 329:16 331:5,8 342:25 <b>licensee</b> 41:17 <b>licenses</b> 328:12 329:8 330:5,14 331:14 332:4 <b>lie</b> 321:22,25 <b>lied</b> 320:17 <b>lies</b> 285:24 <b>life</b> 81:17,19 84:13 90:20 101:17 104:24 109:12 119:25 127:2,6 158:11 185:10 203:17 215:18 217:7 241:6 251:13 265:6 298:5 317:16 338:12 <b>lifecycle</b> 216:19,19 <b>lifelong</b> 101:3 <b>lifetime</b> 87:19,21 96:11 113:5 217:4 <b>liked</b> 121:5 171:9 <b>likelihood</b> 254:25 280:10 <b>limitations</b> 69:4 97:19 98:11 101:21 229:15,15 229:16 241:16 274:18 289:5 295:12,19 299:6 <b>limited</b> 148:16,17 227:20 242:22 <b>limiting</b> 207:17 <b>line</b> 55:24 148:22 346:4,7,10,13,16	346:19 <b>lisa</b> 238:24 272:22 272:24 273:5,12 274:24 275:13 276:5 292:16 294:10 299:22,23 <b>list</b> 90:11 <b>listed</b> 90:22 91:15 <b>listen</b> 119:20 192:7 330:8,14 <b>listening</b> 49:25 <b>literally</b> 163:8 <b>literature</b> 79:5 139:20 252:8,10 252:11,13,16 254:5 <b>litigation</b> 323:19 <b>little</b> 3:23 4:5,14 6:12 16:18 23:22 25:12 80:10 113:18 127:9,11 157:6 167:14 171:19 184:20 237:15,23 244:11 257:25 258:8,9 274:10 281:10 283:20 298:18 302:4 303:4 304:7 318:15 <b>live</b> 90:18 110:7 165:6,15 207:3 212:25 257:25 265:5 274:6 316:2 <b>lived</b> 256:6 <b>lives</b> 78:17 150:12 207:4 217:8 <b>living</b> 96:5 113:15 127:21 142:21 <b>llp</b> 3:3 <b>london</b> 137:14	<b>long</b> 7:7 68:16 79:2 84:16 85:23 85:23 89:2 104:25 119:11 126:17 130:16,17 132:4 133:15 136:17 139:20,22 153:5 153:16 154:23 179:10 180:5,15 180:20 195:5 205:25 207:3 214:16 215:18 221:11 237:20 248:10 251:14 256:24 266:25 318:9 322:25 <b>longer</b> 37:22 51:18 51:19 59:19 82:24 130:2 196:17,21 227:4 228:6 261:9 <b>look</b> 50:12 82:4 121:16 127:25 132:11,11 149:19 237:22 239:22 243:21 262:14 272:2 273:9 280:3 280:4,4 282:18 288:7,23 311:12 313:18 318:19 333:8 <b>looked</b> 230:11,13 243:24 254:19 274:5 280:25 287:5 308:19 <b>looking</b> 52:23 93:11 117:12,13 129:23 172:15 195:20 219:11 234:22 239:23 256:20 270:12 272:17 274:12	308:25 313:7 320:23 <b>looks</b> 160:25 218:24 312:23,24 312:25 <b>lose</b> 220:4 282:15 331:5,14 <b>lost</b> 99:24 100:9 260:2 275:7 289:21 319:10 <b>lot</b> 29:25 50:13 178:23 183:19,21 213:18 233:8 238:17 245:7 252:2 306:13 313:6 314:22,24 340:13 <b>lots</b> 335:4 <b>love</b> 110:5 188:3 224:16,17 <b>loving</b> 180:16 188:2 <b>low</b> 240:25 245:15 290:20 308:21 <b>lower</b> 152:17 216:11 <b>lowering</b> 117:13 <b>loyalty</b> 224:16 <b>lumping</b> 30:14 <b>lunch</b> 105:4,10 <b>lying</b> 224:7
			<b>m</b>
			<b>m</b> 342:2,24 <b>m.d.</b> 1:19 2:4 6:21 7:1 8:1 9:1 10:1 11:1 12:1 13:1 14:1 15:1 16:1 17:1 18:1 19:1 20:1 21:1 22:1 23:1 24:1 25:1 26:1 27:1 28:1

29:1 30:1 31:1 32:1 33:1 34:1 35:1 36:1 37:1 38:1 39:1 40:1 41:1 42:1 43:1 44:1 45:1 46:1 47:1 48:1 49:1 50:1 51:1 52:1 53:1 54:1 55:1 56:1 57:1 58:1 59:1 60:1 61:1 62:1 63:1 64:1 65:1 66:1 67:1 68:1 69:1 70:1 71:1 72:1 73:1 74:1 75:1 76:1 77:1 78:1 79:1 80:1 81:1 82:1 83:1 84:1 85:1 86:1 87:1 88:1 89:1 90:1 91:1 92:1 93:1 94:1 95:1 96:1 97:1 98:1 99:1 100:1 101:1 102:1 103:1 104:1 105:1 106:1 107:1 108:1 109:1 110:1 111:1 112:1 113:1 114:1 115:1 116:1 117:1 118:1 119:1 120:1 121:1 122:1 123:1 124:1 125:1 126:1 127:1 128:1 129:1 130:1 131:1 132:1 133:1 134:1 135:1 136:1 137:1 138:1 139:1 140:1 141:1 142:1 143:1 144:1 145:1 146:1 147:1 148:1 149:1 150:1 151:1	152:1 153:1 154:1 155:1 156:1 157:1 158:1 159:1 160:1 161:1 162:1 163:1 164:1 165:1 166:1 167:1 168:1 169:1 170:1 171:1 172:1 173:1 174:1 175:1 176:1 177:1 178:1 179:1 180:1 181:1 182:1 183:1 184:1 185:1 186:1 187:1 188:1 189:1 190:1 190:4 191:1 192:1 193:1 194:1 195:1 196:1 197:1 198:1 199:1 200:1 201:1 202:1 203:1 204:1 205:1 206:1 207:1 208:1 209:1 210:1 211:1 212:1 213:1 214:1 215:1 216:1 217:1 218:1 219:1 220:1 221:1 222:1 223:1 224:1 225:1 226:1 227:1 228:1 229:1 230:1 231:1 232:1 233:1 234:1 235:1 236:1 237:1 238:1 239:1 240:1 241:1 242:1 243:1 244:1 245:1 246:1 247:1 248:1 249:1 250:1 251:1 252:1 253:1 254:1 255:1 256:1 257:1 258:1 259:1 260:1 261:1 262:1 263:1 264:1 265:1 266:1 267:1 268:1 269:1 270:1 271:1 272:1 273:1	274:1 275:1 276:1 277:1 278:1 279:1 280:1 281:1 282:1 283:1 284:1 285:1 286:1 287:1 288:1 289:1 290:1 291:1 292:1 293:1 294:1 295:1 296:1 297:1 298:1 299:1 300:1 301:1 302:1 303:1 304:1 305:1 306:1 307:1 308:1 309:1 310:1 311:1 312:1 313:1 314:1 315:1 316:1 317:1 318:1 319:1 320:1 321:1 322:1 323:1 324:1 325:1 326:1 327:1 328:1 329:1 330:1 331:1 332:1 333:1 334:1 335:1 336:1 337:1 338:1 339:1 340:1 341:1 342:6 343:2 344:1 <b>macrichards</b> 272:14,22,24 273:5,13 274:24 275:13 276:5 <b>mad</b> 224:12 <b>maintain</b> 152:19 <b>maintained</b> 301:25 <b>major</b> 153:10 180:10 277:16,24 278:25 300:20 306:14 317:2 <b>majority</b> 14:22 21:2 31:2 139:5 139:13 146:6 147:11 253:11 257:16 262:22	<b>majors</b> 84:22,23 <b>maker</b> 288:15 <b>making</b> 103:6 122:16 140:22 165:20 170:11 184:2 195:9 249:13 252:21 260:16,25 270:3 314:11 <b>male</b> 96:22 108:17 113:15 115:14 235:25 236:2 238:5,6 256:14 268:8 <b>males</b> 116:13,16 256:22 <b>man</b> 222:15 <b>management</b> 190:6,17 344:4 <b>mandates</b> 329:15 <b>manpower</b> 287:18 <b>manuscript</b> 278:12 <b>march</b> 74:14 87:5 141:17 148:12 181:11 183:15 185:18 343:23 <b>marchiano</b> 238:24 292:16 294:10 295:10,11 299:17 299:23 <b>margaret</b> 303:16 <b>marginalized</b> 104:22 <b>maria</b> 10:12 <b>marijuana</b> 101:23 <b>marital</b> 86:11 343:19 <b>mark</b> 64:7 69:25 86:6 181:6 189:25 234:10 238:25
--	---	---	--

272:6 303:15,17 304:13,14 <b>marked</b> 64:12 65:6 70:9 86:12 149:20 181:12 190:7 234:14 239:6 272:9 <b>market</b> 224:2,22 226:3,9,15 <b>marking</b> 64:19 <b>married</b> 110:8 321:2 <b>marry</b> 110:6 <b>masculine</b> 115:18 115:24,24 116:20 124:2 <b>masculinity</b> 49:22 <b>masculinization</b> 119:2 <b>masculinized</b> 121:7 <b>masochistic</b> 113:21 <b>mason</b> 91:5 92:10 <b>massachusetts</b> 40:9 <b>mastectomy</b> 95:19 95:25 96:4 <b>master</b> 272:25 <b>masturbation</b> 195:15,18 <b>matches</b> 242:13,21 <b>material</b> 9:14 92:3 277:3 278:23 279:11 <b>math</b> 13:9,14,17 <b>matter</b> 5:7 81:23 130:6 147:3 201:11,12 202:16 213:10 222:4 227:24 232:16,19	278:8 <b>matters</b> 98:19 <b>matthews</b> 3:10 6:3 6:4 <b>matthewss</b> 3:11 <b>maturation</b> 188:23 244:12 290:11,12 <b>maturational</b> 158:11 188:20 <b>mature</b> 85:16 196:3,3,9,14,15,16 244:13 <b>maturity</b> 84:13 85:7 <b>maureen</b> 1:25 2:7 342:2,24 <b>mcfarland</b> 271:25 272:14 275:14 <b>md</b> 64:10 67:21 70:8 86:10 239:4 309:24 339:18 343:9,13,18 344:9 <b>mean</b> 14:9 15:13 17:2,6 23:22 25:5 61:4 66:15,17 67:4 68:23 73:22 78:10 79:9,10 84:24 85:13 118:17,21 120:18 123:10 154:8 162:13 166:9,24 167:22,23 171:5 175:24 184:15,24 185:2,11 186:3 206:25 228:22 229:4 249:18,19 249:20 250:21,23 252:9 255:3 259:5 263:7 264:8 273:12 276:10,14	276:15 285:6,6 286:25 299:18 300:14 301:2 302:21 306:22 307:15 309:17 312:8,17 314:22 314:23 319:14 326:9 330:4 331:4 333:8 <b>meaning</b> 25:10 54:22 79:8 80:25 203:15 <b>meaningful</b> 67:7 <b>meanings</b> 67:11 67:13 <b>means</b> 17:18,19,20 25:14 49:24 61:5 90:21 152:15 188:18 230:6 241:19 250:24 276:16 285:7 295:17 329:18 <b>meant</b> 82:11 118:19 167:4 184:22 245:21 254:14 <b>measure</b> 209:2 <b>media</b> 5:4 50:13 50:18,22 52:5,11 321:10,11 <b>median</b> 133:15 <b>medicaid</b> 152:18 182:5 183:13 <b>medical</b> 54:5,9 55:6 56:21 57:24 73:2,10 84:21 87:12 88:23 89:8 89:15 90:11 94:8 100:10,13 110:19 111:22,23,24 128:2,4,16,22	131:7,15 135:19 135:25 136:11,24 138:9,14,19 139:11 140:5,6 142:7 143:10 144:11 145:13,15 148:25 154:15 156:10 157:20 159:14 161:17 162:5 164:4 165:14 166:2,3,23 168:24 174:3 175:14 176:7,10 177:8 178:22 180:10 181:23,24 183:12,23 186:4 187:2,14,15 194:25 202:10,24 204:12 205:11 207:13 208:9,23 210:20 215:4 216:20 217:20 218:20 219:20 220:10,14 222:4 222:17 228:20 229:6 236:13 243:20 259:14,16 269:12 285:11 296:19 297:13 300:20 302:7 310:10 311:21 312:4,6 319:15 323:7 325:14 327:19 328:25 329:5,7,9,14,16 330:6,9,20,21,22 331:8,11,15 332:4 332:10 <b>medicalize</b> 125:23 <b>medicalizing</b> 79:3 140:24 179:6
---	--	--	--

180:6 <b>medically</b> 52:25 53:12 55:4 56:14 56:16,18 57:12 58:9,14 68:3 88:5 336:6 <b>medication</b> 18:25 210:15 236:23,24 248:19 336:10 <b>medications</b> 84:11 248:21,21 <b>medicine</b> 91:20 117:16,17 167:6 246:11 250:15 266:12 267:2 284:6,6 302:4 328:17 336:11 <b>meet</b> 11:3 39:4,6 41:23 42:7,12 45:21,23,23,24,24 151:25 290:11 305:14 <b>meeting</b> 11:8 324:10 <b>meets</b> 41:25 <b>member</b> 134:15 310:7 <b>members</b> 268:23 285:18,20 294:11 318:25 320:4 <b>memories</b> 143:25 <b>memory</b> 59:14 135:21 304:7 <b>men</b> 236:3 238:6 256:14 257:19 320:23,24 <b>men's</b> 266:13 <b>menstruation</b> 180:12 252:4 <b>mental</b> 23:10 39:25 41:6,19	42:24 58:4 93:10 99:20 102:18,23 103:3,10,18,23 104:2,9,12 117:4 117:17 118:9,15 118:18 119:10,16 121:21,24 124:24 125:22 126:3,22 126:25 144:3 164:22,24 165:3 167:11 180:15 193:18 194:2,22 200:24 201:4 212:19 287:23 289:2 293:14,15 293:17 306:16 310:15 322:16 328:23 <b>mentally</b> 124:5 200:21,21 318:11 <b>mention</b> 10:8 41:22 42:6 83:25 100:8 114:5 258:10 295:22 304:24 324:2 <b>mentioned</b> 27:5,14 27:17,24 33:22 34:3 37:4 57:8 58:23 60:21 74:2 77:8 95:15 172:10 223:24 224:3 260:6 261:6 276:7 292:12 332:9 <b>mentions</b> 152:8 <b>merely</b> 150:19 <b>merit</b> 278:3 <b>message</b> 221:23 <b>met</b> 7:6 44:17 45:4 102:2,9 106:15 154:4 219:6 305:12	<b>methodologies</b> 129:24 <b>methodologist</b> 92:2 <b>methodologists</b> 273:23 <b>methodology</b> 230:17 <b>methods</b> 313:10 <b>metropolitan</b> 76:14 <b>mic</b> 155:21 <b>michael</b> 4:15 6:13 307:25 308:2 309:18 345:1 <b>michael.cantrell</b> 4:16 345:2 <b>microphones</b> 124:20 <b>mild</b> 251:22 266:14 <b>millions</b> 219:12 <b>mind</b> 48:10 74:15 113:8 128:10 134:2 143:12 196:11 307:16 322:2 326:15 333:10 <b>mindful</b> 8:16 191:13 <b>minds</b> 299:9 <b>minimum</b> 98:20 <b>minor</b> 14:16 30:23 32:23 33:4 38:13 44:15,25 45:4 63:20 64:3 77:10 79:17,17 80:13,14 80:23 89:18 90:4 90:9 105:14 106:9 128:20 133:5 151:13 159:13	169:21,22 205:11 209:24 214:3,22 229:21 277:17 278:5 279:2 318:20 324:18 325:15 <b>minority</b> 262:22 <b>minors</b> 14:24 24:21 27:11 30:15 30:16,22 31:13,24 44:3,11,12,13 46:17 47:14 53:6 54:21 55:18,20 77:16,19 78:6 81:9 84:22 87:13 89:14 128:2,5,16 131:16 133:3,10 134:22 135:3 136:10 138:9,14 139:12 144:20 145:8,12,15 149:2 149:17 155:16,24 156:12 161:17 162:6 176:11 177:9 178:22 181:25 182:7,8 183:12,24 198:5,9 199:5,25 202:10 207:13 208:10 211:6,10 212:14 219:17,20 220:11 220:21 226:22 228:20,23 229:5 232:2 243:11,20 263:3 285:12 294:19 300:2 310:11 323:8 329:6 330:7 331:16 332:11 338:4
---	--	---	--

<b>minus</b> 137:5 205:5 <b>minute</b> 59:2 60:12 110:11 150:4 161:5 222:9 240:4 297:3 330:15 <b>minutes</b> 25:8 58:12 74:3 79:9 79:10 125:24 151:10 210:18 213:25 229:12 291:12 294:25 295:18,21 299:20 299:21 315:3 <b>miriam</b> 34:18,20 <b>misadventures</b> 302:14 <b>miscommunicated</b> 139:17 <b>miseducation</b> 50:23 <b>misinformed</b> 325:19 <b>missed</b> 314:6 325:11 <b>missing</b> 148:23 <b>missouri</b> 170:4 <b>mistake</b> 283:19 301:18 302:10 <b>mistakes</b> 302:5 <b>misunderstand</b> 273:6 <b>misunderstanding</b> 116:17 250:8 <b>misunderstood</b> 139:15 <b>mixed</b> 17:23 <b>mixture</b> 24:21 <b>modal</b> 340:16 <b>mode</b> 278:15 <b>models</b> 181:10 343:22	<b>moderator</b> 302:21 <b>modern</b> 248:23 249:2 <b>modification</b> 279:2,2 <b>modified</b> 162:22 222:14 <b>modify</b> 53:15 174:20 185:24 <b>moment</b> 11:12 71:15 143:23 150:6 235:10 265:20 327:12 <b>moments</b> 240:17 <b>monday</b> 190:4 344:1 <b>money</b> 286:9 <b>monitor</b> 302:23 <b>monitors</b> 302:24 <b>month</b> 23:21,24 25:5 56:4 259:22 291:21 327:23 <b>months</b> 13:20 18:14,15 23:23 31:3 35:11,12 38:2 39:9,10 42:8 42:9 48:12 54:11 54:11 69:22,23 79:10 86:5,5 95:3 95:24 113:11 117:11 118:10,14 165:8 168:5 183:19,20,21 205:23 259:24 264:9,10 266:21 277:7,8,9 306:8 <b>moral</b> 154:20 <b>morality</b> 231:7 <b>morally</b> 224:18 <b>morning</b> 5:1 7:4 7:12 11:7 148:11	<b>morrison</b> 109:5 <b>mosaic</b> 115:14 116:8,19 123:25 <b>mother</b> 1:7 60:12 227:15 <b>motivations</b> 108:21 140:8,9,10 <b>motives</b> 36:6,19 <b>mouth</b> 155:19 <b>move</b> 113:23 189:7 193:5 335:16 <b>moved</b> 113:18 114:13 <b>muddled</b> 243:16 <b>multicenter</b> 231:3 <b>multiple</b> 244:17 246:8 322:11 <b>multiply</b> 13:5,6,7 31:14 <b>multisite</b> 229:9 231:15 249:5 <b>multistate</b> 231:3 232:21	<b>names</b> 209:17 238:21 <b>narcissistic</b> 155:8 <b>narcon</b> 75:10 <b>narrative</b> 314:8 <b>natal</b> 111:3 112:12 112:15 114:24 143:2,8,14 240:19 242:12,13 <b>nation</b> 328:20 <b>national</b> 141:18 229:9 232:21 <b>nationally</b> 50:9 <b>nature</b> 46:4 60:12 174:2 <b>naïve</b> 224:15 285:7 <b>necessarily</b> 20:17 26:10 29:18 76:9 115:22 167:22 226:13,14,17 229:4,21 250:21 299:11 <b>necessary</b> 26:3 68:3 159:11 173:21 231:17 281:17 347:6 <b>need</b> 8:19,25 9:4 11:14 21:3 26:10 36:19 39:25 41:6 53:4 68:2 79:23 87:24 88:8,10 104:15,16,17,20 110:20 115:12 119:22 120:9 127:18 128:16 130:10 148:17,18 154:16 155:2 157:4,12,17 159:7 161:2,2 173:19,24 184:25 189:14
		<b>n</b>	
		<b>n</b> 3:1 4:1 60:24 230:25 303:19,23 303:24 343:1 <b>naivete</b> 225:4 <b>name</b> 7:9,15 24:9 27:8,9 34:8,10,18 37:14,17,17,20 60:22 91:12 271:25 273:5,13 273:16 275:13 289:19,19 298:23 303:18,25 304:12 304:21 <b>named</b> 284:4 337:25	

191:22 197:7 200:12,16 203:4 205:2 225:18 237:23 246:8 252:4 263:13 297:13 299:12 312:19 316:16 321:18,20 326:7 336:7 <b>needed</b> 37:25 102:15 107:4 232:25,25 303:6 <b>needing</b> 291:5 <b>needs</b> 8:12 164:4 166:5 192:14 227:15 269:8 285:5 326:8 <b>negative</b> 93:14 122:20 174:14,14 218:6 305:25 <b>neither</b> 342:16,19 <b>nervous</b> 312:20,21 <b>neurosurgeon</b> 319:19 <b>neutral</b> 218:13 <b>never</b> 13:2 20:25 30:10 47:15 60:7 80:18,21 81:3,6 95:16 96:2 99:22 100:21 111:12 126:24 186:2 209:15 215:21,24 215:24 217:10 221:10 248:12 249:8 251:19 289:23 297:4,15 304:5 <b>new</b> 3:5,5,15,15 5:17,20,24 6:5 20:17 22:22 34:4 50:25 75:6,7	80:10 81:9 122:12 170:21 171:15,16 172:2,15,23 175:22 186:18 196:22 234:16 257:9 <b>news</b> 323:11 <b>newspapers</b> 282:6 <b>nice</b> 134:13 292:3 303:7 <b>night</b> 251:4 319:10 <b>nightmares</b> 251:9 <b>nine</b> 277:8 306:8 <b>nods</b> 8:13 <b>nodule</b> 266:22 <b>non</b> 116:5,21 125:3 186:6 253:9 257:12 259:16 <b>normal</b> 180:11,12 180:13 201:2 267:25 <b>normality</b> 116:18 <b>normally</b> 51:20 <b>notary</b> 2:10 347:13,19 <b>note</b> 345:10 <b>noted</b> 347:7 <b>notes</b> 54:15 <b>notice</b> 2:6 <b>novak</b> 27:9 60:22 61:20 63:9 77:9 77:19 78:3 79:16 80:19 226:21,25 337:25 338:11 339:16 340:6,7 <b>nuanced</b> 260:24 <b>nuances</b> 188:6 <b>number</b> 7:18 13:16 14:24 16:16 16:21 20:6 24:3 33:4,9 40:14,17	53:25 54:2 55:12 88:17,18 137:9 139:25 156:15 191:16 253:17,19 262:4 268:19 269:6,18,19,23 270:18 <b>numbers</b> 13:3 18:16 20:24 21:7 29:2 56:8 141:6 184:14 230:24 231:2 257:6 258:24 261:15,17 262:11 <b>numerical</b> 55:24 <b>numerous</b> 40:13 <b>nurse</b> 41:10  <b>o</b> <b>o</b> 60:24 <b>object</b> 42:14 44:19 47:19 50:17 53:3 62:11 81:14 83:2 84:7 85:11,25 90:7 100:11 101:13 105:24 121:25 126:12 128:24 131:19 133:8,9 135:20 136:15 138:10,22 139:14 145:20,24 146:12 151:21 157:22 159:16 162:9 164:17 166:13 167:5 169:23 172:7,19 175:15 176:12,18 177:10 179:3 187:7 199:9 200:6 202:17 205:12 207:14 208:11 211:11 214:13	217:15 219:18,21 220:12 222:7 223:22 226:4 228:14 232:4 234:5 247:16 249:10 279:13 283:23 300:11,22 306:11 307:19 315:15 317:21 319:3 320:7 324:20 326:2 327:8 329:10,20 331:18 332:5 333:18 <b>objecting</b> 275:4 <b>objection</b> 119:18 143:11 191:23 <b>objections</b> 215:7 220:23 247:25 <b>objective</b> 313:8,9 313:23 314:7 315:8 <b>objectively</b> 313:18 <b>obligated</b> 160:14 <b>obligation</b> 160:15 <b>obligations</b> 147:15 <b>observe</b> 268:5 313:6,19 <b>obtaining</b> 89:13 <b>obviously</b> 18:15 233:22 <b>occasion</b> 79:22 <b>occasionally</b> 76:8 312:2 <b>occupied</b> 95:2 <b>october</b> 272:8 344:12 <b>offer</b> 296:13 327:17 333:5 <b>offered</b> 163:11 333:3
---	--	---	--

<b>offering</b> 154:9 194:20 <b>office</b> 4:12 6:15 83:20 165:18,19 177:12 323:22 <b>officer</b> 6:23 <b>official</b> 1:10 302:18 303:9 <b>oftentimes</b> 37:12 42:19 45:19 51:15 227:14 278:14 <b>oh</b> 34:24 44:9,9 49:12 59:13 67:25 100:18 125:5 139:18 144:5 216:25 228:7 239:20 248:20 272:14 282:5,12 311:5 315:22 319:9 320:8 327:9 327:10 334:12 <b>ohio</b> 21:5 75:11 209:3,23 210:3,21 211:10 330:9,21 <b>oily</b> 117:13 <b>okay</b> 8:9,10,16,17 8:23,24 9:8,9,14 9:19 10:23 11:3 13:15,23 14:5,21 15:11 19:25 20:21 29:3 33:3,10 39:23 44:24 55:2 55:21 56:2 58:6 60:6 61:22 65:23 67:14 69:14,24 71:5,8,19,20 72:11 73:12 74:11 87:15 87:17 89:4 91:6 91:14 92:20 95:8 97:8 103:11 106:24 110:21	112:24 133:20 138:6 144:2 145:6 150:7 151:3 159:6 164:11 175:6 177:3 181:14 182:9,11,22 183:6 183:9 184:2 190:20 191:25 193:10,14 202:21 207:7 234:10,18 234:22 237:18 240:2,8 243:8 247:9 250:10 251:15 255:6,17 262:16 270:3 271:9 276:7 282:11,20 291:10 293:6 305:7 337:15 <b>oklahoma</b> 170:4 <b>old</b> 19:5 32:14,16 83:13 85:15,15,15 90:10,10,16 95:19 96:4 111:6 112:21 132:2,3,3 140:23 152:8 163:10 169:13 186:8,24 187:3,6 189:10 195:8 201:6 213:10,11,14 217:6 224:9 228:12,13 326:2,4 <b>older</b> 47:4 112:11 112:23 212:4 259:4,4 <b>olds</b> 14:11,13 84:5 92:17 163:6,7 164:13 168:15 170:10 197:21 290:14	<b>once</b> 17:19 23:21 23:23 25:5 31:19 93:18 118:5 <b>one's</b> 38:12 107:10 140:18,19,20 188:14 <b>ones</b> 10:10 157:18 172:4 248:24,24 249:2 <b>ongoing</b> 19:10,21 20:18 31:20 33:13 40:13 75:14 338:14 <b>online</b> 268:6 <b>onset</b> 255:4 259:8 263:22 268:5 <b>open</b> 86:15 190:10 234:19,21 299:9 335:25 336:7 <b>operate</b> 154:17 330:20 <b>operates</b> 330:22 <b>opined</b> 306:10 <b>opinion</b> 9:24 65:4 154:7 197:12 209:16,17 233:23 234:7,8 263:10 286:15 329:24 330:3 333:7 <b>opinions</b> 120:20 120:21 326:20 333:2,5 <b>opioid</b> 302:10 <b>opioids</b> 225:8,15 <b>opponent</b> 177:16 <b>opportunities</b> 101:25 <b>opportunity</b> 83:6 83:8 101:16 <b>oppose</b> 178:21 334:8	<b>opposed</b> 84:18 222:5 310:9 <b>opposing</b> 335:19 337:5 <b>optimism</b> 174:2 <b>option</b> 36:18 <b>options</b> 36:7 160:16,17 338:21 <b>oral</b> 1:17 226:10 <b>orchiectomy</b> 95:16 <b>order</b> 50:19 157:12 158:16,19 230:23 281:17 307:20 312:3 321:18 <b>organization</b> 91:24 92:5 271:10 271:13 283:22 284:20,22,24,25 <b>orgasm</b> 195:18 <b>orientation</b> 42:22 52:2 257:18 <b>original</b> 9:23 281:6,12 <b>originally</b> 10:20 282:22 <b>ought</b> 110:17 257:25 286:20 <b>outcome</b> 180:15 268:3 339:8 <b>outcomes</b> 110:18 215:19 218:6,7 221:13,14 268:14 <b>outdated</b> 237:10 <b>outgrow</b> 267:12 <b>outlaw</b> 184:6,8 <b>outlawed</b> 187:10 <b>outlined</b> 99:19 200:4 325:20 <b>outpatient</b> 23:10
--	---	---	---

<b>outrageous</b> 282:16 <b>outside</b> 39:17 106:20 309:13 <b>outweigh</b> 128:5,22 129:25 130:17 131:3,16 133:2,22 134:7 139:6 141:9 <b>outweighs</b> 139:12 <b>ovaries</b> 213:13 <b>overall</b> 125:13 <b>overarching</b> 289:16 <b>overdose</b> 74:20 75:15 <b>overlap</b> 142:4 <b>override</b> 214:11 215:4 <b>overriding</b> 289:16 <b>overvalued</b> 90:19 <b>overwhelming</b> 14:22 <b>owen</b> 4:3 6:11	<b>pain</b> 75:14,14 290:15,18,19,20 <b>panchankis</b> 194:7 279:22 280:3,12 280:13 282:23 <b>panel</b> 300:18 <b>paper</b> 91:6,14 93:4 94:21,23,25 95:2,6 95:12 142:12 143:22 144:15 146:14 147:4,12 149:21 261:17,18 262:14 277:6,19 277:20,22 278:3,4 281:11,19,19 295:15 <b>papers</b> 35:9 148:5 187:17 282:20 293:25 323:9,15 <b>paradigm</b> 299:4 299:14 <b>paradoxes</b> 316:2,3 <b>paragraph</b> 65:19 69:3 150:3,9 153:20,21 235:7 235:11,12,15,17 235:18 239:25 240:3,5 241:3 267:15,19,22 270:5,10,13 283:10,15,16 <b>parameters</b> 136:19 <b>paraphilic</b> 42:23 <b>paraphrase</b> 292:3 <b>pardon</b> 34:9 <b>parent</b> 16:4 32:18 32:21 111:13 158:18 159:21 169:15 200:20 265:14 311:18	333:12 <b>parents</b> 31:24,25 41:23 42:3 45:20 52:20 55:7 57:19 59:9 62:18 75:8 76:22 83:20 87:24 88:7,22 89:18,22 89:23,25 90:14 111:5,8,16,17 113:8 144:20 151:18 153:6,8 157:13,16,18,25 158:2,4,5,9 159:13 159:19 160:7,18 173:14,24 200:13 201:5 207:10 214:4,11,23 215:5 224:8,12,17 227:12 264:14,15 264:16 265:13 269:2 318:20 324:17,23 325:13 325:22 327:5 338:12,19,22 339:23 <b>part</b> 10:11 31:22 31:22,25 37:6 38:9 41:20 48:16 89:10 93:9 104:3 135:4,5 137:19 155:14 183:13 209:20 216:22 222:10 229:6 232:13 264:7 293:6 312:7 313:3 <b>participate</b> 189:15 232:2 288:16 <b>participates</b> 77:21 <b>participation</b> 234:4 332:14	<b>particular</b> 59:12 60:8 61:13 66:6 81:19 99:15 107:16 222:13 284:7,8 307:16 308:12 <b>particularly</b> 78:8 84:9 328:10 <b>parties</b> 342:18 <b>partner</b> 93:3 195:19 <b>parts</b> 93:21 <b>pass</b> 170:8 210:2 337:14 340:23 <b>passage</b> 71:8,21 73:6 184:5 <b>passed</b> 171:12 202:11 209:23 210:3 220:9 <b>passing</b> 104:11 <b>passion</b> 90:17 328:19 336:17,18 <b>passionate</b> 156:18 229:18 232:18 242:4 336:16 <b>passionately</b> 158:22,23 <b>passions</b> 108:14 <b>path</b> 219:8 <b>patient</b> 13:18 18:4 21:16 23:25 26:22 32:10,15,17,23 33:2 36:10 38:7 39:2 42:6,11,19 43:8 45:14,17 48:4 49:9 51:3 57:7,16 60:8 62:19 63:20 74:17 75:19 80:23 83:7 95:21 98:19,24 99:2,5 100:20,21
<p><b>p</b></p> <p><b>p</b> 3:1,1 4:1,1  304:20,20  <b>p.m.</b> 14:2 341:7  <b>pa</b> 4:3  <b>package</b> 194:24  <b>page</b> 10:15 65:15  71:6,14 98:20,21  149:22 182:10,12  182:19,25 183:3  184:3 190:21,25  191:7,10,12,15,21  191:24 239:14,18  239:19 263:8  272:20 346:4,7,10  346:13,16,19  <b>paid</b> 37:8 122:9  286:8 314:10  315:5</p>			



101:14,24 102:8 103:13 104:17 106:20 109:16 120:12 122:6,22 124:6,7 132:6,7 144:18 153:18 158:5,7 160:6,7 169:2,8,15,20 203:15 214:3,6,22 214:25 216:7 224:7,8 228:10 241:8 244:9 260:16 264:9 289:20 313:6,7,13 314:8,18 321:15 322:19 339:21 340:4,4 <b>patient's</b> 32:18 41:16 51:10 66:19 67:16 210:12 241:6 267:23 311:13 314:17 315:9 317:20 318:4,5 319:25 320:3 321:14 <b>patiently</b> 150:16 <b>patients</b> 12:18,22 13:3,5,12,16 14:4 14:6,16,23 15:17 16:6,13,21 17:9 19:9,16,19 20:6,10 20:14,17,21 21:15 22:25 23:13,17 24:19,24,25 25:9 25:17,21 26:15 27:15,19,22 28:3 28:12,24 29:6,7,20 30:4,13,21 31:10 33:4 35:13,18 36:12,13,16 38:4 38:14,15 40:25	42:23 44:2,8 47:13 50:11 52:16 52:23 53:11,21,22 54:4,17,18,21 55:3 55:4,7 56:13 58:7 61:23 62:3,6 63:2 64:4 66:2,7 68:21 69:16,17 77:10 78:22 79:17 80:13 80:14 81:7,8,9,21 81:22 82:16,22 89:6,14 92:12 93:14 95:10 100:16 101:8 105:14,23 106:3,9 107:5 109:9 110:2 110:24 112:9 113:3 114:25 117:2 118:13 119:4,14 120:7 121:20 123:6,8,20 124:23 126:8,9 128:17 133:17 141:21 142:6,24 143:6,16 144:19 146:9 147:19,21 150:13 151:13,17 163:5,25 172:16 175:2 192:11,25 196:21 197:15 203:2,14 209:24 223:25 224:21 229:21 240:18 247:11,14,21 248:18,20 255:2 310:16 311:8,9 312:18 314:10 317:9 318:24 336:17 <b>patrick</b> 304:17,19	<b>pattern</b> 67:19 <b>patterns</b> 52:11 296:12 <b>paucity</b> 236:14 <b>paul</b> 305:8 <b>pause</b> 11:12 220:2 <b>pawn</b> 209:10 <b>pay</b> 35:8 157:4 200:23 289:17 335:15 <b>payments</b> 152:20 <b>pays</b> 34:25 <b>pediatric</b> 157:3,10 206:21 <b>pediatrician</b> 92:11 165:2 167:10 206:20 216:7 257:24 319:18 <b>pediatricians</b> 157:2,7 160:13,13 160:22 <b>pediatrics</b> 92:16 <b>peer</b> 154:6 274:19 274:21 276:8,11 276:14,24 278:9 279:4,9,18 280:8 281:23 282:3,6,13 282:21,25 290:21 <b>peers</b> 52:10 276:25 <b>pending</b> 9:5 <b>penis</b> 180:11 195:16 <b>pennsylvania</b> 181:17,20 208:18 <b>people</b> 17:2 18:7 19:15 20:15 21:7 22:17,19 23:3 24:6 25:18 27:18 28:21 30:18 35:8 35:22 36:5 38:17	38:20,24 40:14 43:8 46:7,9,12 47:4,10 48:24 49:23 51:22 52:6 53:16,18,19 55:16 57:14,21 58:3 59:23 61:7 71:23 76:6,8,24 78:12,15 79:8 80:3 85:5 88:20 89:24 93:5 93:8,19 94:11 95:14 97:25 98:7 99:24 100:8,25 102:21 103:24,25 104:14,23 106:19 110:20 111:18,19 111:21 113:2 115:13 117:6,9,19 118:4 119:10 120:6,20 121:2,13 122:2 124:13,20 125:18,23 126:23 126:24 127:18 129:9,23 131:5 132:4 137:9 140:7 141:4 142:8 147:7 147:7 148:11,14 154:21 155:2,13 156:4,5 157:8,12 160:17 162:19,24 163:9 164:7,8,12 165:17 167:15 168:19 170:14 173:5,10,11,17,22 174:8 175:8 180:17,23 192:13 192:15,16 194:19 194:25 195:6 196:2 197:19 201:17 204:18 206:11 207:2,23
---	--	--	--

211:24 212:2,10 212:11 213:6,19 218:11 219:5,12 225:11 226:9,10 236:16 238:12,14 241:12,15 243:25 248:9 251:24 254:6,17 257:3,19 258:15,24 259:4 259:13 260:7,10 261:8 262:2,4,19 263:25 267:12 268:21 269:4,10 274:5,15 275:2,6 275:25 276:22 277:3 280:25 281:14,15 282:24 284:11,17,24 286:7,8 287:5,24 288:3 290:6,23,24 293:5 296:6 297:25 299:23 301:3,7,19 302:20 303:6 306:21 309:3,10,14 314:22,24 316:11 320:17,23 321:3 321:11,22,24 322:3 324:15 326:7 330:13 332:18 334:14 335:2,4,18 336:4,5 336:25 339:14 340:17 <b>people's</b> 260:13 296:12 298:7 <b>perceives</b> 41:18 <b>percentage</b> 20:23 21:16 148:14 261:6	<b>perfect</b> 225:8,17 <b>perform</b> 189:3 <b>perfunctory</b> 152:25 <b>period</b> 81:12 119:11 147:3 153:5 227:9 230:19 251:14 253:16 256:24 268:2 293:20 309:4 <b>periods</b> 259:14 <b>permanent</b> 131:25 140:22 180:8 <b>permanently</b> 251:13 <b>permission</b> 339:11 <b>permit</b> 138:18 <b>permitted</b> 134:18 <b>perplexed</b> 184:21 <b>persist</b> 255:6,9 <b>persisted</b> 256:10 <b>persistence</b> 252:11 <b>persists</b> 102:4 <b>person</b> 19:6 22:13 25:25 26:9,22 27:5,10 36:15 37:7 42:17 43:9 43:13,18 45:22,23 45:23,24,24 48:9 48:15,16 51:2,12 51:14 56:20,22 59:7,12,15 61:9 67:18,20,22,25 74:15,24 81:25 82:5,9 83:10 84:12 87:19 91:11 95:20,23 96:5 97:17 98:9,18 99:9,11,13,15,18 99:19,21,21	101:18 102:3,5,14 108:4,23,25 112:3 113:24 114:4,11 115:22 122:8 125:7,14,16 127:8 127:10 140:11 142:22 165:9 169:3 184:19 189:12,13,17,18 224:25,25 225:5 241:7 276:16,18 304:15,16 305:24 314:12,20 317:7 317:11,16 318:10 318:10 322:14 338:5,9 <b>person's</b> 34:10 42:18 81:17,18 83:9 101:19,21 119:25 251:13 312:16 <b>personal</b> 145:3 156:18,18 <b>personality</b> 301:22 <b>personally</b> 16:22 111:13 180:3 305:11 <b>persons</b> 268:25 <b>perspective</b> 216:20 217:5 <b>perspectives</b> 246:10 <b>ph.d.</b> 309:24 <b>ph.d.'s</b> 129:12 <b>phenomena</b> 140:21 <b>phenomenon</b> 51:21 115:3 131:5 <b>phrase</b> 73:21 129:2 196:11	<b>phrased</b> 216:24 327:13 <b>physical</b> 43:4 66:19 166:4 224:20 313:5 328:23 <b>physically</b> 169:24 <b>physician</b> 38:19 41:10,11,14 156:15,17 266:10 <b>physicians</b> 129:11 154:16 163:20 167:8 197:4,6 287:23 297:2,3 328:22 <b>physiologic</b> 164:18 <b>physiological</b> 311:25 312:14 <b>physiology</b> 251:12 <b>pick</b> 297:2 306:25 <b>picked</b> 8:14 279:23 <b>picture</b> 42:16 97:24 <b>piece</b> 127:10 <b>pieces</b> 109:6,8 <b>pill</b> 117:19 <b>pittsburgh</b> 59:16 <b>pivot</b> 16:12 <b>place</b> 76:6 77:6 84:3 158:10 231:12 342:13 <b>placebo</b> 117:18,23 123:22 230:19,20 237:2,3,5,6 249:3 251:21 <b>places</b> 76:17,18 80:5,6 232:23 246:9 257:11 296:6
--	--	---	---

<b>plaintiff</b> 5:7 <b>plaintiffs</b> 1:8 3:2 4:2 5:16,19,23 6:2 6:5,12 7:11 9:25 10:9 241:9 334:13 <b>planning</b> 60:11 187:21 <b>playing</b> 115:10,11 <b>please</b> 5:13 7:14 8:16,20 21:12 28:25 40:22 71:5 86:7 119:22 182:10 183:5 190:24 219:11 221:17,18 234:11 238:22 272:6 286:21,21 304:8 <b>pleasure</b> 188:9 195:15 <b>pleasures</b> 113:21 <b>pockets</b> 298:18 <b>podium</b> 237:23 <b>point</b> 9:4,8 23:21 40:17 48:4,15 49:3 67:17 82:21 148:23 162:11,14 168:24 190:25 197:22 205:5 226:20 242:15 250:9 261:16 268:9 280:14 <b>pointing</b> 280:20 <b>points</b> 278:6 337:5 <b>polarized</b> 335:18 <b>policies</b> 302:18 <b>policy</b> 129:17 131:20,22 132:10 132:12,23 133:7 136:20 167:17 177:21,21 227:17 286:16 288:15	303:9 316:7 323:20 327:4 332:2,7,8 <b>policymakers</b> 296:8 <b>polite</b> 303:12 <b>political</b> 94:5,8 209:9,10 301:16 326:16,20 <b>politically</b> 170:5 <b>politician</b> 177:19 <b>politicians</b> 218:19 <b>politicized</b> 209:11 <b>politics</b> 233:22 <b>pontificating</b> 241:8,9 <b>pool</b> 21:17 106:21 <b>population</b> 254:17 255:2 <b>populations</b> 212:10 <b>portions</b> 1:15 <b>position</b> 114:19 156:7 178:16,18 179:4,25 180:2,20 285:10 301:25 <b>positions</b> 221:16 300:13 <b>positive</b> 126:3 203:16 211:21 218:7 <b>possibility</b> 57:23 93:12 299:10 323:23 <b>possible</b> 57:11 124:17 125:25 187:20,25 205:19 246:22 <b>possibly</b> 133:15 <b>post</b> 268:3	<b>posture</b> 312:24 313:21 <b>potential</b> 203:17 246:10 321:25 <b>potentially</b> 13:11 81:9 <b>power</b> 290:3 <b>powerful</b> 189:3 246:7,7 <b>powerfully</b> 306:21 <b>practically</b> 204:16 331:4 <b>practice</b> 14:5 20:23 21:2 23:3 23:11 24:7,14 27:11,16,19 28:3 29:10,21 34:23 37:6 39:18 60:21 61:10 64:15 66:2 73:2,10,14 80:20 81:5 198:21 199:4 201:16 248:25 266:16 332:10 <b>practices</b> 130:5 140:6 198:18,19 291:25 299:10,11 332:20 <b>practicing</b> 12:25 <b>practitioner</b> 41:10 146:17 147:16 263:20 <b>practitioners</b> 149:8 154:11 <b>pre</b> 258:5 <b>preceded</b> 43:24 <b>precedent</b> 154:24 <b>precise</b> 74:5 <b>precisely</b> 250:3 <b>preclude</b> 62:9 150:19	<b>predispose</b> 216:17 <b>predominance</b> 295:8 <b>prefaces</b> 193:17 <b>prefer</b> 170:23 171:3 212:14,18 <b>prefers</b> 91:13 <b>pregnancy</b> 107:20 158:12 <b>preliminary</b> 102:12 <b>premature</b> 93:15 93:16 <b>prematurely</b> 57:23 <b>preoccupied</b> 174:25 175:4 213:2 <b>preparation</b> 10:21 <b>prepare</b> 9:20 11:4 11:9 12:7 <b>prepared</b> 98:10 <b>preparing</b> 234:16 <b>prepubertal</b> 15:2 15:5,18,22 16:8 33:16,19 112:5,8 252:24 258:20 263:17 <b>prescribe</b> 144:11 249:8 <b>prescribed</b> 66:4 66:13 67:8 69:3 249:12 300:5 <b>prescribing</b> 162:18 <b>prescription</b> 59:18 340:20 <b>prescriptions</b> 66:15 <b>present</b> 4:20 23:10 23:20 25:4,6 26:3
---	---	---	--

26:5,6,11,15,23 27:2 32:10 62:13 116:11 171:10 178:2 291:20 338:25 <b>presentation</b> 37:13 181:9 343:21 <b>presentations</b> 293:8 <b>presented</b> 16:4 22:15,16 25:21 281:4 294:13 <b>presenters</b> 292:11 294:17 <b>presenting</b> 302:16 <b>presents</b> 285:2 <b>preservation</b> 152:9 <b>pressure</b> 189:5 <b>presume</b> 70:24 170:18 178:3 248:2 273:7,9 <b>presumed</b> 324:13 <b>presuming</b> 151:23 <b>pretty</b> 88:3 137:12 240:6,25 <b>prevent</b> 9:11 211:16 <b>preventing</b> 168:17 <b>previous</b> 40:6 96:13 256:13 287:10 311:22 <b>previously</b> 31:15 40:24 174:9 <b>primarily</b> 36:2 96:21,22 165:23 <b>primary</b> 41:9 165:2 206:24 230:4,7,10 262:8 287:22	<b>principle</b> 180:10 <b>principles</b> 106:2 289:12,17 295:23 325:20 326:10 <b>prior</b> 150:16 192:6 342:4 <b>prison</b> 115:4,5 328:12,15,24 <b>prisoner</b> 142:18 <b>prisoners</b> 115:2 <b>private</b> 24:13 224:10 289:22 <b>privileged</b> 288:13 <b>probably</b> 18:11 24:6 35:11,21 54:13 64:6 69:22 74:20 79:21 95:4 107:8 123:22 149:7,12 186:13 200:15 225:2 233:17 250:16 256:12 259:8 267:7 273:16 274:14 275:12 280:18 284:20 286:22 288:9 306:7,24 <b>problem</b> 17:3,5,11 29:15 41:20 43:19 62:12 76:16 79:3 94:18 104:4,8 131:10 158:21 164:4,12,15,19,20 165:24 175:21 188:14 203:17 210:10,12,17 219:23 221:23 222:17 265:2,3 297:8 313:17 317:13 318:12 321:13 338:13	<b>problems</b> 15:14 21:19,20,21 22:2 26:6,7,8,8 29:8 46:6 62:16 78:21 88:24 90:12 104:21,21 210:13 216:4 317:12 335:7 <b>proceed</b> 108:11 <b>proceedings</b> 341:6 342:11 <b>process</b> 19:8 39:2 59:3 87:10 89:5 89:12,17,21 109:21 110:14 115:10 140:17 146:10 147:20 150:18 151:2,15 151:16 152:12 153:4 158:11,12 158:12,13,13 162:23 163:6 174:3,3 184:13 189:6,15 200:4 202:14 205:9,18 208:16 212:22,23 214:7 227:23 230:14,15 248:12 249:2 264:20 279:4,9,18 281:10 281:23 282:23 288:16 290:13 291:5 298:2 331:23 338:16 <b>processes</b> 26:13 107:12 108:3,10 153:2 229:13 267:6,25 289:11 296:6 <b>product</b> 75:13 107:11	<b>profession</b> 131:7 165:14 166:2,3 168:25 210:21 217:20 218:21 <b>professional</b> 2:9 26:20 41:19 58:4 103:3,10,19 104:10,13 126:23 126:25 164:22,24 165:3 167:12 196:8,10 305:15 342:3 <b>professionals</b> 26:5 30:9 125:22 150:14 159:24 196:15 287:24 289:2 306:17 <b>professions</b> 93:11 140:5 <b>profile</b> 201:13 <b>profound</b> 150:11 193:22 <b>profoundly</b> 213:7 <b>program</b> 23:8 25:19 292:22,25 303:4 <b>programs</b> 80:2,3 147:18 <b>progress</b> 337:12 <b>prohibit</b> 172:14 <b>prohibited</b> 137:12 156:11 285:12,14 <b>prohibiting</b> 138:13 205:15 <b>prohibits</b> 162:5 <b>proliferating</b> 268:13 <b>prolonged</b> 231:11 259:14 <b>promise</b> 95:23
--	--	--	---

<b>promised</b> 102:5	170:7 186:25	282:8,8,14 284:21	<b>psychologists</b> 275:8
<b>promote</b> 198:15	187:5 205:8,10	293:11 294:3	<b>psychology</b> 116:6
<b>promoting</b> 179:15	228:6 247:11,13	300:21 302:7	189:20 267:10
188:20 198:17,20	247:20 314:4,14	315:21,23 316:12	296:20
199:3	323:18 329:5	316:17,24 317:10	<b>psychopathic</b>
<b>pronouncement</b>	330:6 332:3,11	319:6 320:4,12	301:21
291:4	339:13	334:18	<b>psychopathology</b>
<b>pronouncements</b>	<b>provided</b> 63:2	<b>psychiatrist</b> 12:17	83:12 153:11
124:19	71:7 149:2 155:16	12:20 22:22,22	185:7,8,9 301:20
<b>proper</b> 24:9	155:23 156:3	34:5,6,7 36:24	<b>psychosexual</b>
212:16	178:13 202:16	77:21 103:9	90:12
<b>proponent</b> 177:15	214:6 227:6	119:15,21 121:22	<b>psychosocial</b>
265:23	229:22 311:13	122:6 207:5 248:3	90:11
<b>proportion</b> 259:6	331:15	248:6,11 305:19	<b>psychotherapeutic</b>
<b>proposals</b> 172:12	<b>provider</b> 39:25	309:22,23 310:14	36:4 62:23 66:8
<b>proposed</b> 94:16	41:7 102:18	319:17	84:18,20 135:24
<b>pros</b> 46:3	<b>providers</b> 23:12	<b>psychiatrists</b>	248:11 288:25
<b>prosecutor's</b>	75:22 77:13 87:10	121:23 248:7	289:22 335:6
165:18	202:23 332:20	300:25	<b>psychotherapist</b>
<b>prosecutors</b> 232:7	333:15 334:3	<b>psychiatry</b> 12:25	67:22
<b>proselytize</b> 109:22	<b>provides</b> 329:4	194:9 238:17	<b>psychotherapists</b>
<b>prostate</b> 266:14,23	<b>providing</b> 9:11	250:17 309:12,13	290:9
267:2	19:10 35:24 90:6	313:15 316:2	<b>psychotherapy</b>
<b>protecting</b> 212:8	145:8,14 146:7	322:21 336:13	71:23 77:24 93:10
<b>protection</b> 4:11	149:16 178:21	<b>psychodynamic</b>	105:16,22 106:3
<b>protocol</b> 135:4	202:24 227:19	36:8	106:25 107:3,5
231:4 233:13	229:24 299:25	<b>psychological</b>	108:20 109:19
295:14	327:6 334:16	87:23 88:24	110:12,16,25
<b>protocols</b> 149:15	<b>provision</b> 310:10	106:11 140:10	111:20 112:16
<b>proud</b> 314:23	<b>provisions</b> 170:24	164:3,20 166:4,16	114:12 136:4,11
<b>prove</b> 205:21,23	171:4	171:13 188:15	136:18 138:17,20
240:13 281:19,20	<b>prudence</b> 221:2	189:21 210:10,11	188:21 189:2
339:16	<b>psa</b> 266:19,21,22	220:15 269:12	227:22 235:25
<b>proven</b> 174:13	<b>pseudonym</b>	290:15 294:5	236:20 237:4
206:6 298:6 299:7	272:23 275:2,10	311:19 313:23	238:4,13,15
<b>provide</b> 44:16	<b>psyche</b> 115:15	314:4	240:18 242:2,20
47:17 48:8 75:17	116:7	<b>psychologically</b>	248:7 289:3,8,14
84:17 102:17	<b>psychiatric</b> 41:13	169:22 210:14	290:23 295:24
145:17 151:12	42:15 48:17 98:5	<b>psychologist</b> 34:4	<b>psychotic</b> 318:14
159:10 161:14	101:4 102:12	266:10	
168:23 169:19	114:6 121:12		

<b>pubertal</b> 258:5 268:3 <b>puberty</b> 49:19 80:15,16,17 136:5 137:16,24 140:2 153:24 156:23 184:11 186:9 197:19 198:4 227:14,19 243:22 244:3,8,20,23 253:3,14,15 254:24 258:3 259:10 300:5 <b>public</b> 2:10 4:11 124:13,18 131:20 131:22 132:10,12 132:22 133:6 177:20 209:14,20 347:19 <b>publication</b> 279:8 283:10 <b>publications</b> 78:21 283:3 307:25 <b>publish</b> 231:14 287:20,21 <b>published</b> 87:3 98:5 101:2 129:10 237:8 242:17 257:5 259:19 261:14 271:9,12 279:7,11 281:9 308:16 <b>publishes</b> 241:2 <b>publishing</b> 273:20 281:5 <b>pull</b> 272:5 <b>pulse</b> 312:16 <b>punish</b> 325:22 <b>punts</b> 206:22 <b>purported</b> 194:13	<b>purpose</b> 42:15 249:17,22 <b>purposes</b> 26:20 209:10 <b>pursuant</b> 2:6 <b>pursue</b> 226:2 <b>pursuing</b> 55:23 <b>put</b> 17:15 28:2 82:22 109:20 128:25 174:7 186:9,10 187:11 187:13 190:25 199:22 227:9 288:3 304:7 336:9 <b>puts</b> 277:4 <b>putting</b> 199:2 219:7 224:15 328:24	118:8,12 119:9 121:19,20 123:2 124:3 126:21 128:8,11 130:20 130:21 131:11 132:16,22,24 133:20 142:18 146:4 147:10 151:22 153:3 166:19 175:17 177:3 178:8 181:5 182:19 186:7 187:14,15 190:11 191:8,9,14 193:3 197:10 199:2,24 204:25 207:19 211:13,20 214:16 218:5,10 220:18 226:25 228:4,16 230:3,4 233:13,16 237:13 243:2 246:17,17,23 247:6 248:16 254:13 255:10,13 255:15,19 257:22 258:14,22 259:12 264:7 269:6 279:15 283:5 285:4 302:15 307:21 319:25 322:23 324:22 325:3,10 335:14 337:23 338:2 <b>questioning</b> 55:24 148:22 <b>questionnaires</b> 313:22 <b>questions</b> 7:22 12:16 38:11 66:11 83:3 126:5,19 128:19 145:22	151:6 184:10 192:8 222:3 229:10 252:22 268:18 270:25 299:18 341:2 <b>quick</b> 282:20 <b>quicker</b> 84:19 <b>quickly</b> 72:2,4 79:9 144:11 170:9 189:8 202:25 <b>quit</b> 275:5,6 <b>quite</b> 12:20 272:12 <b>quote</b> 76:19 198:18 <b>quoted</b> 261:16
	<b>q</b>		<b>r</b>
	<b>qualified</b> 207:25 207:25 <b>qualify</b> 233:12 241:19 <b>quality</b> 90:19 212:19,21 289:18 <b>question</b> 8:3,5,6,9 8:18,21,22 9:6,7 10:5 12:8 17:8 21:11 28:9 29:12 30:2 32:4,12 33:25 39:3 40:5,6 40:19,22 43:15 44:21,22 45:11 47:21 48:24 49:4 49:7 50:20 51:8 53:5 56:7 60:11 79:12 82:13 83:4 83:16,22 89:21 100:2 104:25 106:4 107:7 113:4 116:24 117:21	118:8,12 119:9 121:19,20 123:2 124:3 126:21 128:8,11 130:20 130:21 131:11 132:16,22,24 133:20 142:18 146:4 147:10 151:22 153:3 166:19 175:17 177:3 178:8 181:5 182:19 186:7 187:14,15 190:11 191:8,9,14 193:3 197:10 199:2,24 204:25 207:19 211:13,20 214:16 218:5,10 220:18 226:25 228:4,16 230:3,4 233:13,16 237:13 243:2 246:17,17,23 247:6 248:16 254:13 255:10,13 255:15,19 257:22 258:14,22 259:12 264:7 269:6 279:15 283:5 285:4 302:15 307:21 319:25 322:23 324:22 325:3,10 335:14 337:23 338:2 <b>questioning</b> 55:24 148:22 <b>questionnaires</b> 313:22 <b>questions</b> 7:22 12:16 38:11 66:11 83:3 126:5,19 128:19 145:22	151:6 184:10 192:8 222:3 229:10 252:22 268:18 270:25 299:18 341:2 <b>quick</b> 282:20 <b>quicker</b> 84:19 <b>quickly</b> 72:2,4 79:9 144:11 170:9 189:8 202:25 <b>quit</b> 275:5,6 <b>quite</b> 12:20 272:12 <b>quote</b> 76:19 198:18 <b>quoted</b> 261:16 <b>r</b> <b>r</b> 3:1 4:1 91:2 303:19,19,23,24 303:24 304:20 305:8 342:1 346:3 346:3 <b>radiation</b> 266:24 <b>ragon</b> 4:3 6:11 <b>raised</b> 203:7 <b>raises</b> 269:6 <b>raising</b> 158:13 173:2 184:9 <b>ran</b> 28:17 <b>randomized</b> 247:15,22 248:13 248:17 250:11 251:20 <b>range</b> 310:15 <b>rapid</b> 130:3 137:23 144:10 268:5 <b>rapidity</b> 284:2 <b>rare</b> 79:22 115:13 <b>rate</b> 215:20,23 218:3,22 260:12 260:14,16 261:4

261:23 262:11 308:20 309:8 <b>rates</b> 141:14 225:14 309:7 336:21 <b>ratios</b> 185:22 <b>ratto</b> 1:25 2:7 342:2,24 <b>reacceptance</b> 267:24 <b>reach</b> 281:17 <b>reached</b> 227:5 281:18 <b>read</b> 9:24 10:8,11 10:12,14,18,20,25 11:2 35:9 65:23 65:24 66:9 71:11 71:15,20 72:6,13 87:6 93:5,8 138:3 150:8 151:4 161:21,25 182:16 182:25 183:2,3,15 191:5,10,22 192:3 192:3 217:21 235:11,12,14,20 235:21 240:4 267:21 270:9,11 271:8,13 272:16 273:6 276:19 298:10 306:5,24 307:21 311:21 320:17 323:9,15 333:6,9,11,12 345:9 347:5 <b>readers</b> 241:4 335:9 <b>readership</b> 282:16 <b>reading</b> 10:6 91:7 193:5 209:15,16 232:10 235:19 273:11 305:4	329:12 331:9 <b>readmitted</b> 142:20 <b>reads</b> 219:25 <b>real</b> 273:5,13,16 275:13 <b>realize</b> 84:14 169:3 188:7 <b>realized</b> 180:19 <b>really</b> 32:5 38:18 38:25 50:21 67:15 67:15 90:15 100:24 102:24 116:3,23 120:5 124:15 144:17 152:14,22 162:20 163:13 165:16 169:6 186:8 200:23 202:2 203:22,24 211:14 211:15,20 215:12 221:5,15 237:5 245:4,6,12 248:12 251:7 253:14 254:8 256:20 260:18 274:24 276:25 288:19 299:2 301:14 315:2 316:15 326:16 329:14 331:3 340:5,8 <b>realm</b> 263:22 <b>reason</b> 26:21 28:16 51:7 74:13 99:4 103:4 127:15 132:25 173:8,10 256:8 285:21 296:10 335:12 339:5,7 345:11 346:6,9,12,15,18 346:21	<b>reasonable</b> 114:18 210:8 276:20 280:11 <b>reasonableness</b> 308:6 <b>reasoning</b> 286:4 <b>reasons</b> 95:18 97:21 125:17,21 143:3,9 275:20 277:21 321:20 <b>reassignment</b> 193:19 <b>reassuring</b> 167:25 <b>rebutted</b> 307:9,17 <b>recall</b> 37:9 63:13 63:18 100:25 138:11 176:24 181:18,21 190:17 <b>receipt</b> 345:18 <b>receive</b> 80:15,17 136:10 226:23 228:23 <b>received</b> 64:11 70:9 86:12 98:3 117:3 121:21 142:7 181:11 190:7 234:14 239:5 244:2 272:9 <b>receiving</b> 58:25 59:5 171:7 172:6 172:17 211:7 223:19 225:23 229:5 <b>recess</b> 60:17 105:10 161:10 223:6 291:14,17 337:19 <b>reclaimed</b> 268:7 <b>recognize</b> 36:18 65:8 67:17 70:18 86:19 108:25	109:25 140:16 174:17 234:23 239:11 256:23 296:11 308:5 335:12 <b>recognized</b> 263:16 320:16 338:20 <b>recognizing</b> 171:12 <b>recollection</b> 261:18 <b>recommend</b> 62:5 62:24 68:13,14,15 71:22 82:9 84:20 136:3 160:2,14,16 162:23 321:19 <b>recommendation</b> 63:5 80:7 90:3 98:12 101:3 147:2 <b>recommendations</b> 101:5 137:8 288:2 294:23 <b>recommended</b> 63:10 66:4,23 67:8 68:5 69:2 75:23 97:3,14 135:22 136:3 138:16 148:2 340:6,7 <b>recommending</b> 87:8 98:8 <b>recommends</b> 138:7 160:20 <b>reconsidering</b> 86:9,23 144:15 146:14 149:21 178:11 343:16 <b>record</b> 5:2,14 7:14 7:21 8:6 11:15,20 11:22,25 12:3 39:12 60:14,16,19
--	---	---	--

84:24 85:2,3 105:7,9,12 159:8 161:9,12 193:3 223:3,5,8,12,14,16 243:3 272:18 291:16,19 337:18 337:21 341:5 <b>recorded</b> 5:5 <b>recurring</b> 30:20 54:20 <b>redone</b> 47:2 <b>reduce</b> 109:11 <b>reduced</b> 123:18 <b>reexamining</b> 291:25 <b>refer</b> 36:11,15 204:11 252:10 313:10 <b>reference</b> 133:25 165:21 170:11 <b>referenced</b> 345:6 <b>references</b> 307:24 <b>referred</b> 253:13 254:12 <b>referring</b> 39:19 66:14 69:6 72:18 73:3 99:5 133:24 145:12 252:18 253:4,7 271:4 315:18 <b>refine</b> 155:11 <b>refresh</b> 64:24 239:8 <b>refuse</b> 209:5 <b>refused</b> 209:4,7 <b>regarding</b> 176:6 240:18 241:25 242:10 <b>regardless</b> 82:24 162:8	<b>region</b> 80:8 <b>registered</b> 2:9 309:3 342:3 <b>regnerus</b> 303:15 303:17 <b>regret</b> 131:8 132:10 260:20 261:2 269:11 <b>regular</b> 31:7 54:3 <b>regularly</b> 17:4,16 17:17,18 264:10 <b>regulation</b> 202:12 <b>reidentify</b> 115:2 143:13 <b>reintroduce</b> 7:8 <b>reiny</b> 70:8,19 343:13 <b>reject</b> 277:16 278:25 <b>rejected</b> 277:19,20 <b>related</b> 15:19 16:10,15 23:14 28:4 209:2 293:9 293:22 332:15 <b>relates</b> 62:16 177:4 <b>relating</b> 92:3 208:22 293:25 <b>relationship</b> 23:25 31:20 36:4 48:6 62:23 69:8 104:16 109:15 188:4 289:18 290:4,5 315:11 338:15 <b>relationships</b> 62:17 <b>relative</b> 342:16,19 <b>relatively</b> 207:23 268:2 278:7 <b>released</b> 142:20	<b>relevant</b> 191:6 194:18 <b>reliability</b> 241:21 <b>reliable</b> 279:10,20 <b>reliance</b> 318:23 320:2 <b>relieved</b> 119:3 <b>rely</b> 311:9 <b>relying</b> 273:19 <b>remands</b> 331:6 <b>remember</b> 29:2 37:17,19 59:20 70:22,25 71:2 74:14 99:14 262:17,18,19,21 273:14 292:6 301:23 304:4 305:3,4 307:5 327:15 328:8 331:9 <b>remembered</b> 70:23 <b>remind</b> 96:13 297:14 <b>reminded</b> 312:3 <b>reminding</b> 155:6,9 <b>remote</b> 1:17 <b>removal</b> 329:15 <b>remove</b> 87:22 213:9,13 <b>removed</b> 195:12 <b>removes</b> 331:8 <b>removing</b> 132:2 <b>renal</b> 19:6 95:15 <b>renew</b> 330:14 <b>repeat</b> 21:11 40:21 44:20 73:4 83:21 89:9 139:8,16,17 261:12 263:12 279:15	<b>repeatedly</b> 157:24 203:6 <b>rephrase</b> 20:15 129:3 166:19 220:18 <b>rephrasing</b> 128:10 <b>report</b> 9:24,25 10:12,14,15,18,21 10:24 41:16 65:4 102:20 134:13,14 134:17 138:3,7 161:21 219:15,22 219:25 244:16 259:21 263:11,15 271:3,7,8 272:8,19 272:21 273:17,19 273:21,22 274:9 274:17,22 283:11 304:3,25 305:5 306:5 307:22 311:9,13 314:2 317:20 318:4,6,23 319:25 320:3,3,10 321:15,21 322:7 322:10,18,18 324:6 331:10 333:7,9,12 344:12 <b>reported</b> 1:24 42:2 <b>reporter</b> 2:8,9 6:19 7:21 8:14 90:25 342:3 <b>reporting</b> 329:13 <b>reports</b> 10:9 68:20 129:13 141:16 161:20 176:5,8,15 176:17,25 177:4,5 209:16,17 235:24 236:16,18 238:4 238:16,18 306:13 306:25 307:3,23 333:11
---	---	--	--



<b>reprehensible</b> 224:19 <b>represent</b> 104:18 104:20 109:24 110:13 132:19 149:9 217:18 334:14 <b>representative</b> 182:18 <b>represented</b> 188:16 <b>reputation</b> 79:24 301:8 <b>require</b> 102:23 150:24 164:15 168:22 319:16 <b>required</b> 202:12 347:13 <b>requirements</b> 147:4 158:8 200:10 203:24 <b>requires</b> 107:8 126:18 132:10 318:6 <b>reread</b> 9:23,25 <b>research</b> 49:24 119:14 139:4 232:23 243:9,10 243:13 252:19 275:11 279:19 281:16 <b>researchers</b> 296:8 <b>residency</b> 12:24 <b>resolving</b> 136:13 <b>resource</b> 328:21 <b>respect</b> 68:17 130:13 159:14 204:9 221:18 229:13 230:24 299:25	<b>respectable</b> 290:5 <b>respectful</b> 303:5 <b>respectfully</b> 307:13 <b>respond</b> 165:14 <b>responds</b> 188:8 278:13 <b>response</b> 173:17 281:13 314:17 <b>responsibility</b> 103:6 <b>responsible</b> 195:8 195:9 212:5 <b>rest</b> 22:2 26:25 132:8,13 218:12 <b>restate</b> 214:20 247:18 <b>restrict</b> 233:11,11 <b>result</b> 51:6 117:5 121:22 248:23 289:9 <b>results</b> 117:7 231:14 244:4,6,15 244:19,19 281:2 <b>rethink</b> 226:8 <b>retraction</b> 281:14 <b>retransitioned</b> 142:10,14 <b>retrieve</b> 143:25 <b>return</b> 235:25 236:3 238:5,7 240:19 242:2,20 345:13,17 <b>returned</b> 113:14 142:21 <b>returning</b> 242:12 <b>revascularize</b> 336:2 <b>reversed</b> 137:19 219:8	<b>review</b> 37:2 71:16 113:5 129:16 139:19 154:6 231:5 268:10 271:14 278:10 279:5,9,18 280:8 281:23 282:14 340:24 345:7 <b>reviewed</b> 112:25 129:22 183:20 270:15 271:6 274:19,21 276:8 276:11,14 282:3,6 282:21,25 304:2 <b>reviewer</b> 278:13 278:19 280:2,24 280:24 <b>reviewers</b> 276:24 277:6,25 278:16 278:23 279:24 280:23 <b>reviewing</b> 54:15 210:12 273:25 <b>reviews</b> 71:17 119:7 129:9,13 183:7 185:21 191:17 218:23 243:22,23 <b>revision</b> 277:17,17 277:24 <b>revisions</b> 278:5 <b>revisiting</b> 178:25 202:6 <b>revival</b> 75:10 <b>revocation</b> 328:11 <b>rich</b> 125:19 <b>richard</b> 257:4,20 <b>richness</b> 109:10 <b>rid</b> 211:22 <b>ridiculous</b> 291:6	<b>right</b> 11:10 13:10 13:13 14:6,17 15:6,7,20,21 29:10 29:21 30:7 31:21 32:19 33:11 34:19 36:25 37:7 38:6 39:20 47:18 48:3 52:17 53:8 54:16 54:21,23 56:10 57:9 60:3,23 61:12 65:16 68:17 69:12,18 77:11 78:7 87:8,13 90:2 90:6,24 96:10,25 97:2 106:17 113:14 114:3 127:17 128:17 134:19,22 139:7 141:24 146:3 151:4 154:13 156:12 158:7 159:21 161:13 181:22 182:7 183:24,25 191:4 193:4 196:7,9,10 196:11 198:2,7 203:10 205:21,23 206:8 210:4 215:8 215:15 232:8 235:17 237:11 246:20,21 247:19 248:4 249:25 250:6 258:5 260:15 261:11 262:16 270:23 271:22 272:13 283:5 286:10 292:19 294:4,7 307:6,23 323:11 327:11 333:10
---	---	--	--

<b>rights</b> 94:9 <b>rigor</b> 250:25 <b>rigorous</b> 202:14 <b>rigors</b> 248:13 <b>ring</b> 303:21 <b>rise</b> 298:13 <b>risk</b> 130:17 131:24 174:19 185:22 194:23 200:17 215:8,11 216:25 217:3 218:24 240:12 <b>risks</b> 127:24,25 128:4,15,21 129:7 129:25 131:3,15 131:23 132:4 133:2,22 134:7 139:2,6,11 141:5,8 144:21 151:18 174:21 198:15 203:5 214:8,8 215:2,13,16 216:12 250:19 <b>robust</b> 230:25 245:16 246:6 <b>rock</b> 3:23 4:5,14 6:12 80:10 167:14 <b>rodgerson</b> 3:6 <b>rodgersonb</b> 3:7 <b>rogerson</b> 5:21,22 <b>role</b> 29:5 170:21 <b>romantic</b> 52:9 188:4 207:4 <b>room</b> 75:11 103:15 293:3 <b>roommate</b> 74:25 75:2 <b>rough</b> 55:12 <b>round</b> 278:9 <b>roundly</b> 194:10	<b>rows</b> 293:4 <b>rpr</b> 1:25 342:24 <b>rule</b> 7:24 222:6 <b>ruled</b> 84:5,9 <b>ruling</b> 233:2 <b>run</b> 16:2 26:18 130:16,17 133:14 133:15,16 179:10 312:15 335:9 <b>runs</b> 121:11 <b>rush</b> 125:23 <b>rutledge</b> 1:10 5:9 345:4 346:1 347:1  <b>s</b>  <b>s</b> 3:1 4:1 61:2 91:2 270:19 303:19,23 303:24 343:7 346:3 <b>sad</b> 102:20 <b>sadly</b> 59:7 111:23 <b>sadomasochistic</b> 113:20 <b>safe</b> 155:12 <b>safety</b> 228:19 <b>sample</b> 98:7 257:8 <b>sasha</b> 238:23 292:16 294:10 295:20 <b>satisfied</b> 69:9 <b>save</b> 152:11 <b>saw</b> 15:4 31:6 54:3 58:15,17 98:7 113:8 307:24 <b>saying</b> 41:5 67:16 73:13 79:20 88:7 90:23 102:13 106:17 131:7 139:3 143:17 144:8 146:13 147:12,22 151:9 154:2,2,14,18	156:13 159:4 167:6 172:20 184:24 185:13 193:23 201:10 204:18,24 233:5 258:25 286:18 289:6 298:15 299:3 301:4 311:3 340:8 <b>says</b> 65:24 71:21 73:18 136:21 154:25 158:25 159:2 162:11 163:20 180:17 184:5 193:5 213:12 267:23 270:14,20 271:16 272:20 273:16 274:22 282:12 296:23 314:12 322:6 331:2 <b>scare</b> 109:23 <b>scenario</b> 84:6 <b>scene</b> 80:8,9 <b>scheme</b> 224:11 <b>schizophrenia</b> 222:22 324:16 <b>school</b> 82:4 114:13 121:9 <b>science</b> 88:9,9,21 88:21 94:3,8 104:18,19 110:14 119:22,23 120:10 120:19,21,23 126:18 130:20 131:2,22 132:13 132:15,19 141:10 144:22 145:2,3 147:6,8 148:16,16 148:21 150:20 151:19 156:14,16	156:19 158:24,25 177:14,23 178:6 179:16 180:17 185:5 186:12,15 189:2,19 194:16 198:14 203:5,13 204:14,22 205:24 207:16 208:2 213:5 220:6 221:6 222:11,12 225:10 225:13,19 229:13 229:14,16 232:16 233:10 238:10 272:25 275:24 280:11 285:2,8,9 286:5,19,19 295:12,19 296:15 296:22 297:7 298:10 299:5,6 326:12,18 332:7 335:14,22 <b>scientific</b> 120:15 135:4 139:19 141:2,2 150:23 161:16 176:5 204:6 235:23 236:11 238:3 240:9 242:19 244:22 250:25 271:10,13 274:19 274:22 279:10 283:2,22 284:14 284:19,22,23 285:3 287:25 289:4 306:3 <b>scientifically</b> 163:17 168:18 180:2 198:22 205:3 236:18 <b>scientist</b> 284:10
---	--	--	--

<b>scientists</b> 230:24 282:2 283:25 <b>screen</b> 64:24 <b>scroll</b> 64:25 65:18 71:6 149:22 182:9 190:24 235:6 <b>scrolling</b> 239:13 <b>scrutiny</b> 141:3 <b>se</b> 265:16 316:10 332:22 <b>search</b> 268:12 <b>second</b> 12:14 37:7 59:10 83:22 150:3 150:8 260:5 261:5 270:25 287:4 <b>secondary</b> 170:7 230:5,8,12 <b>section</b> 290:24 <b>see</b> 13:16 14:12 15:22 18:21 19:3 19:9 23:13 28:13 32:17 35:19 43:8 45:19,20 50:8 51:19 58:4 59:19 61:24 65:6,7,19 68:19 70:5,15,17 71:13 76:8 81:21 81:23 84:3 86:17 88:10,16 89:2 90:13,22 91:14 95:23 97:23 99:3 103:16 111:10 115:6,20 116:4,24 117:24 120:9,12 120:22 121:4 122:20 123:9 124:5,17 125:11 125:16 126:4,10 127:9,15,18 132:20 140:24 147:9,22,25	149:24 153:14,21 158:3,18 159:3 160:4,11,20 165:22 166:18 168:6,12 173:24 174:4,16 179:10 180:7,13,24 182:20 188:20,24 189:12 190:12 195:14,22 196:5 196:13 200:16 201:8 206:18 207:5 211:12,18 211:24 215:17 216:4,10,14 218:16,20 220:14 230:18,22 231:5 231:10 233:9 237:21 239:19,21 240:24 244:13,25 245:8 246:5,25 264:10 267:12 270:20 274:4,10 276:3 278:16 279:15,24 290:21 297:22 302:24 309:9 312:17,19 314:5,18,19 316:13 317:6,12 317:17 318:10,12 320:8,8 324:21 326:6 335:17,23 336:14,23 <b>seeing</b> 62:14 74:21 122:6 <b>seeking</b> 44:25 89:7 89:15 <b>seen</b> 13:4,25 14:15 15:4,17 16:7 17:3 17:10 18:11 19:21 20:7 23:18 24:19	25:18 30:18 31:11 31:18,19 33:6,18 53:23 54:8 55:11 55:16 56:13 57:2 57:21 58:8,21 67:24 93:13 97:13 98:8 111:12,18,21 112:7 113:22 115:2,3,7 117:4,6 117:9 120:7,12,14 124:22 208:17 215:21 227:13 325:24 <b>sees</b> 27:11 62:17 62:18 77:18 100:21 <b>segm</b> 91:15 92:20 92:22,23,24,25 94:20,23 283:8,11 283:21 285:10,16 285:17 286:11,24 287:2,13,17 288:15,24 290:22 290:24 294:11 310:7 <b>selects</b> 76:24 <b>self</b> 41:16 43:2 82:3 122:20 188:12,15,15 311:9,13 313:2 317:4,20 318:4,6 318:23 319:25 320:3,10 322:7,10 322:18 <b>seminal</b> 301:15 <b>send</b> 277:23 278:22 282:10,19 328:15 <b>sends</b> 276:21 <b>senior</b> 4:10 22:13 306:14	<b>sense</b> 27:15 29:23 68:4,15,16 84:8 139:2 150:24 197:18 198:4 213:18 220:4,17 240:14 241:18 318:6,7 339:14 <b>sensitive</b> 43:21 78:25 81:17 166:3 <b>sent</b> 63:10 280:22 302:21 345:14 <b>sentence</b> 67:10 72:25 73:4,7 216:24 235:22 270:12 <b>separate</b> 117:22 125:11 129:21 145:2 148:20 156:17 173:11 175:23 270:14 286:5 317:6 <b>separately</b> 135:13 <b>separating</b> 317:15 <b>september</b> 137:20 <b>sequences</b> 74:16 <b>series</b> 56:5 132:12 236:17 240:21 241:22 243:5 244:17,18 245:5 293:8 <b>serious</b> 42:20 179:5,5 245:11 <b>serum</b> 216:15 <b>serve</b> 327:2 <b>service</b> 121:12,12 <b>services</b> 190:7,17 344:4 <b>session</b> 32:21 289:23 302:22 <b>sessions</b> 302:25
--	---	--	---

<b>set</b> 146:21 148:14 155:25 158:5 159:23 160:9 172:25 173:23 230:5 342:14 <b>settings</b> 262:9 276:9 <b>seven</b> 22:21 23:3 23:12 25:18 51:21 86:5 140:17 280:19 281:6 325:9 <b>sex</b> 66:5 86:11 111:3 112:12,15 114:24 136:5 137:16,24 143:2,8 143:14 156:24 188:5 193:18,22 242:14,22 267:24 338:23 343:18 <b>sexual</b> 21:19 38:8 38:12 42:21 51:23 51:25 52:7 108:8 116:9,19,22 153:12 184:6 188:3 216:10 306:15,15 315:25 335:7 <b>sexuality</b> 306:16 <b>sexually</b> 22:4 179:13 <b>shake</b> 312:17,18 <b>share</b> 64:15 234:8 283:25 290:10 <b>sheet</b> 345:11 <b>sherry</b> 37:18 <b>shift</b> 295:5 299:4 299:14 314:21 <b>short</b> 18:12,18 84:15 100:19 133:14 248:10	268:2 337:16 <b>shortening</b> 217:8 <b>shortly</b> 259:9 <b>show</b> 71:8 76:15 77:5 253:25 265:21 296:23 <b>showed</b> 301:15 <b>showing</b> 242:19 <b>shown</b> 253:8,10 <b>shows</b> 243:14 <b>sic</b> 249:7 <b>side</b> 103:13 204:20 307:4 <b>sign</b> 63:12 141:3 232:24 340:24 345:12 <b>signature</b> 239:14 339:17 342:23 <b>signed</b> 63:24,24 64:3 98:15 345:20 <b>similar</b> 20:23 21:16 84:6 129:3 171:25 209:2 234:8 274:21 278:5 <b>simply</b> 32:14 43:12 116:5 122:21 125:20 204:6 322:24 331:19 <b>single</b> 33:12 240:21 241:21 243:5 <b>sissy</b> 257:5 <b>sister</b> 224:9,15 <b>situation</b> 96:18 163:4 226:8 339:4 <b>situations</b> 165:20 173:7 267:11 <b>six</b> 14:2 15:5,17 16:8 18:14 21:20	22:18 23:23 33:22 35:11,22 39:10 42:9 48:12 51:21 59:25 86:4 92:17 112:21 118:10,14 140:17 165:8 168:4 183:18 237:8 264:10 266:21 317:8,10 317:12 <b>skeptical</b> 285:21 299:12 <b>skepticism</b> 204:14 296:22 308:14,15 <b>skilled</b> 129:23 <b>skills</b> 91:7 <b>skin</b> 117:13 <b>sleep</b> 251:4,24 <b>slide</b> 297:24 <b>slow</b> 77:2 125:22 143:25 267:5 321:21 <b>slowed</b> 137:9 <b>small</b> 14:23 20:24 <b>smaller</b> 14:24 54:2 <b>smoking</b> 123:13 <b>social</b> 43:3 49:11 50:13,18,22 52:5,8 52:10,11,16 60:25 61:2,7 62:8 66:5 87:16 88:23 89:7 89:15 92:16 101:22 103:9 108:6 140:9 150:10,22 156:22 166:5 171:13,15 172:21 293:14 296:20 298:8 302:5 312:8 321:10,11 325:24 337:24 338:8	<b>socialize</b> 265:17 <b>socialized</b> 172:23 <b>socially</b> 87:18 88:2 116:11 179:12 257:24 <b>society</b> 91:19 218:5 225:9 284:5 <b>socioeconomic</b> 152:17 <b>sociology</b> 309:25 <b>softly</b> 11:18 <b>solely</b> 213:2 <b>solution</b> 165:10,13 167:21 170:3 <b>solutions</b> 2:6 166:8,9,24,24 167:2,4 170:22 174:4,5 345:23 <b>solved</b> 164:4 <b>somebody</b> 17:4 30:23 34:22 40:2 41:8,25 67:3 69:8 86:4 146:25 152:7 213:20 225:11 234:2 252:3 255:24 273:19 314:2 319:7 323:21 324:6 <b>someone's</b> 121:24 <b>somewhat</b> 299:12 323:17 326:5 <b>son</b> 111:11,12,13 147:22 224:13 319:12 <b>sophia</b> 3:10 6:3 <b>sophisticated</b> 103:2 <b>soporific</b> 251:23 <b>sorry</b> 15:12 19:3 32:22 34:19 40:18 42:6 54:12 73:7
---	--	--	---

89:9 95:13 124:25 131:14 135:15 139:17 143:4 155:7,18,20 172:8 176:15 178:17,18 182:13 192:5 199:13,17 204:4 210:25 223:10 225:8 228:7 235:13 237:12 239:19 243:3,16 272:15 283:12,16 292:23 303:16 309:19,19 310:23 312:2 332:17 <b>sort</b> 19:10 30:14 77:24 95:6 104:11 124:13 127:5 140:5 151:8 169:8 222:3 224:9 256:8 256:9 324:21 325:5 <b>sought</b> 35:10 46:13 47:16 <b>soul</b> 204:14 296:22 <b>souls</b> 85:17 <b>sound</b> 7:2 11:13 13:12 31:20 33:7 97:2 313:2 314:23 <b>sounding</b> 155:7 <b>sounds</b> 13:10 33:10 217:9 304:21 <b>source</b> 224:4 <b>sources</b> 140:9,10 322:11 <b>speak</b> 12:9 47:4 78:19 143:5 155:20 173:9 242:7 274:20 313:19 314:6	315:6 <b>speaking</b> 7:25 15:2 26:11 76:21 102:21 227:21 289:15 331:4 <b>special</b> 80:2 302:21,23 <b>specialist</b> 4:21 <b>specialists</b> 76:20 <b>specialize</b> 293:16 298:21 <b>specialized</b> 79:25 <b>specialty</b> 21:18 35:15 <b>specific</b> 261:17 302:15 <b>specifically</b> 307:2 <b>specifics</b> 87:9 316:21 <b>speculate</b> 50:20 51:2 <b>speculation</b> 220:13 226:5 233:24 266:7 <b>spell</b> 90:24 <b>spend</b> 25:7 31:24 49:23 316:20 321:9 <b>spent</b> 14:4 21:25 22:3 95:5 152:21 173:3 185:3 306:13 325:8 <b>sperm</b> 152:10 <b>sphere</b> 326:16 <b>spironolactone</b> 168:7 <b>spoke</b> 11:17 60:20 238:20 294:24 295:2,17,20,25 <b>spouse</b> 311:17 319:11	<b>spread</b> 33:23 <b>stability</b> 114:9 <b>stabilize</b> 216:9 <b>stabilized</b> 171:15 <b>stable</b> 85:23,24 168:2 <b>staff</b> 22:11,12 23:2 24:24 26:12,19,23 26:25,25 28:6 47:8 61:10,18 <b>stand</b> 99:4 124:20 <b>standalone</b> 338:5 <b>standard</b> 147:14 154:11 156:2 198:16,17 202:8 270:22 319:15 <b>standardized</b> 136:23 <b>standards</b> 71:24 72:5,17,18 73:17 102:22 146:22,25 148:9,15 154:3 155:9 156:2 178:24 273:25 274:6,16 275:20 275:21,22 276:2 288:8 <b>standing</b> 85:23,23 <b>start</b> 7:13 53:10 94:10 117:20 178:17 255:12 258:16 323:5 <b>started</b> 21:4 75:5 193:4 243:8 246:25 259:23 260:7 297:11 <b>starting</b> 94:22 182:20 <b>state</b> 7:14 75:11 99:20 114:13 121:24 147:8,8	150:20 151:18 159:18 161:15 177:13,13,20,21 177:23 178:5 179:16 181:23 183:13 187:10 189:2 197:12 201:18 203:5,13 204:2,3 207:16 208:2,10,14 209:3 212:7 214:9 219:16 220:9 221:6 233:3,3,17 238:9 278:20 295:11 303:20 305:2 327:3 329:9 329:14 330:3,9,20 330:21,21 331:7 331:11 <b>stated</b> 245:25 261:24 <b>statement</b> 133:24 136:20 144:12,13 203:11 220:16 238:2 331:24 334:11 <b>statements</b> 221:9 <b>states</b> 1:1 5:10 43:2 93:22 99:24 100:10 101:22 129:20,21 136:25 140:14 146:19 154:24 171:24 172:12 186:20 207:16 211:22 231:16 233:22 298:20 332:24 <b>statistical</b> 281:8 <b>status</b> 66:19 290:20
--	---	--	---

<b>statute</b> 331:13	96:1 97:1 98:1	218:1 219:1 220:1	339:1 340:1 341:1
<b>stay</b> 28:13 166:8	99:1 100:1 101:1	221:1 222:1 223:1	342:6 343:2,9,12
<b>staying</b> 47:13	102:1 103:1 104:1	224:1 225:1 226:1	343:17 344:1,6,9
119:17	105:1 106:1 107:1	227:1 228:1 229:1	345:5 346:2,24
<b>stays</b> 166:11	108:1 109:1 110:1	230:1 231:1 232:1	347:2,4,12
<b>stenographically</b>	111:1 112:1 113:1	233:1 234:1,13	<b>sterility</b> 131:25
342:12	114:1 115:1 116:1	235:1 236:1 237:1	<b>sterilize</b> 213:14
<b>stent</b> 336:9	117:1 118:1 119:1	238:1 239:1,4	<b>sterilizing</b> 152:13
<b>step</b> 233:15 317:2	120:1 121:1 122:1	240:1 241:1 242:1	<b>stimulating</b>
337:11	123:1 124:1 125:1	243:1 244:1 245:1	290:12
<b>stephen</b> 1:19 2:3	126:1 127:1 128:1	246:1 247:1 248:1	<b>stop</b> 36:17 141:3
5:6 6:21 7:1,16	129:1 130:1 131:1	249:1 250:1 251:1	162:18 163:14,16
8:1 9:1 10:1 11:1	132:1 133:1 134:1	252:1 253:1 254:1	174:15,17 175:6
12:1 13:1 14:1	135:1 136:1 137:1	255:1 256:1 257:1	184:14 191:19
15:1 16:1 17:1	138:1 139:1 140:1	258:1 259:1 260:1	203:8 225:25
18:1 19:1 20:1	141:1 142:1 143:1	261:1 262:1 263:1	<b>stopped</b> 21:9,10
21:1 22:1 23:1	144:1 145:1 146:1	264:1 265:1 266:1	215:9
24:1 25:1 26:1	147:1 148:1 149:1	267:1 268:1 269:1	<b>stops</b> 252:3
27:1 28:1 29:1	150:1 151:1 152:1	270:1 271:1 272:1	<b>stories</b> 127:13
30:1 31:1 32:1	153:1 154:1 155:1	273:1 274:1 275:1	268:19 269:20
33:1 34:1 35:1	156:1 157:1 158:1	276:1 277:1 278:1	322:14
36:1 37:1 38:1	159:1 160:1 161:1	279:1 280:1 281:1	<b>story</b> 25:8,10
39:1 40:1 41:1	162:1 163:1 164:1	282:1 283:1 284:1	<b>straight</b> 115:5
42:1 43:1 44:1	165:1 166:1 167:1	285:1 286:1 287:1	116:20 237:21
45:1 46:1 47:1	168:1 169:1 170:1	288:1 289:1 290:1	<b>strange</b> 44:22
48:1 49:1 50:1	171:1 172:1 173:1	291:1 292:1 293:1	<b>strangio</b> 3:18 5:18
51:1 52:1 53:1	174:1 175:1 176:1	294:1 295:1 296:1	5:18
54:1 55:1 56:1	177:1 178:1 179:1	297:1 298:1 299:1	<b>street</b> 3:4,14,22
57:1 58:1 59:1	180:1 181:1 182:1	300:1 301:1 302:1	4:13
60:1 61:1 62:1	183:1 184:1 185:1	303:1 304:1 305:1	<b>strengthen</b> 274:9
63:1 64:1,10 65:1	186:1 187:1 188:1	306:1 307:1 308:1	<b>strengths</b> 97:18
66:1 67:1 68:1	189:1 190:1,4	309:1 310:1 311:1	101:19
69:1 70:1,7 71:1	191:1 192:1 193:1	312:1 313:1 314:1	<b>strict</b> 150:23
72:1 73:1 74:1	194:1 195:1 196:1	315:1 316:1 317:1	236:11
75:1 76:1 77:1	197:1 198:1 199:1	318:1 319:1 320:1	<b>strike</b> 74:4 213:21
78:1 79:1 80:1	200:1 201:1 202:1	321:1 322:1 323:1	311:6
81:1 82:1 83:1	203:1 204:1 205:1	324:1 325:1 326:1	<b>striking</b> 199:10
84:1 85:1 86:1,10	206:1 207:1 208:1	327:1 328:1 329:1	<b>strong</b> 189:9
87:1 88:1 89:1	209:1 210:1 211:1	330:1 331:1 332:1	198:12 204:19
90:1 91:1 92:1	212:1 213:1 214:1	333:1 334:1 335:1	256:16 305:25
93:1 94:1 95:1	215:1 216:1 217:1	336:1 337:1 338:1	

<b>struggle</b> 116:17 <b>struggling</b> 229:11 317:16 <b>stuck</b> 188:23 <b>student</b> 116:6 <b>students</b> 296:18 296:19,19,20,21 <b>studied</b> 256:8 <b>studies</b> 117:22 118:3 129:11 149:4 186:22 193:16,22 194:5,6 194:7,9 195:3 197:7 236:22,23 237:4 243:24,25 244:4,17 245:18 245:19 246:8 248:14 252:24 253:5,6,8,10,17,19 253:20,23,25 254:11,19 255:5 256:13 259:18 262:7 285:3 301:15 335:16 <b>study</b> 75:4 101:2 159:2 194:7,11,13 216:2,3 229:10 230:17 231:3,6,7,8 231:8,11,15,20 232:6,7,12 233:4 236:13 244:5,15 245:2,3,11,21,23 246:3,7 257:4,21 260:5 261:5,14 262:7 270:18 271:17 276:11 277:21 279:22 280:13,25 281:2,3 286:4 295:13 336:5	<b>studying</b> 233:6 258:12 <b>stuff</b> 319:15 <b>subcommittee</b> 182:4 <b>subject</b> 10:7 94:21 232:17 233:6 256:8,9 276:23 277:2 284:15 326:6 <b>subjective</b> 313:10 321:14 <b>subjectively</b> 116:11 <b>subjectivities</b> 315:12 <b>subjectivity</b> 313:14 314:21 315:9,10,10 <b>subjects</b> 134:17 <b>submission</b> 276:21 <b>submits</b> 276:18 <b>submitted</b> 176:16 235:3 239:12 248:13 304:25 306:6 <b>submitting</b> 176:8 176:24 177:5 <b>subscribed</b> 347:14 <b>subsequent</b> 335:15 <b>subsequently</b> 76:17 255:10 <b>substance</b> 104:22 211:18 322:8 <b>substantial</b> 334:20 338:14 <b>subtle</b> 29:25 38:11 <b>success</b> 127:13 136:19 <b>successful</b> 94:7 127:17,18 136:12	207:3 <b>succinct</b> 107:9 <b>succinctly</b> 306:20 <b>suddenly</b> 288:18 <b>sued</b> 282:15 <b>suffer</b> 22:4 126:13 126:14 162:6 313:17 <b>suffered</b> 66:2 <b>suffering</b> 185:11 211:17 296:11 297:9 <b>sufficient</b> 42:13 138:21 <b>sufficiently</b> 171:18 <b>suggest</b> 291:8 294:17 <b>suggesting</b> 171:5 <b>suggestions</b> 277:13 <b>suggests</b> 187:17 200:17 <b>suicidal</b> 104:23 <b>suicidality</b> 42:25 211:18 309:14 317:4 <b>suicide</b> 74:18 75:12 121:15 215:20,23 216:4 298:7 308:17,20 309:8 336:21 <b>suicides</b> 194:23 309:3 <b>sullcrom.com</b> 3:7 3:9,11 <b>sullivan</b> 3:3,24 5:22 6:1,4 <b>summarize</b> 255:5 300:6 <b>summarized</b> 145:25	<b>summary</b> 110:11 145:5 <b>summer</b> 6:6 <b>supervise</b> 22:8,18 22:21 24:19 34:4 34:22 35:19 37:22 40:15 43:8 61:6 75:23 <b>supervised</b> 22:10 37:5,8 39:16 40:7 <b>supervising</b> 19:15 29:5 <b>supervision</b> 20:2 22:6,23 29:4 35:2 35:8 37:8,10 40:12 226:16 <b>supervisor</b> 61:3 <b>support</b> 45:9 52:20 83:15 95:13 130:24 176:9 177:7 200:3 207:12 208:3 219:16 302:8 324:23 332:2,7 334:10,13 <b>supported</b> 52:15 66:5 67:9 210:20 247:21 <b>supporting</b> 140:25 153:23 285:24,25 299:24 <b>supportive</b> 229:2 301:13 <b>supposed</b> 299:19 <b>suppress</b> 168:9 <b>sure</b> 7:20 16:18 26:3 28:25 37:16 40:23 41:9 49:16 56:23 59:11 60:3 60:7 69:5 71:11 73:6 75:15 79:21
--	---	--	---

85:14 89:11 99:17 100:6,18 105:5 114:8,14 129:15 135:25 139:9 144:18 146:16 151:7 167:4 178:14 180:24 182:14,23 184:2 191:5 193:11 228:3 229:19 237:16 245:10 252:21 253:6 260:14 263:8 270:3 291:13 296:4 <b>surgeon</b> 41:11 104:4 <b>surgeries</b> 84:11 95:11 150:22 193:19,21,25 197:20 <b>surgery</b> 53:14,20 66:6 69:17 80:24 82:10 97:3 99:16 99:21 102:5 150:11 152:13 184:7 193:23 196:25 266:12 336:7 338:7 <b>surgical</b> 84:21 87:14,15 111:24 156:25 192:10 194:3 196:20 197:14,24 <b>surgically</b> 266:24 <b>surprise</b> 97:7 <b>surprised</b> 191:3 267:3 <b>surprisingly</b> 308:21	<b>surreptitiously</b> 48:20 56:20 57:8 58:24 224:13 <b>surrounding</b> 71:11,15 <b>susceptible</b> 233:18 <b>swallowing</b> 117:10 <b>swear</b> 142:22 <b>sweden</b> 101:2 119:6 129:14 133:24 134:3,5,20 134:23 135:2 140:12 186:22 246:12 <b>sweden's</b> 135:11 <b>swedish</b> 216:2 <b>switch</b> 252:7 283:6 302:13 <b>switching</b> 303:14 310:13 <b>sworn</b> 6:18,22 342:6 347:14 <b>symposia</b> 293:12 293:19 <b>symposium</b> 238:12 291:21,25 292:18 294:21 300:4 <b>symptomatic</b> 81:20 <b>symptoms</b> 97:20 104:2 123:19 <b>syndrome</b> 257:6 <b>system</b> 28:19 32:13,13 136:24 189:8 285:20 290:3 <b>systematic</b> 126:16 <b>systemic</b> 126:16 <b>systems</b> 152:3	<b>t</b> <b>t</b> 304:20 342:1,1 343:7 346:3,3 <b>tab</b> 64:8 70:2 86:7 181:7 190:2 234:11 239:2 <b>table</b> 82:23 203:21 <b>take</b> 9:2 46:19 60:11 69:11 71:14 102:10 103:5 104:15 111:15 120:8 125:15 128:7 130:12 144:17 150:4 152:10,10 155:18 156:7 161:6 166:25 167:3 175:19 186:8 192:17 210:23 213:11 220:2 221:16,21 222:25 233:14 235:10 240:4 247:2,3 254:20 255:4 264:14 271:7 272:2 291:8,11 312:4,6,16 315:13 325:25 326:25 337:16 <b>taken</b> 5:6 48:21 60:17 82:23 94:4 105:10 122:7 158:3 161:10 190:15 223:6 224:8 260:20 291:14,17 329:8 330:5 337:19 342:11 <b>talk</b> 15:14 22:24 47:2 59:19 97:16 97:17,18,19,20,22	98:16 105:25 116:7 121:10,11 125:9 133:9 134:18 164:11 166:7 216:25 243:9 252:8,19 264:14 283:8 296:2 303:7 311:17,18,21 316:18 319:11 323:24 324:4,12 326:17 330:15 <b>talked</b> 35:21 68:7 93:22 97:9 111:6 111:9,19 127:23 128:14 133:21 142:3 143:23 171:10 178:10 199:19 202:5 206:25 215:22 226:19 238:13 241:25 242:10 295:4,11,16 296:5 297:17,18 298:12 298:13 302:10 318:18 <b>talking</b> 13:11 29:23 35:10 36:5 48:10,12 50:8 53:5,6 55:9 77:15 79:7 93:23,24,24 94:2,11,13 112:3,4 112:22 116:13,14 138:25 141:10 152:24 153:7 166:22 168:21 176:13 182:2 183:22 192:20 211:3 215:16,17 215:18,19,25 217:3 219:12
--	---	---	---



233:17 236:12 242:16,18 250:11 254:16 283:17 303:11 307:11 313:21 314:25 316:20 326:12 <b>talks</b> 285:2 313:13 <b>tangential</b> 259:12 <b>tangentially</b> 258:22 <b>taught</b> 204:9,13,17 <b>tavistock</b> 275:6 308:19 309:4 <b>teach</b> 155:2 289:13 336:25 <b>teaching</b> 16:2,4 207:10 <b>team</b> 22:19 23:4,6 23:18 24:8,9 40:8 159:21,22,24 164:21,25 167:8 167:12 205:16 227:18 273:23 <b>teams</b> 173:18 <b>tease</b> 55:13 <b>technical</b> 12:14 <b>teen</b> 158:14 268:9 <b>teenage</b> 22:24 30:24 52:13 <b>teenager</b> 14:9 32:2 32:6,10 50:6 55:9 62:20 88:3 113:18 <b>teenager's</b> 50:25 <b>teenagers</b> 14:8 23:9 26:2 31:4 46:22 49:18 259:4 321:9,12 334:17 <b>teens</b> 27:6 175:13 308:18 <b>teleconference</b> 2:5	<b>tell</b> 27:21 38:16,20 46:20 49:13 54:15 66:14 87:7 122:5 122:17 124:6,7,21 134:6 144:7 148:10 198:13 200:12 257:4 259:17 268:24 269:19,23 279:21 289:24 295:2 297:20,22 311:15 321:12 325:11 326:21 331:21 <b>telling</b> 25:8 58:3 148:8 153:23 321:12,16,17 <b>tells</b> 39:2 45:17 46:19 120:19 160:5 298:23 <b>temporarily</b> 34:15 123:21 <b>temptations</b> 57:14 <b>ten</b> 14:2 17:13,14 17:24 20:11,17 27:25 30:18 31:5 54:2,18 55:10,15 56:12,25 58:7,20 132:6 206:12 219:2 243:24 275:8 277:8 297:17,24 298:8 298:12 306:8 309:4 328:12 <b>tend</b> 28:13 48:2 131:3,16 <b>tendency</b> 101:23 <b>tends</b> 157:10 <b>term</b> 18:12,18 69:15 79:2 84:15 84:16 126:17 132:4 133:15	139:20,22 142:4 153:16 180:5,15 195:5 205:25 215:18 248:10,10 256:20 263:5,7 266:2,5,8,11 276:12 281:16 313:9 <b>terminology</b> 66:12 73:21 313:12 <b>terms</b> 32:12 33:3 67:4,10 73:15 79:13 116:25 120:3 149:16 160:24 241:20 <b>terrible</b> 108:8 267:18 301:17 <b>terribly</b> 115:9 120:8 <b>test</b> 266:20,21 311:19 312:10,13 312:19 <b>testified</b> 14:15 15:4 74:6 79:15 96:7 120:2 141:23 195:25 208:8,12 208:13 <b>testifies</b> 6:23 <b>testify</b> 177:25 178:7 207:12,20 208:21 342:7 <b>testifying</b> 148:7 181:18 208:19 <b>testimonies</b> 209:14 <b>testimony</b> 8:12 9:12 12:10 36:23 82:16 96:14 106:8 131:14 139:10 144:7 161:15 179:24 181:16 191:24 195:2	202:22 209:2 323:19 327:17 345:9,18 347:8 <b>testing</b> 314:4 <b>testosterone</b> 48:14 48:21 56:21 57:9 59:18 114:8 186:11 340:18 <b>tests</b> 312:3,14 313:23 <b>texas</b> 323:3,7,12 323:19 326:9 327:4 <b>text</b> 65:20 71:11 71:14,15 149:24 273:3 <b>textbook</b> 306:14 320:18,20 <b>thank</b> 7:4 12:5 17:7 21:13 40:20 45:12 49:7 68:19 72:14 82:14 87:17 91:18 95:8 110:21 214:21 301:4 328:2 <b>theme</b> 293:13,18 <b>theoretical</b> 83:5 <b>theoretically</b> 83:14 84:2 169:25 196:15 <b>therapeutic</b> 26:7 48:6 212:22 227:24 232:17 264:20 268:15 <b>therapeutics</b> 225:20 <b>therapies</b> 248:16 294:18 295:23 <b>therapist</b> 25:11 29:11 63:12 185:14 311:22
---	---	---	--

<b>therapy</b> 19:11,21 35:25 36:12,14 44:7 45:3,9,15 53:13 57:4 58:10 59:5 60:2,5 63:3 63:11,19 68:10,22 75:18,25 77:10 78:6 79:18 82:18 83:15 84:4 85:6 86:12 87:12 97:10 99:6 105:17 110:14 117:3,8 124:10 126:2,10 137:5 151:12 164:14,16 167:2,3 169:14,19 171:8 172:18 187:6 192:25 199:3,25 212:13 214:5,24 220:20 223:21 224:3 225:21,24 226:24 227:4,10 227:15 229:24 242:5 243:11 246:21 248:9,12 289:11,12 297:8 300:2 324:18 327:7 331:15 338:4 343:19 <b>thing</b> 34:21 35:4 47:6 50:10 76:4 82:6 96:24 99:23 100:9,12,14,15 109:12,18 115:13 120:19 157:9 166:16 180:22 192:12 203:11 207:23 208:18 213:8 225:12 231:15 237:7 251:11 269:17	271:16 273:8 274:17 278:5 288:6 290:22 299:8 301:11 313:4,4 316:6 319:18,19,20 336:16 <b>things</b> 10:3,6 46:23 83:10 85:13 101:5,18 108:23 108:24 114:20 115:21 132:4 151:24 152:21 157:24 159:7 160:5,11 179:13 179:14 180:14,22 180:25 187:19 188:10,11 192:21 195:6,24 196:9,11 204:15 209:7,11 209:14 211:16 216:17 218:19 221:4,13 231:19 244:8 274:21 296:16 298:9,13 301:5,6 311:16 314:6 317:15 326:20 330:23 <b>think</b> 9:13 10:16 11:20 13:7 14:19 17:11 18:10 19:23 20:12 21:8,12 28:15,21,23 29:25 30:17,19 31:14 32:25 33:20,24,25 34:5 35:21 36:2 37:5,21 44:17,20 49:3,6 53:4,9 54:6 54:7,12,15 55:19 57:6,10 60:22 63:5 68:10 71:6	71:19 74:2 75:9 75:20 76:5,6 77:8 77:18 79:11,15,21 79:21 85:12 87:10 90:15 92:5,15,16 92:22 93:2 98:9 99:16 100:3 101:11 102:13 105:19 106:2,15 111:4,15 112:24 113:16 114:2,2 119:3,22 122:4 125:21 126:20 128:12,13,25 132:14,21 134:13 134:24 136:2,19 137:14,19,22 142:18 143:24 144:9,16 147:18 148:9 149:4,6,11 151:8 152:4,14 153:8,14 154:4,10 154:23 156:2,25 159:3,25 160:3,21 162:10,21,21 163:2,7,13,15,22 164:6,14,18,19,20 164:24 165:5,16 165:23 167:16 168:16 170:22 171:16,17 173:8,9 173:10,16,20,24 175:8,19 176:3 178:9 179:24 182:3 185:15,16 185:20 186:4,18 187:20,24 188:25 189:8,19 191:8 192:16 197:6,17 198:3,11,11 199:22 200:8,11	200:16 201:23,24 202:7,19 203:23 205:15,19 209:7 209:18,22 211:9 211:24 212:8 213:5,25 214:18 215:3 217:23 219:23 220:2,14 220:16 221:5,16 223:17,23 225:6 225:12,18 226:6 226:20,24 227:17 227:21 228:17 230:23 232:5,6,8 232:11,20 233:5 233:16 237:25 241:10,13 243:23 247:6 250:4,7,14 251:8 253:14 254:5,13 256:12 257:6,14,21 259:11 261:3,8,15 262:13 263:9,9 266:6,8,11 269:7 270:2 271:12,25 275:7,12,12,15,17 275:19,25 276:11 279:14 281:6,24 283:4 284:20,23 285:15,16,19 286:6,10,18 287:17 288:5 289:3 290:13,16 291:6 294:2 299:20 300:6,25 301:21 305:13,16 306:7 307:11,20 311:22 313:16 315:19 316:25 317:2,14,18 318:3 318:18 321:18
--	--	---	---

322:8,20,22 324:17,22 325:17 325:18,21,22 326:22 328:10,14 328:14,20 329:2 329:15 331:6,9,21 332:21 333:4,6,19 335:2 338:6 339:14 340:13 <b>thinking</b> 53:17 100:4 125:4,6 168:22 209:12 228:2 269:3 <b>thinks</b> 113:14 207:2 225:5 266:2 314:13 <b>third</b> 143:24 175:18 199:16 264:17 265:10 287:4 <b>thirds</b> 256:15 <b>thirty</b> 132:7 <b>thorough</b> 145:17 145:18 150:25 151:14,16 152:6 200:3 214:7 <b>thoroughly</b> 144:19 146:9 150:15 202:25 203:3 <b>thought</b> 51:16 83:10 115:7 121:23 157:23 171:17 177:11 208:18 255:16 269:9 274:9,11 321:4 328:13 <b>thoughtful</b> 76:25 92:13 109:14 170:12 184:25 205:17	<b>thoughtfulness</b> 104:15 109:14 <b>thousand</b> 13:12 <b>threat</b> 329:13 <b>threatening</b> 127:6 328:15 331:3 <b>three</b> 10:15 17:20 18:13,14 19:11,20 19:24 30:20 31:6 39:8 42:8 51:24 52:4 54:19 76:3 80:2 88:20 95:21 95:24 98:20,21 108:25 111:10 113:11 122:7 125:9 129:2 162:20 169:5 201:25 233:14 264:9 265:8 276:22 277:5,9,10 277:25 288:9 298:22 <b>thromboembolism</b> 215:13 <b>throughput</b> 189:7 <b>thrust</b> 94:3 <b>time</b> 7:7 11:18 12:3,20,25 18:8 21:24 22:2 24:5 24:20 27:18 28:10 31:24 33:23 42:10 42:13 43:23 47:3 48:5,17,19 59:10 59:11 60:16,19 66:3 68:17 69:20 70:21 71:10 74:12 75:6,16,21 83:19 95:3,5 104:15 105:3,4,9,12 108:11 119:12 122:10 140:16	141:15 144:17 145:16 146:8 150:16 153:5,5 156:21 160:25 161:9,12 171:11 175:18 183:15 185:4 191:5,13 215:10 222:25 223:2,5,8,11,16 227:9 236:10 247:3,4 251:6,14 253:12,16 256:24 259:14 287:19 291:16,19 299:4 306:13 309:11,12 314:18 321:9,10 322:14 328:4 333:20 335:20 337:18,21 341:4 342:13 345:19 <b>timeframe</b> 79:14 345:8 <b>times</b> 7:18 20:12 22:16 31:15 49:14 52:22 95:22 96:10 97:4 102:2,2,3 115:3 124:5 152:3 187:19 201:25 202:2 246:9 249:11 282:8,9,14 <b>timing</b> 73:15 <b>tired</b> 333:20 <b>tissue</b> 180:12 <b>tissues</b> 87:22 <b>title</b> 268:24 292:7 <b>today</b> 7:12 9:12,16 9:20 10:22 12:11 142:2 157:24 186:12,24 187:17 211:3 220:25 221:12,13 265:10	266:6 286:25 315:2 338:16 <b>today's</b> 130:25 297:16 <b>toggles</b> 249:7 <b>told</b> 46:21 55:25 83:18 88:20 120:2 177:17 200:10 265:25 273:14 278:2 <b>tom</b> 176:2 <b>tomorrow</b> 169:18 324:8 <b>tomorrow's</b> 297:16 <b>toni</b> 109:5 <b>top</b> 80:24 183:2 184:4 287:7 329:2 <b>topic</b> 108:19 183:22 268:14 284:8 <b>topics</b> 252:7 295:18 <b>total</b> 16:8 31:6,17 244:5 259:24 <b>touched</b> 42:5 <b>town</b> 76:15,20 77:5 <b>track</b> 18:16 21:7 21:10,10 28:20 278:15 <b>trade</b> 284:25 <b>tradition</b> 188:25 266:25 <b>tragedies</b> 131:24 <b>trained</b> 248:8 <b>trajectory</b> 217:7 <b>trans</b> 19:6 23:4,6 43:25 49:10,24,25 50:2,6,25 51:12,14 52:13 57:14 74:24
---	---	--	---

75:2 86:24 100:14 108:5 111:8 113:19 115:4,22 116:5,5 121:14 142:22 147:24 157:12 189:11,13 189:17 194:25 209:19 210:7 213:17 257:24 275:3,9 280:17 286:17 291:2 295:7 320:24 321:10 324:14 336:15 <b>transcribe</b> 7:22 8:15 <b>transcript</b> 181:8 181:16 190:3,14 342:11 343:20,25 345:6,20 347:5,8 <b>transferred</b> 75:7 <b>transforming</b> 213:2 <b>transgender</b> 22:19 24:8 50:15,15 52:20 98:6 181:10 194:19 197:2 228:2 245:9 254:7 257:14 259:9 292:2 295:24 298:14 321:23 343:22 <b>transgendered</b> 212:9 <b>transition</b> 52:16 54:5,9 55:6 56:22 66:5 87:12,14,15 87:16,19 88:2,13 89:7,8,15,16 92:17 133:16 142:7 144:11 150:10,17	150:19,21,22 156:23 187:2 <b>transitioned</b> 52:25 53:12 54:10 55:4 56:15,16 57:24 88:5,25 89:2 131:6 170:14,16 215:24 <b>transitions</b> 93:15 93:16 <b>transsexual</b> 46:7 180:23 <b>transsexualism</b> 321:7 <b>transvestitic</b> 320:25 <b>treat</b> 222:19 243:11 248:18,20 294:18 310:14 322:3 333:16 334:9 336:6 <b>treated</b> 12:22 16:7 16:22,25 17:17 105:15 110:24 124:2 164:8,9 210:11 251:20 265:12,13,15 <b>treating</b> 17:16 18:7 32:24 66:2 265:18 <b>treatment</b> 12:18 16:13,25 17:22,25 33:13 40:15 43:10 61:11 62:6,15,21 62:24 63:8,11,15 63:16 68:2 76:22 80:2 81:25 84:18 84:19,20,21 94:4 98:23 99:9 101:10 101:11,15,16 111:22,23,25	117:5,7,11 128:22 134:25 135:8,11 140:7 149:16 160:15 163:14 169:5,17 172:6,15 172:16 173:4 174:10 179:20 184:9,23 187:2,22 192:9,10 194:14 194:18,25 196:19 196:20 197:14,15 197:24,24 198:9 198:16 199:20 200:5 211:7 212:2 214:9 215:3,9,11 217:2,3,14 218:8 219:3 222:13,17 228:24 229:22 230:15,21,22 233:12 259:15 260:2,4 261:9,23 287:12 289:6 296:9 297:19,21 298:2,15 304:11 305:22 309:5 310:3 332:16 334:5,16,22 335:4 336:22 338:20 <b>treatments</b> 130:4 163:16,22 164:2 168:17 171:11 172:2,24 179:22 182:6 184:16 194:3,3,21 211:14 217:10 236:23,24 247:10,13,20 269:12 296:13,14 298:6 306:2 <b>treats</b> 35:13 <b>trial</b> 70:24 229:20 230:2 246:19	251:21 <b>trials</b> 135:12 228:18 229:3,7 232:3,9 234:4 247:15,23 249:3,4 250:12 <b>trickle</b> 296:15 <b>tried</b> 18:5 52:22 59:8 119:6,8 198:13 274:5 <b>tries</b> 36:17 <b>triglycerides</b> 216:16 <b>triple</b> 249:3 <b>trouble</b> 231:17 237:15,22 279:25 330:11 <b>troubles</b> 15:15 319:8,9 <b>troubling</b> 108:23 <b>true</b> 61:15 62:19 102:19 105:19 117:24 131:18 133:5 146:5 180:23 204:10 319:5 321:4,6 322:9 342:10 347:8 <b>truly</b> 157:16 160:3 <b>trust</b> 13:14 94:2 166:2,2 168:24 190:23 204:11,13 204:16 239:17 296:2,18,25 297:4 297:6,12,14 <b>trusting</b> 109:15 <b>trustworthy</b> 156:20 240:12 290:4 297:5,6,15 <b>truth</b> 38:19 58:3 60:9 205:3,7
---	--	---	---

275:24 297:7 321:16,22 322:5 342:7,8 <b>try</b> 8:21 9:7 25:10 29:16 36:17 47:22 56:10 107:9,21,25 108:12 109:9,23 110:13 117:22 155:15,20 185:16 195:10 224:2 237:18 335:19 <b>trying</b> 17:5,25 27:15 43:7 53:24 57:17 67:3 72:9 79:14 82:19 92:8 106:24 109:22,22 112:24 113:5 127:9 132:18 140:18 146:21,24 148:14,15 153:13 155:10,23 156:5 163:14,16 173:5 182:4 193:8 211:22,25 219:24 220:5 221:17 289:10 296:10 320:21 331:21 <b>tsunami</b> 140:4 <b>turban's</b> 10:24 308:13 <b>turn</b> 22:5 157:7 175:7 296:17 <b>turned</b> 97:6 224:2 <b>turns</b> 321:8 <b>twice</b> 17:18 <b>two</b> 19:24 22:24 23:25 26:18 30:19 31:6 35:11 39:4 39:21,22 54:19 57:6 76:3 83:3 88:18 93:4,18	95:14 98:20 108:22 110:7 125:9 129:13 137:11,23 143:12 143:15,19 144:3 148:5 162:20 165:11 169:20 172:8 173:16 175:19,22 183:18 186:14 187:21 189:11 193:16,21 195:3 196:12,13 196:23 205:23,24 206:8 221:4 227:12 238:12,12 256:15 257:13 259:18 265:9 270:14 280:22,25 281:7,12 291:23 291:24 292:12,15 309:5,6 315:11 334:25 <b>typed</b> 8:12 <b>types</b> 240:9 <b>typical</b> 35:4,7 50:6 90:16 99:23	<b>umm</b> 72:7 <b>unknownst</b> 302:22 <b>uncertain</b> 56:9 114:19 141:6 160:6 169:12 195:5 213:6 <b>uncertainties</b> 58:2 156:14 261:25 <b>uncertainty</b> 114:17 286:3 <b>unclarified</b> 287:22 <b>unclear</b> 129:9 130:16 132:9 139:21 163:17 193:17,24 194:16 209:12 219:4 <b>uncomfortable</b> 26:13,21 328:10 <b>underestimated</b> 262:4 <b>undergo</b> 157:20 <b>undergone</b> 269:11 <b>underlying</b> 107:23 108:3 200:24 265:2,3 <b>underpinning</b> 150:21 <b>understand</b> 12:19 14:6 21:3 25:11 26:17 29:6 32:11 32:16 34:25 40:4 43:7 46:2,4,6 47:14,25 50:21 57:11 63:15,17 67:3,6 72:17 73:12 79:23 82:15 82:19 85:7 87:7 87:25 88:11,22 92:9,19 98:11 105:13 106:25	108:21,22 115:12 130:11 131:13 140:8 141:20 144:6,14 151:7,10 152:23 153:6 161:24 162:4 163:19 178:14,20 179:23 184:12,20 192:19 195:10,14 200:2 202:21 203:23 205:7 214:2 220:6 229:4 229:20,25 233:21 237:12 239:23 241:5,13,16 250:10 252:18 255:21 263:6,7 267:17 273:4,12 274:2,6 279:5,14 279:16 281:20 283:20 309:21 322:4 326:23 335:10 337:5 <b>understanding</b> 50:12 69:6 78:17 79:15 88:8 96:17 107:3,17 116:18 135:17 136:9 137:3 138:7,12,15 139:4 145:7,11 146:6 147:14 164:10 166:20 173:6 174:21 187:18 188:5 196:8 201:12 237:15 265:7 338:18 339:10 <b>understood</b> 8:23 18:17 29:3 32:15 79:13 139:9 240:16 249:15
	<b>u</b>		
	<b>u</b> 91:2 303:19,23 303:24 305:8 <b>u.k.</b> 119:5 129:14 134:20 137:4,6 138:2,4 140:13 259:21 261:14 270:15 308:3 <b>ultimate</b> 103:16 187:22 <b>ultimately</b> 43:11 225:2 <b>umbrella</b> 154:16 154:17,19,20 175:25 222:10,19		

282:2 287:10 327:25 <b>undertake</b> 87:11 231:20 <b>undertaking</b> 150:17 <b>undervaluing</b> 122:19 <b>underwent</b> 99:21 <b>undisclosed</b> 287:21 <b>unease</b> 97:22,22 97:23 <b>uneasiness</b> 108:6 <b>uneasy</b> 78:24 103:21 <b>unfortunately</b> 209:21 <b>unhappiness</b> 125:13 218:3 <b>unhappy</b> 125:8 <b>uniformity</b> 285:19 286:3 <b>union</b> 3:13 <b>unique</b> 318:25 320:4 <b>unit</b> 5:4 79:4 159:22 160:7,19 <b>united</b> 1:1 5:10 93:22 99:24 100:10 129:20 136:25 140:14 146:19 154:24 186:19 231:16 298:20 <b>units</b> 334:15 <b>universal</b> 50:3 136:23 <b>university</b> 24:16 59:16 91:23 92:6 273:2	<b>unknown</b> 75:8 <b>unproven</b> 150:23 <b>unquote</b> 198:18,19 <b>unrelated</b> 108:19 <b>unsympathetic</b> 165:19 <b>untrustworthy</b> 270:17 <b>unusual</b> 76:4 <b>updates</b> 287:25 <b>upgrade</b> 169:6 <b>uploaded</b> 64:16,21 70:4 <b>urban</b> 184:12 <b>urge</b> 210:21 <b>urged</b> 335:8 <b>urging</b> 153:22 <b>urologist</b> 339:12 <b>urology</b> 267:2 <b>use</b> 17:25 33:14 68:25 84:10 92:21 92:24 96:12 107:12 137:24 145:21 184:8,16 184:22 188:19 226:9 243:10 249:9,12,18,23 250:13,15,20,22 251:2,3,9 266:6 274:25 276:17 292:19 313:12 326:3 334:8 335:5 <b>uses</b> 250:5 279:9 <b>usually</b> 35:7 42:7 97:23 98:20 101:6 276:21 277:5,18	<b>vaginoplasty</b> 195:14 <b>vague</b> 187:8 205:13 247:17,19 300:23 315:16 <b>vaguely</b> 190:19 331:3 <b>valid</b> 240:14 319:24 322:7 <b>valuation</b> 62:22 <b>valuations</b> 270:14 <b>value</b> 163:17 <b>variable</b> 253:15 <b>varied</b> 21:2 125:19 <b>various</b> 84:2 93:21 93:25 108:12 147:17 156:24 233:22 236:25 244:18 246:8,9,9 268:23 308:11 326:20 338:20 <b>varying</b> 25:23 <b>vast</b> 139:5,13 <b>vastly</b> 262:3 <b>verbally</b> 8:13 <b>verification</b> 311:25 <b>verify</b> 311:12 314:5 345:9 <b>veritext</b> 2:5 345:14,23 <b>veritext.com.</b> 345:15 <b>version</b> 151:8 265:10 <b>versions</b> 265:9 <b>versus</b> 5:8 17:4 70:20 167:20 218:6 236:25 237:2 318:2	<b>vessels</b> 336:3 <b>video</b> 4:21 5:5 341:4 <b>videoconference</b> 1:17 <b>videographer</b> 5:1 6:8,17 11:22 12:2 60:15,18 105:8,11 161:8,11 223:4,7 223:11,15 291:15 291:18 337:17,20 341:3 <b>videotape</b> 2:3 <b>videotaped</b> 1:18 <b>view</b> 35:23 39:24 81:16 128:20 139:10 151:11,20 152:5 157:15 159:11 160:22 175:10 187:4 192:22 196:17,21 202:11 203:16 214:3 217:10 236:7 249:15 301:9,16 314:14 314:17,19 328:25 337:6 <b>viewed</b> 276:20 <b>views</b> 122:20 130:25 158:3 178:12 221:19 300:9,12,18,19 305:25 334:4 335:19 <b>vintage</b> 248:8 <b>vintages</b> 25:23 <b>violation</b> 329:7 <b>virginia</b> 65:12 <b>virtually</b> 2:4 <b>visit</b> 127:22 340:19
	<b>v</b>		
	<b>v</b> 1:9 60:24 70:8 190:6 315:22 316:9,14 343:13 344:3		

<b>vocal</b> 268:6 <b>vocational</b> 207:3 <b>vocationally</b> 179:12 <b>voice</b> 115:16 117:14 216:11 <b>vote</b> 326:14 <b>vs</b> 345:4 346:1 347:1 <b>vulnerabilities</b> 107:22 <b>vulnerable</b> 104:22 212:8,10	185:23,24 186:5 191:4,11,19 192:14,21 195:7 195:11,12,13 199:18 203:11 206:10 209:9,10 209:20 212:4 213:12,15 218:7,8 227:21 235:21 238:21 247:3 249:23 252:7 255:15 260:19,22 263:11 281:22 282:15 283:8,20 289:15 290:22 296:2 309:16 315:7 316:19 321:23 326:16 336:17,21,24 340:18 <b>wanted</b> 118:6 123:24 128:3 183:10 192:2 193:11 227:13 237:11,24 239:22 256:24 258:9 265:11 320:18 324:3,12 <b>wanting</b> 84:10 102:4 139:25 274:7 <b>wants</b> 30:6 67:19 71:25 101:14 102:9 104:5,7 189:24 217:21 265:5 274:25 <b>war</b> 232:14 <b>warn</b> 109:23 <b>watch</b> 266:15 267:6,11 314:15 314:16	<b>watched</b> 114:16 114:16 <b>watchful</b> 263:3,20 264:7,12,13,18 265:8,23 266:9,11 266:16 267:8 <b>way</b> 8:21 18:2 29:14 30:20 31:7 46:11 52:6 53:2 53:13 55:13,14 56:11,15 57:4 69:15 82:22 99:4 100:3 127:19 138:23 157:17 166:6,10,12 168:14 174:7 175:5,5 178:19 184:11 199:22 223:20 225:16 228:25 231:9 235:6 236:11,11 258:19 259:12 280:9 293:16 299:3 307:5 308:7 316:24 319:10 324:9 325:24 333:16 <b>ways</b> 22:3 57:12 188:9 226:12 257:2 <b>we've</b> 7:6 35:10 71:6 97:8 152:11 185:3,21 229:10 278:17 302:5 340:9 <b>weak</b> 324:7 <b>weakening</b> 114:3 114:11 <b>weaknesses</b> 97:19 <b>web</b> 1:17	<b>websites</b> 49:25 268:13 <b>week</b> 13:5,19,19 13:21,24 14:3 17:19 26:18 323:21 324:8 <b>weeks</b> 22:24 35:11 93:18 111:10 237:9 323:25 <b>weight</b> 215:14 216:13 <b>weightless</b> 237:5 <b>welcome</b> 293:16 <b>welfare</b> 175:2 <b>went</b> 59:15 74:23 74:24 95:16 122:11 127:19 147:22 206:11 316:23 <b>west</b> 3:22 4:4 65:12 <b>whoa</b> 154:2,2,2 <b>wholeheartedly</b> 336:19 <b>willing</b> 267:23 <b>win</b> 220:3 <b>winded</b> 104:25 322:25 <b>wisdom</b> 178:3 179:6,17,19,21 184:10 195:5 217:25 231:6 250:17 <b>wishes</b> 115:25 <b>withheld</b> 48:21 <b>witness</b> 6:17 7:3 11:17 64:17 65:3 70:11 71:2 161:4 176:19 237:20 303:20 327:3 332:24 337:14
<b>w</b>			
<b>w</b> 91:5 <b>wait</b> 8:8 267:12 <b>waiting</b> 64:20 263:3,20 264:8,12 264:13,18 265:8 265:23 266:9,11 266:17 267:8 <b>waitlist</b> 309:7 <b>walked</b> 315:4 <b>want</b> 11:11 12:16 16:17 29:9 32:11 33:14 35:8 36:9 39:12 46:20,21 47:6 61:15 67:6 68:6 71:10 72:12 73:9 74:4 76:6,11 76:12,21,24 78:18 80:4 83:24 90:13 103:2,4,5,8,8 110:8 126:5 132:17 133:4,12 149:9 150:4,8 151:7 153:15,22 154:10 170:21 174:24 176:19,23 178:14 182:14,23 183:3 184:4			

340:23 343:2 345:8,10,12,19 <b>witnesses</b> 324:16 <b>witnessing</b> 330:19 <b>woman</b> 95:14,20 111:8 125:8 222:15 256:5,6,6 258:11 303:3 <b>women</b> 236:5 238:9 268:7 <b>wonder</b> 285:23 <b>wondering</b> 202:4 <b>woodwork</b> 258:25 <b>word</b> 16:25 33:14 67:9 68:21,25 96:12 107:13 112:2 128:7,11 131:11 145:22 184:20 185:24 186:3 199:16 267:17 292:19 340:6 <b>words</b> 8:15 67:13 107:12 109:13 129:2 142:23 183:16 225:8 331:2 <b>work</b> 13:4 19:14 22:6,8 32:9 56:3,6 61:7 66:8 94:2 102:12 105:3 111:15 122:17 168:13 275:3 280:16 284:16 296:20 298:19 309:18 <b>worked</b> 14:2 22:11 95:4 104:6,9 257:10 288:17 <b>worker</b> 60:25 61:2 62:9 103:9 337:25	338:8 <b>workers</b> 312:8 <b>working</b> 121:9 127:7 288:18 <b>works</b> 92:4 153:6 264:11 272:24 287:14 297:13 304:10 322:20,21 <b>world</b> 43:14 113:19,20 116:4 116:24 120:4 146:20 154:5 155:6,9 157:10,11 189:16 241:11 286:21 295:6 300:10 324:14 337:7,8 <b>worried</b> 88:11 285:22 290:8 <b>worry</b> 85:18 225:18 284:16 301:6 <b>worrying</b> 201:18 <b>worth</b> 122:8 185:16 <b>worthy</b> 231:20 <b>wpath</b> 72:18 73:17 102:22 275:20,25 288:7 <b>wpath's</b> 270:16 291:3 <b>wrap</b> 221:20 <b>write</b> 45:8,22 46:8 46:10,14 67:20 68:12 69:7,10 73:23 83:14 86:3 94:21 96:3 98:16 100:4 101:8 102:6 148:5 217:11 242:6 275:10,11 277:3 281:13	282:9,12 286:9 287:3 306:19 338:24 339:8 <b>writer</b> 278:12,13 <b>writing</b> 66:15,17 67:2 69:3 81:11 93:6 94:23 102:10 155:17 163:2 <b>writings</b> 144:7 <b>written</b> 53:19 80:12,22 82:17 85:20 86:10 93:8 94:12 95:9 96:8 98:4,4,15 187:18 215:12 226:21 287:8 343:17 <b>wrong</b> 91:16 205:21,23 249:21 273:6 278:2 280:15 <b>wrote</b> 95:12,13,18 142:11 143:22 153:20 217:17 236:6 237:7 281:9 281:14,16 287:3 295:15 333:7 335:5	16:22 17:10,18 18:10 19:5,12,15 19:22 20:4,12,17 20:19 21:3,3 23:18 27:22 28:5 28:11,17 30:19 32:14,16 33:18,19 53:23 54:7,7,19 55:16 57:3 58:9 58:23 84:5 85:15 85:15,15 87:4 90:10,10,16 92:17 95:19 96:4 101:24 101:25 111:5,6 112:21 118:10,14 122:12 129:17 132:2,3,3 140:17 140:23 141:18 152:8 163:6,7,10 164:13 168:15 169:13 170:10 186:8,10,16,24 187:3,6 189:10 197:21 201:6 213:10,11,14 217:6 224:9 228:12,13 236:7 259:20 260:9 261:15,19 290:14 309:4 326:2,4 330:16 <b>years</b> 13:22 18:21 18:23 20:8,13 30:24 31:10 33:6 33:11,21 40:11 48:19 51:21 63:4 63:9,18 64:6 74:7 75:25 76:14 78:5 79:19 83:13 96:20 102:3 110:7 118:7 118:11,14 122:3,7
		<b>x</b>	
		<b>x</b> 1:5,14 260:20 343:1,7 <b>xi01165</b> 2:8	
		<b>y</b>	
		<b>yeah</b> 24:4 28:7 54:22,25 71:9 199:17 242:24 258:9 276:15 306:8 325:11 327:14 <b>year</b> 13:17,20,23 13:25 14:11,13	



148:5 152:19	<b>zeitgeist</b> 197:9
162:20,20 164:14	<b>zero</b> 54:13,13
165:11 168:3	<b>zoom</b> 2:4
169:5,20 173:3	<b>zucker</b> 253:18,21
174:12 183:18	265:22,25 292:14
186:14 189:11	294:13,25 295:3
193:24 194:19	299:16,22 300:3
196:12,23 205:24	
206:8,9,12,19	
218:4 219:2	
233:14,15 248:25	
248:25 256:7,7,7	
257:7 260:20	
261:10 268:10	
275:7,8 288:7,9	
301:25 302:2,2	
309:2 328:12	
330:12,16,20	
<b>yesterday</b> 10:25	
<b>york</b> 3:5,5,15,15	
5:17,20,24 6:5	
22:23 34:4 80:10	
257:9	
<b>young</b> 26:2 61:14	
86:25 125:18	
150:13 168:18	
197:19 212:8	
268:7	
<b>younger</b> 27:6	
156:4 224:14	
254:10 256:19	
<b>youth</b> 130:5	
135:23 233:9	
254:2 286:17	
292:2 295:24	
<b>youths</b> 268:4	
<b>z</b>	
<b>z</b> 91:2,2 305:8	
<b>zeal</b> 90:18	
<b>zebras</b> 252:6	

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS  
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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