No. D-1-GN-22-002569

PFLAG, Inc., et al., *Plaintiffs*, **v.** **Greg Abbott, et al.,** *Defendants*.	**In the District Court of** **Travis County, Texas** **459th Judicial District**

Defendants' Plea to the Jurisdiction

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THE RESOLUTION OF JURISDICTIONAL ISSUES MUST PRECEDE LITIGATION ON THE MERITS

Defendants' Plea must be heard prior to the parties beginning to litigate the merits of Plaintiffs' suit. It is a "**fundamental precept** that a court must not proceed on the merits of a case until legitimate challenges to its jurisdiction have been decided." *Tex. Dep't of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 228 (Tex. 2004) (emphasis added). When a governmental unit is denied a plea to the jurisdiction, it is entitled to an interlocutory appeal from that order. Tex. Civ. Prac. & Rem. Code § 51.014(a)(8). "The policy reasons for providing an interlocutory appeal from an order granting or denying a plea to the jurisdiction is the State should not have to expend resources in trying a case on the merits if it is immune from suit." *City of Galveston v. Gray*, 93 S.W.3d 587, 592 (Tex. App.—Houston [14th Dist.] 2002, pet. denied).

Thus, if a government agency is forced to litigate the merits of a suit before obtaining a ruling on its plea to the jurisdiction, it "stand[s] to lose their substantial rights to an interlocutory appeal *specifically provided* by the Legislature with the purpose of avoiding the expense of pretrial discovery and attending mediation." *Id.* (emphasis added); *see also City of Austin v. L.S. Ranch, Ltd.*, 970 S.W.2d 750, 753 (Tex.App.—Austin 1998, no pet.) (noting high cost of defending suit against governmental entity is ultimately borne by the public, providing motivation for allowing any jurisdictional issue to be resolved before merits of suit are litigated).

Defendants therefore ask this Court to issue a ruling on their Plea prior to any further litigation on the merits in order to ensure the preservation of state and judicial resources as well as avoid denying the State its entitlement to the very purpose of the Legislature's grant of interlocutory appeal.

INTRODUCTION

Plaintiffs consist of three sets of individuals, Voe, Roe, and Briggle, each with a transgender child, as well as one national organization, PFLAG, Inc., which purports to sue on behalf of its approximately 600 Texas members. Pls.' Compl. ¶¶5-6.

Plaintiffs claim that Defendants' policy of investigating alleged child abuse relating to the provision of puberty blockers and hormone therapy (collectively, "PBHT") to minors: (1) violates the Administrative Procedure Act's ("APA") rulemaking requirements; (2) violates the APA by interfering with parents' fundamental right to care for their children; (3) is *ultra vires*; (4) violates the separation of powers doctrine; (5) is void for vagueness; (6) violates their substantive due process rights to care for their children; and (7) denies them equal protection under the law on the basis of sex. *Id*. at ¶¶212-82.

On August 6, 2021, the Governor sent a letter to the Commissioner of the Department of Family and Protective Services (DFPS), Jaime Masters, asking DFPS to issue a determination whether genital mutilation (sex reassignment) of a child for purposes of gender transitioning through reassignment surgery constituted child abuse. Ex. A. The letter suggested that DFPS "should consider making explicit what is already implicit in the statute: that genital mutilation of a child through reassignment surgery is child abuse." *Id*. at 1.

On August 11, 2021, the Commissioner responded that surgical sex reassignment of a child "may cause a genuine threat of substantial harm from physical injury to a child" as defined under the Texas Family Code. Ex. B at 1. The response noted that "[w]hen medically necessary, this surgical procedure may not constitute abuse." *Id*. The letter concluded by acknowledging that all such allegations would be investigated. *Id*. at 2.

On February 18, 2022, the Office of the Attorney General released Opinion No. KP-0401, which concluded that some sex-change treatments and procedures for minors could constitute child abuse. Ex. C. In its own words, the "opinion does not address or apply to medically necessary procedures." *Id.* at 2. Instead, it focused on elective procedures and treatments that could result in permanent sterilization. The Attorney General opined that in some cases these procedures could constitute child abuse because of a child's inability to provide informed consent for such treatments and procedures. *Id.* at 7-8.

On February 22, 2022, the Governor wrote to the Commissioner and directed DFPS to follow the law as explained in the OAG opinion by investigating child abuse claims of this nature. Ex. D.

Since February 2022, DFPS has received a total of 11 reports involving the provision of PBHT to a minor that have advanced to investigations. Ex. E at ¶18; Ex. H at 230:24-231:2. DFPS conducted these investigations in the same way as any other report of alleged child abuse involving underlying medical issues or concerns. Ex. H at 262:15-263:2; *see also id*. Ex. E at ¶¶27-28. Reports that a child is transgender or transexual, without medical intervention, are screened and closed at intake. Ex. E at ¶28. To date, at least 8 out of the 11 reported cases have either been closed or are pending closure—either because the child was not taking PBHT or the child's treating medical providers provided information sufficient for DFPS verify that the treatments were medically necessary. Ex. E at ¶26; Ex. H at 233:19-234:7; Ex. I.

Among the Plaintiffs, Roe's and Briggle's investigations were closed by DFPS with a finding that child abuse was "ruled out." *Id.*; Ex. H at 240:7-12; Ex. H at 273:7-10. A "ruled out" finding means that DFPS did not find abuse or neglect of the child. Ex. H at 234:8-10. When a case

is ruled out, DFPS will not investigate subsequent reports involving the same conduct. *Id.* at 221:8-15.

On June 8, 2022, Plaintiffs filed this suit.

Among the named plaintiffs, only Voe has an open DFPS investigation; however, Voe refuses to sign a release permitting DFPS to obtain information sufficient to verify with the treatment providers that the provision of PBHT is medically necessary. *See* Voe Decl. ¶¶14, 33. This Court has enjoined Defendants from continuing their investigation of Voe. Temp. Inj. Order (July 8, 2022). Voe seemingly refuses to provide this information—which could result in a finding that child abuse is ruled out—because she is offended by the DFPS nomenclature categorizing all subjects of a child abuse complaint as "alleged perpetrators" during investigations or because she is concerned about what DFPS will discover upon speaking with the treatment providers. *See id*. at ¶¶26-27; *but see* Tex. Fam. Code § 261.303(c) (authorizing DFPS to seek a court order for the release of a child's medical records upon a showing of good cause); Tex. Fam. Code § 261.3031 (authorizing DFPS to seek court intervention when an alleged perpetrator refuses to cooperate with the investigation).

STANDARD OF REVIEW

A plea to the jurisdiction challenges the court's authority to determine the subject matter of the controversy. *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553–54 (Tex. 2000). "When a plea to the jurisdiction challenges the pleadings, [the court] determine[s] if the pleader has alleged facts that affirmatively demonstrate the court's jurisdiction to hear the cause." *Miranda*, 133 S.W.3d at 226. "If the pleadings affirmatively negate the existence of jurisdiction, then a plea to the jurisdiction may be granted without allowing the plaintiffs an opportunity to amend." *Id*. at

227. While a plea to the jurisdiction typically challenges "whether the plaintiff has alleged facts that affirmatively demonstrate the court's jurisdiction to hear the case," a plea can also "properly challenge the *existence* of those very jurisdictional facts." *Mission Consol. Indep. Sch. Dist. v. Garcia*, 372 S.W.3d 629, 635 (Tex. 2012) (emphasis in original). "In those situations, a trial court's review of a plea to the jurisdiction mirrors that of a traditional summary judgment motion." *Id.*

"Subject matter jurisdiction is essential to the authority of a court to decide a case." *Tex. Ass'n of Bus. v. Tex. Air Ctr. Bd.*, 852 S.W.2d 440, 443 (Tex. 1993). "Subject matter jurisdiction requires that the party bringing the suit have standing, that there be a live controversy between the parties, and that the case be justiciable." *State Bar of Tex. v. Gomez*, 891 S.W.2d 243, 245 (Tex. 1994). "One limit on courts' jurisdiction under both the state and federal constitutions is the separation of powers doctrine." *Tex. Ass'n of Bus.*, 852 S.W.2d at 444. When granting the relief sought would infringe, preempt, or usurp the inherent powers of another government authority, the Court lacks subject-matter jurisdiction. *See id.*; *Gomez*, 891 S.W.2d at 246.

ARGUMENTS & AUTHORITIES

I. PLAINTIFFS STIPULATED ON THE RECORD THAT THIS CASE INVOLVES ONLY THEIR APA CLAIMS.

"A party who abandons any part of his claim or defense, as contained in the pleadings, may have that fact entered of record, so as to show that the matters therein were not tried." Tex. R. Civ. P. 165; *In re Shaw*, 966 S.W.2d 174, 177 (Tex. App.—El Paso 1998, no pet.). Formal amendment of the pleadings is not required in order to show abandonment. *Id.* Indeed, a stipulation may form the basis for abandonment. *Id.*

A stipulation is an agreement, admission, or concession made in a judicial proceeding by the parties or their attorneys respecting some matter incident thereto. *Laredo Med. Group v. Jaimes*,

227 S.W.3d 170, 174 (Tex. App.—San Antonio 2007, pet. denied) (citing *Shepherd v. Ledford*, 962 S.W.2d 28, 33 (Tex.1998)). Where a stipulation limits the issues to be tried, those issues are excluded from consideration. *Id.* However, if a stipulation is ambiguous or unclear, it should be disregarded by the trial court. *Id.*; *Mann v. Fender*, 587 S.W.2d 188, 202 (Tex. Civ. App.—Waco 1979, writ ref'd n.r.e.). In construing a stipulation, a court must determine the intent of the parties from the language used in the entire agreement, examining the surrounding circumstances, including the state of the pleadings, the allegations made therein, and the attitude of the parties with respect to the issue. *Laredo*, 227 S.W.3d at 174. A stipulation should not be given greater effect than the parties intended, and should not be construed as an admission of a fact intended to be controverted. *Id.*; *see also Austin v. Austin*, 603 S.W.2d 204, 207 (Tex. 1980); *In re C.C.J.*, 244 S.W.3d 911, 921 (Tex. App.—Dallas 2008, no pet.)

Plaintiffs abandoned all non-APA claims during the temporary injunction hearing, stipulating that "**this is an APA challenge**. It is a rule of general applicability that. . . plaintiffs are alleging that defendants violated. It is not about any individual disposition of a case. It's about the procedural and substantive violations of the [APA]." Ex. H at 16:14-19. Plaintiffs' counsel repeatedly stated during the temporary injunction hearing that this matter involved only an APA challenge. *See, e.g. id.* at 24:13-15; 26:9-13; 28:1-11; 276:1-6. Plaintiffs' counsel also repeatedly stated that they did not need to make a showing of harm—an essential element of their non-APA claims—because this case involved **only** an APA challenge. *See id.* at 16:14-25. When undersigned counsel pointed out that Plaintiffs' expert witness testimony was irrelevant because Plaintiffs had abandoned their non-APA claims, Plaintiffs' counsel did not disagree and instead argued that their expert witness's testimony was still relevant under the arbitrary and capricious portion of their

APA challenge. *Id.* at 89:20-92:4. At that time, the Court acknowledged that Plaintiffs appeared to abandon all non-APA claims, but stated that it would wait until closing arguments to see what Plaintiffs' claims for relief were because "**that's not what [Plaintiffs'] pleadings say. . . and so I think we need to understand what their requested relief is and what [Plaintiffs are] claiming legally, because that's important to what's before the court**." *Id.* at 90:25-91:6 (emphasis added).

But, in closing, Plaintiffs' counsel reaffirmed their stipulation that this case is only about whether "DFPS and its Commissioner [have] acted and continue[] to act unlawfully **violating both substantive and procedural APA rules** in establishing a new presumption of abuse by parents with trans young people triggering investigations based solely on that care and prioritizing in an unprecedented way. The plaintiffs have shown a cause of action probable right of recovery as to those claims." *Id.* at 485, 271:14-21 (emphasis added). Finally, Plaintiffs' counsel added, "so with respect to, again, Commissioner Masters and the Department, DFPS, the rule was adopted without following the necessary procedures of the APA. It's contrary to the enabling statute." *Id.* at 276:1-6. The words "due process," "separation of powers," "equal protection," "void for vagueness," "substantive due process," and "*ultra vires*" were never uttered by Plaintiffs' counsel during the hearing; consequently, Plaintiffs have stipulated to the abandonment of these claims.

II. ROE AND BRIGGLE'S CLAIMS ARE MOOT.

A case becomes moot when a justiciable controversy between the parties ceases to exist or when the parties cease to have a legally cognizable interest in the outcome. *See Williams v. Lara*, 52 S.W.3d 171, 184 (Tex. 2001). Mootness occurs when events make it impossible for the court to

grant the relief requested or otherwise affect the parties' rights or interests. *See Heckman v. Williamson County*, 369 S.W.3d 137, 162 (Tex. 2012). When a case becomes moot, the court loses jurisdiction, because any decision would constitute an advisory opinion that is "outside the jurisdiction conferred by Texas Constitution article II, section 1." *Matthews v. Kountze Indep. Sch. Dist.*, 484 S.W.3d 416, 418 (Tex. 2016); *see also Iweanya v. Nat'l Alumni Ass'n of Queen's Sch. Enugu USA, Inc.*, No. 14-21-00311-CV, 2022 WL 4376744, at *3 (Tex. App.—Houston [14th Dist.] Sept. 22, 2022, no pet. h.). If a case is or becomes moot, the court must vacate any order or judgment previously issued and dismiss the case for want of jurisdiction. *See Speer v. Presbyterian Children's Home & Serv. Agency*, 847 S.W.2d 227, 229–30 (Tex.1993); s*ee also Texas Quarter Horse Ass'n v. American Legion Dep't*, 496 S.W.3d 175, 180-82 (Tex. App.—Austin 2016, no pet.) (discussing justiciability doctrines including mootness).

In *Jefferson*, the Third Court of Appeals concluded that the Veterinary Board's dismissal with prejudice of a pending enforcement action mooted a veterinarian's declaratory judgment suit challenging that action. *Tex. State Bd. of Veterinary Med. Examiners v. Jefferson*, No. 03-14-00774-CV, 2016 WL 768778, at *5 (Tex. App.—Austin Feb. 26, 2016, no pet.). The veterinarian, Jefferson, argued that the Veterinary Board refused to disavow the stance it took during the prior enforcement action and without a permanent injunction it could bring the same claims against her in a subsequent proceeding. *Id*. at 6. The Third Court of Appeals disagreed, holding that the Veterinary Board was precluded from bringing an enforcement action raising the same claims, and involving the same conduct, against Jefferson. *Id.* It also noted the significance that counsel for the Veterinary Board assured it that the agency would not institute new disciplinary proceedings against Jefferson for the same conduct, absent some material change in circumstances. *Id.*

The Roe and Briggle claims are moot because DFPS closed their investigations with a finding that child abuse was ruled out. Ex. I; *see also* Ex. H at 240:7-12. A "ruled out" finding means that DFPS did not find abuse or neglect of the child. Ex. H at 234:8-10. When a case is ruled out, DFPS will not investigate subsequent reports involving the same conduct. *Id.* at 221:8-15. DFPS rules provide that "both SWI screeners and investigations supervisory staff may close a report without assigning for investigation if they determine, after contacting collateral sources, that the report is not appropriate for an investigation by us for reasons including: (A) the reported information has already been investigated in a case closed before the date of the new intake. . .." 40 Tex. Admin. Code § 707.489(b)(2)(A); *see also id.* § 707.489(c)(1)(A) (cases may be administratively closed if they have already been investigated). The DFPS Policy Handbook § 2314 (Ex. J) provides for the following procedure when a case has previously been investigated and closed with a ruled out finding:

> The caseworker submits an investigation for administrative closure if, at any point in the investigation, the caseworker determines that both of the following apply:
> - CPI has already investigated or addressed the same incidents and allegations in a previous case that was closed prior to the date of the new intake.
> - There are no new incidents or new allegations in the current case.
>
> The caseworker does the following:
> - Documents the case number of the closed case and explains how information in the new report was addressed in the closed investigation.
> - Submits the investigation for administrative closure as soon as possible, but no later than seven calendar days, after making the determination.
> - Merges the case with the previous case.

In sum, DFPS rules and policy provide that it will not investigate Roe and Briggle again for providing PBHT to their respective children absent some additional allegation(s). Yet, like *Jefferson*, the relief sought by Roe and Briggle is a permanent injunction preventing the agency from doing something it already will not do—investigate them again for providing PBHT to their

respective children. In other words, just as in *Jefferson*, Roe and Briggle seek a relief they have already received. There is no justiciable dispute between the parties. "A case becomes moot when: (1) it appears that one seeks to obtain a judgment on some controversy, when in reality none exists; or (2) when one seeks a judgment on some matter which, when rendered for any reason, cannot have any practical legal effect on a then-existing controversy." *Bexar Metro. Water Dist. v. City of Bulverde*, 234 S.W.3d 126, 131 (Tex. App.—Austin 2007, no pet.). Roe and Briggle will not be investigated again on the sole basis of providing PBHT to their respective children. Thus, their claims, like those in *Jefferson*, are moot.

III. PLAINTIFFS' CLAIMS ARE NOT RIPE.

Ripeness is a threshold issue that implicates the trial court's subject matter jurisdiction. *Waco Indep. Sch. Dist. v. Gibson*, 22 S.W.3d 849, 851 (Tex. 2000); *Rea v. State*, 297 S.W.3d 379, 383 (Tex. App.—Austin 2009, no pet.). A claim is ripe if, at the time the lawsuit was filed, the facts involved show that "'an injury has occurred or is likely to occur.'" *City of Austin v. Whittington*, 385 S.W.3d 28, 33 (Tex. App.—Austin 2007, no pet.) (quoting *Patterson v. Planned Parenthood of Houston & Se. Tex., Inc.*, 971 S.W.2d 439, 442 (Tex. 1998)). In other words, there must be a concrete injury for the claim to be ripe. *See Atmos Energy Corp. v. Abbott*, 127 S.W.3d 852, 857 (Tex. App.—Austin 2004, no pet.). A case is not ripe when its resolution depends on contingent or hypothetical facts, or upon events that have not yet come to pass. *City of Austin*, 385 S.W.3d at 33.

To determine whether a plaintiff's claims are ripe, courts look to the facts and evidence existing when the suit was filed. *Lindig v. City of Johnson City*, No. 03-08-00574-CV, 2009 WL 3400982, at *5 (Tex. App.—Austin Oct. 21, 2009, no pet.) (mem. op.) (citing *Waco Indep. Sch. Dist.*, 22 S.W.3d at 851-52). Courts review "the entire record to ascertain if any evidence supports

the trial court's subject matter jurisdiction." *Perry v. Del Rio*, 66 S.W.3d 239, 260 (Tex. 2001); *see also Waco Indep. Sch. Dist.*, 22 S.W.3d at 853. A plea to the jurisdiction is properly granted if the plaintiff "cannot demonstrate a reasonable likelihood that the claim will soon ripen." *See Drexel Corp. v. Edgewood Dev., Ltd.*, 14-13-00353-CV, 2013 WL 5947007, at *3 (Tex. App.—Houston [14th Dist.] Nov. 7, 2013, no pet.) (internal quotations omitted).

Declaratory judgment actions are subject to a ripeness review. *See Firemen's Ins. Co. of Newark, N.J. v. Burch*, 442 S.W.2d 331, 333 (Tex. 1968) (holding Declaratory Judgments Act does not empower courts to issue advisory opinions). Texas courts have held that a declaratory judgment action is premature if governmental proceedings which will impact the parties' respective rights remain pending. In *Save Our Springs Alliance v. City of Austin*, the court held that the trial court lacked jurisdiction to grant a declaratory judgment that a development agreement was invalid because no permit had yet been issued. 149 S.W.3d 674, 678 (Tex. App.—Austin 2004, no pet.). In *Texas A&M University v. Hole*, the Waco court held that a declaratory judgment action concerning student disciplinary proceedings was not ripe because the students had not yet completed the disciplinary process. 194 S.W.3d 591, 593 (Tex. App.—Waco 2006, pet. denied); *see also Tex. Ass'n of Bus.*, 852 S.W.2d at 444 (holding the Declaratory Judgments Act does not enlarge the court's jurisdiction but merely provides a procedural device for deciding cases already within that jurisdiction); *Tex. Bay Cherry Hill, L.P. v. City of Fort Worth*, 257 S.W.3d 379, 393 (Tex. App.—Fort Worth 2008, no pet.).

In *Rea*, a Texas Medical Board investigation and expert panel concluded that Rea, a physician, likely violated the Texas Medical Practice Act. *Rea*, 297 S.W.3d at 381. An Informal Settlement Conference was held that resulted in a referral to State Office of Administrative

Hearings ("SOAH") to adjudicate the dispute. *Id.* at 382. While the case was pending at SOAH, Rea brought a declaratory judgment action in district court alleging that the Medical Board violated the APA and his constitutional rights during the investigation giving rise to the pending enforcement action. *Id.* The Third Court of Appeals considered and rejected these claims, holding that Rea's claims were not yet ripe because the no final agency action had been taken. *Id.* at 383-84. The Third Court of Appeals explicitly rejected the contention that being investigated by the Texas Medical Board and being made a party to an enforcement action at SOAH, despite the associated time and costs, were concrete harms making Rea's claims ripe for judicial review because no final agency determination had been made. *Id.* at 384.

In *Gates*, the plaintiff brought a declaratory judgment suit alleging due process and equal protection violations arising from DFPS's investigation of reported child abuse that resulted in her placement on its central child abuse registry, and the administrative appeals process challenging that designation. *Gates v. DFPS*, No. 03-11-00363-CV, 2013 WL 4487534, at *1 (Tex. App.—Austin Aug. 15, 2013, pet. denied) (mem. op.). The Third Court of Appeals found that plaintiff lacked standing and her claims were not ripe because "the parent's relationship with her children was not legally affected by [DFPS's] actions." *Id.* at *4 (citing *L.C. v. DFPS*, No. 03-07-00055-CV, 2009 WL 3806158 (Tex. App.—Austin Nov. 13, 2009, no pet.). The Court noted that the plaintiff "did not lose custody or visitation of her children or otherwise have her parental rights affected in any way." *Id.* Finally, the Third Court found that "[w]hatever disruption or disintegration of family life the [parent] may have suffered as a result of **[a] child abuse investigation does not, in and of itself, constitute a constitutional deprivation**." *Id.* at 5 (quoting *Croft v. Westmoreland Cnty. Children & Youth Servs.*, 103 F.3d 1123, 1125–26 (3rd

Cir.1997)) (emphasis added).

Plaintiffs' claims, like those in *Rea* and *Gates*, are not yet ripe because no court order has been obtained that impacts their parent-child relationships. DFPS is required to investigate reports of child abuse and neglect; however, it generally does not have the authority to intervene in the parent-child relationship without a court order. *See* DFPS Handbook Ch. 5000 (CPS Legal Functions); *see also* Tex. Fam. Code § 261.501 (protective orders); *id.* at § 262.101 *et seq.* (taking possession of a child). Thus far, DFPS has closed nearly all cases involving the provision of PBHT to minors with a finding of "ruled out." The cases that remain are only unresolved because the Court has either enjoined DFPS from completing its investigations, or the families are refusing to cooperate with the investigations. No court proceedings have been initiated to remove any children. Unless, and until, DFPS obtains a final court order affecting their parent-child relationships, Plaintiffs' claims are not yet ripe for review.

Alternatively, Plaintiffs' claims are not yet ripe for review because DFPS has not made an initial determination that they engaged in child abuse. *Rea*, 297 S.W.3d at 383–84 (The finality requirement—in the context of ripeness—concerns whether the initial decision-maker has arrived at a definitive position on the issue that inflicts an actual, concrete injury).; *but see Patel v. Tex. Dep't of Licensing & Regulation*, 469 S.W.3d 69 (Tex. 2015) (finding that plaintiffs had standing and their claims were ripe where there was no dispute they were in violation of the regulation, they had received two prior warnings, and the agency had initiated disciplinary proceedings against them). Here, the initial decision-maker, DFPS, has not arrived at a definitive position that would inflict concrete harm on the Plaintiffs, so Plaintiffs' claims are not yet ripe. Unless, and until, DFPS concludes that Plaintiffs engaged in child abuse, and it then seeks court intervention, their claims

are not yet ripe.

IV. Plaintiffs Lack Standing.[1]

Constitutional standing is the doctrine that plaintiffs must have standing to sue. *Heckman v. Williamson County,* 369 S.W.3d 137, 154-55 (Tex. 2012). Standing requires a concrete personal injury traceable to the defendant's conduct, and the relief requested is likely to redress that injury. *Id*. Subject matter jurisdiction requires a plaintiff bringing suit to have standing to do so. *Tex. Ass'n of Bus.*, 852 S.W.2d at 443–45. In this respect, Texas's standing requirements parallel federal standing doctrine. *Id*. at 154. To have standing, the plaintiff must show an "'injury in fact,' an invasion of a legally protected interest that is concrete and particularized, and that is actual or imminent rather than conjectural or hypothetical." *Save Our Springs Alliance, Inc. v. City of Dripping Springs*, 304 S.W.3d 871, 878 (Tex. App.—Austin 2010, pet. denied) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992)).

In addition to the constitutional standing requirements, APA declaratory judgment actions challenging agency rules must also show that "the rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right or privilege of the plaintiff." Tex. Gov't Code § 2001.038(a).[2]

At the temporary injunction hearing, Plaintiffs' counsel ping-ponged between falsely claiming that no showing of harm is necessary to bring an APA rule challenge and claiming that the DFPS investigations themselves were the sole cause of Plaintiffs' harm by interfering with their

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[1] Because they are interrelated legal concepts, Defendants herein adopt and incorporate by reference the arguments in the preceding section on ripeness.

[2] If, indeed, this case involves only an APA challenge, then this court or either party could move to remove this case immediately to the Third Court of Appeals for resolution. Tex. Gov't Code § 2001.038(f).

parent-child relationships. Ex. H at 272:18-273:6 ("To be clear, this is not about any single investigation. All of these investigations have caused harm that is imminent and irreparable. . . based solely on, again, the investigation being[] unlawful. . ..."). The declarations and testimony from the Plaintiffs similarly show that—at its core—their alleged harm is being the subject of DFPS investigations, or their fear that they might become the subject of a DFPS investigation.

But the Third Court of Appeals has already held that DFPS *investigations* do not interfere with, impair, or threaten the legal rights or privileges of alleged perpetrators. *Gates*, 2013 WL 4487534 at *4-5. At most, the alleged rule authorizing DFPS investigations does no more than permit DFPS to conduct investigations. It must still seek court intervention prior to any action that could legally impact the parent-child relationship. *In re Abbott*, 645 S.W.3d 276, 282 (Tex. 2022). Thus, Plaintiffs lack standing because the DFPS investigations, and the purported rule authorizing them, do not, in and of themselves, interfere with, impair, or threaten the legal rights of Plaintiffs.

V. PLAINTIFFS' CLAIMS ARE BARRED BY THE SEPARATION OF POWERS DOCTRINE.

"[L]imits on judicial power are as important as its reach." *American K-9 Detection Servs., LLC v. Freeman*, 556 S.W.3d 246, 252 (Tex. 2018). "'The province of the court,' Chief Justice Marshall wrote, 'is, solely, to decide on the rights of individuals, not to inquire how the executive or executive officers, perform duties in which they have a discretion.'" *Id.* (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 170 (1803)). When allowing a case to proceed would violate the Texas Constitution's separation-of-powers principles, subject-matter jurisdiction is implicated. *See Van Dorn Preston v. M1 Support Servs., L.P.*, 642 S.W.3d 452, 457–59 (Tex. 2022) (discussing the Texas Constitution's separation-of-powers principles in the context of the political question doctrine).

"[T]he Texas Constitution expressly enshrines the separation of powers as a fundamental principal of limited government." *Van Dorn Preston*, 642 S.W.3d at 458. The Texas Constitution, like the U.S. Constitution, divides the powers of government into legislative, executive, and judicial departments, "and no person, or collection of persons, being of one of these departments, shall exercise any power properly attached to either of the others, except in the instances herein expressly permitted." Tex. Const. art. II, § 1. "The separation of powers doctrine prohibits one branch of state government from exercising power inherently belonging to another branch of state government." *Hotze v. City of Houston*, 339 S.W.3d 809, 818 (Tex. App.—Austin 2011, no pet.). The "doctrine means that a 'public officer or body may not exercise or otherwise interfere with a power constitutionally assigned to another public officer or body, nor may either surrender its own constitutionally assigned power, referring in all cases to the 'mass' of its powers or any 'core' paramount power.'"[3] *Univ. of Tex. Health Sci. Ctr. at San Antonio v. Mata & Bordini, Inc.*, 2 S.W.3d 312, 316 (Tex. App.—San Antonio 1999, pet. denied). The doctrine "was designed, as were other checks and balances, to prevent excesses." *Coates v. Windham*, 613 S.W.2d 572, 576 (Tex. App.—Austin 1981, no writ). "The textual difference between the United States and Texas constitutions suggests that Texas would more aggressively enforce separation of powers between its governmental branches than would the federal government." *State v. Rhine*, 297 S.W.3d 301, 316 (Tex. Crim. App. 2009) (Keller, J., concurring).

"The Separation of Powers Clause is violated (1) when one branch of government assumes power more properly attached to another branch or (2) when one branch unduly interferes with

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[3] For example, "[s]ince only the Legislature can waive the right of the State to immunity from suit, neither the executive [n]or judicial branches of the State government may exercise such power." *Dep't of Pub. Safety of Tex. v. Great Sw. Warehouses, Inc.*, 352 S.W.2d 493, 495 (Tex. App.—Austin 1961, writ ref'd n.r.e.).

another branch so that the other cannot effectively exercise its constitutionally assigned powers." *In re D.W.*, 249 S.W.3d 625, 635 (Tex. App.—Fort Worth 2008, pet. denied); *see also Black v. Dallas Cnty. Bail Bond Bd.*, 882 S.W.2d 434, 438 (Tex. App.—Dallas 1994, no writ) (same); *DFPS v. Dickensheets*, 274 S.W.3d 150, 156 (Tex. App.—Houston [1st Dist.] 2008, no pet.) (same). "To determine whether a separation of powers violation involving 'undue interference' has occurred, [courts] engage in a two-part inquiry." *Tex. Comm'n on Env'l Quality v. Abbott*, 311 S.W.3d 663, 672 (Tex. App.—Austin 2010, pet. denied). Courts first look to the scope of the powers constitutionally assigned to the first governmental actor and then to the impact on those powers imposed by the second. *See id.*

The Legislature has assigned to DFPS, an agency in the executive branch, the authority to investigate allegations of child abuse on behalf of the State. The judicial branch violates the separation of powers doctrine to the extent it seeks to usurp the investigative authority and decision-making exclusively within the executive branch's authority. Before DFPS can impose consequences on a family beyond an investigation, it generally must seek court orders authorizing it to intervene. *See generally* Tex. Fam. Code § 262.001 *et seq*. As the Texas Supreme Court recently explained:

> DFPS does not need permission from courts to investigate. . .. The normal judicial role in this process is to act as the gatekeeper against unlawful interference in the parent–child relationship, not to act as overseer of DFPS's initial, executive-branch decision to investigate whether allegations of abuse may justify the pursuit of court orders.

In re Abbott, 645 S.W.3d 276, 282 (Tex. 2022) (emphasis added). As the Supreme Court noted, the authority to conduct investigations is firmly entrenched within the executive branch, while the judicial branch acts as the gatekeeper before any action is taken affecting the parent-child relationship. The separation of powers doctrine deprives this court of subject matter jurisdiction

to require DFPS to obtain its permission prior to conducting certain types of investigations involving alleged child abuse.

VI. The DFPS Commissioner is Immune from Plaintiffs' APA Claim.

Plaintiffs contend that a February 22, 2022 DFPS press statement that it would follow Texas law as explained in Opinion KP-0401 constitutes a rule under the APA, but was adopted without going through the formal rulemaking process. Pls.'Compl. ¶217.

"Not every statement by an administrative agency is a rule for which the APA prescribes procedures for adoption and for judicial review." *Tex. Educ. Agency v. Leeper*, 893 S.W.2d 432, 443 (Tex. 1994). For APA purposes, a "rule" is "a state agency statement of general applicability that: (i) implements, interprets, or prescribes law or policy; or (ii) describes the procedure or practice requirements of a state agency." Tex. Gov't Code § 2001.003(6)(A).

The DFPS statement was not a rule because it was not a statement of general applicability that implements, interprets, or prescribes a law or policy. *Id.*; *R.R. Comm'n of Tex. v. WBD Oil & Gas Co.*, 104 S.W.3d 69, 79 (Tex. 2003) (the term "general applicability" under the APA references "statements that affect the interest of the public at large such that they cannot be given the effect of law without public input," as contrasted with statements made in determining individual rights). The DFPS statement at issue in this case merely stated that the agency would "follow Texas law as explained in Attorney General opinion KP-0401. . . [and] if any such allegations are reported to us they will be investigated under existing policies." Texas law already prohibits female genital mutilation, Tex. Health & Safety Code § 167.001, impairing a child's growth and development, Tex. Fam. Code § 261.001(1)(a), and allowing, permitting or encouraging a child to use a controlled substance (*e.g.*, testosterone), *id.* § 261.001(k). So, the

DFPS statement cannot be said to be implementing, interpreting, or prescribing a *new* law or policy. On the contrary, this is exactly the type of "informal agency statement that does no more than merely restate its own formally promulgated rules would not in itself be a rule." *Teladoc, Inc. v. Tex. Med. Bd.*, 453 S.W.3d 606, 616 (Tex. App.—Austin 2014, pet. denied); *accord Texas Dep't of Pub. Safety v. Salazar*, 304 S.W.3d 896, 904 (Tex. App.—Austin 2009, no pet.) (DPS internal memorandum prescribing that drivers' licenses will include statement of bearer's immigration status "merely reiterates" rule already imposing that requirement). The DFPS statement merely said that it would continue to comply with the law, as interpreted by the Attorney General—it did not create a rule.

Moreover, a ruling otherwise would lead to the absurd result that a state agency silently relying on an Attorney General opinion is *not* adopting a rule, but if it acknowledges that it is relying on the Attorney General's opinion then it *is* adopting a rule. Tex. Gov't Code § 2001.003(6)(A) (defining a "rule" as "a state agency statement"). The Attorney General is authorized to issue opinions by the Texas Constitution and the Texas Government Code. *See* Tex. Const. art. IV, § 22; Tex. Gov't Code § 402.042-43. The opinions of the Attorney General are not controlling authority, *Skypark Aviation, LLC v. Lind*, 523 S.W.3d 869 (Tex. App.—Eastland 2017, no pet.), and are not binding on the courts, *In re Texas Dept. of State Health Services*, 278 S.W.3d 1 (Tex. App.—Austin 2008, no pet.), but may be considered as persuasive, *id.*, and are entitled to great weight, *Southwestern Bell Telephone Co. v. Combs*, 270 S.W.3d 249 (Tex. App.—Amarillo 2008, pet. denied), and careful consideration, *Treadway v. Holder*, 309 S.W.3d 780 (Tex. App.—Austin 2010, pet. denied), unless clearly wrong. *Broom v. Tyler County Com'rs Court*, 560 S.W.2d 435 (Tex. Civ. App.—Beaumont 1977, no writ). State agencies regularly rely on the Attorney General's opinions

interpreting the law. Yet, Plaintiffs ask this Court to find that those agencies must first go through the formal rulemaking process before they can rely on the Attorney General's opinions. Such a process would be unduly burdensome and against public policy—as would a holding encouraging state agencies to silently rely on Attorney General opinions lest their actions be construed as adopting an agency rule.

Alternatively, even if the press statement could be considered a rule, it would fall within an express exception. The APA excludes from the definition of "rule" a "statement regarding only the internal management or organization of a state agency and not affecting private rights or procedures." Tex. Gov't Code § 2001.003(6)(C). "[S]uch statements have no legal effect on private persons absent a statute that so provides or some attempt by the agency to enforce its statement against a private person," neither of which applies here. *Brinkley v. Tex. Lottery Comm'n*, 986 S.W.2d 764, 770 (Tex. App.—Austin 1999, no pet.). "Although the distinction between a 'rule' and an agency statement that concerns only 'internal management or organization. . . and not affecting private rights' may sometimes be elusive, the core concept is that the agency statement must in itself have a binding effect on private parties." *Slay v. Tex. Comm'n on Envtl. Quality*, 351 S.W.3d 532, 546 (Tex. App.—Austin 2011, pet. denied) (footnote omitted).

At most, the press statement about which Plaintiffs complain suggests that DFPS applies the law as set out in the Attorney General's opinion when investigating and identifying child abuse. That would not "itself have a binding effect on private parties." *Id.* In the child-abuse context, private rights may be affected when an abuser is found guilty of a crime or when a child is removed from a home, but the press statement does neither of those things. Even if the press statement itself caused investigations (and there is no reason to think it has or will), an investigation does not affect

private rights. Investigations are what the agency does to determine whether it would be proper for it to try to convince a decisionmaker—a Texas judge—to affect private rights. So too here. The press statement does not bind the agency to any attempt to affect private rights, much less any determination about a particular complaint. And the fact that an individual would prefer not to be investigated for child abuse does not mean that private rights have been affected, much less determined. *See Salazar*, 304 S.W.3d at 905 (special formatting for non-citizens' drivers licenses has no "legal effect on private persons" because the licenses "remain valid").

VII. PLAINTIFFS' *ULTRA VIRES* CLAIMS LACK MERIT.

An *ultra vires* action succeeds only if a plaintiff proves that an "'officer acted without legal authority or failed to perform a purely ministerial act.'" *Hall v. McRaven*, 508 S.W.3d 232, 238 (Tex. 2017) (cleaned up). Neither the Governor's letter nor the Commissioner's agreement with it meets this standard.

The Supreme Court has already reviewed the Governor's letter at issue here, as well as the Attorney General opinion to which it refers, and found that "[t]he Governor and the Attorney General were certainly well within their rights to state their legal and policy views on this topic." *In re Abbott*, 645 S.W.3d at 281. There is nothing *ultra vires* about the Governor's decision to send a letter to DFPS.

In any event, the Governor's letter did not cause the injury Plaintiffs claim, namely, DFPS's initiation of investigations. That decision came from DFPS, which continued its investigations into the Voe, Roe, and Briggle allegations even after the Supreme Court's prior decision in this matter. *Id.* Even if the Governor's letter prompted DFPS to make its decision, there is no chance DFPS mistakenly believed it was bound by that letter.

Nor did the Commissioner act beyond her authority when she agreed with the Governor's and Attorney General's interpretation of the law. For that to be true, it would have to be true "that any legal mistake is an *ultra vires* act," but that is "[n]ot so." *Hall*, 508 S.W.3d at 241. So long as a mistaken conclusion is not made while "exceed[ing] the scope of [an agency's] authority," that mistaken conclusion is not *ultra vires*. *Schroeder v. Escalera Ranch Owners' Ass'n, Inc.*, 646 S.W.3d 329, 335 (Tex. 2022). The Legislature granted to DFPS the statutory responsibility to "make a prompt and thorough investigation of a report of child abuse or neglect." *In re Abbott*, 645 S.W.3d at 281 (citing Tex. Fam. Code § 261.301(a)). And "when deciding whether and how to exercise that authority, DFPS . . . naturally must assess whether a report it receives is actually 'a report of child abuse or neglect.'" *Id.* Even if the Governor, the Attorney General, and the Commissioner were wrong on the law—and they were not—the Commissioner's decision to initiate investigations could not be *ultra vires* because it was made while she was exercising authority specifically vested in DFPS: deciding whether a report of potential abuse warrants investigation.

Nor does any decision by DFPS to find the Attorney General or Governor's opinions helpful exceed its authority. The Commissioner has the authority to "oversee the development and implementation of policies and guidelines needed for the administration of [DFPS's] functions." Tex. Human Res. Code § 40.027(c)(2). The Commissioner, that is, has the authority to decide that the Attorney General's explanation of the Family Code is persuasive. Plaintiffs' suggestion that this decision violated DFPS's general statutory duty to protect children and support families misinterprets both that duty and the Commissioner's authority; disagreements about discretionary questions or conclusions about the best way to help children cannot be superintended through *ultra vires* suits. *City of El Paso v. Heinrich*, 284 S.W.3d 366, 372 (Tex.

2009).

VIII. DEFENDANTS ARE IMMUNE FROM PLAINTIFFS' CONSTITUTIONAL CLAIMS.

Defendants are entitled to sovereign immunity from Plaintiffs' claims under the Texas Constitution because they have failed to plead a viable claim. *See, e.g., City of Houston v. Johnson*, 353 S.W.3d 499, 504 (Tex. App.—Houston [14th Dist.] 2011, pet. denied) ("[I]f the plaintiff fails to plead a viable claim, a governmental defendant remains immune from suit for alleged [Constitution] violations.").

A. Separation of Powers.

Plaintiffs' separation of powers claim against the Governor and the Commissioner is not viable. Appellees claim that the Governor violated the separation of powers doctrine and usurped the authority of the legislature by authoring a letter to DFPS, but the separation of powers doctrine does not bar the Governor from writing to an agency head that the agency should follow the law as set forth in an Attorney General opinion. The Governor's letter does not purport to change the law; it notes that the Attorney General's opinion confirmed the state of "existing Texas law" and states that "DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401." Ex. D at 1-2. The Supreme Court has already rejected the notion that this violates the law, explaining that the Governor "ha[s] every right to express [his] views on DFPS's decisions and to seek, within the law, to influence those decisions[.]" *In re Abbott*, 645 S.W.3d at 281.

Plaintiffs also claim the Commissioner and Governor have violated the separation of powers by interpreting what conduct meets the definition of "child abuse" in current law. Pls. Compl. ¶¶258-59. But neither the Commissioner nor the Governor has purported to change Texas law; they have enforced the already existing definition of abuse provided in the Family Code. Tex.

Fam. Code § 261.001(1). Exs. A-B, D.

B. Equal Protection

Nor do Plaintiffs have an equal protection claim based on sex. The Texas Constitution's Equal Protection Clause guarantees that all free persons have equal rights and those rights "shall not be denied or abridged because of sex, race, color, creed, or national origin." Tex. Const. art. I, §§ 3, 3a. Pleading a claim under this clause requires two steps. First, "determine whether equality under the law has been denied." *In re McLean*, 725 S.W.2d 696, 697 (Tex. 1987). Next, determine "whether equality was denied because of a person's membership in a protected class of sex, race, color, creed, or national origin." *Id.*

Plaintiffs cannot satisfy either step. Plaintiffs assert that post-*Bostock*, discrimination on the basis of transgender status entails discrimination based on sex. *Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1747 (2020); *cf. Tarrant Cty. Coll. Dist. v. Sims*, 621 S.W.3d 323, 329 (Tex. App.—Dallas 2021, no pet.). But neither the Governor's letter nor the DFPS statement mentions transgender youth, much less suggests that they should be treated differently than non-transgender youth. And even if they did, the distinction made is not based on transgender status, but rather on the age of the individual and/or the individual's medical diagnosis. PBHTs, endocrine drugs, are not approved by the FDA for use on children with gender dysphoria, a psychological condition.[4] It does not violate equal protection rights to approve the use of medication on one group of patients with a particular diagnosis but not on another dissimilar group with an entirely different diagnosis that the medication is not approved for.

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[4] For example, a child much younger than the normal age to begin puberty that has been diagnosed with the *endocrine* condition - central precocious puberty – which requires delaying puberty until the normal age of onset.

C. Void for Vagueness

Plaintiffs' claim that the so-called rule authorizing DFPS investigations relating to the provision of PBHT to children is unconstitutionally vague because it could include medically necessary treatment. Pls. Compl. ¶¶272-74.

A due process violation occurs when the conduct that is prohibited is stated in such vague terms that people of common intelligence must guess at what is required. *See King Street Patriots v. Texas Democratic Party*, 521 S.W.3d 729, 743 (Tex. 2017) ("When persons of common intelligence are compelled to guess a law′s meaning and applicability, the law violates due process and is invalid.") (internal citations omitted).

Plaintiff's vagueness claims are without merit. The Attorney General's opinion, Ex. C, explicitly states that it did not address medically necessary treatment. And DFPS has ruled out all investigations upon a showing of sufficient evidence that the child's treatment provider deems the provision of PBHT to them to be medically necessary. Ex. E at ¶26; Ex. H at 233:19-234:7.

D. Substantive Due Process

Plaintiffs' claim that the DFPS investigations interfere with their substantive due process and fundamental rights to care for their children.

But the Texas Supreme Court previously considered and rejected the same arguments made by Plaintiff, holding that "DFPS's preliminary authority to investigate allegations does not entail the ultimate authority to interfere with parents' decisions about their children, decisions which enjoy some measure of constitutional protection whether the government agrees with them or not." *In re Abbott*, 645 S.W.3d at 281–82 (emphasis added). The investigation itself does not interfere with their rights, and before any interference can occur, DFPS must seek court

intervention. *Id*.

These claims lack merit and, therefore, do no waive sovereign immunity.

IX. THE UDJA DOES NOT ABROGATE SOVEREIGN IMMUNITY.

Finally, the Uniform Declaratory Judgment Act does not help Plaintiffs avoid sovereign immunity. The UDJA does not enlarge the courts' jurisdiction beyond an implied, limited waiver of immunity for constitutional challenges to ordinances or statutes. *Tex. Dep't of Transp. v. Sefzik*, 355 S.W.3d 618, 621-22 (Tex. 2011) (per curiam); *see* Tex. Civ. Prac. & Rem. Code § 37.006(b). Plaintiffs do not challenge an ordinance or a statute; they contend Defendants have misinterpreted a statute. Pls. Compl. At ¶¶ 212-82. The UDJA's limited waiver does not extend to a "bare statutory construction claim[]" like that. *McLane Co. v. Tex. Alcoholic Beverage Comm'n*, 514 S.W.3d 871, 876 (Tex. App.—Austin 2017, pet. denied); *see Sefzik*, 355 S.W.3d at 622.3.[5]

CONCLUSION

For the foregoing reasons, Defendants respectfully request that the Court GRANT this Plea to the Jurisdiction and dismiss Plaintiffs' claims, and any further relief to which they are justly entitled.

Respectfully Submitted.

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[5] And to the extent Plaintiffs mean to invoke the UDJA in support of claims against the Governor or Commissioner, they cannot. The UDJA authorizes suit against governmental units, not *ultra vires* claims against officials. *See Patel*, 469 S.W.3d at 77.

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CERTIFICATE OF SERVICE

I, **COURTNEY CORBELLO**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on November 4, 2022 to:

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NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
V.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit A

Letter from Governor Abbott to Commissioner Masters (Aug. 6, 2021)

GOVERNOR GREG ABBOTT

August 6, 2021

The Honorable Jaime Masters
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

The Texas Department of Family and Protective Services (DFPS) is responsible for protecting children from abuse. Please issue a determination of whether genital mutilation of a child for purposes of gender transitioning through reassignment surgery constitutes child abuse.

Subjecting a child to genital mutilation through reassignment surgery creates a "genuine threat of substantial harm from physical injury to the child." TEX. FAM. CODE § 261.001(1)(C). This broad definition of "abuse" should cover a surgical procedure that will sterilize the child, such as orchiectomy or hysterectomy, or remove otherwise healthy body parts, such as penectomy or mastectomy. Indeed, Texas already outlaws female genital mutilation of a child, and presumably that also constitutes child abuse. *See* TEX. HEALTH & SAFETY CODE § 167.001.

DFPS's determination should consider making explicit what is already implicit in the statute: that genital mutilation of a child through reassignment surgery is child abuse. The determination should consider whether an exception should be made for medically necessary procedures for a child whose body parts have been affected by illness or trauma; who is born with a medically verifiable genetic disorder of sex development, such as the presence of both ovarian and testicular tissue; or who does not have the normal sex chromosome structure for male or female as determined through genetic testing.

After clarifying whether genital mutilation of a child through reassignment surgery is child abuse, it may be useful to explain the reporting requirements for all licensed professionals who have direct contact with children who may be subject to that abuse, including doctors, nurses, and teachers, as well as the penalties for failure to report such child abuse. *See* TEX. FAM. CODE §§ 261.101(b), 261.109(a-1).

As you know, classifying genital mutilation of a child through reassignment surgery as child abuse would also impose a duty on DFPS to conduct prompt and thorough investigations of the child's parents, while other state agencies would be obliged to investigate the facilities they license. *See id.* § 261.301(a)–(b).

Thank you for your swift response to this issue.

Greg Abbott
Governor

GA:jsd

No. D-1-GN-22-002569

PFLAG, Inc., et al., ***Plaintiffs*,**	**In the District Court of**
v.	**Travis County, Texas**
Greg Abbott, et al., ***Defendants*.**	**459th Judicial District**

Defendants' Plea to the Jurisdiction

Exhibit B

Letter from Commissioner Masters to Governor Abbott (Aug. 11, 2021)

Texas Department of Family and Protective Services

Commissioner
Jaime Masters

August 11, 2021

The Honorable Greg Abbott
Governor
Office of the Governor
P.O. Box 12428
Austin, TX 78711-2428

Dear Governor Abbott:

In your August 6, 2021 letter, you requested that the Department of Family and Protective Services (DFPS) determine whether genital mutilation of a child for the purposes of gender transitioning through reassignment surgery constitutes child abuse pursuant to state law.

Genital mutilation of a child through reassignment surgery is child abuse, subject to all rules and procedures pertaining to child abuse. Such mutilation may cause a "genuine threat of substantial harm from physical injury to the child." TEX. FAM. CODE § 261.001(1)(C). As you have described, this surgical procedure physically alters a child's genitalia for non-medical purposes potentially inflicting irreversible harm to children's bodies. Generally, children in the care and custody of a parent lack the legal capacity to consent to surgical treatments, making them more vulnerable. *See* Id. § 32.003.

When medically necessary, this surgical procedure may not constitute abuse. It may be warranted for the following conditions including, but not limited to, a child whose body parts have been affected by illness or trauma; who is born with a medically verifiable genetic disorder of sex development, such as the presence of both ovarian and testicular tissue; or who does not have the normal sex chromosome structure for male or female as determined through genetic testing.

Pursuant to Texas Family Code, Section 261.101, a professional who has "cause to believe" a child has been or may be abused must report that belief to DFPS within 48-hours after the professional first suspects the abuse. A professional may not delegate to or rely on another person to make the report. Professionals include teachers, nurses, doctors, day-care employees and others who are either licensed by the state or work in a facility licensed or operated by the state and who have direct contact with children through their job.

Failure to report is a Class A misdemeanor punishable by up to one year in jail, a fine of up to $4,000, or both. TEX. FAM. CODE § 261.109(a-1), (c); TEX. PENAL CODE § 12.21.

If it is shown that the professional intentionally concealed the abuse, then the offense is a state jail felony. TEX. FAM. CODE § 261.109(c).

Finally, allegations involving genital mutilation of a child through reassignment surgery will be promptly and thoroughly investigated and any appropriate actions will be taken.

Sincerely,

Jaime Masters,
Commissioner

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,** **V.** **GREG ABBOTT, ET AL.,** ***Defendants*.**	**IN THE DISTRICT COURT OF** **TRAVIS COUNTY, TEXAS** **459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit C

February 18, 2022 OAG Opinion

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id*. at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

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[1]*See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).

- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id.* § 261.001(1)(B).

- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id.* § 261.001(1)(C).

- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id.* § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse*.

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

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[2] *See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3] SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4] Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5] Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

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[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone /article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www. wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae.* In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

[10]*See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11]*See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12]*See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id.* § 441.256(a).

The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . .".). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/ dictionary/factitious%20disorder.

may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

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[14]*See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15]Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

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[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

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[21] TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id.* A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

S U M M A R Y

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,

K E N P A X T O N
Attorney General of Texas

BRENT E. WEBSTER
First Assistant Attorney General

LESLEY FRENCH
Chief of Staff

MURTAZA F. SUTARWALLA
Deputy Attorney General for Legal Counsel

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Special Counsel to the First Assistant Attorney General

VIRGINIA K. HOELSCHER
Chair, Opinion Committee

CHARLOTTE M. HARPER
Assistant Attorney General, Opinion Committee

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*****,** **v.** **GREG ABBOTT, ET AL.,** ***Defendants*****.**	**IN THE DISTRICT COURT OF** **TRAVIS COUNTY, TEXAS** **459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit D

Letter from Governor Abbott to Commissioner Masters (Feb. 22, 2022)

GOVERNOR GREG ABBOTT

February 22, 2022

The Honorable Jaime Masters
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

Consistent with our correspondence in August 2021, the Office of the Attorney General (OAG) has now confirmed in the enclosed opinion that a number of so-called "sex change" procedures constitute child abuse under existing Texas law. Because the Texas Department of Family and Protective Services (DFPS) is responsible for protecting children from abuse, I hereby direct your agency to conduct a prompt and thorough investigation of any reported instances of these abusive procedures in the State of Texas.

As OAG Opinion No. KP-0401 makes clear, it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen. *See* TEX. FAM. CODE § 261.001(1)(A)–(D) (defining "abuse"). Texas law imposes reporting requirements upon all licensed professionals who have direct contact with children who may be subject to such abuse, including doctors, nurses, and teachers, and provides criminal penalties for failure to report such child abuse. *See id.* §§ 261.101(b), 261.109(a-1). There are similar reporting requirements and criminal penalties for members of the general public. *See id.* §§ 261.101(a), 261.109(a).

Texas law also imposes a duty on DFPS to investigate the parents of a child who is subjected to these abusive gender-transitioning procedures, and on other state agencies to investigate licensed facilities where such procedures may occur. *See* TEX. FAM. CODE § 261.301(a)–(b). To protect Texas children from abuse, DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401.

Sincerely,

Greg Abbott
Governor

POST OFFICE BOX 12428 AUSTIN, TEXAS 78711 512-463-2000 (VOICE) DIAL 7-1-1 FOR RELAY SERVICES

GA:jsd

Enclosure

cc: Ms. Cecile Young, Executive Commissioner, Health and Human Services Commission
Mr. Stephen B. Carlton, Executive Director, Texas Medical Board
Ms. Katherine A. Thomas, Executive Director, Texas Board of Nursing
Dr. Tim Tucker, Executive Director, Texas State Board of Pharmacy
Mr. Darrell Spinks, Executive Director, Texas Behavioral Health Executive Council
Mr. Mike Morath, Commissioner, Texas Education Association
Ms. Cristina Galindo, Chair, Texas State Board of Educator Certification
Ms. Camille Cain, Executive Director, Texas Juvenile Justice Department

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id*. at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

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[1]*See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).
- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id.* § 261.001(1)(B).
- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id.* § 261.001(1)(C).
- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id.* § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse*.

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

[2]*See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4]Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5]Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

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[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone /article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www. wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae.* In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

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[10] *See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11] *See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12] *See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id.* § 441.256(a).

The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . .".). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

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[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/dictionary/factitious%20disorder.

may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

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[14] *See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15] Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

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[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

[21]TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id*. A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

S U M M A R Y

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,

K E N P A X T O N
Attorney General of Texas

BRENT E. WEBSTER
First Assistant Attorney General

LESLEY FRENCH
Chief of Staff

MURTAZA F. SUTARWALLA
Deputy Attorney General for Legal Counsel

AARON REITZ
Deputy Attorney General for Legal Strategy

RALPH M. MOLINA
Special Counsel to the First Assistant Attorney General

VIRGINIA K. HOELSCHER
Chair, Opinion Committee

CHARLOTTE M. HARPER
Assistant Attorney General, Opinion Committee

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,** **v.** **GREG ABBOTT, ET AL.,** ***Defendants*.**	**IN THE DISTRICT COURT OF** **TRAVIS COUNTY, TEXAS** **459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit E

Declaration of Stephen Black

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DECLARATION OF STEPHEN BLACK

Stephen Black swears, affirms, and attests to the following:

1. I, Stephen Black, am over eighteen years of age. I am providing this declaration voluntarily. I have not been promised or given anything in exchange for providing this declaration.

2. I have a bachelor's degree in Mass Communications from Louisiana State University and a master's degree in Political Science from Texas State University.

3. I am the DFPS Associate Commissioner for Statewide Intake (SWI). I have been in this position since September 1, 2020. I have also worked in various other SWI roles, including intake specialist, intake supervisor, program administrator, and division administrator for program improvement, since January 2008.

4. As Associate Commissioner for SWI I am tasked with ensuring that staff at the abuse hotline make proper assessments while keeping certain efficiency standards. Proper assessments are determined by the applicable state laws and DFPS policies, procedures, and regulations.

5. On August 6, 2021, Governor Greg Abbott sent a letter to DFPS Commissioner Jaime Masters inquiring whether genital mutilation (sex reassignment) of a child for purposes of

gender transitioning through reassignment surgery constituted child abuse. **Attachment (Att.) A**.

6. On August 11, 2021, the Commissioner responded that surgical sex reassignment of a child "may cause a genuine threat of substantial harm from physical injury to a child" as defined under the Texas Family Code. The response noted that the surgical procedure might not constitute abuse if it were medically necessary. The letter concluded by acknowledging that all such allegations would be investigated. **Att. B.**

7. Subsequently, SWI staff were advised to accept for further assessment, and investigation if warranted, reports involving allegations of sex reassignment surgery performed on a child.

8. To date, SWI has received no reports of any sex reassignment surgeries performed on a child.

9. On February 21, 2022, the Office of the Attorney General of Texas released Opinion No. KP-0401, which concluded that some sex-change treatments and procedures for minors could constitute child abuse. The Opinion includes the important caveat that "[t]his opinion does not address or apply to medically necessary procedures." Instead, it focused solely on elective procedures and treatments that could result in permanent sterilization, and the Attorney General found that in some cases these procedures could constitute child abuse because of the child's inability to provide informed consent for such treatments and procedures. The Opinion further found that some elective (medically unnecessary) treatments and procedures can be child abuse and gave, as examples, several cases involving mothers with Munchausen Syndrome by Proxy knowingly fabricating, exaggerating, and inducing their child's symptoms. **Att. C.**

10. DFPS does not have medical professionals on staff that can evaluate the medical

necessity of hormone therapy and puberty blockers prescribed by a physician.

11. DFPS staff do not have the medical expertise to determine whether a treatment or administration of a controlled substance or any medication is medically necessary. It relies on the assessments of treating medical providers to evaluate and determine the appropriateness and necessity of treatments and procedures.

12. DFPS does not regulate physicians, investigate physicians, or have the authority to discipline physicians who provide medically unnecessary care to children.

13. On February 22, 2022, Governor Abbott sent a letter to Commissioner Masters alerting DFPS to the Attorney General's opinion. **Att D.**

14. SWI intake specialists assign reports of abuse a priority based on the immediacy of the risk and the severity of the possible harm to the child. Reports can be categorized as Priority 1 (P1), Priority 2 (P2), or Priority None (PN).

15. A P1 assignment usually occurs when there is: (1) a report that a child appears to face an immediate threat to his or her safety or is in immediate risk of abuse or neglect that could result in death or serious harm; (2) any report alleging abuse or neglect that is received within 12 months after a previous investigation was closed as "Unable to Complete"; or (3) a report involving a child's death that has never been investigated, and there is a clear allegation that the death was the result of alleged abuse or neglect, even if no other children are in the home.

16. A P2 assignment usually occurs when the case (1) involves allegations of abuse or neglect that do not involve severe harm and/or (2) does not require an immediate response and otherwise does not meet the criteria for P1 assignment. P2 intakes in which the youngest victim is age six or older, and the family involved has no Child Protective Investigations (CPI)/Child

Protective Services (CPS) case already open in a service stage, are eligible for secondary screening. During secondary screening, DFPS also determines whether the intake can go to Alternative Response (AR) as opposed to a traditional investigation. In AR cases, a CPI caseworker works with the family, but there is no disposition of the allegations. Some physical abuse cases are assigned to AR; however, they are typically in instances of over discipline or parent-teen conflict. Allegations in which the primary concern is the possibility of internal injury would not typically go to AR.

17. A PN assignment usually occurs when SWI intake specialist determines that there is no current safety threat to the child. A PN case goes to secondary screening where the screener obtains collateral contacts to see whether the intake needs to be upgraded to a P1 or P2 investigation, or closed with no further action.

18. From February 22, 2022, through March 16, 2022, DFPS received 11 reports involving the alleged administration of hormone therapy or puberty suppressants to minors.[1]

19. To date, no further reports involving similar allegations have proceeded past the intake stage to investigations by DFPS.

20. SWI intake specialists were instructed to route the 11 incoming reports to traditional investigations based on the guidance received from the AG Opinion and the Governor's Letter.

21. All 11 cases were assigned P2 status after it was determined that they did not require an immediate response.

22. On March 22, 2022, a district court issued state-wide injunction went into effect relating to these cases. DFPS promptly placed all pending investigations on hold. No further action

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[1] Reports that a child is transitioning genders or socially transitioning, without medical intervention, were screened and closed at intake.

was taken in the cases during the pendency of the injunction.

23. On March 23, 2022, SWI directed staff not to accept new intakes based solely on the treatment and procedures described in the Attorney General's Opinion.

24. DFPS generally considers the Opinions of the Attorney General as persuasive authority in the absence of a law or judicial decision ruling otherwise.

25. On May 19, 2022, the Texas Supreme Court issued an order lifting the statewide injunction. No additional intakes have been accepted since the injunction was lifted. SWI directed advised staff that the injunction was lifted. To date, no new reports have been made.

26. To date, 7 out of the 11 reported cases have either been closed or are pending closure because the child was either not taking puberty suppressants or hormone therapy, or because their treating medical providers affirmed that they were and that the treatments are medically necessary. The four remaining cases are all currently enjoined by this Court or identified themselves as members of PFLAG.

27. When an investigation is closed, DFPS will not investigate new reports involving the same allegation that has already been investigated. Subsequent reports regarding the same allegation will be closed without investigation.

28. The SWI intake and assessments of child abuse complaints involving hormone therapy and puberty suppressants are consistent with the Attorney General's Opinion that, under current law, these could be child abuse when they are not medically necessary. These cases are treated like all other cases involving abuse with underlying medical issues or concerns. Indeed, reports that a child is regarded as transexual or transgender have been screened and closed at the intake stage, unless there is also an allegation involving medical interventions like puberty

suppressants or hormone therapy.

DECLARATION

My name is Stephen Black, and I am an employee of DFPS. I am executing this declaration as part of my assigned duties and responsibilities. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Travis County, State of Texas, on the 5th day of July, 2022.

STEPHEN BLACK

No. D-1-GN-22-002569

PFLAG, Inc., et al., ***Plaintiffs*,**	**In the District Court of**
v.	**Travis County, Texas**
Greg Abbott, et al., ***Defendants*.**	**459th Judicial District**

Defendants' Plea to the Jurisdiction

Exhibit F

Expert Report of Dr. Michael Laidlaw

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,** **v.** **GREG ABBOTT, ET AL.,** ***Defendants*.**	**IN THE DISTRICT COURT OF** **TRAVIS COUNTY, TEXAS** **459th JUDICIAL DISTRICT**

Expert Declaration and Report of Michael K. Laidlaw, MD

I, Michael K. Laidlaw, M.D., hereby declare as follows:

1. I am over the age of eighteen and submit this expert declaration based on my personal knowledge and experience.

2. I am a board-certified endocrinologist. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in 2004. I also completed a fellowship in endocrinology, diabetes and metabolism at Los Angeles County/University of Southern California Medical Center in 2006.

3. The information provided regarding my professional background are detailed in my curriculum vitae. A true and correct copy of my curriculum vitae is attached as Exhibit A.

4. In my clinical practice as an endocrinologist, I evaluate and treat patients with hormonal and/or gland disorders. Hormone and gland disorders can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms. Therefore, I frequently assess and treat patients demonstrating psychiatric symptoms and determine whether their psychiatric symptoms are being caused by a hormonal issue, gland issue, or something else.

5. I have been retained by Defendants in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating minors diagnosed with gender dysphoria, including considerations of various proposed treatments.

6. If called to testify in this matter, I would testify truthfully and based on my expert opinion. The opinions and conclusions I express herein are based on a reasonable degree of scientific certainty.

7. I am being compensated at an hourly rate of $450 per hour plus expenses for my time spent preparing this declaration, and to prepare for and provide testimony in this matter. I am being compensated at an hourly rate of $650 for testimony at depositions or trial. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

8. My opinions contained in this report are based on: (1) my clinical experience as an endocrinologist; (2) my clinical experience evaluating individuals who have or have had gender incongruence; (3) my knowledge of research and studies regarding the treatment of gender dysphoria, including for minors; and (4) my review of the various declarations submitted by Plaintiffs in the present lawsuit, PFLAG, Inc. et al. v. GREG ABBOT et al., CAUSE NO. D-1-GN-22-000977, in the District Court of Travis County, Texas, 353rd Judicial District.

9. I was provided with and reviewed the following case-specific materials:
(1) PLAINTIFFS' ORIGINAL PETITION, APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY AND PERMANENT INJUNCTION, AND REQUEST FOR DECLARATORY RELIEF; (2) THE EXPERT DECLARATION OF ARMAND H. MATHENY ANTOMMARIA, MD, PhD, FAAP, HEC-C; (3) THE EXPERT DECLARATION OF DR. CASSANDRA C. BRADY, MD; (4) Attorney General Ken Paxton's Opinion No. KP-0401, dated February 18, 2022; (5) Governor Greg Abbott's Letter Directive to Texas Department of Family and Protection Services ("DFPS") Commissioner Jaime Masters, dated February 22, 2022.

10. In my professional opinion, treatment interventions on behalf of children diagnosed with gender dysphoria must be held to the same scientific standards as other medical treatments. These interventions must be optimal, efficacious, and safe. Any treatment which alters biological development in children should be used with extreme caution. Except in the case of a fatal injury or disease, the minor will become an adult and present to the adult physician. The adult physician must be able to have a thorough understanding of any condition which alters the biological development of children and, in the case of the endocrinologist, be knowledgeable about the long term effects of hormones on the human body, particularly when the hormones are being used in ways that alter development.

11. The following expresses my expert opinion regarding minors who present with a disparity between their biological sex and internal feeling about their gender, specifically with regard to the use of social transition, medications which block normal pubertal development, the applications of hormones of the opposite sex, and surgical procedures that alter the genitalia and/or breasts for those individuals.

I. Background

A. Endocrine Disorders

Before discussing gender dysphoria and gender affirmative therapy from the perspective of an endocrinologist, it is helpful to discuss the background of endocrine diseases. This background demonstrates the difference in gender dysphoria, which is a psychological diagnosis, and other conditions treated by endocrinologists, which are physical diagnoses.

Endocrinology is the study of glands and hormones. Endocrine disorders can be divided into three main types: those that involve hormone excess, those that involve hormone deficiency, and those that involve structural abnormalities of the glands such as cancers.

It is important for the endocrinologist to determine the cause of hormone gland excess or deficiency in order to devise an appropriate treatment plan. The plan will generally be to help bring the hormones back into balance and thus bring the patient back to health.

To give an example of hormone excess, hyperthyroidism is a term which means overactivity of the thyroid gland. In this condition excess thyroid hormone is produced by the thyroid gland. This results in various physical and psychological changes for the afflicted patient. Examples of physical changes can include tachycardia or fast heart rate, hand tremors, and weight loss. Examples of psychological symptoms include anxiety, panic attacks, and sometimes even psychosis.

An endocrinologist can recognize thyroid hormone excess in part by signs and symptoms, but can also confirm the diagnosis with laboratory testing that shows the thyroid hormones to be out of balance. Once this is determined and the degree of excess is known, then treatments can be given to bring these levels back into balance to benefit the patient's health and to prevent other disease effects caused by excess hormone.

To give another example, consider a deficiency of insulin. Insulin is a hormone which regulates blood glucose levels. If there is damage to the pancreas such that insulin levels are very low, then blood glucose levels will rise. If the glucose levels rise to a certain abnormally high level, then this is considered diabetes. In the case of type 1 diabetes, insulin levels are abnormally low and therefore blood glucose levels are abnormally high leading to a variety of signs and symptoms. For example, the patient may have extreme thirst, frequent urination, muscle wasting, and weight loss. They may often experience lethargy and weakness.

In this case laboratory tests of glucose and insulin levels can confirm the diagnosis. Once diabetes is confirmed, the patient is then treated with insulin to help restore glucose balance in the body and prevent long-term complications of diabetes.

To give an example of a structural abnormality, a patient may have a lump on the thyroid gland in the neck. This may be further examined by an imaging test such as an ultrasound. A needle biopsy can be performed so that the cells can be examined under a microscope. A trained medical professional such as a pathologist can then examine the cells to determine if they are benign or cancerous. In the case of a thyroid cancer, a surgical procedure known as a thyroidectomy may be performed to remove the diseased thyroid gland in order to treat the cancer.

Noteworthy in the preceding three examples is that all three disease conditions are diagnosed by physical observations. In other words, a laboratory test of a hormone, an imaging test of an organ, an examination of cells under a microscope, or all three may be employed in the diagnosis of endocrine disease.

B. Gender Dysphoria is a Psychological Diagnosis

Gender dysphoria, on the other hand, is not an endocrine diagnosis, it is in fact a psychological diagnosis. It is diagnosed purely by psychological methods of behavioral observation and questioning.

Likewise what is termed gender identity is a psychological concept. It has no correlate in the human body. In the letter to the editor I wrote with my colleagues, discussed above, we wrote in our critique of the Endocrine Society Guidelines that "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child" (Laidlaw et al., 2019).

For example, one cannot do imaging of the human brain to find the gender identity. Likewise, there is no other imaging, laboratory tests, biopsy of tissue, autopsy of the brain, or genetic testing that can identify the gender identity. There is no known gene that maps to gender identity or to gender dysphoria. In other words, there is no objective physical measure to identify either gender identity or gender dysphoria.

This is in contrast to all other endocrine disorders which have a measurable physical change in either hormone levels or gland structure which can be confirmed by physical testing. Therefore, gender dysphoria is a purely psychological phenomenon and not an endocrine disorder. But as my colleagues and I wrote in our letter to the editor, it becomes an endocrine condition through gender affirmative therapy: "Childhood gender dysphoria (GD) is not an endocrine condition, but it becomes one through iatrogenic puberty blockade (PB) and high-dose cross-sex (HDCS) hormones. The consequences of this gender-affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy" (Laidlaw et al. 2019).

As a practicing endocrinologist and scientist, I have made a study of GD and its treatment for two reasons: 1) I want to be sure that my colleagues and I understand the science before we treat any patients with GD; and 2) I am concerned that the medical society that claims to speak for me and other endocrinologists has abandoned scientific principles in endorsing treatments for GD that have questionable scientific support. The opinions expressed in this report are the result of my own experience, studies, education, and review of the scientific literature related to GD.

C. Gender Dysphoria and Desistance

GD is a persistent state of distress that stems from the feeling that one's gender identity does not align with their physical sex (American Psychiatric Association, 2013). It has been a relatively rare condition in children and adolescents. However there have been very significant increases in referrals for this condition noted around the globe.

For example, in the UK, "The number of referrals to GIDS [Gender Identity Development Service] has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519" (Bell v Tavistock Judgment, 2020). There is evidence that this increase may be in part due to social contagion and fueled by social media/internet use (Littman, 2018).

The French National Academy of Medicine wrote recently: "Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence" (SEGM, 2022).

In "a study of the Finnish gender identity service, '75% of adolescents [assessed] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria' (Kaltiala-Heino, 2015). In fact, '68% had their first contact with psychiatric services due to other reasons than gender identity issues.' The same study also showed that 26% percent had an autistic spectrum disorder and that a disproportionate number of females (87%) were presenting to the gender clinics compared to the past" (Laidlaw in gdworkinggroup.org, 2018).

Desistance is a term indicating that the child, adolescent, or adult who initially presented with gender incongruence has come to experience a realignment of their internal sense of gender and their physical body. "Children with [gender dysphoria] will outgrow this condition in 61% to 98% of cases by adulthood. There is currently no way to predict who will desist and who will remain dysphoric" (Laidlaw et al., 2019).

Because there is no physical marker to diagnose gender identity, and because it is not possible to predict which child or adolescent will desist, it is not possible to know which young person will remain transgender identified as adults. Also, because the rate of desistance is so high, gender affirmative therapy will necessarily cause serious and irreversible harm to many children and adolescents who would naturally outgrow the condition if not affirmed.

D. Biological Sex in Contrast to Gender Identity

A recognition and understanding of biological sex is critical to my practice as an endocrinologist because the endocrine physiology of men and women, boys and girls, differ.

Biological sex is the objective physical condition of having organs and body parts which correspond to a binary sex. There are only two physical sexes, male and female. The male is identified as having organs and tissues such as the penis, testicles and scrotum. The

female sex is identified by having organs and tissues such as the labia, vagina, uterus, and ovaries. Biological sex is easily identified by physical observation such that adults and even young children can identify the biological sex of a newborn baby.

This is in contrast to gender identity, which does not exist in any physical sense. It is a subjective identification known only once a patient makes it known. It cannot be identified by any physical means, cannot be confirmed by any outside observer, and can change over time.

It is also noteworthy that the physical organs described above as representing biological sex have a physical genetic correlate. In other words, it is a well-established scientific fact that two X chromosomes identify the cells correlating to a female person, and an X and a Y chromosome correlate to a male person.

Sex is clearly identified in 99.98% of cases by chromosomal analysis (Sax, 2002). Sex is also clearly recognized at birth in 99.98% of cases (Id.). Therefore, sex is a clear provable objective reality that can be identified through advanced testing such as karyotyping, or simple genital identification at birth by any layperson. The other 0.02% of cases have some disorder of sexual development (DSD). DSDs do not represent an additional sex or sexes, but simply a disorder on the way to binary sex development (Chan et al., 2021).

E. Human Sexual Development

1. Embryologic development

Another confirmation that there are only two biological sexes comes from what is known about embryologic development and fertilization. The biologic development of the human person begins with a gamete from a female termed an ovum or egg and a gamete from a biological male which is termed sperm. The fertilization of the egg by the sperm begins the process of human biological development. The cells of the fertilized ovum then multiply and the person undergoes the incredible changes of embryologic development.

It is noteworthy that the male sperm comes from the biological male and the female egg comes from the biological female. There is no other third or fourth or fifth type of gamete that exists to begin the development of the human person. This is consistent with the binary nature of human sex (Alberts et al., 2002).

The sex binary of the human embryo is further developed between roughly weeks 8 to 12 of human development. There are two primitive structures present within the developing embryo called the Wolffian duct and Mullerian ducts (Larsen et al., 2003). The Wolffian ducts develop into substructures of the genitalia including the vas deferens and epididymis which belong exclusively to the male sex. For the female, the Mullerian ducts go on to form the uterus, fallopian tubes, cervix and upper one third of the vagina which belong exclusively to the female sex (Id.)

Significantly once the male structures are developed from Wolffian ducts, the Mullerian ducts are obliterated. This means that throughout the rest of embryological development the Mullerian ducts will not form into biological female structures. Likewise, in the female, the Wolffian ducts are destroyed by week 12 and will not form male structures at any point in the future (Id.).

Thus we can see in very early development that the sex binary is imprinted physically not only in the chromosomes, but also on the very organs that the body produces. Additionally, the potential to develop organs of the opposite sex is eliminated. Thus, in the human being there are only two physical tracts that one may progress along, the one being male and the other being female (Wilson and Bruno, 2022).

2. Pubertal Development

As mentioned previously, at the time of birth an infant's sex is easily identified through observation of the genitalia. Corresponding internal structures could also be confirmed through imaging if needed.

In early childhood, some low level of sex hormones are produced by the sex glands. The male testes produce testosterone. The female ovaries produce primarily the hormone estrogen. These sex glands remain quiescent for the most part, producing low levels of sex hormones until the time of pubertal development.

Puberty is a time of development of the sex organs, body, brain and mind. There are well known changes in physical characteristics of the male such as growth of facial hair, deepening of the voice, and increasing size of the testicles and penis. Importantly the testicles will develop sperm under the influence of testosterone and become capable of ejaculation. Because of these changes, the male will become capable of fertilizing an egg. The inability to produce sperm sufficient to fertilize an egg is termed infertility.

For the female, pubertal development includes changes such as breast development, widening of the pelvis, and menstruation. The female will also begin the process of ovulation which is a part of the menstrual cycle and involves the release of an egg or eggs from the ovary. Once the eggs are released in a manner in which they can become fertilized by human sperm then the female is termed fertile. The inability to release ovum that can be fertilized is infertility (Kuohong and Hornstein, 2021).

3. Tanner stages of development

From a medical perspective it is important to know the stage of pubertal development of the developing adolescent. This can be determined through a physical examination of the body. The female will have changes in breast characteristics and pubic hair development. Similarly, the male will have changes in testicular size and pubic hair development. These findings can be compared to the Tanner staging system which will allow the stage of puberty to be known.

Tanner stages are divided into five. Stage 1 is the pre-pubertal state before pubertal development of the child begins. Stage 5 is full adult sexual maturity. Stages 2 through 4 are various phases of pubertal development (Greenspan and Gardner, 2004).

Awareness of the Tanner stage of the developing adolescent is also useful to assess for maturation of sex organ development leading to fertility. For girls, the first menstruation (menarche) occurs about two years after Tanner stage 2 and will typically be at Tanner stage 4 or possibly 3 (Emmanuel and Boker, 2022). The first appearance of sperm (spermarche) will typically be Tanner stages 4 (Id.). If puberty is blocked or disrupted before reaching these critical stages, the sex glands will be locked in a premature state and incapable of fertility.

4. Biological Sex Cannot Be Changed

It is not possible for a person to change from one biological sex to the other, and there is no technology that allows a biological male to become a biological female or vice-versa. It is not technologically possible at this time to change sex chromosomes; these will remain in every cell throughout life. It is not technologically possible to transform sex glands from one to the other. In other words, there are no hormones or other means currently known to change an ovary into a testicle or a testicle into an ovary.

Furthermore, as noted earlier, several of the sex specific structures (such as the epidymis of the male or uterus of the female) are produced early in embryological development from around weeks 8 to 12. The primitive ducts which lead to these organs of the opposite sex are obliterated. There is no known way to resuscitate these ducts and continue development of opposite sex structures.

It is also not possible to produce gametes of the opposite sex. In other words, there is not any known way to induce the testicles to produce eggs. Nor is there any known way to induce the ovaries to produce sperm. Therefore, creating conditions for a biological female to create sperm capable of fertilizing another ovum is impossible. The induction of opposite sex fertility is impossible.

In fact, as I will discuss, gender affirming therapy actually leads to infertility and potential sterilization.

F. Iatrogenic Harms

The term iatrogenic is used in medicine to describe harms or newly created medical conditions that are the result of medications, surgeries, or even psychological treatments. In this section I will discuss the iatrogenic harms of "gender affirmative treatment," for females. Each of the four interventions which I will describe (social transition, blocking normal puberty, opposite sex hormones, and surgery) lead to iatrogenic harms to the patient. These harms will be described in detail below. I speak of these harms because it is important to understand that once a patient begins GAT it is more likely the patient will continue on to surgery (de Vries et al., 2014). Thus, GAT interrupts the natural desistence process and instead places the patient on a lifetime regimen of hormonal and surgical care. A good understanding of these harms is also critical to my practice as an endocrinologist, because if I did not understand these harms, I could not advise patients of the risks associated with GAT.

G. Gender Affirmative Therapy

The approaches to gender dysphoria may be divided into three main types. (Zucker, 2020). One is psychosocial treatment that helps the young person align their internal sense of gender with their physical sex. Another would be to "watch and wait" and allow time and maturity to help the young person align sex and gender through natural desistance. The

third option, which is the focus of that which follows, is referred to as gender affirmative therapy.

Gender affirmative therapy (GAT) consists of psychosocial, medical, and surgical interventions that attempt to psychologically and medically alter the patient so that they come to believe they may become similar to the physical sex which aligns with their gender identity (but not their biological sex) and thereby reduce gender dysphoria. GAT consists of four main parts: 1) social transition, 2) blocking normal puberty or menstruation, 3) high dose opposite sex hormones, and 4) surgery of the genitalia and breasts.

The application of this medical therapy to minors is a fairly new intervention and is associated with a number of harms both known and unknown. GAT suffers from a lack of a quality evidence-base, poorly performed studies, and ongoing unethical human experimentation.

1. Social transition

The first stage of gender affirmative therapy is termed social transition. Social transition is a psychological intervention. The child may be encouraged to adopt the type of clothing and mannerisms or behaviors which are stereotypical of the opposite sex within a culture. For example, in the United States a boy might wear his hair long and wear dresses in order to socially transition. A girl may cut her hair short and wear clothes from the boys' section of a department store.

Social transition has been noted by expert researcher in the field of child gender dysphoria, Ken Zucker, to itself be a form of iatrogenic harm (Zucker, 2020). This is because the social transition process may solidify the young person's belief that they are in fact the sex opposite of their biological sex.

From an endocrine point of view, it is understandable that a child having the outward appearance of the opposite sex, would believe that he or she is destined to go through puberty of the opposite sex as they have only a poor understanding of the internal structures of the body, the function of the sex glands, the role of the sex glands in fertility and so forth.

Therefore, it would be quite frightening for a boy who believes he is a girl to be turning into a man with all of the adult features that accompany manhood. Vice versa, the girl who

has become convinced that she is a boy will be frightened by the physical changes brought on by womanhood.

In fact, it would appear that in the minds of the children and adolescents that they are anticipating a sort of disease state in the future by the hormone changes that will occur as a normal and natural part of human development. Until relatively recently in human history, it has not been possible to interfere with puberty through pharmaceutical means.

2. Medications which Block Pubertal Development

a. Background

A second stage of gender affirmative therapy may involve blocking normal pubertal development. This may be done with puberty blocking medications that act directly on the pituitary.

In order to understand what is occurring in this process, it is helpful to be aware of normal hormone function during pubertal development.

There is a small pea-sized gland in the brain called the pituitary. It is sometimes referred to as the "master gland" as it controls the function of several other glands. One key function for our purposes is the control of the sex glands. There are two specific hormones produced by the pituitary referred to as luteinizing hormone (LH) and follicle stimulating hormone (FSH). These are responsible for sex hormone production and fertility. The LH and FSH act as signals to tell the sex glands begin or continue their function.

In the adult male, the production of LH will cause adult levels of testosterone to be produced by the testicles. In the adult female, the production of LH will cause adult levels of estrogen to be produced by the ovaries.

In early childhood, prior to the beginning of puberty, the pituitary function with respect to the sex glands is quiescent. However, during pubertal development LH will signal the testicle to increase testosterone production and this carries the boy through the stages of pubertal development into manhood. Likewise for the female, the interaction of LH with the ovaries increases estrogen production and carries the girl through the stages of development into womanhood.

There are conditions diagnosed by endocrinologists which involve a disruption of this normal communication between the pituitary and the sex glands. There is a medical condition called hypogonadotropic hypogonadism. The meaning of this term is that the pituitary is not sending the hormonal signals (LH and FSH) to the sex glands and therefore the sex glands are unable to make their sex hormones. The result is hormonal deficiencies of LH, FSH, and either testosterone or estrogen.

If this condition occurs during puberty, the effect will be to stop pubertal development. This is a disease state which is diagnosed and treated by the endocrinologist.

Medications such as GnRH agonists act on the pituitary gland to lower the pituitary release of LH and FSH levels dramatically. The result is a blockage of the signaling of the pituitary to the testicles or ovaries and therefore underproduction of the sex hormones. This will stop normal menstrual function for the female and halt further pubertal development. For the male this will halt further pubertal development. If the male had already reached spermarche, then production of new sperm will stop.

b. GnRH Agonist Medication Effects Vary by Use Case

There are a variety of uses for GnRH agonists. The use and outcome can be very different for different applications.

For example, the initial development of the medication called Lupron was for the treatment of prostate cancer. The idea being that blocking pituitary hormones will block the adult male's release of testosterone from the testicles. Since testosterone will promote the growth of prostate cancer, the idea is to lower testosterone levels to a very low amount and therefore prevent the growth and spread of prostate cancer. This is a labeled use of the medication. In other words, there is FDA approval for this use.

Another labeled use of GnRH agonist medication is for the treatment of central precocious puberty. In the disease state of central precocious puberty, pituitary signaling is activated at an abnormally young age, say age four, to begin pubertal development. In order to halt puberty which has begun at an abnormally early time, a GnRH agonist may be used. Here the action of the medication on the pituitary will disrupt the signaling to the sex glands, stop early sex hormone production, and therefore stop abnormal pubertal development.

Then, at a more normal time of pubertal development, say age 11, the medication is stopped and puberty is allowed to proceed. The end result is to restore normal sex gland function and timing of puberty. This is a labeled use for a GnRH agonist medication.

What about the use of puberty blockers such as Lupron in gender affirmative therapy? In these cases, we have physiologically normal children who are just beginning puberty or are somewhere in the process of pubertal development. They have healthy pituitary glands and sex organs. However, a puberty blocking medication is administered to stop normal pubertal development.

In this case the condition of hypogonadotropic hypogonadism described above (a medical disease) is induced by medication and is an iatrogenic effect of treating the psychological condition of gender dysphoria. GnRH agonist medications have not been FDA approved for this use.

c. Adverse Health Consequences of Blocking Normal Puberty

There are a number of serious health consequences that occur as the result of blocking normal puberty. The first problem is infertility. The Endocrine Society Guidelines recommend beginning puberty blockers as early as Tanner stage 2. As discussed earlier, this is the very beginning of puberty. Fertility development happens later generally in Tanner stage 4. One can see that if the developing person is blocked at Tanner stage 2 or 3 as advocated by the guidelines, this is prior to becoming fertile. The gonads will remain in an immature, undeveloped state.

Dr. Brady states that "[f]ertility preservation is offered to all transgender patients prior to the initiation of gender affirming hormones" (Brady declaration, p. 21). Although procedures to preserve fertility are available, studies show that less than 5% of adolescents receiving GAT even attempt fertility preservation (FP) (Nahata, 2017). Moreover, "ovarian tissue cryopreservation is still considered experimental in most centers and testicular tissue cryopreservation remains entirely experimental. These experimental forms of FP would be the only options in children [with puberty] blocked prior to spermarche and menarche and are high in cost and limited to specialized centers. Even with FP there is no guarantee of having a child" (Laidlaw, Cretella, et al., 2019).

Naturally, these children are at a developmental age where they are not thinking about adult related concepts such as having children as they are children themselves. This is only

natural and to be expected. The medical problem imposed on them is that if they remain blocked in an early pubertal stage then even the addition of opposite sex hormones will not allow for the development of fertility. In fact, high dose opposite sex hormones may permanently damage the immature sex organs leading to sterilization. Certainly the removal of the gonads, which will be discussed later, will ensure sterilization.

Another problem with blocking puberty at an early stage is sexual dysfunction. The child will continue their chronological age progression toward adulthood and yet remain with undeveloped genitalia. This will lead to sexual dysfunction including potential erectile dysfunction and inability to ejaculate and orgasm for of the male. For the female with undeveloped genitalia potential sexual dysfunction may include painful intercourse and impairment of orgasm.

The impairment of sexual function was evident in the TLC reality show "I am Jazz". In the show Jazz who was identified male at birth has been given puberty blockers at an early pubertal stage. In an episode where Jazz visits a surgeon and has a discussion about sexual function, Jazz states: “I haven’t experienced any sexual sensation.” Regarding orgasm, Jazz says: “I don’t know, I haven’t experienced it”[1] (TLC, accessed 2022).

In addition to direct effects on the developing genitalia and fertility there are other important aspects of puberty that are negatively affected. For example, puberty is a time of rapid bone development. This time of development is critical in attaining what we call peak bone density or the maximum bone density that one will acquire in their lifetime (Elhakeem, 2019).

Any abnormal lowering of sex hormones occurring during this critical time will stop the rapid accumulation of bone and therefore lower ultimate adult bone density. If a person does not achieve peak bone density, they would be expected to be at future risk for osteoporosis and the potential for debilitating spine and hip fractures as adults. Hip fractures for the older patient very significantly increase the risk of major morbidity and death (Bentler, 2009). Allowing a "pause" in puberty for any period of time leads to an inability to attain peak bone density.

Another consideration is maturation of the human brain. Much of what happens is actually unknown. However, “sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain” (Arain, 2013).

[1] Jazz's age is somewhere in the mid-teens during this episode.

Therefore there are unknown, but likely negative consequences to blocking normal puberty with respect to brain development.

A third major problem with blocking normal puberty involves psychosocial development. Adolescence is a critical time of physical, mental, and emotional changes for the adolescent. It is important that they develop socially in conjunction with their peers. This is well recognized in the psychological literature: “For decades, scholars have pointed to peer relationships as one of the most important features of adolescence.” (Brown, 2009). If one is left behind for several years under the impression that they are awaiting opposite sex puberty, they will miss important opportunities for socialization and psychological development. Psychosocial development will be necessarily stunted as they are not developing with their peers. This is a permanent harm as the time cannot be regained.

Aside from the multiple serious problems that are iatrogenically acquired by blocking normal puberty, there appear to be independent risks of the puberty blocking medication themselves. For example, one can read the labeling of a common puberty blocking medication called Lupron Depot-Ped and find under psychiatric disorders: "emotional lability, such as crying, irritability, impatience, anger, and aggression. Depression, including rare reports of suicidal ideation and attempt. Many, but not all, of these patients had a history of psychiatric illness or other comorbidities with an increased risk of depression” (Lupron, 2022). This is particularly concerning given the high rate of psychiatric comorbidity with gender dysphoria discussed previously.

d. The Effect of Puberty Blockers on Desistance

As stated earlier a very high proportion of minors diagnosed with gender dysphoria will eventually desist or come to accept their physical sex. Puberty blockers have been shown to dramatically alter natural desistance.

In a Dutch study that included seventy adolescents who took puberty blockers, all seventy decided to go on to hormones of the opposite sex (de Vries, et al. 2011). In a follow-up study, the overwhelming majority went on to have sex reassignment surgery by either vaginoplasty for males or hysterectomy with ovariectomy for females (de Vries, et al. 2014). These surgeries resulted in sterilization. This is why puberty blockers, rather than being a “pause” to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries.

e. Infertility as a result of Puberty Blockers in GAT

Dr. Antommaria states that "[p]uberty blockers do not, by themselves, impair fertility. Children with central precocious puberty are routinely treated with puberty blockers and have normal fertility in adulthood" (Antommaria declaration, p. 10). These statements fail to recognize the very different effects of PB medication in early childhood versus during adolescence.

Giving puberty blockers to a four year old with central precocious puberty will obviously not impair fertility, as the four year old has not yet become fertile. The child will at a later time have the puberty blocker discontinued and then normal pubertal development can proceed. Therefore when they are no longer taking the medication, they will gain natural fertility.

In contrast, puberty blocking medication given in GAT occurs at precisely the time that the child will gain reproductive function. This will stop sperm production in the male and ovulation in the female (if these have already occurred, otherwise the functions will not even begin) which produces the infertile condition. Importantly, so long as the minor continues PB they will remain infertile. Should they continue on to opposite sex hormones as part of GAT then they will remain infertile. There is the additional possibility that cytotoxic effects of high dose opposite sex hormones will damage the immature gonads leading to permanent sterility. This is yet to be discovered.

3. Opposite Sex Hormones

The third stage of gender affirmative therapy involves using hormones of the opposite sex at high doses to attempt to create secondary sex characteristics in the person's body.

a. Testosterone

Testosterone is an anabolic steroid of high potency. It is classified as a Schedule 3 controlled substance by the DEA: "Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence" (DEA, 2022). A licensed physician with a valid DEA registration is required to prescribe testosterone.

I prescribe testosterone to men for testosterone deficiency. The state of testosterone deficiency can cause various problems including problems of mood, sexual function, libido, and bone density. Prescription testosterone is given to correct the abnormally low levels and bring them back into balance. The dose of testosterone must be carefully considered and monitored to avoid excess levels in the male as there are a number of serious concerns when prescribing testosterone.

Regarding the potential for abuse, the labeling reads "Testosterone has been subject to abuse, typically at doses higher than recommended for the approved indication...Anabolic androgenic steroid abuse can lead to serious cardiovascular and psychiatric adverse reactions...Abuse and misuse of testosterone are seen in male and female adults and adolescents...There have been reports of misuse by men taking higher doses of legally obtained testosterone than prescribed and continuing testosterone despite adverse events or against medical advice." (Actavis Pharma, 2018)

Adverse events with respect to the nervous system include: "Increased or decreased libido, headache, anxiety, depression, and generalized paresthesia." (Actavis Pharm, 2018)

With regard to ultimate height, "[t]he following adverse reactions have been reported in male and female adolescents: premature closure of bony epiphyses with termination of growth" (Actavis Pharma, Inc., 2018). What this means is that testosterone applied to the adolescent will cause premature closure of the growth plates, stopping further gains in height in the growing individual, and ultimately making the person shorter than they otherwise would have been.

With respect to the cardiovascular system of men using ordinary doses, "Long-term clinical safety trials have not been conducted to assess the cardiovascular outcomes of testosterone replacement therapy in men" (Actavis Pharma, 2018). No clinical safety trials have been performed for women or adolescent girls to my knowledge.

"There have been postmarketing reports of venous thromboembolic events [blood clots], including deep vein thrombosis (DVT) [blood clot of the extremity such as the lef] and pulmonary embolism (PE) [blood clot of the lung which may be deadly], in patients using testosterone products, such as testosterone cypionate" (Actavis Pharma, 2018).

A very recently published study of adverse drug reactions (ADRs) as part of gender affirming hormone therapies in France states that "[o]ur data show a previously unreported, non-negligible proportion of cases indicating cardiovascular ADRs in transgender men younger than 40 years… In transgender men taking testosterone enanthate, all reported ADRs were cardiovascular events, with pulmonary embolism in 50% of cases" (Yelehe et al., 2022).

There are also serious concerns regarding liver dysfunction: "Prolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] —all potentially life-threatening complications" (Actavis Pharma, 2018).

In GAT, what is termed "cross sex hormones" is the use of hormones of the opposite sex to attempt to create secondary sex characteristics. To do so, very high doses of these hormones are administered. When hormone levels climb above normal levels they are termed supraphysiologic.

b. Opposite Sex Hormones - Supraphysiologic Doses of Testosterone for Females

The female person does produce some smaller amount of testosterone relative to the male. The normal reference range for adult females depending on the lab is about 10 to 50 ng/dL. However, in female disease conditions these levels can be much higher. For example, in polycystic ovarian syndrome levels may range from 50 to 150 ng/dL. PCOS has been associated with insulin resistance (Dunaif, 1989), metabolic syndrome (Apridonidze, 2005) and diabetes (Joham, 2014).

In certain endocrine tumors such as adrenal carcinoma these levels may be substantially higher in the 300 to 1000 ng/dl range. Adrenal carcinoma is a serious medical condition and may be treated by surgery and potent endocrine medications.

Recommendations from the Endocrine Society's clinical guidelines related to GAT are to ultimately raise female levels of testosterone to 320 to 1000 ng/dL[2] which is on the same

[2] In the Endocrine Society's Guidelines there is no grading of evidence for the rationale of using such high supraphysiologic doses of opposite sex hormones for the female or male. There seems to be an underlying assumption that because the person believes to be the opposite sex then they acquire the sex specific laboratory ranges of the opposite sex. "The root cause of this flaw in thinking about diagnostic ranges was exemplified in a response letter by Rosenthal et al claiming that gender identity determines the ideal physiologic range of cross-sex hormone levels (5).

order as dangerous endocrine tumors for women as described above (Hembree, 2017). A simple calculation shows this level for the adult may be anywhere from 6 to 100 times higher than native female testosterone levels. In doing so they are creating a hormone imbalance known as hyperandrogenism. These extraordinarily high levels of testosterone are associated with multiple risks to the physical and mental health of the patient.

“"Studies of transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone” (Laidlaw et al.,2021; Alzahrani et al., 2019). A female can also develop unhealthy, high levels of red blood cells referred to as erythrocytosis. These high red blood cell counts in young women have been shown to be an independent risk factor for cardiovascular disease, coronary heart disease and death due to both (Gagnon, 1994).

Other permanent effects of testosterone therapy involve irreversible changes to the vocal cords. Abnormal amounts of hair growth which may occur on the face, chest, abdomen, back and other areas is known as hirsutism. Should the female eventually regret her decision to take testosterone, this body hair can be very difficult to remove. Male pattern balding of the scalp may also occur. Common sense suggests that changes of voice and hair growth could be psychologically troubling should the patient attempt to reintegrate into society as a female.

Changes to the genitourinary system include polycystic ovaries and atrophy of the lining of the uterus. The breasts have been shown to have an increase in fibrous breast tissue and a decrease in normal glandular tissue (Grynberg et al., 2010). Potential cancer risks from high dose testosterone include ovarian and breast cancer (Hembree, 2017).

According to research regarding testosterone abuse, high doses of testosterone have been shown to predispose individuals towards mood disorders, psychosis, and psychiatric disorders. The "most prominent psychiatric features associated with AAS [anabolic androgenic steroids, i.e. testosterone] abuse are manic-like presentations defined by irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or

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Thus, a psychological construct, the ‘gender identity’, is imagined to affect physical reality and change a person’s sex-specific laboratory reference ranges. This is clearly not the case, otherwise there would be no serious complications of high-dose androgen treatment in transgender males" (Laidlaw et al., 2021). Dr. Brady makes the same error in using the wrong reference ranges for his patients: “Many times, the lipid profiles, hematologic profiles, and findings are equivalent to that of the gender these individuals identify as opposed to that of their sex they were born. I note this often when the medical record and lab utilize laboratory data ranges for the sex assigned as opposed to the gender identity and do not align with the true physiologic milieu of the patient. I take this into consideration for all my patients” (Brady declaration, p. 22).

dangerous behavior. Other psychiatric presentations include the development of acute psychoses, exacerbation of tics and depression, and the development of acute confusional/delirious states" (Hall, 2005). Moreover, "[s]tudies... of medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS) have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms" (Hall, 2005).

c. Estrogen

Estrogen is the primary sex hormone of the female. Prescription estrogen may be used if a woman has low estrogen levels due to premature failure of her ovaries. Estrogen is prescribed to bring these levels back into a normal range for the patient's age. Another labeled use of estrogen is to treat menopausal symptoms.

d. Opposite Sex Hormones - Supraphysiologic Estrogen for Males

For the male, estrogen is being used at supraphysiologic doses. The high doses are used in an attempt to primarily affect an increase of male breast tissue development known as gynecomastia. Gynecomastia is the abnormal growth of breast tissue in the male. The occurrence of gynecomastia in the male is sometimes corrected by medication or more commonly by surgery if needed. Other changes of secondary sex characteristics may develop such as softening of the skin and changes in fat deposition and muscle development.

The doses of estrogen given to males for GAT are high and may vary from two to eight or more times higher than normal adult male levels. This produces the endocrine condition called hyperestrogenemia. Long-term consequences include increased risk of myocardial infarction and death due to cardiovascular disease (Irwig, 2018). Also "[t]here is strong evidence that estrogen therapy for trans women increases their risk for venous thromboembolism[3] over 5 fold" (Irwig, 2018).

Breast cancer is a relatively uncommon problem of the male. However the risk of a male developing breast cancer has been shown to be 46 times higher with high dose estrogen (Christel et al., 2019).

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[3] Venous thromboembolism is a blood clot that develops in a deep vein and "can cause serious illness, disability, and in some cases, death" (CDC, 2022).

It is clear that supraphysiologic doses of either testosterone for the female or estrogen for the male can have detrimental health consequences. This is only now being borne out in the literature for adults. However as more children and adolescents are put on these medications one would expect these consequences to become more frequent and to occur earlier in their lives.

4. Surgeries

The fourth stage of gender affirmative therapy is surgical alterations of the body of various kinds in an attempt to somehow mimic features of the opposite sex.

Individual surgical procedures can be a complex topic. It is helpful to first step back and consider conceptually what any surgery can and cannot accomplish.

In its basic form surgery is subtractive. In other words, a portion of tissue, an organ or organs are removed in order to restore health. For example, a diseased gallbladder may be surgically removed to help the patient get back to wellness. An infected appendix may be surgically removed to prevent worsening infection or even death. In both of these cases an unhealthy body part is surgically removed in order to restore health.

In some cases a diseased tissue or organ is removed so that a foreign replacement part may be substituted for an unhealthy organ or tissue. For example, a diseased heart valve may be replaced with a pig valve or a prosthetic heart valve. Another example is a failed liver may be replaced by liver transplant.

Though modern surgical techniques and procedures are astounding, there are very noteworthy limitations. Importantly, surgery cannot de novo create new organs. If a person's kidneys fail, the surgeon has no scientific method for creating a new set of kidneys that can be implanted or grown within the patient. This conceptual background is helpful when considering various gender affirming surgeries.

There are a variety of gender affirming surgeries for females. These may include mastectomies, metoidioplasty, and phalloplasty.

a. Mastectomy

Mastectomies are the surgical removal of the breasts. The procedure is used in GAT in an attempt to make the chest appear more masculine. The surgery results in a permanent loss of the ability to breastfeed and significant scarring of 7 to 10 inches. The scars are prone to widening and thickening due to the stresses of breathing and arm movement. Other potential complications include the loss of normal nipple sensation and difficulties with wound healing (American Cancer Society, 2022).

It is important to note that this operation cannot be reversed. The female will never regain healthy breasts capable of producing milk to feed a child (Mayo Clinic, Top Surgery, 2022).

Another important consideration is that compared to the removal of an unhealthy gallbladder or appendix, in the case of gender dysphoria the breasts are perfectly healthy and there is no organic disease process such as a cancer warranting their removal. The future woman who later desists is left with regret about what happened to her at an age before she could provide true informed consent. Functioning breasts cannot be created by a surgeon and restored to a patient in case of regret. She is left with permanent injury and loss of function with respect to her breasts.

b. GAT Surgeries on the Male

GAT surgeries for the male include removal of the testicles alone to permanently lower testosterone levels. This is by nature a sterilizing procedure. Further surgeries may be done in an attempt to create a pseudo-vagina which is called vaginoplasty. In this procedure, the penis is surgically opened and the erectile tissue is removed. The skin is then closed and inverted into a newly created cavity in order to simulate a vagina. A dilator must be placed in the new cavity for some time so that it does not naturally close.

Potential surgical complications may include urethral strictures, infection, prolapse, fistulas and injury to the sensory nerves with partial or complete loss of erotic sensation (Mayo Clinic, Feminizing Surgery, 2022).

c. GAT Surgeries of the Female Pelvis and Genitalia

Other types of surgery for females include those of the genitalia and reproductive tract. For example, the ovaries, uterus, fallopian tubes, cervix and the vagina may be surgically removed. Removal of the ovaries results in sterilization.

Importantly, removing female body parts does not produce a male. Rather, the female has had sex specific organs permanently destroyed with no hope of replacement, while remaining biologically female.

There have also been attempts to create a pseudo-penis. This procedure is known as phalloplasty. It is not possible to de novo create a new human penis. Instead, a roll of skin and subcutaneous tissue is removed from one area of the body, say the thigh or the forearm, and transplanted to the pelvis. An attempt is made to extend the urethra or urinary tract for urination through the structure. This transplanted tissue lacks the structures inherent in the male penis which allow for erection, therefore erectile devices such as rods or inflatable devices are placed within the tube of transplanted tissue in order to simulate erection (Hembree, 2017). The labia may also be expanded to create a simulated scrotum containing prosthetic objects to provide the appearance of testicles.

Complications may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris (Mayo Clinic, Masculinizing Surgery, 2022).

H. Life Threatening Physical Medical Conditions Versus Suicidal Ideation

Any child or adolescent who has suicidal ideation or has attempted suicide should receive immediate, appropriate psychiatric care. Psychologists and psychiatrists are trained in the recognition and treatment of suicidal ideation and prevention of suicide. A child or adolescent with gender dysphoria who also has suicidal ideation should not be treated any differently. They require compassionate care and a full psychological evaluation of comorbidities such as depression, anxiety, and self-harming behaviors.

However, suicidal ideation or attempts are categorically different than other life-threatening situations, such as a rapidly expanding brain tumor or a severe infection. In these situations, a medication or a surgery is used to stop the progression of an organic

physical condition. In contrast, the danger to the self with suicidal ideation relates to a condition of the mind.

Gender affirmative therapy does not treat any life-threatening physical condition. In fact, it creates a number of new medical conditions as described above. It is also not an appropriate treatment for suicidal ideation. Neither puberty blocking medications, nor testosterone, nor estrogen have been FDA approved for suicide prevention. Moreover, as noted above, the hormone imbalances generated by the medications used in GAT actually increase psychological conditions that lead to suicidal ideation and completed suicide.

I. Informed Consent

Any person who is to take a medication, undergo a surgical procedure, or have a psychological intervention should understand the risks and benefits before proceeding. A discussion of these risks and benefits should be provided by medical professionals and then the person of sufficient intellectual capacity and maturity can consent to the treatment.

Naturally difficulties arise when a minor is involved in the process of medical decision-making. Their intellect, emotions, and judgment are not fully developed and they are not capable of fully appreciating permanent, life altering changes such as described above. Therefore, they cannot provide informed consent. They may sometimes "assent" to a procedure or medication with a parent or guardian making the final decision.

With respect to GAT, in my opinion, it is not possible for the parent or guardian to make a true informed consent decision for the child because of the poor quality of evidence of benefit, the known risks of harm, and the many unknown long-term risks of harm which could only truly be known after years and decades of gender affirmative therapy. A parent or guardian cannot consent to dubious treatments which result in irreversible changes to their child's body, infertility, sexual dysfunction, and in many cases eventual sterilization.

Because this age group is still undergoing brain development and they are immature with respect to intellect, emotion, judgment, and self-control, in my professional opinion there is a significant chance a young person may later regret the irreversible bodily changes that result from hormones or from removing an organ or organs that will no longer function and cannot be replaced.

I would also note that adolescents are more prone to high-risk behavior and less likely to fathom the risks and consequences of these decisions (Steinberg, 2008).

J. The WPATH and The Endocrine Society

Dr. Cassandra Brady is a member of the advocacy group WPATH (Brady declaration, p. 2). Dr. Antommaria refers to the WPATH's Standard of Care 7 document to support the contention that "[t]he potential benefits of such treatment, including gender-affirming medical care, may be sufficient to outweigh the risks" (Antommaria declaration, p. 10).

WPATH's "Standards of Care" were produced over a decade ago in 2011. They were prepared within their advocacy organization and are purported to be a "professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria" (WPATH, 2022). However, the "professional consensus" exists only within the confines of its organization. Furthermore, their "Standards of Care," unlike the Endocrine Society's guidelines, do not have a grading system for either the strength of their recommendations or the quality of the evidence presented.

While the Endocrine Society has issued "Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," these are only "guidelines." The Endocrine Society's guidelines specifically state that their "guidelines cannot guarantee any specific outcome, <u>nor do they establish a standard of care</u>" (Hembree at al, 2017, p. 3895).

In the Endocrine Society's guidelines, the quality of evidence for the treatment of adolescents is rated "very low-quality evidence" and "low quality evidence". "The quality of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies" (Laidlaw et al., 2019).

Unlike some other recommendations for adolescent GAT, the Endocrine Society's guidelines do not include any grading of the quality of evidence specifically for their justification of laboratory ranges of testosterone or estrogen or for adolescent mastectomy or other surgeries.

Endocrinologists W. Malone and P. Hruz and colleagues have written critically of the Endocrine Society's (ES) guidelines: "Unlike standards of care, which should be

authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES claim of effectiveness of these interventions is at odds with several systematic reviews, including a recent Cochrane review of evidence (5), and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being (6). Lastly, the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret" (Malone et al., 2021).

K. The Lack of Evidence of Effectiveness of GAT

There is much additional evidence that questions the long-term benefits of opposite sex hormones and gender reassignment surgery and in fact suggests serious harms.

1. Sweden's Long-term study of 30 years of data by Dhejne

The most comprehensive study of its kind is from Sweden in 2011. The authors examined data over a 30-year time period (Dhejne, 2011). The Dhejne team made extensive use of numerous Swedish database registries and examined data from 324 patients in Sweden over 30 years who had taken opposite sex hormones and had undergone sex reassignment surgery. They used population controls matched by birth year, birth sex, and reassigned sex. When followed out beyond ten years, the sex-reassigned group had nineteen times the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care compared to the general population of Sweden.

2. The Branstrom and Panchankis Retraction

Other published studies of GAT have been shown to have serious errors. For example, a major correction was issued by the American Journal of Psychiatry. The authors and editors of a 2020 study, titled "Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study" (Bränström study, 2020) retracted their original primary conclusion. Letters to the editor by twelve authors including myself led to a reanalysis of the data and a corrected conclusion stating that in fact the data showed no improvement in mental health for transgender identified individuals after surgical treatment nor was there improvement with opposite sex hormones ("Correction", 2020; Van Mol et al., 2020).

The initial reports of this study claimed that the authors found treatment benefits with surgery, and this was shared widely in the media. For example, ABC News posted an article titled "Transgender surgery linked with better long-term mental health, study shows" (Weitzer, 2019). An NBC news/Reuters headline reads "Sex-reassignment surgery yields long-term mental health benefits, study finds" (Reuters, 2019).

However, after twelve authors from around the world including our team investigated the study in detail, a number of serious errors were exposed leading to a retraction (Kalin, 2020; Anckarsäter et al., 2020).

In our letter to the editor which I co-wrote with former Chairman of Psychiatry at Johns Hopkins Medical School, Paul McHugh, MD, we noted key missing evidence in the original Branstrom report when compared to the previous body of knowledge yielded from the Swedish Dhejne study. We wrote that "[t]he study supports only weak conclusions about psychiatric medication usage and nothing decisive about suicidality. In overlooking so much available data, this study lacks the evidence to support its pro gender-affirmation surgery conclusion" (Van Mol, Laidlaw, et al., 2020).

In another letter, Professor Mikael Landen writes that "the authors miss the one conclusion that can be drawn: that the perioperative transition period seems to be associated with high risk for suicide attempt. Future research should use properly designed observational studies to answer the important question as to whether gender-affirming treatment affects psychiatric outcomes" (Landen, 2020).

In another letter to the editor, psychiatrist David Curtis noted that "[t]he study confirms the strong association between psychiatric morbidity and the experience of incongruity between gender identity and biological sex. However, the Branstrom study does not demonstrate that either hormonal treatment or surgery has any effect on this morbidity. It seems that the main message of this article is that the incidence of mental health problems and suicide attempts is especially high in the year after the completion of gender-affirming surgery" (Curtis, 2020).

In yet another critical letter, Dr. Agnes Wold states that "[w]hether these factors involve a causal relationship (i.e., that surgery actually worsens the poor mental health in individuals with gender dysphoria) cannot be determined from such a study. Nevertheless, the data

presented in the article do not support the conclusion that such surgery is beneficial to mental health in individuals with gender dysphoria" (Wold, 2020).

3. Flawed studies based on the problematic 2015 US Transgender Survey

A 2021 study by Almazan and Keurghlian attempted to address mental health outcomes in relation to surgery as a part of GAT (Almazan & Keurghlian, 2021). This was not a randomized controlled study nor a prospective observational study. Rather the study relied upon the 2015 US Transgender Survey (USTS), which has been severely criticized for its serious limitations and weaknesses.

D'Angelo et al. have written about the 2015 USTS survey as part of the criticism of another flawed study in the journal Pediatrics by Jack Turban in 2020 titled "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation" (Turban, 2020). They write in their critique of the USTS that it is "a convenience sampling, a methodology which generates low-quality, unreliable data." (Bornstein, Jager, & Putnick, 2013). Specifically, the participants were recruited through transgender advocacy organizations and subjects were asked to 'pledge' to promote the survey among friends and family. This recruiting method yielded a large but highly skewed sample...Their analysis is compromised by serious methodological flaws, including the use of a biased data sample, reliance on survey questions with poor validity, and the omission of a key control variable, namely subjects' baseline mental health status." They also state that "[s]tigmatizing non-'affirmative' psychotherapy for GD [gender dysphoria] as 'conversion' will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress" (D'Angelo et al., 2021).

4. Mastectomy Surgery for Minors

Any serious look at long-term effects at surgical treatment would follow subjects out at least ten years. For example, an article was published recently examining patients who had mild calcium disorders due to a gland called the parathyroid. They compared a group of patients who had surgical removal of the parathyroid to a control group who had not. They examined data ten years after surgery was completed and concluded that parathyroid surgery in this group "did not appear to reduce morbidity or mortality" in that patient group (Pretorius, 2022).

To my knowledge there exists no comparable studies of minors with gender dysphoria comparing those who had mastectomy surgery to a control group who had not. There are also no known studies of minors followed for 10 years or more to determine the long-term risks and benefits of mastectomy for gender dysphoria.

Good quality studies specifically showing that mastectomy surgery is safe, effective, and optimal for treating minors with gender dysphoria do not exist. For example, there is a study titled "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts" (Olson-Kennedy, 2018). The study authors conclude that "[c]hest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults." However, there are a number of problems with this study. First, the term "chest dysphoria" is a creation of the study authors and is not found as a diagnosis or even referenced in the DSM-5. Second the "chest dysphoria scale" is a measuring tool created by the authors, but which the authors state "is not yet validated." (*Id*., p. 435) Third, the mastectomies were performed on girls as young as 13 and 14 years old and who thereby lacked the maturity and capacity of good judgment for truly informed consent for this life altering procedure. For this reason, in my professional opinion, the research and surgeries performed were flawed and unethical.

There exists another poorly designed study which suffers from similar methodological and ethical problems as the Olson-Kennedy study. A 2021 study published in Pediatrics examined females aged 13-21 recruited from a gender clinic. Thirty young females had mastectomy procedures and sixteen had not. The average age at surgery was 16.4 years (Mehringer, 2021). The follow up time after surgery was only 19 months and no data is provided or analyzed about key psychiatric information such as comorbid psychological illnesses, self-harming behaviors, psychiatric hospitalizations, psychiatric medication use, or suicide attempts.

Information returned from the study surveys were all qualitative and included responses such as "[My chest dysphoria] made me feel like shit, honestly. It made me suicidal. I would have breakdowns". Another respondent stated, "I've been suicidal quite a few times over just looking at myself in the mirror and seeing [my chest]. That's not something that I should have been born with" (Mehringer, 2021). The omission of psychiatric data is a major flaw in the study and also irresponsible given the obviously dangerous psychological states that some of these young people were in.

Since such a high proportion of subjects were using testosterone (83%), some of the responses could be attributed to adverse effects of testosterone. For example, as related earlier, high dose testosterone can manifest in irritability and aggressiveness. One study subject responded, “I get tingly and stuff and it kind of makes me want to punch something" (Mehringer, 2022).

The testosterone labeling also indicates nausea and depression as adverse reactions which are described by another study subject “There’s a feeling of hopelessness, of desperation, of—almost makes me feel physically sick" (Actavis Pharma, Inc., 2018; Mehringer, 2022).

The study appears to have been designed, at least in part, to justify insurance companies paying for mastectomy procedure for minors with GD, even though they have provided no long-term statistical evidence of benefit: "These findings...underscore the importance of insurance coverage not being restricted by age" (Mehrniger, 2021). This also appears to be part of the aim of the flawed Olson-Kennedy study which stated “changes in clinical practice and in insurance plans’ requirements for youth with gender dysphoria who are seeking surgery seem essential” (Olson-Kennedy, 2018). So these two studies, rather than being a thorough examination of the psychological and physical risks and benefits of mastectomy surgery over the long-term appear instead to exist, at least in part, to validate the need for insurance companies to insure the costs of these dubious procedures for minors.

3. Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (“CMS”) has found “inconclusive” clinical evidence regarding gender reassignment surgery. Specifically, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (June 19, 2019) states: “The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population.”

4. Nations and States Question and Reverse Course on GAT

Also noteworthy is that other nations are questioning and reversing course regarding gender affirmative therapy. For example in the *Bell v. Tavistock* Judgment in the UK, regarding puberty blockers in GAT, they concluded that "there is real uncertainty over the

short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment" (*Bell v. Tavistock* Judgment, 2020).

The case was appealed and although the medical decision making was returned to clinicians (rather than the courts), it was noted that great pains should be taken to ensure that the child and parents are properly informed before embarking on such treatments. In its conclusion the appeals court stated that "[c]linicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained " (*Bell v. Tavistock* Appeal, Judgment, 2021).

In the bulletin of the Royal College of Psychiatrists in 2021, in a reevaluation of the evidence, Griffin and co-authors write, "As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory approach with gender-questioning patients should not be considered conversion therapy" (Griffin et al., 2021).

In 2020, Finland recognized that "[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited," and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation (Council for Choices in Healthcare in Finland, 2020). Additionally, "[s]urgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors".

In 2021, Sweden's largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021). "In December 2019, the SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years. These

treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments" (Gauffen and Norgren, 2021).

Dr Hilary Cass "was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020" (The Cass Review website, 2022). In her interim report dated February 2022, it states that "[e]vidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally" (Cass, 2022).

In April of 2022, the Florida Secretary of the Agency for Health Care Administration requested that Florida Medicaid program review "whether treatments are consistent with widely accepted professional medical standards".

On June 2, 2022, the report was completed and concluded: "Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational" (Florida Medicaid, 2022)

L. Assessment of the patient with gender dysphoria

In light of the very serious medical concerns and potential harms of gender affirmative therapy, there are several criteria that I believe would be important to fulfill before applying the GAT model to a patient.

1. Patients should be evaluated to determine if they will follow the natural pattern of desistance which 50 to 98% of pediatric age children will follow[4].
2. Patients, parents and guardians should be made aware of other options for treatment of gender dysphoria including active psychosocial treatment or watching and waiting with support in order to help with natural desistance.
3. The patient should be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model. If underlying psychological conditions are diagnosed then these should be adequately evaluated and treated before proceeding to hormones and surgery.
4. If a medicalized approach with hormones such as testosterone or medications to stop menstruation is being considered then a clear description of the risks and benefits needs to be conveyed to the minor and the parent or guardian. It needs to be verified that they fully understand these risks.
5. If surgical procedures such as mastectomy, hysterectomy, ovariectomy, orchiectomy, or vaginoplasty are being considered then clear descriptions of the risks and benefits need to be conveyed to the minor and the parent or guardian.

However, even if a minor and their parents or guardian are made fully aware of the risks and benefits of hormones and surgeries, in my opinion, the minor does not have adequate maturity and judgment to make permanent changes to their body that may result in infertility/sterility and the permanent loss of organs such as breasts whose functions will not be fully utilized (such as breastfeeding) until adulthood.

II. Conclusion

The gender affirmative therapy model suffers from serious deficiencies in logic and lacks scientific foundation. The deep error hidden in this model is that one cannot in fact change sex. One cannot acquire the deep characteristics of biological sex in order to gain the complete sexual and reproductive functions of the opposite sex. This is not technologically possible.

Children and adolescents are of such immature minds that they are likely to believe that it is possible. In fact they may come to believe that their inherent, biologically necessary puberty is "terrifying" or needs to be stopped. Social transition serves to convince the child

[4] From the DSM-5: "Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary…In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%" (American Psychiatric Association, 2013).

or adolescent that they can be the opposite sex. Puberty blockers sustain this state of mind by retaining a childlike state with respect to the genitalia and body habitus. High dose opposite sex hormones then cause medical conditions such as hirsutism and irreversible damage to the vocal cords in females and gynecomastia in males. These conditions serve to convince the young person that they are going through puberty of the opposite sex when in fact they are not developing sexually and are infertile.

There are known risks, some of which I have described above, including cardiovascular disease, cancer, deficiencies in ultimate bone density, harms to sexual function, infertility, and for some permanent sterility. The child or adolescent cannot consent to these harms when they are not mature enough to fully comprehend what they mean. Long-term studies regarding the treatment effects specifically for minors with hormones and surgeries, using randomized controlled studies or even proper observational studies do not exist.

For the reasons set forth above, in my professional opinion as an endocrinologist, no child or adolescent should receive puberty blockers to block normal puberty, nor should they receive supraphysiologic doses of opposite sex hormones to attempt to alter secondary sex characteristics, nor should they have surgeries to remove or alter the breasts, genitalia or reproductive tracts as part of GAT. The child cannot consent or assent to these procedures. The parent or guardian also cannot consent to the life altering changes resulting from GAT.

Date: ___07/03/2022____ ___________________________________

Michael K. Laidaw, MD

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NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit G

Expert Report of Dr. James Cantor

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., *Plaintiffs*, v. GREG ABBOTT, ET AL., *Defendants*.	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 459th JUDICIAL DISTRICT

EXPERT REPORT OF DR. JAMES CANTOR

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I. Background & Credentials

1. I am a neuroscientist and sex researcher, with an internationally recognized record studying the development of human sexuality and atypical sexualities. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research. These publications span the biological and non-biological development of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research.

2. Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. I am currently the Director of the Toronto Sexuality Centre in Canada. Thus, although I cannot speak for other scientists, I regularly interact with and

am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. I have served as an expert witness in 17 cases in the past four years. In these cases I have provided courts with the research and scientific background regarding the full range of human sexual interest patterns, including the sexual orientation, gender identity, and paraphilias, including the forensic aspects they sometimes involve, and how to distinguish these features, which is not obvious and often confused by non-experts. These cases listed on my *curriculum vitae*, attached here as Appendix 1. They include Frye hearings, custody hearings, trials, and a range of pre-trial

hearings.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. Although I was a member of the hospital's adult forensic program, I remained in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple research projects.

7. For my work in this case, I am being compensated at the hourly rate of $400 per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

II. Executive Summary

- The scientific research literature has long and consistently demonstrated that there is more than one distinct phenomenon that can lead to gender dysphoria. These types show distinct epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to treatment options. Much misunderstanding follows from mis-attributing information across these types.
- For adults with gender dysphoria, studies show that those who are otherwise mentally healthy and undergo thorough (1–2 year) assessments supervised by clinics engaged in gate-keeping roles typically adjust well to life as the opposite sex.
- For pre-pubescent children with gender dysphoria, there have been exactly 11 cohort studies reporting on outcomes. All 11 reported the majority of children to cease to feel dysphoric by puberty, reporting being gay or lesbian instead.
- For pubescent and adolescent age minors using puberty blockers or cross-sex hormones, there have been (also) 11 cohort studies: In four, mental health failed to improve and even deteriorated on several variables. In five, some mental health variables improved, but because psychotherapy and medical interventions were provided together, it cannot be known which treatment caused what changes. The two remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical effects, and neither found medical intervention to be superior to psychotherapy-only. These studies are often misrepresented as support for medicalization by overlooking the concurrent psychotherapy.

- Psychological research importantly distinguishes completed suicide—which occurs primarily among biological males and involves the intent to die—from suicidal ideation, gestures, and attempts—which occur primarily among biological females and represent psychological distress and cries for help. The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion.
- The international consensus of public health care agencies is that there is insufficient evidence to support medicalized transition of minors. Although initially supportive, Sweden, Finland, France, and the United Kingdom have issued increasingly restrictive statements and policies, now prioritizing psychotherapy as the treatment of choice, including an outright ban on medical transition of minors in Sweden.
- For reference, the following table summarizes the age recommendations for the transition of minors within the Dutch Protocol, the Endocrine Society guideline, and the current and the expected upcoming version of the WPATH standards of care:

Procedure	**Dutch Protocol (2012)**	**Endocrine Society (2017)**	**WPATH v7 (2011)**	**WPATH v8 (expected 2022)**
Social Transition	Post-puberty	Neutral	No recommendation	No recommendation
Puberty Blockers	12	As soon as puberty begins	As soon as puberty begins	As soon as puberty begins
Cross-sex Hormones	16	16, unless "compelling reasons"	Age of majority, "in many countries, 16"	14
Mastectomy	18	No recommendation	1 year after cross-sex hormones	15
Breast Augmentation	18	Not mentioned	Not mentioned	16
Vaginoplasty, Metoidioplasty, Orchidectomy	18	18	Age of majority	17
Phalloplasty	18	Not mentioned	Age of majority	18

III. Fact-Check of Plaintiff Expert Declaration

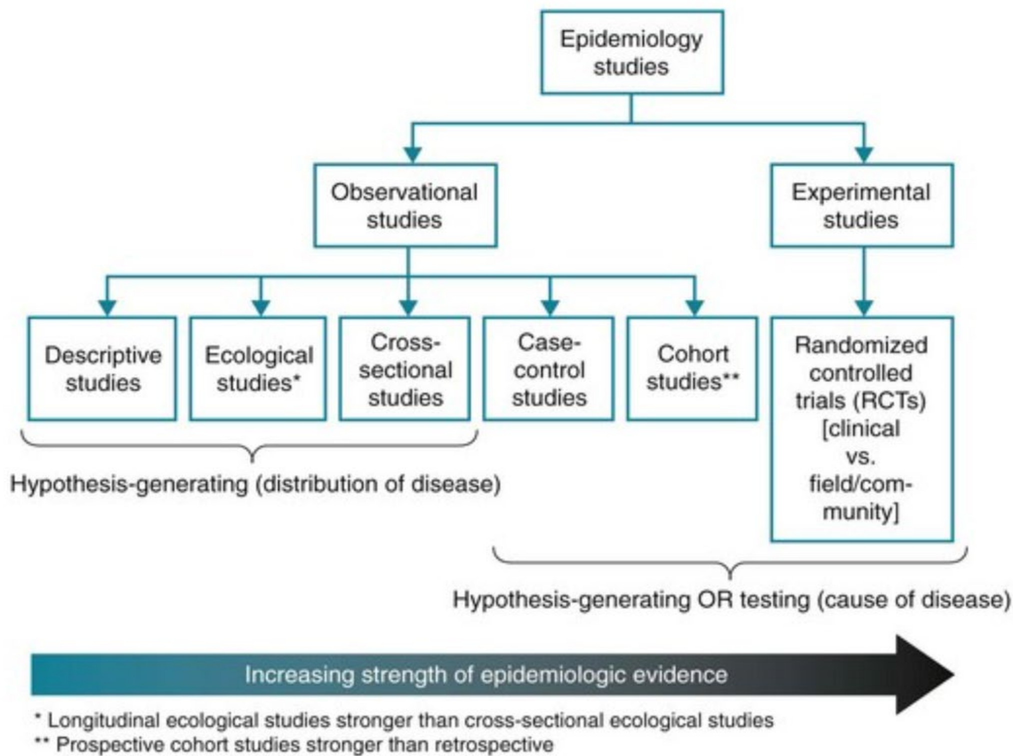
8. In clinical science, there are two kinds of expertise: A physician's expertise regards

applying general principles to the care of an individual patient and the unique features of that case. A scientist's expertise goes the other way around, accumulating information about many individual cases and identifying the generalizable principles that may be applied to all cases. Thus, different types of decision may require different kinds of expert, such that questions about how the general rules might apply to an individual patient's specific situation might be better posed to a physician's expertise, whereas questions about establishing the general rules might be better posed to a scientist's.

9. I have compared the claims in Dr. Brady's declaration with the contents of the peer-reviewed research literature and according to the scientific principles and statistical methods of clinical science and sex research. As detailed in the following, Dr. Brady shared only a small and misrepresentative selection of the relevant research, which, when described in full, supports the very opposite conclusions. The methods Dr. Brady applied in developing her opinions violated multiple basic scientific principles for identifying reliable scientific evidence and interpreting research statistics.

10. In the assessment of the science of this field, prospective *cohort studies* represent high quality research, whereas *descriptive* and *cross-sectional studies* are of very low quality:

Figure 1: Study designs and increasing strength of evidence



Source: Basicmedical Key. Retrieved from https://basicmedicalkey.com/common-research-designs-and-issues-in-epidemiology/

The Brady report excluded most of the high quality, cohort studies, but repeatedly cited inferior cross-sectional survey studies.

11. There have been a total of eleven cohort studies of pre-pubescent children, of which, Dr. Brady cited *none.* In direct contrast with the plaintiffs' claims of "immutability" (Plaintiff petition, para 48), all eleven studies came to the same conclusion: The majority of gender dysphoric children cease to feel dysphoric by puberty. There have also been eleven cohort studies of pubescent/adolescent children treated with puberty-blocking medication or cross-sex hormones. Of these, Dr. Brady cited six,[1] and neglected five.[2] In short, rather than provide a comprehensive

[1] I.e., de Vries, *et al.* (2011, 2014); van der Miesen, *et al.* (2020); Tordoff, *et al.* (2022); Allen, *et al.* (2019); and Achille, *et al.* (2020)

[2] Kuper, *et al.* (2020); Carmichael, *et al.* (2021); Hisle-Gorman, *et al.* (2021); Kaltiala, *et al.* (2020); Costa, *et al.* (2015)

or unbiased summary of the existing science, Dr. Brady's report included only those studies which suggested patient improvement and excluded the studies showing failures of improvement and instances of deterioration. Selective citation such as this represents a gross violation of the basic principles of unbiased scientific analysis.

12. Moreover, of the six cohort studies cited, Dr. Brady also left out a pivotal aspect: The youth in these studies were all receiving psychotherapy at the same time as medical services. In research science, this is called a *confound:* It is not possible for Dr. Brady, or anyone else, to know which of these two co-occurring treatments produced which outcomes. Moreover, one of the six studies, Achille, *et al.* (2020), employed a research design that permitted comparison of medical versus psychotherapeutic methods, and it found medical interventions not to provide any significant improvement above psychotherapy. Importantly, because medical options entail greater risks than psychotherapy, the bar (i.e., the risk:benefit ratio) for medical intervention is higher than for psychotherapy.

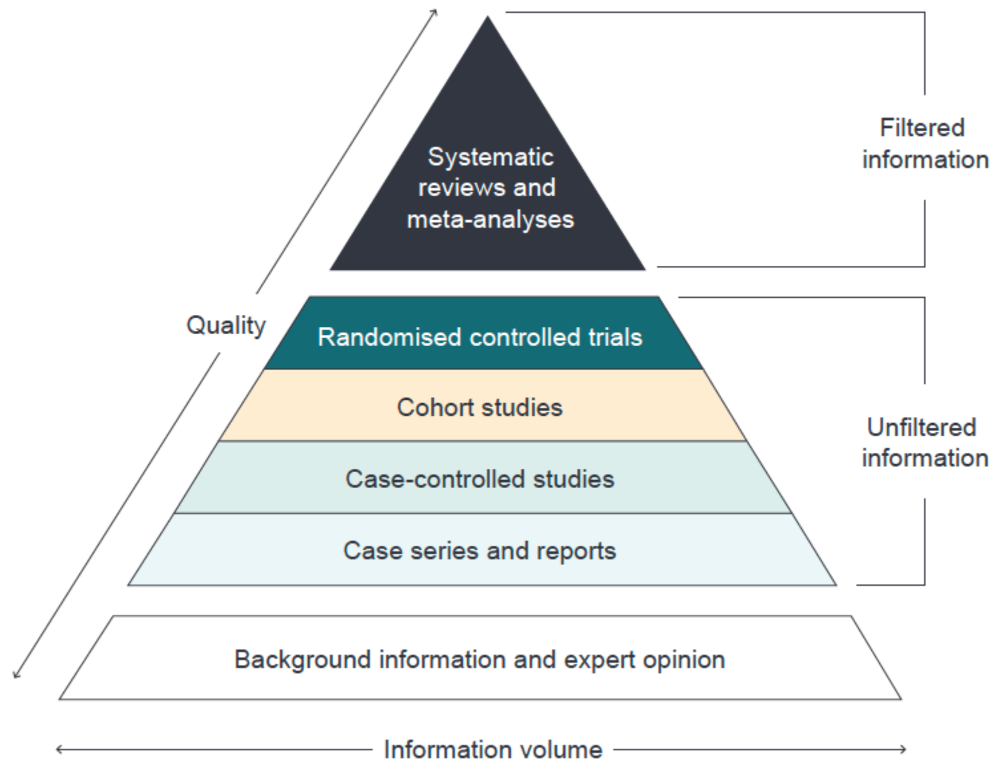
13. The much lower quality descriptive and cross-sectional survey studies included James, *et al.,* (2016);[3] Turban, *et al.* (2020); and Turban, *et al.* (2022). It is straight-forward and inexpensive for interested individuals—professional researchers, political advocates, and marketing companies alike—to assemble a set of questions and post them online for anyone willing to respond to them. Such surveys represent the very earliest step of research projects and can help generate ideas for subsequent research that requires greater resources and time to complete. Unlike surveys of "convenience samples," cohort studies consider a specific, identifiable group, such as attendees of a clinic or people with a distinct genetic feature, and

[3] Dr. Brady's declaration did not provide the complete citation, which is:
James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey.* Washington, DC: National Center for Transgender Equality.

systematically follow up with them to observe and record changes over time (i.e., prospectively). Prospective cohort studies can answer questions issues that surveys cannot, and even a single cohort study can "outweigh" any number of survey studies. Because Internet surveys can be conducted within a few weeks or months, many such studies can be published quickly; however, a 10-year follow-up study of a cohort of gender dysphoric youth requires waiting those 10 years. Research on the present issue has largely been limited to surveys until only recently, with eight of the existing 11 studies published in 2019 or later.

14. Dr. Brady repeatedly relied also her personal recollections of providing medical services to this population, providing what science refers to as anecdotal evidence. Although reporting ongoing experience with such patients, Dr. Brady has never published and did not report engaging in any scientific, statistical, or other systematic analysis that would rule out potential biases to yield generalizable knowledge. In clinical science, expert opinion (in the clinical sense rather than the legal sense) represents only the lowest form of scientific evidence:

Figure 2: Pyramid of standards of evidence



Source: OpenMD. Retrieved from https://openmd.com/guide/levels-of-evidence

15. The advantages of accumulated personal experience is its low cost and potential utility when there do not exist systematic studies of the unique combination of variables represented by some cases. The disadvantages are that it is the most subject to human biases, such as recall bias and confirmation bias, as well as to sampling biases including both self-selection biases (who decides to come into the clinic in the first place) and any variables which led to dropping out of the clinic, leaving clinicians no capacity for determining why.

16. If there did not already exist multiple studies systematically studying cohorts of minors undergoing puberty-blocking or cross-sex hormone treatment, then expert opinion relying on anecdotal evidence might represent the only option available. That is not the current situation, however: Rather than engage in the scientifically valid research method of accepting higher order evidence over lower order evidence (expert opinion), the Brady report retained only the lowest.

17. I have also compared the claims in Dr. Antommaria's declaration with the contents of the peer-reviewed research literature and according to the scientific principles and statistical methods of clinical science and sex research.[4] The Antommaria declaration similarly failed to provide the relevant findings from the research literature. Of the 11 cohort studies of prepubescent children, his report included *none.* Of the 11 cohort studies of adolescent children, his report included *one.* Moreover, of the 24 references that Dr. Antommaria did cite, only 11 were peer-reviewed, and of those, only four pertained to gender dysphoria at all. Instead, Dr. Antommaria repeatedly deferred to the Endocrine Society guideline (cited as Hembree, *et al.,* 2017) as the source of his scientific claims.

18. Drs. Brady and Antommaria both egregiously misrepresent the Endocrine Society guideline, insinuating to the reader that the guideline indicates there being a strong scientific basis for the medical transition of minors, when it actually says the reverse:

> The Endocrine Society, for example, developed its clinical practice guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons using the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group. The Society both grades the quality of the evidence and the strength of its recommendations. It recommends that "adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development (2.1).
> (Antommaria declaration, para 22)
>
> The protocols and policies set forth by the Endocrine Society Guidelines and the WPATH Standards of Care are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States.
> (Brady declaration, para 43)

[4] Dr. Antommaria has not yet provided a declaration in this case, however, she did provide a declaration in the case of *Jane Doe, et al., v. Abbott*, D-1-GN-22-977, which is a case from earlier this year with the same claims against the same Defendants.

Although Drs. Brady and Antommaria both inform the reader that the Endocrine Society *assessed* these recommendation using the GRADE system, they both withheld the actual *results* of that assessment. The guideline used this rating system:

> [S]trong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2.
>
> Cross-filled circles indicate the quality of the evidence, such that ⊕OOO denotes very low-quality evidence; ⊕⊕OO, low quality; ⊕⊕⊕O, moderate quality; and ⊕⊕⊕⊕, high quality.[5]

The section pertaining to adolescents was:

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕OO)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕OO)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕OO)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕OO).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕OOO)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕OO)

Hembree, *et al.* (2017), at 3871, column 1.

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[5] Hembree, *et al.,* 2017, at 3872.

Where Drs. Brady and Antommaria cite the Endocrine Society guideline to insinuate strong science, the GRADE assessment yielded exactly the reverse: In every category, without exception, the research quality was rated as "low" or "very low" (i.e., rated ⊕OOO or ⊕⊕OO).

19. Dr. Brady similarly misrepresented the scientific strength represented by the WPATH Standards of Care document. Although referring to the WPATH Standards with many subjective adjectives, such as "widely adopted" (para 41), "authoritative" (para 43), and "extensively researched" (para 102), Dr. Brady's report did not indicate that the WPATH standards have also undergone objective evaluation with a standardized approach, called the Appraisal of Guidelines for Research and Evaluation ("AGREE II"), as part of an appraisal of all published Clinical Practice Guidelines (CPGs) regarding sex and gender minority healthcare.[6] Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that "[T]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research."[7] The WPATH guidelines received *unanimous* ratings of "Do not recommend."[8]

20. Importantly, despite the repeated citation of WPATH and Endocrine Society as the scientific sources, most of the cohort studies of adolescent did not yet exist when those documents were produced. The WPATH standards were released in 2011, and Endocrine Society guideline, in 2017, whereas 8 of the 11 cohort studies were not published until 2019. That is, the WPATH and Endocrine Society documents were developed almost exclusively from Internet surveys and the necessarily inconclusive interpretations of the correlations in them. Now that cohort studies have become available, it is known that the survey results did not show what they were purported

[6] Dahlen, *et al.,* 2021.
[7] Dahlen, *et al.*, 2021, at 6.
[8] Dahlen, *et al.,* 2021, at 7.

to show: It is *not* the case that youth receiving medical interventions improve in mental health, but that the youth with better mental health are permitted to undergo medical interventions. That is, medication use correlates with mental health, but it does *not cause* mental health—Rather, medication use *reflects* mental health. By relying on the WPATH and Endocrine Society documents, Drs. Brady and Antommaria exclude consideration of 8/11's of the most relevant research. They present no counter-argument to any of the content of this evidence. They neglect it entirely.

21. The reports from Dr. Brady and Dr. Antommaria (and thereby plaintiff's counsel) repeatedly violated another fundamental scientific principle, often known to the public as "*Correlation doesn't imply causation*." None of the plaintiffs' documents cites any research studies employing the scientific methodologies necessary to draw causal conclusions: Indeed, no such studies exist. It is simply not scientifically possible for Drs. Brady or Antommaria (or anyone else) to know which factors are causing which outcomes, yet both repeatedly assume causal relationships in the entire absence of scientific evidence of causality. Examples include:

- "can *cause* extreme distress" (Plaintiff petition, para 61)
- "can *cause* extreme distress" (Brady declaration, para 54)
- "given that gender dysphoria can *cause…"* (Brady declaration, para 38)
- *"effective"* (Antommaria declaration, para 28)
- "the diagnosis *resulting* from the incongruity" (Brady declaration, para 32)
- "distress that *results* from the incongruity" (Brady declaration, para 33)
- "Medical treatment…*can* substantially *reduce*" (Plaintiff petition, para 70)
- "administration of puberty suppression has shown *to* significantly *reduce* suicidality" (Brady declaration, para 96)
- "Pubertal suppression has been shown *beneficial* in psychological functioning and *decreasing* suicidal ideation" (Brady declaration, para 56)
- "my clinical experience confirms that these treatments are highly *beneficial*" (Brady declaration, para 80)
- "These therapies are greatly *beneficial"* (Brady declaration, para 75)
- *exacerbating* lifelong gender dysphoria" (Brady declaration, para 97)
- "withholding pubertal suppression and hormone therapy…is extremely *harmful"* (Brady declaration, para 96)

- "Preventing gender affirming care…*will worsen* their gender dysphoria and health outcomes" (Brady declaration, para 95)
- *"prevent* severe harm including possible death from suicide" (Brady declaration, para 42)
- "these *risks* do *decline* when transgender individuals are supported" (Brady declaration, para 38).
- *"Can save* many lives given that reports of suicidality in trans youth…" (Brady declaration, para 56).
- "Withholding these therapies *can lead to* worsened mental health outcomes and suicide" (Brady declaration, para 67)
- *"life saving"* (Plaintiff petition, para 46)
- *"lifesaving"* (Antommaria declaration, para 36)
- *"life-saving"* (Brady declaration, para 75)
- *"essential"* (Plaintiff petition, para 46)
- *"urgent"* (Antommaria declaration, para 28)
- "assessed to have a medical *need"* (Brady declaration, para 48)
- "medically *necessary"* and "medical *necessity"* (Plaintiff petition, para's 1, 16, 17, 28, 64, 68; Antommaria declaration, e.g., para's 6, 7, 19, 20, 21, 27, 32)

22. Despite such repeatedly confident language, it is not scientifically possible to know which way causality runs. One cannot support any such causal claims on the basis of the existing, entirely correlational, science. When a survey shows a correlation between medication and mental health, it is possible that the medications caused improvement in the mental health variables, and it is possible that only those patients with superior mental health were permitted to receive hormonal treatments in the first place. (Both situations can also be true at the same time, with each factor making partial contributions.) Neither Dr. Brady nor Dr. Antommaria provided evidence to support one interpretation over the other, instead failing to mention any others at all. Moreover, there now exists a generation of more advanced studies, those employing cohort designs, which contradict the first interpretation and instead support the second. These are summarized in their own section to follow.

23. Of the many terms in the plaintiff documents that erroneously claim causality, the most directly relevant is their repeated use of "medically necessary." Whereas the other misused terms convey inaccuracies about the known science, the term "medically necessary" has special technical

meanings in many legal and other contexts, especially regarding insurance coverage, which do not necessarily match the lay public's understanding and everyday use of the term. The plaintiffs' documents obscure which of these meanings applies when.

24. Scientifically, "*necessary*" is a causal statement, and there do not exist any studies using a research design capable of yielding causal conclusions. There only exist observational correlations, and such correlations are scientifically incapable of supporting the claim that medical transition is necessary, medically or otherwise.

25. Dr. Antommaria provided a definition of 'medically necessary' from HealthCare.gov: "[H]ealth care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms *and that meet accepted standards of medicine"* (para 21, italics added). Antommaria asserted flat out that "Gender affirming healthcare is medically necessary" (Antommaria declaration, paragraph 21), but cited no evidence to indicate meeting those standards. As noted already, the only evidence offered in the Antommaria declaration was the Endocrine Society guideline which explicitly and consistently rated the evidence as low and very low quality, never mind meeting the standards required for establishing necessity or any other causal claim.

26. The declaration defines gender identity as an inner sense. The phrase is increasingly popular, but neither "inner sense" nor any similar phrase is scientifically valid. In science, a valid construct must be both objectively measurable and falsifiable. The concept of an "inner sense" is neither. If claims of one's inner sense represented scientifically meaningful evidence, then science would have evidence of people's past life experiences. To base decisions on subjective and unfalsifiable accounts is to fail to provide evidence-based medicine. Gender identity is unlike emotions, which are associated with physiological changes such as heartrate and brain activity. Gender identity is unlike sexual orientation, which is associated with objectively ascertained

evidence, including brain anatomy. Gender Dysphoria is unlike disorders of sexual development (DSD's, also called "intersex conditions"), again in that DSDs are objectively verifiable with physical measures, whereas gender identity is not. DSDs include, for example, genetic disorders which prevent a person's body from responding to testosterone, a disease called Androgen Insensitivity Syndrome.[9] Still more unlike gender identity, the physical nature of such disorders allows many of them to be detected before birth, whereas gender identity has no such feature.

27. Dr. Brady (and plaintiff's counsel) repeatedly belittled the risks posed by medicalized transition procedures by comparing them to treatments for physical medical disorders, relying on Dr. Brady's experience with disorders of sexual development (DSD's) to inform her treatment of gender dysphoria:

- "Effects are not unique to the use of these hormones in transgender individuals" (Brady declaration, para 78)
- "Venous thromboembolism risk is not unique to treating gender dysphoria" (Brady declaration, para 81)
- "Other side effects noted, again, are not unique to transgender individuals placed on these therapies" (Brady declaration, para 82)
- "Treatment for gender dysphoria is in no way the riskiest or potentially harmful" (Brady declaration, para 88)
- "treatments use to treat gender dysphoria are also used to treat other conditions in minors with comparable side effects and risks" (Plaintiff petition, para 73).
- "Many forms of medical treatment carry comparable risks and side effects. Treatment for gender dysphoria is not uniquely risky" (Plaintiff petition, para 75).

28. That comparison avoids the central point: For DSD's and other physical disorders there exists objective evidence of the disorder. There exist medical tests capable of objectively confirming the presence of DSD's with extreme accuracy, and medical decision-making can be made on the basis of very high levels of confidence.[10] No such objective verification exists with regard to gender dysphoria, however. Diagnoses rely entirely on subjective reports and whether

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[9] E.g., Vilain, 2006.
[10] Audi, *et al.,* 2018; Witchel, 2018.

the clinician believes the self-report of the child. Whereas DSD's can be treated when confirmed with physical evidence, treatment of GD is proceeding *in spite of* all available physical evidence.

29. In these comparisons, Dr. Brady again provides only one side of the relevant question. *Psychotherapy also represents healthcare* and poses *zero* attendant physical risk. The relevant comparison is not medical intervention versus nothing, but medical intervention versus psychotherapy. As demonstrated by the cohort studies research cited herein (including those cited by Dr. Brady) psychotherapy is as consistently associated as medical intervention with mental health improvement among these youth. All surgery entails risk. The side-effects associated with of puberty blockers and cross-sex hormones include loss of bone density, decrease in some memory functions, and increases in blot clots, stroke, and heart attack.[11]

30. Dr. Brady claimed gender identity "cannot be voluntarily changed" (Brady declaration, para 27). In actual clinical practice, that is rarely the relevant issue. The far more typical situation is youth who are *mistaken* about their gender identity. These youth are misinterpreting their experiences to indicate they are transgender, or they are exaggerating their descriptions of their experiences in service of attention-seeking or other psychological needs. The claim is not merely lacking any science to support it; the claim itself defies scientific thinking. In science, it is not possible to know that gender identity cannot be changed: We can know only that we lack evidence of such a procedure. In the scientific method, it remains eternally possible for evidence of such a treatment to emerge, and unlike sexual orientation's long history with conversion therapy, there have not been systematic attempts to change gender identity.

31. Whereas Dr. Brady's expert report referred to *voluntary* change in gender identity (allowing for the possibility of spontaneous changes), the plaintiffs' petition instead referred to

[11] Lee, *et al.,* 2020; Getahun, *et al.,* 2018.

gender identity as entirely "*immutable,*" (Plantiff petition, para 48), that is, not allowing for any change at all. No evidence or citation accompanied this stronger claim. It is not at all apparent upon what basis such a statement could be made: It has been the unanimous conclusion of every follow-up study of gender dysphoric children ever conducted, not only that gender identity does change, but also that it changes in the large majority of cases, as documented in its own section of the present report. Such claims also deny the consistent reports of youth de-transitioning[12] and even re-transitioning.[13]

32. Dr. Brady refers to gender identity as "*innate*" (Brady declaration, para 29), having a "strong biological basis" (Brady declaration, para 27). Such claims misrepresent the research literature. Although brain imaging is capable of distinguishing sex and sexual orientation on the basis of neuroanatomical differences, gender identity has repeatedly failed to demonstrate any such analogous features.[14] Rather, the consensus of the scientists (including me) is that childhood onset gender dysphoria is neuroanatomically related to homosexuality, whereas adult-onset gender dysphoria represents an entirely distinct phenomenon that seems similar only superficially.[15] I myself originally published these observations in the research literature, which have been confirmed: As noted by Guillamon, *et al.* (2016), "Following this line of thought, Cantor (2011, 2012, but also see Italiano, 2012) has recently suggested that Blanchard's predictions have been fulfilled in two independent structural neuroimaging studies….*Cantor seems to be right".*[16] To the extent that any neuroanatomical differences have been reported, they have been attributable to sexual orientation rather than gender identity.

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12 Littman, 2021; Vandenbusshe, 2021.
13 Turban, *et al.,* 2021.
14 Baldinger-Melich, *et al.,* 2020; Skorska, *et al.,* 2021.
15 Mueller, *et al.,* 2021
16 *c.f.,* Cantor, 2011; Cantor, 2012; Guillamon, *et al.,* p. 1634, italics added; Italiano, 2012.

33. There is no basis by which the petition and supporting documents to claim there is a "medical consensus" (Plaintiff petition, para 16) or "established best practices" (Plaintiff petition, para 121), to follow guidelines that are "well-established" (Plaintiff petition, para 47) "widely accepted" (Plaintiff petition, para 57). Dr. Brady and Dr. Antommaria are in error to assert there exists a consensus where there does not. Indeed, that there exists enormous controversy and disagreement among experts is itself the topic of major media coverage, including the New York Times' *The Battle Over Gender Therapy: More teenagers than ever are seeking transitions, but the medical community that treats them is deeply divided about why—and what to do to help them.*[17] As detailed within its own section of the present report, the full scientific literature on the outcomes of medical transition of minors has been evaluated by the health care departments of several national governments, including Sweden[18] and the U.K.,[19] with each finding the research to be of very low quality, receiving the lowest quality ratings available. No matter one's views on these issues, they cannot be resolved when their very existence is denied.

34. The plaintiffs' documents repeatedly refer to a national medical consensus on the treatment of gender dysphoric minors. This, however, fails to convey that the international consensus of public health care systems around the world is the opposite, and it is the U.S. which stands as an international outlier. The specific developments in Australia, the United Kingdom, France, Sweden, and Finland are summarized in their own section to follow.

35. In sum, the Brady and Antommaria reports provided only a cherry-picked selection of the science, to which they failed to apply scientific methods of data interpretation. Their multiple instance sharing only decontextualized quotes grossly misrepresented the documents they cited.

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[17] Bazelon, 2022.

[18] Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

[19] U.K. National Health Service (NHS), 2021.

Their conclusions contradict what the existing research evidence and scientific method reveal.

IV. Science of Gender Dysphoria and Transsexuality

A. Introduction

36. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria (cases of *late-onset* gender dysphoria),[20] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD). Very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to another.

B. Adult-Onset Gender Dysphoria

37. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively biological males.[21] They typically report being sexually attracted to women and rarely showed gender atypical (effeminate) behavior or interests in childhood (or adulthood). Some individuals express being sexually attracted to both men and women, and some profess asexuality, but very

[20] Blanchard, 1985.
[21] Blanchard, 1990, 1991.

few indicate having a primary sexual interest only in men.[22] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern involving themselves in female form (medically, a paraphilia called autogynephilia).[23]

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria

38. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[24] Sweden,[25] and the Netherlands.[26]

39. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

40. An important caution applies to interpreting these results: The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

41. The research evidence on mental health issues in gender dysphoria indicates it to be

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22 Blanchard, 1988.
23 Blanchard 1989a, 1989b, 1991.
24 Blanchard, *et al.*, 1989.
25 Dhejneberg, *et al.*, 2014.
26 Wiepjes, *et al.*, 2018.

different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[27] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[28] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless demonstrated (1) that rates of mental health issues among people are highly elevated both before *and after* transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients to become "lost to follow-up." With attrition rates that high, it is unclear to what extent the information from the remaining participants would accurately reflect the whole population. The very high rate of "lost to follow-up" leaves open the possibility of considerably more negative results overall.

42. The long-standing and consistent finding that gender dysphoric adults continue to show high rates of mental health issues after transition indicates a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition—that is, transition does not appear to be what causes mental health improvement. Rather, mental health issues should be resolved before any transition, as has been noted in multiple standards of care documents, as detailed in their own section of this report.

C. Childhood-Onset (Pre-pubertal) Gender Dysphoria

1. Cohort Studies Show Most Children Desist by Puberty

43. Prepubescent children (and their parents) have been approaching mental health

[27] *See, e.g.*, Hepp, *et al*., 2005.
[28] Dhejne, *et al*., 2016.

professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[29]

44. In total, there have been 11 outcomes studies of these children, listed in Appendix 2. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoric are often called "persisters."

45. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound.[30]

46. While the absolute number of those who present as prepubescent children with gender dysphoria and "persist" through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, a clinician cannot take either outcome for granted.

47. It is because of this long-established and unanimous research finding of desistance

[29] Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.,* 2018; Wood, *et al.*, 2013.
[30] Skelly *et al.,* 2012.

being probable but not inevitable, that the "watchful waiting" method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

48. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That is, gender identity is not the same as sexual orientation, and it cannot be assumed that gender identity is as unchangeable as is sexual orientation. Such is an empirical question, and there has not yet been any such study.

49. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such "risk prediction" and "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[31]

50. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single

[31] Singh, *et al.* (2021); Steensma *et al.*, 2013.

composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[32] They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[33] Although the Olson team declared that "social transitions may be predictable from gender identification and preferences,"[34] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[35] Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

51. Although it remains possible for some future discovery to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probability of unnecessary transition and unnecessary medical risks.

52. It was this state of the science—that the majority of prepubescent children will desist

[32] Rae, *et al.*, 2019, at 671.
[33] Rae, *et al.*, 2019, at 673.
[34] Rae, *et al.*, 2019, at 669.
[35] Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, The Dutch Protocol,[36] including its "Watchful Waiting" period. Internationally, the Dutch Protocol remains the most empirically supported protocol for the treatment of children with gender dysphoria.

2. Cohort Studies of Puberty-Blockers and Cross-Sex Hormones

53. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many outlets have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. It total, there have been 11 prospective outcomes studies following up gender dysphoric children undergoing medically induced suppression of puberty or cross-sex hormone treatment. Four studies failed to find evidence of improvement in mental health functioning at all, and some groups deteriorated on some variables.[37] Five studies successfully identified evidence of improvement, but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.[38] In the remaining two studies, both psychotherapy and medical interventions were provided, but the studies were designed in such a way as to allow the effects of psychotherapy to be separated from the effects of the puberty-blocking medications.[39] As detailed in the following, neither identified benefits of medication over psychotherapy alone.

a) Four found no mental health improvement

54. Carmichael, *et al.* (2021) recently released its findings from the Tavistock and Portman

[36] Delemarre-van de Waal & Cohen-Kettenis (2006).
[37] Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.,* 2020; Kuper, *et al.*, 2020.
[38] Allen, *et al.,* 2019; de Vries, *et al.,* 2011, 2014; Tordoff, *et al.,* 2022; van der Miesen, *et al.,* 2020.
[39] Achille, *et al.*, 2020; Costa, *et al.,* 2015.

clinic in the U.K.[40] Study participants were ages 12–15 (Tanner stage 3 for natal males, Tanner stage 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

55. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[41] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to practice guidelines from the Endocrine Society.[42] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[43] Notably, whereas the Dutch Protocol includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[44]

56. Hisle-Gorman, *et al.* (2021) analyzed military families' healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, with their non-gender dysphoric siblings as controls. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not

[40] Carmichael, *et al.*, 2021.
[41] Kuper, *et al.*, 2020, at 5.
[42] Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.
[43] Kuper, *et al.*, 2020, at Table 2.
[44] Kuper, *et al.*, 2020, at 4.

differ from each other. Study participants had a mean age of 18 years when beginning the study, but their initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, "mental health care visits overall did not significantly change following gender-affirming pharmaceutical care,"[45] yet, "psychotropic medication use *increased,"*[46] indicating *deteriorating* mental health.

57. Kaltiala et al. (2020) similarly reported that after cross-sex hormone treatment, "Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life."[47] They concluded, "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development."[48]

b) Five confounded psychotherapy with medical treatment

58. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement.[49] It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.

59. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression[50] and later cross-hormone treatment and surgical sex

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45 Hisle-Gorman, et al., 2021, at 1448.
46 Hisle-Gorman, et al., 2021, at 1448, emphasis added.
47 Kaltiala et al., 2020, at 213.
48 Kaltiala et al., 2020, at 213.
49 de Vries, *et al.,* 2011; de Vries, *et al.,* 2014
50 de Vries, *et al*., 2011.

reassignment.[51] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[52]

60. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[53]

61. In a 2020 update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[54] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it again cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As

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51 de Vries, *et al.,* 2014.
52 Biggs, 2020.
53 de Vries, *et al*. 2011, at 2281.
54 van der Miesen, *et al*., 2020, at 699.

the study authors noted again, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes."[55]

62. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, "whether a patient is actively receiving psychotherapy" may have been a confounding variable.[56]

63. Tordoff, *et al.* (2022) reported on a sample of youth, ages 13–20 years, treated with either puberty blockers or cross-sex hormones. There were improvements in mental health functioning; however, 62.5% of the sample was again receiving mental health therapy.[57]

c) Two showed no advantage of medical intervention

64. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[58] This clinical team subsequently released its final report, finding that neither group actually experienced significant improvement,[59] making moot any discussion of the source any improvement.

65. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not

[55] van der Miesen, *et al*., 2020, at 703.
[56] Allen, *et al.,* 2019.
[57] Tordoff, et al., 2022, Table 1.
[58] Costa, *et al*., 2015, at 2212 Table 2.
[59] Carmichael, et al., 2021.

indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[60] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[61] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*."[62] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

d) Conclusions

66. The authors of the original Dutch studies were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[63] Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 *years*[64]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with

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[60] Achille, *et al*., 2020, at 2.
[61] Achille, *et al*., 2020, at 2.
[62] Achille, *et al*., 2020, at 3 (italics added).
[63] de Vries, *et al*. 2011, at 2282, italics added.
[64] de Vries, *et al*., 2011.

clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

67. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[65] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

3. Social transition may increase persistence/decrease desistance

68. In addition to these, another study followed-up children, ages 3–12 (average of 8), who had already made a complete, binary (rather than intermediate) social transition, including a change of pronouns.[66] (Olson et al., in press). The study did not employ DSM-5 diagnoses, as "Many parents in this study did not believe that such diagnoses were either ethical or useful and some children did not experience the required distress criterion."[67] Rather, children were classified according to their pronoun preference. In contrast with the studies of non-transitioned children, only few (7.3%) in the Olson sample desisted (7.3%, which Olson et al. called "retransitioned").[68] Although the Olson team did not discuss it, their finding matches the Zucker hypothesis that social transition itself represents an active intervention, such that social transition causes the persistence (or, conversely, that social transition prevents desistance, such as by withholding from the child

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[65] Tetelepta, 2021.
[66] Olson, *et al.,* in press.
[67] Olson, *et al.,* in press.
[68] Olson, *et al.,* in press.

opportunities to develop confidence as members of their biological sex).[69]

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

69. As shown by the outcomes studies, there is little evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

70. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first, with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but retains the opportunity to do so later.

71. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a formal DSM diagnosis.[70] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment

[69] Singh, *et al.,* 2021; Zucker, 2018, 2020.
[70] Wallien, *et al*., 2007.

instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[71] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

72. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.[72] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[73] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[74]

D. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

73. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.[75] Unlike adult-onset

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71 Cohen-Kettenis, *et al*., 2003, at 46.
72 Thrower, *et al*., 2020.
73 Thrower, *et al*., 2020, at 703.
74 Janssen, *et al*., 2016.
75 Kaltiala-Heino, *et al*., 2015; Littman, 2018.

or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[76] The majority of cases appear to occur within clusters of peers and in association with increased social media use[77] and especially among people with autism or other neurodevelopmental or mental health issues.[78]

74. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.[79] (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[80] Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to adolescent-onset gender dysphoria. The multiple differences already observed between these groups argue against predicting that features present in one type would generalize to be present in all types of gender dysphoria.

2. Social Transition and Puberty Blockers with Adolescent Onset

75. There do not yet exist prospective outcomes studies either for social transition or for

[76] Littman, 2018.
[77] Littman, 2018.
[78] Kaltiala-Heino, *et al*., 2015; Littman, 2018; Warrier, *et al.*, 2020.
[79] Boivin, *et al*., 2020.
[80] Biggs, 2020; Littman, 2018.

medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective.* It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

76. In 2019, a Special Section appeared in the *Archives of Sexual Behavior* titled, "Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria, by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[81] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[82] with suicide attempts ranging 10 to 45%.[83] Self-injurious thoughts and behaviors range 14–39%.[84] Anxiety disorders and disruptive behavior

[81] Janssen, *et al*., 2019.
[82] Holt, *et al*., 2016; Skagerberg, *et al*., 2013; Wallien, *et al*., 2007.
[83] Reisner, *et al.,* 2015.
[84] Holt, *et al*., 2016; Skagerberg, *et al*., 2013.

difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[85] Gender dysphoria also overlaps with Autism Spectrum Disorder.[86]

77. Of particular concern in the context of adolescent onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria to follow). It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD.[87] That is, some people may be misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

78. DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

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[85] de Vries, *et al*., 2011; Mustanski, *et al*., 2010; Wallien, *et al*., 2007.
[86] de Vries, *et al*., 2010; Jacobs, *et al*., 2014; Janssen, *et al*., 2016; May, *et al*., 2016; Strang, *et al*., 2014, 2016.
[87] *E.g.*, Anzani, *et al.,* 2020; Zucker, 2019.

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

79. Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition, and a primary cause for concern is symptom Criterion 5: Recurrent suicidality. (The research on suicide and suicidality are detailed in their own section herein.) Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality.

80. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that it poses a potential confound: Samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

E. Suicide and Suicidality

81. Social media increasingly circulate demands for transition accompanied by hyperbolic warnings of suicide should there be delay or obstacle. Claims accompany admissions that "I'd rather have a trans daughter than a dead son," and such threats are treated as the justification for referring to affirming gender transitions as 'life-saving' or 'medically necessary'. Such claims

convey only grossly misleading misrepresentations of the research literature, however, deploying terms for their shock value rather than accuracy, and exploiting common public misperceptions about suicide. Indeed, suicide prevention research and public health campaigns repeatedly warn against circulating such exaggerations, due to the risk of copy-cat behavior they encourage.[88]

82. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with different clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[89] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified by "If you leave me, I will kill myself." Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, denoting distress much more frequently than an intent to die.

83. Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of suicide are among middle-aged and elderly men in high income countries.[90] Biological males are at three times greater risk of death by suicide than are biological females, whereas suicidal ideation, plans, and attempts are three times more common among biological females.[91] In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates

[88] Gould & Lake, 2013.
[89] Freeman, *et al.,* 2017.
[90] Turecki & Brent, 2016
[91] Klonsky et al., 2016; Turecki & Brent, 2016

spanning 12.1–33%.[92] Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%).[93] Suicide attempts occur up to 30 times more frequently than completed suicides.[94] The rate of completed suicides in the U.S. population is 14.5 per 100,000 people.[95] The widely discrepant numbers representing completed suicides versus transient suicidal ideation has left those statistics open to substantial abuse in the media and social media. Despite public media guidelines urging "Avoid dramatic headlines and strong terms such as 'suicide epidemic',"[96] that is exactly what mainstream outlets have done.[97]

84. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide.[98] More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: Because of the overlap between people who self-identify as non-heterosexual and as non-cis-gendered, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) homosexuality. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity

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92 Borges et a., 2010; Nock et al., 2008
93 Klonsky, et al., 2016.
94 Bachman, 2018.
95 World Health Organization, 2022.
96 Samaritans, 2020.
97 E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic.*
98 Haas, *et al.,* 2011.

instead reflect the sexual orientation of the members of the sample.[99]

85. Among post-transition transsexuals, completed suicide rates are elevated, but are nonetheless rare.[100] Regarding suicidality, there have been three recent, systematic reviews of the research literature.[101] All three included specific methods to minimize any potential effects of cherry-picking findings from within the research literature. Compiling the results of 108 articles reported from 64 research projects, Adams and Vincent (2019) found an overall average rate of 46.55% for suicidal ideation (ranging 18.18%–95.5%) and an overall average rate of 27.19% for suicidal attempts (ranging 8.57%–52.4%). These findings confirmed those reported by McNeil, *et al.* (2017), whose review of 30 articles revealed a range of 37%–83% for suicidal ideation and 9.8%–43% for suicidal attempts. Thus, on the one hand, these ranges are greater than those reported for the mainstream population—They instead approximate the rates reported among sexual orientation minorities. On the other hand, with measures so lacking in reliability that they produce every result from 'rare' to 'almost everyone', it is unclear which, if any of them, represents a valid conclusion.

86. McNeil *et al.* (2017) observed also the research to reveal rates of suicidal ideation and suicidal attempts to be related—not to transition status—but to the social support received: The studies reviewed showed support to decrease suicidality, but transition not to. Indeed, in some situations, social support was associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[102]

87. Marshall et al. (2016) identified and examined 31 studies, again finding rates of suicidal ideation and suicide attempts to be elevated, particularly among biological females, indicating that

[99] McNeil, *et al.* (2017)
[100] Wiepjes, *et al.,* 2020.
[101] Adams & Vincent, 2019; Marshall, *et al.,* 2016; McNeil, *et al.* (2017).
[102] Bauer, *et al*., 2015; Canetto, et al., 2021.

suicidality patterns correspond to biological sex rather than self-identified gender.[103]

88. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.[104]

89. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities.[105]

F. Conversion Therapy

90. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, one is only very rarely mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy."[106] Indeed, even

[103] Marshall, et al., 2016.
[104] McNeil, *et al.,* 2017.
[105] Reuter, *et al.,* 2016; Rodriguez-Seiljas, *et al.,* 2021; Zanarni, *et al.,* 2021.
[106] D'Angelo, *et al.,* 2021.

actions of non-therapists, unrelated to any therapy, have been (mis-)labelled conversion therapy, including the prohibition of biological males competing on female teams.[107]

G. Affirmation-on-Demand vs Gate-Keeping

91. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

92. Referring to "affirmation" as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word "affirmation" refers to entirely different actions.

93. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

94. Formal clinical approaches to helping children expressing gender dysphoria employ a

[107] Turban, 2021, March 16.

gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as "the affirmation approach." The most extreme decision-tree would be accurately called affirmation-*on-demand,* involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

95. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of "retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

H. Assessing the "Minority Stress Hypothesis"

96. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[108] The association is not

[108] Meyer, 2003.

entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

97. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood, only for the first time.

98. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.[109] The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

99. A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often

[109] Meyer, 2003.

dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve upon transition and integration into an affirming environment.

V. Clinical Guidelines

100. Several sets of recommendations have been offered regarding the clinical treatment of people with gender dysphoria. The best scientifically validated among them is the Dutch Protocol. Many clinics, however, instead employ Endocrine Society or WPATH guidelines, which leave nearly all decisions to the discretion of the physician rather than to establish any boundaries at all. These sets of guidelines are summarized in table form on the Executive Summary at the beginning of the present report. There do not exist any research studies supporting or justifying the lowering of standards from the Dutch Protocol to the Endocrine Society/WPATH levels. Although the cohort studies with the guidelines cannot distinguish benefits of psychotherapy from medical intervention, the studies showing improvement were those using the Dutch Protocol. None of the studies employing Endocrine Society/WPATH methods suggested substantial improvement.

A. The Dutch Protocol (aka Dutch Approach)

101. The purpose of the protocol was to compromise the conflicting needs among: clients' initial wishes upon assessment, the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

102. The Dutch Protocol was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria*

in children and adolescents: The Dutch Approach.[110] The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

103. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[111]

104. The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-off's. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

105. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents.

106. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating

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[110] de Vries & Cohen-Kettenis, 2012

[111] de Vries & Cohen-Kettenis, 2012, at 301.

psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[112] One is actively treating the person, while carefully "watching" the dysphoria.

B. World Professional Association for Transgender Health (WPATH)

107. The WPATH Standards (version seven) acknowledge the high rates of desistance among prepubescent children:

> [I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).[113]

That is, "In most children, gender dysphoria will disappear before, or early in, puberty."[114]

108. Although WPATH does not refer to puberty blocking medications as "experimental," the document indicates the non-routine, or at least inconsistent availability of the treatment:

> Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).[115]

109. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families' decisions:

> Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health

[112] de Vries, *et al*., 2011, at 2280-2281.
[113] Coleman, *et al*., 2012, at 172.
[114] Coleman, *et al*., 2012, at 173.
[115] Coleman, *et al*., 2012, at 173.

> professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.[116]

It does caution, however, "Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria."[117]

110. An eighth version of the WPATH Standards of Care have been circulated for public comment[118] and is expected to be released in 2022. No cohort studies nor any validation studies have been conducted to assess its contents. Regarding transition among adolescents, version eight recommendations these age and developmental cut-off's:

> F. The adolescent has reached Tanner 2 stage of puberty for pubertal suppression.
>
> G. The adolescent is the following age for each treatment:
> - 14 years and above for hormone treatment (estrogens or androgens), unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 15 years and above for chest masculinization; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 17 and above for metoidioplasty, orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.
> - 18 years or above for phalloplasty, unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.[119]

111. Version eight cites most of the cohort studies of adolescent minors undergoing medical transition. It does not, however, compile, assess, or systematically review their results to identify any patterns across them. Rather, Version eight concludes only that the "design makes interpreting

[116] Coleman, *et al*., 2012, at 176.
[117] Coleman, *et al*., 2012, at 176 (quoting Drummond, *et al*., 2008; Wallien & Cohen-Kettenis, 2008).
[118] Coleman *et al.*, 2021.
[119] Coleman, *et al*., 2021, at 60.

outcomes more challenging".[120] The document notes "the data consistently demonstrate improved or stable psychological functioning, body image, and/or treatment satisfaction"[121] and repeatedly emphasizes the inclusion of mental health treatment, but never acknowledges the confound that psychotherapy poses to the demonstrated improvements.

C. Endocrine Society (ES)

112. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

113. The document acknowledged the frequency of desistance among gender dysphoric children:

> Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.[122]

114. The statement similarly acknowledges inability to predict desistance or persistence, "With current knowledge, we cannot predict the psychosexual outcome for any specific child."[123]

115. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in

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[120] Coleman, *et al.,* 2021, at 56.
[121] Coleman, et al., 2021, at 56.
[122] Hembree, *et al*., 2017, at 3876.
[123] Hembree, *et al*., 2017, at 3876.

transition, “In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues.”[124] This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

116. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: “We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional.”[125]

117. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician “provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes.”[126]

D. American Academy of Pediatrics (AAP)

118. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy

[124] Hembree, *et al*., 2017, at 3877.
[125] Hembree, *et al*., 2017, at 3872.
[126] Hembree, *et al*., 2017, at 3877.

instead outright contradicted that policy, repeatedly endorsing watchful waiting.[127] Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.[128].

119. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. *See* Appendix 3. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, "Has the AAP responded to Dr Cantor? If not, have you any response now?" The AAP Media Relations Manager, Lisa Black, responded: "We do not have anyone available for comment."

VI. International Health Care Consensus

120. As detailed in the following, Westernized countries other than the U.S. have followed a remarkably similar pattern of policy development: The health care systems of these countries responded to the demands of transgender advocates by facilitating transition-on-demand, which was followed by the identification of the failure of those efforts to improve the mental health of an exponentially increasing number of youth, and, currently, by the reversal of initial policy, now endorsing psychotherapy as the treatment of choice, with medical interventions representing a method of last resort, if permitted at all. These range from medical advisories to outright bans on the medical transition of minors.

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127 Cantor, 2020.
128 Cantor, 2020, at 1.

A. United Kingdom

121. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes[129]. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019[130].

122. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review[131]. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the "cherry-picking" or selective citation favouring or down-playing any one conclusion[132]. The review's results were unambiguous: "The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low"[133], again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as "very low" the quality of evidence regarding "body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment"[134]. The report concluded that of the existing research, "The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding….They suggest

[129] Marsh, 2020; Rayner, 2018.
[130] BBC, 2021; Donnelly, 2019.
[131] National Health Service, 2020, Sept. 22.
[132] U.K. National Health Service (NHS), 2021.
[133] U.K. National Health Service (NHS), 2021, at 4.
[134] U.K. National Health Service (NHS), 2021, at 5.

little change with GnRH analogues [puberty blockers] from baseline to follow-up"[135].

B. Finland

123. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment[136]. That study showed that despite the purpose of medical transition to improve mental health: "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development"[137]. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

124. Consistent with the evidence, Finland's health care service (Council for Choices in Health Care in Finland—COHERE) thus ended the surgical transition of minors, ruling in 2020 that "Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors" (COHERE, 2020). The review of the research concluded that "[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development." COHERE also greatly restricted access to puberty-blocking and other hormonal treatments, indicating they "may be considered if the need for it continues *after* the other psychiatric symptoms have ceased and adolescent

[135] U.K. National Health Service (NHS), 2021, at 13.
[136] Kaltiala et al., 2020.
[137] Kaltiala et al., 2020, at 213.

development is progressing normally"[138]. The council was explicit in noting the lack of research needed for decision-making, "There is also a need for more information on the *disadvantages* of procedures and on people who regret them"[139].

C. Sweden

125. Sweden's national health care policy regarding trans issues has developed quite similarly to that of the UK. Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16.) At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden's Board of Health and Welfare reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

126. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research[140]. Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence[141].

127. The SBU report came to the same conclusions as the UK commission. From 2022 forward, the Swedish National Board or Health and Welfare therefore "recommends restraint when

[138] Council for Choices in Health Care in Finland, 2020; italics added.
[139] Council for Choices in Health Care in Finland, 2020; italics added.
[140] Orange, 2020, Feb 22.
[141] Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

it comes to hormone treatment…Based on the results that have emerged, the National Board of Health and Welfare's overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole"[142]. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

D. France

128. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. "[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause…such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause"[143]. For hormones, the Académie concluded "the greatest reserve is required in their use," and for surgical treatments, "[T]heir irreversible nature must be emphasized." The Académie did not outright ban medical interventions, but warned "the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to "detransition". Rather than medical interventions, it advised health care providers "to extend as much as possible the psychological support phase." The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, "underlining the addictive character of excessive consultation of social networks which is both harmful to the psychological development

[142] Swedish National Board of Health and Welfare, 2022.
[143] Académie Nationale de Médecine, 2022, Feb. 25.

of young people and responsible, for a very important part, of the growing sense of gender incongruence."

E. Australia

129. In Australia, from 2004 to 2017, court approval was required before starting hormone treatment. The end of that policy was followed by a jump to the opposite extreme: The subsequent Australian standards of care were explicit in indicating "decision making should be driven by the child or adolescent wherever possible; this applies to options regarding not only medical intervention but also social transition",[144] emphasizing that "Social transition should be led by the child."[145] Notably, these guidelines were based, not on the research literature, but on expert consensus.[146] In 2019, however, the Royal Australian and New Zealand College of Psychiatrists withdrew its support for those guidelines, issuing a position statement prioritizing psychotherapy. In an interview with Medscape, the president of the National Association of Practising Psychiatrists in Australia said that exploration of a patients reasons for identifying as transgender is essential, and "There may be other reasons for doing it and we need to look for those, identify them and treat them. This needs to be done before initiating hormones and changing the whole physical nature of the child."[147]

VII. U.S. Professional Associations

130. In stark contrast with the consensus of the international health bodies endorsing evidence-based medicine, some U.S. medical associations instead continue to endorse medical intervention for children. The value of such endorsement should not be either over or under-estimated. The general public typically infers from such support that it followed from the

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[144] Telfer, *et al.,* 2018, at 133.
[145] Telfer, *et al.,* 2018, at 134.
[146] Telfer, *et al.,* 2018, at 132.
[147] *Medscape,* 2021, Oct. 7.

association having conducted a scholarly review of the scientific evidence, ideally using standardized research methods to isolate biases and prevent cherry-picking that favors any specific results. Yet, whereas European public health services have engaged in exactly these comprehensive and transparent methods,[148] the American professional associations have not.

131. With the broad exception of the AAP, the professional associations' statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.
- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

A. Pediatric Endocrine Society and Endocrine Society (ES/PES)

132. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.[149] Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.[150]

133. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society "recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance."[151] However, the Endocrine Society makes neither statement. Although the two-page PES document

[148] U.K. National Health Service (NHS), 2021.
[149] PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.
[150] Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al*., 2017.
[151] Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: "If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action."[152] Despite the PES asserting it as "medically necessary," the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: "We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being."[153]

B. American Academy of Child & Adolescent Psychiatry (AACAP)

134. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

135. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.[154]

136. The AACAP's language repeats the description of the use of puberty blockers only as an exception: "For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using

[152] Hembree, *et al*. 2017, at 3883.
[153] Hembree, *et al*., 2017 at 3872, 3894.
[154] Adelson & AACAP, 2012, at 969.

gonadotropin-releasing hormone analogues."[155]

137. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: "In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,"[156] adding that "[c]linicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality."[157]

138. The policy similarly includes a provision for resolving mental health issues: "Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*."[158] The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).[159]

139. Rather than endorse social transition for prepubertal children, the AACAP indicates: "There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so."[160]

C. American College of Obstetricians & Gynecologists (ACOG)

140. The American College of Obstetricians & Gynecologists (ACOG) published a "Committee Opinion" expressing recommendations in 2017. The statement indicates it was

[155] Adelson & AACAP, 2012, at 969 (italics added).
[156] Adelson & AACAP, 2012, at 963.
[157] Adelson & AACAP, 2012, at 968.
[158] Adelson & AACAP, 2012, at 970 (italics added).
[159] Adelson & AACAP, 2012, at 969.
[160] Adelson & AACAP, 2012, at 969.

developed by the ACOG's Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: "This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed."[161]

141. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally have a primary health care provider.[162]

142. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE),, PES, and the Endocrine Society—and by WPATH.[163] It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: "*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved."[164]

143. The "Eligibility and Readiness Criteria" also include, "Diagnosis established for gender dysphoria, transgender, transsexualism."[165] This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for

[161] ACOG, 2017, at 1.
[162] ACOG, 2017, at 1.
[163] ACOG, 2017, at 1, 3.
[164] ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (italics added).
[165] ACOG, 2017, at 3 Table 1.

DSM diagnosis.

144. ACOG's remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

D. American College of Physicians (ACP)

145. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining "family" by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender health care services in public and private health benefit plans.[166]

146. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting "reparative therapy;" however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that "[s]exual orientation and gender identity are inherently different."[167] It based this statement on the fact that "the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*."[168] The APA's document, entitled "Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*" does not include or reference research on gender identity.[169] Despite citing no research about transgenderism, the ACP nonetheless included in its statement: "Available research does not support the use of reparative therapy as an effective method in the treatment of LGB*T*

[166] Daniel & Butkus, 2015a, 2015b.
[167] Daniel & Butkus, 2015b, at 2.
[168] Daniel & Butkus, 2015b, at 8 (italics added).
[169] APA, 2009 (italics added).

persons."[170] That is, the inclusion of "T" with "LGB" is based on something other than the existing evidence.

147. There is another statement,[171] which was funded by ACP and published in the Annals of Internal Medicine under its "*In the Clinic*" feature, noting that "'In the Clinic' does not necessarily represent official ACP clinical policy."[172] The document discusses medical transition procedures for adults rather than for children, except to note that "[n]o medical intervention is indicated for prepubescent youth,"[173] that a "mental health provider can assist the child and family with identifying an appropriate time for a social transition,"[174] and that the "child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is higher than in their cisgender peers."[175]

E. The ESPE-LWPES GnRH Analogs Consensus Conference Group

148. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).[176] Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

149. The effort concluded that "[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely."[177] However, gender dysphoria was not explicitly mentioned as one of those

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[170] Daniel & Butkus, 2015b, at 8 (italics added).
[171] Safer & Tangpricha, 2019.
[172] Safer & Tangpricha, 2019, at ITC1.
[173] Safer & Tangpricha, 2019, at ITC9.
[174] Safer & Tangpricha, 2019, at ITC9.
[175] Safer & Tangpricha, 2019, at ITC9.
[176] Carel et al., 2009.
[177] Carel et al. 2009, at 752.

other conditions. Such additional investigations have still not appeared in the research literature, and the need for them continues to be expressed by these same professional bodies.

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APPENDICES

Appendix 1

Curriculum Vita

Appendix 2

The Outcomes Studies of Childhood-Onset Gender Dysphoria

Appendix 3

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy, 46,* 307–313. doi: 10.1080/0092623X.2019.1698481

Appendix 4

WPATH Standards of Care For The Health Of Transsexual, Transgender, And Gender-Nonconforming People (Version 7), Chapter 6 (Adolescents)

Appendix 5

WPATH Standards of Care (Version 8),

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EDUCATION

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Doctor of Philosophy Sep., 1993–Jun., 2000
Psychology • McGill University • Montréal, Canada

Master of Arts Sep., 1990–Jan., 1992
Psychology • Boston University • Boston, MA

Bachelor of Science Sep. 1984–Aug., 1988
Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

EMPLOYMENT HISTORY

Director Feb., 2017–Present
Toronto Sexuality Centre • Toronto, Canada

Senior Scientist (Inaugural Member) Aug., 2012–May, 2018
Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Senior Scientist Jan., 2012–May, 2018
Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Head of Research Nov., 2010–Apr. 2014
Sexual Behaviours Clinic
Centre for Addiction and Mental Health • Toronto, Canada

Research Section Head Dec., 2009–Sep. 2012
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Psychologist May, 2004–Dec., 2011
Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Aug. 2013–Jun., 2018
Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
University of New England • Armidale, Australia

Assistant Professor Jun., 2005–Jun., 2010
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Sep., 2004–Jun., 2010
Clinical Psychology Residency Program
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PUBLICATIONS

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PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine, 12,* 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior, 44,* 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior, 36,* 288–292. doi: 10.1080/01639625.2014.935644
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6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior, 41,* 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health, 11,* 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior, 41, 749–752.* doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior, 40*, 863–864. doi: 10.1007/s10508-011-9805-6
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11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association, 19*(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association, 19*(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association, 18*(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach. Journal of Sex and Marital Therapy, 26*, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment, 24*.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment, 23,* 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicates for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 22,* 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 21,* 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research, 38,* 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment, 20,* 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print[Editorial]. *Archives of Sexual Behavior, 37,* 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior, 35,* 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: “Goin’ up” [Editorial]. *Archives of Sexual Behavior, 34,* 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior, 32,* 3–5.

FUNDING HISTORY

Principal Investigators:	Doug VanderLaan, Meng-Chuan Lai
Co-Investigators:	James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title:	*Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds:	$650,250 / 5 years (July, 2018)

Principal Investigator:	Michael C. Seto
Co-Investigators:	Martin Lalumière , James M. Cantor
Title:	*Are connectivity differences unique to pedophilia?*
Agency:	University Medical Research Fund, Royal Ottawa Hospital
Funds:	$50,000 / 1 year (January, 2018)

Principal Investigator:	Lori Brotto
Co-Investigators:	Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title:	*Investigations into the neural underpinnings and biological correlates of asexuality*
Agency:	Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds:	$195,000 / 5 years (April, 2017)

Principal Investigator:	Doug VanderLaan
Co-Investigators:	Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title:	*Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency:	Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds:	$952,955 / 5 years (September, 2015)

Principal Investigator:	James M. Cantor
Co-Investigators:	Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title:	*Neuroanatomic features specific to pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$1,071,920 / 5 years (October, 2008)

Principal Investigator:	James M. Cantor
Title:	*A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency:	Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds:	$10,000 (July, 2008)

Principal Investigator:	James M. Cantor
Co-Investigator:	Ray Blanchard
Title:	*Morphological and neuropsychological correlates of pedophilia*
Agency:	Canadian Institutes of Health Research (CIHR)
Funds:	$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review.* Plenary Session for the 40th Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
2. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
3. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests.* Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered.* Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, April 13). *The responses to* I, Pedophile *from We, the people.* Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to* I, Pedophile. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
8. Cantor, J. M. (2017, November 2). Pedophilia as a phenomenon of the brain: Update of evidence and the public response. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
9. Cantor, J. M. (2017, June 9). Pedophilia being in the brain: The evidence and the public's reaction. Invited presentation to *SEXposium at the ROM: The science of love and sex,* Toronto, Canada.
10. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion.* Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
11. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities.* Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
12. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction.* Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't.* Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: https://vimeo.com/239131108/3387c80652]
15. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research.* Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

16. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole.* Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
17. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World.* Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
18. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't.* Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
19. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process.* Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
20. Cantor, J. M. (2015, June). *Hypersexuality.* Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
21. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future.* Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
22. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles.* Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
23. Cantor, J. M. (2015, March. *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
24. Cantor, J. M. (2015, February). *Hypersexuality.* Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
25. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy.* Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
26. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society.* Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
27. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain.* Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
28. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications.* Invited lecture presented to the Mental Health and Addition Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
29. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor.* Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, April). *Pedophilia and the brain.* Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update.* Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
32. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.

33. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications.* Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
34. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia.* Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update.* Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we* do*?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
37. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications.* McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
38. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain.* Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
39. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy.* Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
40. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy.* Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
41. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art.* Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
42. Cantor, J. M. (2013, January). *Pedophilia and child molestation.* Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
43. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety.* Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
44. Cantor, J. M. (2012, November). *Pedophilia and brain research.* Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
45. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research.* Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
46. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend.* Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy.* Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men.* Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensberg, Germany.

49. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art.* Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
50. Cantor, J. M. (2010, October). *Manuscript publishing for students.* Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
51. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
52. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art.* Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
53. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men.* Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
54. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
55. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men.* Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
56. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia.* Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
57. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles.* Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
58. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders.* Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
59. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model.* Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research.* Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles.* Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism.* Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study.* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI–2).* Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI.* Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice.* Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis.* Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications.* Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research.* Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

preferences. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.

14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences.* Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging.* Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women.* Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies.* Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders.* Paper presented at the 26th annual meetingof the Association for the Treatment of Sexual Abusers, San Diego.
19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology.* Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma.* Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ–PIQ differences in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change…* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders.* Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students.* Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders.* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2).* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention.* Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females.* Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities.* Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior.* Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice.* Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness.* Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia.* Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review.* Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test.* Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayedi, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men.* Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies.* Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V.* Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia.* Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women.* Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia.* Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove. S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality.* Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement.* Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnestic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment	Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression	Jan., 2010–Dec., 2021
Journal of Sex Research, The	Jan., 2008–Aug., 2020
Sexual Abuse: A Journal of Research and Treatment	Jan., 2006–Dec., 2019
Archives of Sexual Behavior	Jan., 2004–Present
The Clinical Psychologist	Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry
Annual Review of Sex Research
Archives of General Psychiatry
Assessment
Biological Psychiatry
BMC Psychiatry
Brain Structure and Function
British Journal of Psychiatry
British Medical Journal
Canadian Journal of Behavioural Science
Canadian Journal of Psychiatry
Cerebral Cortex
Clinical Case Studies
Comprehensive Psychiatry
Developmental Psychology
European Psychologist
Frontiers in Human Neuroscience
Human Brain Mapping
International Journal of Epidemiology
International Journal of Impotence Research
International Journal of Sexual Health
International Journal of Transgenderism
Journal of Abnormal Psychology
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Forensic Psychology Practice
Journal for the Scientific Study of Religion
Journal of Sexual Aggression
Journal of Sexual Medicine
Journal of Psychiatric Research
Nature Neuroscience
Neurobiology Reviews
Neuroscience & Biobehavioral Reviews
Neuroscience Letters
Proceedings of the Royal Society B (Biological Sciences)
Psychological Assessment
Psychological Medicine
Psychological Science
Psychology of Men & Masculinity
Sex Roles
Sexual and Marital Therapy
Sexual and Relationship Therapy
Sexuality & Culture
Sexuality Research and Social Policy
The Clinical Psychologist
Traumatology
World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research,* Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2015 Reviewer. *Czech Science Foundation,* Czech Republic.

2015 Reviewer, "Off the beaten track" grant scheme. *Volkswagen Foundation,* Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council,* Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean's Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine,* Canada.

2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.

2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.

2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research],* Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision
Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug, 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision
Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)
Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolin Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019 Local Host. Society for Sex Therapy and Research.

2015 Member, International Scientific Committee, World Association for Sexual Health.

2015 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers

2012–2013 Chair, Student Research Awards Committee, Society for Sex Therapy & Research

2012–2013 Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers

2011–2012 Chair, Student Research Awards Committee, Society for Sex Therapy & Research

2010–2011 Scientific Program Committee, International Academy of Sex Research

2002–2004 Membership Committee • APA Division 12 (Clinical Psychology)

2002–2003 Chair, Committee on Science Issues, APA Division 44

2002 Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)

2001–2009 Reviewer • APA Division 44 Convention Program Committee

2001, 2002 Reviewer • APA Malyon-Smith Scholarship Committee

2000–2005 Task Force on Transgender Issues, APA Division 44

1998–1999 Consultant, APA Board of Directors Working Group on Psychology Marketplace

1997 Student Representative • APA Board of Professional Affairs' Institute on TeleHealth

1997–1998 Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns

1997–1999 Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges

1997–1999 Liaison • APA Committee for the Advancement of Professional Practice

1997–1998 Liaison • APA Board of Professional Affairs

1993–1997 Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association* (CPA)

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association* (APA)

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
"TA of the Year Award," from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. *Age of Consent.* 14 Jan 2017.
Canadian Broadcasting Company. *I, Pedophile.* Firsthand documentaries. 10 Mar 2016.

Appearances and Interviews

11 Mar 2020. Ibbitson, John. It is crucial that Parliament gets the conversion-therapy ban right. *The Globe & Mail.*
25 Jan 2020. Ook de hulpvaardige buurman kan verzamelaar van kinderporno zin. *De Morgen.*
3 Nov 2019. Village of the damned. *60 Minutes Australia.*
1 Nov 2019. HÅKON F. HØYDAL. Norsk nettovergriper: – Jeg hater meg selv: Nordmannen laster ned overgrepsmateriale fra nettet – og oppfordrer politiet til å gi amnesti for slike som ham.
10 Oct 2019. Smith, T. Growing efforts are looking at how—or if—#MeToo offenders can be reformed. *National Public Radio.*
29 Sep 2019. Carey, B. Preying on Children: The Emerging Psychology of Pedophiles. *New York Times.*
29 Apr 2019. Mathieu, Isabelle. La poupée qui a troublé les Terre-Neuviens. *La Tribune.*
21 Mar 2019. Pope Francis wants psychological testing to prevent problem priests. But can it really do that? *The Washington Post.*
12 Dec 2018. Child sex dolls: Illegal in Canada, and dozens seized at the border. Ontario Today with Rita Celli. *CBC.*
12 Dec 2018. Celli, R. & Harris, K. Dozens of child sex dolls seized by Canadian border agents. *CBC News.*
27 Apr 2018. Rogers, Brook A. The online 'incel' culture is real–and dangerous. *New York Post.*
25 Apr 2018. Yang, J. Number cited in cryptic Facebook post matches Alek Minassian's military ID: Source. *Toronto Star.*
24 Ap 2018 Understanding 'incel'. *CTV News.*
27 Nov 2017. Carey, B. Therapy for Sexual Misconduct? It's Mostly Unproven. *New York Times.*
14 Nov 2017. Tremonti, A. M. The Current. *CBC.*
9 Nov2017. Christensen, J. Why men use masturbation to harass women. *CNN.* http://www.cnn.com/2017/11/09/health/masturbation-sexual-harassment/index.html
7 Nov 2017. Nazaryan, A. Why is the alt-right obsessed with pedophilia? *Newsweek.*
15 Oct 2017. Ouatik, B. Déscouvre. Pédophilie et science. *CBC Radio Canada.*
12 Oct 2017. Ouatik, B. Peut-on guérir la pédophilie? *CBC Radio Canada.*
11 Sep 2017. Burns, C. The young paedophiles who say they don't abuse children. *BBC News.*
18 Aug 2017. Interview. *National Post Radio.* Sirius XM Canada.
16 Aug 2017. Blackwell, Tom. Man says he was cured of pedophilia at Ottawa clinic: 'It's like a weight that's been lifted': But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished. *National Post.*
26 Apr 2017. Zalkind, S. Prep schools hid sex abuse just like the catholic church. *VICE.*
24 Apr 2017. Sastre, P. Pédophilie: une panique morale jamais n'abolira un crime. *Slate France.*
12 Feb 2017. Payette, G. Child sex doll trial opens Pandora's box of questions. *CBC News.*
26 Nov 2016. Det morke uvettet ["The unknown darkness]". *Fedrelandsvennen.*
13 July 2016. Paedophilia: Shedding light on the dark field. *The Economist.*

1 Jul 2016. Debusschere, B. Niet iedereen die kinderporno kijkt, is een pedofiel: De mythes rond pedofilie ontkracht. *De Morgen.*
12 Apr 2016. O'Connor, R. Terence Martin: The Tasmanian MP whose medication 'turned him into a paedophile'. *The Independent.*
8 Mar 2016. Bielski, Z. 'The most viscerally hated group on earth': Documentary explores how intervention can stop pedophiles. *The Globe and Mail.*
1 Mar 2016. Elmhirst, S. What should we do about paedophiles? *The Guardian.*
24 Feb 2016. The man whose brain tumour 'turned him into a paedophile'. *The Independent.*
24 Nov 2015. Byron, T. The truth about child sex abuse. *BBC Two.*
20 Aug 2015. The Jared Fogle case: Why we understand so little about abuse. *Washington Post.*
19 Aug 2015. Blackwell, T. Treat sex offenders for impotence—to keep them out of trouble, Canadian psychiatrist says. *National Post.*
2 Aug 2015. Menendez, J. BBC News Hour. *BBC World Service.*
13 Jul 2015. The nature of pedophilia. *BBC Radio 4.*
9 Jul 2015. The sex-offender test: How a computerized assessment can help determine the fate of men who've been accused of sexually abusing children. *The Atlantic.*
10 Apr 2015. NWT failed to prevent sex offender from abusing stepdaughter again. *CBC News.*
10 Feb 2015. Savage, D. "The ethical sadist." In Savage Love. *The Stranger.*
31 Jan 2015. Begrip voor/van pedofilie [Understanding pedophilia]. *de Volkskrant.*
9 Dec 2014. Carey, B. When a rapist's weapon is a pill. *New York Times*.
1 Dec 2014. Singal, J. Can virtual reality help pedophiles? *New York Magazine.*
17 Nov2014. Say pedófile, busco aydua. *El Pais.*
4 Sep 2014. Born that way? *Ideas, with Paul Kennedy.* CBC Radio One.
27 Aug 2014. Interrogating the statistics for the prevalence of paedophilia. BBC.
25 Jul 2014. Stephenson, W. The prevalence of paedophilia. *BBC World Service.*
21 Jul 2014. Hildebrandt, A. Virtuous Pedophiles group gives support therapy cannot. *CBC.*
26 Jan 2014. Paedophilia a result of faulty wiring, scientists suggest. *Daily Mail.*
22 Dec 2013. Kane, L. Is pedophilia a sexual orientation? *Toronto Star.*
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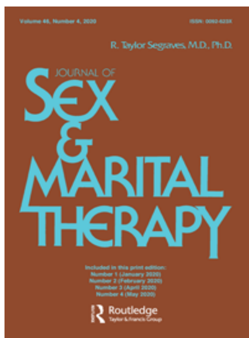
LEGAL TESTIMONY, PAST 4 YEARS

	Year	Case	Venue
1.	2022	A.M. v Indiana Public Schools	Southern District, IN
2.	2022	Ricard v Kansas	Geery County, KS
3.	2022	Eknes-Tucker v Alabama	Montgomery County, AL
4.	2022	Hersom & Doe v WVa Health & Human Services	Southern District, WVa
5.	2022	BPJ v West Virginia Board of Education	Southern District, WVa
6.	2021	Cox v Indiana Child Services	Child Services, IN
7.	2021	Josephson v University of Kentucky	Western District, KY
8.	2021	Cross et al. v Loudoun School Board	Loudoun, VA
9.	2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, IL
10.	2019	US vs Peter Bright	Southern District, NY
11.	2019	Spiegel-Savoie vs Savoie-Sexten (Custody Hearing)	Boston, MA
12.	2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, IL
13.	2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, NY

Prospective Outcomes Studies of Gender Dysphoric Children

2/16 4/16 10/16	gay trans-/crossdress straight/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19, 363–369.*
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,*511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.
17/139 122/139	trans- cis-	Singh, D., Bradley, S. J., and Zucker, K. J. (2021) A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry, 12, 632784. doi: 10.3389/fpsyt.2021.632784



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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

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whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

> "[C]onversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions.... Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42]

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.
29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.
39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.
40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.
41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.
42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP's claims struck me as odd because *there are no studies of conversion therapy for gender identity.* Studies of conversion therapy have been limited to *sexual orientation,* and, moreover, to the sexual orientation *of adults,* not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only.* Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: "The practice and ethics of *sexual orientation* conversion therapy" [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP's citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP's sources *did* repeatedly emphasize was that:

A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced "conversion": The majority of children "convert" to cisgender or "desist" from transgender

regardless of any attempt to change them. "Conversion" only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that "gender identity is not synonymous with 'sexual orientation'" (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP's fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity,* AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: "Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through 'reparative therapy' *in adults* have found little or no change in *sexual orientation,* while causing significant risk of harm to self-esteem" (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP's actual view was decidedly neutral, noting the lack of evidence: "Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed" (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: "In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood" (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP's actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: "Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*" (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic's lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the "mainstream of traditional medical practice" consists of (the logic being that conversion therapy falls outside what an 'ideal' clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: "[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved" (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: "An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the DSM and not unique to GIDC)" (Bryant, 2006, p. 35). How this article supports AAP's claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association's (APA's) update of the DSM, the statement asserted simply that "The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide." Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the DSM as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the DSM revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH's urging. This makes AAP's logic entirely backwards: That WPATH's request to depathologize gender dysphoria was *rejected* suggests that it is *WPATH's* view—and therefore the AAP policy—which fall "outside the mainstream of traditional medical practice." (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used "to prevent children and adolescents from identifying as transgender" (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP's sources is "delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity" in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP's stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it "outdated." The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

> [G]ender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47]

The citations from AAP's reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend.* 2018;19(2):251–268

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry.* 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence,* this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of "persistence-after-interruption." Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is "outdated" either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: "Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *favored by the standards,* we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5" (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: "When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child" (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summaries the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, "This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population"; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, "Current available research and expert opinion from clinical and research leaders … will serve as the basis for recommendations" (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

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Rafferty, J., AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*, *142*(4), e20182162 doi:10.1542/peds.2018-2162

Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*, 147–148. doi:10.1016/j.jaac.2014.10.016

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Appendix

Count	Group	Study
2/16 4/16 10/16	gay* trans-/crossdress straight*/uncertain	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry, 128,* 1283–1289.
2/16 2/16 12/16	trans- uncertain gay	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. *Comprehensive Psychiatry, 19,* 363–369.
0/9 9/9	trans- gay	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology, 4,* 29–41.
2/45 10/45 33/45	trans-/crossdress uncertain gay	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172,* 90–97.
1/10 2/10 3/10 4/10	trans- gay uncertain straight	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior, 15,* 511–517.
1/44 43/44	trans- cis-	Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
0/8 8/8	trans- cis-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia, 146,* 565–569.
21/54 33/54	trans- cis-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1413–1423.
3/25 6/25 16/25	trans- lesbian/bi- straight	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*, 34–45.
17/139 122/139	trans- cis-	Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.
47/127 80/127	trans- cis-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 582–590.

*For brevity, the list uses “gay” for “gay and cis-”, “straight” for “straight and cis-”, etc.

VI
Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

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there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

Statement 12G:

The adolescent is the following age for each treatment:

> ***14 years and above for hormone treatment (estrogens or androgens), unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***15 years and above for chest masculinization; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***17 and above for metoidioplasty , orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***
> ***18 years or above for phalloplasty, unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.***

The ages outlined above provide general guidance on the age at which gender affirming interventions may be considered. Age criteria should be considered in addition to other criteria outlined for gender affirming interventions in youth as outlined in statements 12 A-F. Individual needs, decision making capacity for the specific treatment being considered, and developmental stage (rather than age) are most relevant when determining timing of treatment decisions for individuals. Age has a strong correlation, though not perfect, with cognitive and psychosocial development and may be a useful objective marker in determining potential timing of interventions (Ferguson, Brunsdon, & Bradford, 2021). Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility and/or complexity. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (See 12C).

Recommendations above are based on available evidence; expert consensus; and ethical considerations including, respect for the emerging autonomy of adolescents and minimizing harm in the setting of a limited evidence base. Historically, there has been hesitancy in the transgender healthcare setting to offer gender affirming treatments with potential irreversible effects to minors. The age criteria set forth in these guidelines are intended to facilitate youth's access to gender affirming treatments, and are younger than ages stipulated in previous guidelines (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender affirming intervention being considered youth must communicate consent/assent and be able to demonstrate an understanding and appreciation of potential benefits and risks specific to the intervention (See statement 12C).

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit H

Transcript of July 6, 2022 Temporary Injunction Hearing

03-22-00420-CV

1 **REPORTER'S RECORD**
VOLUME 2 OF 4 VOLUMES
2 **TRIAL COURT CAUSE NO. D-1-GN-22-002569**

FILED IN
3rd COURT OF APPEALS
AUSTIN, TEXAS
8/1/2022 12:56:01 PM
JEFFREY D. KYLE
Clerk

PFLAG, INC., ET AL.,	)	IN THE DISTRICT COURT
Plaintiffs,	)	
	)	
VS.	)	TRAVIS COUNTY, TEXAS
	)	
GREG ABBOTT, ET EL.,	)	
Defendants.	)	459TH JUDICIAL DISTRICT

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12 **HEARING ON MOTION FOR TEMPORARY INJUNCTION**
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20 On the 6th day of July, 2022, the following
21 proceedings came on to be heard in the above-entitled
22 and numbered cause before the Honorable Amy Clark
23 Meachum, Judge Presiding, held in Austin, Travis
24 County, Texas:
25 Proceedings reported by machine shorthand.

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1 **EXHIBIT INDEX**

2

3 **PLAINTIFFS'**

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
2	Letter	133	134	1
3	Statement	135	135	1
5	Dr. Brady's CV	88	88	1
7	Endocrine Treatment	98	--	1
15	Agenda	137	137	1
16	CPS Handbook	138	139	1
17	CPS Handbook	139	139	1
18	CPS Handbook	139	140	1
19	CPS Handbook	140	140	1
20	CPS Handbook	141	141	1
22	PFLAG Articles of Incorporation	63	63	1
23	PFLAG National Bylaws	64	65	1

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1 **EXHIBIT INDEX CONTINUED**

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3 **DEFENDANTS'**

NO.	DESCRIPTION	OFFER	ADMIT	VOL.
1	Dr. Cantor's Report	173	--	1
2	Dr. Laidlaw's Report	202	--	1
3	Mr. Black's Declaration	203	--	1
9	Roe Investigation File **(Sealed Exhibit)**	255	--	1
10	Tommy Roe Audio Interview **(Sealed Exhibit)**	255	--	1
11	Voe Investigation File **(Sealed Exhibit)**	255	--	1
12	Briggle Investigation File **(Sealed Exhibit)**	255	--	1
13	Briggle Audio Interview **(Sealed Exhibit)**	255	--	1
25	Poe Investigation File **(Sealed Exhibit)**	255	--	1
26	Dr. Cantor's CV	200	200	1
31	Business Records Affidavit	266	269	1

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1 THE COURT: This is GN-22-2569, PFLAG,
2 et al. vs. Abbott, et al. This Judge Amy Clark
3 Meachum. We are here today in person, July 6th, 2022,
4 to proceed with a temporary injunction hearing.
5 I've already informed everyone off the
6 record, but I will say it again on the record, there is
7 no recording allowed of these proceedings, no audio or
8 video. It's against Court rule to do so.
9 If any side does wish to take a photo or
10 somebody from the media wishes -- wishes to take a
11 photo, I'm going to ask that they ask for permission of
12 the Court and the parties and the lawyers because that
13 is not something we traditionally do, but I recognize
14 that this is a matter of public import.
15 And we have also been for the past two
16 years mostly doing virtual court and -- which that is
17 always on some level broadcasting. And so I think
18 understanding the -- that times are changing, perhaps
19 some of our approach to how we handle courts and
20 cameras and photography, et cetera, is changing, too,
21 but we are just in a transitional time.
22 At this time, the Court will take
23 attorney announcements for each side, first for the
24 plaintiffs, anybody who is speaking.
25 MR. CASTILLO: Good morning, Your Honor.

1 My name is Paul Castillo with Lambda Legal for the
2 plaintiffs.
3 MS. SAMANT: Good morning, Your Honor.
4 My name is Anjana Samant with the ACLU for the
5 plaintiffs.
6 MR. GONZALEZ-PAGAN: Good morning,
7 Your Honor. Omar Gonzalez-Pagan with Lambda Legal for
8 the plaintiffs.
9 MR. KLOSTERBOER: Good morning,
10 Your Honor. Brian Klosterboer with the ACLU of Texas
11 for the plaintiffs.
12 MR. GUILLORY: Good morning, Your Honor.
13 Nicholas Guillory with Lambda Legal for the plaintiffs.
14 MR. COOK: Good morning, Your Honor.
15 Currey Cook, Lambda Legal, for the plaintiffs.
16 MR. STRANGIO: Good morning, Your Honor.
17 Chase Strangio from the ACLU for the plaintiffs.
18 MS. CORBELLO: Good morning, Your Honor.
19 Courtney Corbello for defendants. And I finally have
20 co-counsel today, Johnathan Stone, as well.
21 THE COURT: Thank you. I may have
22 counsel for the plaintiffs reintroduce your name for my
23 sake -- I think Ms. Racanelli might have it -- but when
24 you speak, just so I make sure I have it the next time
25 you do so.

1 So we will begin with opening statements.
2 Remember, we have to have a pretty strict clock today
3 because the Court has an engagement in Houston tomorrow
4 to speak at a CLE, so at some point I have to get to
5 Houston either tonight or tomorrow morning early. So
6 we are on a strict clock. You may begin with opening
7 statements at this time.
8 MR. CASTILLO: Your Honor, if I may, we
9 have filed a motion to exclude this morning, which we
10 think is pertinent for the rest of the day's
11 activities, to exclude the DFPS investigation files, we
12 believe, in the interest of judicial economy and for
13 reasons that I can further elaborate, or we could start
14 with the...
15 THE COURT: That's your motion? You
16 brought me a courtesy copy?
17 MR. CASTILLO: I did.
18 THE COURT: And I assume that
19 Ms. Corbello has a copy.
20 MR. CASTILLO: I did.
21 THE COURT: I think I have this, too, but
22 this will help me because I just have so much received
23 from all of you by email, and it's coming pretty
24 quickly, that if you hand me things if you have
25 courtesy copies, that would be great.

1 So do you have a response, Ms. Corbello,
2 in writing, or do you just want to --
3 MS. CORBELLO: Well, Your Honor, I
4 received this ten minutes before the hearing started.
5 THE COURT: Sure. So I didn't expect
6 that you did. I just wanted to make sure I gave you an
7 opportunity to hand it to me if you did.
8 MS. CORBELLO: Well, I have the unopposed
9 motion to temporarily seal these investigatory files,
10 so I'm happy to give a courtesy copy to the Court.
11 That was filed yesterday early morning.
12 THE COURT: Okay. Well, let me hear from
13 Mr. Castillo first and then I will come to you. We'll
14 hear this.
15 But any time you're using on this is time
16 that's taken away elsewhere, so just keep that in mind.
17 Do you want to start here, or do you want to start with
18 opening.
19 MR. CASTILLO: Let's start here,
20 Your Honor.
21 THE COURT: Okay. You may proceed.
22 *(Brief interruption by a clerk off the*
23 *record.)*
24 THE COURT: You may proceed,
25 Mr. Castillo.

1 **MOTION TO EXCLUDE INVESTIGATION REPORTS**
2 **ARGUMENT BY MR. CASTILLO**
3 MR. CASTILLO: Thank you, Your Honor.
4 May it please the Court. Paul Castillo for the
5 plaintiffs. We are beginning with plaintiffs' motion
6 to exclude admission of DFPS excerpted investigations
7 files. We want to flag for the Court, in addition to
8 the reasons set forth in the motion, that there are
9 important reasons to exclude these investigation files
10 in their entirety.
11 In the amended re- -- defendants' amended
12 response to plaintiffs' motion for temporary
13 injunction, they identified as Defendants' Exhibits 9
14 through 13 and 25. The Texas Family Code prohibits
15 disclosure of these files. Section 261.201(a)
16 designates the information confidential, including
17 working papers, documents, audiotapes, videotapes, or
18 other information developed in an investigation.
19 261.201 also says that it may be
20 disclosed only for purposes consistent with this code.
21 And to be clear, this is not about -- this is not a
22 case about any specific investigation. It is not a
23 case regarding -- it's not a family law case. It is a
24 civil action challenging statutory and constitutional
25 propriety.

1 In addition, even if these files could be
2 disclosed, Section 261.201(b), the defendants failed to
3 follow the procedural motions. This is not -- these
4 are not cases that are essential to the administration
5 of justice. They are not relevant to the case if DFPS
6 witnesses can testify live, but disclosing or including
7 these records will endanger plaintiffs' parents,
8 children, for their stigmatizing them and potentially
9 exposing them to criminal liability.
10 Indeed, the State has muddled these files
11 confusing, for example, Doe and Poe in the record, and
12 this is also harmful to the individual plaintiffs. The
13 State had plenty of opportunity to follow proper
14 procedure. They sought these exhibits as evidence at
15 the last minute. The State is potentially presenting
16 biased evidence not to be included on the full files on
17 the investigation. And the State's arguments on the
18 motion to seal don't change this analysis.
19 In addition, the State cannot use the
20 names of minors in accordance with the Texas Code of
21 Civil Procedure. We request that the Court grant our
22 motion to exclude the investigation records in their
23 entirety.
24 THE COURT: So be a little more basic
25 with me. You have investigation records for three

1 children, or what do you -- what are they -- what are
2 they?
3 MR. CASTILLO: Exhibit 9 is DFPS Roe
4 investigation file, which includes inter- --
5 Exhibit 10, an interview, an audio file that has not
6 been redacted with respect to Tommy Roe, a minor;
7 Defendants' Exhibit 11, the Voe investigation file;
8 Exhibit 12, the Briggle investigation file; 13, the
9 inter- -- interview with the Briggles, again, an audio
10 file that cannot be -- and is not redacted; and
11 Exhibit 25, the Poe investigation file. These all,
12 again, have au- -- audio files with respect to -- to
13 minors.
14 And, again, this is an APA challenge. It
15 is a rule of general applicability that defendants --
16 that plaintiffs are alleging that defendants violated.
17 It is not about any individual disposition of a case.
18 It's about the procedural and substantive violations of
19 the Administrative Procedures Act. Any -- anything
20 that would re- -- this doesn't require any particular
21 delving into investigation files. And, again, the --
22 not only for the potential disclosure, the harm to the
23 minors, the harm to the families, they are not
24 relevant, and it violates the Texas Family Code because
25 there's -- it does not authorize -- this is a civil

1 case, and it does not op- -- it only operates with
2 respect to a family law case.
3 THE COURT: Thank you. Ms. Corbello.
4 **ARGUMENT BY MS. CORBELLO**
5 MS. CORBELLO: Thank you, Your Honor.
6 First, we'd object to the Court's consideration of this
7 motion given that it was filed ten minutes before this
8 hearing. It was not provided to counsel -- not
9 provided proper notice.
10 Second, plaintiffs dedicated plus 30
11 pages in their petition and declarations regarding the
12 investigations that took place against them. They
13 detail how those investigations went. They detail
14 conversations with the investigator. They talk about
15 their concern about how it's going to turn out. All
16 we've done is provide our side of the stories of how
17 those investigations went.
18 The reason they don't violate the Family
19 Code that Mr. Castillo cited, he ignores other
20 statutory authority. 40 Texas Administrative Code,
21 Section 700.203 states that DFPS is allowed to release
22 these documents, investigatory files that are deemed
23 confidential under the Family Code, to a court of
24 competent jurisdiction in a civil case arising out of
25 investigations into abuse.

1 As I've stated, there are claims upon
2 claims about what happened in these investigations
3 going towards plaintiffs' ultimate claim that DFPS is
4 conducting these investigations in a way that is
5 unlawful. The statute does not make any limitation
6 that it has to be a family court in civil -- in a civil
7 context. It purely says, A court of competent
8 jurisdiction in civil court where the case arises out
9 of investigations conducted --
10 THE COURT: What --
11 MS. CORBELLO: -- by DFPS.
12 THE COURT: What are you citing when you
13 say that?
14 MS. CORBELLO: 40 Texas Administrative
15 Code 700.203. That section also allows us to release
16 the documents to an individual who is alleged by DFPS
17 to be a perpetrator. And so I'll point out to this
18 Court, the rules that plaintiffs cite about
19 violating -- I think it's Texas Rule 21(c) -- is about
20 filing these -- these exhibits. We haven't filed these
21 exhibits. We've taken the proper course. We filed a
22 motion for temporary seal, because we -- we didn't have
23 14 days before we could have a hearing on this. We're
24 at -- we're at the 14 days right now, and so we haven't
25 filed anything. All we've done is released them to the

1 Court, which, again, the statute allows, and released
2 them to plaintiffs through their counsel, which statute
3 allows.
4 THE COURT: I -- I will say this.
5 Remember from last time, I do a -- because in Travis
6 County our courts are both civil and family, I have
7 never had DFPS just release this, even in a CPS case.
8 They have to -- they have always taken the position,
9 until today with you, that they could only do it if the
10 Court orders them to do so.
11 MS. CORBELLO: I understand that might be
12 different in other contexts, other civil cases, but --
13 I don't know about the Court. I've been --
14 THE COURT: That's even in the cases
15 where it's actually about that child and that
16 particular case.
17 MS. CORBELLO: I understand, Your Honor.
18 I -- I think the unique circumstances of this case --
19 again, I couldn't find any -- I don't know if the Court
20 could -- any case where plaintiffs have brought this
21 sort of challenge, an APA challenge, a constitutional
22 challenge, about how these investigations are being
23 conducted.
24 Again, if the Court's going to consider
25 plaintiffs' testimony and declarations about what

1 happened in these investigations, we have every right
2 to provide our side with what happened.
3 THE COURT: I just want to make sure that
4 now CPS is saying -- they will now -- every time we
5 need the CPS case file in any case, CPS is going to
6 say, Great, here you go.
7 MS. CORBELLO: Your Honor, I don't
8 think --
9 THE COURT: I don't -- I don't -- I just
10 want to make sure, because I feel like this is a very
11 different position than CPS/DFPS has ever taken before.
12 And I -- I want you to be understanding of -- of the
13 position that DFPS has always taken until today, which
14 is a very different position. And I want to make sure
15 that you, as their lawyer, have talked to your client
16 and have understood the position you're taking here
17 today and that it doesn't have some problematic effect
18 in how -- in your position in every other case that you
19 do, because generally DFPS' position is we protect
20 children and we protect their records, and today you're
21 taking the opposite position.
22 MS. CORBELLO: Absolutely not,
23 Your Honor. We are protecting their records. Again, I
24 have -- we have not filed these exhibits. We are
25 asking them to be filed under seal. We're asking only

1 the Court, and right now it's only attorneys' eyes
2 only.
3 THE COURT: Thank you. That's what I
4 needed you to tell me. You're asking this Court to
5 accept them under seal?
6 MS. CORBELLO: Apologies. Yes,
7 Your Honor. We -- we do not want these publicly filed.
8 Again, we are -- we are purely complying with what the
9 statutes allow us to do. And in this circumstance, the
10 statute does allow us to prevent -- to provide these
11 exhibits to the Court and to the attorneys, and that is
12 all we are seeking to do, which is why we have filed
13 our motion.
14 THE COURT: So then you would need --
15 since this is a civil case, you cannot do that because
16 of Rule 76a. It's a whole different rule about civil
17 cases not being allowed -- court records not being
18 allowed to be sealed unless we first have a Rule 76a
19 hearing.
20 MS. CORBELLO: Your Honor, I'll -- I'll
21 point the Court to our -- our motion. We have cited
22 Rule 76, Paragraph 5, which allows for a motion of
23 temporary seal when there's not time for hearing and
24 notice.
25 THE COURT: Thank you. That's what I was

1 saying next is your next thing would be. One, I think
2 you're not disagreeing with me exactly. I think you're
3 still maintaining the position that CPS can only
4 release these records if a court --
5 MS. CORBELLO: As statute allows.
6 THE COURT: -- orders them or the statute
7 allows.
8 MS. CORBELLO: Yes, Your Honor.
9 THE COURT: Two, your position is, you
10 would like to produce them as sealed exhibits in this
11 case --
12 MS. CORBELLO: Yes, Your Honor.
13 THE COURT: -- that would remain sealed?
14 MS. CORBELLO: Yes, Your Honor.
15 THE COURT: And you want to do so under a
16 temporary sealing order under Rule 76a?
17 MS. CORBELLO: Yes, Your Honor, until a
18 hearing can be held and notice can be given.
19 THE COURT: Thank you. You put all that
20 in the briefing, but remember, I've been getting
21 things --
22 MS. CORBELLO: I understand.
23 THE COURT: -- from y'all, and I wanted
24 to get to where we needed to get to on what your
25 position actually was.

1 MS. CORBELLO: Understood.
2 THE COURT: So my question to you,
3 Mr. Castillo, and it's a question, which is so much of
4 your petition does include investigation information,
5 and the harm is about investigation by -- that has how
6 it has been represented, is that some of the harm is a
7 result of the investigation.
8 But if you're not making that position
9 and the position is just going to be we are going to
10 have a straight-up legal hearing today about whether
11 this -- what they are doing violates the Administrative
12 Procedure Act, I want to make sure that you're not
13 limiting yourself and you understand the limit that
14 you're possibly putting on, and if you do, you could
15 open the door on this at any moment, even if you --
16 even if the Court agrees with you.
17 It's more like a motion in limine, which
18 is the minute you start putting these issues in the
19 record, certainly the State would have an opportunity
20 to be able to defend themselves in what you're saying
21 in response to the temporary injunction. I don't know
22 why they wouldn't be allowed to. If that's what you're
23 seeking to show is harm, how can they not be allowed to
24 respond to alleged harm.
25 MR. CASTILLO: Well, the purpose of

1 today's hearing is to hear and accept evidence, and so
2 through our actual testimony of witnesses, who will
3 describe and meet the burden that we show imminent and
4 irreparable harm, they will do that, so it centers on
5 the requirement of the receipt of the -- of the
6 temporary injunction.
7 With respect to the -- and the defendants
8 can put on their witnesses as well, so the evidence
9 would be through the particular hearing. I will also
10 indicate that the case -- the citation that defendants
11 mention with regard to Texas Administrative Code
12 700.201 through 209 says that it's claims arising out
13 of an investigation of child abuse and neglect. This
14 does not arise out of those issues. Again, it's an APA
15 case.
16 And with respect to -- I understand
17 Your Honor's point, well-taken, with respect to our
18 witnesses, but we believe that we can introduce through
19 testimony and through today's hearing the relevant
20 information with respect to supporting a cause of
21 action and a probable right to relief and imminent
22 harm.
23 THE COURT: Well, I think we're going to
24 have to treat this almost as if it is a limine type of
25 order, which is at this time the Court is keeping this

1 material out from the defendants, but if the plaintiffs
2 put this in issue, the defendants will have to petition
3 the Court and ask the Court if they can offer those
4 exhibits at that time.
5 If that happens, we'll then have to
6 conduct a temporary sealing order hearing and have an
7 entirely different hearing about that. But that's all
8 we can do because at some point I think the
9 plaintiffs -- they're going to have to be careful with
10 how they put their testimony in, I think, if they want
11 to keep any of this information out.
12 MS. CORBELLO: Your Honor, just very
13 quickly, is the Court intending to then disregard the
14 petition and declarations that talk about the
15 investigations and how they were conducted?
16 THE COURT: I'm here on a temporary
17 injunction hearing. The plaintiffs have the floor, and
18 they can put on their case, and then I'll hear argument
19 from you --
20 MS. CORBELLO: Thank you, Your Honor.
21 THE COURT: -- about how this plays out
22 today. Thank you.
23 MS. CORBELLO: Thank you.
24 THE COURT: Mr. Castillo, opening
25 statement.

1 **OPENING STATEMENT BY MR. CASTILLO**
2 MR. CASTILLO: Yes, Your Honor. Today's
3 hearing is about the need to enjoin DFPS and its
4 Commissioner yet again from the agency's unauthorized
5 attempt to expand the definition of child abuse to
6 target transgender youth and parents who support them
7 in seeking medically-necessary care for their gender
8 dysphoria.
9 DFPS has acted and continues to act
10 unlawfully violating the APA in establishing a new
11 presumption of abuse by parents with trans young people
12 triggering investigations solely based on that care and
13 prioritizing them in an unprecedented way.
14 Defendants will argue that it isn't
15 unreasonable for someone accused of child abuse to be
16 subject to this treatment, but that presumes the
17 definition of child abuse being employed is lawful and
18 nondiscriminatory, neither of which is happening here.
19 DFPS has implemented its rule after the
20 legislators specifically rejected the proposed change
21 to the Texas Family Code. The governor thereafter
22 stated that he had a solution to the problem. Then the
23 Attorney General issued his opinion claiming
24 gender-affirming care may be abuse, but the opinion did
25 not address medically-necessary care and the Governor

1 directed DFPS to investigate such reports without
2 regard to medical necessity.
3 The Texas Supreme Court did not rule in
4 Doe on the merits of the temporary injunction. Indeed,
5 the temporary injunction issued by this Court in Doe
6 remains before the Third Court of Appeals. The Supreme
7 Court of Texas narrowed injunctive relief as to the
8 parties based on the -- solely on the Texas Rules of
9 Appellate Procedure. It left intact the temporary
10 injunction as to the Doe family based on the same
11 unlawful rule being challenged here today.
12 About a week after the Supreme Court
13 issued its decision, DFPS resumed their investigations
14 interfering with a parental decision informed by
15 doctors and the right of youth to access life-saving
16 care they need to survive.
17 Today plaintiffs will present evidence
18 and testimony demonstrating that Commissioner Masters
19 and DFPS followed, ratified, and continued implementing
20 the same unlawful rule. We will hear from two families
21 subject to those unauthorized investigations, the PFLAG
22 executive director and a medical expert. The families
23 have suffered imminent and irreparable harm, and PFLAG
24 members across the state are subject to threatened
25 enforcement of this unlawful ruling.

1 Importantly, the individual case
2 dispositions are not relevant to this Court's analysis.
3 They are -- again, we are challenging an APA matter,
4 and plaintiffs are not asking the Court to weigh in on
5 policy or merits of the individual decisions. DFPS'
6 new rule and actions are traumatizing families,
7 chilling the ability of trans youth to continue getting
8 medically-necessary care. The plaintiffs, these three
9 families, and PFLAG members across the state are facing
10 the harm of investigations now and come before this
11 Court seeking relief. Thank you.
12 THE COURT: Thank you.
13 **OPENING STATEMENT BY MS. CORBELLO**
14 MS. CORBELLO: Your Honor, there are
15 exactly two determinations the Court will be readily
16 able to make upon presentation of the evidence today,
17 first that pubertal blockers and hormone therapy, which
18 I will now refer to as PBHTs, because I know I will
19 mess it up if I have to say all those words all day
20 long -- PBHTs can be harmful to a child physically
21 and/or mentally. The second determination is that the
22 allegation of a child taking PBHTs is within DFPS'
23 discretion to investigate as child abuse under current
24 Texas law.
25 The first point will be easy to reach.

1 Plaintiffs will not be able to stand in front of this
2 Court today and claim PBHTs are always medically
3 necessary and always safe and -- and reversible.
4 Neither's true. Not every child with gender dysphoria
5 requires PBHTs as part of treating that condition. And
6 that necessarily -- their -- their own expert is going
7 to testify to that. And that necessarily means the
8 provision of PBHTs to gender-dysphoric children is not
9 always proper medical treatment.
10 Their experts and our experts are also
11 going to demonstrate to you that PBHTs do not come
12 without risks, serious risks, like infertility,
13 decreased sexual dysfunction, damage or cancer in the
14 liver and heart, and decreased bone density, to name a
15 few. These risks to children should be considered by
16 this Court when plaintiffs are up here today arguing
17 that it's always permissible, never unsafe to give
18 nonconsenting children chemicals to block their bodily
19 development.
20 And to the second determination, this
21 Court is bound by the Supreme Court's ruling in *Jane*
22 *Doe* a few months ago. Quote, DFPS does not need
23 permission from courts to investigate. The normal
24 judicial role in this process is to act as the
25 gatekeeper against unlawful interference in the

1 parent-child relationship, not to act as overseer of
2 DFPS' initial executive branch decision to investigate
3 whether allegations of abuse may justify the pursuit of
4 court orders. That is all plaintiffs are asking this
5 Court to do today, to act as the very overseer that the
6 Supreme Court has forbidden it to do.
7 DFPS is statutorily authorized to conduct
8 investigations of child abuse, and it has done so in
9 accordance with the law. Plaintiffs will not show you
10 one family that has had court intervention based upon
11 the mere allegation that they have a transgender child
12 taking PBHTs. They won't be able to show you anyone
13 who's even come close, because what DFPS will show you
14 is these investigations are conducted no differently
15 than any other child abuse allegation involving a
16 medical concern. And they certainly are not seeking
17 court intervention in the parent-child relationship
18 simply because a transgender child is taking PBHTs.
19 Using children as medical guinea pigs to
20 further a purely social goal has to stop today. These
21 children are being placed in a position of making
22 decisions with their bodies that they will not
23 appreciate the full ramifications of for 10, 20,
24 30 years down the road simply so the adults in the room
25 can go on beating the nonsensical trans-hate drum they

1 use to be divisive.
2 There's a reason we don't let children
3 consent to medical treatment, because they don't
4 appreciate what they're consenting to. And yet we're
5 here today on the premise that some of our most
6 vulnerable children in society not only should make
7 those decisions but should be blatantly ignored by the
8 State and by this Court when they may be in trouble
9 because even questioning whether they or someone on
10 their behalf are making unsafe decisions is hateful and
11 bigoted.
12 Your Honor, defendants would ask this
13 Court consider the real ramifications of its decision
14 today while it hears the evidence as these proceedings
15 go and in the end decline to continue to play into the
16 hands of everyone who ignores the scientifically
17 obvious harms to PBHTs and places that ignorance on the
18 backs of our children just to serve a political cause.
19 THE COURT: You may call your first
20 witness.
21 MS. SAMANT: Thank you, Your Honor. I
22 call Mirabel Voe. And I'm Anjana Samant, counsel for
23 plaintiffs.
24 THE COURT: Ms. Voe, come on up. It's
25 going to be on this side, and I'm going to swear you

1 in. Please raise your right hand and be sworn.
2 *(Witness sworn in.)*
3 THE COURT: Thank you. You may have a
4 seat. This door swings out.
5 **MIRABEL VOE**,
6 having been first duly sworn, testified as follows:
7 **DIRECT EXAMINATION**
8 BY MS. SAMANT:
9 Q. Good morning.
10 A. Good morning.
11 Q. Could you please state your name for the
12 record?
13 A. Mirabel Voe.
14 Q. And are you over the age of 18?
15 A. I am.
16 Q. How long have you lived in Texas?
17 A. I was born and raised here my entire life.
18 Q. Do you have any connection to the lawsuit
19 PFLAG vs. Abbott?
20 A. I am. I am a plaintiff, I am a parent of a
21 transgender child who is a plaintiff, and I'm a member
22 of PFLAG.
23 Q. And is Mirabel Voe your real name?
24 A. It is not. It's a pseudonym.
25 Q. Why are you proceeding under a pseudonym?

1 A. I am proceeding under a pseudonym because I
2 have learned of other families who have been vocal
3 about their support of their child who have been
4 ostracized, including attacked, and I want to shield my
5 family and myself from that.
6 Q. And why are you testifying here today?
7 A. I am testifying because, again, I am a
8 plaintiff. My family has been investigated by DFPS. I
9 just want to do what I can in order to -- to protect,
10 support, and love my child.
11 Q. You mentioned one of your child -- one of your
12 children is involved in the lawsuit as well?
13 A. That is correct.
14 Q. And what is this child's name?
15 A. Antonio Voe.
16 Q. Okay. And how old is Antonio Voe?
17 A. He is 16.
18 Q. Is Antonio his real name?
19 A. It is not.
20 Q. And why is Antonio using a pseudonym?
21 A. Again, I do not want his identity to be
22 revealed so that he -- you know, {*inaudible*} other
23 people {*inaudible*} give him a hard time --
24 THE REPORTER: I'm sorry. I'm having a
25 little bit of a hard time. I think it's the mask.

1 THE COURT: I don't -- I mean,
2 honestly --
3 THE REPORTER: Yeah.
4 THE COURT: -- I don't want her to --
5 THE REPORTER: Okay.
6 THE COURT: -- unless she wants to.
7 THE REPORTER: That's fine.
8 THE COURT: We're just going to have to
9 speak a little more clearly. You can also remove your
10 mask if you wish to. You do not have to. And so --
11 but you are going to have to be mindful that we need to
12 understand you.
13 THE REPORTER: Maybe speak a little
14 slower, too.
15 THE WITNESS: Okay.
16 THE REPORTER: It should help. Just
17 enunciate. Thanks. Sorry.
18 THE WITNESS: Okay.
19 Q. (MS. SAMANT) Ms. Voe, you said that Antonio
20 is transgender.
21 A. That is correct.
22 Q. How did you learn that Antonio is transgender?
23 A. In 2020, Antonio came to us and mentioned that
24 he was transgender. All his life I had noticed that he
25 didn't really fit the norm that everyone would think,

1 you know, a child should be as born female, so he came
2 to us and said that he was transgender.
3 Q. And what was your reaction?
4 A. My reaction is that he is my child, and I love
5 him no matter what.
6 Q. And at that time, what was your understanding
7 of what it meant to be transgender?
8 A. My understanding of what it meant to be
9 transgender was that you were born as one gender but
10 identified as another. We at that point decided that
11 we would do research as a family. And out of that
12 research, we decided that we would let him socially
13 transition.
14 Q. And as a parent, what did you observe about
15 Antonio after he started socially transitioning?
16 A. So before socially transitioning, I noticed
17 that with onset of puberty, he started becoming
18 distressed, you know, that I -- he -- and then he
19 described that it was -- you know, that he was
20 transgender. Once we allowed him to use, you know, the
21 correct pronouns to allow him to be his authentic self,
22 he began to flourish.
23 He's always been an extrovert. He's been
24 really -- you know, he's a great child, he's very
25 empathetic, you know, very social. And before that, I

1 had noticed that he was, you know, introverted. And
2 once he was socially transitioning, he -- he was back
3 to his -- his self.
4 Q. And just to clarify, you said you had noticed
5 he had started to become introverted. When did you
6 notice that that happened?
7 A. At puberty. On the onset of puberty.
8 Q. Okay. Did you seek medical advice for Antonio
9 in connection with him being transgender?
10 A. I did. After a year of allowing him to
11 socially transition, I noticed that with the
12 continuation of puberty, he -- he was still stressed.
13 You know, he was still anxious. And then we decided
14 to -- to seek medical and professional advice.
15 Q. And did -- the doctor you took him to, did
16 they provide a diagnosis?
17 A. They did. The pediatrician diagnosed him with
18 gender dysphoria.
19 Q. And did the pediatrician make any
20 recommendations?
21 A. The pediatrician recommended that he begin
22 therapy.
23 Q. And has Antonio seen a therapist?
24 A. He began seeing a therapist that year and then
25 has since, so the summer of -- of 2021.

1 Q. And has that therapist made any diagnosis?
2 A. The therapist gender -- or diagnosed him with
3 gender dysphoria as well.
4 Q. And what grade is Antonio in?
5 A. When school begins, he will be going to the
6 11th grade, so a junior in high school.
7 Q. And during the pandemic, did Antonio attend
8 school remotely?
9 A. He did.
10 Q. And how was Antonio as a student during the
11 pandemic?
12 A. So that was the year that he had just -- prior
13 to that had just come out as transgender, had -- we had
14 allowed him to begin social transitioning. And because
15 he was home, he -- he flourished. You know, he was
16 able to be his truth authentic self without, you know,
17 any other outside forces. So he's normally, you know,
18 a straight A student, served on the student, you know,
19 body council, so he was -- it was wonderful.
20 Q. And when did Antonio return to in-person
21 school?
22 A. The 2021-2022 school year.
23 Q. And what did you experience -- sorry. What
24 did you observe as Antonio's demeanor once he
25 started -- resumed in-person school?

1 A. He was excited. You know, he was excited that
2 he was going to be back with his -- his friends. He
3 was excited that, you know, he was now going to be able
4 to go back to school and everybody know who he truly
5 was. But then I also started noticing that, you know,
6 he -- he continued to be a little anxious. You know,
7 he continued -- it was, you know, kind of a complex
8 situation.
9 Q. And did there come a time when you -- did
10 there come a time when you found yourself concerned
11 about Antonio's well-being?
12 A. I did. So as I had mentioned, you know, going
13 back to school, being transgender, you know, I did see,
14 you know, that he had anxiety. But then in February of
15 this year when Ken Paxton issued his opinion and then
16 Abbott issued the directive, it really made a turn for
17 the worse in Antonio's demeanor and Antonio's life and
18 all of our lives.
19 Q. And did something significant happen with
20 respect to Antonio's health or well-being?
21 A. Yes. He made an attempt upon his life.
22 Q. And how did you learn that your son attempted
23 to take his own life?
24 A. He had been throwing up, so I decided to take
25 him to urgent care, and they -- when we pulled up into

1 the urgent care, he turned to me and stated that he had
2 ingested an entire -- an entire bottle of aspirin.
3 Q. Do you recall the date on which this happened?
4 A. February 22nd.
5 Q. And when he told you that he had injected an
6 entire bottle -- ingested an entire bottle of aspirin,
7 what was your reaction?
8 A. So first, you know, I -- we rushed him to --
9 into the emergency room. And when they began to do the
10 intake and stabilize him, they asked him there, the
11 nurse, in my presence, why he did what he did. And he
12 stated that the political environment, you know, the
13 directive that Abbott had issued, you know, the other
14 issues of being transgender at school, along with just
15 gender dysphoria is what caused him to do what he did.
16 Q. And what did -- you said that you had taken
17 Antonio to the emergency room, correct?
18 A. Correct.
19 Q. Okay. Was Antonio discharged?
20 A. He stayed in -- at the hospital for two days
21 and then discharged to a psychiatric facility.
22 Q. And how long was Antonio at the psychia- --
23 psychiatric facility for?
24 A. About nine days or so.
25 Q. And did Antonio receive any therapy there?

1 A. He did. He had daily group therapy, he had
2 individual therapy, and he had family therapy as well.
3 Q. And can you describe, what was your life like
4 when Antonio returned home?
5 A. Well, we were relieved he was home with us,
6 but with the ongoing knowledge of what was happening
7 with the State, you know, that -- we were all beyond
8 anxious. You know, we were stressed beyond measure.
9 We were just making sure that -- wanting to make sure
10 that he was okay.
11 Q. I wanted to go back quickly. When you took
12 Antonio to the pediatrician, did the pediatrician, upon
13 giving a diagnosis, also give any recommendation of
14 medical care?
15 A. She did.
16 Q. Okay. So going back to now once Antonio came
17 home with you after being released from the psychiatric
18 facility, were -- was there a time when the state
19 actually investigated you?
20 A. Yes. Shortly after Antonio was released -- he
21 was released I believe on the 9th. And on the 11th, a
22 CPS investigator arrived at our home.
23 MS. CORBELLO: Your Honor, just for the
24 record, I'd -- I'd like to state that at this point
25 plaintiffs have now entered into evidence about the

1 investigations that were conducted, and so their motion
2 to exclude should be denied.
3 THE COURT: That's not an objection in
4 the middle of testimony, and so that is not something
5 the Court is going to take up. I heard no objection,
6 so I don't need to make a ruling.
7 MS. CORBELLO: Well, objection,
8 Your Honor; this testimony is irrelevant based on
9 plaintiffs' prior motion.
10 MS. SAMANT: Your Honor --
11 THE COURT: I -- this is -- we're going
12 to go back to this issue. I think everybody needs to
13 understand a few things. One, for whatever reason,
14 DFPS is choosing to ignore their usual policy and are
15 wanting to make investigatory files exhibits in civil
16 court. Once they offer them, even if the Court does
17 not admit them, they are part of the court record.
18 That is just how trial court works, so I want everyone
19 to understand that. I can't keep them from violating
20 their own policy or changing their own policy if that
21 is what they are choosing to do.
22 MS. CORBELLO: And I just want to state
23 for the record that's not the choice. As I stated
24 before, DFPS is simply following what they are
25 statutorily allowed to do with their investigatory

1 files.
2 THE COURT: Allowed to do is a choice.
3 MS. CORBELLO: It is a choice within the
4 confines of the statute, Your Honor. It is what
5 DFPS --
6 THE COURT: And it's a choice that DFPS
7 has never made before to this Court that I am aware of,
8 but I'm still saying it's a choice. But I also want
9 the plaintiffs to understand, admitted or not admitted,
10 they are part of the record whenever they offer them.
11 MS. SAMANT: Your Honor, plaintiffs'
12 counsel, we would request for a five-minute recess to
13 confer.
14 THE COURT: Thank you. We'll take a
15 break, and we will be back.
16 *(Recess was taken.)*
17 THE COURT: I think we can deal with this
18 after your direct is over with the witness, but I just
19 wanted you to understand that there are certain things
20 that -- once offered, they are taken control over by
21 the court reporter, and the Court can do an in camera
22 inspection, we can do the temporary sealing order, but
23 she cannot refuse to accept an offered exhibit, nor can
24 I.
25 MS. SAMANT: Yes, Your Honor. I -- we

1 understand. Thank you.
2 THE COURT: Thank you. All right. Let's
3 go back on the record and make sure we're -- or back to
4 the testimony.
5 MS. SAMANT: Sure. Your Honor, if I may
6 address some of the points made before the recess
7 quickly before resuming?
8 THE COURT: Yes. Sure.
9 MS. SAMANT: Okay. So we are going to
10 proceed, and at -- at -- we are not waiving the
11 arguments made in our motion to exclude. And should
12 the State choose to try to introduce the CPS
13 investigation files during cross, we will further
14 elaborate with specific objections at that time.
15 THE COURT: And -- and can I also ask --
16 because I haven't seen them yet. I don't know where
17 they are, nor do I necessarily want to have seen them.
18 They're not in the Box. I appreciate that you haven't
19 uploaded them to the Box yet.
20 THE REPORTER: Judge -- Judge --
21 THE COURT: Have you all seen them?
22 THE REPORTER: Okay. They -- they are in
23 the Box. They are in a secure folder that you can see
24 and they can -- and they can see, but that's it.
25 THE COURT: Okay. But y'all haven't seen

1 them yet?
2 MS. CORBELLO: Yes, Your Honor. I've
3 shared the -- I've shared the exhibits yesterday with
4 plaintiffs' counsel.
5 THE COURT: And are these fully redacted?
6 MS. CORBELLO: Yes, Your Honor.
7 MS. SAMANT: They're -- they're --
8 Your Honor, we noticed there were some failures to
9 redact --
10 MS. CORBELLO: No, Your Honor. We sent
11 them the updated versions that were fully redacted.
12 They can't point to any page that's not redacted. And
13 if they can, again, we'll go ahead and fix it. The
14 only parties that have seen it are the Court and
15 plaintiffs' counsel.
16 MS. SAMANT: Your Honor, if I may --
17 THE COURT: Well, I haven't seen them
18 yet, but I -- I take my -- I'll just get with my court
19 reporter on a break and figure out where they are.
20 MS. SAMANT: One -- one more point of
21 clarification on the lack of redaction, Your honor.
22 THE COURT: Yes.
23 MS. SAMANT: As a reminder, the audio
24 files are not redacted in any way, even if there was an
25 attempt to make redactions to the physical files.

1 THE COURT: I'm going to ask on the lunch
2 break, too, that Ms. Corbello gets me the policy from
3 her client about how they treat investigative files,
4 because -- I would like to know, because it's very
5 different what is happening today and what is usually
6 happening. So will you at least talk to your client
7 one more time and make sure they want to voluntarily
8 admit exhibits in a temporary injunction hearing in a
9 civil matter?
10 MS. CORBELLO: Your Honor --
11 THE COURT: Because the Court is not
12 ordering you to. The Court is not asking you to. The
13 Department is making a voluntary decision to do this.
14 MS. CORBELLO: To be clear, the
15 Department is not making a decision to publicly file
16 any of these exhibits. These are purely for the
17 Court's eyes only because plaintiffs have put the
18 investigations that were conducted in this case into
19 evidence into consideration by the Court and are
20 telling this Court that their harm is being derived
21 from the fact that these investigations are open and
22 these investigations will lead to something worse for
23 them. DFPS has every right to defend itself in this
24 unique situation other than the situation that this
25 Court has had DFPS files in before.

1 THE COURT: I hear you. I just want you
2 to double-check with your client one more time and make
3 sure that that is their position, because it might have
4 unintended consequences in criminal cases, in general
5 family cases, and in general civil cases going forward.
6 MS. CORBELLO: Your Honor, I will -- I
7 will talk to them again, but as I've said on the record
8 several times, DFPS' position, it is following what it
9 is statutorily allowed to do, which it does in every
10 other case involving DFPS investigatory files. This
11 Court sees a different action, but, again, the statute
12 allows multiple actions by DFPS --
13 THE COURT: You're choosing to do it, as
14 long as we are both very clear that you're choosing to
15 do it and the Court is not ordering you to do so. The
16 Court has not taken a position that you must do so.
17 MS. CORBELLO: The Texas Administrative
18 Code gives DFPS the discretion to determine if it wants
19 to release documents under seal to the proper
20 authorities under that statute. That does not belie or
21 negate any other statute that requires a court order if
22 DFPS chooses within its discretion not to follow
23 those -- not to abide by any of those statutory choices
24 that they have.
25 THE COURT: And you're saying to the

1 Court that you have done your required legal duty to
2 de-identify every investigated person who is not an
3 official?
4 MS. CORBELLO: Yes, Your Honor.
5 THE COURT: And -- and no other
6 proprietary information is included that would risk a
7 child's records which are treated very securely under
8 Texas law?
9 MS. CORBELLO: Your Honor, I will
10 represent to this Court that both myself and Mr. Stone
11 have made every good faith effort to redact these
12 documents to protect every possible sensitive bit of
13 information.
14 Again, we sent these documents to
15 plaintiffs' counsel yesterday. They pointed out some
16 errors in the redaction, and we immediately fixed them
17 and resent them. They've had the time to look at them
18 and raise any other objections. So far we haven't
19 heard any. We are happy to work with plaintiffs and
20 the Court if they feel like our redactions are
21 insufficient. That is why we only secure-shared them
22 with the Court and the attorneys at this point.
23 THE COURT: And so after we take the
24 direct testimony, we will need to take up a Rule 76a
25 matter where we have a temporary sealing order hearing

1 before you make any offer.
2 MS. CORBELLO: Yes, Your Honor. Just to
3 be clear, I don't know that we'll be introducing the
4 investigatory files with this witness. So it's up to
5 the Court when you want to have that hearing, but I'll
6 just tell -- say for the Court that it might not be
7 necessary right this second.
8 THE COURT: Before you make any offer of
9 any of those exhibits, you're going to need to first
10 have a motion of temporary sealing order with the
11 Court. Do you understand?
12 MS. CORBELLO: Yes, Your Honor. We
13 have -- we have those hard copy and also on file.
14 THE COURT: Thank you. Now let's
15 proceed.
16 MS. CORBELLO: Okay.
17 MS. SAMANT: Thank you, Your Honor.
18 Q. (BY MS. SAMANT) Ms. Voe, I just want to
19 refresh where we left off before the break. You
20 were -- I had asked you about what -- what life was
21 like when Antonio had been discharged and had come back
22 home with you and your family.
23 A. Again, we were relieved that he was home. We
24 were relieved that, you know, I can now physically see
25 him, but it was stressful, and our anxiety levels were

1 through the roof.
2 Q. And were there -- what in particular were you
3 concerned about at that point?
4 A. Mostly that there was this looming directive
5 out there from the state that I've only known as home,
6 that because I love my child enough to take him for
7 gender care, that they were labelling me as an abuser,
8 or any parent that was doing this, and that they could
9 potentially come to my home and rip it apart.
10 Q. And did, in fact, a CPS investigator come to
11 your home?
12 A. They did.
13 Q. And what happened when the investigator
14 arrived?
15 A. She arrived at my home. She knocked on the
16 door. I opened the door assuming at that point that
17 she was there to speak of the attempt and treatment he
18 had received or treatment that we were on for the
19 attempt. But she walked into my living room and stated
20 that they had been instructed to make my case -- or
21 cases such as mine a priority and that I had been
22 reported by the psychiatric facility that my son was at
23 for being an alleged perpetrator of child abuse.
24 Q. And did -- did the investigator ask you any
25 questions while she was there?

1 A. She did. She sat down at my table and she
2 asked all sorts and manners of questions. You know,
3 they were all intrusive. They were all very personal.
4 She wanted to know about, you know, the gender
5 dysphoria diagnosis. She wanted to know about any
6 treatment. She asked my, you know, son questions,
7 interviewed him as well. She took pictures of,
8 you know, his -- his body, his arms, his legs, his
9 torso to see if there were any injuries.
10 MS. CORBELLO: Your Honor, so as not to
11 interrupt the flow, I'd just like to make a running
12 objection to this line of questioning as having waived
13 what this Court considers a motion in limine filed by
14 the plaintiffs.
15 THE COURT: Overruled. You have a
16 running objection.
17 Q. (BY MS. SAMANT) And as the investigator was
18 asking Antonio these questions, what did you observe
19 as -- to be Antonio's demeanor and reaction?
20 A. As his mother I know him. I know him very
21 well in and out, and I noticed that he was becoming
22 more and more increasingly anxious. He was fidgeting.
23 You know, he was beginning to sweat. He looked scared.
24 That was my observation.
25 Q. And what was your reaction to the questions

1 that were being asked by the investigator?
2 A. No one ever wants to be told that they're a
3 bad parent, and especially by the state that they live
4 in, you know, because that they love their child enough
5 to take them to receive medical advice, medical
6 treatment. It was -- it was like a -- it was
7 sickening. You know, it was maddening. It was
8 horrific, to say the least. You know, again, because I
9 love my child enough to take him to get medical
10 treatment, the State was then telling me that I was a
11 child abuser.
12 Q. Did -- were you presented with any documents
13 by the investigator?
14 A. I was. They asked me to sign a medical
15 release form.
16 Q. And what happened next in connection with the
17 signed medical release?
18 A. To my knowledge, the form was sent to get
19 medical records for my son but was rejected because I
20 had initially failed to check off a box.
21 Q. And were you asked for anything else by CPS in
22 connection with the medical release?
23 A. Just, you know, all the personal questions.
24 You know, they -- they wanted to know, you know, what
25 treatment had been prescribed to my child.

1 Q. And what did CPS say about the
2 incorrectly-signed medical release, if anything?
3 A. They asked me -- she continually called and
4 left messages and asked me to resign it. I -- she then
5 showed up at my home unannounced. My child told me at
6 that point -- you know, my oldest child told me at that
7 point that, you know -- or told her that I was working.
8 And so then in the interim, I had learned of the
9 temporary injunction that had been put in place by the
10 courts for these types of cases. And so when I did
11 finally speak to her, I mentioned that I was seeking
12 legal counsel and that I would not be signing the form.
13 Q. And after you informed her that you wouldn't
14 be signing the form and you were seeking counsel, did
15 CPS continue to try to contact you?
16 A. They did.
17 Q. And when did CPS last contact you?
18 A. I do not know the actual date, but I do know
19 that it was the day that the temporary restraining
20 order hearing had occurred for this case.
21 Q. In this case?
22 A. Correct.
23 Q. Okay. Thank you. And is the investigation
24 still open at this time?
25 A. It is.

1 Q. Ms. Voe, how has the investigation impacted
2 your life?
3 A. It's devastated our lives. You know, again,
4 you know, there's a stigma that comes with being
5 investigated by CPS, you know, by being called a bad
6 parent. Antonio has had to stay home and finish out
7 the school year at home. You know, my youngest is now
8 on -- in therapy as well. Antonio's medication has
9 been increased because his anxiety and his depression,
10 you know, has substantially gone up again. We watch
11 him to make sure there isn't another crisis, because we
12 have this looming over our heads at all times,
13 you know, that CPS could at any point potentially come
14 to our home and take my children away from me.
15 You know, it's affected us in every
16 aspect that it can medically, physically, emotionally,
17 and, you know, to a certain extent financially. I have
18 a medical condition that flares up with stress, and so
19 because I have two jobs, my second job requires me to
20 stand for long periods of time, and I'm not able to
21 pick up as many shifts as I normally would because my
22 legs are hurting.
23 My oldest has decided to take -- she quit
24 her full-time job to take a part-time job working from
25 home so that she can always be available as well when

1 I'm not to make sure that there isn't another crisis
2 with my son.
3 Q. And what do you hope for your family through
4 this lawsuit?
5 A. My hope is that we can put this behind us,
6 that my child -- that, one, I will not be labeled a
7 child abuser; two, that my child can continue to
8 receive his medical necessary treatment that has been
9 prescribed to him. My hope is that my child can live
10 his true authentic self, that no other family will have
11 to go through what we go through, that no other child,
12 no matter how they identify, knows that they are
13 valuable, they're -- they're an invaluable part of
14 society, and that no other child will have to think
15 that there is no other recourse than to try and take
16 their life because the State is threatening to take
17 them from a home that loves them and that cares enough
18 to take them for treatment.
19 MS. SAMANT: Thank you, Your Honor.
20 **CROSS-EXAMINATION**
21 BY MS. CORBELLO:
22 Q. Mirabel, you don't work for D- -- DFPS, right?
23 A. I do not.
24 Q. And you don't have any personal knowledge of
25 how DFPS conducts intakes of reports of child abuse, do

1 you?
2 A. Not how they conduct the intakes, no.
3 Q. Okay. And you don't have any personal
4 knowledge of how DFPS conducts any other investigations
5 of child abuse other than your own, right?
6 A. I actually worked for a nonprofit for several
7 years. I worked very closely with DFPS.
8 Q. You haven't worked with DFPS before, right?
9 A. I haven't, no.
10 Q. You don't work for DFPS currently, right?
11 A. I do not.
12 Q. You don't have any personal knowledge of how
13 they conduct investigations as of today, right?
14 A. Correct.
15 Q. You're not aware of DFPS actually seeking a
16 court order in the investigation they're conducting
17 into your family, are you?
18 A. I'm sorry. Can you repeat that?
19 THE COURT: Ms. Corbello, you need to
20 slow down.
21 MS. CORBELLO: Sorry, Your Honor.
22 Q. (BY MS. CORBELLO) You're not aware of DFPS
23 seeking a court order against you in the investigation
24 that you've just testified about, right?
25 A. They would be working with my attorneys, so

1 it's not my knowledge, no.
2 Q. So the answer is no, you're not aware of any
3 court order as you sit here today?
4 A. Correct.
5 Q. After your contact with DFPS and the
6 investigators that you just described in detail, has
7 anyone discontinued any medical ne- --
8 medically-necessary treatment for Antonio?
9 MS. SAMANT: Objection, Your Honor.
10 There's also a protective order that we agreed to in
11 place, but also we're -- apologies. Objection also
12 based on this is questioning related specifically to
13 the CPS investigation.
14 MS. CORBELLO: Your Honor --
15 MS. SAMANT: It goes to the merits of
16 that.
17 MS. CORBELLO: Your Honor, they -- they
18 asked about the investigation, and she talked about the
19 medications that she told the investigator her child
20 was on. All I'm asking is whether those medications
21 she testified to have been discontinued in any way.
22 That's the only question I'm asking about them as well.
23 MS. SAMANT: Your Honor, I'm going to
24 direct our client to take the Fifth Amendment.
25 MS. CORBELLO: Again, Your Honor, the

1 Fifth Amendment has been waived because she
2 testified -- and the court reporter can read it back --
3 as to the medica- -- that she told the investigator her
4 child was on medications. I'm not asking about any of
5 the medications' names. I'm simply asking one question
6 about them.
7 MS. SAMANT: She actually -- counsel is
8 misstating the witness' testimony. She stated that the
9 doctor prescribed recommended treatment.
10 THE COURT: If counsel is -- if counsel
11 is instructing you to plead the Fifth Amendment, the
12 thing that you need to understand is, in civil court,
13 pleading the Fifth Amendment is a right you have just
14 like you have in criminal court. The difference is in
15 criminal court -- everyone knows this probably from TV.
16 You -- nothing you don't say can be held against you.
17 In civil court, the Court can assume bad
18 facts when you plead the Fifth. And so that is where
19 we are, and I am not going to disallow her to plead the
20 Fifth, but the Court can make assumptions by her
21 choosing to about what her answers would be if she had
22 not.
23 MS. CORBELLO: Thank you, Your Honor.
24 I'll -- I'll reask it again just for clarity of the
25 record.

1 Q. (BY MS. CORBELLO) Mirabel, after contact with
2 DFPS and the investigators, has anyone discontinued any
3 medically-necessary treatment for Antonio?
4 MS. SAMANT: And, again, I'm going to
5 direct our client to plead the Fifth Amendment.
6 A. I plead the Fifth.
7 Q. (BY MS. CORBELLO) You recall giving a
8 declaration in this case, right?
9 A. I do.
10 Q. And you testified to matters in your
11 declaration under penalty of perjury, right?
12 A. Correct.
13 Q. And you put things in your declaration that
14 you want the Court to consider today when granting a
15 temporary injunction, right?
16 A. Correct.
17 Q. Your declaration contains multiple paragraphs
18 regarding the investigation DFPS conducted against your
19 family in this case, right?
20 A. Correct.
21 Q. And you're not asking the Court to ignore
22 those details in your declaration today, are you?
23 A. I am not.
24 MS. CORBELLO: Nothing further.
25 THE COURT: Anything further?

1 MS. SAMANT: No, Your Honor.
2 THE COURT: Thank you. You may step
3 down. You may call your next witness.
4 MR. COOK: Your Honor, Plaintiffs call
5 Brian Bond to the stand.
6 THE REPORTER: I'm sorry. Your name?
7 MR. COOK: Currey Cook.
8 THE REPORTER: Currey Cook. Thank you.
9 THE COURT: Mr. Bond, come on up. Please
10 raise your right hand.
11 *(Witness sworn in.)*
12 THE COURT: Thank you. Please have a
13 seat. This door opens out. You can keep your mask on
14 or remove your mask. That is your call.
15 You may proceed.
16 MR. COOK: Thank you, Your Honor.
17 **BRIAN BOND**,
18 having been first duly sworn, testified as follows:
19 **DIRECT EXAMINATION**
20 BY MR. COOK:
21 Q. Good morning, Mr. Bond.
22 A. Good morning.
23 Q. Could you please state your full name for the
24 record?
25 A. Brian Keith Bond. My pronouns are he, him,

1 his.

2 Q. And where --

3 THE COURT: You're going to have to speak

4 way up.

5 THE WITNESS: Sure.

6 THE REPORTER: Yeah.

7 Q. (BY MR. COOK) Where do you live?

8 A. Washington, D.C.

9 Q. And where are you employed?

10 A. PFLAG, Inc.

11 Q. Is PFLAG a plaintiff in this case?

12 A. Yes, it is.

13 Q. What is your role at PFLAG?

14 A. I'm the executive director.

15 Q. And what are your job responsibilities as the

16 executive director at PFLAG?

17 A. I set the strategic priorities for the

18 organization and operations of the organization, manage

19 the staff, and I'm responsible for the budget and

20 fiscal oversight of the organization.

21 Q. How long have you served as executive

22 director?

23 A. About three and a half years.

24 Q. What is PFLAG?

25 A. PFLAG is the largest and first organization

1 for LGBTQ+ individuals and their families. We have
2 hundreds of chapters around the country, about 250,000
3 members, and we focus on support, advoca- -- support,
4 education, and advocacy.
5 Q. And as executive director, do you make
6 decisions about whether PFLAG participates in
7 litigation?
8 A. Yes, I do.
9 Q. Why did you decide to participate in this
10 litigation?
11 A. When the opinion came out from the AG and then
12 the directive from the Governor and then the actions of
13 the agency involved, we started hearing from parents
14 who are terrified from our chapters across the state,
15 from members across the state, who were fearful for
16 what was going to happen to them and their families, so
17 we were asked to and felt the need to engage on behalf
18 of them.
19 Q. As executive director, are you familiar with
20 PFLAG's history?
21 A. Yes.
22 Q. Okay. How did PFLAG start?
23 A. So PFLAG started by a mom in 1973 who wanted
24 to rally parents and family around their LGBTQ+ kids.
25 She was a schoolteacher.

1 Q. Is PFLAG a 501(c)3?
2 A. Yes, it is.
3 Q. Okay. What is that?
4 A. We're a (c)(3), started in 1982, with a focus
5 mostly around support and education in the nonprofit
6 space.
7 Q. Does PFLAG have articles of incorporation?
8 A. Yes.
9 Q. As the executive director, are you familiar
10 with those articles of incorporation?
11 A. Yes.
12 MR. COOK: Your Honor, may I approach the
13 witness?
14 THE COURT: Yes. What exhibit did you
15 hand him?
16 MR. COOK: Your Honor, I handed
17 Plaintiffs' Exhibit 22 to Mr. Bond.
18 Q. (BY MR. COOK) Mr. Bond, are you familiar with
19 this document?
20 A. Yes, I am.
21 Q. And what is it?
22 A. It is our articles of incorporation, charter,
23 so forth.
24 Q. Okay. And does it appear to be a true and
25 accurate copy of PFLAG's articles of incorporation?

1 A. It does.
2 MR. COOK: Your Honor, plaintiffs move to
3 introduce Plaintiffs' Exhibit 22 into evidence.
4 MS. CORBELLO: No objection.
5 THE COURT: 22 is admitted.
6 *(Plaintiffs' Exhibit 22 admitted.)*
7 Q. (BY MS. CORBELLO) Mr. Bond, does PFLAG have
8 bylaws?
9 A. Yes.
10 Q. As executive director, are you familiar with
11 those bylaws?
12 A. Yes.
13 MR. COOK: Your Honor, may I approach?
14 THE COURT: Yes. And I should state this
15 for the record because we did this by email, but I want
16 to make it clear for the record. What the Court asked
17 both parties to do was upload their exhibits to Box,
18 and that's going to be our official record, but we're
19 handing the witnesses courtesy copies. And as I'm
20 admitting them, I'm admitting the copies that are in
21 the Box, so, Ms. Corbello, just so you know which ones
22 we're looking at and so you can follow along, same
23 thing with the plaintiffs' lawyers. We all agree to
24 that, correct?
25 MR. COOK: Yes, Your Honor. Thank you.

1 MS. CORBELLO: Yes, Your Honor.
2 THE COURT: Thank you. And so you've
3 handed him exhibit?
4 MR. COOK: Yes, Your Honor. Plaintiffs'
5 Exhibit 23.
6 THE COURT: 23.
7 Q. (BY MR. COOK) Are you familiar with this
8 document, Mr. Bond?
9 A. Yes.
10 Q. What is it?
11 A. It is the bylaws of the organization.
12 Q. Okay. Is this a true and accurate copy of
13 PFLAG's current bylaws?
14 A. Yes, it is.
15 Q. Okay. And the amendments to the bylaws from
16 4-11-21 that are reflected on the document, are those
17 the most recent amendments to PFLAG's bylaws?
18 A. Yes.
19 Q. So this is a current version of PFLAG's
20 bylaws?
21 A. Correct.
22 Q. Okay.
23 MR. COOK: Your Honor, plaintiffs move to
24 introduce Plaintiffs' Exhibit 23 into evidence.
25 MS. CORBELLO: No objection.

1 THE COURT: 23 is admitted.
2 *(Plaintiffs' Exhibit 23 admitted.)*
3 Q. (BY MR. COOK) Mr. Bond, do the bylaws outline
4 the structure of PFLAG?
5 A. Yes.
6 Q. Is PFLAG a membership organization?
7 A. Yes, it is.
8 Q. How do people become members of PFLAG?
9 A. People become members of PFLAG either through
10 their local chapter or through the national office.
11 Q. To clarify, if someone becomes a member
12 through a local chapter of PFLAG, do they also become a
13 member of the national organization?
14 A. Yes. The chapter sends a portion of those
15 proceeds and the roster to the national office making
16 them a member of the national organization.
17 Q. Okay. So two routes?
18 A. Correct.
19 Q. Someone can join PFLAG national directly or
20 become a member through the local chapter?
21 A. Correct.
22 Q. And what role do members play within the
23 organization?
24 A. Members play an important role in the
25 governance of the organization nationally. You want me

1 to elaborate on that or...
2 Q. If you can elaborate --
3 A. Okay.
4 Q. -- on what role they play. Thank you.
5 A. We have a 21-member board of which seven are
6 elected directly by the membership, and seven of those
7 21 are elected as reg- -- regional directors of the
8 board. The regional directors of the board are then
9 elected by each of the members within the 13 regions of
10 the board. And then finally, the seven remaining board
11 members are elected by the board, which constitutes the
12 majority, having some direct connection or indirect
13 with the membership.
14 Q. Okay. And is the role of members that you
15 just described contained within the bylaws?
16 A. Yes.
17 Q. Okay. Thank you. As executive director, do
18 you learn who your members are?
19 A. Yes.
20 Q. Okay. And how so?
21 A. That comes through multiple ways. We have
22 systems in place for communication between members.
23 Chapters communicate together. The chapters
24 communicate with their regional director. We have a
25 chapter engagement shop that is communicating with the

1 regional director and the chapters directly. We do
2 forums, town halls, things like that. Chapters -- or
3 members all have my email dres -- arres -- dres --
4 gosh, excuse me -- address. And, in fact, last night I
5 was with some Austin PFLAG chapter members last night.
6 Q. Thank you. You mentioned that you have
7 chapters across the country. Do you have chapters in
8 Texas?
9 A. Yes.
10 Q. How many?
11 A. Seventeen.
12 Q. And where are they located?
13 A. Everywhere from Beaumont to El Paso, places
14 like -- big cities like, obviously, Houston, Austin,
15 Fort Worth, Dallas, but places like San An- --
16 San Angelo, Midland, Odessa, across the state.
17 Q. Okay. And you have PFLAG members who join
18 through their Texas chapters and now belong to the
19 national organization?
20 A. Correct. The majority come through the
21 chapters.
22 Q. And you also have members who -- you also have
23 members who live in Texas but have joined the national
24 organization directly?
25 A. Correct.

1 Q. Okay. Approximately how many Texas members do
2 you have, counting the ones that joined through their
3 local chapters and directly with national PFLAG?
4 A. Sure. I think today is approxi- -- probably
5 around a little over 700.
6 Q. And do you have a sense of how many of those
7 members have children who are transgender?
8 A. I don't have a specific sense. I know from
9 each and every one that I've heard from and from our
10 chapters across the state there -- there are family
11 members there that have kids, they have transgender
12 kids, they care about transgender kids, and they're
13 focused on that.
14 Q. Okay. You mentioned earlier that through the
15 systems you have in place with PFLAG, you were hearing
16 from your members in the wake of Attorney General Ken
17 Paxton's opinion, Governor Abbott's directive, and
18 DFPS' implementation of that. What kind of support, if
19 any, has PFLAG provided to Texas members with
20 transgender children?
21 A. Sure. A considerable amount of support has
22 been on the ground, peer-to-peer support within our
23 chapters, also trying to provide guidance on how to
24 seek additional support or -- or just candidly bringing
25 people together, walking through how to get through

1 this.
2 Q. And why did you provide the support that you
3 just described?
4 A. Because this is important. These are families
5 just trying to keep their kids safe, and these families
6 are terrified.
7 Q. Today you heard the testimony just now from
8 Mirabel Voe. Is she under investigation by DFPS?
9 A. Yes.
10 MS. CORBELLO: Objection; lack of
11 foundation.
12 MR. COOK: Your Honor, he just said that
13 he heard the testimony from Ms. Voe, and she testified.
14 THE COURT: Yeah. Overruled.
15 Q. (BY MS. CORBELLO) Is Ms. Voe a PFLAG member?
16 A. Yes.
17 Q. Are you aware of other PFLAG members currently
18 being investigated by DFPS?
19 A. Yes.
20 Q. Okay. How so?
21 A. Through the declarations, through these court
22 proceedings, chapter individuals telling me so.
23 MS. CORBELLO: Objection as to the
24 hearsay portion of his testimony.
25 THE COURT: It is hearsay as to that

1 portion. Sustained.
2 MR. COOK: Yes, ma'am.
3 Q. (BY MS. CORBELLO) What sort of structures do
4 you have in place to hear about what your various
5 members are experiencing?
6 A. Sure. Again, that would be through our
7 support meetings, chapter meetings -- we have a chapter
8 meeting every month and many chapters more than once a
9 month -- through a Facebook page for our families in
10 this area, and then also just any communication when
11 individuals write to us. Those would be the main
12 avenues.
13 Q. And through the structure that you just
14 described, do you understand through that that you have
15 PFLAG members in Texas who are being investigated by
16 DFPS?
17 A. I understand both that we have members that
18 are being investigated, but also a lot of our members
19 who are extremely terrified, and I've heard directly
20 from them and some --
21 MS. CORBELLO: Objection; hearsay.
22 THE COURT: Okay. So this is hearsay.
23 The question is, is there an exception to hearsay given
24 the associational standing issue? And what is your
25 argument to how you get around the hearsay, which is

1 definitely hearsay? Is there an exception that would
2 apply?
3 MR. COOK: Yes, Your Honor. Pursuant to
4 Texas Rules of Evidence 801(d), we are not offering the
5 fact for the truth of the matter asserted. We're
6 really offering that the statement is relevant because
7 it shows the information that he relied upon in making
8 decisions as behalf -- as executive director of PFLAG.
9 MS. CORBELLO: Your Honor, they -- they
10 simply asked if his members are terrified, not whether
11 he was making decisions on that basis or anything about
12 his decision-making.
13 MR. COOK: Your Honor, I'm not asking,
14 again, that -- the statement members are terrified is
15 offered for the truth of the matter asserted, only that
16 that statement he relied upon in making decisions and
17 actions -- taking actions on behalf of PFLAG. So we're
18 not offering that for the truth of the matter asserted,
19 so that is an exception to hearsay.
20 THE COURT: Overruled. You may ask that
21 question. You may answer.
22 Q. (BY MR. COOK) So, Mr. Bond, I asked how do
23 you -- what structure -- you mentioned that you have
24 structures in place to hear about what's happening with
25 your members. How did you hear about what was

1 happening with your members in Texas?
2 A. It was a combination of people reaching out
3 directly to PFLAG national, telling them what was going
4 on. It was a -- it was a combination -- or partially
5 from hearing from my team, who works directly with
6 individuals in Texas, and from our regional director as
7 well. This was not a secret. This was scary. This is
8 what was happening. And we have parents trying to
9 figure out did they need to leave the state. You know,
10 they were getting notifications from doctors that,
11 sorry, we may not be able to help you anymore. I mean,
12 this is about protecting their kids and trying to keep
13 their kids from harm. So that -- that's how we heard
14 about it. Like, what do we do next? How do we protect
15 our families? How do we protect our kids?
16 Q. And you testified by what was happening. What
17 do you mean by what was happening?
18 A. By the directive and then the investigations
19 by the agency.
20 Q. Okay. And that includes members being
21 investigated?
22 A. Yes.
23 Q. Now, I'd like to switch to some questions
24 about PFLAG's mission and vision. What is PFLAG's
25 vision?

1 A. So our -- our -- our mission is to create a
2 caring, just, and affirming world for LGBTQ+
3 individuals and their families. Our vision is for an
4 equitable world where LGBTQ+ plus individuals are safe,
5 celebrated, empowered, and loved.
6 Q. As executive director, is it part of your job
7 to ensure PFLAG's mission is carried out?
8 A. Absolutely.
9 Q. And what do you do to ensure that PFLAG
10 achieves its mission?
11 A. Part of that is to ensure that we are
12 adequately supporting our pillars, whether it be around
13 support with our chapter network on the ground,
14 especially with what's going on right now, pillar
15 around education, again, to make sure people know
16 what's going on and to provide multiple avenues for
17 people to be aware of that, and third, it's around
18 advocacy, to speak out in support of individuals'
19 families speaking out in support of their kids.
20 Q. Why is advocacy around their kids in an
21 integral society part of your mission?
22 A. I think that once people hear individual
23 stories, their journeys, that they -- they -- we live
24 everywhere, that we're part of their community, the
25 more those stories can be shared and/or share what

1 harms are being done to them, it -- I believe it helps
2 move individuals to -- to -- to action and support.
3 Q. Are you aware of whether there are Texas PFLAG
4 members who have engaged in the kind of advocacy you've
5 described?
6 A. Yes. Yes, absolutely.
7 Q. And how so?
8 A. PFLAGers have been extremely engaged in the
9 last legislative session, and so there are activities
10 going around the state speaking out on behalf of their
11 trans kids and non-binary kids. They -- they want
12 their kids to be treated the same as every other kid in
13 the state.
14 Q. And what do you --
15 A. That's all.
16 Q. Sorry.
17 A. Oh, sorry. Go ahead.
18 Q. Thank you. What do you see, if any, of the
19 benefits of that kind of advocacy?
20 A. I just think it's really important for people
21 to be able to safely share their stories and to just be
22 able to connect with other individuals across the
23 state, again, that we're in your churches, we're in
24 your shopping centers, we're in your -- in your small
25 towns, we're everywhere. We just want our families to

1 be treated equally and fair.
2 Q. And on the flip side, what, if any, risk do
3 you see of engaging in such advocacy?
4 A. There is -- there are a couple of risks. I
5 mean, one, not everybody's there. I mean, it's -- and
6 we have to as safely as possible protect our families
7 or encourage them how best to advocate to do it safely.
8 But also in a situation like this, by speaking out, as
9 we've seen, you run the risk of -- of being
10 investigated if you speak out. If you're -- if you
11 become visible in trying to protect your kids and your
12 family and rights, you have the risk of being
13 investigated, which is just wrong.
14 Q. Mr. Bond, one last question for you. What
15 result do you hope to see for your PFLAG members who
16 have transgender children who live in Texas?
17 A. I want our Texas families and any families
18 across the country just to be able to live their lives,
19 to -- to -- to -- to experience life. I -- I don't
20 know how to say this other than there are so many kids
21 out there that do not have loving homes. These are
22 parents and families that are doing their best to
23 ensure their kids are affirmed and loved.
24 I just want us to get back to a place
25 where those families, along with their medical

1 providers, are making decisions to help affirm their
2 lives so they can live their lives, literally live
3 their lives, and that their families can be whole.
4 MR. COOK: Thank you.
5 **CROSS-EXAMINATION**
6 BY MS. CORBELLO:
7 Q. You don't work for DFPS, do you?
8 A. No.
9 Q. You don't have any personal knowledge about
10 how DFPS is currently conducting intakes of allegations
11 of child abuse, do you?
12 A. Only what I've been reading.
13 Q. And you don't have any personal knowledge of
14 how DFPS is currently conducting investigations into
15 child abuse, right?
16 A. Only what I've been reading.
17 Q. And that reading is not personal knowledge,
18 right?
19 A. Correct.
20 Q. PFLAG is bringing suit in this case in order
21 to halt specific types of investigations being
22 performed by DFPS, right? Is that a fair
23 characterization?
24 A. Can you repeat that?
25 Q. Sure. PFLAG's bringing suit in this case in

1 order to halt or challenge specific investigations
2 being conducted by DFPS currently, right?
3 A. Well, I think what we're trying to do is to --
4 sorry, my words -- stop these investigations of
5 accusing families of child abuse.
6 Q. So stop investigations; that's fair?
7 A. Stop this -- this whole process.
8 Q. Right. This process of specific
9 investigations, correct?
10 A. Of accusing --
11 MR. COOK: Objection, Your Honor; asked
12 and answered.
13 THE COURT: Overruled.
14 MS. CORBELLO: I'm going to go ahead and
15 withdraw.
16 Q. (BY MS. CORBELLO) You mentioned stopping
17 these -- these specific investigations. Can you go
18 ahead --
19 MR. COOK: Objection, Your Honor; I think
20 that's a --
21 MS. CORBELLO: I haven't finished the
22 question.
23 MR. COOK: -- mischaracterization of the
24 witness' testimony.
25 MS. CORBELLO: Your Honor, the witness --

1 THE COURT: Ask your question.
2 MS. CORBELLO: Yes, Your Honor.
3 Q. (BY MS. CORBELLO) Can you provide all the
4 names of cases in which PFLAG has brought suit to halt
5 other investigations done by a state's child protective
6 services?
7 A. I believe this is the first time we have done
8 so.
9 Q. You're not here today testifying that every
10 child that has gender dysphoria should be taking
11 pubertal blockers and hormone therapy, right?
12 A. I'm not a medical professional. What I'm here
13 to say is there needs to be a space for parents and
14 their medical providers to provide what is best for
15 their care.
16 MS. CORBELLO: I'm going to object as
17 nonresponsive.
18 Q. (BY MS. CORBELLO) My question's a little
19 different. You're not here today testifying to the
20 Court that every child with gender dysphoria should be
21 taking pubertal blockers or hormone therapy, right?
22 That's not what you're here today to do?
23 A. I'm not totally sure what you're asking me.
24 Q. You've provided testimony to the Court, right?
25 A. Correct.

1 Q. You haven't testified to the Court yet today
2 that every child with gender dysphoria should be on
3 pubertal blockers and hormone therapy, have you?
4 A. No.
5 Q. You didn't testify at any point today that a
6 child without gender dysphoria should be taking
7 pubertal blockers and hormone therapy, right? Did you
8 offer that testimony at any time?
9 MR. COOK: Objection, Your Honor; that's
10 outside the scope of direct.
11 THE COURT: Overruled.
12 Q. (BY MS. CORBELLO) Would you like me to reask
13 it?
14 A. No. If I -- I'm trying to understand you, and
15 I apologize if I don't. What I am saying, though, is
16 I -- I think a parent and their doctor need to make
17 those decisions.
18 MS. CORBELLO: I'm going to object as
19 nonresponsive. My question's a little more specific.
20 Q. (BY MS. CORBELLO) You've provided testimony
21 so far to the Court, right?
22 A. Correct.
23 MR. COOK: Objection, Your Honor;
24 argumentative. Argumentative at this point.
25 THE COURT: That question was not

1 argumentative, so that has to be overruled. In
2 addition, in Texas court, cross-examination isn't
3 necessarily limited to the topics of direct
4 examination, so that was the overruling of that.
5 MR. COOK: I understand, Your Honor.
6 THE COURT: Ms. Corbello, you may
7 proceed.
8 MS. CORBELLO: Thank you, Your Honor.
9 Q. (BY MS. CORBELLO) Once again, you've provided
10 testimony to the Court today, right?
11 A. Correct.
12 Q. At any point in the testimony that you just
13 provide -- provided, did you tell the Court that a
14 child without gender dysphoria should be taking
15 pubertal blockers and hormone therapy?
16 MR. COOK: Objection, Your Honor; that
17 question has been asked and answered.
18 MS. CORBELLO: It has not been answered
19 yet, Your Honor.
20 THE COURT: Overruled.
21 A. I -- I -- I -- I'm fully not getting why
22 you're asking this question. I'm sorry. Maybe I'm
23 supposed to just answer something, but I don't know
24 what you're wanting me to answer.
25 Q. (BY MS. CORBELLO) You still have to answer

1 whether you told the Court that at any point in your
2 testimony today.
3 A. I did not tell the Court that.
4 MR. COOK: Objection, Your Honor --
5 MS. CORBELLO: Thank you, Your Honor.
6 Nothing further.
7 THE COURT: Anything else?
8 MR. COOK: Just -- nothing further,
9 Your Honor.
10 THE COURT: All right. Thank you. You
11 may step down, sir.
12 MR. GONZALEZ-PAGAN: Good morning,
13 Your Honor. I'm Omar Gonzalez-Pagan for the
14 plaintiffs. If we could get a brief just two-minute
15 recess to get our next witness who will be testifying
16 remotely.
17 THE COURT: Yes, we'll take a five-minute
18 break, and you can get that set up. Thank you.
19 MR. GONZALEZ-PAGAN: Thank you.
20 *(Recess was taken.)*
21 THE COURT: You may call your next
22 witness.
23 MR. GONZALEZ-PAGAN: Thank you,
24 Your Honor. May I remove my mask just for purposes
25 of the record?

1 THE COURT: You may.
2 MR. GONZALEZ-PAGAN: Thank you.
3 Your Honor, at this point we would call Dr. Cassandra
4 Brady to the stand.
5 THE COURT: Thank you. Dr. Brady, can
6 you hear me? This is Judge Meachum.
7 THE WITNESS: Yes, I can hear you.
8 THE COURT: Thank you. Rather than
9 getting up and going to the camera, I'm just going to
10 ask you to please raise your right hand and be sworn.
11 *(Witness sworn in.)*
12 THE COURT: Thank you. You may proceed,
13 Counselor.
14 MR. GONZALEZ-PAGAN: Thank you,
15 Your Honor.
16 **CASSANDRA BRADY, M.D.**,
17 having been first duly sworn, testified as follows:
18 **DIRECT EXAMINATION**
19 BY MR. GONZALEZ-PAGAN
20 Q. Good morning, Dr. Brady. Could you please
21 state your name for the record and spell it out for the
22 court reporter?
23 A. Yes. Good morning. I'm Cassandra Brady,
24 C-a-s-s-a-n-d-r-a, and Brady, B-r-a-d-y.
25 Q. Dr. Brady, could you please describe for the

1 Court your formal education and training?
2 A. Yes. I have a bachelor of science from the
3 Indiana University. I also have a medical degree from
4 Indiana University School of Medicine in Indianapolis,
5 Indiana. I have a general pediatrics residency from
6 the Children's Hospital at Vanderbilt. And I have a
7 fellowship training in pediatric endocrinology from the
8 Cincinnati Children's Hospital.
9 Q. Dr. Brady, are you board certified?
10 A. Yes. I am board certified in both general
11 pediatrics as well as pediatric endocrinology.
12 Q. Do you hold any academic positions?
13 A. Yes. I'm an assistant professor of general
14 pediatrics at the Vanderbilt University Medical Center.
15 Q. Do you practice medicine?
16 A. Yes. I practice medicine in the division of
17 endocrinol- -- pediatric endocrinology here, and I am a
18 clinical director of two specialty clinics within
19 pediatric endocrinology.
20 Q. You mentioned that you're a clinical director
21 of two specialty clinics. Which are these clinics?
22 A. The two specialty clinics that I am a medical
23 director of are a Differences of Sex Development Clinic
24 as well as a gender dysphoria clinic or a gender clinic
25 for adolescents.

1 Q. Dr. Brady, what is the care that you provide
2 at each of these clinics?
3 A. At the Differences of Sex Development Clinic,
4 we provide a comprehensive multi-disciplinary approach
5 to these patients with pediatric endocrinology,
6 pediatric urology, genetics, as well as clinical
7 psychology and social work. We provide evaluation --
8 hormonal evaluation, genetics, potentially imaging, and
9 work with patients and families regarding this.
10 In the endocrinology clinic that is our
11 gender diverse clinic, we provide medical care to
12 individuals who are adolescents with gender dysphoria.
13 Our team is multi-disciplinary, however, so we do
14 contain a clinical psychologist, as well as adolescent
15 providers, adolescent gynecologist, a dietician, social
16 worker, case manager. That team not only provides
17 medical care, but we can also provide resources to
18 individuals to give them information regarding gender
19 care.
20 Q. As clinical director, do you oversee the
21 function of both of those clinics?
22 A. I do. I oversee the function of them.
23 Q. How many patients do you treat at the
24 Differences of Sex Development Clinic?
25 A. I see over 100 patients in that clinic.

1 Q. How many patients do you treat at the
2 Pediatric and Adolescent Gender Clinic?
3 A. I see over 200 patients at the gender clinic.
4 Q. As part of your practice at the gender clinic,
5 are there any clinical guidelines that you utilize or
6 follow?
7 A. Yes. The clinical guidelines that I utilize
8 and follow are the -- the Endocrine Society Clinical
9 Practice Guidelines for the care of gender dysphoria or
10 incongruence, as well as the WPATH, the World
11 Professional Association of Transgender Health
12 Standards of Care.
13 Q. As part of your practice, do you keep up to
14 date with the scientific literature regarding the
15 nature and treatment of gender dysphoria?
16 A. I do. It is part of our practice and part of
17 our team to keep up to date.
18 Q. As part of your practice, do you keep up to
19 date with the scientific literature regarding the
20 nature of treatment of gender dysphoria as it pertains
21 to adolescents?
22 A. Yes. In particular as it -- as it pertains to
23 adolescents, as those are the typical age group or type
24 of patient we are seeing.
25 Q. Have you published or conducted any research

1 into the subject of gender dysphoria?
2 A. Yes. So I am involved in a study regarding
3 autoimmunity in gender dysphoria and adolescents, as
4 well as publications, mainly regarding the advocacy in
5 this population.
6 Q. And are these publications peer-reviewed?
7 A. Peer-reviewed, yes.
8 Q. Have you presented any posters or symposiums
9 pertaining to gender dysphoria?
10 A. Yes. Our autoimmunity poster was presented at
11 a conference. And our discussion about advocacy,
12 I've -- I've personally presented at symposiums and
13 panels before at national meetings.
14 Q. Dr. Brady, you mentioned that you were an
15 assistant professor. What courses do you teach?
16 A. As an assistant professor, I teach medical
17 school courses and nursing school courses, as well as
18 education courses for our residents and fellows. At
19 the medical school I teach regarding differences of sex
20 development, and I also teach about gender dysphoria
21 across the medical center and at the nursing school.
22 Q. Dr. Brady, is the prac- -- practice of
23 pediatric endocrinology a -- a -- a specialized
24 practice it takes from general adult endocrinology?
25 A. Yes. It -- it -- you have to have a general

1 pediatrics residency, and then you have to have a
2 specific pediatric endocrinology fellowship. That is
3 another three-year training period.
4 Q. Dr. Brady, are you familiar with the term
5 grand rounds?
6 A. I am familiar with the term grand rounds.
7 Q. Could you please tell us what grand rounds
8 are?
9 A. Yes. So grand rounds are a setting in which
10 we provide continuing medical education to
11 already-established providers or learners regarding
12 evidence-based topics.
13 Q. As part of your practice, do you provide any
14 grand rounds on the subject of gender dysphoria?
15 A. Yes. I provide endocrine grand rounds here.
16 I provide grand rounds across the medical -- across the
17 medical center here as well to all specialties. And I
18 also have presented outside of our medical center to
19 local and national programs.
20 Q. Dr. Brady, are you involved in any
21 professional associations?
22 A. I am. I am involved in the American Academy
23 of Pediatrics, the World Professional Association of
24 Transgender Health, or WPATH, the Endocrine Society,
25 and the Pediatric Endocrine Society.

1 Q. Dr. Brady, I'm going to show you what's been
2 pre-marked as Plaintiffs' Exhibit 5. Dr. Brady, do you
3 recognize this document?
4 A. Is this supposed to be shared on the screen?
5 Q. No. You should have received it on e- --
6 A. Oh, in my email. Yeah. Let me pull it up
7 here. Yes, I do recognize that. That's my CV.
8 Q. Thank you. Did you prepare this document?
9 A. I did prepare this document.
10 Q. Does this document accurately reflect your
11 education, training, and professional activities,
12 including those that you have discussed here today?
13 A. Yes, as -- as of the time that I drafted it.
14 MR. GONZALEZ-PAGAN: Your Honor, at this
15 time I would move to admit Plaintiffs' Exhibit 5 for
16 the record.
17 MR. STONE: No objections, Your Honor.
18 THE COURT: 5 is admitted.
19 *(Plaintiffs' Exhibit 5 admitted.)*
20 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, have you
21 previously testified as an expert witness on matters
22 relating to the provision, protocols, and treatment
23 regarding gender dysphoria?
24 A. Yes, I have earlier this year.
25 Q. Was that in the case *Doe v. Abbott*?

1 A. It was.
2 Q. Dr. Brady, are you being compensated for your
3 time?
4 A. Yes.
5 Q. Does your compensation depend on the content
6 of your testimony?
7 A. No.
8 MR. GONZALEZ-PAGAN: Your Honor, at this
9 time, pursuant to Rule 702, I would move to qualify
10 Dr. Brady as an expert witness of the nature of gender
11 dysphoria, the provision, protocols, and treatment of
12 gender dysphoria in adolescents, as well as the field
13 of pediatric endocrinology.
14 MR. STONE: Your Honor, I don't think
15 the -- they've laid a predicate showing that she's an
16 expert -- they've laid a predicate showing that she's
17 an expert generally in the field of pediatric --
18 pediatric endocrinology, although they have talked
19 specifically about gender dysphoria.
20 But more broadly, Your Honor, Rule 702,
21 to be admissible, an expert's knowledge has to help the
22 trier of fact understand the evidence or determine a
23 fact issue. And at the beginning of this case, we
24 heard from plaintiffs' counsel that this is just an APA
25 challenge. This is just about whether or not DFPS

1 followed rulemaking proceed- -- proceeding --
2 procedure. So this -- this -- this expert's testimony
3 is irrelevant in this case. It's not going to help
4 this Court understand evidence that has been admitted
5 or determine a fact issue in this case given that
6 they've contended that it's only an APA claim.
7 MR. GONZALEZ-PAGAN: Your Honor, if I may
8 just quickly respond. Dr. Brady testified to her years
9 of experience as a clinical -- clinic director as a
10 pediatric endocrinologist both in the Differences of
11 Sex Development Clinic as well as the gender dysphoria
12 clinic, care that she oversees for over 300 patients in
13 both of these clinics, research that she has done,
14 research that she routinely relies on as part of her
15 practice. Not only that, but counsel for the defense
16 in their opening statement articulated that this --
17 that their -- that the evidence would show that the
18 provision of what they termed PBHTs is dangerous and
19 that the provision of it is actually treating youth as
20 medical guinea pigs.
21 THE COURT: I -- I -- I hear the
22 arguments on both sides. I think we are at some point
23 going to need to -- but it might be closing where we
24 fully understand what the relief is the plaintiffs are
25 seeking, because I think I heard that a little bit in

1 opening, but that's not what their pleadings say.
2 MR. STONE: Right.
3 THE COURT: And so I think we need to
4 understand what their requested relief is and what
5 they're claiming legally, because that's important to
6 what's before the Court. But nevertheless, there are
7 petitions in place that certainly put these matters in
8 issue. So part of your argument I think is overruled
9 on that issue. And then I do think she's qualifies as
10 an expert, and the Court will accept her as such on the
11 matters laid out to the Court, so any objection on that
12 basis is overruled.
13 MR. STONE: Just for clarification,
14 Your Honor, so are -- are you finding right now that
15 their claims do exist beyond the APA claim as they've
16 alleged in their petition? Or just as they represented
17 at the beginning of this hearing, are we just going to
18 be limited to the APA claim?
19 MR. GONZALEZ-PAGAN: Your Honor, if I
20 could provide some clarity here with regards to the APA
21 claim. The APA claim includes an arbitrary and
22 capricious claim, and the -- the DFPS has relied upon
23 the opinions of the Attorney General, which speaks to
24 the provision of this care, its medical necessity, and
25 the general accessibility of this care.

1 THE COURT: The Court is accepting
2 Dr. Brady as an expert, and that's all the Court needs
3 to do at this time.
4 MR. STONE: Thank you, Your Honor.
5 MR. GONZALEZ-PAGAN: Thank you,
6 Your Honor.
7 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, what is
8 gender dysphoria?
9 A. Gender dysphoria is a medical condition that
10 is the distress associated with the individual having a
11 gender identity that does not match their sex assigned
12 at birth.
13 Q. Is gender dysphoria a diagnosis that is used
14 for adolescents?
15 MR. STONE: Objection; leading.
16 THE COURT: Overruled.
17 A. Yes. Gender dysphoria is a diagnosis for
18 adolescents. It is described in the DSM-V, as well as
19 ICD-10.
20 Q. (BY MR. GONZALEZ-PAGAN) You mentioned that
21 gender dysphoria is a medical condition. Where is it
22 recognized?
23 A. It is recognized in the ICD-10.
24 Q. What are the symptoms of gender dysphoria?
25 A. The symptoms of gender dysphoria can be from

1 anxiety to depression to suicidal ideation.
2 Q. Are there risks associated with gender
3 dysphoria if it is left untreated?
4 A. Yes. If gender dysphoria is left untreated,
5 this distress can worsen and lead to further
6 psychiatric comorbidities and -- and -- and then that
7 suicide risk which equates to -- to death?
8 Q. Dr. Brady, have you developed expert opinions
9 with regards to this case?
10 A. Yes, I have developed expert opinions. And
11 given that I'm a pediatric endocrinologist that sees
12 adolescents with gender dysphoria daily, I do provide
13 medically-necessary care that is evidence-based
14 utilizing standards of care that are peer-reviewed and
15 recognized by societies across the country, medical
16 societies across the country.
17 I am very concerned with the directives
18 from the Attorney General, as well as the Governor,
19 that by banning this care --
20 MR. STONE: Objection --
21 A. -- there would be increased risk --
22 MR. STONE: -- narrative.
23 A. -- for these comorbidities --
24 THE COURT: Hold on.
25 A. -- including increased risk --

1 THE COURT: Please stop for a --
2 THE WITNESS: Oh, sorry.
3 THE COURT: -- second. He has objected
4 to a narrative, and I do think I have to sustain at
5 this point to narrative, and counsel needs to ask
6 another question.
7 MR. GONZALEZ-PAGAN: Thank you,
8 Your Honor.
9 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, in -- in
10 response to the prior question, you were providing an
11 overview of your opinions. Could you please summarize
12 for the Court your opinions regarding this case?
13 A. Yes. Banning the care of -- medically --
14 banning the medically-necessary care for adolescents
15 with gender dysphoria will increase comorbidities and
16 the risk of suicide.
17 MR. STONE: Objection, Your Honor. They
18 did not designate her as an expert on banning
19 medical -- medically-necessary care for the treatment
20 of jan- -- transgender -- or gender dysphoria in
21 minors. It's not a topic that they designated her as
22 an expert on.
23 MR. GONZALEZ-PAGAN: Your Honor, my
24 motion specifically stated the provision, protocols,
25 and treatment of gender dysphoria in adolescents. She

1 can speak to --
2 THE COURT: Overruled as to your
3 objection, but -- but this needs to be question and
4 answer. You cannot just say to an expert, Give me all
5 of your opinions.
6 MR. GONZALEZ-PAGAN: Understood,
7 Your Honor.
8 THE COURT: That is not how we can do
9 things. You have to ask her -- they have to be broken
10 up in question and answer form.
11 MR. GONZALEZ-PAGAN: Understood,
12 Your Honor. We were just providing a high-level
13 roadmap for the Court.
14 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, earlier
15 you mentioned that you followed certain guidelines as
16 part of your clinical practice; is that right?
17 A. Yes.
18 Q. Dr. Brady, if you can open what has been
19 pre-marked as Plaintiffs' Exhibit 7.
20 A. Okay.
21 Q. Dr. Brady, do you recognize this document?
22 A. Yes. It's the endocrine guideline for the
23 treatment of gender dysphoria.
24 Q. Are these the guidelines to which you referred
25 earlier that you follow in your practice?

1 A. Yes.
2 Q. Who publishes these guidelines?
3 A. Endocrine Society. And these are within a
4 journal called the *Journal of Clinical Endocrinology*
5 *and Metabolism*.
6 Q. Is this journal a peer-reviewed journal?
7 A. Yes, it is a peer-reviewed journal and has a
8 good rating score.
9 Q. Are the Endocrine Society guidelines contained
10 in Exhibit 7 evidence-based?
11 A. Yes, they're evidence-based. They utilize
12 research to support their conclusions.
13 Q. In your professional opinion and as part of
14 your research and practice, are these guidelines that
15 are generally accepted in the medical community?
16 MR. STONE: Your Honor, objection; this
17 assumes facts not in evidence. He has not offered
18 Exhibit 7, but he's asking questions specifically about
19 this document and about whether or not it's -- she's
20 relied on it and specifically about what it found.
21 THE COURT: 7?
22 MR. GONZALEZ-PAGAN: Your Honor --
23 THE COURT: I think right now I'm
24 sustaining that.
25 MR. GONZALEZ-PAGAN: Your Honor,

1 Dr. Brady can speak to the use of these guidelines in
2 the general community.
3 THE COURT: But do you want to offer it?
4 MR. GONZALEZ-PAGAN: Well, I haven't
5 offered it yet, Your Honor.
6 THE COURT: Well, then right now I think
7 it is assuming facts not in evidence.
8 MR. GONZALEZ-PAGAN: Understood,
9 Your Honor.
10 THE COURT: Yes.
11 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, you
12 mentioned that you rely on these guidelines as part of
13 your clinical practice, correct?
14 A. Yes.
15 Q. Okay. And these are guidelines that --
16 that -- you testified earlier that these are guidelines
17 that -- well, actually, Dr. Brady, what do these
18 guidelines entail?
19 A. These guidelines entail recommendations for
20 the treatment --
21 MR. STONE: Your Honor, objection; again,
22 it assumes facts not in evidence. Now he's asking what
23 do the guidelines in Exhibit 7 entail? He needs to
24 offer this if he's going to ask her questions about
25 Exhibit No. 7.

1 THE COURT: Are you going to make an
2 offer?
3 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, are these
4 the guidelines that you use in your practice?
5 A. Yes.
6 MR. GONZALEZ-PAGAN: Your Honor, at this
7 point I would move that we admit Plaintiffs' Exhibit 7
8 into the record.
9 MR. STONE: Objection, Your Honor; this
10 is hearsay and it should not be admitted. There is an
11 exception in hearsay for -- under 803.18 for statements
12 in a learned treatise, which I think this would perhaps
13 be an example of, but the -- there's specific
14 guidelines in 803.18 on how you use it. And it says, A
15 statement contained in a treatise, periodical, or
16 pamphlet can -- is -- is an exception to the hearsay
17 rule if the statement is called to the attention of an
18 expert witness on cross-examination or relied on by the
19 expert on direct examination and the publication is
20 established as a reliable authority by the expert's
21 admission or testimony. If admitted, the statement may
22 be read into evidence but not received as an exhibit.
23 So while he can ask questions about specific --
24 THE COURT: Well, pick one. That's the
25 problem. You have to pick one. So now you've made me

1 think then -- then do you want to withdraw your
2 previous objection, or do you want me to admit the
3 exhibit?
4 MR. STONE: Well, Your Honor, he is -- he
5 didn't --
6 THE COURT: Which one?
7 MR. STONE: I -- I will -- I will
8 with- -- withdraw my prior objections and stick with
9 the objection to its offer -- being offered as an
10 exhibit.
11 THE COURT: Okay. Then you don't have to
12 offer it as an exhibit, but she can testify about it,
13 and those objections will be overruled.
14 MR. GONZALEZ-PAGAN: Thank you,
15 Your Honor.
16 MR. STONE: Could --
17 THE COURT: And you have a running
18 objection if you wish to.
19 MR. STONE: Yes, Your Honor. I would
20 like to have a running objection. It says, If
21 admitted, a statement may be read into evidence, so to
22 the extent --
23 THE COURT: Well, we just didn't admit it
24 because you said you didn't want to admit it.
25 MR. STONE: No, Your Honor. We're --

1 we're saying -- we're talking -- not admitted as an
2 exhibit. But if the periodical is admitted, it's not
3 admitted as an exhibit. Instead, the statements are
4 read from it when there's a specific question about
5 them. So to the extent --
6 THE COURT: Correct. So we aren't
7 admitting it as an exhibit.
8 MR. STONE: Right, Your Honor. Okay.
9 We're on the same page.
10 THE COURT: And then you are objecting --
11 you were objecting and -- or still going to object to
12 him -- to her talking about it at all, and I'm
13 overruling those objections. And I'm asking you, do
14 you want a running objection?
15 MR. STONE: Yes, Your Honor.
16 THE COURT: You have it.
17 MR. STONE: Okay. Thank you, Your Honor.
18 THE COURT: And you can go back to your
19 original plan, because he seems to like your original
20 plan better.
21 MR. GONZALEZ-PAGAN: Thank you,
22 Your Honor.
23 THE COURT: Yes.
24 MR. GONZALEZ-PAGAN: I was a bit confused
25 as to what the objection was.

1 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, let -- let
2 me ask you about the guidelines. Are these guidelines
3 that are generally accepted within the medical
4 community?
5 A. Yes. And they're generally accepted by major
6 organizations such as American Academy of Pediatrics
7 and Pediatric Endocrine Society and others.
8 Q. Do you consider this -- in light of that
9 general acceptance and your use of these guidelines, do
10 you consider these clinical practice guidelines to be a
11 reliable treatise by which you conduct your practice?
12 A. I do.
13 Q. Dr. Brady, can I turn to -- your attention to
14 Page 3870 of the exhibit?
15 A. Sorry. I'm there.
16 Q. Beginning with the first full sentence that
17 starts with "recommend," can you read to us what the
18 guidelines dictate with regards to the provision of
19 hormone therapy and puberty blockers for adolescents
20 with gender dysphoria?
21 A. Are you talking about the very, very beginning
22 of the 3870?
23 Q. Yes, the sentence starts "We recommend." It's
24 part of --
25 A. Yes, yes. "We recommend treating

1 gender-dysphoric/gender-incongruent adolescents who
2 have entered puberty at Tanner Stage G2/B2 by
3 suppression with gonadotropin-releasing hormone
4 agonists. Clinicians may add gender-affirming hormones
5 after a multidisciplinary team has conferred with the
6 persistence of gender dysphoria/gender incongruence and
7 sufficient mental capacity to give informed consent to
8 this partially irreversible treatment."
9 Do you want me to keep going?
10 Q. Can you please keep going until the next
11 several sentences?
12 THE REPORTER: And can she slow down when
13 she's reading?
14 Q. (BY MR. GONZALEZ-PAGAN) And, Dr. Brady, if
15 you --
16 THE REPORTER: Thank you.
17 Q. (BY MR. GONZALEZ-PAGAN) -- can please slow
18 down a bit when you're reading.
19 A. Oh, I'm sorry. Yeah. Sorry. Let me go back
20 to that.
21 Q. I believe it starts "Most adolescents."
22 A. Yes. "Most adolescents have this capacity by
23 age 16 years old. We recognize that there may be
24 compelling reasons to initiate sex hormone treatment
25 prior to age 16 years, although there is minimal

1 published experience treating prior to 13 and a half to
2 14 years of age. For the care of peri-pubertal youths
3 and older adolescents, we recommend that an expert
4 multidisciplinary team comprised of medical
5 professionals and mental health professionals manage
6 this treatment. The treating physician must confirm
7 the criteria" --
8 Q. Dr. Brady, that's okay. Thank you.
9 A. Okay. Thanks.
10 Q. Dr. Brady, you earlier also mentioned that you
11 utilized the WPATH Standards of Care as a -- as a
12 clinical guideline within your practice; is that right?
13 A. Yes.
14 Q. How long have the WPATH Standards of Care have
15 been in use?
16 A. For many decades.
17 Q. When was the current version of the WPATH
18 Standards of Care published?
19 A. 2012.
20 Q. Do you know whether the WPATH Standards of
21 Care are being updated?
22 A. Yes, they are being updated and likely
23 published within the next few months. We were told
24 summer of 2022.
25 Q. Have you reviewed the draft of the new version

1 of the WPATH Standards of Care?
2 A. Yes. Members of the WPATH were given the
3 opportunity to review the -- the draft.
4 Q. Does the new version of the standards of care
5 recommend that you use puberty hormones and hormones as
6 treatment for adolescent gender dysphoria?
7 MR. STONE: Objection; leading.
8 THE COURT: Rephrase your question.
9 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, you just
10 read into the record that the Endocrine Society
11 guidelines recommend the use of puberty blockers and
12 hormones as treatment for adolescent gender dysphoria.
13 Do you recall that?
14 A. Yes.
15 Q. Is that recommendation -- are the WPATH
16 Standards of Care consistent with that recommendation
17 containing the Endocrine Society guidelines?
18 MR. STONE: Objection; leading.
19 THE COURT: Overruled.
20 A. Yes. The WPATH Standards of Care also
21 recommend pubertal-blocking treatment and
22 gender-affirming hormone therapy to adolescents with
23 gender dysphoria.
24 Q. (BY MR. GONZALEZ-PAGAN) And you mentioned
25 that you -- you have reviewed a draft of the new

1 version of the WPATH Standards of Care. Do you recall
2 that?
3 A. Yes.
4 Q. Does the new version of the standards of care
5 also recommend the use of puberty blockers and hormones
6 as treatment for adolescent gender dysphoria?
7 MR. STONE: Objection; leading.
8 THE COURT: Overruled as to leading.
9 Though, Mr. Gonzalez-Pagan, you must go a little
10 slower --
11 MR. GONZALEZ-PAGAN: Understood,
12 Your Honor.
13 THE COURT: -- or Ms. Racanelli is going
14 to chastise you, and she is much scarier than I am.
15 MR. GONZALEZ-PAGAN: I believe that.
16 THE COURT: Go ahead.
17 Q. (MR. GONZALEZ-PAGAN) You may answer,
18 Dr. Brady.
19 A. Yes.
20 Q. In your opinion as a practicing pediatric
21 endocrinologist in the field of trea- -- of gender
22 care, are the WPATH Standards of Care generally
23 accepted within the medical community?
24 MR. STONE: Objection; leading.
25 THE COURT: Overruled.

1 A. Yes, they are as well, similar to the
2 endocrine clinical practice guidelines.
3 Q. (BY MR. GONZALEZ-PAGAN) Are they based on
4 scientific study and research?
5 A. Yes, they are as well. They contain
6 peer-reviewed, evidence-based studies.
7 Q. Dr. Brady, as part of your care of adolescents
8 with gender dysphoria, what is the treatment that you
9 provide these adolescents?
10 A. The treatment I provide to adolescents with
11 gender dysphoria that is medical treatment involves
12 pubertal-blocking hormones as well as gender-affirming
13 hormones.
14 Q. Is any treatment provided to a patient prior
15 to puberty?
16 A. No.
17 Q. What is the goal of treatment for gender
18 dysphoria in adolescents?
19 A. The goal of treatment is to alleviate the
20 distress associated with the gender dysphoria.
21 Q. As a practicing physician in this field, do
22 you regularly speak with providers of other gender
23 clinics across the country to -- to inform your
24 practice?
25 MR. STONE: Objection; leading.

1 THE COURT: Overruled.
2 A. Yes, I do.
3 Q. (BY MR. GONZALEZ-PAGAN) Does that include
4 providers in Texas?
5 A. Yes, I -- I speak with providers in Texas as
6 well.
7 Q. Dr. Brady, to your knowledge, is treatment
8 provided in clinics in Texas different from the
9 treatment that you provide at your clinic?
10 MR. STONE: Objection, Your Honor; lack
11 of personal knowledge under 602. Also, this question
12 is leading.
13 THE COURT: Overruled.
14 A. No.
15 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, you
16 mentioned that you provide puberty blockers as a
17 treatment for gender dysphoria in adolescents; is that
18 right.
19 A. That is correct.
20 Q. Based on your knowledge of the research and
21 your clinical experience, do you consider the provision
22 of this care to be safe?
23 MR. STONE: Objection, Your Honor;
24 leading.
25 THE COURT: Overruled.

1 A. Yes. I use pubertal blockers for this
2 population as well as individuals with central
3 precocious puberty, and they are safe in both those
4 populations.
5 Q. (BY MR. GONZALEZ-PAGAN) Are puberty blockers
6 reversible?
7 A. Yes.
8 Q. Would you consider it a use of puberty
9 blockers to treat gender -- is -- Dr. Brady, is the use
10 of puberty blockers effective to treat gender dysphoria
11 in adolescents?
12 MR. STONE: Objection, Your Honor;
13 leading.
14 THE COURT: Overruled.
15 A. Yes. The use of pubertal blockers is
16 effective in treating gender dysphoria in adolescents.
17 Not only based on my clinical experience have I seen
18 that, but there are studies to support that.
19 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, you
20 mentioned that you use puberty blockers to treat also
21 central precocious puberty; is that right?
22 A. Yes.
23 Q. Are the side effects of the treatment of
24 puberty blockers comparable when used to treat central
25 precocious puberty as opposed to gender dysphoria?

1 MR. STONE: Objection; leading.
2 THE COURT: Overruled.
3 A. Yes, the side effect for -- of pubertal
4 blockers is the same for all populations that use them.
5 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, you also
6 mentioned that you provide hormone therapy; is that
7 right?
8 A. Yes. I provide gender-affirming hormone
9 therapy to gender -- to adolescents with gender
10 dysphoria. And I also provide hormone therapy to
11 individuals who might have conditions such as
12 hypogonadism and may need estrogen or testosterone to
13 go into puberty.
14 Q. Is the use of hormone therapy to treat gender
15 dysphoria safe?
16 MR. STONE: Objection, Your Honor;
17 leading.
18 THE COURT: Overruled.
19 A. Yes.
20 Q. (BY MR. GONZALEZ-PAGAN) Is the use of hormone
21 therapy -- in your opinion, is the use of hormone
22 therapy to treat gender dysphoria effective?
23 MR. STONE: Objection, Your Honor;
24 leading.
25 THE COURT: Overruled.

1 A. Yes. The use of gender-affirming hormone
2 treatment in adolescents with gender dysphoria is safe
3 and effective. I base that off my clinical experience
4 and evidence-based guidelines.
5 Q. (BY MR. GONZALEZ-PAGAN) Dr. Brady, what is
6 the basis for your opinions that these treatments are
7 safe and effective?
8 A. So I have many years of clinical experience,
9 and -- and there are published evidence-based studies
10 that have been peer-reviewed that also support this.
11 Q. Dr. Brady, are there any risks if -- of not
12 providing treatment when a child -- when an adolescent
13 has gender dysphoria?
14 A. Yes. If we do not provide treatment to
15 adolescents with gender dysphoria, they may have an
16 increased risk for anxiety, depression, and suicide
17 depending on where they are with their mental health.
18 Q. Are there risks associated with interrupting
19 the provision of this care?
20 A. Yes. If we interrupt this care -- the same
21 goes forth that there are risks for mental health,
22 complications, and suicide, but if you also interrupt
23 any of these medical treatments abruptly, there can
24 also be a significant medical change that can occur,
25 too, that needs to be monitored and handled closely by

1 experienced physicians.
2 Q. Dr. Brady, in your clinical experience and
3 based on your review of the literature, is the
4 provision of this care harmful for adolescents with
5 gender dysphoria?
6 MR. STONE: Objection; leading.
7 THE COURT: Overruled.
8 A. No. In my -- in my experience, as well as my
9 review of the literature of this, this is not harmful
10 to adolescents with gender dysphoria.
11 MR. GONZALEZ-PAGAN: That's all at this
12 time, Your Honor.
13 THE COURT: Mr. Stone.
14 **CROSS-EXAMINATION**
15 BY MR. STONE:
16 Q. Good morning, Dr. Brady.
17 A. Good morning.
18 Q. How many patients have you prescribed puberty
19 blockers to that did not have a diagnosis of gender
20 dysphoria but believed that they were the wrong gender?
21 A. Can you repeat that one more time?
22 Q. How many minor patients have you prescribed
23 puberty blockers to that did not have a diagnosis of
24 gender dysphoria but believed that they were the wrong
25 gender?

1 MR. GONZALEZ-PAGAN: Objection,
2 Your Honor; lack of foundation.
3 THE COURT: Overruled.
4 A. All the patients I've prescribed pubertal
5 blockers to have a diagnosis of gender dysphoria, and
6 they're all adolescents.
7 Q. (BY MR. STONE) Would you ever prescribe
8 puberty blockers to a minor that believed they were the
9 wrong gender but did not have a diagnosis of gender
10 dysphoria?
11 A. No. They have to have a diagnosis of gender
12 dysphoria based on the standards of care in our
13 guidelines.
14 Q. So is it always medically necessary in your
15 opinion when you prescribe puberty blockers to a minor
16 for the treatment of gender dysphoria?
17 MR. GONZALEZ-PAGAN: Objection --
18 A. Yeah.
19 MR. GONZALEZ-PAGAN: -- vague.
20 THE COURT: Overruled.
21 Q. (BY MR. STONE) How do you determine what is
22 medically necessary for the treatment of gender
23 dysphoria in minors?
24 A. So we have a multi-disciplinary approach based
25 on our standards of care, and that involves the

1 health -- mental health providers to evaluate the
2 gender dysphoria and provide to us the information and
3 then medically necessary -- once we receive that
4 information stating that these are medically necessary
5 based on that diagnosis, that medical diagnosis of
6 gender dysphoria and necessary in the fact that it will
7 help prevent comorbidities and suicide.
8 Q. Would you prescribe puberty blockers to a
9 minor -- minor with gender dysphoria if it were not
10 medically necessary?
11 A. Can you repeat your question?
12 MR. GONZALEZ-PAGAN: Objection; calls for
13 speculation.
14 MR. STONE: Well, Your Honor, she
15 has been di- -- or she's been designated as an expert,
16 so she can answer hypotheticals in this case, and I'm
17 asking her -- she also probably has personal knowledge.
18 THE COURT: You're -- you're going to
19 repeat the question anyway because I think she needed
20 to have it repeated, so let's repeat the question.
21 MR. STONE: Thank you, Your Honor.
22 Q. (BY MR. STONE) Would you prescribe puberty
23 blockers to a minor with gender dysphoria if it were
24 not medically necessary?
25 MR. GONZALEZ-PAGAN: Same objection.

1 MR. STONE: And same response,
2 Your Honor. She's been desig- -- designated as an
3 expert. She can answer hypotheticals. And in this
4 case she's also a treating physician and treats --
5 THE COURT: She can answer hypotheticals,
6 so I'm overruling the objection. If the witness can
7 answer this question, then the witness may answer.
8 A. I -- I would say as a physician all care
9 provided is medically necessary.
10 Q. (BY MR. STONE) In your opinion, would it
11 violate the standard of care to prescribe puberty
12 blockers to a minor without a gender dysphoria
13 diagnosis but who simply wants -- wants to change their
14 gender?
15 A. Our standards of care rely on evidence base,
16 and they also state that we should have a good
17 discussion with our mental health providers confirming
18 gender dysphoria. So in order to provide adolescents
19 with pubertal blockers, they should have gender
20 dysphoria.
21 Q. And would it violate the standard of care to
22 provide them with puberty blockers if they did not have
23 a diagnosis -- a diagnosis of gender dysphoria?
24 A. It would not be following our guidelines.
25 Q. So when you say it would not follow your

1 guidelines, are you saying that it would not be within
2 the standard of care?
3 A. Right. We -- we don't treat individuals who
4 do not have gender dysphoria.
5 Q. What about -- next I'm going to ask about
6 cross-sex hormones. How many patients have you
7 prescribed cross-sex hormones to that did not have a --
8 how many minor -- let me strike that. Let me start
9 again. Be careful with my wording here.
10 How many minor patients have you
11 prescribed puberty blockers to that did -- not puberty
12 blockers but cross-sex hormone therapy to that did not
13 have a diagnosis of gender dysphoria but believed that
14 they were the wrong gender?
15 A. All patients that I've prescribed gender -- I
16 mean, hormones to have received a diagnosis of gender
17 dysphoria.
18 Q. Is it your testimony today that it would
19 violate the standard of care to prescribe cross-sex
20 hormone therapy to a minor patient who wished to change
21 their gender but did not have a diagnosis of gender
22 dysphoria?
23 A. I guess my -- I guess I don't really
24 understand what you're asking me in this setting.
25 Q. Sure.

1 A. When you're saying -- okay. The -- can you --
2 when you're saying -- someone who is asking to change
3 their gender? Is that what you're...
4 Q. Sure. Let me clarify. So --
5 A. Yeah.
6 Q. -- a patient comes --
7 A. Yeah.
8 Q. -- patient comes in the door, minor patient --
9 A. Yeah. Yeah.
10 Q. -- and they say, Dr. Brady, I want to change
11 my gender. The patient has not been diagnosed with
12 gender dysphoria. Would it violate the standard of
13 care to -- simply based on that patient's statements
14 that they wish to change their gender, to prescribe
15 them cross-sex hormones?
16 MR. GONZALEZ-PAGAN: Objection; compound.
17 MR. STONE: It's a hypothetical,
18 Your Honor, and I'm just teeing it up.
19 THE COURT: It's overruled. If the
20 witness can answer the question, the witness may
21 answer.
22 A. Based on our standards of care, we provide
23 hormone therapy, medically-necessary therapy, to
24 individuals with gender dysphoria.
25 Q. (BY MR. STONE) So -- so it would violate the

1 standard of care to provide that patient with cross-sex
2 hormones without a diagnosis of gender dysphoria?
3 A. Our standards of care say that they should
4 have a mental health evaluation confirming the gender
5 dysphoria.
6 Q. It's -- it's just a yes or no. I have some --
7 would it violate the standard of care to prescribe --
8 MR. GONZALEZ-PAGAN: Objection; asked and
9 answered.
10 THE COURT: Sustained.
11 Q. (BY MR. STONE) Would it violate the standard
12 of care to perform top surgery on a patient -- a minor
13 patient who wished to change their gender but did not
14 have a diagnosis of gender dysphoria?
15 A. Same thing goes with this. Gender dysphoria
16 diagnosis are recommended by the standards of care
17 before medically-necessary treatment is provided.
18 Q. What is Munchausen syndrome by proxy?
19 MR. GONZALEZ-PAGAN: Objection,
20 Your Honor; beyond the scope of expertise.
21 THE COURT: Overruled. If the witness
22 believes the witness can speak on Munchausen syndrome
23 by proxy, the witness may do so.
24 A. Yeah. As a pediatric endocrinologist, I can't
25 give you, like, an exact definition, but I can -- my

1 interpretation of Munchausen by proxy and my experience
2 with it is when a parent may present their child with
3 medical conditions that they may not necessarily have
4 for individual gain.
5 Q. (BY MR. STONE) Have you encountered
6 Munchausen syndrome -- or Munchausen by proxy in your
7 personal practice?
8 A. Not as a pediatric endocrinologist.
9 Q. Have you encountered it in any other context
10 other than as a pediatric endocrinologist?
11 A. The only time I could speak to that would have
12 been when I was a pediatric resident several, several
13 years ago.
14 Q. Now, you perform a diagnostic assessment
15 before beginning puberty blockers or hormone therapy
16 for minors with gender dysphoria, right?
17 A. A diagnostic assessment is not conducted by
18 myself. I do not -- I'm a pediatric endocrinologist.
19 I don't diagnose gender dysphoria.
20 Q. Do you require a diagnostic assessment before
21 beginning treatment for gender dysphoria with puberty
22 blockers or hormone therapy?
23 A. Yes. I follow the standards of care, and
24 every one of my adolescent patients that receives care
25 will have a mental health evaluation that is

1 diagnostic.
2 Q. How many -- now, you said you don't diagnose
3 gender dysphoria; is that correct?
4 A. I rely on mental health providers to give me
5 the diag- -- or to provide me with the information
6 regarding that diagnosis for the patient.
7 Q. So who diagnoses a patient with gender
8 dysphoria?
9 A. The mental health providers.
10 Q. Okay. How many psych- -- psychological
11 evaluations do you require before beginning puberty
12 blockers or hormone therapy for the treatment of a
13 minor diagnosed with gender dysphoria?
14 A. There is not a set requirement. It's very
15 much individualized, but it's based on standards of
16 care, and it is guided by the mental health providers
17 and multi-disciplinary evaluation from our team. I
18 can't give you a specific number because every patient
19 is different.
20 Q. But does every patient require at least one
21 that you treat?
22 A. Oh, abs- -- absolutely.
23 Q. And in some cases do they require two?
24 A. They would -- they would have more than two
25 for sure.

1 Q. In some cases do they require three?
2 A. Yes. I've seen patients require -- I mean,
3 when we use the word "require," it's more what they
4 need.
5 Q. Right.
6 A. So many patients may need, you know, 17
7 visits. I can't give you an exact number, but it's
8 where they are and how -- and how well they're doing
9 and how that -- that treatment is -- is going with them
10 and how that evaluation and diagnostic procedure are
11 going as well.
12 Q. So in some cases, a patient might need 17
13 psychological evaluations prior to you beginning
14 puberty blockers or hormone therapy for the treatment
15 of gender dysphoria, right?
16 A. I said 17. That was just a random number.
17 And I would say they don't necessarily -- that's not a
18 number where, like, okay, you've acquired 17; you've
19 had 17 sessions; you need to come in. I'm just saying
20 that as an example. So some individuals may have had a
21 number of sessions with a mental health provider before
22 they receive care from a pediatric endocrinologist.
23 Q. How many minor patients that you've treated
24 have been ruled out for puberty blockers or hormone
25 therapy by the psychological evaluation prior to you

1 beginning your treatment?
2 A. Well, if they've been ruled out as not having
3 gender dysphoria by the medical -- or by the
4 psychologist, I would not be providing them medical
5 care.
6 Q. How many times has -- have you referred a
7 patient who presents with apparent gender dysphoria and
8 you've referred them for the psychiatric evaluation to
9 diagnose them -- how many of them have subsequently
10 been ruled out; in other words, they don't have gender
11 dysphoria, if I'm understanding your testimony
12 correctly?
13 A. How many have I referred? So typically, if
14 they are coming to me, they have a diagnosis of gender
15 dysphoria.
16 Q. So by the time the patient gets to you,
17 they've already been diagnosed with gender dysphoria?
18 A. Yes, I would say so. There may be some on
19 occasion where we provide them with information from
20 the -- about mental health providers and they go have
21 interactions with them and -- and then they return to
22 us after those.
23 Q. So if a patient presents to you and they've
24 been diagnosed with gender dysphoria, do you require
25 them to undergo any further psychiatric evaluation

1 prior to you beginning puberty blockers or hormone
2 therapy?
3 A. So if an individual already has a diagnosis of
4 gender dysphoria at our first visit? Is that what
5 you're asking?
6 Q. Yes.
7 A. So every individual -- and let me just say
8 I -- this could vary. But based on our -- based on
9 evidence base and based on my clinical experience, we
10 don't rely on that first visit to say we're just going
11 to automatically start you on any hormones. We
12 interact with that mental health provider. That
13 individual may continue with mental health care and we
14 introduce ourselves to them. So it's not -- and this
15 doesn't begin at first visit even if they have gender
16 dysphoria right there.
17 Q. Isn't it true that some advocate for no
18 psychiatric evaluations at all prior to beginning a
19 treat- -- treatment for gender dysphoria in minors by
20 prescribing puberty blockers or hormone therapy?
21 MR. GONZALEZ-PAGAN: Objection; calls for
22 hearsay. Objection; calls for speculation.
23 THE COURT: Overruled. The witness may
24 answer if the witness can do so.
25 A. Among pediatric endocrinologists, I would say

1 a vast majority of us believe that the individual
2 should have the mental health support as we continue to
3 follow the standards of care and evidence-based
4 guidelines that we have.
5 Q. (BY MR. STONE) Isn't it true that some argue
6 that gatekeeping for hormone replacement therapy for
7 transgender patients is dehumanizing?
8 MR. GONZALEZ-PAGAN: Objection; vague.
9 Objection; calls for speculation.
10 THE COURT: Sustained.
11 A. I was actually going to ask you to repeat that
12 because you kind of cut out for a second.
13 Q. (BY MR. STONE) Yeah.
14 A. Please.
15 Q. Absolutely. At this time I want to show you
16 something.
17 *(Discussion off the record between*
18 *counsel.)*
19 Q. (BY MR. STONE) Are you familiar with the
20 *Journal of Medical Ethics*?
21 A. I -- yeah, I've -- I've heard of it, yes.
22 Q. Okay. And is it a -- a -- a learned
23 publication, if you will?
24 A. I don't utilize it often, but -- so I can't
25 comment to that --

1 Q. Okay.
2 A. -- 100 percent.
3 Q. Have you ever read the *Journal of Medical*
4 *Ethics* or any articles published by it in the past?
5 A. I'm sure I have, but I can't recall which
6 ones.
7 Q. Do you have any reason to believe that the
8 *Journal of Medical Ethics* is unreliable?
9 A. I can't comment to that 100 percent, but no.
10 Q. Could you open Defendants' Exhibit 21, marked
11 as Exhibit 21?
12 MR. GONZALEZ-PAGAN: Objection,
13 Your Honor. To the extent that counsel intends to ask
14 questions about this document as an exception under
15 803.18, she -- counsel has not established that it is a
16 reliable periodical or treatise that the witness would
17 use or utilize.
18 THE COURT: What say you to that,
19 Mr. Stone?
20 MR. STONE: Your Honor, I can lay further
21 predicate.
22 THE COURT: You may proceed.
23 MR. STONE: Okay.
24 A. Can you tell me again what exhibit I'm
25 supposed to be opening or if I'm even supposed to be

1 opening one?
2 Q. (BY MR. STONE) Yeah, don't open it yet.
3 A. Okay.
4 Q. I've got some -- a couple of follow-up
5 questions. Okay?
6 A. Oh, okay.
7 Q. You testified earlier that you're familiar
8 with the *Journal of Medical Ethics,* right?
9 A. Yes, I've heard of it.
10 Q. You've heard of it. And how -- how have you
11 heard of it?
12 A. Through just -- you know, just searches,
13 you know, evidence -- or not evidence-based, but when
14 you go on to PubMed, for example, you can search things
15 and it may have popped up, but I've -- I've heard of
16 it.
17 Q. And what is PubMed?
18 A. It's a -- you can go in there and type in
19 questions, and basically any source may pop up with
20 information, any published, like, medical source.
21 Q. And what is a -- what do you mean by published
22 medical source?
23 A. It could -- like a journal, medical journal.
24 Q. And what are medical journals used for?
25 A. Sharing information regarding medical care or

1 opinions. Some people will publish opinions that may
2 not have, you know, evidence base to support them.
3 Q. And do you rely on medical journals and --
4 in -- in your practice of medicine?
5 A. I -- I rely on medical journals. I -- I can
6 say that I've not really relied a lot on the *Journal of*
7 *Medical Ethics* or at all. I don't have a whole
8 repertoire of articles from there.
9 Q. But you've encountered it when you did
10 searches on PubMed; is that correct?
11 A. I don't -- it hasn't been recent. I'm even
12 wondering if it was, like, an exercise for medical
13 school. But yes, I have -- I've heard of the journal.
14 Q. Okay. Prior to your testimony today, did you
15 re- -- did you review any of defendants' exhibits --
16 proposed exhibits in this case?
17 A. No, not that I'm aware of.
18 Q. Okay.
19 MR. STONE: Your Honor, at this time I --
20 well, let me ask the question.
21 Q. (BY MR. STONE) Could you open Defendants'
22 Exhibit 21?
23 MR. GONZALEZ-PAGAN: Objection,
24 Your Honor.
25 THE COURT: She can open it.

1 A. It's open.
2 Q. (BY MR. STONE) Okay. Does this appear to be
3 a -- an article from the *Journal of Medical Ethics*?
4 A. Yes.
5 Q. Okay. And what is -- what is the title of
6 this document?
7 A. Well, first off it says viewpoint, so I
8 interpret that as an opinion case. It -- but it says
9 gatekeeping hormone replacement therapy for transgender
10 patients is dehumanizing. Again, it says viewpoint.
11 Q. Okay. Is there --
12 MR. GONZALEZ-PAGAN: And, Your Honor, at
13 this point I would object to any further questioning
14 from the content of the document.
15 THE COURT: Let's -- let's hear a
16 question, and then I think your objection will be more
17 relevant. But we don't have a question on the table
18 right this second, so let's hear a question.
19 Q. (BY MR. STONE) And is there an author
20 identified in this article?
21 A. Florence Ashley.
22 Q. And is there a -- is there a -- associated
23 with Florence Ashley any professional titles or degrees
24 in this article?
25 A. Yeah. It says faculty of law.

1 Q. Where?
2 A. McGill University in Montreal, Canada.
3 Q. In the second column, do you see where -- a
4 sentence that begins --
5 MR. GONZALEZ-PAGAN: Objection,
6 Your Honor --
7 THE COURT: Yes. That's going to be
8 sustained. It's not in evidence.
9 MR. STONE: I'm -- I'm -- I'm not
10 offering the exhibits, Your Honor. I was going to ask
11 her to read a statement from it pursuant to the
12 exception in 803.18.
13 THE COURT: And this doesn't meet 803.18,
14 as you just explained it to the Court awhile back. If
15 you wanted to bring your own expert and attempt to have
16 your own expert rely on this and give opinion on this,
17 I think we'd be in a different position. But I don't
18 think you can use a legal viewpoint made in the *Journal*
19 *of Medical Ethics* and ask questions to an expert about
20 it.
21 MR. STONE: Okay.
22 Q. (BY MR. STONE) Now, you're on -- you're a
23 member of WPATH, right?
24 A. Yes.
25 Q. And remind us again what WPATH is.

1 A. The World Professional Association of
2 Transgender Health.
3 Q. Are you on an actual committee for WPATH?
4 A. No, I'm not on a committee for WPATH.
5 Q. Okay. If you know, are there providers out
6 there -- medical providers out there who are
7 prescribing -- who prescribe puberty blockers or
8 hormone therapy for the treatment of gender dysphoria
9 without requiring any kind of official diagnosis of
10 gender dysphoria?
11 MR. GONZALEZ-PAGAN: Objection,
12 Your Honor; this goes beyond expertise into pure
13 speculation.
14 MR. STONE: It's -- it's a hyp- --
15 THE COURT: Overruled. It's
16 cross-examination of an expert. If the expert can
17 answer, she may answer.
18 A. I'm not aware of anyone doing that.
19 MR. STONE: Okay. I'll pass the witness,
20 Your Honor.
21 THE COURT: Thank you.
22 MR. GONZALEZ-PAGAN: Your Honor, we are
23 done with this witness.
24 THE COURT: All right. Dr. Brady, I
25 believe you are excused. You can --

1 THE WITNESS: Oh, okay. Great. Thank
2 you.
3 THE COURT: Thank you for your time. If
4 you want to disconnect your Zoom link.
5 MR. GONZALEZ-PAGAN: Yes, Your Honor.
6 THE COURT: We are coming up on the noon
7 hour. If you have a short witness that you wanted to
8 get in before lunch, we could do that, if there's
9 somebody waiting that you feel like you need to offer
10 and take testimony of. And if not, we'll go ahead and
11 take our lunch break at this time.
12 MR. KLOSTERBOER: Your Honor, this is
13 Brian Klosterboer. We do have a short witness, so we'd
14 be happy to proceed if the Court wants to or if you'd
15 prefer --
16 THE COURT: It's your call. If somebody
17 needs to have their testimony done and wants to be
18 excused for the rest of the day, I am fine with that.
19 We are happy to go into the lunch hour. It's your
20 call.
21 MR. KLOSTERBOER: Sounds good,
22 Your Honor.
23 THE COURT: You want to call someone?
24 MR. KLOSTERBOER: Yes. Plaintiffs call
25 Randa Mulanax.

1 THE COURT: All right. Ms. Mulanax,
2 please come up. Please raise your right hand.
3 *(Witness sworn in.)*
4 THE COURT: Thank you. You may have a
5 seat. And you can keep your mask on or take your mask
6 off, whichever would make you more comfortable.
7 And you may proceed.
8 MR. KLOSTERBOER: Your Honor, may I
9 approach the witness to pass our exhibit binder?
10 THE COURT: Yes.
11 MR. KLOSTERBOER: Thank you.
12 **RANDA MULANAX**,
13 having been first duly sworn, testified as follows:
14 **DIRECT EXAMINATION**
15 BY MR. KLOSTERBOER:
16 Q. Please state your name?
17 A. Randa Mulanax.
18 Q. In what capacity are you testifying today?
19 A. As a private citizen.
20 Q. What is your connection to the Texas
21 Department of Family and Protective Services?
22 A. I'm a previous employee for CPS.
23 Q. How long did you work for CPS?
24 A. For five years and seven months.
25 Q. What was your position in February of this

1 year.
2 A. I was an investigation supervisor for CPS.
3 Q. How long did you hold that position for?
4 A. Approximately eight months.
5 Q. When did you leave that position?
6 A. March of this year.
7 MS. CORBELLO: Your Honor, at this time
8 I'd like to lodge an objection. Ms. Mulanex's
9 testimony is entirely irrelevant to this case. She
10 hasn't been employed by DFPS for four months -- five
11 months.
12 THE COURT: Overruled.
13 Q. (BY MR. KLOSTERBOER) What led to you leaving
14 your position?
15 A. I ultimately left due to the order sent out by
16 Governor Abbott and the legal opinion by Ken Paxton.
17 Q. How did you first learn about the letter sent
18 by Governor Abbott?
19 A. A supervisor in my area, my program director
20 area, we had a group chat in Teams, and she sent the
21 article through there. That's how I initially found
22 out about it.
23 Q. Will you turn to what's marked as Plaintiffs'
24 Exhibit 2? Do you recognize this document?
25 A. Yes, I do.

1 Q. What is it?
2 A. It is the order sent from Governor Abbott to
3 our -- the DFPS commissioner.
4 MR. KLOSTERBOER: Your Honor, plaintiffs
5 move to admit Exhibit 2 into evidence.
6 MS. CORBELLO: Your Honor, no objection
7 to the extent Ms. Mulanax is testifying as to her
8 reaction on the letter, not to any extent that she's
9 testifying as to her understanding of what the letter
10 says or what it means.
11 THE COURT: She can't give legal
12 testimony for sure. That's up to the Court. And so I
13 think --
14 MS. CORBELLO: That's our only --
15 THE COURT: -- as long as that's
16 understanding -- I mean, as long as we don't call for a
17 legal conclusion, I think you can ask her questions
18 about this and her interpretation of it or her
19 understanding of it, those sorts of things, yes.
20 MR. KLOSTERBOER: Yes, Your Honor. And
21 just to clarify, this is an opposing party statement
22 that we're seeking to admit into evidence. We're not
23 going to ask her for --
24 THE COURT: So --
25 MR. KLOSTERBOER: -- any legal opinions

1 on it.
2 THE COURT: Sure. So 2 is admitted.
3 *(Plaintiffs' Exhibit 2 admitted.)*
4 MR. KLOSTERBOER: Thank you.
5 Q. (BY MR. KLOSTERBOER) Ms. Mulanax, can you
6 turn to -- well, actually, let me ask you first, after
7 you learned about the Governor's letter, what was DFPS'
8 public response?
9 A. The public --
10 MS. CORBELLO: Objection; Ms. Mulanax is
11 not here testifying on behalf of DFPS.
12 THE COURT: Understood. She is not
13 testifying on their behalf. She is testifying in her
14 individual capacity. And with that understanding, your
15 objection's overruled.
16 MS. CORBELLO: Thank you, Your Honor.
17 A. My understanding was, based on the statements
18 released to the press, that the Department would be
19 following the legal opinion of Ken Paxton and pursuing
20 these investigations.
21 Q. (BY MR. KLOSTERBOER) And could you turn to
22 Plaintiffs' Exhibit 3?
23 A. Uh-huh.
24 Q. Do you recognize this document?
25 A. I do.

1 Q. What is it?
2 A. It is a statement, I don't know by who, but it
3 was by a representative of the Department stating that
4 there are no -- there were no current investigations at
5 the time of the statement.
6 Q. And how did you first encounter this
7 statement?
8 A. It was in a news article. I can't remember
9 exactly when I saw it, but I believe the article was
10 published on the 22nd of that month.
11 MR. KLOSTERBOER: Your Honor, plaintiffs
12 move to admit Exhibit 3 into evidence.
13 MS. CORBELLO: No objection with the same
14 understanding about individual versus legal opinions.
15 THE COURT: The Court still has that same
16 understanding. 3 is admitted.
17 *(Plaintiffs' Exhibit 3 admitted.)*
18 Q. (BY MR. KLOSTERBOER) Ms. Mulanax, in the days
19 following the Governor's letter and this statement,
20 what happened?
21 A. Cases in regards to specific allegations
22 started to come into Travis County.
23 Q. Before February 22nd, had you personally
24 encountered any of the cases involving these specific
25 allegations?

1 A. I had not.
2 Q. What else happened -- or what -- what
3 guidance, if any, were you given following
4 February 22nd?
5 A. There was a meeting held on February 24th,
6 just a couple of days after the order came out. I was
7 not present for the entire meeting, but I did get on
8 the tail end, and I also received notes from the
9 meeting, and I spoke with my program director at the
10 time and other supervisors in my unit who were on the
11 meeting stating that we were instructed not to put
12 anything about these cases in writing via email or text
13 message through our work devices, and we were only to
14 staff them through phone calls or in person or through
15 Teams and that we were to refer to them as specific
16 cases I believe was the verbiage.
17 Q. Could you turn to what's marked as Plaintiffs'
18 Exhibit 15?
19 A. Uh-huh.
20 Q. Do you recognize this document?
21 A. I do.
22 Q. What is it?
23 A. These are the meeting notes that I was emailed
24 from my regional director.
25 Q. And when did you --

1 A. At the time. Sorry.
2 Q. When did you receive that email?
3 A. I believe it was the same day as the meeting
4 was held, so the 24th.
5 MR. KLOSTERBOER: Your Honor, plaintiffs
6 move to admit Exhibit 15 into evidence.
7 MS. CORBELLO: Your Honor, we would
8 object on the basis of relevance. Ms. Mulanax has not
9 testified to any knowledge of whether anything within
10 this exhibit is still in effect today. This is a
11 temporary injunction hearing about current and future
12 harm, and this document is, again, from five months
13 ago. It has no relevance as to what's occurring today,
14 at least insomuch as her testimony has provided.
15 THE COURT: Overruled.
16 MR. KLOSTERBOER: Your Honor, is
17 Exhibit 15 now admitted?
18 THE COURT: 15's admitted.
19 *(Plaintiffs' Exhibit 15 admitted.)*
20 MR. KLOSTERBOER: Thank you.
21 Q. (BY MR. STONE) After this -- the meeting that
22 you held on February 24th, what other guidance, if any,
23 were you given?
24 A. That these cases were not eligible for
25 priority none status or a PN if it fit the current

1 policy and that they were also not eligible for
2 administrative closure if it fit the current policy.
3 Q. How does that compare to the policies that you
4 followed before February 22nd?
5 A. It is -- in my opinion, it was discriminatory
6 towards these cases because the only other cases
7 prioritized that way were child death investigations or
8 cases involving children in conservatorship.
9 MS. CORBELLO: Your Honor, I'm going
10 to -- Your Honor, I'm going to object to this question
11 and answer. Ms. Mulanax previously testified she never
12 personally encountered an investigation like this, so I
13 don't know how she's testifying to the policy on them.
14 THE COURT: Overruled.
15 Q. (BY MR. STONE) Turning to the policies, can
16 you turn to what's marked as Plaintiffs' Exhibit 16?
17 A. Okay.
18 Q. Do you recognize this document?
19 A. Yes, I do.
20 Q. What is it?
21 A. It is part of the CPS handbook stating the
22 foundation for investigations.
23 MR. KLOSTERBOER: Your Honor, plaintiffs
24 move to admit Exhibit 16 into evidence.
25 MS. CORBELLO: No objection.

1 THE COURT: 16's admitted.
2 *(Plaintiffs' Exhibit 16 admitted.)*
3 MS. CORBELLO: Again with the
4 understanding that she's not testifying on behalf of
5 DFPS' document.
6 Q. (BY MR. KLOSTERBOER) Can you now turn to
7 Plaintiffs' Exhibit 17?
8 A. Okay.
9 Q. And do you recognize this -- it's part of the
10 same collection, but do you recognize this document?
11 A. Yes. It's also part of the handbook.
12 MR. KLOSTERBOER: Plaintiff's move to
13 admit Exhibit 17 into evidence.
14 MS. CORBELLO: No objection with the same
15 caveat.
16 THE COURT: 17's admitted.
17 *(Plaintiffs' Exhibit 17 admitted.)*
18 Q. (BY MR. KLOSTERBOER) And can you turn to
19 Exhibit 18?
20 A. Okay.
21 Q. What is this document?
22 A. This is also part of the handbook. This part
23 is focused on screening intakes.
24 MR. KLOSTERBOER: Plaintiffs move to
25 admit Exhibit 18 into evidence.

1 MS. CORBELLO: No objection with the same
2 caveat.
3 THE COURT: 18 is admitted.
4 *(Plaintiffs' Exhibit 18 admitted.)*
5 Q. (BY MR. STONE) Can you turn to Exhibit 19?
6 A. Okay.
7 Q. What is this document?
8 A. It's also part of the handbook that goes
9 into -- this is more detailed about all of the
10 screening and supervisors' roles and screening on
11 intakes.
12 MR. KLOSTERBOER: Plaintiffs move to
13 Exhibit -- to admit Exhibit 19 into evidence.
14 MS. CORBELLO: No objection with the same
15 caveat.
16 THE COURT: What number are we at?
17 MR. KLOSTERBOER: 19, Your Honor.
18 THE COURT: 19 is admitted.
19 *(Plaintiffs' Exhibit 19 admitted.)*
20 Q. (BY MR. STONE) One more. Can you please turn
21 to Exhibit 20?
22 A. Okay.
23 Q. Do you recognize this document?
24 A. Yes, I do.
25 Q. What is it?

1 A. It is -- it is also part of the handbook,
2 policy in regards to how investigations are handled.
3 MR. KLOSTERBOER: Plaintiffs would move
4 to admit Exhibit 20 into evidence.
5 MS. CORBELLO: No objection with the same
6 caveat.
7 THE COURT: 20 is admitted.
8 *(Plaintiffs' Exhibit 20 admitted.)*
9 MR. KLOSTERBOER: No further questions,
10 Your Honor.
11 THE COURT: Do you have any questions for
12 this witness?
13 MS. CORBELLO: A very short amount,
14 Your Honor, if you want to just get her done.
15 **CROSS-EXAMINATION**
16 BY MS. CORBELLO:
17 Q. Ms. Mulanax, the last time you worked for DFPS
18 was March 2022, right?
19 A. Yes.
20 Q. That's about four months ago, right?
21 A. Yes.
22 Q. At any time in the past four months have you
23 been personally involved in an intake process at DFPS?
24 A. No.
25 Q. At any time in the past four months have you

1 been part of an investigation with DFPS?
2 A. No.
3 Q. Have you been in any meetings with DFPS
4 supervisors or leadership in the past four months?
5 A. No. Actually, just to go back, I did have to
6 testify at a hearing I think last month. Is that
7 included? I had to testify in a termination trial.
8 Q. For an investigation you had been a part of --
9 A. Yes.
10 Q. -- before?
11 A. Yes. Sorry.
12 Q. Okay. Other than testifying in court on a
13 previous investigation, have you been a part of any
14 other investigation with DFPS --
15 A. No.
16 Q. -- in the past four months?
17 A. No.
18 Q. So is it fair to say you have no information
19 for this Court as to what DFPS' current practices are
20 today as you sit here today?
21 A. No.
22 Q. That's fair to say, you don't have that
23 information, right?
24 A. I don't have information on any directives
25 that have currently been sent out.

1 Q. Okay. If the current DFPS director of
2 investigations gets up here after -- after you do and
3 tells the Court how these investigations are actually
4 currently happening and will continue to happen, you
5 have no information to contradict that, do you?
6 MR. KLOSTERBOER: Objection, Your Honor;
7 calls for speculation and argumentative.
8 MS. CORBELLO: She can tell us whether
9 she has information that would contradict that,
10 Your Honor.
11 THE COURT: Overruled.
12 Q. (BY MR. STONE) Do you want me to ask it
13 again?
14 A. No. No, I don't have any current information.
15 MS. CORBELLO: Nothing further.
16 THE COURT: Anything further from you,
17 Mr. Klosterboer?
18 MR. KLOSTERBOER: No, Your Honor.
19 THE COURT: All right. Thank you. You
20 may step down. Why don't you hand -- hand back the
21 exhibit binder.
22 All right. At this time it is 12:10, and
23 we will take our lunch break. We will break until
24 1:30. The time that I have -- remember I keep general
25 time. I don't know if one of you has some sort of

1 chess clock or not, but my time is the plaintiffs used
2 an hour and 40 minutes, and the defendants have used
3 55 minutes. That's what I have. And I will see
4 everybody at 1:30.
5 MR. STONE: Thank you, Your Honor.
6 MS. CORBELLO: Thank you, Your Honor.
7 MR. KLOSTERBOER: Thank you, Your Honor.
8 *(Lunch recess.)*
9 THE COURT: Plaintiffs may call your next
10 witness.
11 MR. GUILLORY: Plaintiffs would like to
12 call Wanda Roe to the stand via Zoom.
13 THE COURT: Yes. And this is Wanda Roe?
14 MR. GUILLORY: Yes, Your Honor.
15 THE COURT: Ms. Roe, can you hear me?
16 THE WITNESS: I can.
17 THE COURT: This is Judge Meachum, and
18 I'm going to ask you to please raise your right hand
19 and be sworn in as a witness.
20 *(Witness sworn in.)*
21 THE COURT: Thank you. You may proceed,
22 Counselor. One -- one more time, can you tell us your
23 name again?
24 MR. GUILLORY: Nicholas Guillory.
25 THE COURT: Thank you.

1 **WANDA ROE,**
2 having been first duly sworn, testified as follows:
3 **DIRECT EXAMINATION**
4 BY MR. GUILLORY:
5 Q. What brings you here today?
6 A. I am a plaintiff in the case. I'm a member of
7 PFLAG. But most importantly for me, I'm here to
8 protect the rights of myself and my son who is
9 transgender.
10 Q. Wanda Roe is not your real name, correct?
11 A. It is not.
12 Q. Is Wanda Roe a pseudonym?
13 A. It is.
14 Q. Why are you proceeding under a pseudonym?
15 A. Because I need to protect the identity of my
16 family to prevent us from being harassed or suffer any
17 violence or retaliation for seeking to protect our
18 rights.
19 Q. Why do you feel -- hold on. You mentioned
20 your son Tommy. You mentioned your son. For the
21 purposes of the lawsuit, what is his name?
22 A. His name is Tommy Roe.
23 Q. Is Tommy Roe a pseudonym?
24 A. It is.
25 Q. You mentioned earlier that Tommy is

1 transgender. What did you do when you learned Tommy
2 was transgender?
3 A. Well, I cried for a week, but my immediate
4 reaction, because I could see that he was nervous and
5 shaking when he told me, was to hug him, simply hug him
6 and tell him that I loved him and tell him that
7 everything was going to be okay.
8 I then took the next week to find myself
9 a counselor because I needed to deal with my own issues
10 that were not a part of what Tommy was going through,
11 but also we did go to his primary care physician to
12 discover what we needed to do next.
13 Q. And what did that primary care physician
14 recommend, if anything?
15 A. The primary care physician recommended -- or
16 referred Tommy to a gender-affirming specialist.
17 Q. Have any of these providers made any diagnosis
18 in connection with Tommy being transgender?
19 A. They have. They diagnosed him with gender
20 dysphoria.
21 Q. Have these providers made any recommendations
22 pertaining to Tommy's gender dysphoria?
23 A. They have recommended counseling, and they
24 have recommended gender-affirming therapy in terms of
25 hormone therapy.

1 Q. Does Tommy live openly as a boy?
2 A. He does.
3 Q. What observations have you made from seeing
4 Tommy live authentically as himself?
5 A. He is so much happier. He used to be -- he's
6 so -- he was almost invisible. He didn't want people
7 to see him or look at him. I didn't understand why.
8 If we were out, he would always walk behind me in my
9 shadow. He never wanted to speak to people directly.
10 He never could make eye contact. And he seemed so sad,
11 just sad all the time. And since he's been able to be
12 himself and present as himself, he has been happier.
13 He comes out of his room. He joins us for family
14 discussions. He's a completely different person.
15 Q. You mentioned earlier an investigation. How
16 did you learn about the investigation?
17 A. So I got a text from my son who was at school
18 telling me he had something important to tell me, but
19 he was too upset to discuss it on the phone. I went to
20 pick him up from school. And on the way home from
21 school, we had dropped off some other friends, and
22 another one of my sons called me to say that there was
23 someone waiting for me at my house to investigate me --
24 or to ask me questions about, you know, a CPS
25 investigation. And that's when Tommy looked at me and

1 was very upset but did say to me, That's what I was
2 going to talk to you about. I got pulled out of class
3 today and interviewed by a CPS investigator, and that
4 person was waiting -- that same person was waiting for
5 me at my house.
6 Q. And what did that CPS caseworker tell you?
7 MS. CORBELLO: Your Honor, at this time
8 I'd like to make a running objection that plaintiffs
9 have now opened the door and waived what this Court has
10 construed as a motion in limine that they filed earlier
11 today.
12 THE COURT: But now is not the proper
13 time to do that, I don't think. I think the proper
14 time is when you ask your questions or you make an
15 offer. So you're just putting them on notice, and
16 there's no ruling for the Court to make at this time.
17 MS. CORBELLO: Thank you, Your Honor.
18 MR. GUILLORY: Your Honor, I'll proceed,
19 but for the record, we're not waiving any arguments
20 made in our motion to exclude, and we will off- -- and
21 if offered during cross, the investigation or the audio
22 recording, we will make specific and timely objections.
23 THE COURT: Thank you. You may proceed.
24 Q. (BY MR. GUILLORY) I'll ask the question
25 again. What did the CPS caseworker tell you?

1 A. She told me that she needed to come into my
2 house and interview everybody that was in my house,
3 living in the household. And I asked why, and she said
4 that a report had been made charging me with child
5 abuse and that the child abuse was because I had been
6 accused of giving gender-affirming care to my son.
7 Q. Did the caseworker tell you anything about how
8 these investigations were being investigated?
9 A. She told me that she had to investigate
10 because this -- a report was made, was given top
11 priority over all -- all other CPS cases, that any case
12 involving a parent giving gender-affirming therapy to
13 their minor child was to be prioritized above every
14 other case as directed by Governor Abbott.
15 Q. And you mentioned that the caseworker said you
16 were being investigated because you had a transgender
17 child. Did she give you any other reason why you were
18 being investigated?
19 A. No.
20 Q. Have you heard from CPS since?
21 A. Yes. I -- we engaged a lawyer, legal
22 representation, after the interview was over. And we
23 received an email asking for a letter from Tommy's
24 doctor stating that hormone therapy was reversible.
25 Q. Was there any other requirement of that

1 letter?
2 A. I don't believe so.
3 Q. Okay. And when was this request for a
4 physician letter made?
5 A. Early June.
6 Q. Okay. How has the CPS investigation affected
7 Tommy?
8 A. Well, we began to lose him again. He went
9 back into his shell. I mean, it was just devastating.
10 It was -- it has been so harmful to our family and
11 particularly to Tommy. His grades dropped. He was
12 a -- he was a grade A student. His grades dropped. He
13 couldn't focus on anything. And he couldn't finish the
14 school year on campus. He was always looking over his
15 shoulder wondering if someone was going to come and
16 take him out or take him away, so he had to finish up
17 the school year from home.
18 Q. And how has the CPS investigation affected
19 your family as a whole?
20 A. It's been awful, absolutely devastating. We
21 are a family that, you know, automatically believes
22 that we live on the right side of the law. We love our
23 community. We chose to live in Texas. We're very much
24 a part of the community around us. I have a son --
25 autistic son who is very much a part of the special

1 needs community, and that's our family, too. And so
2 we've always done the right thing. We have a good
3 relationship with law enforcement. I mean, it's --
4 this has been such a shock to all of us. It's just
5 completely out of the blue and unheard of that -- that
6 we should be charged with something like this.
7 Q. And what do you want to achieve through this
8 lawsuit?
9 A. To prevent these investigation from going
10 ahead. They're so harmful to families that are doing
11 nothing wrong. All we're trying to do is make sure
12 that my son Tommy can be who he is and be the person
13 that he is. We need to prevent this for Tommy and for
14 other families with similar situations with transgender
15 members.
16 MR. GUILLORY: Thank you, Ms. Roe. No
17 further questions.
18 **CROSS-EXAMINATION**
19 BY MS. CORBELLO:
20 Q. Good morning, Ms. Voe -- or good afternoon.
21 Apologies. Just a few quick questions. You don't work
22 for DFPS, right?
23 A. Sorry. I don't work for DPS?
24 Q. You won't work for DFPS, do you?
25 A. DFPS. No, I do not.

1 Q. Okay. You don't have any personal knowledge
2 of how DFPS conducts intakes of reports of child abuse,
3 do you?
4 A. No.
5 Q. And you don't have any personal knowledge --
6 outside of your own investigation you just testified
7 about, you don't have any personal knowledge of how
8 DFPS conducts investigations of child abuse, do you?
9 A. No.
10 Q. You're not aware, as you sit here today, of
11 DFPS seeking a court order against you in the
12 investigation that they've been conducting, are you?
13 A. Sorry. Could you repeat the question?
14 Q. Sure. Your investigation with DFPS is ongoing
15 at the moment, right?
16 A. Correct. As far as I know, yes.
17 Q. As you sit here today, are you aware of any
18 court order that DFPS has sought against you in your
19 investigation?
20 A. I'm not a legal expert. I don't know about
21 court orders. I just know that I'm -- there's an open
22 investigation against me charging me with child abuse.
23 Q. Have you received an order from any court in
24 your investigation case?
25 MR. GUILLORY: Objection, Your Honor;

1 asked and answered.
2 THE COURT: Overruled.
3 A. I -- I have not received a court order.
4 Q. (BY MS. CORBELLO) After contact with DFPS and
5 investigators, what you just testified to, has anyone
6 discontinued any medically-necessary treatment for your
7 child?
8 MR. GUILLORY: Objection, Your Honor;
9 relevance. This goes to the substance of the
10 investigation.
11 MS. CORBELLO: They just talked about the
12 investigation over multiple questions, Your Honor.
13 THE COURT: I mean, I think it's
14 relevant. And so what is the objection beyond that?
15 MR. GUILLORY: Then I will instruct the
16 witness to plead the Fifth.
17 THE COURT: Okay. All right. So the
18 objection was overruled.
19 The witness has been instructed by her
20 counsel that she can plead the Fifth if she chooses to.
21 Q. (BY MS. CORBELLO) Ms. Roe, did you -- did you
22 hear all that?
23 A. Yes.
24 Q. Okay. So let me ask the question again
25 just -- just for clarity of the record, and -- and I'll

1 get your answer.
2 After contact with DFPS and
3 investigators, the investigation you just talked about,
4 has anyone discontinued any medically-necessary
5 treatment for your child?
6 MR. GUILLORY: Your Honor, I instruct the
7 witness to plead the Fifth.
8 A. I plead the Fifth.
9 MS. CORBELLO: Your Honor, at this time
10 we'd ask the Court to take an adverse inference from
11 that -- that plea.
12 THE COURT: As I stated earlier, in -- in
13 criminal cases when you plead the Fifth and choose not
14 to testify, the Court can make no inference. In civil
15 court, the Court can make inferences, and so that rule
16 is in place right now.
17 MS. CORBELLO: Thank you, Your Honor.
18 Q. (BY MS. CORBELLO) Ms. Roe, you submitted a
19 declaration in this case, right?
20 A. I did.
21 Q. And you provided statements under penalty of
22 perjury that you think are relevant to your case,
23 right?
24 A. Yes.
25 Q. You're not asking the Court today to disregard

1 any portion of your declaration, are you?
2 A. I'm not.
3 Q. Okay.
4 MS. CORBELLO: No further questions.
5 Thank you, Ms. Roe.
6 THE COURT: Anything further?
7 MR. GUILLORY: No further questions,
8 Your Honor.
9 THE COURT: All right. Thank you,
10 Ms. Roe. You are excused as a witness, and you are
11 free to disconnect. Thank you.
12 THE WITNESS: Thank you.
13 THE COURT: All right. You may call your
14 next witness.
15 MR. GONZALEZ-PAGAN: Your Honor, at this
16 time we are done with our -- our presentation of the
17 evidence.
18 THE COURT: Thank you.
19 MS. CORBELLO: Your Honor, we'll -- we'll
20 need maybe five minutes just to call our witness and
21 log in remotely, if that's possible.
22 THE COURT: Sure. You want to take a
23 five-minute break?
24 MS. CORBELLO: Yes. Thank you.
25 THE COURT: Thank you. We'll take a

1 five-minute break. Let's go off the record.
2 *(Recess was taken.)*
3 THE COURT: The Department may call their
4 witness.
5 MR. STONE: Thank you, Your Honor. At
6 this time we call our first witness, Dr. James Cantor.
7 THE COURT: Dr. Cantor, can you hear me?
8 This is Judge Meachum.
9 THE WITNESS: I'm not hearing you. I
10 took off my earbuds. Let me see if a different speaker
11 works. Say something clever and devastating.
12 MR. STONE: Can you hear us now?
13 THE WITNESS: That's not working. Let me
14 go back to the earbuds.
15 MR. STONE: Can you hear us now?
16 THE WITNESS: Yes, I can.
17 THE COURT: All right. Can you hear me
18 as well? This is Judge Meachum.
19 THE WITNESS: Yes, I can.
20 THE COURT: Please raise your right hand
21 and be sworn in as a witness.
22 *(Witness sworn in.)*
23 THE COURT: Thank you. You may proceed,
24 Counsel.
25 MR. STONE: Thank you.

1 **JAMES CANTOR,**
2 having been first duly sworn, testified as follows:
3 **DIRECT EXAMINATION**
4 BY MR. STONE:
5 Q. Good afternoon, Dr. Cantor. Could you state
6 your full name for the record?
7 A. Dr. James Michael Cantor.
8 Q. And what educational background do you have,
9 Dr. Cantor?
10 A. My undergraduate degree is in
11 interdisciplinary science concentrating in physics and
12 mathematics. My master's degree is in psychology. And
13 my doctoral degree is in psychology. I then continued
14 on to post-doctoral studies in neuroscience.
15 Q. What is your current occupation?
16 A. I'm a neuroscientist and a clinical
17 psychologist, and I'm the director of the Toronto
18 Sexuality Center.
19 Q. Do you hold any occupational licenses?
20 A. Yes. I'm licensed as a clinical psychologist
21 in my home province of Ontario, Canada.
22 Q. And how long have you been licensed?
23 A. Oh, goodness. About 25 years.
24 Q. Have you ever testified in a court proceeding
25 before?

1 A. Yes, I have.
2 Q. Approximately how many times have you
3 testified before?
4 A. About 25. Well, over my entire career, about
5 25; in the past two years about a dozen -- in the past
6 four years about a dozen.
7 Q. And generally what were you testifying about
8 in those cases?
9 A. Various aspects about the development of human
10 sexuality, especially atypical sexuality. Sometimes
11 these were cases involving sex offenders and the nature
12 of different sexual interests that can increase the
13 probability of recidivism or the condition of a sexual
14 offense. Others have been specifically about trans
15 issues and -- and the mental health status of trans
16 people.
17 Q. In those cases, those approximately 25 cases,
18 were you testifying as an expert witness?
19 A. Yes, I was.
20 Q. In clinical science, what is the difference
21 between a physician's expertise and a scientist's
22 expertise?
23 A. In general, questions for physicians are about
24 how to take general principles that we know about
25 science and we know about medicine and to apply them to

1 one particular case, to apply them to the particular
2 patient in front of us.
3 For scientists, expertise works the other
4 way around. We take the information available from
5 many individual cases and try to derive those general
6 principles that should -- generalizable principles
7 which would apply to everybody.
8 Q. Do you have any scientific expertise in the
9 treatment of gender dysphoria in minors?
10 A. Yes, I do.
11 Q. What is your -- your scientific expertise as
12 it relates to the treatment of gender dysphoria in
13 minors?
14 A. My knowledge really spans the develop- --
15 because my background is in the development of human
16 sexuality, my expertise is usually needed in trying to
17 project the different trajectories of -- of people over
18 the course of their entire lifespan. So my expertise
19 continues really in utero with actual brain development
20 from the point of conception forward, then tracing
21 those various aspects of development of body and mind
22 and brain over the course of childhood, through the
23 related changes that occur over puberty, and then, of
24 course, are expressed as adult -- sexuality in
25 adulthood.

1 Q. Have you ever testified previously on the
2 science and research related to the treatment of gender
3 dysphoria in minors?
4 A. Yes, I have.
5 Q. When?
6 A. The -- practically all of them. I think I --
7 I listed each of them in my -- on my CV. Almost all of
8 them have been in the past two years as these issues
9 have exploded in public attention and especially on
10 social media.
11 Q. And speaking of your CV, could you turn to
12 Appendix 1 to Defendants' Exhibit 1?
13 A. Okay. I'm sorry. I'm there. Which page?
14 MR. GONZALEZ-PAGAN: Your Honor,
15 objection; this is still not in evidence.
16 THE COURT: Well, I think he's trying to
17 put in evidence his CV, but unfortunately the way it's
18 currently done in the Box, I'm going to have to have
19 you re-upload it because we can't admit parts of
20 exhibits in the Box, and you have it as Appendix 1 to
21 full Exhibit 1. And so --
22 MR. STONE: Yes, Your Honor. I was going
23 to offer the -- the full exhibit momentarily. I was
24 just laying the predicate for that before making an
25 offer.

1 THE COURT: So I'm just telling you you
2 might have a problem in a minute with the full exhibit.
3 MR. STONE: I see.
4 THE COURT: But as to the CV, I'm going
5 to overrule that objection. I'm going to allow him to
6 ask questions about the CV.
7 Q. (BY MR. STONE) Do you recognize this
8 document?
9 A. Yes, I do.
10 Q. What is it?
11 A. It is my curriculum vitae. It's a summary of
12 my academic career.
13 Q. Is it a true and accurate representation of
14 your academic career?
15 A. Yes, it is.
16 Q. Are you an expert on the science relating to
17 the treatment of gender dysphoria in minors?
18 MR. GONZALEZ-PAGAN: Objection,
19 Your Honor --
20 A. Yes, I am.
21 MR. GONZALEZ-PAGAN: -- it calls for a
22 legal conclusion.
23 THE COURT: Overruled.
24 A. Yes, I am.
25 Q. (BY MR. STONE) And do you have expert

1 opinions on the science related to the treatment of
2 gender dysphoria in minors to give in this case?
3 A. Yes, I do.
4 Q. Okay.
5 MR. STONE: At this time, Your Honor,
6 defendants designate Dr. Cantor as an expert on the
7 science relating to the treatment of gender dysphoria
8 in minors.
9 MR. GONZALEZ-PAGAN: Objection,
10 Your Honor. Pursuant to Rule 705(b) of the Rules of
11 Evidence, we're allowed to conduct a voir dire. I
12 don't believe that enough has been presented.
13 THE COURT: You can conduct a voir dire
14 at this moment, yes.
15 MR. GONZALEZ-PAGAN: And, Counsel, have
16 you shared the exhibits with -- plaintiffs' exhibits
17 with Dr. Cantor?
18 MR. STONE: We shared the exhibits that
19 you provided to us previously.
20 **VOIR DIRE EXAMINATION**
21 BY MR. GONZALEZ-PAGAN:
22 Q. Good afternoon, Dr. Cantor.
23 A. Good afternoon.
24 Q. You're not a physician, correct?
25 A. Correct.

1 Q. You do not hold any medical degree; is that
2 right?
3 A. Correct.
4 Q. You have only practiced clinical psychology in
5 Canada; is that right?
6 A. Correct.
7 Q. Earlier you referenced that you provided
8 testimony in a transgender rights -- in a case
9 involving transgender youth. Do you recall that?
10 A. Yes.
11 Q. Are you familiar with the *Eknes-Tucker v. Ivey*
12 case in Alabama?
13 A. Yes.
14 Q. You testified in a hearing in that case; is
15 that correct?
16 A. Yes.
17 Q. Dr. Cantor, if you can open what's been
18 designated as Plaintiffs' Exhibit 37.
19 MR. STONE: Yeah. Your Honor --
20 THE WITNESS: 37.
21 MR. STONE: -- we don't have 37. We've
22 never been provided a copy of 37. This is one of --
23 this is one of the supplemental things that came in
24 this morning, and we -- we don't -- we don't even have
25 a copy of it.

1 THE COURT: Let me see if I do.
2 MR. GONZALEZ-PAGAN: Just to clarify,
3 Your Honor, counsel has been provided a copy. They
4 were rebuttal exhibits that in the interest of Cantor
5 were --
6 THE COURT: Well, I don't think you can
7 do rebuttal -- I also think it's not probably not
8 proper on a voir dire to --
9 MR. GONZALEZ-PAGAN: Well, it goes -- it
10 just goes to his qualifications, Your Honor.
11 MR. STONE: But --
12 MR. GONZALEZ-PAGAN: I can just -- I can
13 ask the direct question without relying on the exhibit.
14 THE COURT: Yeah. Just -- let's not
15 admit an exhibit at this time.
16 MR. GONZALEZ-PAGAN: Yeah. Your Honor --
17 THE COURT: Why don't you just ask
18 questions.
19 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, have you
20 reviewed the Court's decision in *Eknes-Tucker*?
21 A. Portions of it. Not in its entirety, no.
22 Q. Did you review the portions relating to
23 yourself?
24 A. Yes.
25 Q. Okay. In the Court decision in *Eknes-Tucker*,

1 the Court stated, Dr. Cantor admitted that his patients
2 are on average 30 years old. He had never provided
3 care to trans- -- to a transgender minor under the age
4 of 16. He had never diagnosed a child or adolescent
5 with gender dysphoria. He had never treated a child or
6 adolescent with gender -- for gender dysphoria. He had
7 no personal experience monitoring patients receiving
8 transitioning medications, and he had no personal
9 knowledge of the assessments or treatment methodologies
10 used at any Alabama gender clinic.
11 Do you recall that portion of the
12 *Eknes-Tucker* decision?
13 A. Yes, roughly.
14 Q. Do you dispute the Court's description of your
15 experience?
16 A. I can't say that that's a complete --
17 Q. Is anything in --
18 A. I -- I -- the content of it is complete, but
19 removed from the context around it isn't exactly the
20 full story.
21 Q. It is not an incorrect representation; is that
22 right?
23 A. Of that content of the decision, yes.
24 Q. Okay. And to follow up, do you have any
25 personal knowledge of the assessments or treatment

1 methodologies used in Texas gender clinics?
2 A. I don't believe any has made any official --
3 oh. Yes, there would -- no. There was a
4 recently-closed clinic in Texas which published a
5 report of the methods that it used, and it said it
6 used, I think it was, the Endocrine Society guidelines.
7 Q. But you don't have any personal knowledge.
8 This is something you read in a study; is that correct?
9 A. Personal knowledge? No.
10 Q. And you have not con- -- conducted any
11 original scientific research on the efficacy or safety
12 of the medical treatment of gender dysphoria; is that
13 right?
14 A. Not on that specific question for original
15 research, no. I've conducted comprehensive reviews of
16 the research in order to make theoretical conclusions
17 about it.
18 MR. GONZALEZ-PAGAN: Your Honor, at this
19 point in time, we would object to the qualification of
20 Dr. Cantor as an expert. As the Court concluded in
21 *Eknes-Tucker,* which involved similar issues to the case
22 at hand, the Court gave very little weight to
23 Dr. Cantor's opinion regarding the treatment of gender
24 dysphoria.
25 THE COURT: Well, but you just said

1 something pretty key. The Court gave very little
2 weight.
3 MR. GONZALEZ-PAGAN: And, Your Honor, if
4 I may, and like the purported -- purported experts, in
5 the *Kadel v. Folwell* decision in the U.S. District
6 Court for the Middle District of North Carolina, which
7 Dr. Cantor has admitted that his expertise is limited
8 solely --
9 THE COURT: You've got to slow down.
10 Slow down.
11 MR. GONZALEZ-PAGAN: I apologize.
12 Dr. Cantor has admitted that his expertise is limited
13 solely to a review of the scientific literature.
14 Merely reading literature in a scientific field does
15 not qualify a witness, even an educated witness, as an
16 expert. Moreover, Your Honor, I would note --
17 THE COURT: But is that in --
18 MR. GONZALEZ-PAGAN: That was a
19 qualification decision, Your Honor. I'm -- I'm happy
20 to provide the Court with a copy.
21 THE COURT: Of what?
22 MR. GONZALEZ-PAGAN: Of the decision in
23 *Kadel*.
24 THE COURT: In a different case?
25 MR. GONZALEZ-PAGAN: Yes. Correct.

1 THE COURT: Not in *Eknes-Tucker?*
2 MR. GONZALEZ-PAGAN: Correct. In
3 *Eknes-Tucker,* there was no objection to his
4 qualifications.
5 THE COURT: So the Court just gave a
6 written opinion as part of the dicta -- and may have
7 even been a part of the ruling -- about the weight to
8 give his testimony, not about the qualification of the
9 witness, correct?
10 MR. GONZALEZ-PAGAN: Correct.
11 THE COURT: And you're wanting to hand me
12 another case. A Texas case?
13 MR. GONZALEZ-PAGAN: It's a Middle
14 District of North Carolina case, Your Honor --
15 THE COURT: Why would I look at a Middle
16 District of North Carolina case?
17 MR. GONZALEZ-PAGAN: It is instructive on
18 the issues at hand, and it -- it did go for the
19 actual -- a *Daubert* motion that was granted pertaining
20 to an ex- -- to -- to expert witnesses in -- pertaining
21 to gender dysphoria.
22 THE COURT: I will look at it.
23 MR. STONE: Your Honor -- Your Honor,
24 what -- what page of this? It's the first time I've
25 ever seen this document. It's really thick.

1 THE COURT: It's a -- it's an opinion,
2 and so the Court can take judicial notice of a
3 persuasive court case, I suppose, but -- so I've never
4 seen it before either. We're both in the same position
5 here. Let's see what he wants us to look at.
6 MR. GONZALEZ-PAGAN: Your Honor, if you
7 go to Page 12, and in fact --
8 THE COURT: And -- and I will say, all
9 this is taking up your time. I want to make sure you
10 know this is taking up your time.
11 MR. GONZALEZ-PAGAN: Understood,
12 Your Honor.
13 THE COURT: I want to make sure you know
14 that this is a case to the Court and there's not a
15 jury, and so we're either going to do this --
16 MR. GONZALEZ-PAGAN: Well --
17 THE COURT: -- with offer of proof or
18 we're going to do this -- you're -- you're not going to
19 keep him from testifying. The question is, does he
20 testify as part of the case-in-chief, or do you want
21 this Court to take a recess, charge the time to you,
22 make a decision about whether to allow this witness to
23 testify as an expert, and then decide on weight, all
24 understanding that they're going to get to ask this
25 witness questions anyway, because just if we had a

1 jury, I would have to proceed with however long of
2 testimony of an offer of proof outside the presence of
3 the jury in order to make a determination about whether
4 to allow this witness to testify and to go before the
5 trier of fact?
6 MR. GONZALEZ-PAGAN: Your Honor --
7 THE COURT: So I don't want to hear it
8 twice. I'm just going to hear it once, but I am going
9 to hear it.
10 MR. GONZALEZ-PAGAN: Understood,
11 Your Honor. At this point in time I would just ask the
12 Court to weigh in -- in how Dr. Cantor is -- Dr. Cantor
13 is qualified, and I would -- and to what opinions he
14 can provide given the voir dire that has occurred
15 evidentiary-wise. And I would note that the burden of
16 establishing qualifications is with the proponent of
17 the expert witness, and --
18 THE COURT: And you are challenging his
19 qualification. What I'm saying to you, if I'm going to
20 exclude him as not qualified, I'm not going to do that
21 without reading this extensive case law, and I'm not
22 going to do it without also hearing an offer of proof
23 from them because they will have an opportunity to put
24 on that offer of proof if the Court decides initially
25 to exclude the testimony.

1 MR. GONZALEZ-PAGAN: At this point in
2 time, Your Honor, we would ask that the Court keep the
3 motion to exclude under advisement, and we would
4 revisit it after the conclusion.
5 THE COURT: I think the Court can always
6 keep a motion to exclude in a bench trial under
7 advisement and make a decision about that. I think
8 that has a practical -- perhaps is a practical way to
9 move forward here, understanding that the defendants
10 are still going to now ask some questions to this
11 witness. And at least until the Court says otherwise
12 and unless the Court later determines he is not
13 qualified, as of now the Court's going to accept him as
14 a qualified witness and allow testimony from him.
15 MR. GONZALEZ-PAGAN: Thank you,
16 Your Honor.
17 THE COURT: Thank you. And all of his --
18 even if there is qualification here, the Court
19 determines the weight of the evidence because I am the
20 finder of fact. I think everybody understands that.
21 Thanks.
22 MR. STONE: Thanks, Your Honor.
23 **DIRECT EXAMINATION CONTINUED**
24 BY MR. STONE:
25 Q. All right. Dr. Cantor, could you turn to

1 Exhibit D-1?
2 A. Yeah.
3 Q. Do you recognize this document?
4 A. Yes. It's the report I submitted for this
5 case.
6 Q. Who wrote it?
7 A. I did.
8 MR. GONZALEZ-PAGAN: Your Honor, I would
9 object that the report is hearsay. And it --
10 THE COURT: Well, they haven't offered it
11 yet, so let's let them offer it.
12 MR. STONE: Thank you.
13 THE COURT: Your next question is?
14 Q. (BY MR. STONE) Who wrote it?
15 A. I did.
16 Q. Okay. And what did you review when you wrote
17 it?
18 A. Goodness. I -- I reviewed the plaintiff
19 documents that were submitted to me. I reviewed
20 similar reports from similar cases that I -- that I
21 previously wrote. And then I -- I added my specific
22 comments about the opposing side's experts and then
23 expanded as time allowed other parts of the research
24 literature. I included the relevant parts of the
25 research literature, including a comprehensive coverage

1 of every cohort study of these children ever conducted.
2 Q. Is this a -- is this a true and accurate
3 representation of your expert opinions in this case?
4 A. Yes, it is.
5 Q. And do you adopt and incorporate by reference
6 as your testimony today the statements contained within
7 Exhibit D-1?
8 A. Yes, I do.
9 MR. STONE: Your Honor, at this time the
10 defendants offer Exhibit D-1 into evidence.
11 MR. GONZALEZ-PAGAN: Your Honor, I would
12 object. It's hearsay. The witness is obviously
13 available to testify. They can conduct the direct of
14 the testimony that they can and not -- {*inaudible*}.
15 THE COURT: It is hearsay, and the
16 Court's going to sustain that objection. I'll tell you
17 for 12 years I've been consistent in this. I don't
18 admit reports of experts unless both sides agree.
19 Different courts treat this differently. The appellate
20 courts treat it differently. I have maintained
21 consistent on this for 12 years. So the report is not
22 admitted. A CV can be admitted if you re-upload a CV
23 as a separate exhibit later.
24 MR. STONE: Yes, Your Honor. Then
25 let's -- let's do that now. We'd like -- well, I guess

1 I'm going to have to --
2 THE COURT: We can't do it now --
3 MR. STONE: Yeah, we can't do it now.
4 THE COURT: -- because we have to make it
5 part of the Box. So if you'll work on that, I don't
6 think I would have a -- he might have an objection, but
7 in general I do -- I do allow and admit curriculum
8 vitae of experts, but I do not admit and allow -- allow
9 expert reports to be admitted.
10 MR. STONE: Thank you, Your Honor. We're
11 working on that now, and we'll revisit this shortly.
12 THE COURT: But you can still proceed
13 without that admitted. Go ahead and go forward.
14 MR. STONE: Yes, Your Honor. Thank you.
15 Q. (BY MR. STONE) Dr. Cantor, what is a cohort
16 study?
17 A. A cohort study is a longitudinal study. That
18 is a study that's conducted over a long period of time
19 to follow how a group of people turn out over time.
20 It's different from a survey study or a cross-sectional
21 study, which is just one single survey at just one
22 slice of time.
23 Q. In terms of reliability, how are cohort
24 studies, surveys, and the other study that you
25 mentioned ranked?

1 A. Cohort studies are generally considered very
2 high quality. They do take a long amount of time to
3 conduct, and they require a high amount of expertise in
4 a topic. That's different from survey studies or just
5 general expert opinion, which is considered very low
6 order evidence. There's no way to control, for
7 example -- there are no way to control the many
8 different variables that go into the progression of --
9 of some situation.
10 So as I say, in general cohort studies
11 are considered very high level evidence and survey
12 studies, especially survey studies of convenient
13 samples collected from the Internet, those are
14 considered very -- very low level evidence.
15 Q. Have there been any cohort studies on gender
16 dysphoria in prepubescent children?
17 A. Yes, there have. In total there have been 11.
18 Q. And what do those 11 studies say about gender
19 dysphoria in prepubescent children?
20 A. They've been remarkably unanimous, which does
21 not happen a lot in behavioral science. But all 11 out
22 of 11 cohort studies said that the majority of these
23 kids cease feeling gender dysphoric usually by the time
24 puberty hits.
25 Q. When you say the majority, is there a specific

1 percentage you're referencing?
2 MR. GONZALEZ-PAGAN: Objection,
3 Your Honor; leading.
4 A. Well, the studies can come up with the exact
5 same numbers, but they were roughly between 65 percent
6 and 90 percent-ish, depending on exactly how you look
7 at it. All of them were over 50 percent. All of them
8 were the majority, but none of them said 100 percent
9 either.
10 THE COURT: I would have overruled your
11 leading objection in any case, so that's overruled.
12 I would ask the witness if you hear an
13 objection from the other side, if you could stop
14 talking.
15 THE WITNESS: Oh, I'm sorry. I -- I
16 didn't actually hear an obj- -- hear anybody say
17 objection.
18 THE COURT: I know. I'm just telling
19 you --
20 THE WITNESS: I don't know if the
21 microphone was off.
22 THE COURT: He needs to be louder, but if
23 you hear it, if you would, stop talking so I have a
24 chance to rule on the objection.
25 THE WITNESS: I understand.

1 THE COURT: And he'll hopefully be louder
2 next time if he has an objection. So let's keep going.
3 Q. (BY MR. STONE) Dr. Cantor, have there been
4 any cohort studies on gender dysphoria in adolescents?
5 A. Yes, there have; coincidentally also 11.
6 Q. And what -- what do those 11 studies say about
7 gender dysphoria -- the treatment of gender dysphoria
8 in adolescents?
9 MR. GONZALEZ-PAGAN: Objection,
10 Your Honor; calls for a narrative.
11 THE COURT: Overruled.
12 A. Those studies came out a little bit more
13 complex. They didn't all say exactly the same thing.
14 Of those 11, four of them said that there was no
15 overall improvement in the samples, and on some
16 variables there was even some deterioration.
17 In five studies, there was some
18 indication of improvement on at least some substantial
19 variables, but we can't make any definite conclusions
20 about it because, even though these kids were receiving
21 medicalized transition services, they were also
22 receiving psychotherapy at the same time. So even
23 though they were showing improvement, we don't know
24 whether that's because of medi- -- medicalized
25 treatments they were receiving or the psychotherapy

1 they were receiving.
2 And of the final two studies, again, they
3 provided both medical interventions and psychotherapy,
4 but they were structured in a way that allowed us to
5 compare at least a little bit the medical interventions
6 with the psychotherapy, and neither one of them showed
7 any advantage of the medicalized treatments --
8 treatments above the psychotherapy.
9 Q. What is a differential diagnosis?
10 A. Most people --
11 MR. GONZALEZ-PAGAN: Objection,
12 Your Honor; he's not qualified --
13 A. -- think of diagnosis -- the differential
14 diagnosis is --
15 MR. STONE: Just a moment, Dr. Cantor.
16 I'm sorry. We have an objection.
17 THE COURT: Yes.
18 THE WITNESS: I'm sorry.
19 MR. GONZALEZ-PAGAN: Objection,
20 Your Honor; he's not qualified as a medical expert.
21 He's qualified as an expert on the review of scientific
22 literature.
23 THE WITNESS: In my province,
24 psychologists can --
25 MR. STONE: Wait.

1 THE COURT: Hold on. He can't answer.
2 Yes, Mr. Stone.
3 MR. STONE: Sorry. I was trying to tell
4 the witness to stop talking, Your Honor.
5 THE COURT: Do you have a response?
6 MR. STONE: Yes. This -- this --
7 Dr. Cantor has been designated as an expert on the
8 science related to the treatment of gender dysphoria in
9 minors. A differential diagnosis goes to as -- I'm
10 just laying a predicate. He's going to explain why,
11 but it goes to the science. It relates specifically to
12 the science. So I'm not asking him about making any --
13 whether he makes a medical diagnosis of patients. I'm
14 going to be asking him about whether the studies
15 distinguished between different things and -- different
16 diagnoses. Ergo, I'm asking him about what is a
17 differential diagnosis. So it's --
18 THE COURT: It's close and very
19 confusing, but I will overrule the objection. It can
20 go to weight.
21 Q. (BY MR. STONE) Go ahead and answer if you
22 can, Dr. Cantor.
23 A. In a differential diagnosis, one is not only
24 saying what one believes is the actual cause of a
25 problem in a -- in a patient but also ruling out

1 competing potential diagnoses.
2 Q. In reviewing the scientific studies related to
3 the treatment of gender dysphoria in adolescents,
4 was -- can you tell whether those studies ruled out
5 any -- any other diagnoses?
6 MR. GONZALEZ-PAGAN: Objection,
7 Your Honor; leading.
8 THE COURT: Overruled.
9 A. Usually the studies made no attempt to record
10 alternatives. Sometimes they do record how many people
11 have what we call a comorbid diagnosis, that they
12 qualify for more than one diagnosis at -- at the same
13 time. But there haven't been any studies attempting to
14 see if these alternative diagnoses actually explain
15 entirely what's being diagnosed as gender dysphoria on
16 top of the original diagnosis.
17 Q. (BY MR. STONE) I want to switch gears and go
18 back for a moment to gender dysphoria in prepubescent
19 children. You testified a moment ago about what the --
20 the 11 cohort studies showed, right?
21 A. Correct.
22 Q. What conclusions can you draw from reviewing
23 those cohort studies about the treatment of gender
24 dysphoria for prepubescent children?
25 A. Oh, goodness. What one can conclude really

1 depends on what other information is added. That --
2 that set of studies is really one piece of the larger
3 puzzle of -- of how does human sexuality develop in
4 general.
5 The outcome of those studies didn't only
6 say that most of these kids ceased feeling gender
7 dysphoria by puberty; they also said that the majority
8 of these kids tend to figure out or tend to realize
9 that they're gay or lesbian by the time puberty hits.
10 The best interpretation we have of that so far is that
11 these kids really just realize that they don't fit in
12 with most of their same sex peer group as kids, which
13 is a very, very common experience of what I'll call
14 pre-gay and pre-lesbian people.
15 So because that does tend to be the
16 long-term outcome, the best conclusion, as I said, that
17 we have is that these kids are misinterpreting or
18 misunderstanding the reason for why they feel like they
19 don't fit in. They come to believe or they come to
20 develop the idea that, Oh, inside I must be the other
21 sex; that's why I like the -- whatever kind of play
22 game as opposed to the other kinds of typical play
23 games.
24 So in that context, as I say, it -- it
25 shows as -- this probably is a typical stage to

1 pre-homosexuality, but these kids aren't going to
2 realize it until they start experiencing sex drive
3 after -- after puberty hits. And as best as we can
4 tell, that hypothesis fits with what -- when we start
5 taking brain scans and looking at other -- other
6 information about these people as they grow up.
7 Q. Is -- is gender dysphoria -- is -- let me
8 start again. Is prepubescent gender -- onset gender
9 dysphoria the same as adolescent onset gender
10 dysphoria?
11 A. There's no evidence to suggest that it is, and
12 there's an enormous amount of evidence to suggest that
13 these are completely independent phenomenon. They
14 really only look alike in a very superficial way
15 because the people are complaining using -- complaining
16 that something's bothering them using very similar
17 words, but all of the --
18 MR. GONZALEZ-PAGAN: Objection;
19 narrative.
20 A. -- epidemiology, all of the outcome research,
21 everything --
22 THE COURT: Yes. Please stop talking.
23 There's been a narrative objection, which the Court is
24 going to sustain. You can ask another question,
25 Counselor.

1 MR. STONE: Thank you, Your Honor.
2 Q. (BY MR. STONE) How is prepubescent onset
3 gender dysphoria different than adolescent onset gender
4 dysphoria?
5 A. Prepubescent gender dysphoria has been
6 relatively well studied now over about 20 years.
7 Adolescent onset gender dysphoria is brand, brand-new.
8 We have very limited research on it, and there are zero
9 outcome studies under anyone, but we can tell that it's
10 different by the basic presentation --
11 I'm sorry. I saw hands moving up. I was
12 wondering if there was another objection.
13 Q. No. I'm sorry. I was going to ask a
14 question, but I'll let you finish.
15 MR. GONZALEZ-PAGAN: No. Objection;
16 narrative.
17 MR. STONE: Okay. Well, if you can stop.
18 There's an objection.
19 THE COURT: Yeah. Ask another question.
20 I think at this point we're just to another question.
21 MR. STONE: Yes. Thank you, Your Honor.
22 Q. (BY MR. STONE) And, Dr. Cantor, if I,
23 you know, raise my hand -- I'll raise my hand if we get
24 an objection or if I'm trying to ask a question. Okay?
25 A. Perfect.

1 Q. What is adolescent onset gender dysphoria?
2 A. These are people who only just started talking
3 about feeling uncomfortable about their gender
4 post-pubescent. They seem to be a completely different
5 trajectory of person than the people who realized it
6 pretty much from the get-go, since early childhood.
7 Q. What are you basing your opinion on that these
8 are completely different things, prepubescent onset
9 gender dysphoria and adolescent onset gender dysphoria?
10 MR. GONZALEZ-PAGAN: Objection,
11 Your Honor; leading.
12 MR. STONE: Your Honor, I asked him what
13 he is basing it on. That's an open-ended question.
14 THE COURT: Leading is overruled.
15 A. Primarily the epidemiology. These people, for
16 every objective measure we can provide, just show a
17 completely different profile. They show a different
18 profile in not only their -- their age range but also
19 the sex ratios, how many biological males versus
20 biological females come forward, and the pattern of
21 other psychological issues that they come forth with.
22 They're a completely different -- different pattern.
23 Q. And what does the -- you mentioned that there
24 have been 11 cohort studies on adolescent onset gender
25 dysphoria, right?

1 A. They weren't adolescent onset. Most of
2 those -- really all of them -- just about all of them
3 were childhood onset. They were persisters. They were
4 the 20 percent-ish who didn't desist, so aged into
5 adolescence, already gender dysphoric, and then started
6 receiving transition services.
7 Q. Have there been any cohort studies on
8 adolescent onset gender dysphoria?
9 A. No.
10 Q. Okay. What is a -- you used the word a moment
11 ago. What is a persister?
12 A. A persister is really a nickname of the
13 childhood onset cases. Some, as I say, cease to feel
14 gender dysphoric by the time puberty hits. They --
15 their -- their gender dysphoria desists, so we tend to
16 call them desisters. The people for whom the feelings
17 of gender dysphoria persist we've nicknamed persisters.
18 Q. What is the Dutch protocol?
19 MR. GONZALEZ-PAGAN: Objection; lack of
20 foundation.
21 THE COURT: Overruled.
22 A. The Dutch protocol was the first set of
23 standards proposed by one of the main clinics doing
24 research on these kids. It started roughly 20 years
25 ago-ish. They first published the details about ten

1 years ago-ish in which they would start permitting
2 cross-sex hormone treatment for minors. Before that
3 point only adults -- only people 18-plus were permitted
4 any medicalized transition services. So in the --
5 MR. GONZALEZ-PAGAN: Objection;
6 narrative.
7 A. -- Dutch protocol, nobody was allowed --
8 MR. GONZALEZ-PAGAN: Objection;
9 narrative.
10 THE COURT: All right. Now I'm going to
11 stop and say the narrative objection is sustained.
12 MR. STONE: Yes, Your Honor.
13 THE COURT: Keep it question and answer
14 to the best you can.
15 MR. STONE: I'm -- I'm -- yes,
16 Your Honor.
17 A. Sorry. My apologies. I'm a professor.
18 Q. (BY MR. STONE) It's okay, Dr. Cantor.
19 We'll -- we'll do our best. I -- I know you're
20 talkative. We're -- we're going to do our best. Okay?
21 What does the Dutch protocol recommend
22 with respect to the age of social transition for gender
23 dysphoria?
24 MR. GONZALEZ-PAGAN: Objection;
25 relevance.

1 A. They're entirely neutral. In general --
2 MR. STONE: Whoa, whoa.
3 THE WITNESS: I'm sorry.
4 THE COURT: Hold on. It's very hard
5 because the objection -- do you have your mic on? You
6 do, right?
7 MR. GONZALEZ-PAGAN: I do, Your Honor.
8 THE COURT: It's just -- I think it's
9 just --
10 THE REPORTER: You can move it forward.
11 THE COURT: You may just need to move a
12 little closer. The objection to relevance is
13 overruled. So you can reask that question. And then
14 maybe -- maybe what the witness should do is -- well --
15 MR. STONE: I -- I --
16 THE COURT: -- just do our best to -- to
17 object as best you can.
18 MR. GONZALEZ-PAGAN: I can, Your Honor.
19 I apologize.
20 THE COURT: All right. So ask the
21 question again. Thank you.
22 MR. STONE: Thank you, Your Honor.
23 MR. GONZALEZ-PAGAN: Your Honor, is it
24 okay if I take off the mask?
25 THE COURT: Yes. Yes.

1 Q. (BY MR. STONE) What does the Dutch protocol
2 recommend with respect to the age of social transition
3 for the treatment of gender dysphoria?
4 MR. GONZALEZ-PAGAN: Same objection.
5 THE COURT: Overruled.
6 Q. (BY MR. STONE) Okay. Go ahead.
7 A. No transitions in prepuberty, at least until
8 age 12.
9 Q. And what does the science say about not
10 providing social -- or not socially transitioning a
11 child with pre- -- with -- with gender dysphoria until
12 they're post-puberty?
13 MR. GONZALEZ-PAGAN: Objection,
14 Your Honor; vague, what does the science say.
15 THE COURT: Sustained as to what does
16 science say, yes.
17 Q. (BY MR. STONE) Have there been any studies on
18 social -- socially transitioning minors post-puberty
19 for gender dysphoria?
20 A. Study...
21 MR. GONZALEZ-PAGAN: Objection;
22 relevance.
23 MR. STONE: Don't answer.
24 THE COURT: Overruled relevance.
25 Q. (BY MR. STONE) Okay. Now you can answer.

1 A. I'm trying to think if there's such a study.
2 The -- these would have been -- the closest studies are
3 the 11 cohort studies of the persisters. Social
4 transition usually occurs -- well, let me start over
5 again because there's one exception. There --
6 THE COURT: I don't think -- I think at
7 this point, I -- I -- I think if he doesn't know, he
8 doesn't know, and we need to move on to another
9 question.
10 MR. STONE: Thank you, Your Honor.
11 Q. (BY MR. STONE) Have there been any studies on
12 the age of beginning puberty blockers for the treatment
13 of gender dysphoria?
14 A. Not exactly. There have only been studies
15 tracking what a given clinic does and then what
16 happened.
17 Q. What does the Dutch protocol -- or what age
18 does the Dutch protocol recommend for beginning puberty
19 blockers for the treatment of gender dysphoria in
20 minors?
21 A. The later of onset of puberty or age 12.
22 Q. Are you aware of any science supporting that
23 recommendation?
24 MR. GONZALEZ-PAGAN: Objection,
25 Your Honor; vague, any science.

1 MR. STONE: Let me rephrase that,
2 Your Honor, if I may.
3 THE COURT: You need to, yes.
4 Q. (BY MR. STONE) Dr. Cantor, are you aware of
5 any scientific studies that support the recommendation
6 that puberty blockers be provided at the age of 12 for
7 minors for the treatment of gender dysphoria?
8 A. The studies are mixed. The studies that came
9 out of the Dutch protocol showed some indication of
10 improvement, but, of course, this is one of the clinics
11 that provides psychotherapy at the same time, so it's
12 hard to be -- there's no good way to cleave those
13 apart.
14 Q. What age does the Dutch protocol recommend for
15 beginning cross-sex hormone treatment in minors for the
16 treatment of gender dysphoria?
17 A. 16.
18 Q. And are you aware of any scientific studies
19 that support the age of 16 as the recommended age to
20 begin cross-sex hormones in minors for the treatment of
21 gender dysphoria?
22 A. Those would be the same set of 11 cohort
23 studies.
24 Q. What is WPATH?
25 A. I keep forgetting exactly what the acronym

1 stands for. Essentially, it's an association of -- of
2 people who provide various transition services to
3 people undergoing -- to people with gender dysphoria
4 undergoing transition.
5 Q. I'm sorry. I want to go back to Dutch --
6 Dutch -- Dutch protocol one more time. I'm sorry. I
7 have one more question about this.
8 What age does the Dutch protocol
9 recommend for when to receive surgical intervention for
10 the treatment of gender dysphoria?
11 A. 18.
12 Q. And are you aware of any scientific studies
13 that support the recommendation of the age of 18 for
14 when a child should begin treatment for gender
15 dysphoria with surgical intervention?
16 A. There haven't been specifically surgical
17 follow-up studies, I don't think. No, only the
18 hormonal studies.
19 Q. Do you know how the Dutch protocol arrived at
20 the age of 18 for recom- -- as the age of
21 recommendation for surgical intervention for the
22 treatment of gender dysphoria in minors?
23 A. Matching their local legal standards. That's
24 the age of adulthood in that country.
25 Q. Okay. All right. Now I want to talk about

1 WPATH. When does the WPATH -- what age does WPATH
2 recommend puberty blockers begin for the treatment of
3 gender dysphoria in minors?
4 A. They say essentially as soon as possible; as
5 soon as puberty begins.
6 Q. And what age does puberty typically begin?
7 A. These days? Ages 9 and 10, including -- as a
8 matter of fact, the WPATH guide standards themselves
9 indicate that this is -- often is ages 9 and 10.
10 Q. And let's clarify. When we're talked about
11 the WPATH, I want to specify, which version of the
12 WPATH are you -- are you referencing when you -- when
13 you give your answers right now?
14 A. The current version, which is Version 7.
15 Q. And when was Version 7 published?
16 A. It was first released in 2011. It was
17 published in print in 2012.
18 Q. What -- what does the 2012 version of the
19 WPATH recommend as the age to begin cross-sex hormones
20 for the treatment of gender dysphoria in minors?
21 A. It's a bit sketchy in how it describes it. On
22 one hand it says age 16, but then at the same time it
23 will say if there are, you know -- that there are
24 circumstances under which, you know, the doctor may
25 also lower that. It presents itself merely as

1 guideline -- merely as guidelines.
2 Q. Do you know what the 2022 Version 8 WPATH
3 recommendations are for the age of beginning cross-sex
4 hormones for the treatment of gender dysphoria in
5 minors?
6 MR. GONZALEZ-PAGAN: Objection; lack of
7 foundation, and they do not exist yet.
8 THE COURT: Sustained.
9 MR. STONE: All right.
10 Q. (BY MR. STONE) Dr. Cantor, are you familiar
11 with the draft version of the WPATH Version 8?
12 A. Yes. They were released for public comment in
13 December of 2021.
14 Q. Have you -- did you review the draft that was
15 released for public comment in 2021?
16 A. Yes, I did.
17 Q. What did the draft of Version 8 of the WPATH
18 guidelines -- what was the age that they recommended
19 for cross-sex hormones to begin for the treatment of
20 gender dysphoria in minors?
21 A. Age 14, and at the same time that they
22 acknowledged that there was no scientific basis for it.
23 Q. So how did they state they arrived at the
24 number -- the age of 14?
25 A. They gave really kind of a hand-waving

1 description of it being, you know, expert consensus and
2 consultation with the community. They didn't draw any
3 particular line except to acknowledge that this is --
4 this was the lowest standard of any of the -- the
5 proposed cutoffs, boundaries.
6 Q. What did the draft Version 8 of the WPATH
7 guidelines say was the age -- recommended age for
8 beginning -- for providing mastectomies to minors for
9 the treatment of gender dysphoria?
10 A. I think it also said age 16, at the same time
11 adding the caveat that in some cases it might be even
12 younger.
13 Q. And what did the draft Version 8 of the WPATH
14 guidelines say was the minimum age for vagin- --
15 vaginaplasty for the treatment of gender dysphoria in
16 minors?
17 A. I would have to check my notes. I think it
18 was age 16 also and, again, with the added caveat that
19 in certain circumstances, if it was okay with the
20 patient and the patient's doctor, then lower was also
21 acceptable.
22 Q. What is a vaginaplasty?
23 A. The mechanism of the surgery changes from
24 patient to patient, but essentially it's the surgical
25 construction of a vagina from penile tissue.

1 Q. And what did the Version 8 of the WPATH
2 guidelines say was the scientific studies that they
3 relied on in reaching that age for recommendation for
4 vaginaplasty?
5 A. They, again, didn't write any one-to-one
6 correspondence and didn't claim to have any specific
7 studies to justify their procedures. Instead, they
8 listed that these are the studies that have been done
9 and then said we subjected these to expert opinion and
10 came out with a list of recommendations compromising
11 the outcomes of those studies with insurance demands,
12 demands from the patients, and demands from --
13 MR. GONZALEZ-PAGAN: Objection;
14 narrative.
15 A. -- their legal provider.
16 THE COURT: Yes, sustained on narrative.
17 Q. (BY MR. STONE) Who diagnoses gender dysphoria
18 in minors?
19 A. People with the appropriate credentials, which
20 changes jurisdiction by jurisdiction.
21 Q. Are children with gender dysphoria at an
22 increased risk of suicide if they are not provided with
23 puberty blockers or hormone therapy?
24 A. It's a two-part question really.
25 MR. GONZALEZ-PAGAN: Objection; compound.

1 A. There does seem to be --
2 THE COURT: Hold on.
3 MR. STONE: Stop, stop, stop.
4 THE COURT: Hold on. I'm sorry. What
5 was your objection?
6 MR. GONZALEZ-PAGAN: Compound. Even the
7 witness recognized it.
8 THE COURT: Oh. Then maybe ask the
9 question -- let's do -- let's do it again. Ask the
10 question or ask -- go ahead and split the question up.
11 MR. STONE: Thank you, Your Honor.
12 Q. (BY MR. STONE) What do the scientific studies
13 that you've reviewed say about the increased risk of
14 suicide for minors with gender dysphoria who do not
15 receive puberty blockers?
16 A. There's a statistically significant
17 correlation between those factors, but they're often
18 misunderstood because people confuse suicide with
19 suicidality.
20 Q. What is suicide?
21 A. Suicide is the actual intent to die.
22 Generally it's associated with a more lethal means.
23 It's more common in biological males, and it's more
24 common in middle age, and it's also more common in
25 wealthier than poorer jurisdictions. Suicidality --

1 Q. What is suicidality?
2 A. Suicidality is less associated with an intent
3 to die, and it's usually associated with a cry for help
4 or a signal of distress. It's much more common in
5 biological females and much more common in -- in
6 adolescents. Those are the ones that involve suicidal
7 ideation or threats. And as I say, usually they're --
8 they're indications of distress and cries for help
9 rather than intent to die.
10 Q. Have there been studies on suicidality in
11 minors with gender dysphoria?
12 A. Yes, there have been cross-sectional studies
13 and survey studies.
14 Q. And what do those studies say about
15 suicidality among minors with gender dysphoria?
16 A. That they are more likely -- that they report
17 elevated rates of suicidality, more on par with a --
18 with homosexuality than with heterosexuality or
19 cisgender status.
20 Q. What do you mean by more on par with
21 homosexuality?
22 A. There's also an el- -- elevated rates of
23 suicidality among people with atypical sexual
24 orientations, gays -- gays and lesbians. People who
25 report transgender status report suicidality rates

1 elevated on par with those -- with the gay and lesbian
2 minors.
3 Q. Have there been any studies on suicides among
4 minors who have been diagnosed with gender dysphoria?
5 A. Not suicides, no. They're very, very rare, so
6 we can't actually get reliable comparison kinds of
7 statistics on them.
8 Q. So then what do you mean when you say that
9 suicide and suicidality are being conflated?
10 A. People are talking about suicidality, these
11 indications of just stress as if these are super normal
12 indications of death giving rise to I'd rather have
13 a -- a trans daughter than a dead son.
14 MR. GONZALEZ-PAGAN: Objection,
15 Your Honor; narrative.
16 THE COURT: It is narrative. I also want
17 counsel to be weary of time. I wasn't worried when you
18 started, but the longer it goes on, I just want you to
19 keep in mind you don't have unlimited time. I'm not
20 for sure if you have other witnesses. I'm not getting
21 involved with how you use your time, but we have been
22 going almost an hour.
23 MR. STONE: Yes, Your Honor.
24 THE COURT: Just -- I mean, if that's
25 fine, that's fine. I just wanted you to know where you

1 were.
2 MR. STONE: Thank you. Could I do a time
3 check? How much time do we have left?
4 THE COURT: Let me count. You're at
5 basically two hours.
6 MR. STONE: Okay.
7 THE COURT: So you have 45 minutes left
8 total.
9 Q. (BY MR. STONE) Dr. Cantor, gender dysphoria
10 is a psychological condition, right?
11 A. Yes.
12 Q. Have you ever been disqualified as an expert
13 witness in a case?
14 A. No.
15 Q. How many cases have you testified as an expert
16 in?
17 A. In my career, about 25.
18 MR. STONE: Your Honor, at this time we
19 would like to -- we -- we've uploaded to the Box
20 Dr. Cantor's CV. It's marked as Exhibit DO1B. We
21 would like to offer it at this time, Your Honor.
22 THE COURT: Let's go off the record for a
23 minute.
24 *(Off the record.)*
25 THE COURT: You are at this time moving

1 to offer the CV of Dr. Cantor as D-26; is that correct?
2 MR. STONE: Yes, Your Honor.
3 THE COURT: And because we're treating
4 the Box as the official record here, you will re-upload
5 it as D-26 in the nonconfidential portion of the
6 exhibits, correct?
7 MR. STONE: Yes, Your Honor.
8 THE COURT: And do you have any objection
9 to D-26?
10 MR. GONZALEZ-PAGAN: No objection to
11 D-26, just that being the CV, correct, Your Honor.
12 THE COURT: And D-26 is hereby admitted.
13 *(Defendants' Exhibit 26 admitted.)*
14 MR. STONE: Thank you, Your Honor.
15 Q. (BY MR. STONE) Dr. Cantor, I just have a
16 few -- few questions left and we'll wrap up.
17 Dr. Cantor, what are the potential side
18 effects of puberty blockers when administered to a
19 minor?
20 A. We're creating a person who's now a late
21 bloomer in the beginning of their adolescence and their
22 primary physiological deficit is in bone density.
23 We're preventing the people from -- from growing up.
24 And the most relevant one is we're also blocking the
25 person's sex drive from starting. And it's usually the

1 onset of the sex drive that tells the person that
2 they're gay or lesbian rather than trans.
3 Q. And, Dr. Cantor, what are the potential
4 adverse side effects to cross-sex hormones in minors
5 for the treatment of gender dysphoria?
6 A. Primarily they're increases in risks of
7 certain blood disorders, such as strokes and certain
8 cardiac events.
9 MR. STONE: All right. Your Honor,
10 before I pass this witness, we -- we do want to do an
11 offer of proof on his expert report before the --
12 before we wrap up today, if possible. We'd also like
13 to offer --
14 THE COURT: Well, you don't need to do an
15 offer of proof on just a piece of -- it's part of the
16 record. You have made an offer of D-1 in its original
17 form, and you objected to it being hearsay. Am I
18 correct?
19 MR. GONZALEZ-PAGAN: Yes, Your Honor.
20 THE COURT: And the Court sustained the
21 hearsay objection. But D-1 remains part of the record
22 because it is an unadmitted exhibit that is part of the
23 case.
24 MR. STONE: Thank you, Your Honor. At
25 this time we'd also like to offer into evidence

1 Exhibit D-2. This is an -- the expert declaration and
2 report of Michael K. Laidlaw, M.D.
3 MR. GONZALEZ-PAGAN: Your Honor, there's
4 not even a witness even authenticating this exhibit.
5 MR. STONE: With respect to
6 authentication, Your Honor, it is an unsworn
7 declaration. If you go to -- that meets all the
8 requirements in the Civil Practice & Remedies Code. If
9 you go to Page -- I'll show you specifically where that
10 is. It is Page --
11 THE COURT: If it meets authentication,
12 do you have another objection?
13 MR. STONE: -- 35.
14 MR. GONZALEZ-PAGAN: Your Honor, again,
15 this is hearsay. It's a report. This is a witness
16 that's available that's on the witness list.
17 THE COURT: It is hearsay. What is your
18 response to hearsay?
19 MR. STONE: Well, Your Honor, we -- we
20 ask for a little leeway in this case. Declarations and
21 expert reports are often admitted, perhaps not in your
22 court, but in temporary injunction proceedings they are
23 often in other cases admitted.
24 THE COURT: But still it would be
25 hearsay. This person's report would be complete

1 hearsay. They're not here.
2 MR. GONZALEZ-PAGAN: Correct, Your Honor.
3 THE COURT: So I'm going to sustain
4 hearsay, and this exhibit is not admitted either.
5 MR. GONZALEZ-PAGAN: And just for
6 completeness of the record, I would note that the State
7 previously objected to the introduction of expert
8 reports in the *Doe v. Abbott* case under the same basis.
9 MR. STONE: Your Honor, I wasn't in the
10 *Doe* case, so I wasn't here or there, so -- or I guess I
11 wasn't there. I am here.
12 All right. Last one, Your Honor.
13 Defendants would like to offer into evidence
14 Exhibit D-3, which is a declaration of Stephen Black.
15 He's a DFPS employee.
16 MR. GONZALEZ-PAGAN: Objection,
17 Your Honor. This is a witness that could be called.
18 It's in the witness list. If they want to introduce
19 it, they can have the witness at least authenticate it
20 at -- in any event, we would be objecting on hearsay
21 grounds, and it shouldn't be admitted.
22 MR. STONE: Well, with respect to
23 authentication, it is an unsworn declaration that
24 complies with the Civil Practice & Remedies Code. And
25 on Page 6, you'll see that the unsworn declaration,

1 again, meets all the requirements of the Civil Practice
2 & Remedies Code.
3 MR. GONZALEZ-PAGAN: Again --
4 THE COURT: It's sustained on -- the
5 objection on hearsay is sustained.
6 MR. STONE: Your Honor, I have a note
7 that the Court did allow declarations in the *Doe* case,
8 so we'd just like to note that for the record.
9 THE COURT: I don't remember that.
10 MR. GONZALEZ-PAGAN: That --
11 THE COURT: But --
12 MR. GONZALEZ-PAGAN: Your Honor --
13 THE COURT: -- I don't want to get into
14 an argument about it. I think -- I -- I -- I don't --
15 I cannot argue with you if that is what I did, but I am
16 not allowing declarations in this case. You can call a
17 witness. If we wanted to call him, he would be allowed
18 to testify, but we can't just admit his declaration
19 because how would they cross him?
20 MR. STONE: Thank you, Your Honor. At
21 this time we pass the witness.
22 THE COURT: Thank you. So let's take a
23 break. Why don't we take a ten-minute break. And if
24 the witness will stay with us -- you can take a break,
25 too, sir, but don't -- just don't disconnect. We're

1 going to take a ten-minute break, and I'll see
2 everybody back at 3:10.
3 MR. GONZALEZ-PAGAN: Thank you,
4 Your Honor.
5 THE COURT: Thanks.
6 *(Recess was taken.)*
7 THE COURT: Dr. Cantor, if you're still
8 with us, we're now going to have cross-examination.
9 MR. GONZALEZ-PAGAN: Thank you,
10 Your Honor.
11 **CROSS-EXAMINATION**
12 BY MR. GONZALEZ-PAGAN:
13 Q. Dr. Cantor, can you hear me?
14 A. Yes, I can.
15 Q. Thank you. Earlier today you expressed some
16 opinions pertaining to when a child with gender
17 dysphoria will desist in their -- in their gender
18 identification; is that right?
19 A. Yes, roughly.
20 Q. No medical treatment is recommended under any
21 care model prior to Tanner Stage 2 of puberty; is that
22 correct?
23 A. It depends on what you consider a medical
24 intervention.
25 Q. No puberty blockers are recommended prior to

1 Tanner Stage 2 of puberty; is that correct?
2 A. Correct.
3 Q. No hormone treatment is recommended prior to
4 Tanner Stage 2 of -- of puberty; is that correct?
5 A. Correct.
6 Q. No surgery is recommended prior to Tanner --
7 prior to puberty; is that correct?
8 A. Correct.
9 Q. Okay. The desistance studies to which you
10 referred, and I believe there were 11, all pertained to
11 prepubescent children; is that right?
12 A. Well, I wouldn't call them a desistance study.
13 There were follow-up studies no matter what happened.
14 Q. Did they all pertain to prepubescent children?
15 A. The first set of 11 cohorts studies, yes.
16 Q. Okay. Isn't it correct that these studies --
17 the -- the youth that were the subjects of these
18 studies were not diagnosed with gender dysphoria under
19 the DSM-V?
20 A. That's kind of a misleading question. The --
21 there were several DSMs under effect over the past
22 30 years, and the outcomes from the DSM-III, III-R, IV,
23 and IV-TR were the same.
24 Q. It --
25 A. It takes --

1 Q. All right.
2 A. -- 10 to 15 years to --
3 Q. Dr. Cantor, if you can --
4 MR. GONZALEZ-PAGAN: I'm going to object
5 based on narrative.
6 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, the
7 question is --
8 MR. STONE: Your Honor --
9 THE COURT: I -- I mean, I think the
10 objection was nonresponsive, which I would sustain and
11 narrative, yes.
12 MR. GONZALEZ-PAGAN: Thank you,
13 Your Honor.
14 THE COURT: So the objection is
15 sustained.
16 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, I -- I
17 understand that there are various DSMs. I'm asking a
18 very direct question. The desistance stu- -- the
19 studies in which -- that follow prepubescent children
20 that you indicated in support of desistance rates, the
21 subject of those studies were not diagnosed with gender
22 dysphoria under the DSM-V, correct?
23 A. That's correct.
24 Q. They were diagnosed with gender identity
25 dis- -- disorder under prior DSM versions; is that

1 correct?
2 A. Yes.
3 Q. And the diagnostic criteria of gender
4 dysphoria under the DSM-V differs from the diagnostic
5 criteria of gender identity disorder under those prior
6 DSM versions; is that right?
7 A. Slightly, yes.
8 Q. Okay. Dr. Cantor, do you agree that the
9 number and percentage of adolescents with gender
10 dysphoria who do not go on to identify as transgender
11 is currently unknown?
12 A. Yes.
13 Q. Dr. Cantor, would you agree that under mo- --
14 any of the models of care, including the Dutch model,
15 puberty blockers and hormone treatments are not
16 recommended to be started until after the onset of --
17 of puberty; is that correct?
18 A. Correct.
19 Q. Dr. Cantor, sexual orientation and gender
20 identity are distinct concepts; is that correct?
21 A. Yes.
22 Q. And a transgender person may identify as gay
23 or lesbian; is that correct?
24 A. Yes.
25 Q. Dr. Cantor, you also made reference to a

1 number of cohort perspectives studies that followed
2 adolescents that were being provided with puberty
3 blockers and hormone therapy and psychotherapy. Do you
4 recall that testimony?
5 A. Yes.
6 Q. The majority of these studies concludes that
7 the provision of puberty blockers and hormone therapy
8 to treat gender dysphoria in adolescents leads to
9 improved mental health and well-being; is that correct?
10 A. No, that's not the whole truth.
11 Q. The maj- -- let me reask the question. I'm
12 asking about whether the majority of the studies
13 conclude it, that the provision of puberty blockers and
14 hormone therapy to treat gender dysphoria in
15 adolescents leads to improved mental health and
16 well-being.
17 A. The authors that -- I'd -- I'd have to check
18 to see if it's a majority. It could be about half and
19 half, but that's not far off. They leave out that
20 psychotherapy -- well, some do, some do -- don't leave
21 out that psychotherapy was given at the same time when
22 they discuss their own findings.
23 Q. And the WPATH Standards of Care recommend
24 psychotherapy along with the provision of medical care
25 to prevent -- to treat gender dysphoria; is that

1 correct?
2 A. I don't know what they would count as a
3 recommendation. It's usually followed by a long
4 discussion acknowledging that it's not often available.
5 MR. GONZALEZ-PAGAN: Move to strike as
6 nonresponsive.
7 THE COURT: I will sustain nonresponsive,
8 and you can ask the question again, but I'm not going
9 to strike it.
10 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, you
11 indicated that you provided testimony in some other
12 cases pertaining to transgender youths. Do you recall
13 that?
14 A. Yes.
15 Q. Were you deposed in the *B.P.J. v. West*
16 *Virginia Board of Education* case?
17 A. Yes.
18 Q. Okay. In your deposition you were asked about
19 conclusions and results of a number of these cohort
20 perspective studies involving transgender adolescents.
21 Do you recall that?
22 A. Yes, roughly.
23 Q. You were asked if a study by Tordoff, et al.
24 published in 2022 concluded that gender-affirming care,
25 both psychotherapy and medical care, was associated

1 with 60 percent lower odds of moderate or severe
2 depression and 73 percent lower odds of suicidality
3 over a 12-month follow-up, and you answered in the
4 affirmative, correct?
5 A. I can't say that I remember that specific
6 question. I remember general questions about that
7 article.
8 Q. Okay. Is there anything that would refresh
9 your recollection?
10 A. I -- I -- I guess re-reading the text of the
11 deposition itself.
12 Q. All right. Dr. Cantor, if you can please open
13 what's been pre-marked as Plaintiffs' Exhibit 47.
14 MR. STONE: Two things, Your Honor.
15 First, we would like an opportunity to inspect this.
16 And then number two, we had not been provided a copy of
17 this. We -- we only have plaintiffs' exhibits up
18 through No. 27. That's all we've been provided. So we
19 don't have 46, 41, whichever one was just referenced.
20 We don't have a copy of it, Your Honor, and neither
21 does Dr. Cantor.
22 MR. GONZALEZ-PAGAN: Your Honor, these
23 exhibits were provided, what, yesterday.
24 THE COURT: Well, I think you have a
25 functional problem because the witness can't see the

1 exhibit. So how would we -- I mean, that's just -- I
2 don't -- I don't know -- if it was --
3 MR. GONZALEZ-PAGAN: Your Honor, we're in
4 a catch-22. We provided these exhibits to counsel.
5 THE COURT: But -- but when?
6 MR. STONE: That is not true.
7 MR. GONZALEZ-PAGAN: Last night.
8 THE COURT: I don't know. I -- I
9 understand y'all have a disagreement about this. My
10 problem is we don't have a practical answer. So even
11 if what you are saying is correct, how do we show this
12 witness this exhibit if he doesn't have them currently
13 here? I'm not -- I'm not being -- I'm asking you --
14 MR. GONZALEZ-PAGAN: No. I understand,
15 Your Honor. It's a logistical problem. Your Honor, if
16 I can have a brief one-minute recess to try to recess
17 in light of the lack of provision of the -- of the
18 exhibit to the witness.
19 THE COURT: I don't think so.
20 MR. GONZALEZ-PAGAN: Okay.
21 MR. STONE: Thank you, Your Honor.
22 Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, do you
23 dispute that Tordoff, et al., published in 2022
24 concluded that gender-affirming care, both
25 psychotherapy and medical care, was associated with

1 60 percent lower odds of moderate or severe depression
2 and 73 percent lower odds of suicidality for a 12-month
3 follow-up?
4 A. I'm sorry. Could you say that again?
5 Q. Do you dispute that the study Tordoff, et al.,
6 published in 2022 concluded that gender-affirming care,
7 both psychotherapy and medical care, was associated
8 with 60 percent lower odds of moderate or -- or severe
9 depression and 73 percent lower odds of suicidality
10 over a 12-month follow-up?
11 A. No, I don't.
12 Q. Dr. Cantor, do you dispute that a study by
13 Achille, et al., in 2020 concluded that endocrine
14 intervention was associated with decreased depression,
15 suicidal ideation, and improved quality of life for
16 transgender youth?
17 A. I would have to qualify that in that study
18 they -- they didn't find anything significant for
19 puberty blockers but they did for cross-sex hormones,
20 so saying endocrine intervention is ambiguous.
21 Q. Do you dispute that a 2020 study by
22 van der Miesen, et al., indicated that trans youth
23 showed fewer emotional and behavioral problems after
24 puberty suppression and similar or fewer problems
25 compared to same-age cisgender peers, and you answered

1 in the affirmative?
2 A. Again, I can't remember the exact question and
3 answer then, but the context -- but the authors of that
4 study themselves were -- noted that psychotherapy --
5 that they themselves couldn't use their own data to
6 suggest improvement because it was people who were
7 already doing well -- continuing to do well rather than
8 people who were doing poorly, then coming to do well.
9 Q. Okay. Dr. Cantor, you cannot cite to any
10 study showing that psychotherapy alone can resolve an
11 adolescent's gender dysphoria; is that correct?
12 A. That's correct.
13 MR. GONZALEZ-PAGAN: That's it for
14 plaintiffs on cross, Your Honor.
15 THE COURT: Anything further from you?
16 MR. STONE: No, Your Honor.
17 THE COURT: Okay. Then, Doctor, you are
18 excused. You are free to disconnect yourself and free
19 to go. Thank you.
20 MR. STONE: Thank you, Dr. Cantor.
21 THE WITNESS: My pleasure. Good luck,
22 everyone.
23 MR. STONE: And, Your Honor, could I get
24 a time check before we call our -- this is our last
25 witness.

1 THE COURT: You -- you have 40 minutes
2 left.
3 MR. STONE: Thank you, Your Honor.
4 THE COURT: You may call your next
5 witness.
6 MR. STONE: Thank you, Your Honor.
7 THE REPORTER: Can you just tell me who
8 that is so I can write it down?
9 MR. STONE: Yeah. Sorry. Just a second.
10 Defendants call Marta Talbert.
11 THE COURT: Ms. Talbert, please raise
12 your right hand.
13 *(Witness sworn in.)*
14 THE COURT: You can leave your mask on or
15 take your mask off, whatever's more comfortable for
16 you.
17 You may proceed.
18 **MARTA TALBERT**,
19 having been first duly sworn, testified as follows:
20 **DIRECT EXAMINATION**
21 BY MR. STONE:
22 Q. Good afternoon, Ms. Talbert. Could you state
23 your name for the record?
24 A. Yes, Marta Talbert.
25 Q. And what is your educational history,

1 Ms. Talbert?
2 A. I have a bachelor's in social work.
3 Q. What is your current occupation?
4 A. So I am currently the child protective
5 investigation director of field.
6 THE COURT: Director of field? Is that
7 what it was?
8 THE WITNESS: Director of field.
9 Q. (BY MR. STONE) How long have you been in that
10 position?
11 A. So I've been in that position for a little
12 over a year.
13 Q. And who is that position with?
14 A. With Department of Family and Protective
15 Services.
16 Q. Have you held any other positions with the
17 Department of Family and Protective Services?
18 A. Yes, I have.
19 Q. What positions?
20 A. So I've been a caseworker, I've been a
21 supervisor, a program director, a program
22 administrator, a regional director. So for the last
23 25 years I've been with DFPS.
24 Q. What are your current job duties?
25 A. So I currently oversee all field for

1 investigations. And so I primarily supervise all the
2 regional directors throughout the state of Texas, but
3 my job is investigation basically.
4 Q. What is a DFPS investigation?
5 A. So it is -- it's an investigation if there's
6 a -- concerns for abuse or neglect to a child.
7 Q. Are DFPS investigations governed by
8 Section 2000 of the DFPS handbook?
9 A. Yes.
10 Q. What are the general stages of a DFPS
11 investigation?
12 A. So general stages. It comes into our
13 statewide intake -- to our statewide intake as an
14 intake or a report, and then it is routed out to the
15 regions or county for investigation.
16 Q. What is the general timeframe of a DFPS
17 investigation?
18 A. 30 -- about 30 days to complete an
19 investigation, but we really give them 45 days to
20 actually submit it to their supervisor.
21 Q. And is a DFPS investigation timeframe chart
22 contained in Appendix 2251 in the DFPS handbook?
23 A. Yes.
24 Q. What are caseworkers?
25 A. Caseworkers are -- I'll speak for

1 investigations. I mean, there's all kinds of
2 caseworkers with DFPS. But for investigations, I have
3 a group of staff of investigators and alternate
4 response staff that investigate child abuse and
5 neglect.
6 Q. What are collateral contacts in the DFPS
7 investigation context?
8 A. Yes. So collaterals could be anything to help
9 us determine the safety of a child, so that could be
10 teachers or neighbors or doctors or therapists. It's
11 basically anyone that possibly could help us make sure
12 that child is safe and if there's any risk or abuse or
13 neglect of the child.
14 Q. What is an alleged victim in the DFPS
15 investigation context?
16 A. Yes. So it's -- it's basically how we label
17 someone to know that they are a victim child. So if
18 someone calls in to statewide intake and reports abuse
19 or neglect to a child, that child is then considered an
20 alleged victim until the time we disposition the case.
21 Q. And what is an -- what is an alleged
22 perpetrator in the DFPS investigation context?
23 A. Yes. So the alleged perpetrator is -- when
24 the intake comes in to statewide intake, whoever the
25 person is that's supposedly abused or neglected the

1 child -- and that's just supposedly, right? It has not
2 been confirmed -- they are considered an alleged
3 perpetrator until the time we have dispositioned the
4 case.
5 Q. Why do you call them alleged perpetrators?
6 A. Alleged perpetrator because they're alleged to
7 have perpetrated abuse or neglect to a child.
8 Q. But when you -- when you call somebody an
9 alleged perpetrator, are you making a final
10 determination about whether they are a perpetrator?
11 A. No, absolutely not. That comes at the
12 disposition. That comes after all information is
13 gathered to determine if there was abuse or neglect.
14 And then if they -- if they are not found to have
15 abused or neglected a child, that alleged perpetrator
16 actually comes out of the system. They -- they end up
17 showing as no role.
18 Q. Is it important to put eyes on an alleged
19 victim during a DFPS investigation?
20 MR. COOK: Objection, Your Honor;
21 leading.
22 THE COURT: Sustained. Ask another
23 question.
24 Q. (BY MR. STONE) How are DFPS investigations
25 initiated?

1 A. The initiation, typically we attempt to
2 contact the reporter first to see if we can gather any
3 additional information. And then at that point, once
4 we can talk to the reporter -- hopefully we can -- we
5 absolutely look at criminal and CPS history just to see
6 if there's anything out there. And then our very first
7 thing we want to do is attempt to see the victim child
8 and interview the victim child.
9 Q. And why do you try to interview or see the
10 victim child?
11 A. I mean, there's -- there's a lot of reasons,
12 but I always take it back to safety. You know, if
13 there is abuse or neglect of that child, I definitely
14 want to see that child and interview that child before
15 I talk to the parents or alert the parents of the
16 allegations to make sure they don't coach or change
17 anything that we're going to speak to the child about.
18 Q. Earlier you mentioned dispositions. Do you
19 recall that?
20 A. Yes.
21 Q. What are the potential dispositions of a DFPS
22 investigation?
23 A. Yes. For an investigation, we could rule out,
24 which basically means that we do not find any
25 preponderance of evidence of abuse or neglect. We

1 could reason to believe, which means that we did find
2 evidence of abuse or neglect. We could what we call
3 UTD, unable to determine, which means we know abuse
4 occurred, but we don't know who the perpetrator was. I
5 feel like I'm leaving one out. There's a UTC, which is
6 unable to complete, which means probably the family
7 left, ran, we can't find them.
8 Q. When you have a ruled-out disposition, how do
9 you treat subsequent complaints involving exactly the
10 same alleged conduct?
11 A. Yes. So if we have investigated -- and it
12 could be any disposition except for unable complete,
13 but if we have completed an investigation and the exact
14 same complaint come back in, we do not work that case
15 again.
16 Q. How many medical providers does DFPS have on
17 staff in their investigations division?
18 A. I have zero medical providers.
19 Q. How does DFPS then make determinations about
20 the medical necessity of any particular claim?
21 A. So I -- I mean, our -- first and foremost is
22 to try to find who -- find out who is seeing the child
23 or the youth. Right? Like, who is that doctor? Is it
24 a therapist? Is there anyone as far as the medical
25 field involved with that youth and talk to -- talk to

1 those people who know the youth the best or child?
2 Q. Who in DFPS investigations makes
3 determinations as to whether treatment provided by a
4 medical provider is medically necessary?
5 MR. COOK: Objection, Your Honor; lack of
6 foundation.
7 THE COURT: Overruled.
8 A. I'm sorry. Could you repeat that?
9 Q. (BY MR. STONE) Who in DFPS, in the DFPS
10 investigations department, makes determinations about
11 whether or not the treatment provided by a medical
12 provider is medically necessary?
13 A. We do not -- we do not do that. We count on
14 our -- the doctors and the therapists and all the
15 people that are surrounding that youth to tell us.
16 There's -- we don't debate or argue or change what a
17 medical professional is telling us.
18 Q. What is the Forensic Assessment Center
19 Network?
20 A. So, yes, we do use -- FACN is what I'm going
21 to call it, but, yes, we use them at times. I'd say
22 typically it's if we have conflicting information.
23 You know, maybe we have a serious injury to a child
24 that's nonverbal, and at that point we -- maybe the ER
25 doctor's saying one thing and then we have maybe one of

1 the other physicians saying something else, that we can
2 refer and they kind of help guide us on if they find
3 the injury to the child to be abuse or neglect.
4 Q. And is information about the forensic
5 assessment, or FACN, is that contained within
6 Section 2232 of the DFPS handbook?
7 A. Yes.
8 Q. How long has FAC been -- FACN been available
9 to DFPS investigations?
10 A. Yeah. So I'm thinking it's around 2005 to
11 2006 that we started with the FACN.
12 Q. When do you make FACN referrals?
13 A. We make them at the time that we feel like we
14 need additional medical or expert doctor opinions.
15 Q. What is a court order in aid of an
16 investigation?
17 A. Yeah. So an aid to investigate is we complete
18 an affidavit for certain reasons, such as wanting to
19 see a child or have access to the child or have access
20 to medical records. There are times that we can
21 present information and request from the Court for an
22 aid to investigate.
23 Court ordered is just a little bit
24 different because we have to have a high risk to a
25 child, continuing danger to a child, so I think court

1 order is a little bit different. It's actually
2 services to a family versus just gaining access to a
3 home or to a child.
4 Q. What are puberty blockers in the context of
5 gender dysphoria?
6 MR. COOK: Objection, Your Honor.
7 THE COURT: Say it. You've got to give a
8 reason.
9 MR. COOK: Not a medical expert.
10 MR. STONE: Your Honor, I'm asking --
11 she's a DFPS in charge -- she's in charge of DFPS
12 investigations. I'm just asking her if she has
13 personal knowledge. I'm not asking for an expert
14 opinion. She --
15 THE COURT: You're going to have to lay a
16 little more foundation on this, though, because I
17 don't -- I think that just took an about face, and
18 we've got to know if she knows anything about this area
19 at all for her to testify on it.
20 Q. (BY MR. STONE) Do you know anything about
21 puberty blockers in the context of gender -- gender
22 dysphoria?
23 A. I know as much as -- since these cases have
24 started coming in, yes, just -- I'm relying on medical
25 and doctors and those kind of people to help guide us

1 through this.
2 THE COURT: Now ask her, though, which
3 doctors? I think that's the next question. If she's
4 relying on medical doctors, you need to ask her which
5 doctors.
6 Q. (BY MR. STONE) Which doctors?
7 A. Yes. So it's -- it's going to be any doctor
8 that we've been able to talk to regarding the youth
9 that was the alleged victim in our cases.
10 THE COURT: But have you spoken to any --
11 you as an investigator spoken to any doctor?
12 THE WITNESS: No.
13 THE COURT: Have you received any doctor
14 giving you a doctor's opinion about what puberty
15 blockers are or what they are used for?
16 THE WITNESS: No.
17 Q. (BY MR. STONE) Do you review the
18 investigations conducted by the DFPS caseworkers?
19 A. Not all investigations, but, yes, these
20 specific investigations.
21 Q. So have you reviewed information provided by
22 physicians or medical providers in the context of these
23 particular DFPS investigations?
24 A. Yes.
25 Q. I'm going to ask one more time. What do you

1 know -- or what are, to the best of your knowledge,
2 puberty blockers in the context of being provided
3 further treatment of gender dysphoria in minors?
4 MR. COOK: Objection, Your Honor; it's a
5 general question. She is a lay witness. She doesn't
6 have any personal knowledge pursuant to --
7 THE REPORTER: I'm sorry. I couldn't
8 hear the last part.
9 THE COURT: You're going to have to speak
10 up, and this is very important. And so --
11 MR. COOK: Sure.
12 THE COURT: -- you need to state it like
13 you mean it --
14 MR. COOK: Sure.
15 THE COURT: -- and give my a real
16 objection that the Court can rule on.
17 MR. COOK: Objection, Your Honor; no
18 personal knowledge of the witness. She is a lay
19 witness. She doesn't have expert -- expertise in this
20 area, evidence rule 602.
21 MR. STONE: Your Honor, 701 says that a
22 witness can provide lay opinion in a case.
23 THE COURT: And 701 does say a witness
24 can provide lay opinion in a case, and so do you have
25 another objection?

1 MR. COOK: Yes. Objection to overly
2 broad. He's asking about gender dysphoria treatment in
3 general, not specific questions about treatment
4 provided in any of the investigations Marta Black has
5 reviewed -- sorry, Marta Talbert has reviewed.
6 MR. STONE: But, Your Honor, she's --
7 she's testified that she's only seen it in the context
8 of having conducted reviews, so it's implicit in the
9 question that -- that it's only going to what she's
10 actually reviewed, having reviewed the case files, for
11 DFPS investigations involving the subject.
12 THE COURT: It's also hearsay, so how do
13 we get past a lot of hearsay? Like, one person told
14 another person who told another person who told another
15 person that she reviewed, so how do we get past that
16 issue? If we're going to let her testify and give lay
17 opinion testimony about medical recommendations, how do
18 we get past all the hearsay to get there? Like, I just
19 want to know where you're going with it because I -- we
20 can allow her to opine on her layperson understanding,
21 and that's okay, but then once you take -- ask the next
22 questions, I think you're going to run into some
23 problems.
24 MR. STONE: Your Honor, under 803 there's
25 an exception for medical diagnosis -- diagnoses as well

1 as medical records and medical treatment records.
2 THE COURT: Sure. A doctor has that
3 exception, though. It's not -- and a patient can maybe
4 have it, but that's not a hearsay upon hearsay upon
5 hearsay, which is what we're talking about here.
6 MR. STONE: Your Honor, for the sake --
7 THE COURT: So I'm just -- I think -- I
8 think she can give a lay answer to the question of what
9 are puberty blockers in her layperson understanding,
10 but where we go next could become a problem.
11 MR. STONE: We're just going to move on.
12 I -- doesn't matter.
13 Q. (BY MR. STONE) When did you first -- when did
14 DFPS first receive a report involving the
15 administration of puberty blockers or hormone therapy
16 to a minor?
17 A. So it was in February of 2022.
18 Q. Do you remember when in February of 2022?
19 A. I cannot.
20 Q. When did DFPS investi- -- DFPS last receive a
21 report of -- involving a minor and the use of
22 hormone -- hormone therapy or puberty blockers?
23 A. It was in March of 2022, but I can't think of
24 the exact date.
25 Q. And I'm going to refer to these, as my

1 co-counsel said earlier, PBHT just for the -- the sake
2 of expedience.
3 So how many total PBHT-related reports
4 has DFPS received?
5 A. We have received a --
6 MR. COOK: Objection --
7 A. -- total of 12 --
8 MR. COOK: Objection, Your Honor.
9 THE COURT: Hold on.
10 THE WITNESS: Sorry.
11 THE COURT: What is the objection?
12 MR. COOK: Lack of foundation. We
13 haven't established how she's come to know any of these
14 or --
15 THE COURT: She testified she was the
16 head of investigations, correct, of field?
17 MR. COOK: She also says that she doesn't
18 review all reports, so we haven't established that she
19 has -- what she's reviewed or not.
20 MR. STONE: Your Honor, she testified
21 specifically. She identified all of these reports --
22 THE COURT: Yeah. I guess we need to
23 know what "these reports" are. I think that may be --
24 somewhere between these two questions is maybe the more
25 specific question.

1 MR. STONE: Yes, Your Honor. I'm also
2 laying predicate here about these, so...
3 THE COURT: I hear you, but I don't -- I
4 don't know sitting here five hours into this how many
5 reports there are either and what you say when you say
6 "these reports," so we need to make it clear for the
7 fact finder.
8 Q. (BY MR. STONE) How many reports of alleged
9 child abuse involving PBHT has DFPS received?
10 A. We have received 12.
11 THE COURT: And is that statewide?
12 THE WITNESS: That is statewide, yes.
13 And I want to preface that with something. 12 is --
14 MR. COOK: Objection, Your Honor; there's
15 not a question.
16 THE WITNESS: Sorry.
17 MR. STONE: Your Honor, I think she was
18 still answering.
19 THE COURT: I guess -- well, ask her a
20 question maybe since the objection was she was speaking
21 and it wasn't a question in front of her maybe -- if
22 you feel like it should be a follow-up, you can ask a
23 follow-up question.
24 Q. (BY MR. STONE) How many of those 12 reports
25 of alleged child abuse involving the use of PBHT

1 advanced to investigations?
2 A. 11.
3 Q. Why did the 12th that you mentioned a moment
4 ago not advance to investigations?
5 A. It was --
6 MR. COOK: Objection, Your Honor; I don't
7 think we've established a foundation for why she knows
8 anything. If she's just doing investigations and one
9 didn't advance to investigation, we don't have any
10 foundation for why she knows what happened to the
11 other.
12 THE COURT: I think ask a couple of
13 foundational questions, and I think we get there.
14 Q. (BY MR. STONE) Have you reviewed all 12 child
15 abuse allegations involving the use of PBHT that DFPS
16 has received?
17 A. Yes, I have.
18 Q. Okay. Why did the 12th case not advance to
19 investigations?
20 A. Yes. So it was actually what we call PN,
21 priority none, because it did not meet definition and
22 it didn't have substantial information in the intake to
23 say that this child or the youth was actually on any
24 kind of hormones or blockers, so it was PN'ed. It was
25 not progressed to investigations.

1 Q. How were the 11 child -- cases involving
2 allegations of child abuse related to PBHT, how were
3 they designated when they arrived in investigations?
4 A. They were designated as what we call
5 Priority 2 investigations.
6 Q. What is a PN in the context of a DFPS
7 investigation?
8 A. Yes. So it's a priority none, which at times
9 we receive intakes or information prior to stage
10 progressing it to an investigation, and we can close it
11 as a PN if we find that there's evidence to show that
12 there was not abuse or neglect to a child.
13 There's some other little reasons in
14 there, such as the child -- the jurisdiction's
15 incorrect or the child is not -- is under HTN, so
16 there's some other pieces. But the main thing is that
17 we were able to make phone calls or contact people, and
18 it basically let us know that there was not allegations
19 of abuse or neglect.
20 Q. Did DFPS instruct staff not to PN these --
21 these cases, these 11 cases?
22 A. Yes.
23 Q. Why?
24 A. Well, there was -- we had already reviewed
25 them. We knew it was going to be high profile. We

1 knew possibly there would be some kind of litigation,
2 and so we had already reviewed them. And I definitely
3 wanted to protect my staff and them not treat them
4 differently or do something differently after the
5 review had already been completed.
6 Q. Did you instruct your staff not to discuss
7 these 11 cases?
8 A. No, I did not.
9 Q. Why didn't these 11 cases conclude within
10 30 days? Wait. Pause. Let met -- let me -- let me
11 stop -- let me ask that again.
12 Did any of the 11 cases resolve within
13 30 days?
14 A. No.
15 Q. Why not?
16 A. Litigation. We were staying. We couldn't
17 complete some of the investigations. We are on stay.
18 I mean, it was a lot happening.
19 Q. As of today, how many of those 11 cases have
20 been resolved?
21 A. Five. Completely resolved and closed is five.
22 Q. And what was the disposition of those five?
23 A. All five had been ruled out.
24 Q. Are there any -- how many of the 11 are
25 pending closure?

1 A. Well, there's two that we are real close to
2 being able to finish. It's really about documentation
3 and approvals, but two of -- two more should be closed
4 within the next week or two.
5 Q. And what is the recommended disposition of
6 those two that are pending?
7 A. Ruled out.
8 Q. So of the remaining -- what does ruled out
9 mean?
10 A. Ruled out is that we did not find abuse or
11 neglect to the youth.
12 Q. What is the status of the remaining four of
13 the 11 cases involving PHB- -- PBHT?
14 A. Yes. We currently cannot continue with the
15 investigation because of litigation and us being under
16 a stay.
17 Q. And that's because of this PFLAG case and the
18 *Doe* case?
19 A. Correct, yes.
20 Q. But all other place -- cases that you've
21 received involving PBHT have been closed with a finding
22 of ruled out?
23 A. Yes, except for the two that should be.
24 Because when you say "closed," I think it's officially
25 closed. So we have two that should be quickly, yes.

1 Q. Right. Thank you. And -- and you testified
2 earlier that you reviewed them. Can you tell us why
3 that there was a determination made that they -- in the
4 five that were ruled out?
5 A. Yes. So we were able -- well, one of two
6 things seemed to come up as a pattern in these cases.
7 One is that we found that the youth was not on any kind
8 of blockers or hormones, and that was verified either
9 by child, parent, collaterals, kind of a general.
10 But the main ones that we had that was
11 ruled out was because the doctor that is involved with
12 the youth was able to provide us information, and so
13 that doctor provided, like, how long they'd been seeing
14 the child and what were the recommendations and are the
15 parents following the recommendations, and so that
16 doctor that was seeing the child was able to give us
17 enough information that we determined there was not
18 abuse or neglect to that child or youth.
19 Q. Have you reviewed the four cases that are
20 currently stayed?
21 A. Yes.
22 MR. STONE: Your Honor, at this time we
23 would like to raise our Rule 76a because I'm going to
24 ask -- I'm almost done with this witness, but I want to
25 ask about the specific investigations and offer them as

1 exhibits, so we want to take up the 76a issue now.
2 THE COURT: That is fine with me. Now
3 would be a good time. Do you want to take a break?
4 You can step down for a few minutes.
5 And, again, this could take awhile.
6 THE WITNESS: Okay.
7 THE COURT: Let me see the order that is
8 proposed.
9 MS. CORBELLO: Your Honor, so this is the
10 latest one that we have. We just filed a -- sorry. We
11 just filed a -- an amended one to make it cleaner on --
12 online. Essentially, I talked to counsel a little bit
13 about including the words "and testimony" in there, and
14 then counsel pointed out that Poe -- the Poe file
15 wasn't on there previously because it's already been
16 provided to counsel and the Court. I just wanted to
17 make sure that that was encompassed in the order. I'm
18 not sure if that -- that file's going to be used yet,
19 but I don't want it left out.
20 MR. CASTILLO: Just to be clear,
21 Your Honor --
22 THE COURT: Hold on. I'm not there yet.
23 Let me say a couple of things. So I want to go to -- I
24 have been provided with Defendants' 9, Defendants' 10,
25 Defendants' 11, Defendants' 12, Defendants' 13, and

1 Defendants' 25. They have been uploaded into a
2 confidential portion of Box.
3 MR. CASTILLO: I'm...
4 THE COURT: My long experience on the
5 district court bench with CPS and DFPS, in every
6 family, in every civil case that I have ever presided
7 over, excluding Chapter 262 cases, it has been the
8 policy of CPS that they will not produce individual
9 investigatory fi- -- investigatory files to the Court,
10 even if the Court asks nicely, unless the Court orders
11 them to do so.
12 I am not ordering them to do so in this
13 case, but I -- and I do not believe CPS needs me to do
14 so in order to mount a defense of their -- in their --
15 at the claims against them.
16 That said, nevertheless, the defendant is
17 choosing to offer these exhibits, not under 261, under
18 40 Texas Administrative Code, Section 700.203. The
19 Court has reviewed that code and does see that DFPS may
20 release these records. But all it says is that the
21 Courts may re- -- that DFPS may release this record,
22 and the record is still confidential, but they can
23 release the record under Section 8 to a court of
24 competent jurisdiction in a criminal or a civil case
25 arising out of investigation of child abuse and

1 neglect.
2 And so that's where we are. They are
3 choosing to release this file to the -- these multiple
4 files, including some audio investigation testi- --
5 recording that I have never seen them ever release,
6 even in Chapter 262 cases. That's something I've never
7 seen. But I'm -- I've seen that they have released
8 them to me and they have done so and made a decision to
9 do so.
10 So the Court currently has them. The
11 Court has them under that section of the Texas
12 Administrative Code. And they are now moving, I
13 believe -- well, before we do that. So because the
14 Court has those and because it's a civil case, the
15 Court cannot treat those documents as sealed unless we
16 seal them.
17 And so there is a process in Texas state
18 court called Rule 76a, and Rule 76a is about sealing
19 court records. And we are now moving to a temporary
20 request, because that's all the Court can do under
21 Rule 76a, is to temporary -- temporarily seal them.
22 They are some of our most confidential records under
23 state law. They are confidential under multiple
24 different provisions of Texas law, and I think for that
25 reason we get to a pretty simple decision under

1 Rule 76a.
2 That said, before we get there, what
3 we're not doing yet is making a determination about
4 whether they are admissible in this case. That is a
5 whole separate issue that we will get to in a moment.
6 But because they have been provided to the Court and
7 the Court is not involving themselves in a decision by
8 a state agency about whether it is the proper decision
9 under their own policy or even the proper decision
10 under state law, the Court's going to allow this agency
11 to make that decision for themselves.
12 **RULE 76a TEMPORARY SEALING ORDER HEARING**
13 THE COURT: They have chosen to hand me
14 these documents, and having handed me these documents,
15 the Court must treat them as confidential and must now
16 move toward a sealing hearing under 76a. Here we are.
17 I need to make some findings. Is there
18 anything that the plaintiff -- or I see lawyers are
19 standing up. Make your announcements to the Court.
20 MR. KING: Thank you, Your Honor. Sean
21 Patrick -- sorry. Sean Patrick King and Mr. Ian
22 Pittman on behalf of the plaintiffs, Wanda Roe, Amber
23 Briggle, and Adam Briggle. We are the attorneys in the
24 investigations conducted by the Texas Department --
25 THE COURT: Can I ask you a question?

1 MR. KING: -- of Family and Protective
2 Services.
3 THE COURT: Are these open
4 investigations?
5 MR. KING: Yes, they are currently open
6 investigations, and they are ongoing.
7 MR. PITTMAN: Your Honor, actually, the
8 Briggle's case has been closed. The Wanda Roe case is
9 still open, just to clarify. Mr. King was not aware of
10 that.
11 THE COURT: Okay. So Briggle's closed,
12 but I don't think I -- do I have those? I do?
13 MS. CORBELLO: Yes, Your Honor.
14 THE COURT: And Voe is still open.
15 MR. PITTMAN: Roe.
16 THE COURT: Roe? Which ones are -- who
17 do you represent? Say it again.
18 MR. KING: Wanda Roe, R-o-e.
19 THE COURT: Roe, but not Voe?
20 MR. KING: Correct, Your Honor.
21 THE COURT: And not Poe.
22 MR. KING: Correct, Your Honor.
23 THE COURT: Got it. So what do -- yes.
24 MR. KING: Yes, Your Honor. We have
25 filed a motion for protection pursuant to Texas Family

1 Code 261.201(a) essentially arguing that the State
2 should not be able disclose this confidential
3 information because they did not provide us, as
4 interested parties, with proper notice or set that
5 matter for a hearing before the disclosure of that
6 confidential information.
7 Unfortunately, we were unable to file
8 that motion until yesterday because the first
9 notification that we had that the State was introducing
10 this confidential information occurred on the 3rd.
11 THE COURT: You want me to -- you want me
12 to not accept records?
13 MR. KING: Correct, Your Honor.
14 THE COURT: What power do you think that
15 would not be abuse of discretion that a trial court
16 judge has allows me to refuse to accept proper
17 documents handed to me? And moreover what power do you
18 think this court reporter has to not accept documents
19 marked and handed to her as an officer of the court as
20 marked exhibits?
21 MR. KING: Yes, Your Honor. We do
22 believe that 261.201 is very clear that there is a
23 proper procedure that the State needs to follow before
24 the disclosure --
25 THE COURT: Do you think I have power to

1 not take custody of documents handed to me in a trial
2 court?
3 MR. KING: I do believe that the State
4 does have to follow this proper procedure, and they
5 cannot overstep that procedure by directly filing the
6 documents in the -- into a link to --
7 THE COURT: I -- I -- I do not believe I
8 have the power that you think I do. If I did, I would
9 exercise it, but I just don't have that power. This is
10 a trial court, and a trial court has to follow due
11 process. And when people hand me documents, I can't
12 just say no. The ACLU is over here representing
13 plaintiffs, and I want them to tread very carefully
14 with how they expect a trial court to accept or not
15 accept when somebody hands them documents. Can I
16 simply say I'm not touching them; you have to take them
17 back? That's your argument?
18 MR. KING: So I'm going to allow
19 Mr. Pittman to fill in real quick. I believe he --
20 THE COURT: I just want to know, do you
21 have any case, do you have any interpretation of any
22 law anywhere that would support what you're arguing?
23 MR. PITTMAN: Judge, the Court's own
24 rules of procedures relating to exhibits uploaded to
25 Box state that simply uploading the exhibits to Box do

1 not constitute an offer of an exhibit, and if they're
2 not offered, they will be deleted.
3 We're asking the Court to follow its own
4 procedures, and we're asking the Court to order the
5 State to comply with Chapter 261 of the Family Code
6 before the exhibits are even offered to allow the Court
7 to do an in camera review.
8 THE COURT: I just can't do -- I can make
9 an in camera -- I've already made an in camera review.
10 MR. PITTMAN: Correct.
11 THE COURT: So I've done that over the
12 lunch hour. I looked at all these documents already.
13 MR. PITTMAN: And what we're asking the
14 Court to do is to set a hearing that the State should
15 have requested so that the plaintiffs --
16 THE COURT: But I still have the problem
17 on the table right this second, which is they are
18 hanging me documents, and I cannot reject them. I
19 maybe can't admit them on what you're asking this Court
20 to do, but what you're asking goes further than that.
21 You're asking me to simply say I can't even take them.
22 And, one, I already have taken them because they've
23 already been uploaded. And more importantly for my
24 court's sake, she's already taken them, and she has an
25 ethical duty as well to take documents that were sent

1 to her and going to be offered as evidence and to
2 handle them properly under her ethical duties.
3 MR. PITTMAN: And, Judge, my point of
4 clarification is that the same way that the State would
5 provide records to the Court to review under seal
6 before they're offered -- or not under seal, I'm
7 sorry -- for in camera, we're asking the Court to treat
8 these records that are -- that the Court I believe
9 should seal at this moment --
10 THE COURT: I'm going to seal them.
11 MR. PITTMAN: -- and not even allow them
12 to be offered until that 261.201 hearing is conducted.
13 THE COURT: Do you read 261 -- 261
14 already refers to other state law.
15 MR. PITTMAN: Correct.
16 THE COURT: And they are choosing -- in
17 261 -- I know you know this, Mr. Pittman, because you
18 argue this. It's -- it's almost for the respondent
19 parents to receive a copy of the investigation file.
20 MR. PITTMAN: Correct, Your Honor.
21 THE COURT: That is the usual context.
22 MR. PITTMAN: Correct and -- and the
23 respondent parents in this -- well, the plaintiffs in
24 the case have not received -- I -- I am their attorney
25 for their investigation. We have received no notice of

1 this. We have not received the actual investigative
2 files themselves.
3 THE COURT: Well, that is a problem.
4 That's something interesting. If the parents have not
5 received the investigatory file, how do we handle that?
6 MS. CORBELLO: Correct, Your Honor. So
7 two points. First, Mr. Pittman is on the service list,
8 so he received the exhibit list the same time the
9 plaintiffs' counsel did. He also works quite closely
10 with them. The investigatory files have only been
11 provided to the attorneys of record in this case, as
12 we've agreed to them being attorneys' eyes only.
13 Because we are in the middle of --
14 THE COURT: I think if you produce them,
15 they have to go to the plaintiffs themselves. I don't
16 think that's --
17 MS. CORBELLO: Well (crosstalk)
18 stipulation by the Court, Your Honor. We've stipulated
19 that because there's no protective order in place at
20 the moment as to these records, we simply wanted to
21 ensure that there was going to -- ensure the parents
22 cannot share these documents outside of themselves and
23 their spouses and their attorneys.
24 THE COURT: But right now the parents
25 don't even have them.

1 MS. CORBELLO: Correct, Your Honor.
2 Their attorneys have them because the documents have
3 been agreed to as per attorneys' eyes only.
4 MR. PITTMAN: Judge, I've had my notice
5 of representation on file with the Department since
6 March of this year. They are on notice that both the
7 Briggle family and the Roe family have an attorney who
8 is representing them for the purposes of the
9 investigation. They communicated with me in that
10 context. There is no way they are not aware that I am
11 an interested party. They have not provided me notice.
12 And I am not on -- or was not on the service list until
13 yesterday afternoon at 4:45. Over the weekend I was
14 not on the service list.
15 THE COURT: So the question is, if you
16 want to provide these to the Court, do you have to also
17 provide them to the respondent parents?
18 MS. CORBELLO: To the parents themselves,
19 Your Honor? Oh, I mean, DFPS cannot communicate
20 directly with the respondent parents. And the
21 attorneys representing the respondent parents in this
22 case --
23 THE COURT: But I meant to the
24 attorneys -- you hand them to the attorney who can --
25 MS. CORBELLO: Yes, Your Honor.

1 THE COURT: -- hand them to their client.
2 MS. CORBELLO: I cannot hand them to
3 their client.
4 THE COURT: I know. But you're saying
5 they don't get them at all.
6 MS. CORBELLO: No, Your Honor, that is
7 not what I'm saying. I've already spoken with the
8 attorneys for plaintiffs' parents and said we will not
9 be opposed to the parents receiving those documents;
10 however, we would like a protective order in place, as
11 they had wanted one with their pseudonyms, to ensure
12 these documents are properly protected within the
13 parents so they --
14 THE COURT: So you're in agreement that
15 the parents can also receive their own records?
16 MS. CORBELLO: Yes, Your Honor. We just
17 want the assurances of protection.
18 MR. PITTMAN: Judge, the harm that I'm
19 trying to protect my clients from is the even offering
20 of confidential information that 261 sets a gatekeeper
21 function for in camera review before --
22 THE COURT: That's 261 in a Chapter 262
23 case. That's not where we are. We're in a civil
24 proceeding. And I just don't see how you overcome
25 40 Texas Administrative Code 700.203.

1 MR. PITTMAN: I do, Your Honor, because
2 that -- the Court -- or I'm sorry. The Department may
3 release those records to a court of competent
4 jurisdiction in a civil or criminal case arising from
5 an investigation. This is not a civil or criminal case
6 arising from an investigation. This is a civil case
7 arising from allegations of improper rulemaking. This
8 is not the Court either civil or criminally determining
9 whether or not abuse or neglect occurred.
10 THE COURT: Well, I stated on the record
11 that I had doubts about whether they should or could do
12 this, but they are making an offer to this Court of
13 evidence. And so now all I can do is take custody of
14 these under confidentiality and make a sealing order
15 that temporarily seals them, and then we move to
16 whether I can admit them.
17 I understand why you're upset. I
18 understand the problems. I have stated the problems.
19 I have said that I doubt this is a good idea for them
20 to do because, quite honestly, it calls into question
21 every time any one of their investigators or
22 caseworkers has appeared in front of this Court and
23 told me they cannot give me investigation files. It
24 now means that I'm going to just tell them yes, they
25 can, and so -- and I'm going to share that with my

1 criminal colleagues and probably my civil colleagues,
2 too. I think it changes a body of policy that they've
3 built up, in the Travis County courts at least, for the
4 last 20 years.
5 But that said, it's not a way for me not
6 to accept something that somebody is handing me. I've
7 already -- my court reporter's already taken custody of
8 it. I've already taken custody of it, so I have to
9 overrule if this is an objection. We just can't do --
10 we don't have the power to do what you are asking.
11 MR. PITTMAN: And, Judge, what I am
12 trying to do is, for the purposes of the record,
13 requesting the Court to seal those records, not allow
14 them to be offered until after the 261.201 hearing
15 occurs --
16 THE COURT: I can't stop them from being
17 offered. I am going to seal them. That's all I can
18 do.
19 MR. PITTMAN: Thank you, Judge.
20 THE COURT: Thank you. Do the plaintiffs
21 want to say anything?
22 MR. CASTILLO: No, Your Honor.
23 MS. CORBELLO: Your Honor, if I could
24 just ask one clarifying question.
25 THE COURT: Yes.

1 MS. CORBELLO: Is the Court making a
2 finding today that DFPS is waiving any sort of
3 protection under any of the relevant statutes?
4 THE COURT: No, I don't think so. I -- I
5 just -- I want you to understand every family case
6 that's not a 262 case, every civil case where -- that's
7 not a 262 case, the answer has always been from DFPS
8 that they don't do this unless I order them to. And I
9 do understand why this is different. I'm not making a
10 finding. I couldn't making a finding. I think you're
11 aware of that. Everybody's aware of that.
12 I'm worried about the precedent that this
13 sets from their office, and so I just wanted to make
14 sure because I think it could be troubling for them in
15 other cases that this has now been done. But I
16 can't -- nothing that we're doing here controls cases
17 in the future, and I'm not making a finding that we
18 are.
19 MS. CORBELLO: Thank you, Your Honor.
20 MR. CASTILLO: Your Honor, I just wanted
21 to make clear the last -- that that includes plaintiff
22 Poe also as well because --
23 THE COURT: Yeah. We're going to go
24 through it now. Now we're going to get to the actual
25 sealing because the Court has to make some findings,

1 and we have to actually set a hearing, and there's
2 members of the media here. And usually no media cares
3 enough in a 76a case to object, but the whole purpose
4 of Rule 76a is to post that we're going to seal records
5 and to allow anyone to object to that and to be heard
6 when we set the hearing on the sealing order.
7 Now, you're going to have to do two
8 things. I think you know this. You've got to post
9 both with the clerk's office and you've got to post
10 with the Supreme Court of Texas. You understand that?
11 MS. CORBELLO: Yes, Your Honor.
12 THE COURT: When are you going to set
13 this Rule 76a sealing order hearing?
14 MS. CORBELLO: Your Honor, my
15 understanding is, you know, we -- we need 14 days under
16 the statute in order to do the proper notice, so I
17 guess that puts us at end of July, early August. If I
18 had a preference, it would be early August, because I'm
19 trying to take my children on a quick vacation at the
20 end of July, but we can make whatever the Court needs.
21 **COURT'S RULING**
22 THE COURT: Well, first I think I need to
23 say that I believe, and I stated this, that all of the
24 different confidentiality concerns regarding juveniles
25 and regarding minors are at play here, so I do believe

1 that that's a specific serious and substantial interest
2 which clearly outweighs the presumption of openness and
3 any probable adverse effect that sealing will have upon
4 the general public. Any -- and I also make the finding
5 that any probable adverse effect that sealing would
6 have upon the general public health and safety is also
7 outweighed by this specific serious and substantial
8 threat. And so just to make the temporary sealing
9 order, I think I need to do that.
10 And then what we're doing is -- I stated
11 the exhibits from the beginning. And I said -- and I
12 want to make sure we're clear on the exhibits. It is
13 9, 10, 11, 12, 13, and 25.
14 MS. CORBELLO: That's correct,
15 Your Honor. Those are the TI exhibits.
16 THE COURT: And those are the current
17 unadmitted exhibits that are presented to the Court and
18 that the Court has reviewed -- reviewed in camera and
19 that the Court believes are highly confidential and, in
20 fact, it might be a violation of state law for the
21 Court not to seal them and to do anything other than
22 treat them with the utmost confidentiality. Those are
23 the matters that the Court is sealing temporarily and
24 that we will have a hearing about in?
25 MS. CORBELLO: Whenever the first few

1 weeks of July -- of August this Court is available.
2 THE COURT: The week of August 1st. We
3 can do this hearing by virtual. 2:00 p.m. on Wednesday
4 the 3rd?
5 MS. CORBELLO: Yes, Your Honor.
6 MR. CASTILLO: Yes, Your Honor.
7 THE COURT: We'll set this 76a hearing at
8 2:00 p.m. on August the 3rd.
9 Mr. Pittman, Mr. King, you will be here
10 for that hearing?
11 MR. PITTMAN: And that's virtual,
12 Your Honor?
13 THE COURT: Yes.
14 MR. PITTMAN: Yes, we will -- we will be
15 here.
16 THE COURT: And the posting will say
17 anybody who wants to object, anybody who wants to state
18 their objection can be here, but I hope they heard the
19 Court when the Court said that I think as a matter of
20 law, I, my court reporter, the Department, the
21 plaintiffs, the clerk's office, everyone has the utmost
22 duty to keep these confidential. So the Court has them
23 right now as confidential records and takes possession
24 of them as such.
25 I have an order that has been presented

1 to me that temporarily grants defendants' motion to
2 seal DFPS investigatory records. Have you had a chance
3 to review this?
4 MR. CASTILLO: The order? Yes.
5 THE COURT: We've added the DFPS Poe
6 investigation file. I don't know if that's one of the
7 exhibits. Is it?
8 MS. CORBELLO: It's Exhibit 25,
9 Your Honor.
10 MR. CASTILLO: Your Honor, I'm not sure
11 if defendants' appeal would have any impact on the
12 hearing that is set, but...
13 THE COURT: Well, let's go off the record
14 for a second.
15 *(Off the record.)*
16 THE COURT: The Court has granted a
17 temporary sealing order. The Court has amended the
18 order that was presented to the Court. And I'm going
19 to show it back to both parties before we file it
20 because I have a little -- I want y'all to look at what
21 I'm doing as well. The only thing we're not making
22 part of it at this time and I'm not accepting at this
23 time is -- is Line 6, which was some sort of amended
24 response. And I just don't understand what exactly the
25 defendants want to do, and I think they just need to

1 have a little more clarity.
2 If they're going to file a document, they
3 need to file a document. And if they want to -- parts
4 of that under seal, the way they do it is they file it
5 without that portion as part of the document, and then
6 they ask the Court in a future order for a temporary
7 sealing order to also seal that portion.
8 And then I think what you need do on
9 No. 7 is we said 7 is Exhibits 6 to 8 to the original
10 response, and the Court is including that as part of
11 the temporary sealing order, but I want you to file a
12 separate motion so the clerk doesn't have any confusion
13 about what those documents are. And so it will be
14 something like motion for clerk to accept documents
15 under Court's sealing order signed on 7-6-2022.
16 MS. CORBELLO: Understood, Your Honor.
17 THE COURT: And then we will sign this in
18 a minute, and we'll talk about that in a minute. So
19 that is just -- the Court has now confidentially
20 accepted those exhibits. And where do you want to go
21 next?
22 MR. STONE: Your Honor, defendants move
23 to admit Exhibits 9, 10, 11, 12, 13, and 25.
24 MR. COOK: We object, Your Honor.
25 THE COURT: State all the reasons.

1 MR. COOK: With respect --
2 THE REPORTER: Can you stand at the
3 podium so I can hear you better?
4 THE COURT: Maybe take your mask off.
5 MR. COOK: Your Honor, we object that the
6 reports are hearsay, the investigation files are
7 hearsay.
8 MR. STONE: Your Honor, subject to
9 Rule 803.6 they are subject to a hearsay exception
10 because they are business records.
11 THE COURT: That allows you to admit
12 portions of the exhibits, but it does not allow you to
13 admit all the hearsay. The documents as you have
14 currently presented to the Court are full of hearsay,
15 double hearsay, sometimes even triple hearsay, so the
16 hearsay objection is sustained as to all of the
17 exhibits.
18 If you wanted to, if you had time -- I
19 don't think you do -- but -- but the only thing -- and
20 this has actually happened -- I actually conferred with
21 people on this today. The only thing I think you could
22 admit is, like, the most basic kind of non-hearsay
23 portions, and the Court could admit that. But just to
24 move this along, I believe quite strongly that they are
25 all hearsay, double hearsay, and triple hearsay, and so

1 the Court's sustaining that objection.
2 So while you could offer them if they
3 were redacted appropriately as business records, they
4 aren't currently redacted appropriately, and so all the
5 Court can do is deny their admission.
6 **DIRECT EXAMINATION CONTINUED**
7 BY MR. STONE:
8 Q. Ms. Talbert, you testified that you -- you
9 reviewed the -- you reviewed the cases that are
10 currently -- the -- the cases that are currently stayed
11 by the TRO in this PFLAG case?
12 A. Yes, that's correct.
13 Q. Okay. After having reviewed those files, how
14 would you describe the conduct of the caseworkers in
15 conducting the investigation?
16 MR. COOK: Objection, Your Honor.
17 MR. STONE: Your Honor, before I -- I'm
18 going to only ask general questions, but before I even
19 go down that path, we may need to clear the courtroom
20 if I'm going to be asking about these specific cases,
21 although I'm only going to ask about her review of the
22 caseworkers and whether their -- any of their conduct
23 was inappropriate.
24 THE COURT: On what authority can the
25 Court clear a courtroom?

1 MR. STONE: Your Honor, just in case that
2 we start -- we discuss any of the sealed information.
3 THE COURT: Oh, I -- I have a problem
4 with it, too, but I'm just asking you, on what
5 authority can the Court clear a public courtroom that
6 the taxpayers pay for and that people have a right to
7 sit in a courtroom? I'm asking. I'm -- I'm not
8 being -- believe me, I'm asking you, do you have any
9 authority for the Court to clear a courtroom?
10 MR. STONE: Your Honor, it's -- it is --
11 this absolutely -- I don't have a cite in front of me,
12 but it is routine. It absolutely does happen where
13 testimony is given that is confidential and under seal,
14 and there are instances where --
15 THE COURT: In a family court case there
16 is a specific part of the Family Code provision that
17 allows if all parties agree and the Court agrees, it
18 does allow the Court to ask anybody who is not
19 specifically at issue as part of the case to leave the
20 courtroom. I know of no such civil analog.
21 MS. CORBELLO: Well, the records in this
22 case are sealed or will be sealed pursuant to an order.
23 I've haven't been a part of this before --
24 THE COURT: They are currently sealed.
25 MS. CORBELLO: -- but I don't know how

1 the Court normally deals with a record that's been
2 sealed that someone is then testifying.
3 THE COURT: The Court doesn't seal the
4 courtroom. That's how the Court has always ever dealt
5 with it. So if we're going to -- I mean, the issue is
6 going to be if the Department wants to ask questions
7 that they have a legal responsibility to keep
8 confidential, I don't -- I don't know how we handle
9 this. We're at an impasse because we do sit as a
10 public court of law in a public courtroom, and I'm
11 asking you for any authority anywhere to seal it.
12 MS. CORBELLO: Well, I believe Rule 76
13 allows for the sealing of court records --
14 THE COURT: It does.
15 MS. CORBELLO: -- which includes
16 testimony.
17 THE COURT: No, it does not. In fact, I
18 think it specifically -- specifically doesn't include
19 that. And you've hit on something that's actually
20 quite debated amongst my colleagues and has been for
21 about 15 years, but I don't -- that's the problem with
22 this. It's very, very difficult territory. I'm not
23 trying to be difficult. It's difficult, which is why
24 what you're attempting to do is so hard and probably
25 why you've never done it before.

1 MS. CORBELLO: Your Honor, I don't see
2 any mention of testimony in this rule, and it -- it
3 specifically references court records, which I -- I
4 mean, testimony is a court record.
5 THE COURT: Let's read the Open Courts
6 Provision of the Texas Constitution. I'm going to find
7 it.
8 MS. CORBELLO: This doesn't happen in
9 federal court.
10 THE COURT: It doesn't happen in federal
11 court. They don't have this same problem. I agree
12 with you.
13 The Texas Constitution's Open Courts
14 provision ensures that litigants receive their day in
15 court. The Open Courts provision of the Texas
16 Constitution provides that all courts shall be open and
17 every person for injury done to him and his lands,
18 goods, person, or reputation shall have remedy by due
19 course of law. The Texas Supreme Court has held -- it
20 gets very hard. I'm having to look at a whole bunch of
21 case law at one time.
22 MR. STONE: Yes, Your --
23 THE COURT: Hold on one second.
24 MR. PITTMAN: Your Honor, may I approach
25 with the Family Code, the annotated Family Code? I

1 think there's a --
2 THE COURT: Well, there is a portion of
3 the Family Code and I would -- if you have it.
4 MR. PITTMAN: It's -- it's the Rules of
5 Procedure attached to the annotated Family Code, and
6 there's a Texas Supreme Court case directly on point
7 that says that Rule 76a does not exclude oral
8 testimony.
9 MS. CORBELLO: I have to look at it,
10 Your Honor. I haven't found them yet.
11 MR. PITTMAN: *In re M-I LLC*.
12 THE COURT: I believe that's right.
13 MR. PITTMAN: The very first annotation.
14 THE REPORTER: What case did he say?
15 MR. KING: *In re M-I LLC*.
16 THE REPORTER: Thank you.
17 THE COURT: Yes. I think that's right.
18 I'm going to show you this, too, but I -- I want to be
19 clear on this because -- I'm not trying to be
20 difficult, but we do have members of the media here, we
21 have members of the public here who care about this
22 case, and I just have a duty, and I take it seriously,
23 to follow the Constitution, and I'm not trying to be
24 difficult for the sake of being difficult.
25 MS. CORBELLO: We don't think you are,

1 Your Honor.
2 MR. STONE: We understand, Your Honor.
3 THE COURT: I -- I -- I do think there is
4 this case, though, and it was the one that I was trying
5 to think of, that oral testimony is not a court record.
6 And I will tell you, not because I'm being difficult,
7 my -- my previous experience with this issue is there
8 isn't the interest that there is -- that there is in
9 this particular case, but I have never asked people to
10 leave a public courtroom except under the Family Code
11 exception that allows us to do so under the Family
12 Code.
13 MR. STONE: Yes, Your Honor. We
14 understand, and I'll wrap up.
15 Q. (BY MR. STONE) You've reviewed the 11 cases
16 that we've been discussing, correct?
17 A. That is correct.
18 Q. Okay. And having reviewed them, do you have
19 an opinion as to whether or not the investigations were
20 conducted appropriately?
21 MR. COOK: Objection, Your Honor;
22 she's -- she doesn't have the foundation to establish,
23 like, what the conduct of the caseworkers were.
24 THE COURT: Overruled.
25 A. Yes. Overall, yes. The policy procedures

1 were followed as best as they could through the
2 circumstance.
3 MR. STONE: Thank you. Pass the witness,
4 Your Honor.
5 THE COURT: Let's just take a five-minute
6 break just so I can get a brief breather and you can
7 get a breather as well, and then we're going to go
8 obviously after 5:00, but let's just take a break. And
9 you have enough time, but we'll come back and do
10 cross-examination.
11 MR. COOK: Okay.
12 THE COURT: Thank you.
13 *(Recess was taken.)*
14 THE COURT: You may begin your
15 cross-examination.
16 **CROSS-EXAMINATION**
17 BY MR. COOK:
18 Q. Good afternoon, Ms. Talbert. Currey Cook for
19 the plaintiffs. You testified on direct that the
20 11 cases where there were allegations that the minor
21 was being provided healthcare, gender-affirming
22 healthcare, that those were all treated as category --
23 or Priority 2 cases; is that right?
24 MR. STONE: Objection, Your Honor.
25 A. That is correct.

1 MR. STONE: Objection, Your Honor;
2 misstates prior testimony.
3 THE COURT: Overruled.
4 A. That is correct.
5 Q. (BY MR. COOK) And that categorization of
6 those types of reports that you testified to, that was
7 not in place prior to February 22nd; is that right?
8 A. Oh, no. We've always had P2s.
9 Q. But the categorization of those particular
10 types of allegations that a minor was receiving
11 gender-affirming healthcare as Category 2 -- as
12 Priority 2, excuse me, that was not in place prior to
13 February 22nd for that type of allegation; is that
14 right?
15 A. And I may not be answering it, so you tell
16 me if I -- we have always had P2s. We've always had
17 physical abuse allegations. So there was no new
18 allegation or no new type of investigation, no policy
19 change. It was just -- we haven't implemented anything
20 new or different.
21 Q. But you testified that -- on direct that where
22 there are allegations of gender-affirming healthcare
23 provided to a minor, that those were category -- would
24 be treated as Priority 2?
25 MR. STONE: Objection, Your Honor;

1 misstates prior testimony, specifically the phrase he's
2 using for gender-affirming healthcare. We use the term
3 PBHT.
4 THE COURT: Sustained. I think you need
5 to ask a more specific question.
6 Q. (BY MR. COOK) Ms. Talbert, for the -- the
7 types of cases where there are allegations that the
8 minor was receiving PBHT, those were categorically
9 treated as Priority 2 by DFPS; is that right?
10 A. That is correct.
11 Q. Okay. Prior to February 22nd, 2022, were
12 cases where there was an allegation of PBHT being
13 provided to minors categorized as P2 automatic?
14 A. I don't know that because, you know, there's
15 about 240,000 investigations a year, so I cannot
16 confirm that none of those cases were not about a child
17 receiving some kind of medical treatment.
18 Q. And you're the statewide supervisor of
19 investigations; is that right?
20 A. No. I'm the director of field for
21 investigations.
22 Q. Okay. And you've been at the agency for over
23 a year?
24 A. Over -- over -- almost 25 years.
25 Q. And given the volume of cases that come in for

1 investigation, you can't possibly be involved in each
2 and every one of those cases; is that right?
3 A. That's correct.
4 Q. And prior to February 22nd, you had not been
5 personally involved in any cases where there were
6 allegations of PBHT being provided to minors; is that
7 true?
8 A. That is correct.
9 MR. COOK: No other questions,
10 Your Honor.
11 THE COURT: Anything else?
12 MR. STONE: Yeah. Just -- yes,
13 Your Honor, just one thing. We'd like to offer
14 Exhibit 27. I'm --
15 MS. CORBELLO: It's 31.
16 MR. STONE: It's 31?
17 MS. CORBELLO: Yes.
18 MR. STONE: What we're planning on
19 marking as Exhibit 31.
20 THE COURT: And have you uploaded it to
21 the Box?
22 MS. CORBELLO: Yes, Your Honor.
23 MR. STONE: Yes, Your Honor. This is a
24 business records affidavit for the exhibits that the
25 Court did not admit because of hearsay. But I just

1 wanted to make sure that we have a business records
2 affidavit actually in the record, because in looking
3 back at the files, I saw that there wasn't actually one
4 attached.
5 MR. COOK: Objection, Your Honor; that
6 wasn't provided at the time that these were offered.
7 THE COURT: Isn't there a requirement --
8 maybe there's not -- about when you have to provide
9 those before the hearing?
10 MR. STONE: No, Your Honor. Also, this
11 is specifically in response to the objection that they
12 made, so the -- we're just authenticating these.
13 THE COURT: And -- and she testified,
14 my -- my -- I -- I want to be clear. You -- you clear
15 the business record hearsay objection.
16 MR. STONE: Ah. Okay.
17 THE COURT: What you don't clear is the
18 double and triple hearsay contained in the exhibit. If
19 you had a very redacted version, it'd be very -- it'd
20 have to be very redacted. I -- I don't want to
21 misrepresent what I am saying to what I think would
22 exclude it from -- would exempt it from the double and
23 the triple hearsay, but I just want to be clear for the
24 record, I do believe it meets and her testimony met,
25 without this affidavit, a business record, but because

1 you don't have redacted versions, I cannot admit them.
2 They're not ready. And so currently they are denied
3 admissibility.
4 MR. STONE: Yes, Your Honor. We
5 understand that's the reason why they were denied.
6 We're just trying to protect the record, if it goes up
7 on appeal by either side, by making sure that we did --
8 we do include a -- a business records affidavit. In
9 the alternative, I could --
10 THE COURT: But she also testified. I
11 don't -- I mean, I don't -- about it, right?
12 MR. STONE: Well, she testified generally
13 about them. Again, I -- I recognize, Your Honor, that
14 you accept them as business records and -- and we
15 really appreciate that, but just for the purposes if
16 this case were to go up on appeal, the -- in the
17 alternative, we could supplement the exhibits that we
18 submitted and just add this in.
19 THE COURT: I don't really -- I mean, at
20 this point -- I mean, it's -- it's hearsay. It's an
21 affidavit. Do you have an objection?
22 MR. COOK: Yes, Your Honor.
23 THE COURT: What does matter if we admit
24 this at this point?
25 MR. COOK: We do have a -- just to state

1 for the record, we do have a general objection of
2 whether these investigation files meet the business
3 record exception, so I just want to lodge that.
4 THE COURT: Okay. Well, I would -- that
5 is overruled, but, again, the double/triple hearsay
6 problem and the problem that the records aren't
7 adequately redacted to correct that problem, the Court
8 maintains.
9 In terms of business records, I do
10 believe they could qualify as business records if they
11 were properly redacted and they could be admitted, but
12 they aren't properly redacted and we're here and
13 they -- there's too much hearsay in them for the Court
14 to admit them. They're double hearsay, triple hearsay.
15 It's just plain hearsay, under any understanding of
16 basic evidence rules, and so for that reason the
17 Court's not admitting them. I will go ahead and admit
18 this exhibit, though.
19 MR. STONE: Thank you, Your Honor.
20 THE COURT: It's hereby admitted.
21 THE REPORTER: It's 31?
22 MS. CORBELLO: 31, yes.
23 *(Plaintiffs' Exhibit 31 admitted.)*
24 THE REPORTER: Thanks.
25 MR. STONE: No further questions for this

1 witness. Thank you, Your Honor.
2 THE COURT: Anything else?
3 MR. COOK: No.
4 THE COURT: You can step down. So we
5 will have closing argument now, I think. Do you rest,
6 defendants?
7 MR. STONE: Yes, Your Honor. At this
8 time defendants rest.
9 THE COURT: And do plaintiffs fully rest
10 as well?
11 MR. COOK: Yes, Your Honor.
12 THE COURT: All right. Let's have
13 closing argument.
14 MR. GONZALEZ-PAGAN: Your Honor, can we
15 have a time check?
16 THE COURT: I don't think you need more
17 than 15 minutes for closing argument.
18 MR. GONZALEZ-PAGAN: Okay.
19 THE COURT: I would like to see, though,
20 if you have a draft order that you're asking the Court
21 to sign. I'm just telling you right now, though, I
22 don't think I'm going to sign off on anything today or
23 rule from the bench. I'm going to take this under
24 advisement. That's my current plan.
25 I know your TRO stays in effect through

1 Friday, and so I have a couple of days to decide what
2 I'm going to do. But I would like to see a proposed
3 version if you have one. Understand that currently
4 right now in my email queue are like 30 unopened
5 emails.
6 *(Off the record.)*
7 THE COURT: All right. Thank you. You
8 may proceed, Mr. Castillo.
9 **CLOSING ARGUMENT BY MR. CASTILLO**
10 MR. CASTILLO: Thank you, Your Honor, and
11 may it please the Court. The application for temporary
12 injunction that the Court heard today I will start off
13 where I started today; that is that the Department
14 of -- DFPS and its Commissioner has acted and continues
15 to act unlawfully violating both substantive and
16 procedural APA rules in establishing a new presumption
17 of abuse by parents with trans young people triggering
18 investigations based solely on that care and
19 prioritizing in an unprecedented way.
20 The plaintiffs have shown a cause of
21 action probable right of recovery as to those claims.
22 Specifically, with respect to the cases -- rather, with
23 respect to the testimony that this Court heard today,
24 ultimately, Your Honor, for the purposes of the relief
25 sought, this Court does not have to manage a battle of

1 experts because, taking a step back, at most what the
2 State has shown is that medical treatment for gender
3 dysphoria has side effects and some providers disagree
4 with the current protocols governing treatment. And
5 they have argued that there are providers who do not
6 meet the current guidelines; however, no other course
7 of medical care has been targeted such that they are
8 presumptively investigated which in and of itself
9 causes the harm.
10 There's no disagreement that after
11 February 22nd every single one of the cases that was
12 cited by defendants' witness has -- has been forwarded
13 from intake, not allowed to close those, receded any
14 discretion and forwarded automatically for review for
15 every single one of these cases, but that is true with
16 respect -- but that is untrue with respect to any other
17 course of care.
18 What the State is seeking to do is to
19 interfere with the rights of parents to make
20 fundamental decisions about the care for their children
21 and in consultation with doctors and, without more,
22 have every one of those parents be subject to an
23 investigation.
24 To be clear, this is not about any single
25 investigation. All of these investigations have caused

1 harm that is imminent and irreparable as provided by
2 the testimony particularly of Wanda Roe and Mirabel Voe
3 as to what their experiences have been based solely on,
4 again, the investigation being an -- an unlawful role
5 that opens every single one of these cases without
6 more.
7 THE COURT: Question. Roe, Voe, and
8 Briggle, are all three of those investigation files
9 still open?
10 MR. CASTILLO: Briggle is closed.
11 THE COURT: And so are you seeking any
12 relief on behalf -- any temporary injunctive relief on
13 behalf of the Briggle family today?
14 MR. CASTILLO: We are, Your Honor.
15 THE COURT: And explain that argument to
16 the Court.
17 MR. CASTILLO: With respect to the
18 testimony that was provided today, they've indicated
19 that the same allegation would not be opened, but based
20 on the way the allegation provided could circumvent and
21 expose the Briggles to a different allegation,
22 particularly as we don't know how long this temporary
23 injunction or trial, particularly if it is appealed,
24 will last.
25 If allegations that deviate from DFPS' --

1 if allegations come into DFPS with respect to the
2 Briggles, they don't -- they never testified today that
3 that exhumes *{phonetic}* them from further
4 investigations. So, again, the scope of relief is
5 narrow --
6 THE COURT: Isn't that what PFLAG is
7 there to do as your plaintiff, to stand in the shoes of
8 investigations on behalf -- well, you state it for me.
9 Maybe you need to tell me what PFLAG is there to do and
10 why if -- if the Court were to grant an injunction on
11 behalf of PFLAG, why you would also need a specific
12 injunction on behalf of the Briggles.
13 MR. CASTILLO: Your -- your point is well
14 taken. Absolutely, Your Honor, PFLAG represents the
15 members of -- its members that -- across the state of
16 Texas, and the Briggles are indeed a member of PFLAG,
17 so they would be -- they would be protected under an
18 order with respect to PFLAG and all of its members and
19 families.
20 Commissioner Masters and DFPS implemented
21 a new rule expanding the definition of child abuse to
22 include gender-affirming care. The rule
23 operationalized Governor Abbott's February 22nd letter
24 to Commissioner Masters, particularly with respect to
25 the lack of medical necessity, and Attorney General

1 Paxton's opinion, which annou- -- which DFPS has
2 announced the statement. I will also offer for the
3 Court the fact that this is the same rule that is at
4 issue in *Doe vs. Abbott*.
5 THE COURT: Let me ask you a question
6 about *Doe vs. Abbott* and if you're seeking an
7 injunction against the Governor, because the Supreme
8 Court basically -- my interpretation of the Supreme
9 Court's opinion was that Governor Abbott doesn't have
10 any power here, and so we're not going to grant an
11 injunction against him -- or we're not going to affirm
12 the injunction against him because he can't do anything
13 anyway.
14 So would that not apply -- since you're
15 saying it's the same issues, does that not apply to the
16 Court in this case as well? How could I grant an
17 injunction against the Governor when the Supreme Court
18 has already said he has no power to do anything and his
19 directive, in fact, wasn't one, that it didn't have any
20 legal effect?
21 MR. CASTILLO: To be clear, Your Honor,
22 the application for temporary injunction was only as to
23 the Commissioner and to DFPS. We are not seeking a
24 T -- a temporary injunction as to the Governor for that
25 very reason.

1 So with respect to, again, Commissioner
2 Masters and the Department, DFPS, the rule was adopted
3 without following the necessary procedures of the APA.
4 It's contrary to the enabling statute. It's beyond the
5 authority provided to the Commissioner and to DFPS and
6 is otherwise contrary to law. Put simply, this --
7 these -- an injunction is necessary to prevent imminent
8 and immediate harm that has been caused and will be
9 caused absent an injunction. The status quo is clear
10 that DFPS was not pursuing these cases as presumptively
11 investigatory prior to February 22nd without any
12 additional allegations.
13 With respect to the imminent harm, we
14 have the testimony of Roe and Voe regarding how the
15 investigations alone have impacted their families, how
16 it has created chaos. And, again, the defendants'
17 theory of the case is that it's no different than any
18 other investigation and they should be able to come to
19 that conclusion. That presumes that the law has been
20 followed from the outset as to whether or not the case
21 was accepted for investigation. Here that is not the
22 case.
23 Plaintiffs have proved imminent and
24 irreparable harm that traces to the DFPS unlawful
25 actions. The claims before the Court is ripe. We

1 would request that this Court grant temporary
2 injunctive relief. We have clearly established through
3 the testimony, the evidence, and the information in the
4 petition that we have demonstrated a probability of
5 success as to the right of relief and to -- as to the
6 irreparable harm.
7 So to be clear, plaintiffs are asking for
8 Commissioner Masters and the Department of Family and
9 Protective Services to be enjoined from enforcing the
10 DFPS rule and from implementing the Governor Abbott's
11 directive and Attorney General's opinion with regard to
12 the plaintiff families and members of PFLAG and then
13 such restraint encompasses but not limited to any
14 allegation -- any investigation, rather, for plaintiff
15 families and members of PFLAG for possible child abuse
16 or neglect solely based on al- -- solely -- and I want
17 to emphasis that -- solely based on allegations that
18 they have a minor child who is transgender, gender
19 nonconforming, gender transitioning, or receiving or
20 being prescribed medical treatment for gender dysphoria
21 or taking any actions against plaintiff families and
22 other members of PFLAG solely based on allegations that
23 they have had -- they have a child who is transgender,
24 gender nonconforming, gender transitioning, or re- --
25 receiving or being prescribed.

1 THE COURT: Be careful when you're
2 reading. It's late in the day.
3 MR. CASTILLO: Thank you. And --
4 THE COURT: So the defendants seem to
5 argue that there is a difference -- I'm going to hear
6 from them in a minute, but that their -- that their
7 trigger is puberty blockers, hormone therapy, and it's
8 not simply supporting a transgender child. And -- and
9 I want to know if you have a response to that, because
10 I feel like that's where they have spent some of the
11 day, that that's the -- that to them is their
12 investigation point rather than the investigation point
13 of just an intake for a child being transgender but
14 more an intake for a child being on PBHT. And do you
15 have a response to that or how we would address that or
16 if that should be addressed at all in any injunction
17 that the Court may grant?
18 MR. CASTILLO: Well, I would say,
19 Your Honor, to be -- if that is their contention, then
20 they should have no problem with respect to -- if
21 they're limiting the scope --
22 THE COURT: Well, I don't know if they
23 are or they aren't. We'll ask them that in a minute.
24 MR. CASTILLO: Right.
25 THE COURT: But there seemed to be

1 something about that distinction that they were
2 arguing.
3 MR. CASTILLO: Yeah. So we are aware,
4 for example, that the Poes' family investigation is
5 open and that, you know, they have been provided
6 information that there is -- a child has not received
7 any gender-affirming care as they term PBHT.
8 MR. STONE: PBHT.
9 THE COURT: Did I say it wrong?
10 MR. STONE: No, Your Honor.
11 THE COURT: Oh.
12 MR. STONE: You said it correctly.
13 THE COURT: Okay. All right.
14 MR. CASTILLO: And with respect -- and --
15 and so if -- if -- you know, this -- you know, with
16 respect to that portion of the proport- -- that part of
17 the proposed order, if that is their contention, then,
18 you know, it -- it causes no harm on the balance of the
19 equities.
20 With respect to PBHT, the -- what they
21 have -- have stated is that they're presumptively
22 treating every single case as being able to be
23 investigated, thereby passing -- thereby bypassing, not
24 being able to have the discretion to close the case at
25 intake without being forwarded to the investigation

1 staff for further inquiry.
2 THE COURT: So a couple of things,
3 because what you're asking for is a restraining order
4 and not a mandamus. And so what is it that you want to
5 restrain, you know, and injunc- -- enjoin them from
6 doing, because you currently have two clients, the
7 implication being -- and it -- it certainly wasn't -- I
8 understand they didn't testify to this, but there was
9 some implication that what was keeping them from
10 closing those files was this case and that somehow this
11 case was keeping them from getting that -- those
12 families to resolution.
13 And so if I grant an injunction, doesn't
14 that potentially harm your clients rather than help
15 them? And that -- I can't order it be closed. I order
16 them almost to stay permanently in purgatory. I --
17 I -- I just -- I mean, if you were arguing for a
18 mandamus to have a -- a state employee not commit
19 ultra vires or saying something they were doing is
20 ultra vires, I think this Court might have the power to
21 order them to do something. But since the relief you
22 are seeking at this time is sort of an ongoing
23 injunction, does that not harm your clients, not help
24 them?
25 MR. CASTILLO: It's my understanding

1 that, you know, based on the information that I have
2 and have seen, that it was not a simple matter of
3 administrative -- administratively closing or whatever
4 the process they were going to take to close. There
5 was further activity that is being requested of the
6 plaintiffs in order to check off the boxes.
7 THE COURT: Well, the testimony I
8 heard -- and maybe you -- I -- I -- correct me if I
9 missed something from your client's testimony in the
10 record, was that there is any sort of current
11 investigation, they are -- they are currently being
12 called by the Department, you know, asked to provide
13 additional information from the Department, that that
14 would be a violation of a court order, I think, and a
15 court order that they agreed to.
16 So -- so what is currently happening --
17 what is the evidence of harm that is currently
18 happening? And I'm wrestling with this. I'm really
19 wrestling with this. I mean, if we're really here --
20 and I think I'm really here, and I know that genuinely
21 you're really here, to try and make an order that is
22 equitable and consider what is harming -- or not
23 harming -- irreparable harm to this family, how do we
24 answer that question? Like, how do we -- how do you
25 possibly -- how do I possibly draft an order that

1 allows them to get to resolution rather than makes them
2 stay in this permanent place of an unknown?
3 MR. CASTILLO: So the proposed order has
4 sort of two specific areas. One is investigations, and
5 the second is with respect to actions, in addition to
6 the overall, you know, enjoining.
7 With respect to actions here, you know,
8 to the extent that they are seeking to rule out the
9 allegations or otherwise administratively close them --
10 well, and I'll just say, to the extent that they're
11 seeking to rule out, if that's -- if that's their
12 course of action, such that there's no repercussions
13 for the families, there might be a carve-out there such
14 that the families -- you know, if it doesn't require
15 further, you know, cont- --
16 THE COURT: So I guess the TI you would
17 be seeking would be eliminating the need for the Roe
18 family and the Voe family to respond to any more
19 inquiries, but it wouldn't be enjoining the Department
20 from ruling out if they chose to do so. You'll respond
21 to this in a minute.
22 I'm just trying to understand from them
23 what they're seeking.
24 MR. CASTILLO: That's correct,
25 Your Honor, in addition to presumptively opening the

1 investigations at intake.
2 THE COURT: And that would be the -- the
3 PFLAG plaintiff would be that --
4 MR. CASTILLO: Right.
5 THE COURT: -- party, right?
6 MR. CASTILLO: That's correct.
7 THE COURT: Am I missing something?
8 MR. CASTILLO: No. That's -- that's
9 correct.
10 THE COURT: All right. Finish up. Thank
11 you for answering my questions. If there's anything
12 else you want to say? And I can leave you a couple of
13 minutes for additional rebuttal time at the end.
14 MR. CASTILLO: Given -- in the interest
15 of time, Your Honor, we'll pass it on to defendants'
16 counsel.
17 **CLOSING ARGUMENT BY MS. CORBELLO**
18 MS. CORBELLO: Your Honor, first, this
19 has been provided for in our TI response, but I'd like
20 to reiterate it here on the record. This Court lacks
21 jurisdiction over plaintiffs' claims, which is the
22 first reason why they will not succeed in this case.
23 There are ripeness issues, standing issues,
24 associational standing issues, improper ultra vires
25 claims that don't waive sovereign immunity. These are

1 all jurisdictional issues that plaintiffs haven't
2 overcome today.
3 Secondly, we've provided the Court with
4 the evidence to make the two necessary determinations
5 that I told you at the beginning of this hearing would
6 need to be made. First, the Court's received evidence
7 and heard testimony that it is not always safe to give
8 a child PBHTs. Even plaintiffs' own expert, Dr. Brady,
9 stated that she would not give a child PBHTs without a
10 gender dysphoria diagnosis. That's one way that she
11 acknowledged a circumstance that giving a child PBHTs
12 could be unsafe.
13 She also told this Court that the patient
14 needs to have multiple diagnostic assessments before
15 giving them PBHTs. Every patient is different. So,
16 again, a patient could be given PBHTs while not being
17 provided the appropriate amount of diagnostic
18 assessments beforehand, and according to Dr. Brady,
19 that would be a medical concern. That would be against
20 the standard of care.
21 And by the way, the Court's injunction,
22 what plaintiffs are seeking, would encompass those kids
23 necessarily, right? I mean, if this Court grants a
24 temporary injunction as to the PFLAG members -- for
25 example, if a person calls in and says X has a

1 transgender kid who is in -- is giving them PBHTs and
2 that's all DFPS gets, that's within what plaintiffs are
3 wanting this Court to stop, right?
4 Well, those very kids, their expert
5 said -- let's say that that kid is receiving PBHTs
6 before their expert said they should be receiving
7 PBHTs. Again, as long as a PFLAG member says I'm a
8 PFLAG member, this child is being given PBHTs in a way
9 that plaintiffs and defendants acknowledge is an unsafe
10 medical condition, it's unnecessary medical treatment,
11 their doctor has said that, that kid --
12 THE COURT: Let me ask you this.
13 MS. CORBELLO: Yes, Your Honor.
14 THE COURT: Would the defendant agree to
15 an injunction that limited the defendant from
16 investigating plaintiffs' families and members of PFLAG
17 for possibly -- for possible child abuse or neglect
18 solely based on allegations that they have a minor
19 child who is transgender -- transgender, gender
20 nonconforming, or gender transitioning?
21 MS. CORBELLO: Your Honor, I don't know
22 that we need to agree or disagree because that's not
23 the inv- -- that's not what's occurring now, so there's
24 nothing to enjoin.
25 MR. STONE: And -- and the example,

1 Your Honor, is the 12th case that we heard testimony
2 about where it was NP'ed where the only allegation was
3 that it was a transgender child with nothing else. So
4 in the absence of -- of PBHT allegation and there's
5 nothing else involved, it's just a child that's
6 transgender, it wouldn't -- based on the testimony we
7 heard, it wouldn't even advance to investigations
8 potentially.
9 MS. CORBELLO: Right. There's nothing in
10 the record currently that would say that this Court is
11 enjoining an action that's actually occurring, which is
12 the only permissible scope of an injunction, to enjoin
13 current behavior. The current behavior is those aren't
14 investigated.
15 THE COURT: I'll hear from the plaintiff
16 on that in a minute. Thank you.
17 MS. CORBELLO: Again --
18 THE COURT: So, no, you don't agree to
19 that --
20 MS. CORBELLO: Well --
21 THE COURT: -- because you don't think
22 it's necessary? That's the argument.
23 MS. CORBELLO: Right, Your Honor. It's
24 not an appropriate injunctive relief in this case.
25 And, again, just to be clear, all a PFLAG

1 member is going to have to do is say I'm a PFLAG
2 member, and whatever the aggravating circumstances are
3 beyond this transgender child is taking PBHTs, maybe
4 they're too young, maybe they haven't done the
5 diagnostic assessments, whatever it is that might put
6 them at harm is now going to be enjoined. That is not
7 a permissible scope of an injunction as well.
8 Texas Family Code, Section 26.001,
9 several provisions there allow DFPS to investigate when
10 an allegation of child abuse where they're suffering
11 harm that is physically and mentally detrimental. The
12 Court has been presented evidence that the situation --
13 this situation can happen with PBHTs. Again, our
14 expert explained to you PBHTs can be harmful. They can
15 cause --
16 THE COURT: I know it's late. Slow down.
17 MS. CORBELLO: Sorry, Your Honor. They
18 can cause damage to a child both -- both physically and
19 mentally. No, not every time. That is not what we
20 have argued today. We have never argued that. This
21 Court doesn't have to find that to be the case in order
22 to rule against plaintiffs. All the Court has to
23 consider is whether plaintiffs have demonstrated that
24 there is no instance where a child taking PBHTs is
25 going to be a medical concern that DFPS can investigate

1 as potential child abuse. Again, they haven't done
2 that.
3 Plaintiffs were also required to show
4 that DFPS has not been acting accordance -- in
5 accordance with established law in investigating these
6 claim. Again, they brought you exactly one witness
7 from DFPS testifying as to their practices who had
8 nothing to offer this Court. She acknowledged she has
9 no idea what is currently happening.
10 DFPS, on the other hand, offered their
11 witness that is currently involved in intakes and
12 investigations and has told this Court, again, there
13 have been 12 cases. Five have been ruled out. One has
14 been PN'ed at the start, contrary to what Mr. Castillo
15 said a moment ago that none had been. And two are
16 pending closure absent the stay in this case.
17 Plaintiffs make a lot about the fact that
18 there's a practice of P2'ing these -- these
19 investigations. Again, that's not consistent with what
20 the evidence has shown. But again, even if that is a
21 DFPS practice, given the nature, again, of these
22 potential harms, plaintiffs have not pointed this Court
23 ever in either case to a statute that prohibits DFPS
24 the discretion to determine which allegations when they
25 come in are P1, P2, or PN status. That is within DFPS'

1 discretion as given to them by the Legislature.
2 Just to briefly address Briggle, because
3 I think there were a few incorrect things said. The
4 Briggle case has been closed. The testimony the Court
5 heard today, the only testimony, is that DFPS does not
6 reinvestigate the same claims against a family.
7 Mr. Castillo said something that
8 there's -- there's no -- defendants have not shown that
9 they will never be investigate -- investigated again.
10 No, we haven't shown that, because like any other
11 family in Texas, the Briggles are not exempt from any
12 investigation by DFPS, but plaintiffs can't have it
13 both ways. Either the Briggles were investigated
14 because their child was transgender and on PBHTs --
15 that was the allegation -- or they weren't. And if it
16 was the allegation, DFPS is not going to be able to
17 reinvestigate those claim. There have to be other
18 claims involved.
19 So as to the Briggles, their request for
20 relief is entirely with outside -- outside the
21 jurisdiction of the Court and inappropriate for an
22 injunction as they are not suffering nor will they
23 likely suffer any future harm.
24 Quickly as to status quo, again, I'd like
25 to point to the Court -- the Court to the Supreme Court

1 of Texas opinion in the *Jane Doe* case. The Lehrmann
2 concurrence -- Justice Lehrmann concurrence stated,
3 quote, DFPS bears the responsibility of investigating
4 reports of child abuse or neglect which necessarily
5 includes assessing whether a report it receives is
6 actually a report of child abuse or neglect. A proper
7 judicial remedy cannot go so far as to curb that
8 discretion beyond legislative and constitutional
9 limits. That is the remedy for an allegedly improper
10 limitation on DFPS' investigatory discretion -- I'm
11 sorry. That is, the remedy for an allegedly improper
12 limitation on DFPS' investi- -- investigatory
13 discretion cannot be the placement of a different but
14 equally improper limitation on DFPS' investigatory
15 discretion. Either amounts to a change in the
16 status quo that the Court is seeking to preserve.
17 Again, that is exactly what plaintiffs
18 are asking for here, is to simply require the Court to
19 place improper limitations on DFPS.
20 THE COURT: What is different now?
21 Summarize. Because at the end of the day, the Supreme
22 Court affirmed the injunction with regard to the Doe
23 family. They didn't -- I guess what was the posture,
24 because they didn't -- that -- that injunction still
25 stands. It's -- it is still standing with regard to

1 the Doe family, even after its going all the way to the
2 Supreme Court. So what is different now about this
3 injunction being requested? How do you see them as
4 different?
5 MS. CORBELLO: So I just want to be
6 clear. The appeal of the temporary injunction order in
7 the *Jane Doe* case has not gone all the way to the
8 Supreme Court. What has occurred is plaintiffs
9 challenged the automatic stay that occurs when the
10 State appeals a TI.
11 THE COURT: Yes.
12 MS. CORBELLO: Rule 29.3, the Third Court
13 of Appeals sided with plaintiffs, and so we went up to
14 the Supreme Court on mandamus. The Supreme Court made
15 very clear in that opinion that it was not going to the
16 merits of the injunction ruling as to plaintiffs'
17 claim. All it was simply doing was --
18 THE COURT: Thank you for that
19 clarification. Yes. I'm glad that you were here to
20 clarify that. That is what happened.
21 MS. CORBELLO: Yes.
22 THE COURT: And I don't -- I don't
23 disagree that that's what happened. Thank you for
24 clarifying that.
25 MS. CORBELLO: And if I could just point

1 out one other thing about the opinion. The Supreme
2 Court did make a point to start its opinion saying,
3 you know, we'd like to get kind of an overview of the
4 Governor, the AG, the DFPS, kind of how these all work
5 together, and the judicial role in all of these. And
6 so that's where these quotes that I've been giving the
7 Court have been coming from.
8 THE COURT: The *Doe* injunction still
9 stands, correct?
10 MS. CORBELLO: Yes, Your Honor. Briefing
11 just completed in the Third Court of Appeals, I
12 believe.
13 THE COURT: To not grant an injunction
14 here, would we have an equal protection problem given
15 that the *Doe* injunction still stands?
16 MS. CORBELLO: Well, the *Doe* injunction
17 only stands as to the Doe family.
18 THE COURT: Uh-huh. And so now we have a
19 problem. That's the equal protection issue, argued to
20 me many times by the AG, of giving relief for one party
21 and not giving equal relief to another party who stands
22 in the same position.
23 MS. CORBELLO: Well, see, that's the
24 problem with the argument that plaintiffs choose to
25 make. They don't stand in the same position, right?

1 Your Honor was at that TI hearing. I had about
2 24 hours to prepare. Most of my evidence put on was
3 cross of plaintiffs' witnesses. There were no
4 investigatory files of Ms. Doe. The evidence I think
5 before this Court -- and I think this Court would
6 agree, the evidence today of how these investigations
7 have happened, where they are, what the policy and
8 practices are are very different than what Jane Doe
9 presented to the Court. And -- and that's simply by
10 virtue of that case occurred right after these reports
11 started happening, and then these various
12 stays/non-stays since then. So, again, the Court is
13 receiving very different updated evidence in this case
14 that it simply didn't have available to it in *Jane Doe*.
15 If the Court has any --
16 THE COURT: No.
17 MS. CORBELLO: It looked like you were
18 thinking. And then finally, just as to irreparable
19 harm, I think the Court touched on this a few times,
20 that there -- there are issues with irreparable harm
21 here. Again, the first issue is these are DFPS
22 investigations at this point. Every parent who
23 testified told you that there -- there is no court
24 order in their case. They have not been told by anyone
25 that there will be a court order in this case. And the

1 evidence presented by DFPS is most likely that's not
2 going to happen.
3 Now, of course, DFPS has to continue to
4 investigate, which they are stalled from doing at this
5 point, but that's not through any action of DFPS. So,
6 again, that goes to a -- a lack of harm being shown
7 by -- by plaintiffs.
8 There's -- and I think the important
9 thing to note about the lack of a court order is,
10 therefore, there is no interference with a parent-child
11 relationship. And as I gave the quote to the Court
12 earlier, the Supreme Court of Texas, that's how it
13 defines that interference. Plaintiffs have complained
14 about interference of that relationship today. The
15 Supreme Court of Texas sees that interference --
16 interference is occurring when a court order comes into
17 play. There are no court orders in play before this
18 Court today.
19 Ms. Talbert told you -- told this Court,
20 again, so far the evidence shows no likelihood, much
21 less immediate chance, of a court order in this case.
22 The -- DFPS has never gone any further after talking to
23 a child and a doctor. That's the evidence before the
24 Court. That's what matters.
25 And unless the Court has any further

1 questions, for those reasons defendants would ask that
2 this Court deny the temporary injunction motion.
3 MR. STONE: Can I say one -- one thing?
4 MS. CORBELLO: It's up to Your Honor.
5 MR. STONE: Your Honor, may I say one
6 thing?
7 THE COURT: You may.
8 **CLOSING ARGUMENT BY MR. STONE**
9 MR. STONE: Thank you, Your Honor. I
10 think you -- Your Honor, I think you hit the nail on
11 the head when you said if you grant a TI with respect
12 to the named plaintiffs in this case, aren't you sort
13 of continuing their harm? The testimony that was
14 provided by the DFPS employee showed that so far all
15 the cases that are not stayed that have been able to be
16 resolved have all been ruled out, and one of two things
17 happened. Either DFPS determined that the child was
18 not taking PBHT or they determined the child was taking
19 PBHT, but they had a letter from the doctor or they
20 spoke with the doctor, and the doctor said they were
21 prescribing it and that they were -- the -- the family
22 was compliant and the child was compliant.
23 So in this case, unless their
24 circumstances are different, if this Court were to lift
25 the stay in this case and allow these investigations to

1 proceed, presumably they would also be resolved and
2 ruled out. So by granting an injunction and not
3 allowing them to be completed, this Court, in fact, is
4 potentially harming the named plaintiffs in this case.
5 THE COURT: Final word for the plaintiff.
6 Since he's already appeared, I also want to make sure
7 that Mr. Pittman doesn't want to enter and say anything
8 at this point. Since he already said something at some
9 point, I want to make sure there's nothing to say from
10 Mr. Pittman or Mr. King since there were a lot of
11 references there to, I think, the clients that you
12 represent.
13 **CLOSING ARGUMENT BY MR. PITTMAN**
14 MR. PITTMAN: Your Honor, I'm trying to
15 choose my words wisely because I don't know --
16 THE REPORTER: Can you come to the
17 podium? I'm sorry.
18 MR. PITTMAN: I'm sorry.
19 THE REPORTER: Just for me.
20 MR. PITTMAN: I'm trying to choose my
21 words wisely because I was in another court this
22 morning and I was not here for all the testimony. I do
23 not know what testimony was put on this morning when I
24 wasn't here. However, argument by --
25 THE COURT: You can choose to say

1 nothing. I don't want to make you -- but I'm -- I'm
2 giving you an opportunity to say something if you feel
3 like you need to.
4 MR. PITTMAN: What I'm trying to
5 delicately say is that I am aware of misrepresentations
6 by the State in closing argument right now with regard
7 to one of my -- my families. The investigation that
8 was closed with the Briggles was not done after any
9 sort of letter from the Department -- letter provided
10 to the Department.
11 MS. CORBELLO: Your Honor, I'm going to
12 object. Counsel is now testifying to things that this
13 Court has not heard.
14 THE COURT: Yeah. I -- I -- I don't know
15 that I can have you testify about evidence. I guess I
16 wanted to ask just -- you -- you have as your clients
17 in the investigation by DFPS the Briggles.
18 MR. PITTMAN: Yes, Your Honor.
19 THE COURT: And you also have?
20 MR. PITTMAN: Wanda Roe.
21 THE COURT: Roe. And I just wanted to
22 make sure, more addressing the question I asked the
23 plaintiff, about the harm, about granting an injunction
24 and whether granting an injunction was potentially more
25 harm for Roe than not granting one.

1 MR. PITTMAN: Your Honor, my opinion
2 about that as Wanda Roe's counsel for the investigation
3 is that -- my understanding of the State's argument is
4 that an allegation that has been received and ruled out
5 or dispositioned cannot be reinvestigated. However, my
6 understanding is that these treatments are not static,
7 and so treatments that are being provided now may be
8 different than treatments that are providing --
9 provided next year or the year after that.
10 And so if Ms. Wanda Roe has a ruled out
11 disposition for some sort of PBHT now but there's a new
12 allegation of new PBHT in the future, I don't know if
13 she would be immune from investigation at that point in
14 time.
15 THE COURT: Understood. I just wanted to
16 make sure everyone appreciated the effect of an
17 injunction and what the Court can and can't do with
18 regard to injunctive relief, so...
19 MR. PITTMAN: Yes, and so I -- I -- I
20 do -- do believe that she would be protected enough for
21 the harm because there is a possibility of further
22 investigation for -- if the -- if the treatment in the
23 future -- the allegations of treatments in the future
24 are different than the allegations of treatment that
25 started this --

1 THE COURT: Thank you.
2 MR. PITTMAN: -- investigation.
3 THE COURT: Thank you. All right.
4 Mr. Castillo.
5 MS. CORBELLO: Your Honor, if I can just
6 briefly respond to just one thing?
7 THE COURT: Yes.
8 **FURTHER CLOSING ARGUMENT BY MS. CORBELLO**
9 MS. CORBELLO: Mr. Pittman's argument
10 just then was entirely speculation, which is exactly
11 what a temporary injunction is not allowed to try to
12 rectify. Thank you.
13 THE COURT: Thank you. Mr. Castillo,
14 final word.
15 **FURTHER CLOSING ARGUMENT BY MR. CASTILLO**
16 MR. CASTILLO: Your Honor, the entry
17 point, the fact that there is carte blanche every
18 single allegation of PBHT is investigated is what is
19 changed from the status quo that is unlawful outside of
20 the statutory authority, and that is arbitrary and
21 capricious when no other course of medical care that
22 may be -- if -- if the allegation was another course of
23 medical care, they don't open every single
24 investigation to contact the physician outside of any
25 specific allegation that it was outside of medical

1 necessity or gave any impact.
2 In fact, when the temporary injunctive
3 relief as to the Does was in place, the Department made
4 it clear that it was not prohibited under the
5 injunction for the temporary -- for the Doe -- in the
6 *Doe* case from continuing to pursue if they had other
7 information that was alleged in the allegation to
8 indicate, for example, that any course of care was not
9 medically necessary.
10 What -- this is a narrowly scope --
11 you know, this -- the proposed order is narrowly
12 tailored to prohibit and bar the presumptive position
13 that every single one of these cases must be
14 investigated, and it is narrowly tailored to prohibit
15 and to prevent the irreparable harm that was faced by
16 the Briggles, by the -- by the Roes, the Voes, and all
17 the other cases that had indicated had been closed.
18 The mere opening based on nothing further
19 other than medical care is where the -- the Department
20 exceeded its authority. It's not treating these
21 different. It's a different rule. It was contemplated
22 by the Legislature and rejected, and nevertheless they
23 proceeded outside of their authority in an arbitrary
24 and capricious way, and we have shown the probable
25 right of relief with irreparable harm.

1 And at this stage, we not -- as counsel
2 knows, the burden on the plaintiff is not to show
3 conclusively but merely that there is a bona fide
4 dispute. We've clearly exceeded that threshold in the
5 testimony that was provided today. For that reason, we
6 request a temporary injunction on behalf of the
7 plaintiffs. Thank you.
8 THE COURT: Thank you.
9 **TAKEN UNDER ADVISEMENT**
10 THE COURT: The Court is going to take
11 the request under advisement. The current TRO is still
12 in place through Friday, and I will rule in the next
13 couple of days. Thank you. Everybody's excused.
14 MR. STONE: Thank you, Your Honor.
15 MS. CORBELLO: Thank you, Your Honor.
16 MR. CASTILLO: Thank you, Your Honor.
17 *(Court adjourned.)*
18
19
20
21
22
23
24
25

1 **REPORTER'S CERTIFICATE**

2

3 STATE OF TEXAS)
)
4 COUNTY OF TRAVIS)

5 I, Alicia Racanelli, Official Court Reporter in and
6 for the 201st District Court of Travis County, State of
7 Texas, do hereby certify that the above and foregoing
8 contains a true and correct transcription of all
9 portions of evidence and other proceedings requested in
10 writing by counsel for the parties to be included in
11 this volume of the Reporter's Record, in the
12 above-styled and numbered cause, all of which occurred
13 in open court or in chambers and were reported by me.

14 I further certify that this Reporter's Record of
15 the proceedings truly and correctly reflects the
16 exhibits, if any, offered in evidence by the respective
17 parties.

18 WITNESS MY OFFICIAL HAND this the 14th day of July,
19 2022.

20

21

22 /s/ Alicia Racanelli
Alicia Racanelli, Texas CSR No. 3591
23 Expiration Date: April 30, 2023
Official Court Reporter, 201st District Court
24 Travis County, Texas
P.O. Box 1748, Austin, Texas 78767
25 Telephone (512) 854-4028

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,** **V.** **GREG ABBOTT, ET AL.,** ***Defendants*.**	**IN THE DISTRICT COURT OF** **TRAVIS COUNTY, TEXAS** **459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit I

Defendants' Advisory to the Court concering the Roe Family (August 15, 2022)

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DEFENDANTS' ADVISORY

Defendants Greg Abbott in his official capacity as Governor of the State of Texas ("Governor Abbott"), Jaime Masters in her official capacity as Commissioner of the Department of Family and Protective Services ("Commissioner Masters"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants") file this advisory to update the Court on matters impacting the temporary injunction issued in this case.

In granting, in part, Plaintiffs' motion for temporary injunction on July 8, 2022, this Court prohibited DFPS from "taking any actions, including investigatory or adverse actions, against Plaintiffs VOE and ROE and their minor children . . . except that DFPS shall have the ability to administratively close or issue a 'ruled out' disposition in any of these open investigations based on the information DFPS has to date – if this action requires no additional contact with members of the VOE or ROE families." As is seen in the attached **Exhibit A**, DFPS' investigation involving the Roe family has been "ruled out" and the case is now closed. The Roe Family was made aware of this development through their counsel on August 8, 2022.[1]

[1] Counsel for the Roe family has stated the Roe family is opposed to any dissolution of the preliminary injunction order as it relates to them.

This Court declined to grant a temporary injunction to PFLAG and the Briggles. The Briggles—like the Roes—had a DFPS investigation closed with a "ruled out" finding that involved the alleged provision of PBHT to a minor for gender dysphoria. A DFPS witness testified at the temporary injunction hearing that DFPS will not open a new investigation into a family for the same conduct that it previously investigated and made a "ruled out" finding. The Roes and the Briggles are similarly situated because both are the subject of "ruled out" investigations by DFPS involving the alleged provision of PBHT to a minor to treat gender dysphoria. *See Ahmed v. Shimi Ventures, L.P.*, 99 S.W.3d 682, 691 (Tex. App.—Houston [1st Dist.] 2003, no pet.) (holding the trial court had jurisdiction to enter the modified temporary injunction order while appeal on the original temporary injunction order was pending); *see also* Tex. R. App. P. 29.5 ("While an appeal from an interlocutory order is pending, the trial court retains jurisdiction of the case and unless prohibited by statute may make further orders, including one dissolving the order complained of on appeal.").

Defendants will continue to endeavor to inform this Court if there are any further developments regarding the Roe or Voe families.

Respectfully Submitted.

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Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

GRANT DORFMAN
Deputy First Assistant Attorney General

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CERTIFICATE OF SERVICE

I, **COURTNEY CORBELLO**, Assistant Attorney General of Texas, hereby certify that a true and correct copy of the foregoing document has been served electronically through the electronic-filing manager in compliance with TRCP 21a on August 15, 2022 to:

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Assistant Attorney General

Texas Department of Family and Protective Services

COMMISSIONER
Jaime Masters

Wanda Roe

Mailing Date: 07/26/2022

Re: Case# 5520; Notice of Findings of CPI Investigation

Dear Wanda Roe :

The Department of Family and Protective Services (DFPS) has completed its investigation of alleged abuse or neglect reported on 02/23/2022 involving one or more children in your family and made the following findings:

Alleged Perpetrator	*Alleged Type of Abuse or Neglect*	*Alleged Victim*	*Finding*
Wanda Roe	Medical Neglect	Tommy Roe	Ruled Out
Wanda Roe	Physical Abuse	Tommy Roe	Ruled Out

This investigation is now closed and there will be no further agency involvement with your family unless we receive another report of abuse or neglect, which, by law, we would need to investigate.

How Findings are Determined.

- A finding of "**Ruled Out**" means that, based on the available information, it was reasonable to conclude that the alleged abuse or neglect did not occur.

How Certain Types of Abuse or Neglect are Defined.

Medical Neglect includes the following acts or omissions by a person:

- failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child.

Physical Abuse includes the following acts or omissions by a person:

- physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm; or
- failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child; or

EXHIBIT A

- the current use by a person of a controlled substance as defined by Chapter 481, Health and Safety Code, in a manner or to the extent that the use results in physical injury to a child; or
- causing, expressly permitting, or encouraging a child to use a controlled substance as defined by Chapter 481, Health and Safety Code.

Right to Request Records. You have the right to request a copy of the investigation records. The records will be redacted to remove the identity of the person who reported the alleged abuse or neglect and any other information which you are not entitled by law to receive. Release of records may be delayed or denied if the release would interfere with an ongoing criminal investigation or for other valid legal reason. You may be charged a fee for copies of these records. You may contact me to obtain a copy of the form needed to request these records or you may obtain a copy of this form at:
http://www.dfps.state.tx.us/Child_Protection?About_Child_Protective_Services/faqcpsrecord.asp

Right to Request Role Removal. Since all the allegations against either you or any child in your family have been "ruled out", you have the right to request that we remove information regarding yourself in the role of alleged perpetrator(s) in this investigation. If you decide to request removal of role information, you must complete and submit the enclosed form(s) within 45 calendar days of the "mailing date" listed at the top of this letter.

If you have any questions or concerns regarding the investigation or any of the information discussed in this letter, you may contact me at the address or phone number provided below.

Request For Removal Of Role Information

Role Removal Unit, Y-960
Texas Department of Family and Protective Services (DFPS)
PO BOX 149030
AUSTIN TX 78714-9030

Or E-mail form to roleremovalunit@dfps.state.tx.us

For Role Removal status inquiries please call 512-929-6470. Please allow sufficient time for mail delivery before seeking status. Forms may also be scanned and e-mailed.

An individual alleged to have committed abuse or neglect of a child is entitled to request removal of information from DFPS records concerning that person's role as an alleged perpetrator in an investigation conducted by CPI if all of the allegations against that individual in that investigation are ruled out. To request removal of role information relating to the following investigation, you must complete and sign this form and return it to DFPS at the above address within forty-five (45) days after the date on the accompanying letter. If your minor child was the alleged perpetrator in this investigation, you may make this request on your child's behalf.

In Regard to the Investigation That is Subject to Role Removal

Date of Report	Case Name	Case Number
02/23/2022	Wanda Roe	5520

Specific Allegations that were investigated and "ruled out":			
Alleged Perpetrator Name	Type of Abuse or Neglect	Alleged Victim Name	Disposition
Wanda Roe	Medical Neglect	Tommy Roe	Ruled Out
Wanda Roe	Physical Abuse	Tommy Roe	Ruled Out

To be completed by the person requesting removal of role information:

Name	*Area Code and Telephone Number*
Mailing Address (Street or P.O. Box, City, State, Zip)	
E-mail address for electronic notice of completion	
Name of child if parent or guardian is making this request on behalf of a minor child	

Important Information About Your Rights

Upon receipt of a properly submitted request for removal of role information, DFPS will initiate procedures to remove information from department records about the alleged perpetrator's role in the abuse or neglect report identified. Once this role information is removed from our records, IT WILL BE DESTROYED AND WILL NOT BE AVAILABLE TO YOU. If, for any reason, you wish to prove that someone falsely reported you for abuse or neglects, our records would no longer reflect the fact that this report against you was made and ruled out.

NOTE: THE FACT THAT YOUR ROLE AS AN ALLEGED PERPETRATOR IN THIS PARTICULAR INVESTIGATION HAS BEEN RULED OUT OR THAT YOU REQUEST REMOVAL OF THIS ROLE INFORMATION DOES NOT PRECLUDE FURTHER INVOLVEMENT WITH YOUR FAMILY BY DFPS, INCLUDING THE PROVISION OF SERVICES, COURT INVOLVEMENT, OR EVEN TERMINATION OF PARENTAL RIGHTS.

Because this decision may have important consequences, you may wish to consult a private attorney for legal advice as to whether you should request the above role information to be removed from DFPS records.

I have read the foregoing information about my rights and have made the decision to request that information about my role as an alleged perpetrator in this investigation be removed from DFPS records.

Signature of person requesting removal of role information	Date Signed

NO. D-1-GN-22-002569

PFLAG, INC., ET AL., ***Plaintiffs*,**	**IN THE DISTRICT COURT OF**
v.	**TRAVIS COUNTY, TEXAS**
GREG ABBOTT, ET AL., ***Defendants*.**	**459th JUDICIAL DISTRICT**

DEFENDANTS' PLEA TO THE JURISDICTION

Exhibit J

Texas Department of Family and Protective Services
Child Protective Services Handbook

Texas Department of
Family and Protective Services

Child Protective Services Handbook

2200 Basic Investigation Process

2210 General Provisions

CPS September 2017

Ongoing Child Safety Assessment

The caseworker must assess child safety throughout the investigation.

Staff At Any Time

The caseworker may staff an investigation with the supervisor or program director at any time.

Definition of Parent

As used in policy, the term parent generally refers to a person legally responsible for the child.

Reporter Confidentiality

The caseworker must not reveal the identity of the reporter except to law enforcement or other entities charged with investigating abuse and neglect.

DFPS Rules 40 TAC §700.203

Texas Family Code §261.101(d)

CPS Actions When Danger to a Child is Present

If danger to a child is present at any point during an investigation, the caseworker must staff with the supervisor and take one of the actions described in 3200 CPS Actions When Danger to a Child is Present.

CPS Actions When a Child or Principal Cannot Be Located

If a child or principal cannot be located at any point during an investigation and this prevents the caseworker from gathering enough information or taking action to ensure child safety, the caseworker must staff with the supervisor and follow the actions described in 3100 When a Child Who is With His or Her Family Cannot be Located.

Uncooperative Principal

- DFPS does not have jurisdiction to investigate because another authorized entity, such as law enforcement, another state agency, or another DFPS program, has jurisdiction to investigate. See 2293.1 Exceptions to Notifying Clients of Investigation Findings.
- The abuse or neglect, danger, or risk of abuse or neglect is not occurring in Texas and did not occur in Texas. See 2372 Abuse Out of State.
- The alleged perpetrator is younger than 10.

DFPS Rules, 40 TAC §707.489(b)(1)(C)
DFPS Rules, 40 TAC §707.497(a)(1)

The caseworker submits the investigation for administrative closure as soon as possible, but no later than seven calendar days, after making the determination.

2314 Allegations Were Already Investigated

CPS October 2020

The caseworker submits an investigation for administrative closure if, at any point in the investigation, the caseworker determines that both of the following apply:

- CPI has already investigated or addressed the same incidents and allegations in a previous case that was closed prior to the date of the new intake.
- There are no new incidents or new allegations in the current case.

DFPS Rules, 40 TAC §707.489(b)(1)(a)

The caseworker does the following:

- Documents the case number of the closed case and explains how information in the new report was addressed in the closed investigation.
- Submits the investigation for administrative closure as soon as possible, but no later than seven calendar days, after making the determination.
- Merges the case with the previous case.

2315 Investigation Is Open for More Than 60 Days

CPS October 2020

If an investigation has been open for more than 60 days from the date of the intake, the supervisor administratively closes the investigation if all the following criteria are met:

- No previous reports of abuse or neglect involve any principal in the investigation.
- DFPS has not received any more reports of abuse or neglect of any alleged victim in the investigation. (A new report does not count, for the purpose of this bullet point, if it involves the same incidents and allegations already under investigation.)
- The supervisor determines, after contacting a professional or another credible source, that the child will be safe without further investigation, response, services, or help.
- CPI determines that no abuse or neglect occurred.
- Closing the case would not put the child at risk of harm.
- All the following apply:
  - The caseworker has interviewed and examined all alleged victims.