EXHIBIT 39
REDACTED

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRIANNA BOE, et al., Plaintiffs,	)
UNITED STATES OF AMERICA, Intervenor Plaintiff,	) Civil Action No. 2:22-cv-184-LCB
vs.	)
HON. STEVE MARSHALL in his official capacity as Attorney General of the State of Alabama, et al., Defendants.	)

VIDEO-RECORDED DEPOSITION OF
DAN KARASIC, M.D.
Tuesday, May 7, 2024
Volume I
*** CONFIDENTIAL ***

Reported by:
CARLA SOARES
CSR No. 5908
Job No. 6671384
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Intervenor Plaintiff,)
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HON. STEVE MARSHALL in his official capacity as Attorney General of the State of Alabama, et al.,)
)
Defendants.)
_____)

VIDEO-RECORDED DEPOSITION OF DAN KARASIC, M.D., Volume I, taken on behalf of Defendants, beginning at 8:58 a.m., and ending at 5:34 p.m., on Tuesday, May 7, 2024, before CARLA SOARES, Certified Shorthand Reporter No. 5908.

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REFERENCED EXHIBITS

(None.)

INSTRUCTIONS NOT TO ANSWER

(None.)

--o0o--

San Francisco, California
Tuesday, May 7, 2024
8:58 a.m.

P R O C E E D I N G S

THE VIDEO OPERATOR: Good morning. We are going on the record at 8:58 a.m. on May 7th, 2024.

Please note that the microphones are sensitive and may pick up whispering and private conversations. Audio- and video-recording will continue to take place unless all parties agree to go off the record.

This is Media Unit 1 of the video-recorded deposition of Dan Karasic, M.D., taken by counsel for defendants, in the matter of Brianna Boe, et al., Plaintiff, and United States of America, Intervenor Plaintiff, vs. Honorable Steve Marshall, in his official capacity of Attorney General of the State of Alabama, et al., filed in the United States District Court for the Middle District of Alabama, Northern Division, Civil Action No. 2:22-cv-184-LCB.

The location of the deposition is 415 Mission Street, San Francisco, California 94105.

My name is Cassia Leet, representing Veritext Legal Solutions, and I am the videographer.

The court reporter is Carla Soares, from the firm Veritext Legal Solutions.

I am not related to any party in this action, nor am I financially interested in the outcome.

Would counsel and all present, including remotely, please state your appearances and affiliations for the record, beginning with the noticing attorney.

MR. RAMER: John Ramer, from the law firm Cooper & Kirk, on behalf of defendants.

MR. LANNIN: Cortlin Lannin, of Covington & Burling, representing the witness, Dr. Dan Karasic, in his capacity as a fact witness. I'm joined this morning by my colleague Noah Goldberg, also of Covington.

MR. STOLL: Christopher Stoll, of the National Center for Lesbian Rights, for the private plaintiffs.

THE VIDEO OPERATOR: Remote counsel?

MR. MINTER: Shannon Minter, also with NCLR, for the private plaintiffs.

MS. WILLIAMS: Good morning. Renee Williams for the United States.

THE VIDEO OPERATOR: Thank you.

Would the court reporter please swear in the witness, and then counsel you may proceed.

DAN KARASIC, M.D.,

having been administered an oath, was examined and testified as follows:

EXAMINATION

BY MR. RAMER:

Q Good morning, Dr. Karasic.

A Good morning.

Q My name is John Ramer. I represent the defendants. And I know you've been deposed several times before. This will be the normal drill.

I'll try to take a break about every hour, but if at any point you need a break, just let me know. And the only request is that you would answer any pending questions.

If you don't understand a question, just let me know, and I'll try to rephrase it. Otherwise, I'll assume you understand it.

Does that all make sense?

A Yes.

Q Great.

MR. LANNIN: Counsel, I wonder -- before you get started, as we discussed earlier, Dr. Karasic is here both in a fact witness capacity

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and in his capacity as an expert witness in this litigation. And I'm here to represent him in his fact capacity, and Mr. Stoll here is here on behalf of the plaintiffs to represent Dr. Karasic in his expert capacity.

To minimize disruptions to the record, I'll endeavor to object to form when necessary. And can we agree that an objection on one party's behalf is an objection for all?

MR. RAMER: Yes.

MR. STOLL: Agreed.

MR. LANNIN: Very good.

BY MR. RAMER:

Q Dr. Karasic, are you an expert?

A Yes, on this subject matter.

Q And when you say "this subject matter," what do you mean by that?

A I would say I'm an expert on healthcare provision for transgender people.

Q Any other areas in which you're an expert?

A Yes. I'm a psychiatrist, a consultation liaison psychiatrist in terms of my career initially, and so I think I have broader expertise in psychiatry as a professor emeritus of psychiatrist at UCSF.

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Q Any other fields?

A Other than -- I would say more broadly in transgender health, and then in psychiatry.

Q Are you an expert in the treatment of gender dysphoria in children?

A So I am a -- an expert in the care of children, adolescents; adolescents in terms of my clinical practice, my years as a psychiatrist for the Dimensions Clinic for trans youth, where I was a psychiatrist for 17 years. And that clinic saw patients from 12 to 25, and also in my own faculty practice and private practice where I saw some people who were younger even than 12.

Q And in this field, do you agree that there is a distinction between children and adolescents?

A Yes.

MR. LANNIN: Object to the form.

THE WITNESS: Yes.

BY MR. RAMER:

Q And what is that distinction?

A So medical treatment is first contemplated at the start of puberty. And so with that, diagnostically, there's a separate diagnosis for gender dysphoria in prepubertal children and one in -- another diagnosis for those in adolescence and

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adults. So they're -- it is distinguished in that -- in that way.

Q Is it fair to say that the beginning of puberty is often described as the beginning of Tanner Stage 2?

MR. LANNIN: Object to the form.

THE WITNESS: So it's fair to describe Tanner Stage 2 as the onset of puberty, yes.

BY MR. RAMER:

Q And so you said there were separate diagnoses for children and adolescents. So how do you determine which diagnosis is applicable to a particular patient?

A So that is prior to the onset of puberty versus at Tanner Stage 2 or afterwards.

Q And so today, if -- let me start again.

Unless you or I say otherwise, if we use the term "children," is it fair to say we're talking about prepubertal individuals?

A Yes.

Q And if we use the term "adolescents," is it fair to say we're talking about individuals between the beginning of puberty and the age of majority?

A Yes. Yes.

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Q And so are you -- are you an expert in the treatment of gender dysphoria in children along the lines we've just described?

A My clinical practice does not extend to prepubertal children.

Usually when I -- when I see patients, they are at Tanner Stage 2 or older. And -- but I do have expertise more broadly as somebody who has been in the field of transgender health for many decades, and have been involved in conferences and publications.

For example, on -- I edited a book about questions for DSM-V that was -- that were articles written early on in the stage of discussion of how the gender identity diagnoses of DSM-IV might be changed, and those included the diagnosis for prepubertal children.

So I have -- I have academic expertise there. I don't have -- my clinical practice isn't young children.

Q And so your clinical practice involves only adolescents or older patients; is that right?

A Yes.

Q But you have published in the field of gender dysphoria in children specifically?

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A I have -- I edited a book which included discussion on the DSM diagnoses of -- for gender identity disorder in children, and I was involved in meetings and discussions with WPATH and the American Psychiatric Association and the World Health Organization about the diagnoses for children as well as for adults.

Q Would you say that your relationship to WPATH is relevant to the expertise that you're testifying about in this case?

MR. LANNIN: Object to the form.

THE WITNESS: Yes.

BY MR. RAMER:

Q And I understand that your clinical practice does not currently have -- let me start again.

Your clinical practice does not currently extend to children with gender dysphoria.

Have you ever treated a child for gender dysphoria?

MR. LANNIN: Object to the form.

THE WITNESS: So the youngest people I've treated were right at the start of Tanner Stage 2.

So in my faculty practice, I may have seen people as young as 10 or 11.

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My practice at Dimensions Clinic was only 12 to 25 years old because that was the age range for people to be able to receive care at that clinic.

BY MR. RAMER:

Q And when did you first begin treating adolescents for gender dysphoria?

A So I was hired to be the psychiatrist for the Dimensions Clinic in 2003, and -- but as early as the 1990s, in my faculty practice, I was seeing some adolescents with gender dysphoria.

Q Were you seeing them for treatment of gender dysphoria?

A So I was not seeing them for medical treatment of gender dysphoria, but I was seeing people as their psychiatrist or for mental health reasons who were being treated medically for gender dysphoria.

Q And when you say you weren't "seeing them for medical treatment of gender dysphoria," what do you mean by that?

A I wasn't -- I wasn't prescribing hormones or puberty blockers. Back then it was just hormones.

So I wasn't the person prescribing

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hormones, but I was seeing people for mental health issues that they -- that they had.

Q Just to make sure I understand, is your role as the psychiatrist actually prescribing the medication or recommending it?

MR. LANNIN: Object to the form.

THE WITNESS: So I prescribe psychiatric medication. I don't prescribe puberty blockers or hormones.

BY MR. RAMER:

Q What would you describe what you do with respect to puberty blockers or hormones for your patients?

MR. LANNIN: Object to the form.

THE WITNESS: So, mostly I have -- I'm part of a treatment team which varies in different -- over different settings.

So the Dimensions Clinic was a clinic in faculty practice. In private practice, it's kind of a more virtual team, where most patients have a psychotherapist, a psychiatrist, and a pediatrician or pediatric endocrinologist or internist if they're over -- 18 and over.

BY MR. RAMER:

Q And so what do you do in the context of

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that team?

A So I am addressing mental health issues with the -- with the patient, and consulting and working with the team that is providing other aspects of care.

Q Are you ever the member of the team who is recommending hormone treatment?

MR. LANNIN: Object to the form.

THE WITNESS: So sometimes I will have a patient where there is either a mental health assessment that is needed or discussion in terms of psychiatric stability, or sometimes there's a letter required. It can be different in different settings.

But I communicate to the person who's providing medical care, and also communicate with the psychotherapist if there's a separate psychotherapist about -- about recommendations for care.

The recommendation, you know, can come from different parts of the team, but I can end up assuming kind of some different roles, very often about mental health stability, sometimes in terms of a primary person that I've worked with in terms of their eligibility per standards of care for medical

treatment.
BY MR. RAMER:
Q So you said the recommendation can come from different parts of the team. Does the recommendation ever come from you?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. It's typically not my -- my saying to the patient, "I recommend that it's time to start hormones or puberty blocker."
They've often been seen, you know, in therapy, and sometimes then, at some point, they might get a referral to a pediatric endocrinologist.
And the pediatric endocrinologist might want my opinion, and I might speak with a therapist, and include my own experience with the patient in communicating that to the pediatric endocrinologist.
BY MR. RAMER:
Q Do you diagnose gender dysphoria in adolescents?
A Yes.
Q And then do you ever assess the adolescent patient to determine whether hormone therapy would be an appropriate treatment for the gender dysphoria?
A Yes.

Q And then do you reach a conclusion that it would be appropriate?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: Yes. So it would be appropriate in -- right. Yes.
BY MR. RAMER:
Q And then who do you relay that decision to?
MR. LANNIN: Object to the form.
THE WITNESS: So in that particular case, it can be to the pediatric endocrinologist or pediatrician who might be prescribing the medical intervention.
BY MR. RAMER:
Q And when was the first time that you recommended hormone therapy to treat gender dysphoria in an adolescent?
A It would -- I would say probably in the early 2000s.
Q And have you ever recommended puberty blockers as a treatment for gender dysphoria in a patient?
A Yes.
Q And when was the first time you

recommended puberty blockers as a treatment for gender dysphoria in a patient?
A So that was later. In the early part of my practice, puberty blockers weren't available, and adolescents would, though, get started on hormones.
So I would guess that that was in the late -- late 2000s. It would have been in my faculty practice, I think.
Typically, though I worked at various times with the Child and Adolescent Gender Center at UCSF, I wasn't typically the person doing the evaluation for puberty blockers. It was more often for hormones, but there were instances that I did.
Q When you say "late 2000s," what do you mean by that?
A So -- well, I'm trying to think.
So the Child and Adolescent Gender Center didn't start until -- officially until 2012, but there were pediatric endocrinologists as early as maybe 2009 that were prescribing puberty blockers at UCSF.
So it would be somewhere in that early period. I guess it could be between 2009 and 2012 in my -- via my faculty practice.
The people at the Dimensions Clinic did

start cooperating or working with the Child and Adolescent Gender Center, but that wasn't until a little bit later.
Q And so approximately sometime between 2009 and 2012 was the first time you recommended puberty blockers as a treatment for gender dysphoria; is that right?
MR. LANNIN: Object to the form.
THE WITNESS: Yeah, that would be my recollection.
BY MR. RAMER:
Q And for recommending hormone therapy for adolescents, did I hear you correctly, you said early 2000s?
A Yes. So the -- I became the psychiatrist at the -- at the Dimensions Clinic for trans youth that -- even though you often see, like, a history of pediatric gender care, just going back to Norm Spack at Boston Children's, the Dimensions Clinic has been providing care for trans adolescents since the 1990s, and I was hired as a psychiatrist in 2003.
Q And so when you say "early 2000s," we're talking, approximately 2003 would have been the first time you recommended hormone therapy to treat

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gender dysphoria in an adolescent?
A Well, before that, I may well have seen adolescents -- I mean, I got hired from them because I was already seeing adolescents in my faculty practice.
And so -- so I can't say precisely the year, but it was in that -- in that early 2000s period, I would say.
Q So approximately 2003 would have been the first time that you recommended hormone therapy to treat gender dysphoria in an adolescent, correct?
MR. LANNIN: Object to the form.
THE WITNESS: Certainly through the Dimensions Clinic. It's possible I -- in my faculty practice, I would guess that I had made those recommendations beforehand because I was already kind of known when they hired me as the psychiatrist.
BY MR. RAMER:
Q And so you're saying that, if anything, it's -- earlier than 2003 could have been the first time?
MR. LANNIN: Object to the form.
THE WITNESS: It's possible. I don't recall.

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BY MR. RAMER:
Q But it was not after 2003 that was the first time that you recommended hormone therapy to treat gender dysphoria in an adolescent, correct?
MR. LANNIN: Object to the form.
THE WITNESS: It's hard for me to remember specific patients, but I started in a clinic that was seeing adolescents and young adults.
And at that time, we did see adolescents who had started hormones on their own and then moved to San Francisco. And then the pediatricians, the family practitioners, started -- you know, often were starting the provision of hormones in a monitored way for people who had already started them.
BY MR. RAMER:
Q Approximately how many patients have you had for whom you've recommended puberty blockers as a treatment for gender dysphoria?
A I don't know if I can say a number because I've been working over so many years.
But I would say more commonly, I had gotten involved with a patient after they were already on puberty blockers, or I had patients, before puberty blockers were routinely given, who

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were just being started on hormones as their first intervention.
Q I guess, just to kind of understand a ballpark, I mean, are we talking -- have you recommended puberty blockers as a treatment for gender dysphoria in over 50 patients?
A It's hard for me to say. It may well be, when we're talking about puberty blockers, fewer than that. But it would be hard for me to give a number.
As I said, I would say more often over the course of my career, people were either already on puberty blockers, or we were recommending recommendations before puberty blockers were widely available.
But I did recommend people for puberty blockers over the course of those years, particularly in my faculty practice, and then private practice.
Q Would you say that you've recommended puberty blockers as a treatment for gender dysphoria in more than 10 patients?
A Yes.
Q More than 20?
A Yes.

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Q More than 30?
A You know, then I would just -- I just never really thought about how many. And I've seen so many patients over so many years.
There was a time when there were relatively few practitioners, and -- but puberty blockers weren't so -- there were many young people that I saw for hormones, and then puberty blockers weren't really available until UCSF pediatric endocrinology started prescribing them in the late 2000s before the multidisciplinary clinic was set up.
And then I was asked to be involved on the steering committee to set up the Child and Adolescent Gender Clinic, and that was probably around in 2009 or 2010.
And then the clinic officially didn't have its first meeting until 2012, but there were a lot of meetings about the provision of puberty blockers in that period, I'd say, between 2010 and 2012, including Norm Spack, who had -- was the original prescriber, the person who started the first clinic in the U.S. at Boston Children's, came out to San Francisco, and we met with him in 20- -- probably 2010 is my guess.

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And then I was involved in kind of organizing a set of therapists who worked with transgender -- or gender-diverse youth who -- and that was -- that's a group led by Diane Ehrensaft. So that was also in that period.

I remember doing a presentation with Diane Ehrensaft in 2009. So in that period between 2009 and 2012, there was a lot of discussion about setting up services for people who might receive puberty blockers as well as hormones.

Q Why were you mentioning all that background?

MR. LANNIN: Object to the form.

THE WITNESS: I was just -- you were trying to relate, like, how -- I was trying to maybe kind of talk through the -- evaluating people for puberty blockers and the timeline for that, because puberty blockers weren't widely available until probably 2009, and then -- but there wasn't a structured clinic until 2012.

So I was -- I've been in practice for a long time, and so the years are arbitrary things. So I was just kind of talking through when those services were set up to provide puberty blockers in San Francisco.

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BY MR. RAMER:

Q And approximately how many minor patients have you had for whom you've recommended hormone therapy as a treatment for gender dysphoria?

MR. LANNIN: Object to the form.

THE WITNESS: So -- well, I've certainly taken care of many hundreds of adolescents over the years, but I don't -- I don't know if I could say how many I wrote the letter for them starting hormones versus their psychotherapist, because there were many of them who also saw a psychotherapist, and the psychotherapist wrote the letter.

But I was involved with the treating team, as well as at the Dimensions Clinic where there was a group of therapists that I would meet with and where we would discuss cases, as well as with the hormone prescriber.

BY MR. RAMER:

Q And so you've treated over hundreds of adolescents for gender dysphoria. And is your point that it's not always some clear distinction of who's -- what individual on the team is doing the recommending? Is that --

A Right.

Q Okay.

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A So a lot of times it's -- I would say most commonly there's a psychotherapist who's doing it, and the person -- it's a patient who has a psychotherapist and a psychiatrist, and then there's a letter that's going to the pediatrician or pediatric endocrinologist, or at Dimensions there was often a family practice doctor who took care of kids.

Q Have you ever recommended surgery as a treatment for gender dysphoria in an adolescent?

A I have recommended -- I have recommended chest surgery, mastectomy, in adolescents.

Q Any other surgeries?

A No.

Q What age was the youngest patient for whom you've recommended surgery as a treatment for gender dysphoria?

A So for an adolescent, probably 13 or 14 was the earliest. Typically, my patients have received chest surgery later in adolescence.

Q And when was the first time you recommended surgery as a treatment for gender dysphoria in an adolescent?

A Good question.

We didn't have -- in the early years of

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the Dimensions Clinic, there wasn't wide access to surgery for those who needed chest surgery, but there were a few people who did get it privately.

I'm just trying to think of specific patients. But I'll just -- I don't remember a year.

Q And when you first began recommending hormone therapy as a treatment for gender dysphoria in adolescents back in the early 2000s, what evidence were you relying on?

MR. LANNIN: Object to the form.

THE WITNESS: So there -- so we obviously had far less evidence, but there were many adolescents who were already benefiting from hormones.

So the circumstance I can recall the most from that time was adolescents who had -- who had originally self-treated or had gotten hormones on their own, and then presented with -- to the clinic.

There was a pretty robust mental health component, and so they would work with the therapists.

And there was -- I think the initial treatment was really, even before I started there, from the 1990s, from the Tom Waddell Clinic, of kind of harm reduction, of providing supervised hormones.

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And then at some point, particularly adolescents in later adolescence would come to the clinic seeking initiation of hormones, and they would meet with therapists there and then initiate hormones. And that preceded the availability of puberty blockers.

BY MR. RAMER:

Q And so in the early 2000s, in your opinion, there was sufficient evidence to conclude that giving adolescents hormone therapy was effective for treating gender dysphoria, correct?

MR. LANNIN: Object to the form.

THE WITNESS: So we used the information we had. There already was a long history of people, even adolescents, on hormones.

You know, the famous case of Agnes Torres who started treating herself with her mother's hormones in 1951 or '52, and then that was very well-documented, although they originally thought that she had -- that she was intersex because she didn't tell them. But they did -- she got vaginoplasty in 1959 at UCLA.

And I had -- did my psychiatry residency training at UCLA and was just kind of aware of the long history of that care being provided. And it

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was clear that there were adolescents who had received hormones and benefited from it, even though the evidence base obviously was much less than we have now.

BY MR. RAMER:

Q But you would not have recommended hormone therapy as a treatment for gender dysphoria in adolescents if you did not think there was sufficient evidence to conclude that it was effective, correct?

MR. LANNIN: Object to the form.

THE WITNESS: Correct. Yes.

BY MR. RAMER:

Q And when you first recommended puberty blockers as a treatment for gender dysphoria in the late 2000s, what evidence were you relying on?

MR. LANNIN: Object to the form.

THE WITNESS: So -- so the evidence at that point was evidence that was being used successfully in Amsterdam, and then in Boston. And then that information was shared with pediatric endocrinology at UCSF.

And -- so it was information from the Dutch clinic and their clinical experience, as well as, I believe, their early publication. Certainly

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by 2011, they had published. But in 2009 at the WPATH conference in Oslo, they discussed their experience pretty -- the Dutch group -- pretty extensively, from my recollection.

BY MR. RAMER:

Q And when you say "information was shared with pediatric endocrinology at UCSF," who are you referring to as sharing information?

MR. LANNIN: Object to the form.

You can answer.

THE WITNESS: So between the Dutch group, I remember Annelou de Vries coming to San Francisco, who published the 2011 and 2014 publications on their group, and the pediatric endocrinologist was Steven Rosenthal, who had been the pediatric endocrinologist for people with disorders of sexual development before starting to take care of trans kids, and so would provide puberty blockers for people with precocious puberty before doing that care for trans youth. And so he was already familiar with the provision of that care.

And then there was the information that this was helping youth in the Netherlands.

BY MR. RAMER:

Q And so in your opinion, in the late 2000s,

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there was sufficient evidence to conclude that giving adolescents puberty blockers was effective for treating gender dysphoria, correct?

MR. LANNIN: Object to the form.

THE WITNESS: Well, it was certainly true that we welcomed more research as it came about, but there was certainly promising research of the benefits that had been going on for quite a number of years in the Netherlands. And so there was the start of people getting that care in San Francisco.

BY MR. RAMER:

Q When you say "the start of people getting that care in San Francisco," what are you referring to?

A People getting -- youth getting puberty blockers through pediatric endocrinology at UCSF in the late 2000s, and then leading to the opening of a formal interdisciplinary clinic in 2012.

Q And you mentioned you served as the psychiatrist for the Dimensions Clinic; is that right?

A Yes.

Q And what age group did that clinic serve?

A Ages 12 to 25.

Q Why did the clinic provide care up to age

25?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: So, many youth clinics provide care for adolescents into young adults. So I just -- I think -- I don't know why they picked those specific ages, but it's not unusual to see youth clinics that span between providing care to adolescents and to young adults.
BY MR. RAMER:
Q Do you think 18- to 24-year-olds should be treated as adolescents rather than adults with respect to gender-affirming care?
MR. LANNIN: Object to the form.
THE WITNESS: So there are recommendations that are specific to age, but I think that there are youth who are more or less mature.
So one has to certainly pick an age. And generally, for legal capacity to consent to care generally, that age has been 18.
On the other hand, in the Dimensions Clinic, there was a substantial provision of psychotherapy and mental health care for people in, you know, also 18 to 25, recognizing that there were young people who needed mental health support or

needed to better understand themselves in terms of their gender identity.
So there -- there are reasons both for why care is separated at 18, why people go from pediatricians and child and adolescent psychiatrists to adult psychiatrists at 18. That is just kind of practice. But there's certainly, as you know, individual variability as well.
And so, you know, I think it was useful that the clinic provided, you know, care for people through young adulthood.
BY MR. RAMER:
Q Doesn't the WPATH Standards of Care 8 provide different requirements depending on whether you're treating an adolescent or an adult?
A Yes.
Q And how do you determine which requirements apply to a particular patient?
MR. LANNIN: Object to the form.
THE WITNESS: So, remember, you know, these are clinical guidelines, and individual clinicians can use their own judgment with a patient.
But it reflects that in younger people, it is particularly important to have a comprehensive

bio-psychosocial -- that's how it's often described -- understanding and evaluation of -- of the patient. And that there is variability as people get older in terms of their own understanding of themselves, such that it may well be clinically advisable for young adults to -- to have more care around transition.
But they're typically -- you know, because ages are set in terms of things like legal capacity, 18 is -- you know, is the divider in that way, and people generally, at 18, are considered to have the capacity to consent on their own for medical care.
BY MR. RAMER:
Q When you say clinicians can use their individual judgment with a patient, does that mean that a clinician could have a 22-year-old patient and determine that the clinician is going to use the requirements from the "Adolescents" chapter?
MR. LANNIN: Object to the form.
THE WITNESS: So, you know, again, they're practice guidelines. And so I wouldn't describe them as requirements for a 22-year-old, but there are 22-year olds who would benefit from more time, you know, kind of understanding gender identity and, you know, what they -- what course of action they

want to take.
But then there are many 22-year-olds who are -- who don't have that ambiguity, and so that's why an individual clinician, working with an individual patient, might, you know, spend more time with that patient; and even some people who were middle-aged or sometimes some people who need the most years of, you know, work in terms of what they want to do are people in their 50s and 60s.
And so there are individual circumstances in terms of -- particularly in the mental health field in working with people, in terms of helping them with the path that is best for them.
BY MR. RAMER:
Q With respect to the clinician's individual judgment, could a clinician have a particularly mature 17-year-old where the clinician would decide they're not going to use all the recommendations from the "Adolescents" chapter?
MR. LANNIN: Object to the form.
THE WITNESS: So they're practice guidelines, and they're not laws.
So it -- it certainly is, you know, possible that somebody might make that determination.

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I do think that if you are making that determination in an adolescent, in a way, in terms of your process of making that recommendation, you're utilizing the WPATH guidelines because you're assessing the cognitive maturity of the adolescent in order to decide, you know, what course of treatment is best.

BY MR. RAMER:

Q And switching gears just a little bit, I thought I read that you helped run WPATH's global education initiative; is that right?

A So I wasn't the -- one of the two leaders. There were two chairs. But I was very active in it from its inception until 2018.

Q And can you just kind of describe what that is?

A Sure.

So there was a recognition from, really, the -- around the start of my board service -- I guess others had probably had that recognition earlier -- that it was important for WPATH to use the knowledge of its experts to train a larger population of health professionals to provide transgender health and to -- to come up with some guidelines of how that education should work,

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looking at other health organizations that provided education of how -- how they organized that and how they did it.

And so providing a broader education program, and then also a certification where one could -- if one went through a fairly long process of trainings and took an exam and got mentoring with a senior clinician, one could call themselves "certified."

So that it was similar to what other organizations have done, especially in the mental health field; so that clients or patients could see that this was somebody who had received training, received formal training in the provision of transgender care.

Q And how do providers access the GEI programming?

A So they sign up for sessions on the WPATH website.

Q Are they, like, videos saved somewhere that people then --

A So when I was on GEI, it was all live trainings. And then with the start of the pandemic, they started doing both videotaped presentations and, I think, live Zoom sessions. But I haven't

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been involved during that period.

But it was a switch-over that, I think, probably would have happened anyway, but like many things, I think really got pushed forward by the pandemic when people were switching how they take in information to Zoom and watching videos.

Q And when you referenced "mentoring with a senior clinician," can you just kind of describe how that works?

A Yeah.

MR. LANNIN: Object to the form.

THE WITNESS: So I had left the WPATH board, and with it, my involvement in GEI, in 2018, just as the mentoring system was being set up.

The mentoring system was, I think, most important for psychotherapists, but there also was a mentoring program for people providing medical care.

So someone who had gone through all of the trainings and taken the exam would be matched with a mentor with whom they could discuss their cases.

And so it was a further step of trying to improve the kind of competency of people coming into the field to -- you know, in terms of their abilities to provide good care.

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BY MR. RAMER:

Q How were the mentors for that program selected?

A So, much of this happened just as I was leaving the board; so I am not familiar with all of it.

But there was an application process, is my recollection, where people would apply to be mentors. And they had to, I think, be certified themselves and have a certain amount of experience, and then they could apply to be mentors.

And then there were meetings of the mentors before they would be matched with -- with somebody needing mentoring.

Q Is it fair to say the mentors are experts on the topics that they're mentoring about?

MR. LANNIN: Object to the form.

THE WITNESS: I think it's fair to say that they're very knowledgeable in that they did need to be certified themselves.

But I have not been involved with the mentoring process since its early -- you know, since early on. So I can't say -- I can't vouch for the mentors or who were mentors now because I just haven't -- it's been six years since I've been

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involved with GEI.
MR. RAMER: We've been going about an hour. Is this a good time to take a break?
THE WITNESS: Sure.
MR. RAMER: We'll go off the record.
THE VIDEO OPERATOR: Going off the record, the time is 9:56 a.m.
(Recess, 9:56 a.m. - 10:12 a.m.)
THE VIDEO OPERATOR: Back on the record. The time is 10:12 a.m.
BY MR. RAMER:
Q Dr. Karasic, you are testifying both as an expert witness and as a fact witness in this case, correct?
A Yes.
Q And you've been deposed as an expert witness before, correct?
A Yes.
Q Did you give truthful testimony during those depositions?
A Yes.
Q And you have testified at court hearings as an expert witness before, correct?
A Yes.
Q And did you give truthful testimony at

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those hearings?
A Yes.
Q What did you do to prepare for this deposition?
A I reviewed my declaration, and I reviewed a little bit of literature, and I spoke with both the plaintiffs' lawyers and with the Covington lawyers about the deposition.
Q Did you speak with anyone else about the deposition?
A No.
Q And what literature did you review?
A So I looked over just my declaration. I reread the Cass report which was, you know, recently released in its final form, and some of the systematic reviews that were done: Joe Taylor, I believe, in association with the Cass report.
Q And do you know Dr. Aron Janssen?
A Yes.
Q When was the last time you spoke?
MR. LANNIN: Object to the form.
To Dr. Janssen, you mean?
BY MR. RAMER:
Q I'm sorry. Yes. When was the last time you spoke with Dr. Janssen?

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A I would say the last time I spoke with him was in Florida. We were both experts in Doe vs. LaDapo, and we went to dinner.
Q Are you aware that Dr. Marci Bowers and Dr. Eli Coleman were deposed last week?
A Yes.
Q Have you spoken with anyone other than counsel about their depositions?
A No.
(Exhibit 1 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what has been marked as Karasic Exhibit 1.
Does this appear to be Chapter 18 of the WPATH Standards of Care 8?
A Yes.
Q And if I refer to the Standards of Care 8 as the SOC-8, will you know what I'm talking about?
A Yes.
Q And you were the chapter lead for this chapter, correct?
A Yes.
Q And am I correct that the SOC-8 revision committee essentially had a three-tier structure,

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with co-chairs at the top, then chapter leads, and then chapter authors?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. There was the chair and co-chair as -- right, and then chapter authors, and then -- I mean chapter leads, and then chapter authors. Yes.
BY MR. RAMER:
Q Would you agree that all those people were experts in the field of transgender medicine?
MR. LANNIN: Object to the form.
THE WITNESS: I can't speak to the people outside of my chapter. I wasn't involved in the selection of all the people in all the chapters.
BY MR. RAMER:
Q So you are unable to say that the other authors outside of Chapter 18 were experts in the field of transgender medicine?
MR. LANNIN: Object to the form.
THE WITNESS: I would assume -- I mean, I know that there were many experts involved. I can't speak to every one of the 120 or however many there were.
My experience with Standards of Care 8 was limited to the tasks which, you know, I was expected

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to do.
BY MR. RAMER:
Q And what were those tasks?
A So it was being -- as chapter lead -- so in terms of all my tasks with standards of care, I had a little bit broader involvement when I was still on the board early on in terms of the selection of Eli Coleman, who had been chair of Standards of Care 7, for him to carry on to Standards of Care 8.
And then I applied for and I was made lead for the "Mental Health" chapter and worked on -- read the resumes and applications of the people applying to be on that chapter, reviewed those with the editors, and we selected a committee.
Q And just to go back to what we were previously discussing about the authors outside of Chapter 18, are you saying there's a chance that some authors of the SOC-8 were not experts in the field of transgender medicine?
MR. LANNIN: Object to the form.
THE WITNESS: No. I'm just saying I can't say under oath that they all were. I never met many of them.
So we were originally going to have -- our

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chapter met with the editors in Buenos Aires at the WPATH conference in 2018. And then we were all going to meet in 2020 at WPATH Hong Kong, but there was a little thing that happened in China in 2020, and that meeting didn't take place.
So we never had the opportunity to have a meeting of everyone. The next meeting we had of a WPATH meeting was 2022, which was just after the publication of Standards of Care 8.
BY MR. RAMER:
Q Would you be surprised if somebody was an author of SOC-8 and was not an expert in transgender medicine?
A I mean, my assumption is that the other authors, you know, had considerable expertise, and that's why they were selected for the chapter.
There was -- also, each chapter had a stakeholder who was appointed to the chapter, including ours, and our stakeholder was a psychotherapist who was trans but was not selected as part of the original group, who were mostly academics.
And so there may well be stakeholders who don't have the same kind of expertise, but I just don't want to vouch for everyone on as I don't even

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know who all of them are.
Q And you mentioned the WPATH conference in Buenos Aires; is that right?
A Yes.
Q Can you just tell me what that was?
A So WPATH has a conference every two years. And so 2018 was the international -- you know, every two-year WPATH conference.
And so during that conference, they had each -- the members of each chapter meet with the editors.
Q Did you -- were there any -- let me start again.
At that conference, were there any presentations about the drafting of the SOC-8?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. There was some sort of update about SOC-8 at that conference, I assume by the editors. I don't remember -- I don't remember what sessions there were, but I -- I'm sure that there were discussions about -- you know, sessions about Standards of Care 8 at the 2018 conference.
BY MR. RAMER:
Q Would you agree that the vast majority of the SOC-8 revision committee were people who were

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either publishing in the field of transgender health or had reputations for the clinical programs they led in transgender health?
MR. LANNIN: Object to the form.
THE WITNESS: So that was certainly the experience with the people whose names I recognized, and it was definitely true of the people on my chapter.
BY MR. RAMER:
Q And was a particular co-chair assigned to oversee your chapter?
A Yes.
Q And who was that?
A That was Jon Arcelus.
Q And who were the other co-chairs?
A Asa Radix was the other co-chair, and then there was the chair, Eli Coleman.
Q Can you just give me a general overview of Jon Arcelus as either a clinician or an author?
A Yeah.
MR. LANNIN: Object to the form.
THE WITNESS: So John Arcelus is a psychiatrist. He -- I was aware of him with his -- he had published with Cecilia Dhejne and others about psychiatric illness in people who are trans,

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which was really the topic of our chapter. So he certainly was somebody who had -- who was well-known and had expertise in that area.
BY MR. RAMER:
Q And was he a practicing clinician in the field of gender-affirming care?
A Yeah. My understanding is that he was both practicing and did academic work in -- in the United Kingdom.
Q And similar to how you just described Dr. Arcelus's background, can you provide a background of Dr. Radix?
MR. LANNIN: Object to the form.
THE WITNESS: So Dr. Radix I knew well from conferences over the years. He was a -- a clinician for health programs for trans people in New York and also had a faculty appointment, and taught and did research.
BY MR. RAMER:
Q Who is Dr. Karen Robinson?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: Dr. Karen Robinson is an academic from Johns Hopkins who has been involved with systematic reviews and -- and clinical

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guidelines. And she was, I think, the lead of the team that WPATH hired from Johns Hopkins for reviewing the literature and providing guidance in terms of practice guidelines.
BY MR. RAMER:
Q Were you involved in the process of helping select Dr. Robinson and her team to help with SOC-8?
A Yes. I recall there was a -- I think there was a request for proposals. I think the executive committee had -- after discussion with the board -- had recommended Johns Hopkins, and we, as a board, voted to hire the Johns Hopkins team for that purpose.
Q I think you described it generally, but could you kind of explain what the role was for Dr. Robinson and her team with respect to the SOC-8?
A Yes. So they had a responsibility for doing systematic reviews, and so contacting chapter leads about whether or not that was something kind of possible for that chapter.
And then they provided -- from their own kind of systematic review of the literature, they provided a very large document of publications that might be related to that chapter.

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Q Why is it important to conduct systematic reviews?
MR. LANNIN: Object to the form.
THE WITNESS: So systematic reviews are a widely accepted way of trying to look at evidence kind of broadly in a field. It's -- I think looking at systematic reviews is, you know, a common part of discussing the literature in any field.
BY MR. RAMER:
Q Would you say Dr. Robinson is an expert in transgender medicine?
MR. LANNIN: Object to the form.
THE WITNESS: No, but I really can't -- I really can't make a judgment. I don't -- I don't know her other than very kind of limited contact, and I don't recall the extent of her background as it might relate to transgender health, other than doing the systematic review.
BY MR. RAMER:
Q Do you know if Dr. Robinson is a clinician who treats children and adolescents for gender dysphoria?
A That's not my understanding of what she does, but I really don't know her background.
You know, we -- I was part of a board that

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made a recommendation to hire Johns Hopkins, and then she was the representative from Johns Hopkins who -- so my contact with her was really limited to her reaching out to me as -- as chapter lead and having a discussion about the literature for the "Mental Health" chapter.
Q Do you have any personal knowledge regarding WPATH restricting Dr. Robinson's ability to publish research?
MR. LANNIN: Object to the form.
THE WITNESS: No.
BY MR. RAMER:
Q And I think you touched on it briefly, but how did you come to be a chapter lead?
A Okay. So I'd been involved in WPATH for quite a while, involved particularly with WPATH's recommendations on diagnosis.
I had chaired, in 2003, the APA symposium about the gender identity disorder and the other disorders in that chapter in DSM-IV, and looking ahead to DSM-V, and edited a book on that. And then I had -- was involved in WPATH recommendations related to psychiatry.
And so then I was appointed to the Standards of Care 7 committee and was actively

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involved in Standards of Care 7, and so -- all before being on the board, but then, you know, I was also known, you know, being on the board.

And specifically, I was appointed -- I applied and was appointed for this chapter because that was a particular area that -- that I had done a number of presentations and some publishing about working with transgender people who had co-occurring mental illness.

Q So is it fair to say that the chapters of the SOC-8 were divided up among the revision committee by expertise?

MR. LANNIN: Object to the form.

THE WITNESS: Yeah. So the editors came up with the chapters, and then people applied to be on the chapters and they were accepted onto the chapters, presumably related to their expertise.

(Proceedings interrupted.)

THE WITNESS: May I have the question again, please?

BY MR. RAMER:

Q Yeah.

I was just asking, is it fair to say that the chapters of the SOC-8 were divided up among the committee based on the authors' expertise?

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MR. LANNIN: Object to the form.

THE WITNESS: So the process was that the editors established the chapters, and then there was an application process where one could apply to be a member of any of the chapters. And some people applied to multiple chapters.

If you were chapter lead, you were only involved with one chapter because that was felt to be enough work. If you were one of the chapter authors, you could be on multiple chapters.

But you had to apply to the chapter lead to be on the chapter, and then, you know, a decision was made really based on somebody's expertise of whether or not they were the best people for the chapter.

BY MR. RAMER:

Q Is it fair to say that the authors of one chapter may not have expertise in the subject matter of a different chapter in SOC-8?

MR. LANNIN: Object to the form.

THE WITNESS: Yes.

BY MR. RAMER:

Q Did you complete a conflict-of-interest disclosure form for the SOC-8?

A My recollection is yes.

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Q Do you recall reporting any conflicts?

A No.

Q Did the authors of the "Mental Health" chapter complete a conflict-of-interest form?

MR. LANNIN: Object to the form.

THE WITNESS: I assume they did. I think that was part of their -- there was an application packet for each member.

BY MR. RAMER:

Q Did you review them?

A My recollection is that I reviewed, you know, the whole packet that included the conflict form. But it was, you know, many years ago that that happened. But my recollection is that that was part of each application.

Q Do you recall any of the applicants for the "Mental Health" chapter having conflicts that you determined should preclude them from working on the chapter?

A No.

Q Were there any conflicts that you elevated to the co-chairs?

MR. LANNIN: Object to the form.

THE WITNESS: No.

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BY MR. RAMER:

Q Are you aware whether any of the authors of the "Mental Health" chapter had conflicts?

MR. LANNIN: Object to the form.

THE WITNESS: No.

BY MR. RAMER:

Q Do you recall whether anyone reviewed your conflict-of-interest form?

A I assume that that was reviewed by the editors because that was part of the process in which the editors selected me as chapter lead.

Q Did anyone ever ask you any questions about your conflict-of-interest form?

MR. LANNIN: Object to the form.

THE WITNESS: Not that I can recall.

BY MR. RAMER:

Q Did you update your conflict-of-interest form when you first began serving as an expert witness?

MR. LANNIN: Object to the form.

THE WITNESS: Update my conflict-of-interest form on Standards of Care 8?

BY MR. RAMER:

Q Yes.

A So that conflict-of-interest form was

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before I had served as an expert witness on any of these cases.
Q Right.
And my question is, once you began serving as an expert witness after you submitted the form, did you ever update the form?
A No.
Q After you submitted your conflict-of-interest form, do you recall ever discussing potential conflicts of interest again while drafting the SOC-8?
MR. LANNIN: Object to the form.
THE WITNESS: Can you repeat the question?
BY MR. RAMER:
Q After you submitted your conflict-of-interest form, do you recall ever discussing potential conflicts of interest again while drafting the SOC-8?
MR. LANNIN: Same objection.
THE WITNESS: No.
BY MR. RAMER:
Q Switching gears a little bit, or maybe zooming out, rather, can you just describe the drafting process for Chapter 18?
A Yes.

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So we had phone meetings. I don't remember when Zoom came into wide use, but it may have been -- I think it was originally phone, and then Zoom meetings. And we discussed what our recommendations might be.
And we had discussion with the editors, and they gave recommendations that our recommendations for the Delphi process should be ones that people can be -- that people using the document could act on as opposed to just only kind of good care documents. So they provided some guidance in terms of winnowing things down to fewer statements. And so we ended with ten statements.
And -- were you asking about -- what were you asking the process? I don't want to drag on further than --
Q No, I was just asking -- that was very helpful -- a general overview of the process.
A Yeah.
Q And can you explain the timeline of what you were kind of describing, the course of that drafting process?
A Sure.
MR. LANNIN: Object to the form.
THE WITNESS: So I think that the calls

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were in 2018. We had our ten statements already completed before Buenos Aires, which was in the fall of 2018. And so we discussed each of those, and our committee discussed each of those.
And then we submitted those statements to go to the Delphi process, and our chapter was in the first set of Delphi statements, which I think was 2019 that went to all of the authors of Standards of Care 8.
BY MR. RAMER:
Q And how did you communicate with your co-authors during the drafting process?
A So we talked by phone, by -- eventually, I think, by Zoom. We had a common document on Google Docs that people could edit. And we spoke by emails, which were all emails to SOC-8 mental health.
Q And can you explain a little more about your particular role as chapter lead with respect to the chapter authors and with respect to the co-chairs?
MR. LANNIN: Object to the form.
THE WITNESS: Yes.
I would be in communication with the co-chairs about tasks, and then would communicate

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those to chapter authors after we got the -- after we had our statements. Those went to Delphi, and all ten were approved.
And then there was -- we were supposed to take into account comments during Delphi. But if there were any major changes, it needed to go back to Delphi, and we didn't have any major changes.
And then at that point, we had a task of writing the explanatory text, and that task was divvied up among chapter authors, and that was sent to me, and I edited that.
And then it went to the editors, and they provided feedback. That's my recollection.
BY MR. RAMER:
Q And when you were communicating with co-chairs, were you primarily communicating with Dr. Arcelus?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, but the email chain, from my recollection, always included SOC mental health because we wanted the administrative staff from WPATH to get the emails. And Eli Coleman and Asa Radix were also, I think, getting those -- those emails, in addition to John Arcelus.
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BY MR. RAMER:
Q And looking at this chapter, how did you select the studies that are cited in here?
A So there was an initial selection by -- by members of the chapter committee, and then there were citations that I added and there were citations that -- that John Arcelus added.
Q Do you know how the other chapters in SOC-8 selected the studies that they cite?
MR. LANNIN: Object to the form.
THE WITNESS: No.
BY MR. RAMER:
Q Do you have any reason to think they did it differently?
MR. LANNIN: Object to the form.
THE WITNESS: I don't know the process in the other -- for the other chapters.
BY MR. RAMER:
Q Did you ever assess the risk of bias that you cite in this chapter?
A So typically with risk of bias, I think of, like, of a study where certain people might have dropped out and others might not have.
But generally, in this particular area, which is about treating people with co-occurring

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conditions, the research is maybe more limited. And so we used authors in these various areas who we were familiar with or the chapter author who had taken primary responsibility for that recommendation was familiar with.
But, you know, so there certainly was some overall assessment of a particular -- a particular reference, but I'm not quite sure how that might relate to bias.
Q What do you mean -- at the end there, what do you mean by that?
MR. LANNIN: Object to the form.
THE WITNESS: Well, different people use that term differently. So I don't know if you have -- if you're more specific about what you mean.
BY MR. RAMER:
Q What's your understanding of "bias" in the context of assessing the method used in a particular study?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: Sure.
Well, as I said, that term is used in different ways. Sometimes it can be used in terms of the particular populations that is -- that's

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measured.
I was saying, in terms of this chapter, there was really a very wide range of kinds of papers that were -- that were cited because it's a field where, for certain questions, there are certain kinds of evidence, and for other questions, there are kind of recommendations of clinical practice that have been made, but maybe not as much in terms of -- of a study determining it.
So there were times where the consensus of the clinicians, backed up by what we knew from the literature, you know, was more of a basis.
There were other things that were maybe a little more clear-cut, like about addressing nicotine in our patients, you know, where the health effects of nicotine are well-known.
BY MR. RAMER:
Q Do you know if the authors of the other chapters in the SOC-8 ever assessed the risk of bias of the studies they cite?
MR. LANNIN: Object to the form.
THE WITNESS: So my experience was really contained to my -- the chapter that I was chapter lead on, voting for Delphi's statements, and not the process that was going on in the other chapters.

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BY MR. RAMER:
Q Did you ever assess the risk of bias of the studies you cite in your expert report in this case?
MR. LANNIN: Object to the form.
THE WITNESS: So, again, that -- "bias" is used in different ways.
And so there is bias in a clinical trial which might involve who was reported on with, for example, drop-outs, as well as the population that -- from where the data was recruited.
And so those are potential sources of bias that -- you know, that I would look at with a particular -- with a particular study.
BY MR. RAMER:
Q And did you do that for the studies you cite in your expert report in this case?
MR. LANNIN: Object to the form.
THE WITNESS: Well, for -- I think that's always an assessment in terms of looking at a particular article.
Like, I cited Cavve from Western Australia where they took everyone who had completed treatment in their clinic, and they -- because of the geographic isolation of Perth and Western Australia,

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they were able to track down almost everyone who had been seen in the clinic and terminated care.

And so a study like that, you know, has less bias because there aren't people that are loss to follow-up.

BY MR. RAMER:

Q And so "loss to follow-up" is one example of a form of bias, right?

A Right.

Q And when you are assessing the degree of bias in a study, how do you do that?

MR. LANNIN: Object to the form.

THE WITNESS: So I would -- I'd look at the -- at the methods, at the clinical population that they were studying; and if there is that information, how they were recruited, how someone came into a study.

And so there are various kind of points along the way where one can try to get some assessment of what particular biases could be.

BY MR. RAMER:

Q And so basically you're reading the study and using your judgment to determine where there may be methodological weaknesses in the study as you read it; is that right?

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MR. LANNIN: Object to the form.

THE WITNESS: Yes.

BY MR. RAMER:

Q Have you ever used a tool to help you assess the risk of bias in a study?

MR. LANNIN: Object to the form.

THE WITNESS: No.

(Exhibit 2 was marked for identification and is attached hereto.)

THE WITNESS: I would say, like, systematic reviews are -- you know, do use -- include the risk of bias in their assessments. And so that is part of the use of systematic reviews and that they've made an assessment or tried to make a formal assessment on risk of bias.

BY MR. RAMER:

Q And, Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 2.

A Um-hum.

Q And looking at just the cover, does this appear to be a presentation from the meeting in Buenos Aires we were talking about earlier?

MR. LANNIN: Object to the form.

THE WITNESS: Well, yeah. I don't remember the slide, but it does look like it was

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from that meeting.

BY MR. RAMER:

Q I'll represent to you this is an excerpt of this document.

And I'd like to turn to page 4 -- I apologize for the stapling of this -- page 4 which has the Bates stamp JHU3259 in the bottom right, and the slide at the top says, "Hierarchy of Evidence."

Do you see that?

A Yes.

Q Can you explain what this slide is communicating?

MR. LANNIN: Object to the form.

THE WITNESS: Yeah.

So it is from another publication, and that there are these kind of different levels of evidence, each which can have value, but are ranked in a way in systematic reviews because they are looking at -- a kind of broader body of literature are at the top, and randomized controlled trials are also up there because that is a -- you know, an important source of evidence.

BY MR. RAMER:

Q And I think we touched on it at a general level, but can you explain more about what a

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systematic review is?

A Yes.

So a systematic review is when one tries to take the entirety of the literature in a particular area, and then to have a filtering protocol, essentially, that one decides upon in advance, and use that to filter this very -- what can be a very large literature into the papers, the studies, that meet one's criteria, and then to try to just analyze those studies.

So you're trying to take the broader literature that might be quite difficult to analyze, and then filter them to a smaller group that meet those criteria that might be easier to kind of assess and synthesize.

Q Is it your understanding that as part of a systematic review, researchers would assess the degree of bias in the individual studies?

MR. LANNIN: Object to the form.

THE WITNESS: Yes. Typically they assess bias in a systematic review.

BY MR. RAMER:

Q And are you able to explain why randomized controlled trials are above cohort studies in this pyramid?

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A Yes. So randomization is a way of reducing bias in terms of who gets a particular intervention.

So in a -- in some other sorts of studies, everyone might get -- who signs up for the study -- might get a particular intervention, and in a randomized controlled trial, people are randomized typically to either get the intervention or not get it.

Q And so what is a cohort study?

MR. LANNIN: Object to the form.

THE WITNESS: So a cohort study is when you are looking at a group of people who have received a particular intervention and trying to see whether that intervention has an impact.

BY MR. RAMER:

Q And so how is it -- how is it different from the randomized controlled trial?

MR. LANNIN: Object to the form.

THE WITNESS: In a cohort study, you don't have to have randomized people to the intervention or not. It could be -- you could have had -- you could be looking at a group of people who have received a particular intervention.

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BY MR. RAMER:

Q And so cohort studies represent lower-quality evidence than randomized controlled trials; is that right?

MR. LANNIN: Object to the form.

THE WITNESS: So in the -- in the methodology of ranking the quality or certainty, a randomized trial is valued higher.

BY MR. RAMER:

Q Do you think that's right?

MR. LANNIN: Object to the form.

THE WITNESS: Yes. I've conducted a randomized controlled trial myself, and I see the value there.

But there also are interventions, and that certainly is the case with patients that we treat where it's more difficult or impossible to do a randomized controlled trial.

BY MR. RAMER:

Q Do you think it's unethical to do a randomized controlled trial in this context?

MR. LANNIN: Object to the form.

THE WITNESS: I think in certain circumstances, yes.

If we know that one intervention has a lot more evidence of its efficacy than another intervention, then it could be unethical to randomize people to -- you know, if we know that that randomization might cause harm to one of the groups of people when there is a treatment that is well established.

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BY MR. RAMER:

Q What if you don't know that a particular treatment is well established?

MR. LANNIN: Object to the form.

You can answer.

THE WITNESS: There are -- there are certainly a number of -- of settings in which randomized controlled trials are done, but there are also challenges to doing them based on the -- on the intervention.

For example, when I was involved in a study where we did randomize people, both groups got an intervention that would be considered efficacious.

We didn't do a placebo group because we wouldn't consider that ethical when we knew that there were interventions that might be efficacious.

BY MR. RAMER:

Q In the context of treating adolescents for gender dysphoria, would it be unethical to create a study where participants are randomized into two groups, where one group receives only psychotherapy and the other group receives psychotherapy and hormone therapy?

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MR. LANNIN: Object to the form.

THE WITNESS: So if you had availability of hormone treatment and you had healthcare providers who had determined that those people would benefit from medical treatment, it would be unethical to randomize them to not getting that medical treatment.

So there are many people who can benefit from psychotherapy, but there's no evidence that in the subset of people who have a gender dysphoria diagnosis with the clinically significant distress and impairment of that, that psychotherapy alleviates that gender dysphoria.

So under that circumstance, I don't think it would be ethical to randomize that population of people for whom gender-affirming medical care has been indicated and recommended.

BY MR. RAMER:

Q But doesn't that sort of assume the conclusion if the question is, can the psychotherapy

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achieve similar results, and the answer is, well, we're not going to do the study because there's no evidence that the psychotherapy achieves similar results?

MR. LANNIN: Object to the form.

THE WITNESS: So I think you can look back to even a publication by Brown in 1960, who was with the Air Force, but he had done some research with the UCLA group that was providing care to both -- across age groups in the 50s, 60s, 70s.

And for -- so they, at that time, you know, recognized that prepubertal youth might desist from their gender diversity. They didn't have a diagnosis at that time. But they recognized that after puberty, that wasn't likely.

Anyway, in that 1960 publication, the person was specifically referring to adults, but saying that they had never seen someone whose gender identity had changed as a result of -- of psychotherapy.

So in another talk that Brown had given, he had said that he hadn't seen it in adolescents, but in younger -- basically younger people could desist, and that was what they eventually published out of UCLA. Again, not people with a diagnosis,

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but people who were brought in, in that case the young people, by their parents.

So my point is that we're not coming in without decades of experience. And there have been multiple case reports, attempts at literature in terms of psychotherapy back from the psychoanalysis days to cognitive behavioral therapy.

And so through all of that, there just hasn't been any evidence of efficacy that -- for psychotherapy only for those people who need medication.

And so taking those people who have been determined to have a gender dysphoria diagnosis and have -- within that diagnosis, need -- have great distress about aspects of their physical body, typically, to randomize people to either get an intervention that we have a long experience of being successful versus an intervention where we have a long experience of lack of success, that that would not be ethical to randomize between those two choices.

BY MR. RAMER:

Q Are you saying we don't have evidence to show that psychotherapy alone is effective, or are you saying that we know that psychotherapy alone is

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ineffective?

MR. LANNIN: Object to the form.

THE WITNESS: So I think we can -- when it comes to adolescents and adults, I think that we have -- we don't have evidence of efficacy, and we have substantial clinical experience of inefficacy. And that's something that's been known really for decades.

As I said, there's been controversy on prepubertal children, but not adolescents and adults.

BY MR. RAMER:

Q Do you see a distinction between psychotherapy that is provided with the purpose of changing an individual's gender identity and psychotherapy that is provided for the purpose of reducing the distress associated with gender incongruence?

MR. LANNIN: Object to the form.

THE WITNESS: So I do work, and the therapists I work with do work, in terms of reducing distress or improving someone's ability to cope with the distress of gender dysphoria. But we don't see that as a replacement for treating gender dysphoria medically when -- in the cases where it makes sense

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to do so.

BY MR. RAMER:

Q And do you think it would be unethical to study whether that psychotherapy alone would be effective?

MR. LANNIN: Object to the form.

THE WITNESS: So I think that there has been -- there have been decades in which people have had that opportunity. And, you know, there have been transgender people and people with gender dysphoria, you know, for -- certainly for many decades that have been documented.

And you look at someone like Robert Stoller, who started the Gender Identity Research Center at UCLA in 1963 and was a mentor, he was a psychoanalyst. So psychoanalysts really believe that almost everyone, you know, should get therapy, basically. They're strong proponents.

But with this population, he supported medical intervention because his experience was there was a subset of the people he saw where medical intervention was the only thing that helped them.

And so -- so the reason I bring that up is it's like -- it's not a new thing like, you know,

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COVID appearing and stopping our WPATH conference in 2020. It's not something that just arose de novo, you know.

Clinicians have been working with these folks for decades and decades and decades. And if there was -- it seems like you would need to have some glimmer that there was an intervention that was effective given that there has been a long opportunity to do interventions, and interventions have been tried for decades without success.

And so that's why I'm saying it's not ethical just like when -- the clinical trial that I did, we didn't have a placebo group because we knew that interventions helped, it wouldn't have been ethical to give placebo to some of our patients.

BY MR. RAMER:

Q Are you aware of a study designed along the lines of the study I previously described?

MR. LANNIN: Object to the form.

THE WITNESS: So in terms of randomizing people to psychotherapy versus a medical intervention, no.

BY MR. RAMER:

Q And you think that we should not do that study because it would be unethical, correct?

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MR. LANNIN: Object to the form.

THE WITNESS: I think if you were actually doing a randomized group as opposed to selecting people who -- who were -- like, a select population of people who really were seeking exploration of their gender identity and not seeking -- not having clinicians saying that a medication was indicated, you know, that there could be a clinical trial of people who were gender questioning, you know, of different interventions on them.

But for people for whom a medical intervention is indicated, to randomize those people to not getting that intervention and getting a psychotherapeutic intervention, I don't think it's ethical.

It's also not practical because I don't think that they would -- you would be able to get people to join that study.

BY MR. RAMER:

Q In the randomized controlled trial that you did that you were referencing, which I assume is the one with the individuals who are HIV positive, and you gave them a particular psychiatric --

A Right.

Q -- were they randomized?

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A So they were randomized to two different kinds of intervention.

One was usual care where they would get their prescription and be responsible for it themselves, the way which is how most everyone gets an antidepressant, how they were getting antidepressants before, versus getting a weekly form of an antidepressant that -- with directly observed therapy, where they would come in, and it was observed that they would swallow the medication. And it was a medication that only needed to be given once a week.

So we knew that there was a problem with adherence in this population. And because they were people with HIV, the problem with adherence was also with their HIV medications. And we knew that the mortality was much higher in that particular population than other populations of HIV-positive people with better adherence -- we were looking at homeless people who had particular difficulties taking their medications -- and trying to see if there was a better intervention for those who were depressed to treat their depression.

Q So am I wrong in thinking that that study divided up the individuals into the treatment arm

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which received -- I'm going to butcher the pronunciation -- fluoxetine --

A Yes.

Q -- and the referral arm which received group therapy?

MR. LANNIN: Object to the form.

THE WITNESS: No. So that was a different study. So that study was way earlier. That was while I was still at UCLA in my residency, and -- when that was done. And that was a group therapy focused on therapeutic interventions for depression versus fluoxetine.

And that was a different -- a different study because those were specific group therapies that were known to be effective treatments for depression, and those were people who were motivated to get that kind of treatment as well, with or without fluoxetine. So that was a different study.

I was referring to a study with homeless HIV-positive people for whom -- and this was many years later -- for whom -- the first group was before there were any HIV medications; and having interventions -- group interventions to treat depression and to teach them to better cope with the stress of having AIDS or HIV, that was the intent of

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the intervention.
The study with the second population, everyone got fluoxetine. Some people got it weekly, directly observed therapy. Some people got it as a usual care prescription like they would if they weren't in the study.
BY MR. RAMER:
Q In the earlier study with fluoxetine and group therapy, was that study ethical?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, because we were -- in that study and in that population, we were looking, within this limited time period, of intervening for depression with psychotherapy.
So unlike gender dysphoria, cognitive behavioral therapy and interpersonal therapy have been determined to be effective treatments for depression.
I would say since that study, there have been some systematic reviews that have shown cognitive behavioral therapy to be effective, and fluoxetine to be effective, but fluoxetine may be more effective; so maybe that changes the balance of the ethics.
But that -- but from the information we

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had then, a cognitive behavioral therapy for depression and fluoxetine were both efficacious treatments for depression in that population.
BY MR. RAMER:
Q Just one more question, and maybe we'll take a break.
But back on Exhibit 2 and that page with the pyramid, do you agree that out of the types of medical evidence listed on this pyramid, that "expert opinion" represents the lowest form of medical evidence?
MR. LANNIN: Object to the form.
THE WITNESS: So expert opinion on its own, but I do think that clinical guidelines refer heavily and with good reason to expert opinions that try to synthesize -- both synthesize the data and the end clinical practice as it is.
And so -- so all these other levels are important, but consensus of experts is important as well.
BY MR. RAMER:
Q Sorry. Just clarifying, do you agree that "expert opinion" on this pyramid is referring to what might be referred to as clinical observations?
MR. LANNIN: Object to the form.

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THE WITNESS: So -- yeah. So I think "expert opinion" can include based on one's clinical observations. I think that, you know, might be a reasonable --
BY MR. RAMER:
Q Yeah, and I wasn't trying -- I was just -- you know, you can understand there could be expert opinion that is informed by all the studies.
A Right.
Q That's one example.
A Right.
Q But I don't think that's what that's referring to.
A Right.
Q And that's referring to clinical observations, I assume.
MR. LANNIN: Object to the form.
THE WITNESS: Yeah, I would assume that that's like in isolation, but all of these other things should be taken into account as well.
MR. RAMER: Maybe good time for a break?
MR. LANNIN: Sure.
THE VIDEO OPERATOR: This marks the end of Media Unit 1 of the deposition of Dan Karasic, M.D. The time is 11:21 a.m. We're off the record.

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(Recess, 11:21 a.m. - 11:31 a.m.)
THE VIDEO OPERATOR: We are back on the record at 11:31 a.m. This marks the beginning of Media Unit 2 of the deposition of Dan Karasic, M.D.
Please continue.
BY MR. RAMER:
Q Dr. Karasic, one question I meant to ask earlier is, did you review any -- I'll start again.
In preparation for this deposition, did you review any deposition transcripts from this case?
A No.
Q In the context of reviewing medical research, are you familiar with the term "narrative review"?
A I'm not sure. Can you say anything more?
Q I'm just curious if you've heard that term and what your understanding of that term is.
A I'm not sure.
(Exhibit 3 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, the court reporter has handed you what's been marked as Karasic Exhibit 3, and it says, "Appendix A Methodology" at the top.

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A Um-hum.
Q And does this appear to be Appendix A to the SOC-8?
A Yes.
Q And does this appendix discuss the methodology used to create the SOC-8?
MR. LANNIN: Object to the form.
THE WITNESS: Yes.
BY MR. RAMER:
Q And on this page, which has "S247" in the upper right corner, I'd like to go to the left column, the first paragraph, and the third sentence. And I'll just read it and first ask if I read it correctly.
It says, "Evidence-based guidelines include recommendations intended to optimize patient care and are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."
Did I read that correctly?
A Yes.
Q For the "Mental Health" chapter, did you or your co-authors seek a systematic review of evidence?
A So we discussed that with Karen Robinson,

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and she didn't feel, based on the ten statements that we had, that a systematic review would add anything versus just trying to reference the research. Many of the things had not had a specific systematic review.
Q And when you say she explained that a systematic review would not add anything, what do you mean by that?
A Well, it was a long time ago, but we had a conversation where I said, "These were our statements of recommendation. Do you recommend or do you think we could do systematic reviews on this?"
And my recollection was that -- that she said no.
Q So it was Dr. Robinson's decision as to whether a systematic review was conducted for the "Mental Health" chapter; is that correct?
MR. LANNIN: Object to the form.
THE WITNESS: Well, if I felt -- if I disagreed, I might have pressed the point.
But I asked her opinion as a -- you know, our systematic review group, asked her about -- my understanding is that there were -- would be chapters where systematic reviews might help and

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other chapters in which they wouldn't add much. And I asked her about that, and that's my recollection.
BY MR. RAMER:
Q And you agreed with her conclusion that a systematic review would not add much to the "Mental Health" chapter; is that right?
MR. LANNIN: Object to the form.
THE WITNESS: Yeah. I didn't -- I certainly didn't contest her -- her point.
BY MR. RAMER:
Q And do you think that's true, that a systematic review would not have added much to the chapter?
A Well, I think that -- I mean, I think it's a good question.
I think that there -- we were treading on an area where the literature, as it relates specifically to transgender people, is limited, and I think we were drawing on the broader literature, for example, on the provision of or capacity for informed consent.
And so I -- you know, I think it was reasonable for us to just look at the specific literature in -- in those specific areas, given the kind of disparate nature of the recommendations

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where we were kind of basing them on kind of different fields of medicine and mental health.
Q And so is it fair to say that, in your opinion, a systematic review would have confirmed what you already knew, which is that the evidence in this area is limited?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, and that we often had to look at the broader -- the broader research. Like, whether it might be for nicotine affecting surgical outcomes, we know that from the broader plastic surgery literature; or whether it's about -- capacity to give informed consent is from the broader literature, not specifically from the transgender health literature.
BY MR. RAMER:
Q And outside of just Chapter 18, can you name a systematic review that supports the conclusion that people receive benefit from gender-affirming medical care?
MR. LANNIN: Object to the form.
THE WITNESS: So I think that the systematic review for hormones that was done, that that one, which was done by the Hopkins group and published by them, provides support for people

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getting benefit from -- psychological benefit, for example, from -- from gender-affirming hormones.
BY MR. RAMER:
Q And you're referring to the systematic review that was published, correct?
A Yes.
Q And are there any other systematic reviews you're aware of that support the conclusion that gender-affirming medical care will benefit people?
MR. LANNIN: Object to the form.
THE WITNESS: So I think that there have been a range of systematic reviews showing benefit. Even most recently from the Cass report, the systematic review for hormones showed a moderate level of support for mental health benefit.
I think the Cornell systematic review of what we know, which reviewed the literature from early on, I think early 1990s to 2017, found benefit within that systematic review. I think the Bustos systematic review of regret showed that that was very uncommon.
So I think there have been systematic reviews that -- you know, that have been supportive of providing gender-affirming care.
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BY MR. RAMER:
Q Am I right in thinking that the Cornell review applied only to adults?
MR. LANNIN: Object to the form.
THE WITNESS: My recollection is that it was the literature as a whole and not -- not specific to adolescents.
I don't know whether there were any youth included in any of the papers that they reviewed. They reviewed a lot of papers.
BY MR. RAMER:
Q Sticking with Exhibit 3, which is Appendix A to the SOC-8, I'd like to go to -- stick with the same page, same column, actually same paragraph. And there's, just over halfway, a sentence that begins with, "The process." And I'll read it and first ask if I read it correctly.
It says, "The process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and the World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process."
Did I read that correctly?

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A Yes.
Q And then following that sentence, it cites two documents.
Do you see that?
A Yes.
Q Have you ever read -- sorry. Go ahead.
A Yeah. Okay. Yeah, I see the two documents. Okay.
Q Have you ever read either of those documents?
A I don't recall reading either of them, but I can't say no, either.
Q Are you able to say that the SOC-8 followed the recommendations of those documents with respect to the SOC-8's conflict-of-interest policy and committee composition?
MR. LANNIN: Object to the form.
THE WITNESS: I think that they -- they had a conflict-of-interest policy, and they had a transparent process for appointing the committees.
I can't say whether they met, you know, all of the recommendations from the two papers.
BY MR. RAMER:
Q In your answer just now, who is the "they"?

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A Oh. So I would say the editors of Standards of Care 8.
Q And so sticking with the same Exhibit 3, same column, and then skipping down two paragraphs, about halfway -- a little over halfway through that paragraph, there's a sentence referring to the Delphi process.
Do you see that?
A Yes.
Q And you've mentioned that a little bit today already.
A Yes.
Q Can you just -- can you just explain broadly what that is?
A Sure.
MR. LANNIN: Object to the form.
THE WITNESS: So Delphi process is a means of producing a consensus recommendation in practice guidelines, and particularly where consensus of experts is part of the process for developing the guidelines.
And so for Delphi, we submitted our recommendations, and they needed 75 percent approval; but also, each of the larger group of authors of Standards of Care 8 had the opportunity

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to provide any feedback for each -- for each statement.

And they wouldn't be included in Standards of Care 8 unless they or the revised version had received 75 percent support.

BY MR. RAMER:

Q And the "they" in that answer is referring to the statements?

MR. LANNIN: Object to the form.

THE WITNESS: Yes. The statements wouldn't be included unless the statements had received 75 percent support.

BY MR. RAMER:

Q And can you describe, just as a practical matter, how the authors voted on a statement?

A Yeah.

It was a survey program that provided a -- as I recall, like a Likert or modified Likert scale of level of approval to disapproval. It may have been 1 to 10. And so people could vote level of approval to level of disapproval.

And a high level of approval was required, but there was still variability that people could -- could report, even if they're approving.

And then whether approving or

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disapproving, there was space on the form for their comments or any recommendations for changes that were especially important if they were not approved for Delphi. But we were also encouraged to take that into account if we needed to make modifications even if a statement was approved.

Q And did you say "Likert scale"?

A Oh, that's just like a 1 to 5 or 1 to 10 from "strongly disagree" to "strongly agree" that you see in polling, basically.

Q And so can you explain who all voted in the Delphi process?

MR. LANNIN: Object to the form.

THE WITNESS: So that was all of the authors of Standards of Care 8; you know, over 100 people.

And I think they had to have -- I think 65 percent of them had to have voted in order for the poll to be complete. So there was a deadline to complete the poll. And if they didn't reach a minimum, then presumably there could be more time given or more urging for people to vote.

BY MR. RAMER:

Q And so a statement, under the process as you just described it, could be approved even though

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not all of the authors voted on the statement, correct?

MR. LANNIN: Object to the form.

THE WITNESS: So -- right. So all of the broader authors -- a statement didn't go to Delphi until there was consensus of the chapter authors.

So all of our statements had kind of full consensus of the people in our chapter, but only 75 percent had to approve of all of the authors who voted.

BY MR. RAMER:

Q I guess my question was a little bit different, which is that -- and maybe I'm misunderstanding.

I thought you said that you had to hit a threshold of 65 percent for the vote to count, meaning that you could have up to 35 percent who did not vote, yet the vote would still count; is that right?

A That is my recollection, but I'm not sure if that was the -- there was a number threshold that you wouldn't complete the poll if -- you know, if enough people hadn't voted. Knowing that you have this very large group of authors and there are going to be people that don't respond, that they set a

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threshold.

And then -- I also don't recall if it was the 75 percent -- my assumption is it was 75 percent of the people voting and not 75 percent of all the authors, but I would have to look that up to see what that was.

Q Sorry. I think my question was less about the precise number, but just understanding that a statement could be -- let me restart.

A statement could pass the Delphi process even though some authors did not participate in the vote for that statement; is that right?

MR. LANNIN: Object to the form.

THE WITNESS: Yes. And so, like this statement says, "was approved by 75 percent of the members."

But I'm not sure whether that was 75 percent of all the people on the chapter versus 75 percent of the people who voted.

BY MR. RAMER:

Q And do you recall, did you vote on every statement in the SOC-8?

A Yes. To my recollection, yes.

Q Okay. So sticking with Exhibit 3, I'd like to go to the fourth page, which is S250 at the

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top. And right column, there's a bold "3.9 Grading criteria for statements."
Do you see that?
A Yes.
Q And the first sentence says that "Chapter members graded each statement using a process adapted from the Grading of Recommendations, Assessment Development and Evaluations (GRADE) framework."
Do you see that?
A Yes.
Q And did you do that?
MR. LANNIN: Object to the form.
THE WITNESS: So we -- we did that, but just in regards to classifying statements as a strong recommendation if we recommend versus a weak recommendation if we suggest. And we had the criteria here that was a way of -- with the editors -- of making that recommendation.
BY MR. RAMER:
Q So basically you're saying that the criteria listed here in Section 3.9 is the modified version of GRADE that was used for the SOC-8; is that right?
MR. LANNIN: Object to the form.

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THE WITNESS: That's my understanding.
BY MR. RAMER:
Q And can you just describe how you, in the "Mental Health" chapter, did that process?
MR. LANNIN: Object to the form.
THE WITNESS: Sure.
So as I said, we didn't have really systematic reviews to inform us, but we made recommendations for which there -- for which we felt there was substantial evidence and few downsides, essentially, and in which there was a high degree of acceptance. All of our recommendations passed on the first time with a very high percentage.
And so, you know, the recommendation that somebody has to have capacity to consent in order to consent for transgender care was something that I think everyone could agree on and substantially supported by the literature.
And I didn't view our chapter as particularly controversial, and, in fact, I haven't heard any -- none of the controversy that's gone on about SOC-8 has been about our chapter.
I don't think many people object to the idea that transgender people should receive good mental health care, which was basically kind of our

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goal in our chapter.
BY MR. RAMER:
Q Are there chapters in SOC-8 that you do view as controversial?
A Well, only in the sense that there's -- there are chapters that one, you know, sees being brought up in media or in, you know, social media, and really just, you know, a couple chapters that -- where I have seen things, certainly.
Certainly the "Adolescents" chapter, which is the subject of -- you know, it's controversial in the context of the legal actions that have been taken.
Q And are there any other chapters that you're referring to when you say you've seen them brought up in media and social media?
A I've seen the "Eunuch" chapter brought up in media and social media.
Q Is it fair to say the grading process for your chapter was a collaborative process between the authors?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. It was a collaborative process between the authors and the -- and also the editors.

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BY MR. RAMER:
Q And that was my next question. Did they then -- did the editors review the grading of the chapter?
A Yes.
MR. LANNIN: Object to the form.
BY MR. RAMER:
Q Did they ever -- I guess -- let me back up.
Were there ever disputes about the grading?
MR. LANNIN: Object to the form.
THE WITNESS: I wouldn't make -- have it rise to the level of "dispute."
There were discussions over what's the level of evidence, the strength of consensus, the downsides of a given recommendation.
And so it was discussed, but I don't think it was ever really disputed.
BY MR. RAMER:
Q And then returning to Exhibit 1, which is the "Mental Health" chapter, and the first page of that chapter, which is S171, in looking at the statements in the box at the bottom of that page, all of those statements are listed as "We

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recommend," correct?
A Yes.
Q And so then returning to Exhibit 3, Appendix A to SOC-8, same page we were on before, which is S250, under the bold section, 3.9, about halfway through that section, it says, "The statements were classified as: Strong recommendations ('we recommend') are for those interventions/therapy/strategies where," and the first bullet says, "the evidence is of high quality"; is that right?
A Yes.
Q And so did you and the chapter authors all conclude that the evidence supporting the statements in the "Mental Health" chapter is of high quality?
MR. LANNIN: Object to the form.
THE WITNESS: So, you know, not in the sense of, you know, where that might be applied elsewhere in terms of a -- these statements weren't -- not all of them were supported certainly by randomized clinical trials, for example.
But these were all statements that we felt were strongly supported, at a minimum, by the consensus of experts where there was a lack of, let's say, a clinical trial.

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BY MR. RAMER:
Q And when you were talking about where that term might be applied elsewhere, are you alluding to the standard GRADE framework for high-quality and low-quality evidence?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. So this, in a way, was maybe more -- there were statements in which there weren't that type of study, but there was strong clinical consensus and a lack of controversy that these recommendations should be followed, you know, among clinicians.
BY MR. RAMER:
Q And so the reference to the evidence being of high quality in that bullet is different from what high-quality evidence means in the traditional GRADE framework; is that right?
MR. LANNIN: Object to the form.
THE WITNESS: Well, I think that it was using the evidence that we had, and, you know, I mean, I think that terminology might be used differently in different contexts.
So, you know, I do think it was different than, let's say, had we done a systematic review of each of these statements and, you know, could, you

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know, provide a label to the quality based on a GRADE score of a systematic review.
This was more so, I think, than -- than, say, a "Medical" chapter, for example, related to consensus of clinical practice in some cases.
There were some that, you know, are certainly very strongly supported by the literature, and there's some that -- where there's not a lot of literature, but there is a clinical consensus to make a recommendation.
BY MR. RAMER:
Q So just so I understand, so some of the statements -- backing up, in the "Mental Health" chapter, for some of the "We recommend" statements, is it fair to say that for some of those, the evidence underlying the statement would not be deemed high-quality evidence under the traditional GRADE framework? Is that what you're saying?
MR. LANNIN: Object to the form.
THE WITNESS: Well, in that it may be difficult to even do a systematic review.
I'm just thinking of -- you know, of just some of the recommendations. There's really a wide range of how much literature there was for the various recommendations that we -- you know, that we

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made, like -- well, there's some that, you know, only providing care to people with capacity to consent has a vast literature. Maintaining existing hormones when somebody goes on an inpatient unit, there's a fairly small literature on that, but there was strong clinical consensus that that was the recommendation, and it is a question that's often asked.
BY MR. RAMER:
Q So when you were applying this methodology for the "Mental Health" chapter, how did you decide whether the evidence is of high quality?
MR. LANNIN: Object to the form.
THE WITNESS: So I think I was looking at these statements as a group. And so there is a variation by statement in how much literature, how much research has been done, how much is just clinical reporting and clinical policies.
But there were some where there was -- more had to do with consensus of experts, and there were others in which there was a much larger literature that one could draw on.
BY MR. RAMER:
Q And then basically it was the judgment of the authors, with all of your expertise, to

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determine whether the evidence was of high quality?
MR. LANNIN: Object to the form.
THE WITNESS: It was ultimately our determination of whether to use -- the authors and editors -- of whether to use "recommend" versus "suggest."
So, again, we weren't looking at only statements for which a systematic review had provided high-quality research. There was kind of a range in research by recommendation.
BY MR. RAMER:
Q Do you think that there's a distinction between "high-quality evidence" and the "best available evidence"?
MR. LANNIN: Object to the form.
THE WITNESS: So "high-quality evidence" has its definitions in context, you know, like in a GRADE context. That's different from "best available evidence."
And it certainly is important to look at -- you know, at both. But there certainly are times when we are just looking at best available evidence where there haven't been clinical trials done, and we still need to make a recommendation.
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BY MR. RAMER:
Q In talking about the more formal GRADE methodology, in the context of that methodology, do you know what a "discordant recommendation" is?
MR. LANNIN: Object to the form.
THE WITNESS: Not that I can recall.
BY MR. RAMER:
Q As a general matter, do you agree that the strength of a guideline recommendation should be linked to the strength of the evidence supporting that recommendation?
MR. LANNIN: Object to the form.
THE WITNESS: I think that it's strength of the available evidence, but there are also guidelines that -- where there is strong clinical consensus based on clinical practice, and I think that can be important, too.
BY MR. RAMER:
Q What do you mean by that?
A Well, one can make -- one can make a recommendation, you know, in the absence of a graded systematic review, basically. So it's great to have that. It's great to have randomized clinical trials.
I was looking at it in the context of our

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chapter, which is one in which -- in which clinical practice, though guided by evidence, a lot of it really is related to consensus of experts because, you know, no one has done a clinical trial on whether -- if someone is on hormones, whether to stop them or continue them when someone is admitted to the hospital.
But the experts in transgender health would feel that that's very important, and that is based on the clinical experience that -- of the harm that can happen to people if they're stopping and starting and stopping and starting hormones when, let's say, going into a psychiatric institution.
So there are areas in which there's not a lot of research, but there is a strong recommendation by consensus of experts. And we just happen to be a chapter where -- where there is a variation in terms of amount of research that's been done.
Q So if there is only low-quality evidence to support an intervention under the traditional GRADE framework, is it unreasonable for a medical provider to say, "I'm not going to provide this intervention until there's better evidence supporting it"?

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MR. LANNIN: Object to the form.
THE WITNESS: So I think that would be really problematic when you look at -- that the majority of medical interventions are supported by only low or very low GRADE scores, that only a minority of national practice guidelines are supported by high-grade evidence.
And so, you know, there was -- one of the studies I cited, only 10 percent of clinical practice and emergency medicine, critical care medicine and anesthesiology was supported by high-grade evidence, but people still need to go to the ER and they still need to go to the ICU and they still need anesthesia before surgery.
And so, you know, it's great to have more information, and typically what systematic reviews and GRADE scores have been used for are to point to areas where more research might be beneficial.
And what is very different about what has been happening in the United States is people have been pointing to GRADE scores in terms of what should be legal and what should be illegal.
And our standards of care aren't telling people what care is to be legal or illegal. We are trying to provide recommendations based on our

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understanding of the literature and our consensus of expert advice so somebody can go to the standards of care if they have a question, a practice question, and maybe get some advice that might be helpful.

This standards of care was not done in the context of, you know, should a doctor go to prison for doing this care or not. It was to provide our best advice to be helpful to people as best we could in providing the care.

BY MR. RAMER:

Q Do you think the SOC-8 should be used by medical licensing boards in terms of assessing a provider's medical practice?

MR. LANNIN: Object to the form.

THE WITNESS: Well, there might be circumstances. Medical boards will sometimes assess a -- the practice of a physician who has been accused of harming patients.

And in that context, if somebody is acting outside of kind of community standards in their practice of care, that could be evidence for them to act.

It's not our, I think, intention with standards of care to -- you know, to make that kind of determination, which seems to be much broader

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than did they follow WPATH standards of care.

You know, if they followed WPATH standards of care but they, you know, didn't prescribe a medication within a particular guideline, or if they assaulted a patient, you know, one would make a recommendation to the medical board.

I don't think, you know, that anyone has ever made a complaint because, you know, 18.8 of the "Mental Health" chapter wasn't, you know, followed or because, you know, any other particular thing, aside from gross malfeasance, wasn't -- wasn't covered.

So anyway, so that's where I just kind of draw a distinction between -- between the purpose of -- what I perceived as the purpose of WPATH standards of care and I think what's purported as the purpose, which is to provide practice guidelines that might be helpful for a practicing clinician.

BY MR. RAMER:

Q And returning back to the formal GRADE methodology, in the context of the GRADE methodology, are there ever situations where strong recommendations can be made based on low-quality evidence?

MR. LANNIN: Object to the form.

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THE WITNESS: That's a good question.

There's certainly -- one can make a stronger recommendation based on kind of a collection of evidence, but I think it's difficult to make a strong -- well, I guess I would -- maybe I'll back up a little bit.

So there are strong recommendations that are made based on low quality -- what's called low quality on GRADE, and those recommendations form the majority of, like, national practices guidelines.

Much of the practice -- you know, like, I'm thinking of antidepressants and where there was a well-known systematic review for antidepressants in adolescents, children and adolescents, where only fluoxetine separated from placebo for the treatment of depression in minors, and yet fluoxetine is not the only drug that is used to treat depression in minors.

And so you don't have -- you don't have -- you have low-quality evidence kind of throughout our practice that still is the best evidence that we have and is used in practice guidelines to make recommendations.

So I think that's where I distinguish between low- -- you know, low-quality evidence and

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making a strong recommendation, viewing, you know, what we know as a whole.

BY MR. RAMER:

Q I guess my question is more about the actual GRADE methodology rather than what happens.

In the grade methodology, are there situations where strong recommendations can be made based on low-quality evidence in accordance with the methodology?

MR. LANNIN: Object to the form.

THE WITNESS: So within -- GRADE is referring to a level of -- a level of evidence, you know, from strong, moderate, low, very low. And I think that's distinct from a recommendation for care that might be made by a practice guideline.

So a systematic review might provide a GRADE for a particular intervention, but not -- a GRADE score, but not a recommendation of whether or not you should do it. That seems like a realm of someone else.

BY MR. RAMER:

Q What do you mean?

A So, meaning the Endocrine Society or Hilary Cass or other people using systematic reviews and GRADE scores and making -- making

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recommendations for care.
Q And so the point is that ultimately somebody has to make the judgment of whether to provide the intervention. And you're saying that it's not just, you plug things into the GRADE computer and GRADE tells you whether or not to do it; is that what you're saying, basically?
A Yes.
MR. LANNIN: Object to the form.
BY MR. RAMER:
Q And if I said that there were five paradigmatic contexts in the GRADE methodology where a strong recommendation can be made based on low-quality evidence, would you be familiar with what I'm referencing?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: Yeah, I don't recall the specifics of that, of kind of how theoretically one might make a recommendation using -- using GRADE scores.
BY MR. RAMER:
Q And do you know if, in your view, gender-affirming care falls within any of those contexts, to the extent they exist?

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MR. LANNIN: Object to the form.
THE WITNESS: GRADE context for providing care?
BY MR. RAMER:
Q Right. The contexts in the GRADE methodology where a strong recommendation can be made on the basis of low-quality evidence, does gender-affirming care fall into any of those contexts, to your knowledge?
MR. LANNIN: Same objection.
THE WITNESS: I don't know.
(Exhibit 4 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q And, Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 4, and it says, "Expert Rebuttal Report of Dan H. Karasic, M.D."
Does this appear to be the report you submitted in this case?
A Yes.
Q And I'd like to go to page 30.
(Proceedings interrupted.)
MR. RAMER: Let's go off the record.
THE VIDEO OPERATOR: Going off the record, the time is 12:21 p.m.

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(Recess, 12:21 p.m. - 12:23 p.m.)
THE VIDEO OPERATOR: Back on the record. The time is 12:23 p.m.
BY MR. RAMER:
Q And, Dr. Karasic, picking up on your report at page 30, I'd like to look at paragraph 80. And I think this is sort of what we were discussing where you cite the Chong study.
A Yes.
Q And then on the next page, paragraph 82, you cite the Conway study.
Do you see that?
A Yes.
Q I think you've already described it somewhat, but can you just explain the purpose for why you're citing those articles here?
MR. LANNIN: Object to the form.
THE WITNESS: Sure.
So the purpose is that systematic reviews and GRADE scores can provide guidance for areas for further research. They can provide some guidance to clinical decision-making. But it's actually uncommon for -- or there are many interventions that are done without high GRADE scores. The state of

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the research for many of the interventions we make everyday are not supported by high GRADE scores. So that was the purpose that I was listing that.
So just because a guideline for care is not supported by high GRADE scores doesn't mean that that care should be made illegal. It means that there may be areas in which we should be trying to get more evidence.
And I think that is the real shift, even between the Europeans in making -- those that made decisions based on GRADE scores, and the U.S. where care is being -- is being banned, as opposed to government is supporting more research so that, you know, perhaps there will be higher GRADE scores in the future.
BY MR. RAMER:
Q In your view, is the quality of the evidence under GRADE irrelevant to making treatment decisions?
MR. LANNIN: Object to the form.
THE WITNESS: No, and that's why I used the example of a systematic review for antidepressants in adolescents, finding, of all the antidepressants, only fluoxetine separated out from placebo for treating depression, I tend to use

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fluoxetine in minors as a first line. But -- and that's only based on a moderate GRADE score on that systematic review.

All the other antidepressants had low or very low GRADE support if there was any separation from placebo; however, I and my colleagues very often use other medications; people -- if someone doesn't tolerate fluoxetine or they don't respond to it or they need a combination of medicines.

So it's just not part of our practice that everything has to be supported by a high GRADE score. We look at the alternatives, and we look at clinical experience, you know, when we don't have the best evidence.

I was -- like with the example -- I was kind of struck -- in the Cass report, they give an example of providing risks and benefits to a patient, and they say, let's say you're starting them on an antidepressant, presumably in an adolescent, a child or adolescent, and it has an 85 percent response rate and a 5 percent side effect rate. That was just their example.

And so my reading of that is, that's the most unrealistic thing in the whole Cass report. Show me an antidepressant with an 85 percent

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response rate and a 5 percent side effect rate.

So we work in a field where the response rate for interventions often aren't that great, where the evidence for some interventions don't separate greatly from placebo in terms of medications.

The number needed to treat can be high. How many do you have to treat for there to be a distinguishing between someone on meds and not on meds?

And yet we don't abandon all of those fields of medicine. We keep on practicing, and hopefully, you know, more research happens that can better guide us, or new medicines come out that separate, you know, in a greater way.

BY MR. RAMER:

Q So how did the Cass review get it so wrong, in your view?

MR. LANNIN: Object to the form.

THE WITNESS: I don't think the Cass report got everything so wrong, but that was a place where, obviously whoever wrote that part was not a practicing -- I don't think -- I would be surprised if Hilary Cass wrote that part because by reports, she was a practicing pediatrician. And

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pediatricians do prescribe antidepressants.

And they could never -- that part of the Cass report, rather than saying 85 -- as an example, 85 percent response, 5 percent side effect, should have said, you know, there's a systematic review where there's only a 10 percent difference between drugs and placebo, that antidepressants have a -- you know, at least in the U.S. -- an FDA warning that in minors, they increase the chances of suicidality, not decrease. And yet we use them all the time.

So it -- it just speaks to kind of a level of evidence and what we have, you know, how we work with what we have.

And so I think using that example was just -- it was just something that struck me as a clinician, because, you know, you would never -- if you're doing risks and benefits -- I know they were just using that as an example -- you would never use that example. Maybe you would use an antibiotic for strep throat as something that had, you know, a high response rate and a low side effect rate.

But it was just very peculiar to me. And it just goes to show how people don't recognize -- and this is where it speaks to this, you know, how

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at zero percent of all the endocrine interventions under systematic review had a high grade score, that we practice all the time under limited evidence, and we do the best we can.

BY MR. RAMER:

Q And earlier, we were discussing how, at some point, some person is making a decision based on the evidence of whether an intervention should be provided or not.

And I take it Dr. Cass, in her report, has reached a conclusion that differs from your conclusion; is that fair?

MR. LANNIN: Object to the form.

THE WITNESS: So there definitely are things that I disagree with Dr. Cass. So -- but I'm free to respond kind of more specifically to recommendations.

I think that there's a lot in there, and not everything -- there are things that are contradictory between even kind of the report and things she said, you know, in interviews. And so -- but, you know, it's a large government report that has, you know, aspects that are more interesting and less interesting to me.

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BY MR. RAMER:
Q And I guess my question is just kind of general, of, like, if Dr. Cass is looking at the same body of evidence that you're looking at, and Dr. Cass concludes the evidence is insufficient to justify the use of puberty blockers to treat gender dysphoria in adolescents, how did she get that conclusion wrong?
A Okay.
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: So I disagree with the premise of your question in terms of my interpretation of what she wrote.
She wrote that she found that puberty blockers, as they were being used in the U.K., had insufficient evidence, and she wanted it to be prescribed in an investigational way where they're collecting data.
And she's pointed out in interviews, and it's alluded to in the Cass report, that the average age of people in the U.K. getting puberty blockers is 15, which is at Tanner Stage 5, which is beyond when they're particularly useful unless in combination with hormones as a bridge.

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At 15, usually people are prescribed hormones, but it's a flaw of the system where you have to wait three to five years to get an initial appointment.
And so I can see her saying, "Okay. Our current practice, plus generally hormones are widely available and will continue to be widely available if you're 16 or over in the U.K."
So it seems like what happens in the U.K. right now is people turn -- people get their appointment at age 15 and get referred to pediatric endocrinology. It's just a few people in the entire country that even get that referral out of thousands who are waiting.
By the time they get on puberty blockers, they're too old for them. And it's maybe not the appropriate treatment, but they can't be on hormones until they're 16, so they're on puberty blockers through 15, and then at 16 they get on hormones.
To look at that practice, because it's not in accordance with the U.S. or with the German language countries or with -- the Netherlands or Belgium don't use that practice.
And so if the Cass report results in young people getting puberty blockers appropriately, and

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that data is gathered and studied in terms of that response, I don't think that's necessarily a bad thing.
I think it could be an improvement over the current situation where, if you need puberty blockers, you have to wait until you no longer need puberty blockers. If you're having -- if you need puberty blockers and you wait three to five years, at that point, you don't need puberty blockers, you might need hormones. You've aged out of where they provide the greatest benefit.
BY MR. RAMER:
Q Well, then, I guess, why wouldn't the recommendation in the U.K. from Dr. Cass, for example, be not that we're going to prohibit providing puberty blockers, except for research trials, but we're going to say that you have to provide them earlier when the patient is closer to Tanner Stage 2?
MR. LANNIN: Object to the form.
THE WITNESS: So she has said that they're planning to expand and have more access to care, and perhaps when there is more access to care, that people will be able to get care sooner.
So I'm not -- I don't want to put words

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into Dr. Cass's mouth, but, you know, even if we have some disagreement, I do agree with -- that what they appear to have been doing in the U.K. wasn't appropriate care. And if there is a path through -- not prohibiting care, but as Dr. Cass claims, expanding care, but in an investigational setting -- if that actually happens, that could be better than what happens now.
I wouldn't agree with someone who is saying, you know, we shouldn't use puberty blockers. And Dr. Cass, when interviewed, said -- she was asked, "Do you believe puberty blockers are dangerous?" And she said no.
So she just wants -- she wants more data and perhaps a different use -- I mean, she was the one who brought up this -- in that interview, the -- you know, the average age, and it's also brought up in the Cass report.
And so -- so I -- you know, I can understand her wanting a more rational use of them, but she hasn't said, "We're banning the use of puberty blockers," or "We're stopping the use of puberty blockers." She is saying using them in an investigational setting.
She had previously alluded to there being

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some other pathway -- before the final report, she had alluded to there being some other pathway perhaps where people could -- could get them.

And my belief is that people shouldn't be forced into a research study. And so even if they predominantly want to do research, that there should be a pathway if clinicians have said, "This person really needs puberty blockers," that they could get them, and that's a place of objection with -- you know, if that other pathway, if people are being forced to be in a study in order to get treatment.

BY MR. RAMER:

Q And so your point there is, it still wouldn't be reasonable even if you said, "We're going to allow it only in a controlled study"; is that what you're saying?

MR. LANNIN: Object to the form.

THE WITNESS: I'm saying it's good that they're allowing it and collecting data, and hopefully they are trying to use it appropriately.

But I -- my belief is that shouldn't be the only pathway. That is a disagreement I have with Dr. Cass. I don't think that should be the only way that you should be able to get care.

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BY MR. RAMER:

Q And so earlier, you said that you didn't -- you didn't think that the quality of the evidence under GRADE is relevant to making a treatment decision.

I guess my question is, how do you determine when it is relevant for making a treatment decision?

MR. LANNIN: Object to the form.

THE WITNESS: So I think it is in a broader context, which includes trying to determine the best treatment for someone who needs treatment. And so one looks at the alternatives.

So if, let's say -- using the antidepressant example -- if fluoxetine has a moderate GRADE score, but the alternatives -- you know, in that systematic review, it was more effective than anything else except the combination of fluoxetine and cognitive behavioral therapy was, you know, similar, but that you were still getting fluoxetine. So my takeaway from that is, if someone is depressed, that it does seem like the best alternative supported by that study.

Now, it's not only that study that determines how I treat somebody, but it may make a

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difference if one is making a -- you know, a treatment decision.

BY MR. RAMER:

Q And returning to your report, Exhibit 4, and sticking on the same page, well, page 31, the carryover paragraph, in the last sentence you refer to "complex intervention." And you say, "Gender-affirming care certainly qualifies as a complex intervention."

Do you see that?

A Yes.

Q What makes an intervention complex as opposed to simple?

A So a complex intervention is one where you have -- you can have multiple steps in the implementation of the intervention, and you can also have an indirect means of assessing whether that intervention was effective.

So an example would be, when you look at puberty blockers, and your question is just, do they stop puberty, that's a very direct intervention. You are taking somebody, you're giving them puberty blockers, and you're seeing if -- physically, if puberty is stopped.

If you are saying you give someone -- you

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have someone transition, and that involves puberty blockers, and then your outcome is, are they happy, there are -- there may be a number of steps, you know, that happen that could be -- that could complicate things: the intervention of other aspects of transition as well as the puberty blocker.

And then in determining the effect, you're not just looking at did the puberty blocker stop puberty, but did stopping puberty presumably affect the person's self-perception, or perception of their body in a way that reduced distress or improved quality of life.

And so you have this kind of -- you have a level of complexity that, when you add that into an intervention, it is -- rarely, if ever, do you get high GRADE scores.

And, in fact, NICE, N-I-C-E, the British agency that did the original systematic review and grading of puberty blockers, before doing that, they had actually long resisted adopting GRADE because of its weakness with complex interventions, and -- but they did adopt it in time, certainly, to do the grading of the systematic review of puberty blockers. So they ultimately did do it.

But there apparently, in the systematic

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review world, has been some disagreement about its utility in particular circumstances, in circumstances where all the studies have low GRADE scores.

Q Is the use of psychotropic medication a complex intervention?

MR. LANNIN: Object to the form.

THE WITNESS: So it's certainly a less complex intervention than gender-affirming care. But from my experience actually trying to do a -- a clinical trial, you know, there are levels of complexity there as well. It's certainly more complex than the person with strep throat. You give them medication, and you -- you get the result.

Just because, you know, in this case, you can have a very defined intervention, but there can be variation on your outcome measures that relate to a lot of other kind of aspects that make it more difficult than a simple, maybe perhaps, medical intervention.

I think mental health interventions generally are harder to get higher grades of evidence because of the -- of that kind of variability when you're trying to measure how someone feels.

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BY MR. RAMER:

Q Is there any medical intervention that you think is reasonable to ban?

MR. LANNIN: Object to the form.

THE WITNESS: Not on the basis of a systematic review.

I think that it might be -- it's possible, but it would just be speculative. I can't think of anything off the top of my head.

I mean, it might be possible that there could be an intervention that -- where everyone dies, you know. And so, you know, there's something -- something out there, you know, that happens, you know.

But I don't -- not things that have been, like, approved treatments in recent years, at least, that -- you know, that should be banned.

BY MR. RAMER:

Q Would it be reasonable, in your view, to ban the use of ketamine as a treatment for bipolar disorder in adolescents?

MR. LANNIN: Object to the form.

THE WITNESS: No.

So I would say, you know, there's growing -- there's growing evidence of the utility

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of ketamine in unipolar depression, that there certainly is more caution in treating bipolar people. But I don't think it's something that should be banned.

BY MR. RAMER:

Q And apart from medical interventions that kill everybody, how would you determine whether it is or is not reasonable to ban a particular medical intervention?

A So I think that if there is a ban, it should come from the great consensus of care providers and experts in the field. It shouldn't -- it certainly shouldn't be a ban that is done top-down when the actual people providing the care believe there's benefit.

So obviously it's a theoretical case and, you know, maybe not everyone has to die. But, you know, there would have to be, I think, great consensus that this is something that is -- that this is something harmful.

There are -- there's all kinds of care that's not given very often because of harm. You know, there are -- there has been the ban of, you know, conversion therapy that I know you're aware of, and I think that's a -- you know, certainly a

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subject for debate that I probably don't need to wade into right now.

But, I mean, there are times where there is, you know, kind of a great consensus that there's harm being done. But I think that by and large, politicians should stay out of it because most care that is -- that doesn't show benefit and is harmful gets weeded out in and of itself; that interventions have been tried and found, you know, not to be -- not to be helpful, and, you know, the field of medicine moves on.

Q But take the example of ketamine that we were discussing. Who would you ask to determine the consensus of whether it's appropriate? Only the providers who are actually providing the ketamine to adolescents?

MR. LANNIN: Object to the form.

THE WITNESS: No, you would look at the research as well.

Generally, it's difficult for adolescents to access ketamine as treatment, but, you know, I know from my patients that there are some who have -- I have patients who have benefited from, you know, ketamine for treatment-resistant depression. That said, it's been difficult for them to get it

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until they're 18.
I wouldn't want to see the government step in and say, "You can't have that."
I would -- I'd want to have there be more research and, you know, continue a greater understanding as we need to have in terms of that, you know, treatment.
And if anything, the government has been going back on banning substances that might have clinical utility like, you know, they're proposing changing the schedule level for cannabis and funding more research into psilocybin.
And so I think, you know, it should be a very rare case that politicians ban a particular care. I think it is something that should be left up to the practice community.
And if somebody is, you know, practicing in a way that's harmful, there are, you know, state medical associations -- or medical boards that -- you know, that people can go to and file complaints.
BY MR. RAMER:
Q And I just want to return to one thing in Exhibit 3, which is Appendix A to the SOC-8. And I'd like to go to the very last page, which has "S251" in the upper right. And right column,

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there's a bold "3.17. Approval by the WPATH Board of Directors." I just wanted to read the sentence below that, and I'll just first ask if I read it correctly.
It says, "The final document was presented to the WPATH Board of Directors for approval and it was approved on the 20th of June 2022."
Did I read that correctly?
A Yeah. Where is that again?
Q Sorry. So right column, 3.17, about halfway down.
A Okay. Yeah.
Q I did read it correctly?
A Yes.
Q And is that true?
MR. LANNIN: Object to the form.
THE WITNESS: I assume so. I wasn't on the board at the time, but I have no reason to believe that that's not true.
MR. RAMER: Is this a good time for lunch?
MR. LANNIN: Sure.
THE VIDEO OPERATOR: This marks the end of Media Unit 2 of the deposition of Dan Karasic, M.D. The time is 12:55 p.m. We're off the record.
(Recess, 12:55 p.m. - 1:31 p.m.)

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THE VIDEO OPERATOR: We are back on the record at 1:31 p.m. This marks the beginning of Media Unit 3 of the deposition of Dan Karasic, M.D.
Please continue.
(Exhibit 5 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 5, and that is "Chapter 6 Adolescents" at the top.
Do you see that?
A Yes.
Q Does this appear to be the "Adolescents" chapter of the SOC-8?
A Yes.
Q And I'd like to go to page S61. And in particular, I'd like to look at Statement 6.12.c.
Do you see that?
A Yes.
Q And do you use this statement and supporting text to guide you in obtaining informed consent?
MR. LANNIN: Object to the form.
THE WITNESS: Yes.
///

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BY MR. RAMER:
Q And on the same page, the left column, the second full paragraph underneath "Statement 6.12.c" states that, "A necessary step in the informed consent/assent process for considering gender-affirming medical care is a careful discussion with qualified HCPs trained to assess the emotional and cognitive maturity of adolescents."
Do you see that?
A Yes.
Q And do you agree that you must assess the emotional and cognitive maturity of adolescents for purposes of informed consent?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, informed consent or assent legally for adolescents.
BY MR. RAMER:
Q Is the only difference there the age and the terminology, or is there a substantive difference between "informed consent" and "informed assent"?
A There's -- the difference is mainly that in practicality, that you have to get the assent of the minor and the informed consent of the parents.
Q And how do you assess the emotional and

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cognitive maturity of an adolescent?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: So I have -- first of all, I typically do it with patients that I've known for a while because as a psychiatrist, I'm often involved in a patient's life for long periods of time, prescribing medications, sometimes doing therapy, but often they're seeing a therapist but continuing to see me over time.
And I can assess their ability to make decisions, understanding the risks, benefits, and alternatives of the decision; to have some cognitive flexibility about thinking about the future.
Would they make a different decision in the future? Should that inform the decision that's being made now? Is their decision-making really, on this subject, very consistent over time? Do they have a good understanding, you know, of what would be the benefits for them? What could be the potential risks as well?
BY MR. RAMER:
Q Have you ever had an adolescent patient whom you've deemed lacks the cognitive maturity to provide informed assent?

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A Yes.
MR. LANNIN: Object to the form.
THE WITNESS: Yes.
BY MR. RAMER:
Q Why?
A So I was thinking of a circumstance where I went -- where a patient was scheduled to see me, who was seeing other providers regularly, but they wanted me to see this person because of my experience and expertise.
And in that particular case, I didn't think that this person -- even though I only had that kind of cross-sectional experience with them, I didn't think that they had really thought through this substantially; that there -- it wasn't clear to me that there was kind of consistency in terms of their identity over time.
Again, I was hindered by just seeing this person once. There didn't seem to be a maturity in terms of the way they made their decisions.
And so I -- I'd been asked to consult, and I reported that back to the people who were providing ongoing care for that patient.
So that's a case that comes to mind.
Q Do you think the patient's IQ is relevant

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to the patient being able to provide informed assent?
MR. LANNIN: Object to the form.
THE WITNESS: So I think it can be relevant in terms of having to make sure that they understand risks, benefits, and alternatives; that the communication both ways is -- you know, is adequate.
So I think potentially there could be an impact.
BY MR. RAMER:
Q Is there a point at which you would conclude an individual's IQ is so low that he or she cannot provide informed assent for puberty blockers?
A So I'm not usually working with people with that severe of a developmental disorder; so that circumstance hasn't come up in my practice. They probably would be working with folks who are more specializing in people with severe developmental disorders.
Q Is that -- is the answer to that question outside the scope of your expertise?
MR. LANNIN: Object to the form.
THE WITNESS: I would say it's not -- it's not a decision I've had to make.

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BY MR. RAMER:
Q And so do you have an opinion about whether an individual could have an IQ so low that would preclude them receiving gender-affirming medical interventions?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. I think that if cognitively they couldn't understand sufficiently the intervention to be able to -- to understand the risks and benefits, I think theoretically, yes.
BY MR. RAMER:
Q But you've never come across it in your practice; is that right?
A Right. I haven't -- I haven't worked with anyone like that.
Q If a patient tells you, "I'm going to kill myself if I don't get puberty blockers," is that patient capable of providing informed assent?
MR. LANNIN: Object to the form.
THE WITNESS: So it's actually -- it's interesting because my patients don't express it that way.
So I do have patients with either intermittent or chronic suicidality. That's extremely common in my patients; and, of course, as

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part of the assessment of anything they do and part of the discussion about, you know, stressors of transition, for example.

Just having suicidality doesn't -- because it is so ubiquitous -- doesn't prevent somebody from getting gender-affirming care, but it's certainly something that we take seriously.

I just haven't -- I've never had a patient, like, threaten me with suicide if I didn't write a letter. It just hasn't -- it's never come up.

BY MR. RAMER:

Q Before you recommend hormone therapy for an adolescent patient, do you confirm that the patient has experienced several years of persistent gender diversity or incongruence?

A So I take a history, and I think the wording of that is maybe not the best in the sense that it's including two different things: gender -- kind of gender diversity and having gender dysphoria.

And when I take a -- when I've worked with people, young people, sometimes they -- usually they do express having aspects of gender diversity even though they haven't even come out to themselves as

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trans.

But I'm not quite sure that -- of the wording of that particular sentence, kind of conflating one sentence, gender diversity, several years of gender diversity or -- or gender incongruence.

I certainly would want them to have had gender dysphoria that has gone on for -- for quite a while, you know -- DSM says six months -- but for there to be evidence that goes back further than that. And I just -- I'm not that big of a fan of the wording of that sentence.

Q How would you fix it?

A So I would -- where is the --

Q It's not on S61. It's actually on S60, the previous page, and it's left column below 6.12.b, second full paragraph, and then it's about the second long sentence in that paragraph.

A Well, even if you look in that paragraph, it says (as read), "However, in this age group of younger adolescents, several years is not always practical nor necessary given" -- this is for puberty blockers -- "the premise of the treatment to buy time while avoiding distress from irreversible pubertal changes."

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And so I think even within that paragraph, there is some description of a range of considerations that should be taken into account.

So -- so this is saying, "Prior to initiating less reversible treatments," and that's a sentence, and that might speak to if you're -- if you have somebody who perhaps presented -- who hadn't already been in care, receiving puberty blockers before their moving on to hormones -- if somebody presented in your practice in that particular circumstance where they might be going directly to hormones, or if somebody was presenting to your practice who was having a lot of chest dysphoria and wanting chest surgery, I do think that more caution about the persistence, you know, is -- of their symptoms is advised.

I don't know about "several years." Certainly, like, for puberty blockers, "several years" doesn't make any sense. And then also, the idea of gender diversity versus gender dysphoria, because not all the people with -- presenting with gender dysphoria have the same childhood history. There's variability in terms of how people have presented in terms of gender diversity.

So, anyway, that's -- that was my question

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about saying, "gender diversity/gender incongruence."

I would say if somebody is presenting during adolescence and they hadn't -- you didn't know them already from puberty blockers, you would want to spend more time with them and make sure they've had a careful evaluation and that they -- their gender identity has been using the bold "marked and sustained" description, has been marked and sustained, has been going on for -- you know, over time.

But I do think that "several years" might not be the best descriptor. And even then, they were using "several years" in combination with saying "gender diversity" as opposed to "gender dysphoria."

So that's just my -- my commentary on that -- on that part.

Q And just to sum that up --

A Sorry about my verbosity.

Q Not a problem at all.

But do you disagree with the requirement that's articulated in that sentence?

A I don't disagree with the sentiment that if -- if they're saying someone is seeking a less

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reversible treatment, one would want to know that their gender incongruence has been going on for a while. That is one of the reasons that puberty blockers are sometimes given, which doesn't really fall under this part and is described kind of later in that paragraph.

But certainly the general sentiment of exhibiting caution when working with adolescents is one that I would agree with.

Q What do you think the phrase "several years" means?

MR. LANNIN: Object to the form.

THE WITNESS: Well, I think that's a problem because it's kind of -- it's kind of vague.

So, you know, the gender incongruence diagnosis is six months. But I can understand why, depending on the intervention, that one might, you know, need more time than that with -- working with an adolescent, just depending on circumstances.

And so, you know, adolescents can -- their presentation can be so different when you're actually making that assessment, that there are -- there are adolescents who need very careful consideration, and there are adolescents who might come in needing an intervention where they've been

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clearly very stable and living in their transgender identity for a long time where it may not be as -- one might not have as much concern. I think that really depends on the individual.

BY MR. RAMER:

Q Do you agree that one year is not several years?

MR. LANNIN: Object to the form.

THE WITNESS: I agree that one year is not several years.

BY MR. RAMER:

Q And so a provider who is trying to faithfully follow the supporting text in this statement, what are they supposed to do with that sentence that we've been discussing?

MR. LANNIN: Object to the form.

THE WITNESS: Well, I think that -- I would hope they would kind of generally get that it's communicating to be cautious when you're using less reversible treatments; that in younger adolescents needing puberty blockers, that that might not be necessary, but generally having a sense of caution.

When they say "several years of gender diversity," gender diversity is not a diagnosis, and

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people might not be engaged in care for being gender-diverse, certainly much less so now than perhaps in the past.

And so I don't see that as that individual provider needing to have taken care of that person for several years, but I think you would look in their history, that there have been aspects of gender diversity that have been going on certainly for a while. Certainly longer than the six months that they've had a gender incongruence diagnosis, which is the minimum to give them a diagnosis that they would be eligible for care.

BY MR. RAMER:

Q And when you say "going on for a while," you mean going on for several years?

MR. LANNIN: Object to the form.

THE WITNESS: Well, you know, certainly that's not practical for puberty blockers.

Sometimes there are people who get pretty strong gender incongruence at puberty where you didn't know them before and, you know, you would certainly look for that in the history.

But, again, I'm not sure that that would be -- I don't like that wording of "several years" because there are some people who -- some

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adolescents who present who clearly have a gender dysphoria diagnosis who are very symptomatic and, you know, who come into care at that time, and you wouldn't tell them to wait several years, for example, before getting care. So I think that there's an individual assessment involved in those cases.

I do agree with the sentiment that one should be cautious in those circumstances.

BY MR. RAMER:

Q So is it fair to say that you do not require several years of persistent gender diversity as a rule before initiating hormone therapy for an adolescent?

MR. LANNIN: Object to the form.

THE WITNESS: So gender diversity is not a diagnosis, and people aren't necessarily in clinical care. I think it would be -- so I think it's something that is -- it might be kind of challenging as a requirement, anyway.

I would say, you know, exhibiting caution, and, you know, if -- if you don't -- if it's not somebody with onset of -- like, childhood onset gender dysphoria, if it's somebody in adolescent onset, I would just have caution in working with

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them, and having a sense that their -- of the stability of their gender dysphoria. But I wouldn't put a marker of "several" years for that -- that process.

BY MR. RAMER:

Q Sticking with Exhibit 5, which is the "Adolescents" chapter, I'd like to go to the next page, S61. And right column, the first long paragraph, a third of the way down or so, there's a sentence that begins with "Gender diverse youth." and I'm just going to read that and first ask if I read it correctly.

It says, "Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects" --

A Oh, okay. I'm sorry. I was looking at the sentence after.

Q I'll just restart. "Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of a treatment, as well as the limits of what is known about certain treatments (e.g., the impact of pubertal suppression on brain development...)," and then there's a citation.

Did I read that correctly?

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A Yes.

Q And do you ensure that your patients fully understand all these enumerated items?

MR. LANNIN: Object to the form.

THE WITNESS: So certainly in counseling both the youth and their family, we try to go through each aspect. The impact of pubertal suppression on brain development is not well known, but I think it's fair to, you know, say that that is an unknown that, you know, could be of concern.

But the -- certainly understanding the risks and benefits and alternatives for each aspect of treatment is important.

BY MR. RAMER:

Q When you say that the impact of pubertal suppression on brain development is unknown and could be a concern, what do you mean by that?

A So it's an area certainly that requires more research.

There have been papers trying to summarize the research which -- of about which a lot is not known, including -- many of the studies have been on animal models.

There's not a lot of data on people, and there's not a lot of data on -- you know, to guide,

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like, how long somebody should be on puberty blockers before switching to gender-affirming hormones if -- you know, if an overly prolonged puberty is -- is of concern.

But certainly with whatever treatment someone gets, one is trying to weigh risks and benefits. And trying to present that to -- to a family is more difficult, you know, if -- depending on kind of a level of -- you know, of knowledge.

There's a difference between animal models, a very strong -- I mean a very small amount of kind of human research on people, and then also weighing that with a young person who has a lot of gender dysphoria where it might be impacting their ability to go to school and study and be successful academically.

So, I think, you know, it's something that one can mention, but it's -- you know, there are a lot of other considerations that affect people cognitively for which there's more evidence which is, for example, that if somebody does have prolonged depression or gender dysphoria that's impairing their functioning, that they might not be able to learn in the same way.

Q And when you were referring to papers that

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discuss the lack of evidence we have regarding the impact of pubertal suppression on brain development, are there any papers you were specifically thinking of?

A I have read them, but I can't cite them.

But I have read reviews of, you know, how much of a concern this might be, and even I think a systematic review of papers where most of the papers in the systematic review were on animal models. And it described a few cases, including one that was just a case report of one person, and came to the conclusion that the evidence is still very limited.

Q And what are the animal studies you're referring to?

A So there was one that I've seen that I saw presented at a WPATH conference that was about cognitive development in sheep who were given puberty blockers; where that was raised as, you know, could there be some -- so, like, in a sheep, you can kill the sheep afterwards, basically, and look histologically at the brain, and so you get a certain level -- a different kind of evidence. So that's why they tried to look at that in a sheep model.

Q And what was the -- just generally

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speaking, that sheep study? Was it a negative impact on brain development?
MR. LANNIN: Object to the form.
THE WITNESS: I can't tell you the results, but I think that there were -- it was raising questions of, you know, should this be something that is studied further?
And that study was several -- it must have been several years ago because I remember seeing the data presented at the WPATH conference in either 2009 or 2011.
(Exhibit 6 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q And you've been handed, Dr. Karasic, what's been marked as Karasic Exhibit 6. And this is an article entitled "Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth."
Do you see that?
A Um-hum.
Q And the lead author on this is Diane Chen, correct?
A Yes.

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Q And have you heard of Diane Chen before?
A Yes.
Q And she's an expert in the field of transgender medicine, correct?
MR. LANNIN: Object to the form.
THE WITNESS: Yes.
BY MR. RAMER:
Q Have you seen this paper before?
A I don't remember. I may have, but I don't remember.
Q I'd like to just go to page 248, which I think is like the third page. And right column, first full sentence up toward the top, it says, "In human studies, pubertal progression has been linked to developmental changes in reward, social, and emotional processing as well as cognitive/emotional control."
Do you see that?
A Yes.
Q And do you agree with that statement?
A I have no reason to believe that those references don't support that statement. I don't see a disagreement with it.
Q Is the impact of pubertal suppression on brain development beyond the scope of your

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expertise?
MR. LANNIN: Object to the form.
THE WITNESS: I think that it's -- that it's an area in which -- in which the science is still young. So I'm not sure what -- it's not -- it's certainly not the focus -- a research focus of mine, but it's something that -- it's, you know, not, I think, something that we have definitive answers on.
I do think that because the question has been raised, that it does provide support for not having a really prolonged period of time on pubertal suppression before going to cross-sex hormones if they're indicated, as in some European countries who don't -- who don't start hormones until 16, for example, kind of arbitrarily, whereas they might start puberty blockers at Tanner Stage 2.
So I think there are reasons to have people go through puberty, including cross-sex hormones, in a way that doesn't linger in puberty too long.
But we do have, you know, substantial use of puberty blockers in people with precocious puberty in these relatively shorter periods of time where it seemed to have been done safely.

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And I do have patients who have -- were on puberty blockers who are now attending Ivy League colleges. So I don't think that that experience on puberty blockers profoundly affected them.
I think that -- just as a clinician, that in those cases, receiving gender-affirming care really allowed them to focus on school in a way to excel and to -- you know, to get into a college that was consistent with -- with their goals.
So that's how -- you know, I think it's, you know, something that, you know, deserves more research, but also is taken into the context of people needing -- needing care.
BY MR. RAMER:
Q And sticking with Exhibit 6, which is the Chen article, I'd like to go to page 253. And right column, about three quarters of the way down, there's a sentence that starts with "In addition."
And in that sentence, it says, "studies in rodents show ovarian hormones, acting during puberty, program cognitive flexibility by exerting long-lasting effects on excitatory-inhibitory balance in the prefrontal cortex."
Do you see that?
A Yes.

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Q And did you know that before reading it in this article?
MR. LANNIN: Object to the form.
THE WITNESS: You know, I knew that there had been studies in animals, and I didn't know the -- I still don't know the applicability of that to human beings.
BY MR. RAMER:
Q Well, I guess if animal studies find long-lasting effects of pubertal -- excuse me. Start again.
If animal studies find long-lasting effects of pubertal hormones on animal brain development, would a reasonable scientist think there could be a risk that pubertal hormones also have a long-lasting effect on brain development in humans?
MR. LANNIN: Object to the form.
THE WITNESS: So I think that animal models and findings in animal models are reason to do more research, you know, with people. It raises an avenue for -- for supporting doing more studies.
(Exhibit 7 was marked for identification and is attached hereto.)
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BY MR. RAMER:
Q Dr. Karasic, you've just been handed what's been marked as Karasic Exhibit 7.
A Yes.
Q And it's an article entitled "Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists."
A Yes.
Q And you helped author this article, correct?
A Yes.
Q I'd like to go to page 60. And right column, down at the very bottom, the section says, "Gender Development," and then below that it says, "Biological considerations."
Do you see that?
A Yes.
Q And the first sentence says, "Animal research has established that sex differences in the phenotype of both body and brain as well as behaviors are the result of multiple, sex-biasing factors."
Do you see that?
A Yes.
Q And so animal studies of brain development

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are, therefore, relevant to understanding human brain development, correct?
MR. LANNIN: Object to the form.
THE WITNESS: So they -- so animal studies can be. Certainly there are many studies on animals for the safety of drugs and people, and sometimes there's reason for concern. Sometimes the result of using that drug on people, you know, show that it's safe despite concerns from an animal model.
So I think that it certainly -- you know, animal research can lead to an interest in having, you know, more research with people.
BY MR. RAMER:
Q And sticking with this exhibit, and just a sentence later, two sentences later, it says, "The sensitivity of brain tissues to organizational effects of sex hormones appears to be particularly high at prenatal/perinatal stages of development and gradually declines toward young adulthood."
Do you see that?
A Yes.
Q And the next sentence says, "The timing of hormonal secretions in the course of development, however, gives the impression of three discrete sensitive periods: (1) pre/perinatal; (2) pubertal;

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and (3), for females, the first pregnancy"; is that right?
A Yes.
Q And in the first sentence where you refer to the "organizational effects of sex hormones," what are you referring to?
A So this was a section of the paper written by Heino Meyer-Bahlburg, who is an expert on intersex development.
And so he was referring here to how sex hormones might affect development, both in intersex people and potentially in -- in trans people when you're talking about perinatal hormone exposure which there is some belief that there can be a link to gender identity with that.
And so I think that he was writing about -- that in this section, he was writing from his position of expertise on the development particularly of intersex people, and also kind of applying that more broadly to development of gender identity in people generally.
Q And so is what's written here within the scope of your expertise?
A So I would say that this part is not an area where I've done research or -- you know,

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obviously we had, you know, read it and discussed it, you know, as -- we did it as a group, but it was also not -- it was written from the perspective of an expert in this particular area of the impact in hormones and genetics of intersex people and how that might contribute to our understanding of gender identity and other folks.

Q Why is puberty a sensitive period, as it says here?

MR. LANNIN: Object to the form.

THE WITNESS: So I -- again, like, our discussions on this were from several years ago. I, you know, can't comment on why each particular descriptive word was used.

Yeah, I think I'd leave it at that.

Clearly pre/perinatal hormone secretion, you know, can have an impact, and we have some sense of that. Otherwise, I'm not quite sure what Dr. Heino Bahlburg -- what he was referring to.

BY MR. RAMER:

Q Can we refer to Exhibit 6, which is the Chen "Consensus Parameter" article? And I'd like to go to page 248. The first full paragraph -- sorry. Right column, first full paragraph.

The first sentence also -- well, I'll just

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read it. It says, "The combination of animal neurobehavioral research and human behavior studies supports the notion that puberty may be a sensitive period for brain organization."

So Chen is also referring to puberty as a sensitive period, correct?

A Yes.

Q And can you explain why puberty is a sensitive period?

MR. LANNIN: Object to the form.

THE WITNESS: Well, the rest of her sentence describes to what she's referring from that, in which -- that it can be a time in which neural connections are shaped by both hormones and experiential factors.

So that's -- that's what she's referring to in calling it a "sensitive period."

BY MR. RAMER:

Q And then returning to your article, which is Exhibit 7, and where we were before, page 61, left column, in the first full paragraph, so after we were just reading, it says, "In humans, statistical sex differences in brain structure are well-documented."

Do you see that?

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A Um-hum.

Q And you're referring to a distinction between male and female brains here, correct?

MR. LANNIN: Object to the form.

THE WITNESS: Yes.

It is important, too, in that literature in that they are kind of overlapping dot graphs when you look at characteristics. But they do distinguish themselves statistically, like in the size of particular structures.

BY MR. RAMER:

Q And do you agree that we do not have studies analyzing the lasting effect, if any, on brain development caused by pubertal suppression?

MR. LANNIN: Object to the form.

THE WITNESS: So I think I would just endorse that it's an area that could use study, but other than that, I don't think I can comment.

BY MR. RAMER:

Q Do you agree that we do not have studies analyzing the long-term effect, if any, on brain development caused by exposing a male brain to high levels of estrogen that the brain would not naturally be exposed to?

MR. LANNIN: Object to the form.

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THE WITNESS: So I do think that we have -- first of all, that -- the goal in cross-sex hormone treatment is to try to approximate the hormone levels of the person assigned to the other sex at birth.

And so -- and I know we have -- so I don't think that necessarily the premise of the question that -- I don't know exactly what that means in terms of harm.

Somebody is, at least as a goal of treatment, trying to have a hormonal milieu similar to the gender to which they identify, and certainly people assigned female at birth who are not trans, you know, have those levels of hormones in their brain. I don't think that there's evidence that, you know, that -- I don't think that there's any further evidence of harm there.

Certainly any cognitive effects that patients of mine experience are not getting in the way of -- certainly of their academic achievement or occupational achievement, and they're generally living with hormones that are within physiological ranges.

BY MR. RAMER:

Q Physiological ranges of what?

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A Of the sex -- of the -- cisgender people aside, in this case, female, if we're talking about female hormones.
Q What were you talking about in your paper about statistical sex differences in brain structure? Are you referring to differences in brain structure of -- how are you using the word "sex" in that sentence? Let's start there.
MR. LANNIN: Object to the form. But you can answer if you know what counsel is referring to.
THE WITNESS: So in this case, when it says, "In humans, statistical sex differences in brain structures are well-documented," and they're referring to people assigned -- it's referring to assigned sex at birth in this case, there is also some evidence of sex differences in trans people that are different from cisgender people of the same sex assigned at birth.
But this sentence is specifically, I think, referring to cisgender people and cisgender males and females and their differences in brain structure; not referring to trans people specifically.
BY MR. RAMER:
Q So it's not just referring to all humans?

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A So it's referring to all humans, but it's not -- it's not separating out statistically transgender people.
There have been some papers that have separately looked at brain structures in transgender people and have found some differences. Some trans women who have brain structures that are more intermediate in size between male and female structures, for example.
Q So do you think that we can look at individuals' brains to determine whether they are transgender?
A No.
MR. LANNIN: Object to the form.
THE WITNESS: No. I think you need to speak with them.
BY MR. RAMER:
Q Then what was the study you were referring to?
A There have been some studies that have looked at brains of trans people and have found that their sizes of brain structures are different from people of the same sex assigned at birth.
Q And do you think those studies have established that you can look at individuals' brains

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to determine --
MR. LANNIN: Object to the form.
THE WITNESS: So there's an overlap in the size of those structures so that there are cisgender men and cisgender women who are within that overlap, too. So I don't think that looking at brain structures is a particularly efficient way to determine someone's gender identity.
BY MR. RAMER:
Q Do you think that clinicians should warn patients about the animal studies we've been discussing regarding pubertal suppression?
MR. LANNIN: Object to the form.
THE WITNESS: So I think it's a good question. I think it's a reasonable thing to warn just that, you know, we need to do more research in terms of cognitive effects.
I think animal studies alone are interesting, but, you know, don't always -- are not always reflective of the phenomenon in people. So I think there's kind of a judgment call.
But I think it's reasonable to include in a discussion that more research may need to be done in terms of any cognitive effects, and that it's reasonable to limit the amount of time on a puberty

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blocker if somebody then is ready to go on to cross-sex hormones, just because there is this question.
But our information is still limited.
BY MR. RAMER:
Q Do you think we have sufficient information to say that the use of puberty blockers to treat gender dysphoria is fully reversible?
MR. LANNIN: Object to the form.
THE WITNESS: So we have substantial information from people with precocious puberty that they -- once they're getting their -- they're on hormones again, that they don't seem to have been harmed by that experience of having a period of time in which puberty is delayed.
So that's the biggest circumstance where people fully reverse on puberty blockers. There are some people who go on puberty blockers and then discontinue. But certainly the larger number are people who are doing that, who are on those medicines just to delay puberty so that they go through puberty with their peers.
BY MR. RAMER:
Q When you're referring to individuals with precocious puberty being on hormones again --

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A I'm sorry. On puberty blockers.
Oh, going back on their own -- their own natural hormones. When they go off puberty blockers, their production of their own -- you know, of hormones, pubertal hormones, their own pubertal hormones, starts up again.
Q Are you confident that the experience of an individual going through puberty with their natal hormones will be the same as an individual going through puberty based on cross-sex hormones?
MR. LANNIN: Object to the form.
THE WITNESS: So I think for someone who has extreme distress because of gender dysphoria, going through puberty with the hormones of the sex, the gender to which they identify, that they can go through puberty with much less distress and often with much higher functioning, because they're not impaired by the distress of gender dysphoria.
BY MR. RAMER:
Q Right; but I thought we were discussing the impact of pubertal suppression on brain development.
And my understanding of what you were saying is, you know, we have individuals who use puberty blockers when they have precocious puberty.

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And then once they go through puberty with their natal hormones, it seems there are not major problems; therefore, we can conclude that when you have an individual whose puberty is suppressed to treat gender dysphoria, and then goes through puberty on cross-sex hormones, that the result will likely be the same.
Is that what you're saying?
MR. LANNIN: Object to the form.
THE WITNESS: What I'm saying is that brain development is affected by a number of factors, including trauma and depression. And so you also have to -- you can take into account, you know, if there could be some theoretical effect from puberty blockers.
But you also have to take into account the very real effect of a -- an adolescent who is -- who's really suffering; and that if there is relief from that suffering, whether they -- whether they might have better brain development because they're not depressed and anxious all the time.
And we know that chronic depression, for example, can affect cognitive functioning.
BY MR. RAMER:
Q You're saying they might have better brain

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development as compared to what?
MR. LANNIN: Object to the form.
THE WITNESS: As compared to if they had been forced to go through a puberty that was exacerbating their gender dysphoria and causing them to suffer because of gender dysphoria.
So presumably the only people that we're treating first with puberty blockers and then cross-sex hormones are people who have quite a bit of suffering from gender dysphoria, and that suffering can often impair, or almost by definition, impairs their functioning, and that can have impacts in terms of development and in terms of functioning at school.
MR. RAMER: We've been going for a little over an hour. Maybe take a break, if that's all right.
MR. LANNIN: Sure.
THE VIDEO OPERATOR: Going off the record, the time is 2:34 p.m.
(Recess, 2:34 p.m. - 2:51 p.m.)
THE VIDEO OPERATOR: Back on the record. The time is 2:51 p.m.
BY MR. RAMER:
Q Dr. Karasic, I'd like to discuss the 2017

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USPATH conference.
You were the conference chair for that event, correct?
A Yes.
Q And you were also the chair of the scientific committee for that event, correct?
A Yes.
Q And can you explain what the scientific committee's role was at that conference?
A Yes.
So the scientific committee reviewed the abstracts for the conference and scored them, and then each -- so that each abstract had an average score. And then there was a cutoff score, and everything above that score was accepted.
Q So just backing up a little bit for my own sake, what is an abstract?
A So an abstract is a summary of a paper or presentation. It's what you see at the top of a scientific article.
And when you apply to present at a conference, you write an abstract that summarizes what you're going to talk about.
And then the scientific committee reviews all the abstracts, gives a rating score to make a

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decision about who gets to present.
Q And how many people were on the scientific committee for the 2017 conference?
A It was quite a large committee, as I recall, but I can't -- it was several years ago; so I can't say the exact number.
Q I'm completely ignorant with respect to this, so what's, like, approximate for something like this?
A 20, 25.
Q And when you are grading the abstracts, how do you do that?
A So we had -- we have criteria that -- where we're scoring presentations in regard to their addition to scientific knowledge or clinical practice, and also their interest to the audience.
Q And is the grading process blind?
MR. LANNIN: Object to the form.
THE WITNESS: So sometimes it is and sometimes it isn't. And I don't remember the 2017 process, if -- I think we knew the names of the people who were -- my recollection is that we knew the names of the people that submitted the abstract or who would be presenting for each one, and so that it was not -- not blinded in that way.

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BY MR. RAMER:
Q And when you say you knew the names, or that your recollection is that you knew the names, do you mean that when members of the committee were grading the abstracts, they knew the name associated with that abstract?
A Yes, I believe they did. They knew the authors.
So it would be a spreadsheet with the title, the authors, and the abstract. And the members of the scientific committee who had been assigned to score that abstract would have all that information.
Q Do you remember anybody else who was on the scientific committee with you?
A I -- you know, it was so long ago, I just -- I don't think I could say.
But undoubtedly, it was, you know, quite a number of people involved in trans health who -- who were -- typically who were involved in WPATH or in conferences on transgender health.
Q Was Dr. Jamison Green on the committee with you?
A Yes. I don't remember if he was on -- he may have been on the scientific committee for legal

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presentations.
He was on the -- there was an organizational committee, and he may have been some sort of, like, organizational co-chair. I don't remember. But he was -- he was definitely involved, and I think he may have been involved in terms of presentations that were related to law or public policy.
Q When you say there was an organizational committee, do you mean within the scientific committee?
A No. Within -- so this was the first USPATH conference, and future USPATH conferences were organized by the USPATH board, but there wasn't a board yet.
They were just in the process of -- we were in the process, as WPATH, of creating the USPATH chapter. There already was EPATH for Europeans that was associated with WPATH, and then other chapters that were not associated with WPATH, like the Canadian CPATH.
So there was a committee within WPATH of people who were involved in the -- in organizing the conference, and then there was the scientific committee which was people to review the abstracts.

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And I don't remember if Jamison Green was on both, but I believe he was on the committee involved in organizing the -- the conference.
Q And so when we were discussing you serving as the conference chair, is that in reference to that organizational committee?
A Yes.
Q And so CPATH is not affiliated with WPATH; is that correct?
A Right.
Q How did that come about?
MR. LANNIN: Object to the form.
THE WITNESS: They -- they formed before there was chaptering.
And so WPATH, under Gail Knudson, who was president at the time, felt -- was particularly committed to the idea of further chaptering.
EPATH had already formed as a chapter of WPATH, and then it made sense for USPATH to also be a chapter.
And on the off years when WPATH wasn't doing their conference, USPATH and EPATH would do their conferences.
BY MR. RAMER:
Q And in addition to your role as the

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conference chair and your role as -- I guess -- sorry.

Were you the chair of the scientific committee?

A So I was chair of the scientific committee. And my conference chair part was just kind of leading the organization because there was no USPATH board.

I found the facility, like the conference center at UCLA, and dealt with some of the practicalities along with the WPATH staff.

Q And so in addition to those roles, you also presented on a panel, correct?

A Yes.

Q And do some people refer to a panel like that as a "mini symposium"?

MR. LANNIN: Object to the form.

THE WITNESS: So WPATH and USPATH refers to them, for some historical reason, as "mini symposia." I don't know why, but I think that's just a historical thing, that they called them that.

BY MR. RAMER:

Q And the mini symposium at which you presented was organized and chaired by Dr. Bahlburg who we were previously discussing, right?

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A Right, that we were just discussing.

I had been working with him on this paper in transgender health, and -- yeah, 2018 -- and he emailed me and asked if -- so Dr. Meyer-Bahlburg worked with Ken Zucker on the DSM-V committee, I believe, because of his expertise working with intersex people.

And so he asked if he could put together a panel with -- where both Dr. Zucker and I were presenting.

Q And could you just give me a little bit of background about Dr. Bahlburg?

A Yeah.

MR. LANNIN: Object to the form.

THE WITNESS: He's probably emeritus now, but a professor at Columbia University. He's a neuroscientist and is an expert in intersex development.

BY MR. RAMER:

Q Is he a respected scientist?

MR. LANNIN: Object to the form.

THE WITNESS: Yes, I would say so.

BY MR. RAMER:

Q So you're saying Dr. Bahlburg invited both you and Dr. Zucker to be on this panel, correct?

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A Yes.

Q And Dr. Bahlburg drafted the summary abstract for the panel, correct?

A Yes.

Q And then who -- I guess, would you have been, for lack of a better term, "recused" from the scientific committee of reviewing an abstract that you're on, or how does that work?

MR. LANNIN: Object to the form.

THE WITNESS: Yes. So I don't think I reviewed most of the abstracts because I was busy with other things. That was left to other people. But I would not have reviewed my own abstract if I were reviewing a batch of abstracts.

BY MR. RAMER:

Q And do you remember what you were presenting on for this panel?

A Yes. So Dr. Meyer-Bahlburg asked me to present about trans people with dissociative identity disorder.

Q And do you recall what Dr. Bahlburg was presenting about?

A I don't remember his presentation.

I believe that Dr. Zucker was talking about his desistance data from when he had been at

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MH at University of Toronto.

Q For Dr. Bahlburg, would "gender variations in somatic intersexuality" sound right?

A Yes. He was probably presenting on what he was talking about in that paragraph. That was -- his speaking and writing is -- has tenses, one might expect, from a German scientist.

Q And so Dr. Zucker was presenting on gender variations during childhood; is that right?

MR. LANNIN: Object to the form.

THE WITNESS: Yeah. My recollection of his presentation was he was talking about desistance data, talking about prepubertal youth in his clinic and their various presentations of gender, including desistance.

BY MR. RAMER:

Q And before this panel, were you aware of Dr. Zucker?

A Yes.

Q Had you ever interacted with him?

A Yes.

Q And what did you think of him as a professional?

MR. LANNIN: Object to the form.

THE WITNESS: So I had interacted with him

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starting in 2003 when I chaired an APA panel on the gender identity disorder and related chapters in DSM-IV and what might be proposals for DSM-V. And I had asked him to -- to participate in that panel, and he had declined.

But we had other folks who were kind of defending DSM-IV as it is. The purpose was to both present challenges to the current chapter and suggestions for revising it, as well as people who were kind of defending the current chapter.

BY MR. RAMER:

Q Did you respect Dr. Zucker as a professional?

MR. LANNIN: Object to the form.

THE WITNESS: Yes.

BY MR. RAMER:

Q Do you think he practices conversion therapy?

MR. LANNIN: Object to the form.

THE WITNESS: So that is really -- what he does is kind of outside of my -- you know, what happened in his office.

We worked together on Standards of Care 7, which was the first standards of care to reject conversion therapy, and we all had to come to

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consensus on it. And he said at that time that he was not practicing conversion therapy.

He was accused of it, and the whole Provincial Parliament of Ontario, I think, unanimously voted to ban conversion therapy.

And he was the subject of a lot of controversy among accusations that he had mistreated children, and his program was terminated. And he became -- he was already, I think, a controversial figure, but he became more controversial, you know, in the wake of that whole -- you know, of all those things that happened.

And then shortly before the conference, he appeared on a British documentary, during which he referred to transgender youth or gender-diverse children, he compared them to dogs. He said, "If your child said he were a dog, would you feed him dog food?"

So -- this was just before the conference, and so there was also kind of added attention to his presence at the conference.

BY MR. RAMER:

Q And protestors interrupted your panel with Dr. Bahlburg and Dr. Zucker, correct?

MR. LANNIN: Object to the form.

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THE WITNESS: Yes. Specifically, there was a protester who was not a member of WPATH and didn't even know who the panelists were, because she interrupted Dr. Heino Meyer-Bahlburg, and -- for a few minutes, and then left.

BY MR. RAMER:

Q And when you say this individual interrupted Dr. Bahlburg, how did she do that?

A She stood in front of him and spoke.

I don't recall what she actually said, but she did, like, kind of -- he was at a podium, and she just kind of stood in front of him at the podium.

Q Was she alone or were others also protesting at that time?

MR. LANNIN: Object to the form.

THE WITNESS: So I think in the room she was alone, but there were some people in the room who were sympathetic, you know, to her, to the objection to Dr. Zucker.

However, I did my presentation and Dr. Zucker did his whole presentation, and I think didn't get any challenges until Q&A.

BY MR. RAMER:

Q And what happened at Q&A?

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A I can't remember, but I think somebody might have objected to his being there. But I can't remember.

Q Is it fair to say that Dr. Zucker was the target of the interruptions?

MR. LANNIN: Object to the form.

THE WITNESS: So there was -- there may have been more, but I just recall this one woman who, even though she interrupted Heino Meyer-Bahlburg, she intended to interrupt Ken Zucker.

But clearly she wasn't somebody working in WPATH or in transgender health or she would know who -- you know, she would know this German-speaking man was not -- that Ken Zucker wasn't German.

BY MR. RAMER:

Q And did the protesters limit the panel's ability to give the fully planned presentation?

MR. LANNIN: Object to the form.

THE WITNESS: So they -- I know they interrupted Heino, Dr. Meyer-Bahlburg, but I think I spoke over time, and Dr. Zucker I think went well over time.

So I think we were able to give our presentations.

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BY MR. RAMER:
Q And you touched on it a little bit, but how did the members of the panel -- so you, Dr. Zucker, Dr. Bahlburg -- react to the interruption?
MR. LANNIN: Object to the form.
THE WITNESS: I think we initially just tried to let her say her piece, and I don't remember whether we, at some point, were like, "Okay. You've said your piece. It's time to go."
I can't remember specifically.
BY MR. RAMER:
Q Did someone call security in response to the interruption of the panel?
A So, yes, I learned that later that somebody had called security.
But that -- I think if there was any protest needing security, it would have probably been outside of the -- of the conference room that we were doing the presentation in, because I think we gave our presentations uninterrupted.
They may have been protesting out in the hall. I don't recall.
Q What is the protest outside of the conference room you're referring to?

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A I mean, like, in the hallway of the conference center.
We were in a room, but we were able to speak. So I'm not sure what happened outside of the room that we were speaking in.
Q And do you know who called security?
A No.
Q And Dr. Zucker was scheduled to appear on another panel at the conference, correct?
A Yes.
Q And what happened to that panel?
MR. LANNIN: Object to the form.
THE WITNESS: So that session ended up being canceled.
We realized we had held the conference on this university campus, and we didn't really have the capacity to keep people who weren't registered for the conference from coming in.
And the president of WPATH at the time, Gail Knudson, received some threat that the -- that that session wouldn't happen, and made the decision that it was for the best for us to cancel that session and to try to keep the conference safe for its participants.
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BY MR. RAMER:
Q And what do you know about that threat you're mentioning?
MR. LANNIN: Object to the form.
THE WITNESS: I actually don't know very much. I was busy -- I mean, my conference chair thing was quite an unglamorous thing of making sure that all the different sessions and different things that were going on were happening properly.
And so I wasn't there for all of the discussions, but Gail Knudson told me that there had been a threat, and the threat was that the session wasn't going to happen, and that she thought that it would be for the best for us not to do that session because we couldn't guarantee people's safety, especially, you know, being on this campus where people could -- could come and go.
And so -- so a decision was made to cancel that session, and I think I was in agreement. And if anyone else was in agreement, that we just needed to make sure that we were putting on the conference safely.
BY MR. RAMER:
Q Do you think WPATH suppressed Dr. Zucker's presentation?

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MR. LANNIN: Object to the form.
THE WITNESS: So I think that WPATH had always been very supportive of having Dr. Zucker speak, up to my agreeing to be on that presentation kind of in the hopes that even with my presence, it would make it more likely that everything would go smoothly, which was probably a misunderstanding of my importance.
But we were really trying to have a diverse set of viewpoints at WPATH and at the conference, including, for example, a session of de-transitioners, who were quite anti-WPATH, having the opportunity to speak at the conference as well.
And I think we kind of prided ourselves on at least trying to provide kind of a diversity of viewpoints and to allow them to be discussed in an open environment. But when we were faced with the possibility that it might not be safe to do so, that it made sense to -- to cancel the session.
I would note that, you know, there was the USPATH and the EPATH conference that year, and the EPATH conference took place a couple months later in Belgrade, and Dr. Zucker was able to present without incident, as far as I know, in Belgrade.
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BY MR. RAMER:
Q Did you post an apology for the panel on Facebook?
A Yes.
Q And what were you apologizing for?
A So I felt that kind of an approach of humility was maybe what made the most sense in terms of kind of settling things down.
And people had brought to my attention to some degree -- I didn't realize the extent of it -- that having Ken Zucker there -- in the light of the accusations of abusing children and the television evidence of his comparing gender-diverse children to dogs -- that by having him there, WPATH was making a statement itself in support of those ideas.
And I think I'd been kind of dismissive about them, in the laudable goal of, you know, free expression.
I think that in retrospect, probably there should have been an attempt at conversation with people who objected before the conference, and -- but it wasn't something that we realized was going to kind of blow up in that fashion until it did.
Q And so to whom were you apologizing?
A So I don't remember the Facebook -- I

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mean, I remember posting it. I don't remember what was in it. That time was kind of a blur.
But I was apologizing to the people who were upset with how things went down.
Q And do you think that trans women of color in particular were owed an apology?
MR. LANNIN: Object to the form.
THE WITNESS: I don't remember what I said or what it was in response to.
(Exhibit 8 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Zucker, you've been handed -- I'm sorry.
Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 8.
And does this appear to be the Facebook post we were discussing?
A Yes.
Q And at the bottom, a few sentences up, you refer specifically to "trans women of color."
And I'm just curious if that has to do with the presence of Dr. Zucker or the fact that, as you're saying here, they're the most vulnerable of people.

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MR. LANNIN: Object to the form.
THE WITNESS: So I included a response, and I don't know where that came from. But someone had communicated to me that trans people, especially trans women of color, were feeling threatened by the current -- in the current political environment. And so while I was apologizing, I included that in.
It was not an apology related to Dr. Zucker on behalf of that, but I was acknowledging that trans women of color were vulnerable. That was a group that had -- there was a group representing trans women of color who had lodged a particular complaint about feeling vulnerable in this environment, and WPATH not being supportive of the trans community or trans women of color.
So I think it was in response to that complaint against WPATH that I included that in my -- in my -- in this apology. But it was -- that wasn't, I don't think, particular to Ken Zucker, but rather to complaints in the wake of the protest that we got about WPATH.
BY MR. RAMER:
Q And after the panel, did you attend a meeting with the individuals who opposed

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Dr. Zucker's presence at the conference?
A Right. It was after the panel. After the panel, I was busy with these other sessions that were going on. I went back and I learned that Ken Zucker wouldn't be -- that that session wouldn't be happening.
And then I was asked to -- to go to that session as part of an attempt to kind of diffuse the -- the kind of protests that had led to that threat. We were wanting to try to calm people down.
(Exhibit 9 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q And, Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 9. And I'll note that this is stamped "Confidential - Subject to Protective Order," and it has Bates stamp BOEAL_WPATH_064098.
You can see from the subject at the top, the subject line says, "Re: Forward: NYTimes Mag fact-checking."
Do you see that?
A Yes.
Q And as we look at this email, the first one in the chain says, "My responses are integrated

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below."
Do you see that?
A Yes.
Q Then as we move down the chain, we see the previous message said, "New set of fact checks below."
Do you see that?
A I was just trying to see what this is, okay?
Q All I'm asking is, do you see that? It says, "New set of" --
A Yes.
Q And then you move down to the prior email in the chain. It is from an individual named Mark de Silva, with an email address at the New York Times, correct?
A Yes.
Q And in the first paragraph of this email from Mark de Silva, which is dated June 7th, 2022, the second sentence says, "In the meantime, I have some further questions for WPATH."
Do you see that?
A Yes.
Q And then I'd like to go to the next page, and about halfway down the paragraph above the

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number 6 that starts with, "We also have questions."
Do you see that?
A Yes.
Q And that paragraph says, "We also have questions about a protest in February 2017," and then there are brackets with a YouTube link, correct?
A Yes.
Q And the following sentence says, "We have spoken with" -- redacted -- "and he believes it is generally accurate, but we would also like see [sic] if WPATH sees anything inaccurate here," correct?
A Yes.
Q And then No. 8 -- I'm sorry. I'll start with No. 7. It says, No. 7, "At this conference, protestors interrupted and picketed a panel featuring" -- redacted.
Do you see that?
A Yes.
Q And then after that, it says, "Yes," correct?
A Yes.
Q And then No. 8, it says, "That evening of the protest at a meeting with the conference leaders, a group of activists led by transgender

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women of color read aloud a statement in which they said the 'entire institution of WPATH' was 'violently exclusionary' because it 'remains grounded in 'cis-normativity and trans exclusion'"?
Do you see that?
A Yes.
Q And then after that, in brackets it says, "Quotes are from video."
Do you see that?
A Yes.
Q And then there is a dash, and then there's a redaction, and then it says, "Yes."
Do you see that?
A Yes.
Q Are those quotes referenced there consistent with your recollection of that meeting?
A Yes.
Q Did you speak at that meeting?
A Yes.
Q Do you recall who else spoke at that meeting?
A No.
Q Did Dr. Jamison Green speak at that meeting?
MR. LANNIN: Object to the form.

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THE WITNESS: I would assume that he was -- he did. I think he would have been past president of WPATH and kind of involved with the conference.
BY MR. RAMER:
Q And what did you say at the meeting?
A What did I say at the meeting?
Q Correct.
A I don't think I could say. I -- I'm sure I apologized in some way.
Beyond that, I know that I was kind of asked to go and to try to, you know, kind of humbly calm people down, but I don't remember what I said at the meeting.
Q And I'd like to play a clip for you on this iPad.
(Addressing Counsel) And I can represent that I have it on here (indicating) if you want it as well.
I'll also represent that this is a clip from the YouTube video that's at the link that's listed in the document we were just looking at.
THE REPORTER: Do you want me to take this down, or just indicate that it is played?
MR. RAMER: Just indicate, please.

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THE REPORTER: Thank you.
MR. RAMER: I'll first just ask you just to watch it, and then I'll have some questions afterward.
THE REPORTER: One more question. Do you want this as an exhibit?
MR. RAMER: Yes, please. And on the thumb drive that I gave to counsel and to the court reporter, this video is labeled "Karasic_Dep_Video1."
(Exhibit 10 was marked for identification and is attached hereto.)
(Video played.)
BY MR. RAMER:
Q Dr. Karasic, is that a video from the meeting we were just discussing?
A Yes.
Q And is that you speaking in that video?
A Yes.
Q And in that clip, you say that you wrote an op-ed urging the Ontario legislature to pass a ban on conversion therapy that contributed to Dr. Zucker being fired, correct?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. There was an op-ed by

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one of the colleagues of Dr. Zucker at that program in support of conversion therapy, I think, at least opposing the ban on conversion therapy.
And then I wrote an opposing view saying that conversion therapy should be banned. And the Ontario legislature did end up banning conversion therapy.
Ken Zucker was -- had said he wasn't committing conversion therapy, and there was actually some litigation with him and the university.
And -- but they had said that he -- well, he had been accused of mistreating young people, and I think they felt that was sufficient to -- to close the program. Whether or not that was conversion therapy, I think they didn't feel it was a benefit to the university.
So that's what had happened. Obviously there were -- you know, I wasn't the principal person involved, but I did write the kind of counterargument op-ed for when Ontario was considering their conversion therapy ban.
BY MR. RAMER:
Q And in that video, you say that even if the abstract for the panel with Dr. Zucker was

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getting a high enough score, you didn't think that you should have let Dr. Zucker present, correct?
MR. LANNIN: Object to the form.
THE WITNESS: Yes. We couldn't -- as it turns out, we couldn't do that and have the conference safely go on. And I didn't think that -- I mean, I think Dr. Zucker has many, many places to present his views.
I obviously did support his being able to present that at USPATH until it led to potentially a threat to the safety of the participants of the conference.
And so I didn't think -- so I was supportive despite my disagreements with Dr. Zucker to present them side by side. And, you know, if that is something that could have been done safely -- but in retrospect, it was a mistake because it couldn't be done safely in that particular environment.
We later were in agreement, though, that Dr. Zucker shouldn't be, you know, canceled in any way, and he did present at the next WPATH conference a couple months later in Serbia.
BY MR. RAMER:
Q At the USPATH 2017 conference, did you

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attend the gala or banquet event?
A Yes.
MR. RAMER: I'm going to play another video on the thumb drive. It is Karasic_Dep_02. It's about five minutes long.
THE REPORTER: Will this be 11?
MR. RAMER: Yes, please.
So this will be Karasic Exhibit 11.
(Exhibit 11 was marked for identification and is attached hereto.)
(Video played.)
BY MR. RAMER:
Q Dr. Karasic, I've stopped that video, Exhibit 11, at the one-second mark.
Is that you standing in the background there?
A Yes. I think that was the board of WPATH and the staff of -- yeah, the board and staff of WPATH who were standing up there in the background before all this happened.
Q And does that video depict events that occurred at the 2017 USPATH gala that you attended?
A Yes.
MR. RAMER: I have one more video on the thumb drive. This is Karasic_dep_video3.

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I'll ask to mark that as Exhibit 12.
(Exhibit 12 was marked for identification and is attached hereto.)
MR. RAMER: And this is also about five minutes long.
(Video played.)
BY MR. RAMER:
Q Dr. Karasic, did that video depict events that occurred at the 2017 USPATH gala that you attended?
A Yes.
Q And I've paused Exhibit 12 at the 2:49 mark.
The individual on the right of the screen in the purple shirt, is that Dr. Jamison Green?
A Yes.
Q I've now paused Exhibit 12 at the 55-second mark.
Who is the individual holding the microphone?
A I believe that is Danielle Castro.
Q I have now paused Exhibit 12 at the mark.
Do you know who that individual is who's holding the microphone?

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A I forget her name. She is a leading activist in the Los Angeles transgender community. But -- I met her at that conference, but I don't remember her name.
Q Did the WPATH executive committee release an apology regarding Dr. Zucker's presentation?
MR. LANNIN: Object to the form.
THE WITNESS: I think there was a reference on the website about when -- basically there was an agreement that was hashed out between Dr. Knudson, the WPATH president, and the activists who were on stage. And with that, there was -- there was a statement of some sort on the website.
(Exhibit 13 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, the court reporter has handed you what's been marked as Karasic Exhibit 13.
A Yes.
Q Does this appear to be the statement you were just referencing?
A Yes. It's from the WPATH executive committee, and I was -- I'm not -- I was not on the executive committee. But they wrote this statement.
Q Did you help write it at all?

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MR. LANNIN: Object to the form.
THE WITNESS: I don't recall if I contributed at all. It was not a board message. It was a message from the executive committee, and I was not on the executive committee. So I don't -- I don't recall if I had any input in this.
Again, there was -- the WPATH president met with the activists, and they -- and this was part of -- I guess this was kind of what they had hashed out, theoretically, in executive committee meeting. An agreement would then need to be approved by the board as a whole, but I don't have any recollection if that -- if that happened.
BY MR. RAMER:
Q Was this statement later removed from the WPATH website?
MR. LANNIN: Object to the form.
THE WITNESS: I assume it was. I don't know if I -- I don't recall seeing it on the WPATH website. So -- but it was a long time ago.
BY MR. RAMER:
Q Do you know why it was removed?
MR. LANNIN: Object to the form.
THE WITNESS: No, I don't recall.
///

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BY MR. RAMER:
Q Do you recall voting to remove it?
MR. LANNIN: Object to the form.
THE WITNESS: I don't recall. It was a long time ago.
BY MR. RAMER:
Q What was your reaction to this statement in Exhibit 13?
MR. LANNIN: Object to the form.
THE WITNESS: I don't recall.
It was a process that happened between the WPATH president and the activists, and they had made this agreement that, I think, preceded that -- that last video that -- where they tried to create some sort of settlement to essentially make sure that the conference was -- could go on safely, and then I'm -- I don't know what happened with it.
I do think that there didn't need to be, for example, two seats on the SOC-8 committee for trans people of color because there were at least a couple of trans people of color, you know. There were a number of trans people of color who were -- you know, who were on the committee, not because of being activists.
But I was not the person who developed

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this statement, and I don't recall what ended up happening with it.
BY MR. RAMER:
Q I'm going to read the first two sentences, and I'll first ask if I read them correctly.
It says, "On February 3, 2017 a WPATH member presented at the USPATH conference on a clinical modality that WPATH opposes. A conference attendee disrupted the offensive session due to this act of negligence."
Did I read that correctly?
A Yes.
Q Do you think those two sentences accurately portray what happened at your panel?
A No.
Q Do you think this statement from WPATH is reflective of a commitment to the open exchange of ideas?
MR. LANNIN: Object to the form.
THE WITNESS: I think it was something that was hashed out by members of the WPATH executive committee and some transgender activists who were kind of occupying the conference center.
I don't think it was -- I don't think the presentation was an act of negligence. I think, you

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know, we should have worked with people in advance and tried to decide if this could be done safely before doing it.
I suppose if it was negligence, it was that we didn't, you know, think about the -- you know, the potential for acts of violence.
BY MR. RAMER:
Q Do you think your panel was offensive?
MR. LANNIN: Object to the form.
THE WITNESS: I don't think so, but it did offend people.
BY MR. RAMER:
Q Do you recall how the other members of your panel reacted to this statement?
MR. LANNIN: Object to the form.
THE WITNESS: I think that Heino Meyer-Bahlburg was unhappy with it. I didn't -- I'm not in regular communication with Ken Zucker.
But Heino and I were working on the paper together, and so we were in communication and -- we were in communication, and I know he was unhappy with this session being characterized that way.
MR. RAMER: We've been going for over an hour. Maybe time for a break?
MR. LANNIN: Great.

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THE VIDEO OPERATOR: This marks the end of Media Unit 3 of the deposition of Dan Karasic, M.D. The time is 3:58 p.m. We're off the record.
(Recess, 3:58 p.m. - 4:12 p.m.)
THE VIDEO OPERATOR: We are back on the record at 4:12 p.m. This marks the beginning of Media Unit 4 of the deposition of Dan Karasic, M.D.
Please continue.
(Exhibit 14 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 14, which is stamped "Confidential," and has the Bates stamp of BOEAL_KARASIC_8.
Do you see that?
A Yes.
Q And about -- just a little over halfway down the page, do you see that you are cc'd in this email?
A Yes.
Q And up at the very top, the subject is "Forward: A message from the WPATH Executive Committee (re USPATH meeting, February 3, 2017)," correct?

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A Yes.
Q And on the next page, the first sentence -- I'll just read it first and ask if I read it correctly -- says, "The Mini-Symposium entitled 'Development of Gender Variations: Features and Factors' that I convened and chaired was interrupted twice by a small group of protestors."
Did I read that correctly?
A Yes.
Q And the paragraph below that, the first sentence says, "Because of the time used up by the first disruption and related questions from the audience later, I decided to give the first two speakers" -- redacted -- "('Gender dysphoria and dissociative gender identity disorder combined') and" -- redacted -- "('Gender variations during childhood') more time for their presentations and Q&A sections and was, therefore, unable to present my own lecture ('Gender Variations in Somatic Intersexuality,' which also included a summary of the fourth lecture by" -- redacted -- "who was unable to attend)."
Did I read that correctly?
A Yes.

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Q Is it fair to say this email was written by Dr. Bahlburg?
A Yes.
Q And next paragraph, the final sentence, which is fairly long, it starts about halfway through the paragraph. I'm just going to read that first and ask if I read it correctly.
"By misrepresenting the content of the session and labeling the entire session as 'offensive,' 'due to this act of negligence,' (a vague formulation that also needs explanation), you are aligning yourselves with the small group of protestors, insult the speakers involved, and violate a primary condition of a scientific meeting, namely the open and constructive exchange of ideas, which is particularly important in an area of research as emotion-laden as gender."
Did I read that correctly?
A Yes.
Q And then there's a short one-sentence paragraph, and then there's a sentence below that. I'm sorry -- a paragraph below that.
And the first sentence says, "As similar incidents occurred already in two symposia I was involved with at the recent WPATH meeting in

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Amsterdam, I think WPATH's leadership needs to become more proactive in furthering a constructive style of scientific exchange - rather than inhibiting scientific exchange by suppressing presentations as you did in L.A., when you canceled" -- redacted -- Mini-Symposium on February 4."
Did I read that correctly?
A Yes.
(Exhibit 15 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked Exhibit 15, and this is stamped "Confidential" and has a Bates number of BOEAL_WPATH_101671.
Do you see that?
A Yes.
Excuse me. Where is the -- oh, down there. 101671. Yes.
Q And the subject of this email is "Forward: A message from the WPATH Executive Committee" at the top.
Do you see that?
A Yes.

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Q And then the -- at the top email, the "From" is redacted, and the "To" is to the WPATH EC Listserv.
Do you see that?
A Yes.
Q And do you see, two lines down in the email, it says, "Begin forwarded message."
Do you see that?
A Yes.
Q And then "From" is redacted, and "To" is redacted, correct?
A Yes.
Q And then below that, "Subject: A message from the WPATH Executive Committee," correct?
A Yes.
Q And I'd like to go to the number 1 that says, "The first sentence reads: 'On February 3, 2017 a WPATH member'" -- brackets, redacted -- "'presented at the USPATH conference on a clinical modality that WPATH opposes.'"
Do you see that?
A Yes.
Q And that is quoting the WPATH statement that we previously looked at, correct?
A Yes.

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Q And then below that, the comment says, "Let me begin by saying that I do not know if you or" -- redacted -- "were at the Symposium (organized and chaired by...)" -- redacted. "The sentence simply astonishes me. My talk was not at all about any 'clinical modality' - it was a summary of follow-up studies of children diagnosed with GID (the diagnostic label that was in place for a number of the follow-up studies) or children subthreshold for the diagnosis."
Do you see that?
A Yes.
Q And moving down to the number 2 in the email, it says, "The third sentence reads: 'Later that day the same presenter was asked to leave by a group of professionals attending the conference.'"
A Yes.
Q And that is quoting the WPATH statement that we previously looked at, correct?
It's Exhibit 13 if you want to compare it.
A Oh, here it is.
Q And I believe it's the third sentence in the Exhibit 13.
A Yes.
Q Going back to Exhibit 15, below where we

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were just reading, it says, "Comment: This sentence also simply astonishes me. No one asked me to leave," correct?
A Yes.
Q Is it fair to say this email was written by Dr. Zucker?
A Yes.
Q Moving down to No. 3, it says, "There is, of course, a broader issue at stake here. At WPATH in Amsterdam last June, activists disrupted a Symposium on DSDs and defaced a poster. I find it remarkable that the leadership of WPATH has remained silent about this. If there cannot be meaningful dialogue about complex issues at WPATH or USPATH, how can the organization consider itself to be 'professional'?"
Did I read that correctly?
A Yes.
Q Do you recall whether the opponents of Dr. Zucker's presence at the conference responded to either your apology or the WPATH statement we've been looking at?
MR. LANNIN: Object to the form.
THE WITNESS: I don't recall. I wouldn't be surprised if my statement on Facebook had people

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responding.
I had said I didn't -- I wasn't responsible for the executive committee message or the -- or those emails; so I don't -- I don't recall.
(Exhibit 16 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 16. This is stamped "Confidential," and the Bates number is BOEAL_WPATH_143750, correct?
A Yes.
Q Have you seen this document before?
A Not that I recall. I wasn't on the executive committee. And I think that the negotiation between the activists and the executive committee took place without my participation. So I don't recall all the communications involved.
Q And going down to Question 2 on this page -- sorry, I guess it's not a question -- Statement 2 on this page, it says, "This statement fails to include the multiple people and range of identities that were affected by the violence that Zucker and WPATH allowed and perpetuated."

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Do you see that?
A Yes.
Q Do you think Dr. Zucker's presentation constituted violence?
MR. LANNIN: Object to the form.
THE WITNESS: I don't -- that is not terminology that I use; so I -- I wouldn't call it that, no.
BY MR. RAMER:
Q Do you think it would be reasonable for somebody to say that Dr. Zucker's presence at the conference constituted violence?
MR. LANNIN: Object to the form.
THE WITNESS: No.
BY MR. RAMER:
Q Why do you think the authors of this document did?
MR. LANNIN: Object to the form.
THE WITNESS: Can I say, "Young people today"?
You know, people have different perspectives. And you go into a world where sometimes other people's perspectives surprise you or are different from you or take things in a different -- a very different way.

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BY MR. RAMER:
Q And sticking with this document, going up to the Statement No. 1 and the underlined response below it, in the second sentence, which is fairly long, it refers to "trans-positive practitioners and researchers."
Do you see that?
A In -- I'm sorry. What paragraph was that?
Q So up to the Statement No. 1 that begins, "This letter fails," do you see that?
A Yes.
Q And then going to the underlined portion after that --
A Oh, I see it.
Q -- the second --
A Yeah. Yes.
Q And what are trans-positive practitioners and researchers?
MR. LANNIN: Object to the form.
THE WITNESS: I wouldn't use that wording, either.
From my recollection, there was a -- you know, kind of a range of presenters for that session. And I don't know if the -- I assume the other three presenters would have a different

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perspective than Ken Zucker, but I don't think that they were there simply to rebut Dr. Zucker's theories. I think the point of the session was to show a range of views.
BY MR. RAMER:
Q Do you have any reason to think Dr. Zucker is not a trans-positive practitioner?
MR. LANNIN: Object to the form.
THE WITNESS: I don't -- for any of those people involved, it's not terminology that -- I don't know what that means.
(Exhibit 17 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 17. And on the first page, it says, "Private Plaintiffs' Supplemental Rule 26 Disclosures."
Do you see that?
A Yes.
Q And I'd like to go to page -- page 3.
A Yes.
Q And do you see you're listed there?
A Yes.
Q And the last sentence states, "He,"

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referring to you, "is also expected to testify in response to claims that WPATH limited debate and robust exchange of ideas across the organization and at conferences hosted by affiliate organizations."
Do you see that?
A Yes.
Q Apart from what we've already discussed today, are there any other claims that WPATH limited debate and robust exchange of ideas across the organization and at conferences hosted by affiliate organizations that you intend to testify about?
MR. LANNIN: Object to the form.
THE WITNESS: I think that -- I think that this was put in for -- about the 2017 conference, because I haven't been involved with WPATH aside from Standards of Care 8 since 2018.
BY MR. RAMER:
Q Dr. Karasic, the minimum ages for providing gender-affirming medical care were removed from the SOC-8 to ensure greater access to care for more people, correct?
MR. LANNIN: Object to the form.
THE WITNESS: So I think that was in the editor's -- an editor remark in terms of that. I wasn't involved with any of that process.

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BY MR. RAMER:
Q So you don't know why the minimum ages were removed; is that right?
MR. LANNIN: Object to the form.
THE WITNESS: Not -- anything would be speculation.
(Exhibit 18 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 18.
A Yes.
Q And this is stamped "Confidential" and has Bates stamp BOEAL_WPATH_105494 at the bottom, correct?
A Yes.
Q And looking at the top, the "From" line first is Asa Radix, correct?
A Yes.
Q And the "To" is Walter Bouman?
A Yes.
Q Who is Walter Bouman?
A Walter Bouman is a -- I think he's the past president of WPATH.
Q And in the "cc" line is the EC Listserv,

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correct?
A Yes.
Q And the date of this email is June 14th, 2022, correct?
A Yes.
Q Okay. I'd like to go to page 3 in this, which is Bates 105496. And at the bottom, do you see there's an email from Walter Bouman, dated June 13th, 2022?
A Yes.
Q And the subject is "The imminent release of the SOC8 - and please be so kind as to give us your support or endorsement," correct?
A Yes.
Q On the next page, which is Bates 105497, about a little over three quarters of the way down, there's a paragraph that begins with, "If you agree to this."
Do you see that?
A Yes.
Q I'm just going to read that first and ask if I read it correctly.
It says, "If you agree to this, we will send you a link to the SOC8 (which is currently under embargo, and currently only ADM Dr. Rachel

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Levine and her Department (HHS/OASH) in the U.S. have access to the full document) and we will provide access following the signing of a nondisclosure document."

Did I read that correctly?

A Yes.

Q Before seeing this email, were you aware that Admiral Levine and her department were provided exclusive access to the completed SOC-8?

MR. LANNIN: Object to the form.

THE WITNESS: No.

(Exhibit 19 was marked for identification and is attached hereto.)

BY MR. RAMER:

[redacted]

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[redacted]

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[redacted]

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[redacted]

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[redacted]

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[redacted]

Q Now switching gears a little bit, have you ever declined to list a patient's diagnosis in medical records in order to ensure that insurance will provide reimbursement for care?

MR. LANNIN: Object to the form.

THE WITNESS: I wouldn't say that I have not listed a diagnosis, but there was a time when there was a -- a CMS exclusion for treatment of gender identity disorder.

So as a psychiatrist, I would be treating people typically for depression, anxiety, for other symptoms, and I would list as a billing diagnosis a symptom that was -- you know, a diagnosis -- a

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different diagnosis that people also had, a co-occurring condition.

BY MR. RAMER:

Q And would you ever intentionally omit the diagnosis for gender identity disorder from those records?

MR. LANNIN: Object to the form.

THE WITNESS: I think there was just a time in which it was considered kind of useless to include that because it -- because it wasn't covered.

And as a psychiatrist, I see people who are seeing me because they're depressed or anxious, and so I would list that as the -- you know, as the billing diagnosis.

We're talking about before -- certainly before 2013. In 2013, California banned denying reimbursement for gender -- transgender-related care.

BY MR. RAMER:

Q Do you think the distress resulting from gender incongruence in children should be categorized as a psychological disorder?

MR. LANNIN: Object to the form.

THE WITNESS: So if -- so if the -- if the

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child is distressed, they're -- you know, they have and would have a diagnosis.

There was for -- there was a debate around gender incongruence of children, which was a World Health Organization ICD 11 diagnosis, that did not include distress. And so -- because gender incongruence doesn't include distress as part of the disorder.

And so there was a debate whether there was utility of the World Health Organization even having a gender-incongruence-of-children diagnosis because it's a diagnosis prior to which they would get specific medical treatment.

BY MR. RAMER:

Q You do think there should be a diagnosis for children, though?

MR. LANNIN: Object to the form.

THE WITNESS: So I think that there is a -- there's a theoretical debate, I think, that when there's a stronger argument for gender dysphoria in children, prepubertal children, then with gender incongruence, which didn't have even distress as part of the diagnosis, and there was the potential harm that -- of gender-diverse children who are perhaps not distressed being subject to

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conversion practices because of their gender diversity; so I think there's kind of an open debate about it.

The World Health Organization opted to include gender incongruence of children in ICD 11.

BY MR. RAMER:

Q Do you think gender incongruence in children should be included in the ICD?

A So I had concerns about it during the process because I didn't see what -- the purpose of it for a diagnosis when you're talking about prepubertal children who weren't getting specific treatment for gender incongruence the way adolescents and adults were.

And so I've had concern of -- others have raised the question of what is the purpose of the diagnosis, and I shared their concerns.

Q What is the harm of having the diagnosis?

A So the potential harm would be -- and I think particularly if it were applying to gender-diverse youth more generally -- is that it could subject similar people who are gender-diverse, whether they -- children -- whether trans or not, or gay or lesbian, to conversion practices.

And there had been a historical precedent

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for that which was, after homosexuality was removed from the DSM and GID of children was introduced to the DSM, GID of children was the diagnosis used for billing for conversion practices in children.

So I think that there was an open question there about the kind of risks versus benefits of having it as a diagnosis before there was specific treatment, and also whether it was maybe pathologizing in a way when the interventions were really about supporting the child and the family, again, prepubertally.

Q Do you think individuals should be permitted to obtain gender-affirming medical interventions even if they are not suffering from debilitating distress?

MR. LANNIN: Object to the form.

THE WITNESS: So in my experience, people who are -- who are seeking care are doing so because of the distress of gender dysphoria.

So I think that that is, you know, kind of a reasonable part of our practice as it stands now.

BY MR. RAMER:

Q But do you think it's possible an individual could conclude that they would have a better quality of life as the other gender even if

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they're not suffering from distress?

MR. LANNIN: Object to the form.

THE WITNESS: That seems like a theoretical question.

The one place where I've seen the question of lack of distress brought up by clinicians was clinicians from the Dutch program, when there were discussions about inclusion of distress in children, that -- what about if you have a child who is only distressed -- let's say on puberty blockers, not progressing in puberty, and in that state, they're not -- or it could even be before puberty starts, and they're supported in their trans identity.

So under those circumstances, the distress might be anticipatory as opposed to -- you know, anticipating the -- they might be very anxious about the fact that puberty is about to start as opposed to puberty having started, and some debate about -- you know, that there has been about letting kind of puberty start first versus not. I've seen that argument.

I don't know about -- if you had no distress about your sex assigned as birth, why you would go through the considerable difficulties of transitioning.

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And so I do think that distress with one's sex assigned at birth is part of what I see my patients experience.

BY MR. RAMER:

Q But doesn't the ICD omit distress as a requirement for the gender incongruence designation?

MR. LANNIN: Object to the form.

THE WITNESS: Yes, and -- but when treatment is discussed, whether it's in Standards of Care 8 or whether it's in European guidance -- I'm thinking about reading some of this German country's guidance that they've released, I think that's where I read it -- but they do make the point of -- in evaluating someone, they're looking for gender incongruence with distress even though the distress is not part of the diagnosis.

BY MR. RAMER:

Q And what does it mean for an intervention to be medically necessary?

MR. LANNIN: Object to the form.

You can answer.

THE WITNESS: A medically necessary intervention is one that, based on -- a clinician makes a determination that a treatment for their patient is necessary based on community practice and

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the scientific literature that's out there.
BY MR. RAMER:
Q And what is the significance of an intervention being labeled "medically necessary"?
MR. LANNIN: Object to the form.
THE WITNESS: So the significance is that -- whether it's insurance or certain government programs like the provision of healthcare in prisons, generally in the provision of healthcare, it's medically necessary care that's provided when they make the determination of what healthcare is covered or provided.
BY MR. RAMER:
Q And so a determination of medical necessity is relevant to insurance reimbursement, correct?
A Yes, to insurance reimbursement and kind of institutional coverage.
Q Is it relevant to court decisions?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: So there have been court decisions on -- that relate to the medical necessity of a particular intervention because that's what's covered, for example, by a state's insurance or

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Medicaid's insurance plan or private insurance, that they are saying they are covering medically necessary care.
BY MR. RAMER:
Q Does SOC-8 contain a statement of medical necessity?
A Yes.
Q Why?
MR. LANNIN: Object to the form.
You can answer.
THE WITNESS: So WPATH, for many years, has periodically put out statements about the medical necessity of -- of interventions that are treatments of gender dysphoria. And the last one that they put out was in 2016. And medical necessity had been mentioned in prior standards of care, but it had generally been done as a separate statement.
In 2016 when the statement was put out as a separate statement, there was conversation that the next revision of that statement should happen with Standards of Care 8.
And so it was included -- the revision of that statement, which was a detailed statement about medical necessity, would be included in

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Standards of Care 8 as opposed to a -- having a revision that was really separately by the board.
BY MR. RAMER:
Q Did you help draft the revised statement of medical necessity for the SOC-8?
A Yes.
Q How did you determine what interventions qualified as medically necessary interventions?
MR. LANNIN: Object to the form.
THE WITNESS: So there already -- there had already been a list from 2016, and it basically was a list of interventions that there was scientific evidence of benefit and that the experts involved believed were used as treatments for gender dysphoria.
And I had a particular concern that I didn't think the 2016 version was just very well written grammatically and wanted to make sure that it was clear.
And so I was part of the conversation that the editor of Standards of Care 8 consulted with several people on how -- how that should be -- how that revised statement should be put in Standards of Care 8.
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BY MR. RAMER:
Q As a general matter, not necessarily in the context of gender-affirming care but medicine more generally, what ordinarily happens when a patient needs medically necessary care but is unable to consent to that care?
MR. LANNIN: Object to the form.
THE WITNESS: So if the person is unable to consent, there -- there is either a person with legal authority to consent for them, or, for example, in San Francisco, there's a public guardian who can consent for people.
And so there's -- there may be -- in emergency situations, it may just be the doctors, you know.
I did consultation liaison psychiatry in the hospital. And, you know, if somebody needed an intervention but couldn't -- you know, was unresponsive, they would usually do the -- you know, the intervention that was necessary to save the person's life even if they didn't, you know, know who the surrogate decision-maker was.
But then if somebody needed ongoing care, then they would identify the legal documents of who consents when that person lacks capacity to consent.

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BY MR. RAMER:
Q Do those same principles apply in the context of gender-affirming medical interventions?
A Yes.
I would say in the context of -- I think it may be more difficult if you're talking about people with the initiation of care.
But if -- if there is someone who, let's say, is transgender and on hormones and then loses the capacity to continue to consent to care, you know, it might be a surrogate decision-maker who might make that decision.
Q Have you ever seen a situation where a surrogate decision-maker consented for the initiation of gender-affirming medical interventions?
A I have not.
Q And what happens in a situation, in the context of gender-affirming medical care, when a parent consents but a minor is unable to provide informed assent for any reason?
MR. LANNIN: Object to the form.
THE WITNESS: So that might be one for an ethics committee meeting.
I haven't -- I haven't been involved in a

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situation like that where the -- where a parent is seeking care that the -- their child is -- lacks capacity to consent for it.
BY MR. RAMER:
Q And what is an ethics committee meeting along the lines you were just describing?
A So just in -- if this is happening in a medical center, they have -- the medical center has an ethics committee that meets whenever there's a challenging case just to make sure that that decision is -- is more kind of broadly thought out before -- before -- you know, before the decision is made.
(Exhibit 22 was marked for identification and is attached hereto.)
BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 22. This is stamped "Confidential," and the Bates stamp in the bottom right is BOEAL_WPATH_139861, correct?
A Yes.
Q Is this a slide deck from your presentation at the WPATH convention in Montreal?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, it looks like it.

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BY MR. RAMER:
Q And I'd like to go to page 3.
A Yes.
Q And in particular, it looks like, on these slides, you're describing -- I don't know if you'd call them "case studies," but examples of --
A Yes.
Q -- situations, correct?
A Yes. Examples that either I have been involved in, or have been brought to me, of when the "well-controlled" term was confusing or not useful to the people involved.
Q And up on -- it's labeled "Slide 5," the first bullet, No. 5; do you see that?
A Yes.
Q It refers to a "Patient in state forensic hospital with DID."
A Yes.
Q What is DID?
A That's dissociative identity disorder.
Q Can you explain what that is?
A So it is a DSM diagnosis where someone has dissociative disorder to the extent where they -- in the formal DID diagnosis, they have amnestic periods between these different aspects of self, and --

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which are sometimes referred to as "alters."
In this particular case, once -- there are people who do therapy with people with dissociative identity disorder. And if there's an integration of alters, they no longer have DID; they have something called OSDD, other specified dissociative disorder, meaning they have a dissociative disorder, but there's no longer amnestic periods between alters.
And so this was a case where there was someone in a forensic hospital who was there for years. They had integration of the alters. They were permitted to transition by one treatment team, and then another treatment team took over, another psychiatrist, who thought that that was a mistake and tried to forcibly de-transition that patient.
So it was -- there was an actual case where -- where this happened; where, in this case, the person did have a severe mental illness, but they did have the capacity to consent to testosterone, but were forced to de-transition with -- with very negative results.
Q And just to go back a little bit, when you refer to an "amnestic period," I assume it's -- the root is somehow related to amnesia, and so it has something to do with --

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A Yes. So in DID, someone has -- they may have alters who -- where they are amnestic for when the alters are present. In other words, they arrive somewhere and don't know how they got there.

And so typically we would say that many of those people lack the capacity to make medical decisions; however, with a lot of work in terms of integrating the alters, they might get to a state where they still might hold the alters in co-consciousness, that they still identify them, but they're no longer having amnesia. And that is often regarded as a place where -- that they've reached a state where they, again, have capacity to consent.

Q And what is co-consciousness in this context?

A Meaning without amnesia.

Q And I'm not sure I -- I think you explained it, but I may have missed it.

But what is an alter?

A So an alter is when someone with dissociative identity disorder has kind of split off parts of their consciousness.

And so with an amnestic period, they might be in one particular state where another mental state doesn't have memory of being in that state.

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And those individual states are called "alters," and sometimes the patient names them.

And so that -- that's what you would call an "alter."

Q When you say the patient names the different parts of consciousness, what does that look like in practice?

MR. LANNIN: Object to the form.

THE WITNESS: So it might look in practice that -- so in a stage where they're having amnestic periods, they might not remember these other experiences. But then with work and integration, they -- they're no longer having the amnesia, but they might recognize these individual states of themselves without being amnestic of them.

BY MR. RAMER:

Q So then what does it look like in practice when the alters are in co-consciousness?

A So that's just meaning that the person is recognizing that they have these alters, but they don't -- they're not amnestic between them.

Q How does a person --

A That's how some of those -- some of the folks with OSDD would refer to the alters, that they still feel that these aspects of themselves are

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present, and they're aware of these aspects being present, but they're not losing consciousness. They're not, you know, having an amnestic period when that alter is present.

Q And so are there situations where the individual will name the alters but the alters are in co-consciousness?

A Yes.

Q And then how does somebody describe that experience?

MR. LANNIN: Object to the form.

THE WITNESS: So people describe it in different ways. It is -- it may be complicated even these days where -- because there are people who have never received a clinical diagnosis of DID but kind of identify with this way that their mind works.

That's not a clinical diagnosis, but I think that's out there as well, and kind of complicates it in terms of people describing their experience.

BY MR. RAMER:

Q And are there situations where an individual's alters can be -- one is male and one is female?

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A Yes.

Q And how do you address that in the context of gender-affirming care?

MR. LANNIN: Object to the form.

THE WITNESS: So you can't -- you can't do that if you're -- if there's this, like, disorganized dissociative kind of state where somebody is having amnestic periods because -- or, you know, you -- you don't really kind of have a handle on what they -- what that person wants.

But if they have done work in therapy and there has been this integration of alters, and they might still identify these different states of self but they're not going in and out of these amnestic periods, then -- then they -- they may be able to -- be able to have the capacity to consent.

Even acknowledging the continued presence of these altered states of mind, they have this consistent consciousness that is able, you know, to -- that is able to make decisions about -- about gender-related care as well as other medical care.

BY MR. RAMER:

Q When you say the alters are integrated, is that the same thing as saying that the alters are in co-consciousness?

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A Yes. Those are different ways that people have -- that people describe it.
Q And when you have a patient who has alters that are in co-consciousness, and one alter is male and one alter is female, how do you determine what the appropriate medical intervention would be?
A Yeah. So -- so there was an interesting web survey that was never published because it was done by these people who identified as having dissociative disorders.
And it does appear that very often people will hide the fact that they have alters of different genders from their clinician and, you know, go ahead with -- with transition.
But people, when they've reached a stable mental state, can also reach a state where they have the capacity to understand risks and benefits of treatment and how to minimize gender dysphoria. And that can be through transition, or sometimes being -- having a nonbinary presentation works best. It just depends on the individual.
Q Can you describe how you -- so you've described how it's done improperly, which is the patient feels forced to hide the alter --
A Yeah.

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Q -- or one of the alters.
Can you explain how you do it properly? Just because as somebody who is ignorant of this, it seems like you would have this tension between a male alter and a female alter.
And I realize that's simplistic; so I'm wondering, can you just explain how you analyze that and arrive at the appropriate intervention?
A Yes.
MR. LANNIN: Object to the form.
THE WITNESS: And there are therapists who particularly specialize in trauma work and are looking -- typically the people who have these severe -- have severe dissociation are people who experience early childhood trauma. And so they often do years of work with therapists that are both in terms of working on addressing trauma and how to cope with trauma without dissociation, and then how to kind of integrate different feeling states without dissociating.
And so therapists -- there are therapists who, like in the examples that I presented, they have been in -- they are people who have been in therapy for -- often for years. The person in the state forensic hospital had almost daily therapy

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for, like, 20 years total before they were released.
So -- but a skilled therapist can work on integrating alters, on building the capacity to cope with stressors without dissociating, and trying to understand and work through some of the trauma that may have led to their starting to dissociate as young children.
BY MR. RAMER:
Q Are children and adolescents diagnosed with DID?
MR. LANNIN: Object to the form.
THE WITNESS: Yes, they can be.
BY MR. RAMER:
Q Have you ever provided gender-affirming medical -- let me backtrack.
Have you ever provided gender-affirming care for a child or adolescent who was diagnosed with DID?
MR. LANNIN: Object to the form.
THE WITNESS: No.
BY MR. RAMER:
Q And am I -- with this example in No. 5 that you were discussing, am I correct in thinking that that individual had been found not guilty by reason of insanity?

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A Yes.
Q And sticking with this slide deck, the same page, the No. 8 refers to, scare quotes, "'Experts' in case over whether gender-affirming care for youth should be banned recommends psychotherapy to help youths accept their bodies as an alternative to transition," correct?
A Yes.
Q And do you think that psychotherapy to help youth accept their bodies as an alternative to transition is conversion therapy?
MR. LANNIN: Object to the form.
THE WITNESS: So I think in the situation where the patient has a gender dysphoria diagnosis that is impairing social, occupational functioning and causing clinically significant distress, that recommending psychotherapy for that person is -- is not indicated.
And so there are people -- there are young people who -- who don't transition, but they're not in that category of people who have severe and long-standing gender dysphoria that relates to parts of their body.
(Exhibit 23 was marked for identification and is attached hereto.)

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BY MR. RAMER:
Q Dr. Karasic, you've been handed what's been marked as Karasic Exhibit 23.
A Yes.
Q And the title is "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents," correct?
A Yes.
Q And you helped author these guidelines, correct?
A Yes.
Q I'd like to go to page 111. The page numbers are on the inside.
And in the left column, second full paragraph, a little over halfway down, there's a sentence that begins with, "By providing concrete."
Do you see that?
A Yes.
Q And I'm just going to read those two sentences and ask if I read them correctly first.
It says, "By providing concrete psychoeducation about how gender for some people can be fluid, not just binary and physical, and concurrent intervention targeting flexible thinking

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and self-awareness, some individuals with less urgent gender presentations may realize that full gender transition does not fit them. These young people may become more comfortable with a less binary solution, such as maintaining a female body while expressing some male-typical interests/behaviors."
Did I read that correctly?
A Yes.
Q Do you think this type of psychoeducation and concurrent intervention that you're describing here should be used with individuals who do not have an ASD?
MR. LANNIN: Object to the form.
THE WITNESS: So I have quite a number of patients who don't transition, who I've treated for their psychiatric illness, who are generally nonbinary, don't feel like cross-sex hormones would benefit them, or occasionally there have been ones who have been on them for short periods of time to lower their voice, and that was kind of enough.
So there are people who don't -- there are many people who are on some kind of spectrum, as this sentence says, who might have other needs other than traditional binary transition. And so one

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should be respectful of those individuals as well.
And that's why I always refer to those people who need medical intervention because of the level of distress that they're having, because the people described here are not having that level of distress and, therefore, you know, may find that a medical intervention is not for them.
BY MR. RAMER:
Q So you don't -- sorry.
Is this not recommending psychotherapy to help these individuals accept their bodies as an alternative to transition?
MR. LANNIN: Object to the form.
THE WITNESS: No, it's something different.
This is specifically referring to, as it says, "people who may realize that full gender transition does not fit them."
And so it's specifically referring to nonbinary people and helping them figure out what interventions they may or may not need, and that may or may not be a medical intervention.
And there certainly are people who don't need a medical intervention. As I said, that's why I refer to when -- when somebody is saying it's an

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alternative to providing gender-affirming care, that, you know, it's okay to ban gender-affirming care because you can just provide everyone with psychotherapy, there's no evidence that that is effective.
That's something different than saying that there are individuals, especially nonbinary individuals, who -- who should work with a therapist in terms of kind of better understanding what care they need and, you know, certainly that care might not involve any medical care.
BY MR. RAMER:
Q You've been saying "nonbinary." Do you mean individuals with ASDs, or do you mean --
A No.
Q -- nonbinary?
MR. LANNIN: Object to the form.
THE WITNESS: I'm talking about nonbinary people because you had brought up even people without ASD. So I transitioned the conversation to just people generally.
So that can apply to people with ASD or not -- people without ASD, but that there are people who -- there are people who don't need medical intervention, and that's why a more involved

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assessment for adolescents is important, and why Standards of Care 8 separates the interventions -- the evaluation for adolescents from the evaluations -- the evaluation for adults, because that is more typically an issue in adolescents.

MR. RAMER: We've been going for a while, and I presume I'm probably pretty close. Do you mind if we take a short break?

MR. LANNIN: Not at all. By my count, you have five minutes.

THE VIDEO OPERATOR: Going off the record, the time is 5:27 p.m.

(Recess, 5:27 p.m. - 5:32 p.m.)

THE VIDEO OPERATOR: Back on the record. The time is 5:32 p.m.

BY MR. RAMER:

Q Dr. Karasic, have you ever practiced in Alabama?

A No.

Q Are you aware of any gender clinics in Alabama?

A No.

Q Have you -- do you have any -- did you review the medical records of any of the plaintiffs in this case?

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A In this case, no.

Q Are you a neurologist?

A No.

Q Are you a surgeon?

A No.

Q Are you an endocrinologist?

A No.

Q Are you a urologist?

A No.

Q Are you a gynecologist?

A No.

Q Are you a --

A This is a bullet round.

Q Are you a bioethicist?

A No.

Q Are you a social worker?

A No.

Q Was Cecilia Dhejne ever part of the "Mental Health" chapter?

A Yes.

Q Why did she leave?

A She had an illness.

MR. RAMER: And those are all the questions that I have for you, Dr. Karasic. Thank you very much for your time today.

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I'll turn it over to your counsel.

MR. LANNIN: Any questions for the plaintiffs?

MR. STOLL: Just one question.

EXAMINATION

BY MR. STOLL:

Q Dr. Karasic, has anything that you've seen or heard today changed any of your opinions expressed in your report in this matter?

A No.

MR. STOLL: That's it. Thank you.

THE REPORTER: Counsel, would you like a copy?

MR. LANNIN: Yes.

MR. STOLL: Yes.

THE REPORTER: For each of you?

MR. STOLL: Yes.

THE REPORTER: Rough drafts or just the final?

MR. STOLL: I'd like a rough.

THE REPORTER: Okay.

MR. LANNIN: I do not need a rough.

THE REPORTER: Okay.

MR. LANNIN: I'll follow -- can we follow -- can we go off the record?

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But before we go off the record, may I say this: No questions on behalf of the witness.

I know there's a protective order in this case, and we prefer to provisionally designate this entire transcript as "Confidential" until we have a chance to review it and make timely designations.

MR. RAMER: No objection.

THE VIDEO OPERATOR: This concludes today's deposition of Dan Karasic, M.D. The number of media used was four and will be retained by Veritext Legal Solutions. The time is 5:34 p.m. We're off the record.

(TIME NOTED: 5:34 p.m.)

--o0o--

I, DAN KARASIC, M.D., do hereby declare under penalty of perjury that I have read the foregoing transcript; that I have made any corrections as appear noted, in ink, initialed by me, or attached hereto; that my testimony as contained herein, as corrected, is true and correct.

EXECUTED this _____ day of _____, 2024, at _____, _____.

(City) (State)

_____

DAN KARASIC, M.D.

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were administered an oath; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that if the foregoing pertains to the original transcript of a deposition in a Federal Case, before completion of the proceedings, review of the transcript [ ] was [X] was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or any party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated this 13th of may, 2024.

Carla Soares

CARLA SOARES
CSR No. 5908