IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs, Case No. 17-cv-264

v.

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

SECOND SUPPLEMENTAL EXPERT WITNESS REPORT OF STEPHANIE BUDGE, PH.D.

I, Stephanie Budge, Ph.D., have been retained by counsel for the Plaintiffs as an expert in the above-captioned lawsuit to provide an expert opinion. I have been asked to review the Defendants' Responses to Plaintiffs' Proposed Findings of Fact (Dkt. 122) and Defendants' Additional Proposed Findings of Fact (Dkt. 121) and to respond to certain factual assertions relating to gender identity, gender dysphoria and the treatment of gender dysphoria.

I have personal knowledge of the matters stated in this supplemental report as well as my other reports. I may further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' experts. My opinions contained in this supplemental report are based on: (1) my clinical experience as a licensed psychologist working with transgender patients; (2) my knowledge of the peer-reviewed research,

including my own, regarding the psychological outcomes related to gender dysphoria and the treatments for gender dysphoria; and, (3) my work training therapists to use evidence-based practice and up-to-date standards of care, specifically with transgender patients.

1. **There are considerable flaws in the Birmingham University report cited by Dr. Mayer and relied on by Defendants in their Response to Plaintiffs' Proposed Finding of Fact ¶ 9 (page 5).**

Because the report was published in 1997 and 2004, most of the assertions in the reports are outdated and no longer accurate at this point in time. The early version of the report (1997) criticizes studies that were conducted in 1979, 1968, 1987, and 1990. Over the past 28 years, the field has evolved to conduct research that is much more sophisticated and sound. For example, the Birmingham University report indicates that most research designs examined had not employed a control group. See my supplemental expert report where I cite the numerous studies that have now used this design (e.g., Fisher et al., 2016; Keo-Meier et al., 2015; Witcomb et al., 2018). An additional criticism of the report is the low follow-up in studies. However, more recent studies report follow-up rates as high as 100% (for example, see Colizzi, Costa, & Todarello, 2014; Zavlin et al., 2018).

The later version of the Birmingham University report (2004) criticizes the absence of randomized controlled trials. In my supplemental expert report I discussed the unethical nature of randomized controlled trials that do not provide treatment to individuals with gender dysphoria (see Deutch, Radix, & Rasa, 2016). The authors of the Birmingham Report note that "if parallel control group is not

feasible, follow up studies must convince readers that they have identified a representative cohort of individuals". There are many longitudinal studies that have addressed these critiques (see for example, Colizzi, Costa, & Todarello, 2014; Heylens et al., 2014; van de Grift et al., 2018). The Birmingham report also notes that there is not enough information to know what types of adverse outcomes may arise out of the data, but recent studies have assessed adverse outcomes and come to the conclusion that these procedures are safe when taking into account adverse events (Tran et al., 2018). Even though the Birmingham University report provided critiques of some studies that had been conducted regarding the efficacy of hormone therapy and surgery, the report was not comprehensive and also did not dispute that these treatments were efficacious. Moreover, its critiques of the studies regarding the efficacy and safety of these medical treatments have been addressed by more recent research.

2. **A number of the assertions refer to purportedly low rates of "persistence" of gender dysphoria in children and draw the conclusion from those rates that treatments aimed at aligning one's gender identity with gender assigned at birth may be successful at ending gender dysphoria. (See, e.g., Resp. FOF ¶ 23 (p.11), Addl. FOF ¶¶ 150, 153).**

Some news media and academic reports have highlighted the rate of children who "outgrow cross gender identification." However, the studies that are cited to promote this argument are: a) often misunderstood, and b) have significant flaws in their design. In these studies, children who did not have gender dysphoria, or children who did not identify as transgender, would have been included because they exhibited behaviors that would have not conformed to gender norms. Therefore,

the concept of gender dysphoria being "outgrown" does not make sense for the vast majority of these children, because many of the children did not have dysphoria to begin with. All of these studies used criteria for diagnosing gender identity disorder that focused mainly on behaviors (and not identity) and had less specific criteria for distinguishing those with the disorder from other children. The current DSM-5 (2013) gender dysphoria criteria require that children/adolescents identify with a gender that is different from their assigned gender for at least six months, which was not the case for any of the studies that are cited to indicate whether or not a youth will experience gender dysphoria in the future (see Temple Newhook et al., 2018 for a comprehensive review of the data).

Steensma & Cohen-Kettinis (2018) agree that their data have been overwhelmingly cited incorrectly to support the purportedly low persistence rates and have stated that their "studies cannot be used to support" (p. 26) the persistence estimation, in that they never calculated or reported rates of persistence/desistence. They also note that the negative social climate for transgender children and adolescents should be taken into account when reading the data (p. 26). They also state that their data did not actually reflect gender dysphoria in children and "expect that future follow up studies using the new diagnostic criteria may find higher persistence rates." (p. 26). Finally, they indicate that the terms "desistence" and "persistence" have been misused; they state that when they were researching youth, there were many youth who may have been

"hesitating, searching, fluctuating, or exploring" and that those youth have been misclassified as desisting. (p. 227).

Mayer indicates that "treatments aimed at aligning one's gender identity with their biological sex may be successful at ending (i.e. treating) gender dysphoria." See my expert report and supplemental report where I cite the various sources indicating the harmful and unethical nature of these types of treatments (usually called reparative therapies or conversion therapies). For example, the American Psychological Association's statement on gender diversity and transgender identity in adolescents indicates: "attempts to force gender diverse and transgender youth to change their behavior to fit into social norms may traumatize the youth and stifle their development into healthy adults" (p. 2, Mizock, Mougianis, Meier, & Moundas, 2015).

It should be noted that medical treatments (hormones and surgery) for children and adolescents are highly regulated and very carefully considered. The WPATH SOC v.7 have strict guidelines surrounding the medical treatment protocols for children and adolescents with gender dysphoria. In my current position as a health psychologist working with adolescents to determine their readiness for hormones and surgery, there is an extensive protocol that is in place to evaluate the appropriateness of the interventions for the youth. I work in an interdisciplinary team with two medical doctors, a nurse, and a social worker. We consult with the adolescent's mental health provider(s) to assess long-term mental health care. We also gather information from guardians and others important in the youth's life.

Children who have not yet entered puberty are not eligible for any medical interventions pertaining to their gender dysphoria. If considered medically necessary, youth entering puberty (Tanner Stage 2) may be given medication to suppress puberty (the effects are fully reversible). If clinicians deem it appropriate, adolescents may be evaluated for hormone therapy typically around the age of 16. Adolescents are rarely even evaluated for surgery prior to reaching the age of majority. It is highly unlikely that a youth who goes through an extensive psychological evaluation and is assessed by multiple health care providers over a long period of time would be "misdiagnosed" with gender dysphoria or inappropriately prescribed irreversible treatment.

It is also my clinical experience that psychotherapy is not effective as the sole treatment for individuals who need medical changes to their bodies to reduce gender dysphoria. I have often worked with individuals diagnosed with gender dysphoria who have financial barriers that do not allow them to receive medical treatments. While psychotherapy can assist them with coping on a day-to-day basis, many of these patients experience significant distress and psychotherapy alone does not alleviate their dysphoria. Clinically, I see extremely high rates of suicidal ideation and suicidal intent with patients who have barriers to receiving medical care for their dysphoria; I have assisted several of these patients with obtaining inpatient care to ensure that they do not kill themselves (which is costly and usually only provides a short term solution to their immediate distress).

3. **The Response to Finding of Fact 33 (page 15) questions the basis for my statement that every major medical association recognizes the medical necessity of gender confirming procedures for gender dysphoria and questions whether their recognition was based on research.**

Baker's 2017 review, cited in my initial report, outlines the history and science behind the medical and psychological associations' recognition of the medical necessity of gender confirming procedures for gender dysphoria. Beyond Baker's review, however, I have personal knowledge of the statements from major medical and psychological associations on this topic.

As far as Mayer indicating that these decisions by the major medical organizations are not rooted in science, the task forces and reports written by these major organizations outline the abundance of scientific data that support conclusions of medical necessity (see: American Psychological Association, 2015; American Psychological Association, 2009; Byne et al., 2012; Coleman et al., 2012).

4. **A number of the proposed findings (e.g., Addl. FOF ¶¶119, 134-136, 140) inaccurately suggest that, because certain aspects or ideals of masculinity and femininity are culturally dependent, that the medical interventions used to treat gender dysphoria are primarily cosmetic.**

The World Professional Association for Transgender Health, as an international organization, addresses cultural factors when providing context for treatments related to gender dysphoria. There is not significant variation across cultures regarding the association of certain sex characteristics with the male gender and certain other sex characteristics with the female gender. There is cultural variation regarding aspects of gender expression and gendered expectations that focus on roles and socialization. However, these variable cultural norms

surrounding gender do not include the significance of possession of primary and secondary male or female sex characteristics, which does not vary from culture to culture: globally, possession of a vagina is associated with being female, for example.

In 2015, the International Bar Association LGBTI Law Committee provided a report outlining information regarding the medical treatments that transgender individuals seek globally; while this report covers a wide range of laws for gender confirmation surgery globally, it is notable that gender confirmation procedures procured worldwide have little cultural variation in the characteristics sought.

In addition, there are cultural differences in ideals for male or female beauty/attractiveness, but these differences pertain to aspects of appearance beyond the possession of primary and secondary sex characteristics. Reconstructive surgery to provide the primary and secondary sex characteristics conforming to the patient's gender identity is different from cosmetic surgery to make bodily features more closely approximate a cultural ideal of beauty or attractiveness. As noted in my expert report and in the supplemental expert report, gender confirmation surgeries are considered reconstructive—they are only used as treatments to provide individuals with the primary and secondary physiological sex characteristics that would have occurred naturally if their bodies had developed in accordance with their gender identity (see Laungani & Brassard, 2017). These reconstructive surgeries are effective in addressing patients' gender dysphoria, as noted above, whereas cosmetic surgeries are ineffective at treating depression, anxiety, body dysmorphic disorder or other conditions, as noted in my supplemental report (p. 3-4

(citing Brunton et al., 2014; Cook, Rosser, & Salmon (2006); Honigman et al., (2004); von Soest, Kvalem, Roald, & Skolleborg, 2009)).

5. Meyer makes an inaccurate assertion that body dysmorphic disorders and gender dysphoria are similar, and therefore he indicates that similar treatments should be used for the disorders (e.g., Addl. FOF ¶132).

Body dysmorphic disorder (BDD) and gender dysphoria (GD) are considered distinct diagnoses that have separate etiology, presentation, and course of treatment. Body dysmorphic disorder is included in a similar classification within obsessive compulsive disorders (though BDD and OCD are not the same disorder) in the DSM-5. Gender dysphoria is classified in its own section. The separate classification of GD being in its own section is because the authors of the section agree that transgender identity in and of itself does not cause distress, but that gender dysphoria is related to the distress that results from ones' body not matching their gender identity. BDD is not attached to an inherent identity.

One of the most common components of BDD is a delusional aspect that other individuals are staring at specific parts of one's body that are flawed. A diagnosis of BDD can occur from outward observation that the "flawed" aspect does not exist, for example, an individual worrying about having acne when the acne is not present. In contrast, individuals with GD are not delusional when they report others' mistreatment of them or staring at them due to their gender identity, since such mistreatment or undesired attention has been demonstrated to be a real occurrence for individuals with GD.

In addition, GD patients report psychological improvement upon experiencing medical interventions to align their bodies with their gender identity. However, studies show that medical interventions to align individuals' bodies with their BDD obsessions do no indicate any psychological relief/improvement (see Crerand, Phillips, Menard, & Fay, 2005). The primary course of treatment for BDD is pharmacotherapy, specifically anti-depressants (Bjornsson, Didie, & Phillips, 2010). While pharmacotherapy can be helpful in reducing some anxiety and depressive symptoms that may be present for transgender individuals, pharmacotherapy has been shown to be ineffective at treating gender dysphoria, because the underlying cause is not depression or anxiety.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed this 7th day of July, 2018.

Stephanie Budge, Ph.D.

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