In The Matter Of:

Alina Boyden, et al. vs

State of WI Department of Employee Trust Funds, et al.

Deposition of STEPHANIE L. BUDGE, PH.D.

August 22, 2018

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Min-U-Script® with Word Index

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IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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ALINA BOYDEN and
SHANNON ANDREWS,
Plaintiffs,
-vs- Case No. 17-CV-0264

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

= =

Deposition of Expert:

STEPHANIE L. BUDGE, PH.D.

Madison, Wisconsin

August 22, 2018

Reporter: Cheri Winter, CSR

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I N D E X

E X H I B I T S

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EXHIBITS (Continued):

(Exhibits attached to original transcript and copies provided to counsel)

REQUESTS

(Original transcript filed with Attorney Schmelzer with a copy to Attorney Dupuis)

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DEPOSITION OF STEPHANIE L. BUDGE, PH.D., called as an expert witness, taken at the instance of the Defendants, under the provisions of Chapter 804 of the Wisconsin Statutes, pursuant to notice, before Cheri Winter, a Certified Shorthand Reporter and Notary Public in and for the State of Wisconsin, at the law offices of Hawks Quindel, S.C., 409 East Main Street, City of Madison, County of Dane, State of Wisconsin, on the 22nd day of August, 2018, commencing at 9:01 a.m.

A P P E A R A N C E S

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STEPHANIE BUDGE, PH.D.,
called as a witness, being first duly sworn,
testified on oath as follows:
--o0o--
EXAMINATION
By Ms. Schmelzer:
Q Good morning, Dr. Budge.
A Good morning.
Q I was just introduced to you. I'm Jody Schmelzer. I'm the attorney for the state defendants in this case.
Before we get started I just want to go over a of couple of ground rules for the deposition.
Everything that you say is going to be transcribed by the court reporter, so it's important to verbalize your responses so they can go on the paper. So head nods and "uh-huhs" don't transcribe very well, so we ask that you say "yes" or "no" to those types of questions; okay?
A Okay.
Q If you need a break just let me know. The only thing I would ask for you to do is to answer any question that was posed to you before asking for a break.
A Okay.

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Q And sometimes I ask bad questions, either compound or something you don't understand, just ask me to rephrase them and I'll do my best to do that.
A Okay.
Q And lastly, you were administered an oath so anything you say today was sworn testimony that can be used in court proceedings. Understood?
A Yes.
Q Okay. Let's get going. And I think I'm going to mark these beforehand. But let's start with a little bit about your background.
(Exhibit Nos. 1 and 2 marked for identification)
Q (Ms. Schmelzer): Exhibit 1 in front of you, is that a copy of your curriculum vitae?
A Yes.
Q And is that consistent with your recollection of what you provided with your expert report in this case?
A Yes.
Q So I see that you went to -- or you started college at Pace University. Is that correct?
A That's correct.
Q And then transferred to University of Utah?
A That's correct.

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Q Why the transfer?
A There are a couple of reasons. The first is that 9/11 happened while I was at Pace University, and Pace is a few blocks away from where the World Trade Center was. That was a challenging experience and I decided that I would like to move home to be with my family.
And the second reason is that I was on the debate team and had a debate scholarship and decided I did not want to do debate anymore.
Q Was there anything about the University of Utah that attracted you?
A My family lives in Utah.
Q And I see that you got your bachelor's of science degree in December of 2003. Is that correct?
A Correct.
Q Is my math correct that you graduated a semester early?
A That's correct.
Q Was there any particular reason for graduating early?
A No, I took a lot of AP classes in high school and I didn't need to take any more classes.
Q And then you got your master's of science at University of Texas at Austin. Is that correct?

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A That's correct.
Q So I see that you graduated in December of 2003 and started your master's degree in 2004, August. Was there a reason for the break?
A Typically, master's degrees start in the fall semester of an academic year, and so I decided that I was going to work full time while I was waiting to hear back from programs that I applied to.
Q Where did you work?
A I worked at a daycare center with infants.
Q Good reason to go back to school.
A Yes.
Q Why educational psychology for your MS?
A I had wanted to go to the University of Texas at Austin, and for me when I was looking at programs I was considering counseling psychology in the long run, and on the website at UT Austin they had indicated that this was a degree that was rooted in science and that it was a good degree to get on your way to getting a Ph.D, and that's how I made that decision.
Q I see your thesis title was "Sexual pressure in gay/lesbian and bisexual relationships." Is that correct?
A That's correct.

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Q Was this the first interest that you expressed in transgendered-type issues or LGBT-type issues?
A From a research perspective, the first time that I had conducted research was on a research team and my master's program that focused on religiosity and sexual orientation and that led me to get some research experience that I could write my thesis on gay and lesbian and bisexual relationships.
Q Did your thesis involve transgender people at all?
A There were transgender people who were in the sample, but the purpose was related to the sexual orientation component.
Q It did not involve evaluating the effectiveness of trans-related surgeries?
A No.
Q And then I see you got your Ph.D. from UW Madison; correct?
A That's correct.
Q And it looks like you made the transition here to counseling psychology; correct?
A That's correct.
Q And why counseling psychology?
A I had decided that I wanted to have a degree that incorporated practice in being able to be a clinician as well as getting research experience,

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and those two components were really important to me to have the scientist/practitioner component of whatever it was I was doing, and counseling psychology fit that bill.
Q What's the difference between counseling and clinical psychology?
A That's a good question. Some of it may depend from program to program in terms of what the actual differences are.

If I were to characterize the difference between them, it seems that clinical programs, stereotypically, they often focus mainly on psychopathology. And counseling programs are considered to be more holistic in terms of thinking about general pieces of well being as well as diagnostic components.

But, in general, you will find that there are potentially more within differences than between difference in clinical and counseling psychology programs.
Q Is there a difference as far as the research aspect goes to psychology between counseling and clinical psychology?
A It depends from program to program. Say, UW Madison, the answer would be no.

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Q I see that you did your pre-doctoral internship at University of Minnesota. Is that correct?
A That's correct.
Q Did you counsel patients as part of that internship?
A Yes, that was my primary job.
Q And describe that experience.
A So, that experience was around a 40-hour work week where I was seeing patients full time as part of that yearlong psychological rotation.
Q Was that at a clinic or a hospital?
A It was. It was at the counseling center at the University of Minnesota's campus.
Q Did you have any opportunity to counsel any transgendered patients during that time?
A Yes, I did.
Q Approximately how many?
A Approximately anywhere from 20 to 30 clients while I was there.
Q And did your counseling of them involve writing letters of recommendation for medical services for them?
A Yes.
Q Of the 20 to 30 transgendered clients that you counseled there, do you know approximately how many you wrote letters of recommendation for?

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A If I were to estimate it would be somewhere between maybe five to seven.
Q And of those five to seven, did you write any medical recommendations for surgery?
A In my recollection they were all for hormones.
Q Okay. So after you got your Ph.D. you went on to the University of Louisville. Is that correct?
A That's correct.
Q And you did some post-doctoral clinical training at the University of Louisville Counseling Center. Did I read that right?
A That's correct.
Q Tell me what that involved.
A That included me seeing clients for about a day a week while I was also an assistant professor there.

So I was at the counseling center for approximately one day and sometimes a little bit more depending on what my caseload was.
Q Did you directly counsel patients during that one day a week?
A I did.
Q And did any of those patients involve transgendered patients?
A The majority of them were transgender.
Q Do you know approximately how many transgendered

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patients you counseled at the counseling center?
A Uh-huh. At the counseling center it was approximately, again, maybe five to seven. My caseload was one day a week, but the majority of them were transgender.
Q So you saw some transgendered patients at the counseling center. I see you also did some clinical training at the Trans Project at the university. Is that correct?
A That's correct.
Q So what would determine if a transgendered patient went to the counseling center versus the Trans Project?
A So they were at two separate time points. So for the first year that I was assistant professor there I worked at the counseling center. And the second year I was assistant professor I saw clients in my office as a private practice as part of my process of getting licensed.
Q Okay. I'm just going to go back to the counseling center for a bit.
You said you saw approximately five to seven transgender patients during that time?
A Yes, it actually might be higher than that because I also ran a group.

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Q Was the group for transgendered patients?
A It was an LGBT group for students on campus and it had about 12 people in the group, and I can't quite recall how many of them identified as trans, but it might have been about half.
Q And of those, you said a little more than five to seven possibly --
A Yes.
Q -- transgendered patients?
A Yes.
Q Did you write letters of recommendation for them to have any medical transition-related services?
A I didn't write any letters for anyone in the group, but at the counseling center, if I recall, I did write approximately two letters.
Q Were any of those letters for surgical treatments?
A Not at the counseling center.
Q Okay. So then let's talk about the Trans Project a little bit. You said that was something new that started that second year you were at Louisville?
A Uh-huh.
Q What is the Trans Project.
A That was a label that I came up with as part of describing the kind of services I could provide.
So it was a private practice that I had opened,

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and because it was involved in my department I did not charge any money for people to receive services. I was under supervision at the time. And I had indicated there that anybody who wanted to seek services that that was possible.
I didn't limit my services necessarily to trans people, but the only people who had inquired about my services identified as transgender, and so I would see people individually for 58 minutes during the week, usually weekly.
Q Did you have any other staff besides yourself with the Trans Project?
A Not technically. There would occasionally be an individual or two who would come in for a letter and not for therapy. And I had indicated that if there was a student as part of their practicum experience that they could sit in on that experience to gain training.
So it wasn't completely solo, but I would say the only time that it wasn't solo was if a student was involved as part of their training process.
Q Was it just clinical services that were provided with the project?
A With that particular postdoctoral component, yes.
Q Was it open to just students or could members of the

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community come as well?
A Anyone could come in.
Q And approximately how many transgendered patients did you see through the project?
A That's a good question. For either therapy or assessments it was anywhere from, again, maybe 30 or more individuals.
Q And did you write letters of recommendation for any of these 30 or more patients to receive medical services for transition-related care?
A I did.
Q Do you know approximately how many letters you wrote?
A That's a good question. It may have been anywhere from 15 to 20 letters.
Q And were any of these letters for surgical treatments?
A Yes.
Q About how many?
A I'm estimating it's probably around half of those letters.
Q Was this the first time you had written a letter of recommendation for surgical treatments for a transgender patient?
A Yes.

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Q So I see just from your experiences at the University of Minnesota and Louisville that not all the clients you saw you wrote letters of recommendation for; correct?
A That's correct.
Q Is there a reason for that? Did they already have letters of recommendation or they just didn't meet criteria for that? Just generally-speaking.
A Yeah. It depends. Some people had already had letters, and some people, it wasn't medically necessary for them to have hormones or surgery.
Q And in any of those situations at the University of Minnesota or the University of Louisville, did some want to have medical interventions but you did not give them a letter of recommendation?
A Not at either of those places.
Q So you were also an assistant professor at Louisville. Is that correct?
A That's correct.
Q I think if you turn to your CV, page 63 -- that's Exhibit 1 for the record -- it has a list of courses that you taught at Louisville. Am I correct?
A Hold on just a second. Did you say 63?
Q 63.
A Yes.

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Q I see that there is one called "Gender and Queer Issues in Psychology." Is that correct?
A That's correct.
Q Did that course involve transgendered issues?
A Yes.
Q And did the course involve an analysis of the effectiveness of treatment for transgendered individuals? Or individuals with gender dysphoria, to let me be specific.
A Peripherally, yes, but not an actual class where we talked through all the components.
Q And did you discuss treatments, medical interventions for transgendered individuals with gender dysphoria in any of the other classes that you taught at Louisville?
A It's likely that it came up in differing components. So, for example, in "Differential Diagnosis," gender dysphoria would have been one of the days that we would have talked about because you go through the different diagnoses on that day -- or in that class.
But it's also likely that I may have given some examples in some of the other courses.
Q All right. We'll move on to the University of Wisconsin. That is your current appointment; correct?

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A That's correct.
Q And your position is an assistant professor?
A I am now an associate professor. My title just changed.
Q When did it change?
A Approximately three weeks ago.
Q Congratulations.
A Thank you.
Q And how do you go from assistant professor to associate professor?
A So, I was in the process of submitting a tenure portfolio in the last year which included the body of all of my work, mostly focusing on my work at the University of Wisconsin-Madison, but also some work at the University of Louisville.
And all of that together included my research, my scholarship and my teaching as part of my portfolio.
Q Do your duties change now that you are an associate professor?
A I am not aware of how my duties will change yet. I'm assuming that there will be some shifts and some changes, but I'm not aware of what those will be.
Q I think you described in the body of your report somewhere that you teach counseling skills,

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conducting psychological assessments and research design; correct?
A That's correct.
Q Let's go back to page 62 and 63 of Exhibit 1 there.
MR. DUPUIS: Just a quick reminder to pause just a second so you are not talking over one another.
THE WITNESS: Okay.
Q (Ms. Schmelzer): So on page 62 and 63, does this contain an accurate list of the courses that you have taught at the University of Wisconsin?
A This does.
Q Did you teach any courses in 2018?
A I did.
Q Am I not seeing those on here? Oh, of the fall of 2017 into the spring of 2018. Got it.
A That's correct.
Q Are you planning on teaching any courses in the fall of 2018?
A I am.
Q Which courses are those?
A I will be teaching two classes. One class is called "Research Practicum," and the other class is "Helping Skills and Relationships."
Q I see a number of these with one or two or three

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students here, independent study or independent research. What are those kinds of classes?
A It may depend on what those classes are. I will also be teaching those classes. I'm using quotes for those. They're not actual classroom time.
So in those classes, for example, I may have a student who wants to do an independent research project, and so in order to get credit for the time that they take doing that research then they may take an independent research class.
Or some of the students may enroll in my research lab and -- which I don't get teaching credit for, but if they enroll in the lab sometimes they can sign up for credit.
Q So would it be fair to say that those are courses where you supervise other students in their research?
A That's correct.
Q And you said that you conduct a research lab course. Is it a course, or how would you describe that?
A I would not describe it as a course. I would say that it was a lab.
Q And what does that entail?
A Typically, during the semester we meet for an hour to an hour and a half weekly, and in that lab we

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discuss research projects that we are either planning on conducting or that we are in the process of conducting.
So it's a -- I would describe it more as consultation time to talk about the research that's happening.
Q Is that the same thing as the trans research lab?
A That is.
Q Do you teach any courses at the University of Wisconsin on LGBT issues?
A I have not taught any courses on LGBT issues here.
Q I see that you listed under "Course or Curriculum Development," LGBT Psychology; correct?
A That's correct.
Q What did you do as far as that course was concerned; what was your involvement?
A I have thought about teaching a class in LGBT psychology and as part of that I created a syllabus that could be used if this is a class that could be offered in the future.
Q So it's not currently offered?
A No.
Q Have efforts been made to offer that course?
A Not yet.
Q Have you, in any of your teaching both at Madison

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and Louisville, taught any courses that focus on the treatment for gender dysphoria?
A None of the courses have focused on the treatment of gender dysphoria as the primary component.
Q Did any of the courses contain topics that focused on the treatment of gender dysphoria?
A I'm trying to remember. I don't think I have ever created an actual PowerPoint or a slideshow that has talked about that piece for any of the formal classes that I have taught.
Q But it may have come up in some discussions?
A Yes. Exactly.
Q I'm going to show you Exhibit 2. Is that a fair and accurate copy of your expert report in this case?
A It appears to be, yes.
Q I won't have you look at each and every page. On page 3, I'm looking at your reference to the Counseling Psychological Training Clinic.
A Yes.
Q Tell me about that clinic.
A It is a clinic within our department that provides therapy to community members and to students where the majority of the clinicians who are at the clinic are trainees from our doctoral and master's programs.

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Q Does this clinic focus on any particular psychological issues like transgendered psychology or any --
A The clinic has a -- it's a broad clinic in terms of who can come and the kinds of concerns that they can come in with.
It may be that on the website there are certain pieces that are included of, you know, you can come in if you're experiencing depression or anxiety if you identify as LGBT, for example.
Q And you might have answered this already, but what's your role in the clinic?
A The first two years that I was working here at UW Madison I had a pretty major role at the clinic. I was the primary supervisor there one day a week, and I also was a primary supervisor to several students at the clinic, and that was my role for two years. I also provided therapy at the clinic.
Q You said that was your role there. Do you have a different role now?
A I do not have a formal role at the clinic right now.
Q And when did you stop participating in the trans clinic?
A In that formal role, I stopped participating during my third year and that would have been when I

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started my tenure track position at the university.
Q So approximately 2010 or so -- or I'm sorry, 2009?
A So, I started my visiting position at the university in 2014, so I would have been at the clinic in the 2014-2015 academic year and the 2015-2016 academic year.
However, I also worked at the clinic as a graduate student, so I would have been there as a graduate student when I was in my studies.
Q Where you were being supervised by someone else?
A That's correct.
Q So, do you recall approximately how many -- did you provide counseling yourself --
A I did.
Q -- at the clinic? And do you recall approximately how many transgendered patients you provided counseling for at the clinic?
A For my own patients I provided therapy to approximately five individuals.
Q Did you supervise therapy for other transgendered patients?
A I did.
Q Do you know approximately how many?
A Are you asking during that particular time?
Q During your time at the clinic from 2014 to 2016.

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A Yes, I provided supervision to approximately 20 to 30 transgendered clients.
Q Of the five transgendered clients that you provided therapy for directly, did you write any letters of recommendation for medical services for them -- transition-related medical services?
A Not to my recollection.
Q When you supervised the approximately 20 to 30 other transgendered clients at the clinic did any of those clients under your supervision receive letters of recommendation for medical services?
A Yes.
Q And who would write the letters for those recommendations? Would it be you or the individuals you were supervising?
A Typically it would be a combination. So if the student hadn't written a letter before, often we would sit down together and write a letter together.
Q Would you both sign it then?
A Yes.
Q Do you know how many letters of recommendation for those -- or how many letters of recommendation you wrote for those individuals you supervised?
A Approximately half.
Q And were any of those letters of recommendation for

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surgical treatments?
A Yes.
Q How many?
A I don't know if I can recall that information.
Q So approximately half, so 10 to 15 or so got letters of recommendation?
A Yes.
MR. DUPUIS: Object as to form. Are we talking about the --
MS. SCHMELZER: For medical interventions.
Q (Ms. Schmelzer): And would it have been more than five? Can you approximate that?
MR. DUPUIS: Objection as to form.
MS. SCHMELZER: Sure.
Q (Ms. Schmelzer): Would it have been more than five of those individuals that you supervised at the clinic that would have received letters of recommendation for surgical treatments?
A So more than five of the individuals who were supervised?
Q Yes.
A Do you mean the clients?
Q Yes. The transgendered clients, yes.
A I would say it's fair to say around five or so. It

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could be more than that.
Q Okay. Let's talk a little bit about the trans research lab.
What is the trans research lab?
A It's a lab that I direct that focuses on research with transgender individuals.
Q Did you establish the lab?
A I did.
Q Is there anyone besides yourself that staffs the lab? Do you have any staff members?
A I have a graduate assistant who works with me. I wouldn't say that her formal title has anything to do with a staff member in the lab, but she does a lot of work that I would characterize as potentially being included as a staff member.
Q And I'm assuming it does research?
A Are you talking --
Q You conduct research at the lab?
A Yes.
Q Do you counsel trans clients at the lab? Do you do any counseling in the trans research lab?
A Can you clarify the question?
Q Sure. I know you do research at the lab. What else do you do at the lab?
A Really, I would say that what we do as part of the

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lab is research. I would say that I train students how to do research and we talk about research processes.
Q So you don't do any counseling services for the individuals that you're researching at the lab?
A So we completed a randomized control trial as part of our research project where there were transgender individuals who received therapy as part of the research project. That's -- yes.
Q Got it. So they may receive counseling services as part of the research. Is that fair to say?
A That's correct.
Q But otherwise this isn't like a clinical setting?
A No.
Q When was the trans research lab established?
A In 2014.
Q And approximately how many, I guess, studies have you conducted at the trans research lab since 2014?
A Can you clarify if we started them or continued them?
Q Let's clarify with started.
A If I'm characterizing this correctly, I think the only project that has actually potentially been started is this randomized clinical trial from start to finish.

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Q And tell me what is this clinical trial for?
A The clinic trial is to determine longitudinal effects of psychotherapy for transgender individuals.
Q And you said this clinical trial was completed?
A We are conducting six-month follow-up assessments next month, so the date of collection isn't complete but the therapy has been completed.
Q Are there any other studies besides this randomized clinical trial that we just talked about that you have started at the trans research lab?
A I'm pausing because we have started other projects that have been borne outside of datasets or projects that I was completing prior or collecting data on prior.
So there are a lot of projects that are in the works that are occurring right now as part of the lab.
Q Sure. That's fair. Do any of the projects that are in the works that you just stated, do any of them involve an analysis of the effectiveness of surgery for treatment for gender dysphoria?
A There is a student of mine who is planning on conducting the study on the effectiveness on gender confirmation surgery.

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Q You said that the student is planning on conducting the study. Have they started that study yet?
A They have not.
Q In what stage of the process is the student currently with that study?
A She is currently researching a literature review and coming up with research questions.
Q Do you know when that study is planned to start?
A It's difficult to say when it comes to student projects. I know that she's planning on proposing the research at the end of December.
Q Besides that one proposed study from the student, are there any other projects at the trans research lab since it started that concern the effectiveness of surgery for treatment for gender dysphoria?
A No.
Q Okay. I see from your CV that you also hold an appointment at the University of Wisconsin Hospital and Clinics?
A That's correct.
Q And as a health psychologist?
A That's correct.
Q And tell me what you do at the UW Hospital?
A My main position there is to conduct psychological evaluations with transgender individuals who are

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referred from the Pediatric and Adolescent Transgender Health Clinic.
Q And you've been there for almost 10 years -- over 10 years; correct -- or I'm sorry, I'm looking at this wrong. For over a year; correct?
A That's correct.
Q And in that year, a little over a year, how many patients have you seen at the hospital?
A Approximately nine to 10.
Q I should ask how often do you work at the hospital?
A I only work in the summertime.
Q Do you work every day in the summer?
A No.
Q Is there a set amount of days that you work?
A No. I have a prn, as needed, position.
Q And those nine to 10 patients, they were all minors I'm guessing, adolescents?
A No, some of them -- two of them were over the age of 18 -- two of them were 18.
Q And they are at the Children's Hospital?
A That's correct.
Q And of those nine to 10 patients that you've seen, did you write letters of recommendation for any of them for medical treatment for transitional care?
A Yes.

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Q How many?
A All of them.
Q And were any of those letters for surgical treatment?
A Yes.
Q How many?
A One was formally for surgical treatment. Some of the other youth had -- some of the adolescents, older adolescents, had indicated that surgery was necessary for them, so I included that information in the report.
I don't follow up after what happens with those youth, but one of them had only come in for a surgical evaluation.
Q And that was one of the adolescents?
A Yes, they were all considered adolescents.
Q So someone who was under the age of 18?
A Yes.
Q Were all the letters of recommendations that you had for surgery all for individuals under the age of 18?
A No.
Q Only one -- or how many were under 18?
A Can you clarify?
Q Sure. Sorry. I'm trying to determine which of the letters of recommendations you wrote for surgery

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were for individuals under the age of 18.
A I'm recalling perhaps three, and all three of them would have been at the age of 17.
Q And you said you saw two adults at the hospital as well?
A Two 18-year-olds.
Q And for any of those, did you write letters of recommendation for surgery?
A For one of them.
Q So in your current positions at the University of Madison and the hospital how much would you apportion -- or how much of that time is spent teaching?
A In my professor's position?
Q Yes.
A I would say anywhere from 40 to 50 percent of my time is devoted to at least preparing for classes and also being in classes.
Q I guess I want to clarify here. I'm talking about your time as a whole, both with the hospital and at the University of Madison.
A Okay.
Q So would that be accurate to say your time as a whole is 40 to 50 percent teaching?
A That's correct.

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Q Does that include supervising individuals in their independent research and studies?
A Yes.
Q And how much of your time would you say is devoted to counseling individual patients?
A From my own individual therapy or group therapy that I do?
Q Yes.
A At the current moment, since I have been at the hospital in the summer, it's been maybe 10 to 15 percent, and that's during the summertime.
Q And that you expect to decrease once school starts?
A Yes.
Q What do you expect that to decrease to, what percentage of your time?
A In this upcoming year I do not plan to see patients.
Q And what percentage of your time would you say is devoted to research?
A Approximately 40 percent of my time.
Q You do good math, because I come up with hundred then.
Is there any other, I guess, duties or projects that you have that wouldn't fall into teaching, counseling and research?
A Yes.

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Q Describe those.
A I have an administrative load as part of my position which includes being on committees, mentoring students, and just general service activities that are included in my position.
Q I take it that is a fairly small percentage of your time?
A Depends on the timing of the year.
Q Anything else besides teaching, counseling, research and your administrative roles that I have missed as far as what you apportion time to?
A Related to my positions?
Q Yes.
A No.
Q Okay. A little further on in the CV I see you were a licensed psychologist in Kentucky from 2011 to 2014 approximately. Is that correct?
A That's correct.
Q Was there ever a period of time in between there that your license was ever suspended or lapsed?
A No, but licensure in Kentucky is different than it is in Wisconsin, so I would have what was called a temporary license. And there was a time when I wouldn't have had that license in the very beginning.

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Q And why wouldn't you have had that license in the very beginning?
A While you're applying for licensure in Kentucky then you're not considered temporarily licensed at that moment, and there was a period of time in which there -- I was not considered under that temporary license, but I was under a licensed supervisor at that time.
Q And you are currently licensed in Wisconsin as a psychologist; correct?
A Correct.
Q From 2015 to the present; correct?
A Correct.
Q Was there ever a time in Wisconsin from that time where your license was suspended or lapsed?
A No.
Q I'm going to look at your research portion of your CV in Exhibit 1. Page 44 is where I'm looking.
A Okay.
Q And under the title "Journal Publications," you state, "Underlining denotes students"; correct?
A Yes.
Q So are these the individuals that would have been involved in those independent research or independent studies in your coursework?

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A Some of them may have been and some of them are not.
Q And then there is, looks like, a little empty circle "denotes invited publication."
What is an invited publication?
A Sometimes an editor or someone involved in a journal will email authors. And in this instance they would email me and say I saw you have this particular expertise and we're really looking for this kind of article published as part of a special section, or something, in their journal. So they would invite that article to come in.
Q So would those invited publications also be published publications?
A Yes.
Q So you just didn't use the star and the circle. The circle also includes a star?
A It depends. Sometimes when it's an invited publication it wouldn't go through the peer review process in the same way that it typically is when you are simply submitting.
Sometimes if it's invited, the editor will review it and won't go through peer review publication but sometimes it will. It depends.
Q But all invited publications would eventually be published; correct?

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A Yes.
Q They just might not be peer reviewed?
A Yes.
Q I think I figured out your key then. Under "Book Chapters," the title is on 47 but they're listed on page 48 of Exhibit 1.
It looks like most of these are for a book called "The SAGE Encyclopedia of Psychology and Gender." Is that correct?
A Yes.
Q So 11 -- 12 of the 14 book chapters. Is that correct?
A 11.
Q 11. Oh, I'm sorry. What is the SAGE Encyclopedia of Psychology and Gender?
A It's a publication that includes a wide array of topics that focus on sexuality and gender or LGBT issues, depending on what the title is, and the purpose is to provide scientific -- kind of a shorter, concise scientific understanding of different topics that are included under that umbrella.
Q Is it actually a published book or is it just available online? I'm trying to understand how you would access this SAGE Encyclopedia.

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A It's typically available in both formats.
Q Do you know if it's used as a textbook at all in any universities or colleges or medical schools?
A I'm not aware.
Q This is a fairly recent book; correct? Is it 2017?
A Yes.
Q How did you get involved with the SAGE Encyclopedia?
A I was emailed and invited to write pieces that are included in my CV by the editor.
Q Would you consider the SAGE Encyclopedia a good resource for anyone wanting to learn about psychology and gender?
A I would.
Q It was in your expert report that you summarized that you had 62 invited and peer-reviewed journal articles and book chapters and 100 academic presentations. Is that correct?
A At the time, yes, that was correct. And I think over a hundred presentations.
Q You said at the time that was correct. What has changed about that?
A I have more publications now.
Q Do you have any publications that are not listed on the CV that you provided in Exhibit 1?
A Yes, there are likely several, maybe two to three

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publications that have just come out.
MS. SCHMELZER: Larry, can we be supplemented with a list of those additional publications?
MR. DUPUIS: Sure. Would an updated CV be sufficient?
MS. SCHMELZER: Yes.
MR. DUPUIS: That would include all the new publications?
THE WITNESS: Yes.
MS. SCHMELZER: Great.
Q (Ms. Schmelzer): I'm sorry, you said there might be an additional how many publications on there?
A Anywhere from two to five.
Q Do you know if those publications were peer reviewed?
A The articles should be peer reviewed and the book chapters were not.
Q How many book chapters are in addition to the ones you listed in Exhibit 1?
A Two.
Q Would those be in the SAGE Encyclopedia?
A No.
Q So with all of these journal articles and book chapters and academic presentations in your CV and your more updated ones, which ones focus on the

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effectiveness of -- if any, focus on the effectiveness of treatment for gender dysphoria -- effectiveness of surgery as treatment for gender dysphoria?
A I make reference to pieces that are included in that, but there is not a publication that solely focuses on that topic.
Q And would you consider yourself an expert in assessing the effectiveness of surgery to treat gender dysphoria?
A Yes.
Q Are you okay to go on? Do you need a break?
A I'm okay.
MR. DUPUIS: Anybody else want one?
MS. SCHMELZER: No, I'm good. Okay. I'm going to mark another exhibit here.
(Exhibit No. 3 marked for identification)
Q (Ms. Schmelzer): I want to talk a little bit about the hierarchy of evidence as far as how to weigh certain evidence that may be presented in a study. I want you to take a look at Exhibit 3. I know it doesn't have a title. Take a minute to review it and let me know if this is something that you have reviewed before coming here today.
(Pause in the proceedings)

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THE WITNESS: This is Dr. Mayer's expert report?
Q (Ms. Schmelzer): Yes. It's one that has been filed in the case, and I'm wondering if you've reviewed it before coming here today.
A This looks similar to the one that I reviewed.
Q Not his first report but a supplemental report?
A It looks similar to something I've seen.
Q Can you turn to, I guess, page 3 of that document where he has the initial "a," that paragraph.
A Uh-huh.
Q Starting there, Dr. Mayer starts to talk about the hierarchy of evidence.
Is that a term that you recognize, "hierarchy of evidence"?
A Yes.
Q And would you agree with his statement that it's a system for weighing the degree of evidence contained in a statistical study?
A Yes.
Q And I guess I'll just read the rest of this. He goes on to say, "At the highest end are double-blind randomized clinical trials. These are the gold standard."
Is that something that you would agree with?

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A I would agree that this is what I've seen in the hierarchy of evidence.
Q Is the hierarchy of evidence something that you agree with?
MR. DUPUIS: Object as to form. It's vague.
Q (Ms. Schmelzer): So you state that you agree that this is something that you have seen in the hierarchy of evidence.
Do you believe that double-blind randomized clinical trials are the gold standard for, I guess, the degree of evidence in the statistical study?
A For many studies that would be -- that would be the case.
Q He goes on a little bit later, "In lieu of such studies, it may be possible to examine other research that may be at the next lowest level evidence. Examples of these studies are case control studies, cohort studies, and matched observational studies."
Do you agree with that statement?
A Yes.
Q And, "These studies must contain explicit analysis of the data and be related to the issue at hand."
Do you agree with that statement?

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A Yes.
Q He goes on to say, "Generally, they are used to increase the statistical power of the primary study, but at times when the evidence is powerful and studies are constrained, these kind of studies may be used as a primary evidence. If this is done, such studies must provide replicable statistical analysis of primary data."
Did I read that correctly?
A That is what it sounds like.
Q And do you agree with that statement that I just read?
A For the most part. I think some of the replicability components, there is some dispute about how some of those pieces can be done. But in general, yes.
Q Is there dispute about how the replication of -- replicable statistical analysis of primary data can be done in transgender research?
A Can you clarify the question?
Q Sure. You said there is some debate about replication of statistical analysis, I guess.
A Uh-huh.
Q What's the basis for that statement that there is debate about that?

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A Well, part of it is, you know, if you conduct a study in New York City and you conduct a study in the Midwest. So part of this is more scientific debate around how you can replicate a study. That's what I mean.
Q Is there anything unique about the research you've conducted with transgender issues that would make replication of that kind of analysis difficult?
A No, not with any research that I've done.
Q So I guess in paragraph (b) he goes on to state that -- I guess in the hierarchy of evidence, under these control studies, cohort studies and matched observational studies there would be "editorials, abstracts, clinical guidelines, clinical reports, ethical statements, secondary statistical analysis, case studies and other similar documents, like reviews and related studies."
MR. DUPUIS: Case "series."
Q (Ms. Schmelzer): I'm sorry. "Case series and other similar documents, like reviews and related studies."
Do you agree with that, that in the hierarchy of evidence those would come below, I guess, the control studies, cohort studies and matched observational studies?

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A Yes.
Q He goes on to state, "While these documents may be useful in providing context for the treatment under scrutiny, they typically, if ever, contribute any statistical power or usable information for estimating the effect of treatment on the primary outcome."
A Can I clarify one piece? I think secondary statistical analysis can also be included in above in the hierarchy, so I would actually disagree with that component. But other than that --
Q Okay. So would you agree with that last sentence that I read, "While these documents may be useful in providing context for the treatment under scrutiny, they typically, if ever, contribute any statistical power or usable information for estimating the effect of treatment on the primary outcome"?
Would you agree with that taking out the secondary statistical analysis in that equation?
A Yes.
Q All right. Let's talk about your expert report, Exhibit 2.
When were you first contacted about this case?
A In my recollection, it was around the beginning of January 2018. It would have been around that time.

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Q Sure. So about a month and a half before you dated your report?
A Yes.
Q And what information were you provided about the case?
A In my recollection, I was told a little bit of information about who the plaintiffs might be, some general information about, you know, what the case was about, and then who was also involved in the defendant's side.
Q Had you ever met Alina Boyden or Shannon Andrews before coming involved in this case?
A I had met them one time before.
Q When did you meet them before?
A Perhaps six months before. I don't really remember exactly the details. It wasn't -- you know, maybe within six months before January 2018.
Q And tell me the context of meeting them. What was going on?
A Some students in my research lab had heard about them and had wanted to reach out to Alina and Shannon to talk with them.
And when we had reached out, they had indicated -- both Alina and Shannon had indicated they wanted to learn about what the research lab was, so we met

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at a coffee shop.
Q So the students came to you when they wanted to reach out to Alina and Shannon?
A It had come up in the research lab just as a discussion.
Q Do you know how they heard about them?
A I'm not sure.
Q And why did they want to reach out to them?
A I don't know that I can guess why they wanted to. I could -- would you like me to guess?
Q No, I don't want you to guess. Why did you reach out to them?
A Because the students had indicated an interest.
Q And you made that contact with them?
A The students and I. It was in one -- one contact.
Q And you said that you met at a coffee shop; correct?
A That's correct.
Q Did you meet together with Alina and Shannon together?
A Yes, and students.
Q How many students were there?
A My memory, I think there were two. There could have been three.
Q Did you discuss the case at all?
A The majority of what we talked about was not about

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the case. It may have come up peripherally, but I actually don't have any memories about what we talked about in detail.
Q Was any part of the discussion about you becoming involved in the case at the coffee shop?
A Not -- no.
Q I know that you interviewed Alina and Shannon as part of your report.
Did you have any other contact with them besides the coffee shop and interviewing them for the report?
A I have not had a conversation with either of them since meeting with them in January. I did see Alina in a meeting -- in a large meeting that we were both in, but I did not talk with Alina.
Q Have you ever worked with the ACLU or Hawks Quindel prior to this case?
A No, but with the caveat that in the prior case I worked on, the Whitaker case, my understanding perhaps the ACLU might have been peripherally involved in that, but I don't know the workings on that and I'm not sure if that's the case.
Q Did you have any contact with the ACLU in the Whitaker case?
A My understanding is that no. The only contact I had

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was with the main lawyer who I was speaking with.
Q What did you understand your task to be in this case?
A My tasks in this case were several-fold. One was to meet with the plaintiffs to do a psychological evaluation with both of them to determine if either of them met criteria for gender dysphoria and medical necessity for gender-related care.
And then I was also asked to determine to look over evidence to determine if there is medical necessity for transgender-related care.
Q I note that your report talks about some materials that you reviewed. In doing the report -- let me see.
Looking on page 6 of Exhibit 2 of your report, in that middle paragraph it says that you reviewed the Plaintiffs' Amended Complaint; State Defendants' Responses to Plaintiffs' Request to Admit; Interrogatories and for Production of Documents; documents produced by the State Defendants concerning insurance coverage of transition-related care; and documents related to appeals of denials of the Plaintiffs' requests for coverage of transition-related care. Is that correct?
A That's correct.

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Q Who provided you with those documents?
A The lawyers who are involved in the case.
Q Besides those documents were you provided with any other documents that were case filings?
MR. DUPUIS: Object as to time.
MS. SCHMELZER: Yeah, I know that's a bad question.
Q MS. SCHMELZER: The did the lawyers in the case provide you with any other documents?
A There are a couple of other documents that I talked about in the report. For example, there was a letter that was written for Shannon for medical necessity for care. So there were a couple of other documents that were included.
Q And it says that you also have several of Alina and Shannon's medical records. Is that correct?
A That's correct.
Q Who provided you with those medical records?
A The lawyers.
Q Do you know if that was a complete set of their medical records?
A I do not know if that was it, if that was the case.
Q It also says that you spoke with one of Shannon's therapists. Is that correct?
A That's correct.

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Q Which therapist was that?
A Nyle Biondi.
Q How long did you speak with her therapist?
A Approximately 30 minutes.
MR. DUPUIS: If I can interject something here. We will probably want to designate, at least initially, under the protective order the discussion of their individual -- the plaintiffs' individual medical conditions as confidential even though ultimately they will probably -- much of it will come in.
MS. SCHMELZER: Sure. Okay. We'll have to follow the protective order process for that.
Q (Ms. Schmelzer): And what did you and Dr. Biondi discuss?
A Nyle has a master's degree, so I will refer to him in that way.
Q Okay.
A So Nyle and I talked about my impressions of Shannon's diagnosis of gender dysphoria. So I was mainly trying to find out if the information I had received was consistent or inconsistent with what Nyle had experienced.

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Q And Nyle, had he previously diagnosed her with gender dysphoria?
A Yes, he had told me that that was the case.
Q Let's mark your supplemental reports.
(Exhibit Nos. 4 and 5 marked for identification)
THE WITNESS: Are we able to have a break?
MS. SCHMELZER: Sure.
(Recess)
Q MS. SCHMELZER: So, I'm looking at page 5 of your expert report, Exhibit 2.
With your prior expert witness experience you talk about being involved in an immigration case. Is that correct?
A Yes.
Q Was that here in Wisconsin?
A No.
Q Where was it?
A Kentucky.
Q Okay. And when were you involved in that case?
A In my recollection it was in early 2014, and it may have even gone into when I moved here as well, because everything was conducted in Kentucky.
Q You prepared an expert report; correct?
A I did.

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Q Can you summarize your opinions in that expert report just briefly?
A Well, it was a different kind of expert report than the one that was included here. It was only a psychological evaluation of the person who was involved in the case.
So the only thing that was asked of me was to do a psychological evaluation and provide diagnostic information.
Q And did you do that?
A I did.
Q And was the diagnosis "gender dysphoria"?
A That was included as one of the diagnoses.
Q And it says that the case was heard in the United States Department of Justice Executive Office for Immigration Review.
Were you part of that, I guess, hearing?
A Yes.
Q And did you provide any testimony at that hearing?
A I did.
Q And do you know what the result of that review was?
A She was granted asylum.
Q What country was she from?
A Mexico.
Q How did you become involved in that case?

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A Someone had contacted me. One of my students was connected -- and this actually might have been through the ACLU. I'm trying to remember.
So I'll clarify that from a previous question. I'm not sure because there were a couple of organizations involved, but there was a person who was connected through one of my students who contacted me.
Q Was this woman someone you had been providing clinical services to?
A No.
Q And then you talk about the Whitaker case, and you state you weren't deposed in that case; correct?
A That's correct.
Q You didn't have to testify in court at all in that case?
A I did not testify in that case.
Q You did provide a declaration and expert report though; correct?
A Yes.
Q And what was your task in the Whitaker case?
A My task was there were a couple of things that I had been asked to do. One was to conduct a psychological evaluation of Mr. Whitaker and also to determine the effects of -- you know, if there was

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discrimination that had happened, what the psychological impact of that discrimination might be.
Q And did you determine whether or not the student in the Whitaker case would suffer psychological impact of discrimination?
A Can you clarify that question?
Q Sure. Did you determine whether or not there was psychological impact for the student in the Whitaker case from the school policy that was at issue?
A I did determine that there was a psychological impact related to the discrimination that he had experienced.
Q And are there any other cases that you're involved with that aren't listed in this after "Prior Expert Witness Experience"?
A There was one additional case that I'm involved in that involves the Medicaid system.
Q The Flack case?
A That's correct.
Q And you provided an expert report in that case; correct?
A That's correct.
Q Currently you have not provided any court testimony though; correct?

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A That's correct.
Q And you have not provided a deposition in that case; correct?
A That's correct.
Q I guess the next section you talk about compensation, that you're receiving $200 an hour for actual time devoted to expert services plus expenses and cost; correct?
A That's correct.
Q Is the $200 directly to you or do you have to give that back to the university?
A It goes directly to me. I am an independent consultant in this case, not an employee of the university.
Q Okay. I want to jump to page 7 of your report where you discuss -- or where you have set forth a definition for sex.
So on the bottom, the last sentence you state: "When sex-related characteristics such as internal or external genitalia, reproductive capacity, chromosomes, or gender identity are inconsistent -- as with many transgender people and people with intersex conditions -- it is most appropriate to define sex based on the person's gender identity."
Did I read that correctly?

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A Yes.
Q So your definition of sex would include gender identity?
A That's correct.
Q Would you agree that sex and gender are considered to be separate?
A I consider them to be constructs that may be intertwined with one another but we can define them separately.
Q Would you agree that sex is determined even before birth?
A There are components of sex that may be determined before birth.
Q So what components of sex can be determined before birth?
A Chromosomes may be determined before birth. And some of the others can all change over time.
Q What components of sex cannot be determined before birth?
A Gender identity cannot be determined before birth. There are also other components that would be difficult to determine before birth as well like hormones, for example.
Q Reproductive organs can be determined before birth, right?

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A For many people. But for some people, no.
Q Can you tell me how gender can be present at birth -- or do you believe that gender can be present at birth? Let's start there.
A It's my opinion that gender is assigned to someone when they're born based on different characteristics that can be included.
Q So is it present at birth?
A The gender assignment is present at birth, yes.
Q And do you believe that that's true for everyone?
A Yes.
Q Are you aware whether or not other professional organizations like the American Medical Association, American Psychiatric Association, American Psychological Association, whether they agree that a person's sex includes their gender identity?
MR. DUPUIS: Object as to form, but you can answer if you understand.
Q (Ms. Schmelzer): Let me rephrase it. Would you agree that these professional associations -- or are you aware whether or not these professional associations would agree with your statement that it's most appropriate to define sex based on a person's gender identity?
A It's my professional understanding that that would

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be how my colleagues would do this work within those organizations would define it.
Q Do you know if the definitions that they adopt for sex include reference to gender identity?
A My understanding is that they would, and that's how people would describe it if you were to talk to them about it.
Q And is there any -- I guess, what is the basis for your statement that it's most appropriate to define sex based on a person's gender identity? What's the basis for that?
A The basis includes several components that are included in the definitions. For example, we know that transgender individuals and people with intersex conditions don't follow the path that may have been defined by several of the characterizations that we usually define by gender assignment at birth.
So there is that component. But also that everybody has a gender identity that's a core part of who we are and that gender identity often doesn't start to form or manifest until usually the age of three and develops over time.
Q So if it doesn't start to form until three and it develops over time how can they have it at birth?

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A Because gender is assigned to an infant when they are born.
Q But their gender identity is assigned as well?
A No.
Q So they don't have a gender identity at birth?
A That's correct.
Q They have a sex at birth but they don't have gender identity?
A It's a gender that's assigned when they were born and that gender identity doesn't start to form until human beings have more of those cognitive capacities.
Q Would it be accurate to say that someone has a sex at birth but they do not have a gender identity until that forms later in their lives?
A I would say there are components of sex that are present at birth. You know, I define the different pieces that are included as one classification for sex. Gender identity is one component of sex.
Q As you just stated -- and correct me if I'm wrong -- gender identity doesn't start to form until around the age of three; correct?
A That's correct.
Q And then can evolve in time; correct?
A Yes.

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(Pause in the proceedings)
(Exhibit No. 6 marked for identification)
Q MS. SCHMELZER: I'm going to show you what's been marked as Exhibit 6. Do you recognize this document?
A I do.
Q And what is this document?
A This document is a gender fluidity chapter.
Q Is this one of the book chapters that you wrote?
A Yes, a student and I wrote this book chapter together.
Q I'm going to have you turn to page 660. It looks like the first full page of text.
In the second column, the first full paragraph, I'm going to start reading, "Sex indicates biological features, including reproductive organs, hormones and chromosomes that often establish classifying an individual as male or female." Did I read that correctly?
A Yes.
Q "Gender is defined as a social construct that influences expectations of an individual's internal identity, behaviors, and experiences based on notions of masculinity and femininity."

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A Correct.
Q You don't include gender identity in your definition of sex in this book chapter, do you?
A No, but I include -- you will see in the definitions that I include in the expert report that gender identities are also listed below.
So it's pretty typical of chapters to list in those fashions. You see that actually listed in the same fashion: The sex, the gender and gender identity in the expert report.
Q But sex is not defined as including gender identity in this book chapter; correct?
A No, we were limited by the amount of words that we could include in the book chapter.
Q I'm going to jump ahead to page 12 in your report, under the heading "Clinical Diagnosis and Treatment Standards for Gender Dysphoria." Do you see where I'm at?
A I do.
Q You mentioned the World Health Organization's International Classification of Diseases in that paragraph under the heading; correct?
A That's correct.
Q What is that, the World Health Organization?
A My understanding is that's an international

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organization that, at least in this instance, provides a long list of diagnoses that many organizations follow.
Q Do you follow -- I guess "WHO" is the acronym for it; right?
A That's correct.
Q Do you follow WHO's list of diagnoses in your work?
A In my work I use the Diagnostic and Statistical Manual V.
Q Does the DSM-V and WHO's, I guess, International Classification of Diseases, the ICD, do they correlate?
A When you say "correlate" --
Q Are they the same -- do they overlap, I guess?
A There is some overlap with some of the diagnoses, yes.
Q Do they overlap with diagnosis for gender dysphoria?
A At the time of writing this report the term "gender identity disorder" had changed from the time of writing this to the current way that it's being classified.
There is some flux related to that understanding for WHO but not for the DSM-V.
Q What is that flux?
A The World Health Organization is -- my understanding

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is that they are planning on changing the term "gender identity disorder" to "gender congruence."
Q And is there any other change that you're aware of that WHO is making as far as that classification in their ICD?
A What do you mean?
Q Are you aware whether or not they're removing it from its classification as a mental health condition?
A Yes.
Q Yes, you're aware, or yes, they're aware?
A Yes, I am aware.
Q And what is your awareness of that removal as a mental health condition?
A Can you clarify the question?
Q Yeah. What do you know about that change?
A My understanding is that it's being moved to the Sexual Diseases or Sexual Disorders section.
I could be -- you know, it's around that kind of classification.
Q And does that change affect your opinions at all in this expert report?
A No.
Q Does that change -- do you know why they made that change?

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A I've read instances for why people say that that has happened. Would you like me to share that with you?
Q Yes, I'm interested.
A So, there is a debate around how to actually classify gender dysphoria and gender incongruence because there is distress that is related to gender incongruence, that's why it's included in the DSM-V under "Gender Dysphoria."
However, the World Health Organization wants it to be known also that this is a disorder that needs to be treated with medical interventions.
And so there has been some controversy. And where do we actually put this diagnosis because they want to make sure the medically-necessary care that's needed for what's happening with people when gender dysphoria happens.
So that's my understanding of what's going on is that people are trying to be able to support individuals getting medically-necessary care.
Q If WHO's position and the ICD-11 is at some point adopted in the DSM will it no longer be classified as a mental health condition?
A I don't know. I can't speculate on that.
Q The removal of it as a mental health condition from an ICD-11, does that affect your opinion on whether

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or not transition-related care is medically necessary?
A No.
Q So a condition that is under the Sexual Health chapter in ICD-11, that could still require medically-necessary treatment?
A Can you say that again?
Q Yes. I guess I'm not familiar with that Sexual Health chapter. Does that have conditions that require treatment?
A I'm not familiar with that chapter either.
Q Okay. Fair enough. Does this change in ICD-11 affect your work at all in the research lab?
A Not that I'm aware of.
Q Okay. Let's move on to page 14. You note, I guess, in the first paragraph there:
"According to the DSM-V Criterion B, a diagnosis of gender dysphoria also requires a finding of clinically significant distress or impairment in social, occupational, educational, or other important areas of functioning."
Did I read that correctly?
A You did.
Q Can you tell me, what does clinically-significant distress mean?

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A Well, that can be classified in many different ways. So we when we're assessing for what distress looks like, we're asking questions related to what kinds of symptoms someone may be experiencing in all areas of their lives.

So, are you eating, are you sleeping, are you engaged in social interactions with other people, can you work, what does that look like.

And then when we ask those kinds of questions, we then ask other questions related to severity of those pieces. So if you're having trouble sleeping, for example, you know, how long does it take you to fall asleep.

I can give you more examples. That's an example of how we assess for that.

Q Okay. So the difference between distress and clinically significant distress would be the severity of that distress. Is that fair to say?

A That's fair to say.

Q Is there a way to measure distress?

A There are many ways to measure distress.

Q How do you measure that?

A There are -- in a psychological evaluation, one would measure that by asking questions regarding frequency and maybe depth of what distress may be

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experiencing.

Often there are measures that can be given that will determine some of those components.

Q What do you mean by "measures"?

A There are psychological instruments that may be given in certain instances to look at those components.

Q What kind of psychological instruments?

A So, for example, on the DSM-V website there are instruments that are included on there that if you want to assess somebody's level of depression, for example, you can give a measure that's related to that.

However, usually the way that we assess this in psychological evaluations is through a diagnostic interview where we use the DSM criteria. And the DSM outlines severity based on you must meet five out of the nine criteria in order to be able to meet. And then based on the frequency of whatever the symptoms are, then you will also label severity.

Q So there is some kind of chart as far as how to determine clinically significant distress by the frequency of it?

A Usually it's frequency and also -- sometimes it's not just like how often does it happen, but then you

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can also ask to what extent does this seem to impact your life.

So you can ask questions related to level of impact, those kinds of things.

Q So this would be part of an interview for diagnosing someone?

A That's correct.

Q And would this kind of diagnostic criteria be solely reliant on somebody's response to those questions?

A It depends on the purpose of the evaluation and the questions of the evaluation.

Sometimes there are outside people who are also considered, so it is not only self-report. It depends on what the purpose of the evaluation is.

Q Besides the sort of interview process that you have, are there any other psychological instruments that can be used to measure a patient's distress level?

A I think that I mentioned -- do you want me to say by name some of the measures?

Q Yes.

A So, I had mentioned, for example, that there are several different measures that can be used to look at, you know, depression, social anxiety, posttraumatic stress disorder.

Q Are these some kind of like tests that can be

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administered?

A They would be called "instruments," if that makes any sense. So they have been validated, for example, and you can compare from sample -- from the norming sample how a person would compare to those.

Q How do you get the data that you would use to compare?

A Usually there is a validation report that has been submitted to indicate what the sample norming characteristics are or there is a manual that's provided.

But a lot of this depends on what the question is and what the evaluation is for.

Q Are there any -- I guess I saw the term "psychometric tests."

Would those be used at all to, I guess, determine whether or not someone was clinically significantly distressed?

A On some -- so I mentioned that there would be a validation component that would be published either in a manual or journal article, and those would include psychometric properties that are included in them.

Q Besides contacting outside sources to sort of validate what someone self-reports, is there any

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other objective criteria that can be used to determine whether or not someone is clinically significantly distressed?
A What do you mean?
Q Besides self-report and then contacting others, is there any other test that can be performed to determine whether or not someone is clinically significantly distressed besides what we just talked about?
A No, there wouldn't be any other tests that you would perform to determine those things.
Q I want to talk a little bit about the term transsexual versus gender dysphoria?
A Uh-huh.
Q Do all transsexuals have gender dysphoria?
A Can you define "transsexual" for me?
Q Yes. Let's see what you define in your report. Let's use the term "transgender."
A Okay.
Q Do all transgendered individuals have gender dysphoria?
A No, not all transgender individuals will have clinical gender dysphoria.
Q Do you know approximately how many transgendered individuals, what percentage of them, have gender

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dysphoria?
A In my clinical experience I would say that, you know, approximately probably 70 percent of my caseload would meet the criteria.
Q Do you know if there have been any scientific studies to try and ascertain that number of transgendered individuals that have gender dysphoria?
A I'm not aware of any population case studies that have tried to determine that.
Q Do all individuals with gender dysphoria -- are all individuals with gender dysphoria transgender?
A From how I would define it, I would say that that is the case.
However, people may not self-identify necessarily as transgender. So part of this may be a self-identification piece in terms of the labels that people use. But from the definition that I provide in the report, I would say yes.
Q Is being transgendered a diagnosable medical or mental health condition?
A No.
Q All right. I'm going to move on to page 15 of your report, Exhibit 2, where you talk about medical necessity for treatment.

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How do you define "medical necessity"?
A I define medical necessity as being care that will improve somebody's functioning to a state where they're not going to die or where they are going to be able to function in society.
Q Are you familiar with how the uniform benefits for the state of Wisconsin Group Health Insurance program defines medical necessity?
A I have read that information. I would like to see the definition of it again if you have it.
Q I don't have it handy, but I was just wondering if you had reviewed that at some point.
A I have.
Q When you wrote your report, are you aware of whether that definition is different than the one you just provided me?
A I'm using the definition that is provided by all the organizations that I was citing in my report. So they were American Medical Association, American Psychological Association. So I'm a relying on information that's provided by these major organizations.
Q Do you think the effectiveness of a treatment should be considered when determining whether something is medically necessary?

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A I do.
Q Do you think economic concerns should be considered in determining whether something is medically necessary?
A I think they can be part of a consideration, yes.
Q Do you think insurance plans should cover all medically-necessary treatment as you've defined it and used in your report?
MR. DUPUIS: Objection. Personal view or --
MS. SCHMELZER: Yes.
THE WITNESS: I think that insurance companies should cover medically necessary treatments when they are shown to be effective and cost effective.
Q (Ms. Schmelzer): On the next page, page 16, in the first half paragraph on the top there it says, "The (standard of care) SOC note that gender confirmation surgery for transgender individuals is considered reconstructive, not cosmetic or aesthetic."
Did I read that correctly?
A That's correct.
Q So do you agree with that statement?
A I agree with that statement.
Q What's the basis for that?

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A The basis for that is that these surgeries -- so gender confirmation surgery in this instance is not a cosmetic procedure, it's not elective.
It's a procedure that if this person had been, you know, born with the body parts that were congruent with their gender identity then they wouldn't need to have these surgeries. So it's reconstructive in this instance.
Q So when it says gender confirmation surgery for transgendered individuals, is that for any transgendered individual?
A These are for individuals who meet criteria for gender dysphoria.
Q So only for that approximately 70 percent in your practice that also have gender dysphoria; correct?
A Can you say that again?
Q Sure. So you have to have gender dysphoria in order for the surgery to be considered reconstructive; correct?
A I think I'm still confused by what you're saying.
Q Sure. Let me, I guess, pose this question:
If a male-to-female transgendered individual has gender dysphoria and wants breast augmentation surgery, that would be considered medically necessary under the standards of care; correct?

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A That's correct.
Q If a male-to-female transgendered individual who does not have gender dysphoria wants breast augmentation surgery that would not be considered reconstruction. Is that correct?
MR. DUPUIS: Object to form.
Q (Ms. Schmelzer): Do you believe that would be considered reconstructive surgery in a situation where a male-to-female transgendered individual does not have gender dysphoria?
A I think if they didn't meet any of the criteria -- if they didn't meet criteria for gender dysphoria there wouldn't be treatment for gender dysphoria. So it doesn't seem like that would be medically necessary.
Q Would it be considered cosmetic for that male-to-female transgendered individual who does not have gender dysphoria but wants breast augmentation surgery?
A It's hard for me to say because I don't know what the circumstance would be with what you're saying.
But in this instance, the reason for the gender dysphoria would be the incongruence of somebody's gender identity.
So part of it is -- I think the example you're

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giving is a little hard for me to try to parse apart.
But if it were a person who did not have gender dysphoria and they wanted breast augmentation surgery then it's possible that that could be considered cosmetic.
Q So in that situation, a transgendered individual who does not have gender dysphoria, would they be sort of considered at the same level as a cisgendered individual who wants breast augmentation surgery as well?
A Can you say that again.
Q Yes. So if a cisgendered individual woman wants breast augmentation surgery would that be cosmetic?
A It depends on the reason for it. If it was breast cancer that would be reconstructive. So it just depends on what the example is.
Q So if it was not to reconstruct any part of her body but just to enhance her appearance, would that be considered cosmetic surgery for a cisgendered woman?
A Yes.
Q For a male-to-female transgendered individual without gender dysphoria who wants to look more like a woman and wants breast augmentation would that be

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considered cosmetic surgery?
A I think this is a highly unlikely scenario, because if a trans woman was coming in and telling me that, you know, she needed breasts as part of her identity confirming of her gender, it's hard for me to believe, actually, in this instance that she wouldn't meet criteria for gender dysphoria.
So part of why I'm struggling with what you're saying is that a lot of what you're saying would be she would meet a lot of criteria or fully meet criteria for gender dysphoria. So --
Q Can you envision a scenario where a person who is transgendered wouldn't want surgery to enhance their appearance to appear more like the gender that they identify with and would not have gender dysphoria?
A It's difficult for me to think of a scenario where that might happen, because that's a primary symptom of gender dysphoria.
Q Okay.
(Pause in the proceedings)
Q (Ms. Schmelzer): And do you have an opinion on whether or not surgery is effective in treating gender dysphoria?
A I do have an opinion.
Q What is that opinion?

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A My opinion is that it is -- that it is effective in treating gender dysphoria.
Q What is the basis for that opinion?
A The basis for that is the large body of research evidence that indicates numerous outcomes for gender confirmation surgery.
Q Okay. And you said research evidence that outlines these outcomes from the surgery.
Do any of these -- this research evidence, do any of them involve any, I guess, the gold standard studies that we talked about in the hierarchy of evidence?
A So, I talked about this in at least one of my reports, but that it's not possible to do a double-blind study with these particular -- with this particular population of particular types of treatments.
Q Why isn't it possible?
A In double-blind studies, the person who is administering the treatment is blind to whatever treatment they're providing. And so is the patient, they're blind to what they're receiving.
That's impossible when you're doing a surgical procedure. The surgeon has to know what kind of surgical procedure they're doing and the patient

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will also be aware of what kind surgical procedure they're getting.
So that's an impossible study to perform in this instance.
Q What about the next level below that, that we talked about earlier, the controlled studies, cohort studies, or matched observational studies. Does any of this evidence that you rely on fall into any of those categories?
A Yes.
Q And are these identified in your report?
A Yes.
Q Let's look at -- I think I marked these already. Let's look at your initial report first, Exhibit 2.
A Okay.
Q Which of these studies would be controlled studies?
A Okay. So, the Heylens study involves a controlled group.
Q Can you tell me what page you're on?
A I'm sorry, yes. That's page 17.
Q And where you are on the page there?
A In the middle of the page.
Q You said Heylens. Okay.
A Yes.
Q 2014 study?

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A That's correct. And that's the primary one that I indicate in this particular piece in the next report that I wrote.
Q Sure.
A I included more information in that one.
Q I'm going to hand you what's been marked as Exhibit 4. Is this your supplemental expert report?
A Yes.
Q And is this the one that was filed after your initial expert report?
A Yes.
Q So, are there any controlled studies that support your opinion as far as the effectiveness of surgery for treating gender dysphoria? Are any controlled studies identified in Exhibit 4?
A Yes, there are two. One is Ainsworth, which is included on page 10. The other one is Tucker, which it would -- let me take me a second. I need to find it.
MR. DUPUIS: Page 9.
THE WITNESS: Page 9? Yes, page 9.
Q (Ms. Schmelzer): Okay. And that's a 2018 report?
A That's correct.
(Exhibit Nos. 5 and 6 marked for identification)

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Q And I'm going to show you what's been marked as Exhibit 5. Is this your second supplemental expert report that you filed in this case?
A It is.
Q This one came after the supplemental report, Exhibit 4; correct?
A Correct.
Q Are there any controlled studies that support your opinion that surgery is effective treatment for gender dysphoria? Are any of those controlled studies identified in Exhibit 5?
A The Fisher, 2016, that one is cited on page 2. And I would need to double check, but I think Witcomb also assessed for gender dysphoria.
Q Did you say Fisher was 2015 or 2016?
A 2016.
Q And you said Witcomb?
A Yes, but I would need to double check that one.
Q And what year was the Witcomb study?
A 2018.
Q And, I'm sorry, what page of Exhibit 5 is the Witcomb study referenced?
A Page 2.
Q Any other controlled studies that support your opinion on the effectiveness of surgery to treat

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gender dysphoria that you're aware of?
A These are the studies that I have cited in the reports.
Q What about cohort studies -- by the way, what is a cohort study?
A So my understanding of a cohort study is that you take a cohort of individuals and follow them throughout time.
So cohort studies, in my experience, are often included in longitudinal research.
Q So do you rely on any cohort studies to support your opinion that surgery is effective treatment for gender dysphoria?
A Yes. For example, on page 3 of the second supplemental report.
MR. DUPUIS: Exhibit 5?
THE WITNESS: Uh-huh. I cite the Colizzi 2014 article, the Heylens 2014 article, and the van de Grift 2018 article.
Q (Ms. Schmelzer): Are there any other cohort studies that you rely on in Exhibit 5?
A Those are the only two that I can see that I cited in Exhibit 5.
Q The only three?
A The only three.

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Q What about in your supplemental expert report, Exhibit 4. Were there any cohort studies that you rely on in that report?
A Let me check.
(Pause in the proceedings)
THE WITNESS: So there are a couple of other studies that are longitudinal.
For example, the Keo-Meier, K-e-o -- the Keo-Meier, et al, 2015 study is a cohort study that was longitudinal. They followed matched control individuals over a period of time.
So there are several studies that may be longitudinal, but perhaps I didn't note them in those sections where I would have talked about the longitudinal studies.
Q (Ms. Schmelzer): So longitudinal studies are cohort studies?
A As long as you follow a cohort over time, yes.
Q And I'm sorry, that one that you mentioned, where was that?
A The Keo-Meier article is on page 7.
Q That was a 2015 study; correct?
A That's correct.
Q Any other cohort studies, whether longitudinal or not, that you rely on to support your opinion that

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surgery is effective treatment for gender dysphoria?
A There may be others that are included in the reports. Those are the ones that I pointed out right now.
Q Okay. What about in your original expert report, Exhibit 2. Are there any cohort studies that you relied on in that report to support the effectiveness of treatment for the effectiveness of surgery for gender dysphoria treatment?
I apologize if I sound redundant. I just want the record to read well.
A Sure. Some of the articles that I cite in the supplemental report are also in the expert reports, but I don't think that there are any other additional ones that we've talked about so far.
Q What about any matched observational studies?
A So there are some matched controlled studies in Exhibit 4.
Q Is that the same thing as a matched observational study?
A In my understanding of how we talk about it in my field that's how we talk about it.
So, Witcomb 2018, which I've already talked about uses a matched control group.
Q And that was in Exhibit 4 you stated; correct?

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A That's correct. On page 7.
Q Any other matched controlled studies in Exhibit 4 that you reference?
A No, not that I can think of at this moment.
Q What about in Exhibit 5. Are there any matched or controlled or observational studies that you reference to support your opinion that surgery is effective for treating gender dysphoria?
A I do not think that I mention more of them, but I do cite the controlled -- I cite the Fisher and the Keo-Meier and the Witcomb articles here.
Q And in Exhibit 2, your expert report, are there any other matched controlled studies that you say here that you didn't cite and that you didn't cite in either Exhibit 5 or 4?
A I do not think that there are additional ones in these particular reports.
Q Do any of these studies that we talked about -- the controlled cohort or matched controlled studies -- do any of them measure an individual's distress as part of the study?
A Yes.
Q Do you know which ones do that?
A Do you have copies of the articles with you?
Q I don't. Not all of them.

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A So, from memory, I can just say in general most of them do measure some type of distress and quality of life and satisfaction measure.
Q Is there some kind of standardized test or scale that studies like these can use to measure distress?
A Uh-huh, some of them. So van de Grift uses the SCL, which is a measure that is widely validated, and, you know, that one is well known. The Keo-Meier article uses the MMPI.
So there are different studies that use different levels of distress measures. And I wouldn't say that there is -- you know, you have to use this specific type of measure, but that many of them use measures that are well-known, that are highly validated and that can be compared.
Q Does it make it difficult to compare these various studies if they use different instruments or measures of distress?
A In my opinion, no. As long as these instruments have been well-validated or that we have a very clear understanding of what the constructs are, then it seems like in all of the entirety of the evidence that we have been able to create, it tells -- you know, the research has a clear implication of what the outcomes are for hormones in surgery.

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Q Looking at your supplemental report, that's Exhibit 4, at the top of page 4 you quote from one of the studies:
"There is currently no evidence to support the view that cosmetic surgery is of lasting benefit to patients with pre-existing psychological or personality problems." Is that correct?
A That's correct.
Q And that's the Cook study of 2006. Is that correct?
A Yes.
Q Did that Cook study involve individuals with gender dysphoria?
A It's possible that there may have been people, but they wouldn't have called it gender dysphoria at the time and it would have been assessed differently than how we understand it now.
Q It would have been gender identity disorder?
A Likely, yeah. I don't recall exactly which disorders were included, but it's possible.
Q Wouldn't gender identity disorder at the time, gender dysphoria possibly now, wouldn't that be considered a pre-existing psychological problem?
A So, I would need to see the actual piece of the -- actual manuscript in front of me.
But if my memory serves, I think that this

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article actually talked about that they didn't include people with gender identity disorder in the analysis or in their discussion when they were talking about this, because it's considered a totally separate condition.
That's my memory. It could be something else that I'm thinking of.
Q Okay. Let's go back to your original report, Exhibit 2. On page 18 under the heading "Ethical Standards and Guidelines for Medical and Psychological Care," you mentioned some professional organizations under the section: The American Medical Association, the American Psychiatric Association, and the American Psychological Association. Is that correct?
A That's correct.
Q And they all take the position that medical interventions are medically-necessary care for transgendered individuals; correct?
A That's correct.
Q Do you know, did any of these -- do you know how these associations came to have these resolutions? What do they rely on for the basis of these resolutions? Are you aware of what they rely on?
A Yes, I can speak most closely to the American

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Psychological Association because that's the association I'm most associated with.
So they have had two separate task forces who have been designated to be able to answer these questions. Both task forces, in my understanding, took at least three years to review the entirety of the evidence that was available from the medical and psychological literatures. And then based on the entirety of the evidence they could find over that three-year period of time for each of those task forces, they made recommendations based on the broad base of literature.
I don't know what the process was like for the other organizations, but I do know that it was very scientific for my organization.
Q Do you know whether or not the American Psychological Association conducted any of its own studies as to the effectiveness of medical treatments for gender dysphoria?
A Can you clarify the question?
Q Did they rely on studies that were already done or you do you know if they conducted any of their own studies?
A My understanding is that they relied on studies that were already done. My understanding is that the

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American Psychological Association does not conduct studies.
Q Do you know any of the other associations that you cited -- the American Psychiatric Association and the American Medical Association -- that they conducted any of their own studies?
A I'm not aware.
Q Would it be fair to say that they reviewed the same body of evidence that you have included in your expert reports?
A Yes.
Q So their resolution and positions are only as strong as those studies that they relied on; correct?
A Can you say that again?
Q Their positions are only as, I want to say, evidence-based as the studies that they relied upon; correct?
A Yes, that they use evidence to be able to provide their recommendation.
Q Do you know whether or not these organizations are always right in their recommendations?
A In my experience there is no organization that is right 100 percent of the time.
Q Do you always agree with the positions taken by the AMA and APA and APA?

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A I don't think there is a hundred percent agreement with everything that is taken upon by all the organizations.
Q So they can take positions that medical professionals disagree with?
A It's possible.
Q Are you aware of any medical associations that do not believe that surgery is effective treatment for gender dysphoria?
MR. DUPUIS: Object as to form and foundation.
THE WITNESS: I'm personally not aware of any of the major organizations that do not support this.
Q (Ms. Schmelzer): Are you aware of any organizations that you wouldn't consider major medical associations that disagree with your opinion?
A Yes, there is one organization, and I can't remember the actual name of it, but it calls itself like "Medical Family Association" that is not an actual medical association, but the name would indicate that they are, and they tend to have -- tend to be unsupportive of transgender individuals.
Q You said it's not a medical association?
A That's right. And I can't remember the actual --

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it's a long title, but it sounds very medical and very professional.
Q I have maybe a little bit more general stuff to get through before I talk about Ms. Boyden and Ms. Andrews, so maybe get through this and take a break before doing that?
MR. DUPUIS: Sure.
MS. SCHMELZER: Okay.
(Exhibit No. 7 marked for identification)
Q (Ms. Schmelzer): I'm showing you what's been marked as Exhibit 7.
MS. SCHMELZER: I'm just going to mark this right away, too.
(Exhibit No. 8 marked for identification)
Q (Ms. Schmelzer): Have you ever seen Exhibit 7 before?
A I think that I've seen parts of this.
Q Do you know what the Centers for Medicare and Medicaid Services is?
A Yes.
Q And are you aware that in August of 2016 they issued this Decision Memo for Gender Dysphoria and Gender Reassignment Surgery?

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A I'm aware of a decision that was made. But in terms of the actual memo itself, is that what you were meaning?
Q Yes. Have you ever reviewed the memo?
A Oh, I have never reviewed the memo involved.
Q Were you aware of this decision that was made even before becoming involved in this case?
A Yes.
Q So, I'm looking at page -- there is page numbers on the bottom, so starting with "1." Let's go with that.
A Okay.
Q So on page 9, under the subheading "C," it says -- I'm going read the last sentence of that first paragraph:
"CMS is interested in answering the following question: Is there sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria."
When you were aware of this decision, is that the question that you were aware that they were trying to answer?
A Can you ask that question again?
Q Yeah. Did you know that that was the question that

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was involved in this decision?
A Yes.
Q And let's go back to page 7, under the heading "General Methodological Principals." I'm going read the paragraph that starts with:
"The overall objective for the critical appraisal of the evidence is to determine to what degree we are confident that: (1) specific clinical question relevant to the coverage request can be answered conclusively; and (2) the extent to which we are confident that the intervention will improve health outcomes for patients."
Did I read that correctly?
A Yes.
Q And were you aware of the type of evidence that they reviewed in making this decision?
A I'm aware of many of the articles that they have reviewed.
Q So back to page 1, the Decision Summary. In that first paragraph it states middle of the way:
"The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is

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inconclusive for the Medicare population."
Did I read that correctly?
A I think I missed -- where are you on?
Q I'm on the first paragraph and I started on the middle of the row.
A Yes.
Q Do you agree that the clinical evidence is inconclusive regarding that question that they sought to answer?
A I do not agree that it is inconclusive.
Q So you disagree with this decision?
A I do disagree with this decision.
Q The last paragraph on page 1, it states:
"While we are not issuing a NCD, CMS encourages robust clinical studies that will fill the evidence gaps and help inform which patients are most likely to achieve improved health outcomes with gender reassignment surgery, which types of surgery are most appropriate, and what types of physician criteria and care settings are needed to ensure that patients achieve improved health conditions."
Did I read that correctly?
A Improved health outcomes.
Q Oh, I'm sorry, "outcomes." Yes.
A Yes.

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Q Do you agree that more robust clinical studies need to be performed in this area?
A I think in all medical and psychological research there should always be improvement on the studies that we are doing. So in that vein, this could be applied to this as well.
Q So you said you disagree with this decision. Why do you disagree with it?
A In my opinion the evidence is not inconclusive. The evidence is conclusive about the benefits of the gender-confirming surgeries and from hormones.
So that's the statement that I disagree with. It seems inconclusive to me.
Q Is there any part about the evidence they relied on that you thought was deficient that you think they didn't consider all the studies that you would consider?
A Well, so this was written in 2016. Is that correct?
Q Yes.
A So, I think that there was a lot of really good evidence that was available up until that point, but even in the last two years the evidence has become even stronger. More longitudinal studies, more controlled studies.
And so for me, a lot of researchers are

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responding to some of the calls to complete more research on this. And that's being done and that the research is indicating even more so that the surgery, the hormones, are beneficial, and that they produce gender dysphoria.
Q Do you think in August of 2016 that the evidence was inconclusive as to the effectiveness of surgery for treating gender dysphoria?
MR. DUPUIS: Can I just clarify?
MS. SCHMELZER: Sure.
MR. DUPUIS: For the Medicare population?
MS. SCHMELZER: For the Medicare population. Correct.
THE WITNESS: I do not.
Q (Ms. Schmelzer): You do not agree with that?
A I do not agree that this was correct at the time in 2016.
Q Would you agree that this decision -- let me strike that.
Would you agree that individuals in the medical profession could disagree about the effectiveness of surgery for treating gender dysphoria?
A Can you say that again?

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Q Right. They obviously don't agree with you; correct?
A That's what it seems like.
Q Do you have any reason to doubt that the individuals authoring this decision are qualified to make that determination?
A I don't know who the authors were who wrote this.
Q Would you agree that there was disagreement in 2016 as to the -- in the medical field and psychological field as to the effectiveness of surgery to treat gender dysphoria?
A I would say that the World Professional Organization for Transgender Health, for example, which is the international organization that sets out the standards of care both medically and psychologically, that there is strong agreement related to the medical necessity of care.
There may be some people who disagree with that information, but the majority of people indicate the medical necessity of the care, and that the research is pretty conclusive.
As well, I have gone through the tables that are included in here, so there are tables that are included at the end, and some of the studies are included incorrectly in the tables.

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So for me when I've gone through this, it seems like perhaps there are a few pieces that were not done correctly as part of this report.
Q Do you know whether or not this report considered WPATH's standards of care.
A I'm not aware of that.
Q I'm going to show you what's been marked as Exhibit 8. Maybe we should mark them separate as 8 and 9. I think there is two of them in there.
(Exhibit No. 9 marked for identification)
MR. DUPUIS: Which one is 8?
Q (Ms. Schmelzer): Exhibit 8 is dated May 15, 2014; correct?
A Uh-huh.
Q And 9 is dated May 9th, 2014. Are you familiar with the Hayes directory?
A I am.
Q What is the Hayes directory?
A My understanding is that I've read pieces of the Hayes directory where people have come together to determine something kind of similar to this where they do a review of the research to determine what is the effectiveness of this specific kind of treatment.
That's my understanding of what is happening

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with the Hayes directory.
Q Is it something that's provided to medical providers or insurance companies? I guess I'm trying to understand what it actually is.
A I'm actually not sure of that. I think in the way that I have been shared information about this is that it's a group of individuals or an organization that kind of basically does a review of the research and makes conclusions. But I could be incorrect.
Q Is the Hayes directory a resource that is relied upon by researchers in psychological studies?
A I have not relied on the Hayes directory. And in fact, the first time I had heard about it was in relation to the case.
Q Have you ever seen Exhibit 8 before?
A I've read components of the Hayes directory. I don't know if it's the exact same piece as this was.
Q This looks to be a report dated May 16th (sic), 2014 regarding sex reassignment surgery for the treatment of gender dysphoria. Correct?
A That's correct.
Q And I'm going to go to page 2 of that document where it says "Relevant Questions." The first one:
"Has SRS been shown to be effective in improving patient-important outcomes such as relief

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of symptoms of GD, quality of life, satisfaction with sex characteristics, psychological well being, or sexual function."
Did I that read that correctly?
A That's correct.
Q And on page 3 of that document it talks about "Quality of Evidence"; correct?
A Uh-huh.
Q And it states, "Very low":
"Overall, the quality of the evidence was very low due to limitations of individual studies, including small sample sizes, few studies evaluating any one outcome, retrospective data, lack of randomization of patients to treatment groups, failure to blind outcome" -- sorry, I don't have my glasses -- "assessors to group assignment, lack of a control or comparator group or minimal adjustment for confounders, lack of baseline assessments to assess change over time, a possible procedural learning curve, and a lack of objective and validated outcome measures."
Did I read that pretty much correctly?
A Yes.
Q Do you agree that in 2014 the quality of the evidence to assess the effectiveness of surgery to

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treat gender dysphoria was very low?
A No, I don't agree with that.
Q And on page 4, it talks about "Conclusions," which is: "The evidence suggests positive benefits but because of serious limitations permit only weak conclusions regarding sex reassignment surgery (SRS) for gender dysphoria (GD). No conclusions can be made about the comparative benefits of hormone therapy alone and SRS, or about different components of SRS."
Did I read that correctly?
A That's correct.
Q Do you agree with that conclusion?
A No. So the reason I don't agree with that is because there are few components of this. The first is that they only looked at 19 studies which is pretty surprising to me because there are a lot more studies than 19 that could help with the research questions that they had.
As well as when they're talking about quality of evidence they're using that hierarchy that we were talking about earlier, and in the hierarchy, if you're going to actually rate a quality of evidence you can only rate a quality of evidence as being anywhere near high if they had a double-blind study.

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And so you're never going to be able to rate study qualities anywhere in the range of being high if you can't conduct the double-blind or a single-blind study.
So, for me, this doesn't actually provide the context for the information regarding the evidence.
Q Do you know if when they assign a quality of the evidence if they're following the hierarchy of evidence there or if they have some other skills that they use?
A My understanding is that they're using something similar. They are using something similar.
But, also, I think I mentioned in my supplemental report, Exhibit -- let's see, I want to make sure I'm telling you the correct one -- Exhibit 5, I provide responses to a lot of the critiques that they have on pages 2 and 3.
And so there have been studies that have been conducted since this report has been, you know, distributed and disseminated that address a lot of those pieces.
Q The Birmingham University report, is that what you're discussing?
A I'm talking about that, but actually the critiques that are included in there are similar to the pieces

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that are included in here.
Q All right. So I'm going to move on to Exhibit 9, which is a Hayes report for Ancillary Procedures and Services for the Treatment of Gender Dysphoria, dated May 9th, 2014; correct?
A That's correct.
Q So these would be for -- and I'm looking under the "Purpose of Technology" section for surgeries such as facial modifications, vocal cord surgery, or voice training surgeries that don't include gender reassignment surgery, correct -- or genital reassignment surgery; correct?
A Genitals. That's correct.
Q So on page 2 of Exhibit 9 it talks about the "Relevant Questions." The first one being:
"Have ancillary procedures and services shown to be effective in improving patient-important outcomes such as relief of symptoms of GD or quality of life"; correct?
A Yes.
Q And on page 3 they find the quality of evidence they use to be very low.
A Uh-huh.
Q The same as in Exhibit 8?
A Sure.

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Q Do you agree that in 2014 the quality of the evidence to assess the effectiveness of other types of surgery besides genital reassignment surgery was very low?
A No.
Q And then the conclusion, again, talks about:
"There is some evidence that transgender patients are satisfied with the results of rhinoplasty and facial feminization surgery, but patient satisfaction with vocal cord surgery and voice training was mixed. The evidence has serious limitations, and the effect of these procedures on overall individual well-being is unknown."
Do you agree with that conclusion?
A No.
Q Why not?
A So, for example, the Ainsworth study that I had mentioned earlier on in the deposition, that study addresses some of the critiques that were mentioned here and that was published in 2010.
That one does not simply ask about satisfaction; that one actually looks at several factors that would be involved in diagnosis of gender dysphoria and improving the components of Criterion B of gender dysphoria.

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And so for me, it feels like they -- I don't actually have the studies that they looked at here, it's not listed here, but it seems like either it's not comprehensive or doesn't include some of the studies that actually would show that there is a higher quality of evidence.

There has also been some other studies that have been published more recently as well.

Q So, on page 2 it says, "Evidence Base: Thirteen case series studies and chart reviews."

A Right.

Q And you think that's under-representative --

A I do.

Q -- under-representative of how many studies were available?

A I do.

Q Do you have any idea how many studies were available on these types of ancillary procedures to treat gender dysphoria?

A I do not know how many were available.

Q I have one last section and then I think we can break for lunch.

A Okay.

Q Okay. I'm going to go to page 22 of your report, Exhibit 2, where you, under the heading "Cost of

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Transition-Related Care."

I guess I'm going to start off with asking you, do you have any specialized education or training or experience with insurance coverage issues?

A No.

Q Do you have any education or training in the cost effectiveness of insurance coverage for specific benefits?

A No.

Q Do you have any education or training in insurance premium rate setting?

A No.

Q Sorry if this seems redundant. Do you have any specialized education or training in projecting long-term cost for insurance coverage of specified benefits?

A No.

Q What about for in the area of value-based insurance design?

A Is the question do I have experience?

Q Yeah. Do you have any education or experience or training in that area?

A No.

Q Do you have any education, training or experience in

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forecasting and budgeting of health plans?

A No.

Q Any education, training or experience in medical claims data?

A No.

Q Are you an actuary?

A No.

Q Do you have any education, training or experience in public health?

A Yes.

Q And that would just be what was in your CV?

A Uh-huh.

Q Okay. So tell me, it looks like your opinion -- let me see if I can find it on here. It is in the first paragraph under Cost of Transition-Related Care," it says:

"It is also considered cost-effective for insurance companies to cover transition-related care."

Did I read that correctly?

A That's correct.

Q And tell me, is that your opinion?

A That's my opinion based on the data that I reviewed.

Q And tell me the basis for that opinion.

A So, the basis for that opinion, there are a couple

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of components that are included in that.

One is that from reading the studies and reading the report that was the ATF memo, it seems. Like it's a pretty negligible cost to members of being either 0.016 cents a month or 0.05. And so that seems pretty negligible. And also from the information that's provided by Padula.

But also the additional piece that's included in here in terms of it actually being cost-effective is that there are problems that can happen if these denials continue.

So, for example, I provided information that the estimated cost of transition -- if you don't allow transition-related care, the estimated costs for treating depression, anxiety, drug abuse and so on are estimated to be $10,712 a year.

But also what's not even included in that is that if somebody attempts suicide, the cost of -- the immediate costs of the emergency care and then also in-patient treatment are even more than that. So that's the basis.

Q How do you know what the estimated costs are, that figure that you arrived at 10,712 for treating depression, anxiety, drug abuse et cetera?

A I cited the information as provided by Beck.

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Q Do you have any education, training or experience in assessing costs for these types of issues of depression, anxiety, drug abuse?
A Well, there is a component of my job where my patients will come in and they will talk to me about here's how much these things are going to cost me and I need to figure out what the costs are involved.
So from a clinical perspective I have lots of information from clients, how they weigh their own personal cost and benefits that are included in that, but also I'm a research scientist and so I'm trained how to read research articles to provide this information. So I've included the information cited here as it was included in the manuscripts that I read.
Q And that was a figure from back in 2015; correct?
A That's correct.
Q Is there any evidence to support that this figure, $10,712 a year, would be incurred for anyone denied these benefits?
I guess how do you assess how much or how often someone is going to suffer these issues of depression, anxiety, drug abuse?
A I'm not aware exactly how Beck came to that actual

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conclusion. I know that in my clinical work, you know, a lot of that is assessed by when a person attempts suicide, we talk in the room about how people often will come in and say this is how much it costs, or this is what my out-of-pocket cost is, and this is what my insurance is paying in trying to figure out those pieces.
So I have personal clinical experience talking to these patients about how much these actually cost for them or when they talk about their insurance pieces, but the person who wrote this article, do an analysis that would indicate, you know, how they came up with that number.
Q Do you know if the Beck study has any information or evidence as to how many people -- how many transgendered individuals denied surgery as treatment for gender dysphoria, how many would incur this cost?
A Do you have that article with you?
Q No, I'm sorry.
A Then I'm sorry, I can't answer that.
Q I have some but I don't really know which one. It's a complicated system I have here.
A Okay. Without that article in front of me I can't answer that question fully.

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Q Do you have any independent knowledge how many individuals would suffer depression, anxiety, drug abuse that would cost somewhere around this figure if they were denied surgery for gender dysphoria?
A When I had patients who had been denied transition-related care, you know, many of them have attempted suicide, many of them continue to experience depression, anxiety, posttraumatic stress disorder, and some of them have some issues with drug abuse and alcohol abuse.
So, in my clinical experience this is something that I've seen happen. I've also seen it happen in evaluating, you know, when I talked to the individuals involved in this case, the plaintiffs, they talked to me about the actual psychological impact that happened to them when they received the denials then these are components that are included in my knowledge.
Q Are you aware of, in those situations, how much the costs of care -- how much healthcare costs they incurred for those issues that they suffer depression, suicidal self-harm acts, things like that?
A I'm not aware of the actual amount.
MS. SCHMELZER: I think this might be a

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good point for lunch.
MR. DUPUIS: Okay.
(Lunch Recess)
Q (Ms. Schmelzer): Okay. I would like to now look at the portions of your expert report concerning the evaluations and opinions on the Plaintiffs, Alina Boyden and Shannon Andrews.
So it looks like you interviewed Alina for 2 1/2 hours. Is that correct?
A That's correct.
Q And is that consistent with the amount of time you would normally spend with a patient to formulate a diagnosis?
A Yes, that's correct.
Q Now, we talked earlier that you had spoken with Shannon's -- one of her therapists.
Did you do that with one of Alina's therapists?
A I did not. I didn't speak with one of Alina's therapists because it had been a longer time that she had been in mental health care.
So Shannon had been previously talking to Nyle up until recently.
Q So do you know if Alina is seeing a clinician at all for her issues concerning gender dysphoria?

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A When I asked her, she had indicated at the time in January that she wasn't seeing someone.
Q Do you know how long it had been since she had seen someone for any clinical issues she was having?
A Let me check. The last time she had talked about seeing somebody was around the time that she was in college was when she had talked about it.
So I'm just double checking in here, but she indicated that she had not had a very positive mental health experiences.
Q Do you have any knowledge of whether or not her insurance covered her counseling for gender dysphoria?
A So my understanding of the counseling that we had talked about when she was in college was that she was going to the counseling center there, and so insurance often is not required if you go to a counseling center for therapy.
Q What about now at the University of Madison. Is that what you're talking about?
A Are you talking about Alina?
Q Yes, Alina.
A No, I was talking about when she was at the University of California, Santa Barbara.
Q Do you know if her current insurance coverage covers

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counseling for gender dysphoria?
A I'm not aware of that.
Q I know you said that you interviewed her. Did you perform any other kinds of diagnostic tests on Alina?
A I did.
Q Which ones?
A So I had mentioned earlier that I usually perform some of the -- I give the instruments that are included in the DSM-V, and so I had given Alina several measures that included depression, some anxiety measures, PTSD measures that are all validated and included in that part of a typical evaluation.
And I usually give these, because in my clinical practice most of the people who are coming in for evaluations typically do have some indicators of some of these kinds of diagnoses because of stress related to their dysphoria.
Q And when you say you gave her these measures, how is it measured on these instruments that you gave her?
A So they are rated on a scale, so usually a depression measure would ask something like I'm having trouble sleeping, and then you would say not at all, a little, sometimes, most of time, all the

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time. And so they are rated on scales that ask those kind of questions.
Q And what would an end result be to one of those instruments, how would that read?
A So usually it is to supplement the clinical interview that I have done. So what has happened at that point is I would have gone through the entirety of a DSM-V interview and psychological review.
I will find out what criteria people meet and severity of what they meet, and these instruments are usually used to be able to quantify some of the diagnoses.
Q Would it be able to quantify, let's say, the amount someone is depressed?
I guess I'm trying to -- you know, would it give you a result significantly depressed, depressed, like on a sort of scale like that? Is that something these instruments do?
A Yes.
Q And what were the results of your assessment of Alina?
A So Alina did not meet criteria for any of the diagnoses other than gender dysphoria, and then anxiety disorder that was otherwise specified. She was experiencing panic attacks.

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Q When you said she did not meet criteria for any other conditions, what were the other ones that she was tested for?
A Depression, several different anxiety components, PTSD. Those were the primary ones because I was actually assessing her based on experiences that she had in the past.
So she had indicated severe levels of depression and anxiety and some components of PTSD in her past.
And so I usually -- I don't give all the measures point blank. I usually give measures that are based on information provided in the clinical interview just to be able to find out the sensitivity of the diagnoses, and this is typical for the clinical interviews that I do.
Q She did not meet criteria for a clinical diagnosis of depression or PTSD?
A At the moment we were meeting for the evaluation.
Q Did you say that she did meet criteria for an anxiety disorder?
A Yes.
Q And you diagnosed her with that?
A Yes.
Q And what was the basis for your determination that

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she had an anxiety disorder?
A So when Alina was talking about her anxiety it didn't fit any of the anxiety disorders that often come up.
So usually when people are meeting criteria for anxiety disorder, specifically when it comes to anxious experiences related to gender, there is usually some type of generalized anxiety or social anxiety disorder.
In this instance, Alina had described her anxiety as kind of coming out of the blue, if that makes any sense.
So she had -- she would be describing her dysphoria and she would be describing some of the experiences she was having, and she would say I'm doing okay in some of these areas. I'm not feeling depressed, but I am finding sometimes I'm having a hard time sleeping, or it's because I can't kind of stop thinking about things.
But it wasn't about anything in general. She just kind of described this buzzing anxiety that she would have.
So it didn't meet criteria for any of the other anxiety disorders. And because she was also describing experiences of panic attacks, that would

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be something that would come into play with that.
Q Did she attribute her anxiety to anything specific?
A Alina did not. My clinical opinion in how she described her anxiety and how she described it seemed like it was this low level -- I wouldn't even say low level because it was definitely a moderate level of anxiety, but this kind of underlying experience of anxiety that she was having all the time, if that makes any sense.
It wasn't cognitive, which is why we wouldn't put it in the generalized anxiety category, but she was constantly having some anxious symptoms.
Q Earlier we talked about the tasks that you were assigned for this case.
Were you ever asked to give an opinion on whether or not Alina suffered psychological harm as a result of being denied insurance coverage for surgery to treat gender dysphoria?
A I was not asked that as part of me writing the report. However, you know, as I do in any clinical evaluation, I was assessing for all components of mental health. That's what you're supposed to do.
And so when I was doing diagnostic interviews with Alina it was clear that she was experiencing distress. And when she described the distress to

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me, a lot of distress she described was specifically related to things like getting a denial letter or having to go to the doctor and having experiences she was having at the doctor and trying to advocate for herself.
And so when I was doing the interview with her pretty much the only experiences that she brought up that were related to any distress were directly related to not being able to access the care that she needed.
Q Let's look at page 27 of your report, Exhibit 2. On the very bottom, two sentences up, you say, "She is not currently experiencing a decrease in functioning related to academics, her social life, or occupational functioning; however, she notes that she is experiencing clinically significant distress related to how she was treated during specific medical appointments." Is that correct?
A That's correct.
Q And I guess before that you say she is experiencing clinically significant distress derived from dysphoria related to her genitals, also.
A That's correct.
Q So distress related to her genitals and distress related to how she was treated during specific

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medical appointments from 2014 to 2017, did she identify any other areas of distress that she was experiencing in her life?
A There were a couple of things that she indicated that were areas of stress. She was -- she's a graduate student and so she had indicated that she experiences some stress that's related to graduate school. It can be a very taxing time for many students.
So that was one thing she said caused some stress for her. And there was some health issues with her father that had happened the week before that we had met, and so we talked about that and that was something that had come up.
Q And I think you kind of generally stated before that she was distressed about not getting the care that she needed; correct?
A Uh-huh.
Q And did she talk more specifically about that with you?
A She did. I had asked her, you know, like what would happen if she's not able to get the care that she needs, and she told me that she could envision cutting her genitals off and -- you know, and either calling an ambulance or just like trying to figure

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out what to do from there with her body.
And to me, that indicates a pretty severe level of distress related to genitals.
Q When you say not getting the care that she needs what do you mean by that?
A Oh, I mean that she had indicated to me that she needs to have genital surgery to be able to decrease her gender dysphoria. So that's what I mean.
Q So, I guess what I'm wondering is, you've identified a couple of areas that cause her distress; from just having genitals, medical appointments grad school, health issues with her dad and not having coverage for genital surgery.
A Uh-huh.
Q Any other areas that she was experiencing distress in her life?
A Those are the primary ones that I recall.
Q So are you able to form an opinion as to how much of her distress was caused by not having insurance coverage for genital surgery alone?
A Yes.
Q And how much distress was she suffering, in your opinion, for not having insurance coverage for general surgery?
A If I were to put a number on it I would quantify it

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as about 90 percent.
Q So even substantially more than even having genitals she's suffering from not having coverage to remove them?
A Yes. She had told me that part of what contributes to that distress was going in and talking to doctors and the way that she had treated when she was having conversations with them. And the constant back and forth with the insurance company was distressing every time she was trying to contact the insurance company and writing letters to be able to get coverage that she needed.
So it was included in a whole host of what she was trying to do to be able to get medically-necessary care.
Q Can you describe for me what the basis for her distress is with how medical providers were treating her? What do you mean by that?
A So we had explained to me that when she would go in to say, oh, you know, I think this might be something that I need, sometimes doctors would say things to her like, oh, this isn't something that you're going to get, or you're going to pay out of pocket. Or the kind of conversations she had with them were often related to does she have access to

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this specific kind of care.
Q Were any of those interactions causing distress because of the manner she was treated by these medical professionals versus just not being able to get coverage for them?
A There were a few interactions that she described to me that were distressing because of the interaction that she had with medical providers.
Q What is the timeframe that you attribute to her having this distress caused by not being able to have coverage for genital surgery?
A So I had written on here 2014 to 2017 because that was the timeframe that she had given me in terms of seeking out the care.
So I would give that timeframe based on what she had shared with me.
Q Was she able to have surgery in 2014? Was she qualified for surgery in 2014 to your knowledge?
A By what qualifications --
Q Did she have letters of recommendation for surgery in 2014?
A So she had a medical letter that was written in 2016, so I'm not aware of letters that were written prior to that time.
Q So would she have been able to have surgery prior to

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having a letter of recommendation in -- was it May 19th of 2016 from Dr. Webster?
A So, I didn't meet Alina before then, but what I'll say is that my understanding is that she was diagnosed at a much younger age. I think Dr. Cook was somebody who she was working with when she was in college. And at that time, according to her, she had been diagnosed with gender dysphoria and she had exhibited a lot of the symptoms she described to me.
My guess would be that at that time if she had brought all these things to a medical doctor and talked about them that she would have qualified at that time.
Q Do you have any basis for that -- I guess you said "my guess would be." Do you have any basis for that?
A I don't have any of that information in front of me.
Q But as you sit here today she would not have gotten surgery prior to getting a letter of recommendation on May 19th, 2016; correct?
A So Alina had told me that one of the reasons why she hadn't sought surgery before this time was for financial reasons, and so this is why I think it's a little hard to quantify some of these pieces or get some of the piece related to timeline, because for

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her, she didn't feel she had access to the surgery because of the financial barrier. So we may not have information related to that during that time.
Q What did she tell you about her, I guess, inability to pay for -- how did you come to that conclusion she wasn't able to pay for the surgery on her own?
A She had disclosed that information to me.
Q Anything more than she can't afford to pay for the surgery on her own, did she disclose anything about her financial information?
A I had not assessed that further. But in my experience I have worked with a lot of patients who come in and share similar pieces of information, and for the most part, you know, it's just the truth that these surgeries are cost-prohibitive for most people. They are very expensive surgeries. And we also know that transgender individuals tend to be of a lower socioeconomic status than most under-representative minority groups.
Q If she had had the money to pay for surgery on her own and didn't, would that change your opinion about the level of distress she was suffering as a result of not having surgery -- done the surgery?
MR. DUPUIS: Objection as to form and foundation.

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THE WITNESS: Can you say the question again?
Q (Ms. Schmelzer): Sure. If she had had access to funds that you didn't know about but didn't use those funds to pay for genital surgery, would that change your opinion that she was suffering psychological harm from not having insurance coverage for the surgery?
A No. No, it wouldn't change. Because I think the way that she describes how she was treated from the insurance company and from the whole process of being denied the access of care, it wouldn't change my opinion on that.
And part of this is that even if somebody is qualified and ready for a surgery, you know, like there may be several different circumstances for several different people for why it is that things may be delayed for them. And in this case, the information was clear that Alina was experiencing distress that was directly related to the denial of coverage.
Q You said that you had done different measures to measure things like depression, anxiety and PTSD.
Did you do any measures to assess her level of distress?

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A So all of those would be included in the ways that we would think about distress in general, so we would use those measures to talk about symptoms that are related to distress.
But also when I conducted an evaluation for gender dysphoria, that Criterion B, that's where we really -- when we do these evaluations we're really specific in talking about what kind of stress it is and how severe it is and describe that in detail.
Q So from that criteria that you were discussing, did you separate the stress for different areas that we identified earlier to just having genitals, medical appointments, graduate school, health issues with dad, and not being able to have coverage for surgery, did you separate that in measuring her distress?
A Uh-huh. From the clinical interview I did ask follow-up questions about how much stress she was experiencing or how she was being impacted by each of those components.
Q And in the instruments that you were using did they quantify that for the separate areas of distress?
A No.
Q So the 90 percent figure that you came up with attributable to lacking insurance coverage for

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genital surgery, that's based on what?
A That's based on my clinical opinion from the amount of information that I have. It's definitely -- most of that is based on what we actually talked about in the clinical interview, and when I asked open-ended questions how often Alina would respond to the questions and the distress-related components. So that's how I would quantify based on what we talked about.
Q And that was the information provided as far as her level of distress regarding lacking insurance coverage that was self-reported by Alina; correct?
A That's correct.
Q Were there any outside sources besides -- any other sources that you relied on in assessing the distress related to not having insurance coverage for surgery?
A No. Not for Alina, no. And that's pretty typical. You know, like I said, there are different reasons why I will ask for different opinions on things, but when I do these evaluations, unless there is something that I really feel like I need to follow up on or if somebody has a treatment provider that they have seen really recently and they are an adult, then these evaluations typically don't

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require getting outside opinions.
Q Were you surprised that she wasn't getting any counseling for gender dysphoria issues that she was having given the level of distress you assessed her as having?
A I wasn't surprised. I wasn't surprised because she has indicated that she has had pretty negative experiences with mental health providers. And that's typical when people come in and talk to me through evaluations or if they come in and see me as a therapist, most of the clients who I see say they have had terrible experiences with therapists and with the mental health system. So, to me, it's unsurprising because it's a lack of access to supportive care.
Q Are there supportive groups at the UW Madison for transgendered individuals?
A There is a group that is run that actually just started last semester. So I think it would have actually started after Alina and I would have met.
Q Were there any other resources available for transgendered individuals looking for support at UW Madison before that group started last semester?
A There is a therapist who is at the University Health Services who specializes in transgender-related

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care.
Q Do you know if Alina ever sought services from that therapist or any other counseling service at UW Madison?
A I do not, no.
Q The therapist that you're talking about that specializes in transgender care, does that therapist -- is there a charge to see a therapist for graduate students like Alina?
A No, there are not. I think the graduate students, many of the students who I've worked with often feel like it's prohibitive to see the -- Shannon is the name of the therapist who is at UHS -- to see Shannon, because they all know each other.
And I don't know what Alina's relationship is to this therapist. I don't know if they know each other. But in my experience, especially with graduate students, the community is very small, and so often that you're doing your work you know each other and there are boundary-related concerns in coming to seek services.
So some of it is just that it's sometimes hard to find a therapist who knows a lot about trans-related issues, but also it's a pretty small community.

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Q Do you think that her level of distress attributed to not having insurance coverage for genital surgery could have diminished had she seen counseling -- regular counseling sessions?
A So, in my experience, you know, we were studying this as part of clinical trial is like what can you do when people are experiencing external stressors, there is something with therapy we can do to be able to decrease some of the components related to external stress that's happening.
So what I will say in short is that therapy can help people come up with coping mechanisms that will assist them with their day-to-day functioning, which is what Alina was doing in general. She was doing her best at being as resilient as possible to be able to manage these stressors.
So you can come up with coping mechanisms but there is nothing a therapist can do if there are external pieces that are demanding stress upon a person.
If you have internal, more biological factors you can do to actually change the situation, then therapy can sometimes help those pieces.
In this instance, I would say the main thing it could have helped her with is maybe having some more

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coping mechanisms in a system of support.
Q Are you aware whether or not Alina had engaged in any acts of self-harm as a result of not having insurance coverage for general surgery?
I know you said she talked about it might come to that but are you aware or not she actually did?
A I would have to look over my notes, and my recollection is she had indicated that's something she had considered doing but not that she was currently engaging in self-harm.
Q Okay. Why don't we talk about Shannon now. So you had a three-hour interview with Shannon; correct?
A That's correct.
Q And I think you said 2 1/2 hours was pretty standard for a interview to diagnose someone with gender dysphoria. Is three hours, I imagine, also consistent with that?
A That's correct. I would say they average between 2 1/2 to three hours. I always schedule three hours.
Q And did you do any diagnostic testing on Shannon?
A I did.
Q Tell me what you did.
A I completed similar testing that I've described in the past, the measures from the DSM-V that have been

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validated with specific disorders like symptoms of depression, anxiety measures, PTSD and so on.
Q And when were your results?
A The results indicated that Shannon met criteria for social anxiety disorder, also with panic attacks.
Q And I'm sorry to do this but I'm going to go back to Alina for a second.
You said that she also had panic attacks associated with her anxiety disorder; correct?
A That's correct.
Q Do you know if there were any triggers to her panic attacks for Alina?
A She had indicated to me that they came out of the blue is what she had used in the way that she had described them.
Q Did you attribute any panic attacks to her not having insurance coverage for gender surgery?
A In my clinical opinion, even though Alina did not describe the two being connected to one another, the way that she described her anxiety I would connect her level of anxiety as being related to having those panic attacks. She was basically suppressing her anxiety pretty much on a daily basis.
So panic attacks often are ways that our body releases anxiety, so it's my opinion that they are

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connected. Alina did not connect them in the interview.
Q Did you attribute a cause for her anxiety disorder for Alina?
A Yes, the anxiety disorder was directly related to the distress she was experiencing from trying to deal with getting access to healthcare that she wasn't able to get.
Q So if Alina would eventually be able to get genital surgery you would expect the anxiety disorder to go away?
A I would.
Q And what's the basis for attributing the anxiety disorder for Alina to lacking insurance coverage?
A She had reported that information to me. And it wasn't just, you know, I feel anxious because these things that had happened; she would describe in detail the experiences she had had related to the appeals process and what it's like to expose yourself and expose the kind of things that are happening to you and not be believed. She would talk about all these instances for her in the process, and she would describe the anxiety she would feel. So it's a pretty clear connection.
Q And you didn't attribute -- or did you attribute the

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anxiety disorder to any other stress or anxiety she was experiencing in her life besides lacking insurance coverage for genital surgery?
A I did not. And the other things she was describing, she didn't describe anything related to them that would reach a level of clinical significance.
Q Okay. Sorry to switch plaintiffs there, but back to Shannon.
You said you diagnosed her with a social anxiety disorder with panic attacks; correct?
A That's correct.
Q Did you diagnose her with anything else?
A With gender dysphoria. And that was true for both of them.
Q And what's the basis for diagnosing her with social anxiety disorder with panic attacks?
A So Shannon had met the criteria for social anxiety disorder in the clinical interview. She also met the criteria in the measure that I gave her.
And this was very clear when she was talking about her social anxiety and how she would, you know, see the way that her face was and the way that she would talk about her, what she described as being this knob on her throat. She didn't want to call it an Adam's apple.

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So she would describe these pieces of how she wouldn't feel comfortable talking to people or having conversations with people because she felt like they were seeing her as being a man.
And so in that event, she was pretty much completely socially isolated and she didn't want to do things that were socially related.
So there are several different criteria that go into social anxiety disorder, but a lot of that is fear of being rejected or fear of being humiliated is the primary component of that, and that was apparent with Shannon.
Q You say that she did not meet criteria for other things. Would that be anxiety, depression or PTSD?
A Social anxiety disorder is an anxiety disorder.
Q That's right. I'm sorry. So did she meet criteria for depression?
A She did not at that moment. She had previous bouts of depression and would have been diagnosed with a gender disorder prior to the time that we had met.
Q Did she meet criteria for PTSD?
A She did not at time of the event.
Q So you said that she experiences anxiety because of the way her face looks?
A Uh-huh.

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Q Do you have an opinion on whether or not Shannon suffers psychological harm as a result of being denied insurance coverage for surgical procedures?
A Yes. So Shannon had specifically talked about the difficulty of the process that she had gone through.
I mean, to the event that she was, you know, covering her own surgeries and paying for them out of pocket. And so that process of even going about trying to pay for these surgeries was, you know, very distressing for her. And then also the financial component after that was distressing.
But, like I said, even going through that process, Shannon had described in detail. She's very specific and detailed in how she describes things.
She talked about how -- the specific process that she had to go through to try to receive gender-confirming surgery was extremely distressing to her. I have some of that information in here.
I think I mentioned, you know, she -- if she hadn't been able to access surgery she would have killed herself. There is no question.
And when I talked to her therapist, Nyle, he confirmed that. And this is also -- you know, this fits a lot of the experiences that I have had with

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the other patients who I've worked with where they have described instances of saying, you know, it's extremely distressing and anxiety-provoking to not be able to access the medical care that they need, and going through the hoops in trying to talk to multiple people about parts of your body can be very difficult.
Q So you talked about her having anxiety about just her facial features.
A Uh-huh.
Q Did that cause her distress, too? I don't want to interchange the terms of distress and anxiety.
A I would say -- I will use both of those. So I will say it does cause anxiety and as a result that is distressing.
Q And then you also said that she suffers from anxiety that is distressing because of not having insurance coverage for the surgical procedures.
Is there any other areas of distress that Shannon described to you in your interview?
A There were a couple of areas of stress. She had indicated that there was some relational stress with her partner. So that was something she had indicated was stressful at the time.
But if my memory serves, that was the main

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thing when she talked about anything else going on in her life.
Q Did you form any opinions as to how much of her distress was caused by lacking insurance coverage for surgical procedures versus the facial features that she had and relational problems she was having with her partner?
A Yes.
Q And what is your opinion on that?
A Would you like me to quantify in the same way?
Q Yes.
A I would say that Shannon actually had -- the relational distress was pretty minimal for her. I would put it around 95 percent, not more.
Q 95 percent of her distress was caused by not having insurance coverage for surgical procedures?
A And the result of what that is after that, so that because she wasn't allowed to have the insurance coverage and therefore have the surgery then she was experiencing social anxiety.
Q And for what timeframe can you give where she was suffering -- 95 percent of her distress was because of not having insurance coverage and the facial features that she was continuing to have?
A Well, let's see. So when she was first trying to

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receive medical care related to her gender dysphoria was when she really started to describe these pieces because she wasn't able to get hormones from here. She had to go to Chicago.
So I think according to my notes here it looks like she began hormone therapy in 2012, and then she also -- she started to funding gender confirmation surgery in 2015.
So she started -- in the way that she described it not being able to access the medically-necessary care that she needed caused distress probably as early as 2012, but that the distress she would experience was kind of isolated in these different instances when she had tried to access care and then she couldn't, and then she would access that care and feel a little bit better but then she couldn't access more of the care that she needed.
So the stress would kind of change and develop over time.
Q So she got letters of recommendation for surgery in June and July of 2015; correct?
A That's what I have on my notes.
Q And then she had reassignment surgery in 2015 as well; correct?
A That's what I have in my notes.

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Q Do you know what kind of surgery she had?
A My understanding is that she had genital surgery at that time.
Q Do you know if at that time she was suffering distress because of her facial features as well?
A I am not sure about that particular time. When I evaluated Shannon in January I was primarily assessing for, you know, the current experience of gender dysphoria even though I do have some previous information about it. I don't know that I have that information.
Q And I think I saw in your report that she had planned facial surgery for earlier this year. Is that correct?
A That's correct.
Q Do you know if she ever had that surgery?
A I personally don't. I haven't spoken with her since the evaluation.
Q And do you know when you interviewed her if that was something that was going to occur or was it still contingent on money or recommendations?
A No, she had indicated that it was -- that she had it planned when we had met.
Q If that surgery did occur in February 2018 that was anticipated in your report, do you have any opinion

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as to whether or not distress related to her facial features and lacking insurance coverage for those continued after having surgery?
A I don't know that I can make an opinion on Shannon, but in my clinical experience that when people actually have the surgery -- and the research also says this -- that people do tend to have a much better quality of life, that their stress is reduced.
So I would say at least related to dysphoria I think you can expect in general that people will feel better. But also from my clinical experience when I've met with clients who have been through similar procedures, they may still experience some stress because they had to pay out of pocket, but usually the dysphoria will decrease.
Q Do you have any indication from when you interviewed Shannon in your meeting with her whether the financial cost of the facial surgery was causing her distress?
A From my recollection, we had talked about the finances and it did sound like it was causing some distress to her.
Q Do you know how she was going to pay for it?
A I don't know.

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Q So, I think I'd ask for a timeframe of when you thought she was suffering -- when 95 percent of her distress was attributable to lacking insurance coverage for surgery.
I know you said you thought maybe as early as 2012. Is that what you said?
A I think this is where it starts to get a little -- so the question you had asked was from the moment -- the way I interpreted this is that when I was evaluating her I was asking her about her current level of distress. So the 95 percent was related to her current level of distress.
In general, I think I can say from 2012 she was experiencing dysphoria and distress because of her gender dysphoria and she needed to access hormones and surgeries.
So if I were to clarify that, I would say the 95 percent was attributable to that current time that I had been assessing.
Q So an individual's distress can change throughout various times through their life. Is that fair to say?
A That's fair. As human beings our emotionality and levels of distress can change over time.
Q And what is causing an individual distress can

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change over time as well. Isn't that correct?
A That's true for every human being, yes. But I would say in this instance you wouldn't just expect that a stress to just magically change if the medical situation doesn't change.
Q In your opinion, did either Alina or Shannon suffer any distress about being denied coverage for hormone therapies?
A When I had met the both of them they had both been using hormones for a period of time.
So when I was doing the clinical evaluation, I had a history related to those things but I was primarily looking at current levels of distress.
So it's hard for me to actually tell you about what that would have looked like, because the primary thing I was evaluating was current level of distress and they were both on hormones for some time.
Q Did they have distress about not having coverage in the future for hormone therapy?
A No, that was not something that had come up in the interviews.
Q So, Shannon had, you said, genital surgery in 2015 and still continued to be clinically significantly distressed. Is that fair to say?

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A That is fair to say. I would say, though, that she had described having a change in her dysphoria after having genital surgery such that she was feeling quite a bit better related to her genital dysphoria and felt really, really satisfied with that surgery and felt like that was something that was extremely beneficial to her.

So when I was assessing for her gender dysphoria and we were talking about it in the clinical interview, she had indicated that she no longer has that genital dysphoria. Her dysphoria was mainly focused to the masculinization of her face.

Q So do you think genital surgery was effective at treating Shannon's gender dysphoria if she was still clinically significantly distressed after it?

A I think it was effective at reducing the gender dysphoria that she experienced related to her genitals.

Q Do you think facial surgery will be effective at treating Shannon's gender dysphoria?

A In my opinion, I expect that it will be very helpful for her in reducing her gender dysphoria.

Q Do you think she will still be clinically significantly distressed after facial surgery?

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A It's hard to say. In my clinical experience with other patients who I've worked with and the research I would expect that would be the case.

Q That she would still be clinically --

A No, no, that she would experience improvement. That she would no longer experience gender dysphoria as a diagnosis.

Q And I'm sorry to go back to the timeline again.

A That's okay.

Q But you said it's hard to, I guess, set a timeframe for when insurance coverage or lack of insurance coverage for surgeries for Shannon caused her significant distress.

I know we talked about 2012 and 2015 when she had surgery. I guess I'm trying to put it into perspective.

If you were asked what period of time did Shannon experience distress because of not having insurance coverage for surgeries to treat her gender dysphoria what would you say?

A I would say that she experienced distress at all three of these time points that we discussed: When she had needed to have hormones, when she needed to have genital surgery and the facial feminization surgery.

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Q And for how long did she suffer this distress attributable to lack of insurance coverage?

A So she had indicated related to the hormones -- I have this on page 31 of the report.

She indicated that she was beginning hormone therapy and that she felt a little bit better at that time but that she was actually experiencing, you know, pretty significant gender dysphoria at that time because she had not had any of the surgical procedures. And so that caused quite a change in her functioning related to her workplace environment and those pieces.

But she did say after having been on hormones and coming out to most people in her life, 2014 felt like the year where she could really start to be herself and that's when she really started seeking out the gender-confirming surgery.

So that's how the timeline worked for that. So there were pieces of her that she would start to feel a little bit better or motivated because some of her dysphoria decreased.

But diagnosis of gender dysphoria never went away because she was never able to fully have the gender-confirming surgeries that she needed up until the time that I met her.

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Q Besides your interview with Shannon, what other resources did you have to support your opinion that her distress was caused by denial of insurance coverage for surgery?

A I talked to her therapist, Nyle Biondi, and I had asked him questions related to how long he had been working with her and what his experience was related to her distress.

And he had indicated to me that her being denied access to these medically-necessary treatments had increased her distress. He had said that she was one of the people who he had worked with who he worried about the most in terms of completing suicide at the time of -- you know, not being able to get the surgeries that she had needed.

Q Do you know if during this time period -- I think you said it started after hormones in 2012 up until even her facial surgery, do you know if she ever engaged in any acts of self-harm?

A I do not recall.

Q Did Mr. Biondi indicate to you whether or not she engaged in any acts of self-harm during that time?

A I do not recall that.

Q Anything else besides your interview with Shannon and talking with Mr. Biondi to support your opinion

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regarding the distress caused to Shannon because of denial of insurance coverage?
A The only other document that I would also indicate was the letter from Susanne Gill that I had seen. That's on page 32 of Exhibit 2.
And I used this document also just to learn more about the previous diagnosis of gender dysphoria. So I used that also to inform my opinion.
Q Did that document indicate any type of level of distress that Shannon was attributing to lack of insurance coverage for surgery?
A I would need to read the document again to see in detail what it says.
Q Is it possible that surgery will not alleviate Alina's distress?
MR. DUPUIS: Alina's. You mean Ms. Boyden's distress?
MS. SCHMELZER: Yes.
MR. DUPUIS: Just checking.
THE WITNESS: According to the research, it is unlikely that it would not alleviate her distress. Most people experience positive outcomes related to gender dysphoria and the reduction of that after they have had

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surgery.
(Exhibit No. 10 marked for identification)
Q (Ms. Schmelzer): I'm going show you what's been marked as Exhibit 10. I believe this is a publication that was cited in one of your bibliographies; correct?
A That's correct.
Q And I'm going to have you turn to page 123 in the corner there. It has page numbers.
A Uh-huh.
Q I'm looking at the last column, midway through the paragraph where it starts, "Furthermore, sleeping problems became significantly higher after SRS" -- which would be sex reassignment surgery I'm guessing -- "compared with a general population. After SRS, trans people probably experience more distress as they are again confronted with stigma and other burdens."
Did I read that correctly?
A That seems correct the way you read. But I would say, even if you read that correctly that there are a few people who talk about and contextualize this information.
So there are a couple of studies that have been

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done recently that look at people who have had hormones only, hormones and surgery, and then surgery alone, and that a lot of those studies indicate that individuals who have had both hormones and surgery tend to have much better outcomes.
So, part of this is how you contextualize who has had surgery, what kind of surgery. Because SRS can be a whole bunch of different things: Is it just breast augmentation, is it genital surgery too, is it facial feminization surgery, breast augmentation and genital surgery.
So a part of this is that we would kind of see this potentially for Shannon, for example, who, after she had genital surgery still had some distress, but that was because her medical necessity for the treatments weren't complete.
So I would contextualize this finding and what other research has shown and also what we have seen here.
Q But it's possible that Alina may still suffer distress after surgery; correct?
A I would still say that it's pretty unlikely for Alina. I think the reason why I say that is that the majority of her distress and her dysphoria is focused on her genitals.

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For some people we see their dysphoria is related to a lot of different things, and this happens a lot in my clinical experience. They have a lot of rejection in their lives, they have had a lot of other pieces. They don't necessarily pass very well, for example -- I'm using air quotes -- related to that concept.
But with Alina, she indicates that she -- people read her as being female, so she -- people will experience her as female and that's how she sees herself. So she doesn't experience any dysphoria related to those pieces. Her dysphoria is related primarily on her genitals and I would expect that she would have very successful outcome related to surgery.
Q I'm going to go down to the next sentence after that. So reading that next paragraph:
"While Mate-Kole, et al., suggested the most important factor to be SRS, we found that the biggest decrease in psychological dysfunctioning is caused by initiation of hormone therapy or confirmation of the diagnosis by a professional caregiver."
Did I read that correctly?
A That's how I see it on here as well.

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Q So is it possible that the biggest decrease in the distress that Alina feels could have come after initiation of hormone therapy?
A I would say in this instance that, personally in my opinion, I did not think that is the case in the level of distress that she has.
And she would show up here as having a lot of distress if she were to be in the sample, because that's what she was experiencing, or at least was experiencing when I met with her in January.
So for Alina specifically, she would show a decrease in psychological functioning after hormones because she is in need of having genital surgery.
Q Am I correct, though, that in this study they found the biggest decrease was after initiation of hormones versus surgery; correct?
A That's something that they are indicating here.
Q Okay. I want to look now back to your supplemental report, Exhibit 4. We're going to talk about some of these studies again.
A Okay.
Q On page 6, one of the studies that you said supports the effectiveness of surgery to gender dysphoria is the Garcia study; correct?
A That's correct.

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Q I want to have you look at the same time, Exhibit 3, which was the Mayer supplemental report.
And on the -- I should number these pages.
MR. DUPUIS: There are page numbers in the upper right, so you could use that.
Q (Ms. Schmelzer): Oh, yeah. On the upper right there, what's indicated as page 5. Do you see that on the right-hand corner?
A Yes.
Q Paragraph 11, Dr. Mayer talks about the Garcia article. I'm going to just read that here.
"The document by Garcia is not a scientific study, it is an abstract and contains no details, data, or analysis. It is a measurement validation exercise. It provides no evidence for or against medical or surgical intervention as a treatment for gender dysphoria."
Did I read that correctly?
A Yes.
Q Do you agree with that statement?
A No, I don't. So this was actually a study that was presented at a scientific conference, so it is a scientific study.
And what was included that Mayer is talking about was the abstract from the scientific study.

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And it wasn't simply a measurement validation exercise. They also found that individuals who had taken their gender dysphoria measure reported a decrease in some mental health measures; so depression anxiety and so on. So it wasn't simply a validation study.
Q Dr. Mayer goes on to quote part of that study where he says, "To date, no inventory that measures/quantifies the degree of gender dysphoria a patient associates with his or her body has been described. Furthermore, no inventory for gender dysphoria allows for pre- and postsurgery assessment of gender dysphoria, to allow measurement of the effect of specific gender affirming surgeries to reduce gender dysphoria for transgender patients."
Did I read that quote correctly?
A Yes.
Q Do you have any reason to doubt whether or not that quote is actually in the Garcia publication?
A No.
Q Do you know whether or not it is in there?
A I have seen that quote in the Garcia and Karasic study.
Q So tell me why this quote doesn't affect your opinion that it's a reliable study to show the

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effectiveness of surgery for gender dysphoria?
A Say that again.
Q Yeah. This quote talks about limitations, correct, in the study?
A That's correct.
MR. DUPUIS: Objection to the extent that it is describing that up until this time there was no inventory. That's what they're proposing, that they got inventory.
MS. SCHMELZER: Got it.
Q (Ms. Schmelzer): So is it your understanding that in the quote the author is saying that their study is different than what they're describing in here?
A That's correct.
Q Okay. And then paragraph 12 below that he talks about the Glynn publication; correct?
A That's correct.
Q And he states, "The document by Glynn is a study which uses a community-based design, one of the weakest statistical designs, to examine psychological well-being of transgender sex workers."
Is that correct?
A I would say that part of that sentence is correct.
Q Which part is correct and which part of incorrect?

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A That the Glynn study used a community-based design to examine well-being of transgender sex workers.
Q A community-based design, you do not agree is one of the weakest statistical designs?
A I do not agree that is one of the weakest statistical designs.
Q Why not?
A I can think of 1,000 weak statistical designs, you know, using one person to correlate with another person, using one item on one person, a single-based case study.
There are a lot of designs that would be considered useful but potentially weak. For this particular study, I wouldn't call that design to be weak.
Q In paragraph 13 he talks about the Fisher publication.
"The document by Fisher is not a scientific study. It is another abstract." Is that correct?
A That's not correct.
Q And why is it not correct?
A It's a published manuscript.
Q And, again, Dr. Mayer quotes part of that publication underneath that:
"To date, no study investigating the effects

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of cross-hormonal treatment (CHT) alone without the use of genital reassignment surgery (GRS) on gender dysphoria (GD) is available."
Did I quote that correctly?
A What you read here is correct. I don't have the other document in front of me.
Q Okay. Was Fisher a study investigating the effects of cross-hormonal treatment alone without gender reassignment surgery?
A Let me look and see. Because I describe it in this report on page 7 on Exhibit 4.
So they compared a cross-hormone therapy group to a non cross-hormone therapy group in individuals diagnosed with gender dysphoria. And the analysis indicated that gender dysphoria showed a statistically significant decrease over four time points for those engaging in hormone therapy. So that's the --
Q So you don't know if it involved hormone therapy alone without surgery?
A I would need to look at the actual article.
Q And then on the next page he talks about the van de Grift publication, paragraph 14:
"The document by van de Grift is a study which measures the effect of satisfaction with surgery on

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quality of life -- not the effect of surgery on the incidence or severity of gender dysphoria."
Do you agree with that statement?
A That's incorrect.
Q What incorrect about that statement?
A They used a validated gender dysphoria measure as one of the outcomes for that study.
Q Do you know what gender dysphoria measure they used?
A It's called the gender identity/gender dysphoria scale in adults and adolescents.
Q He goes on to say, "Quality of life is a secondary outcome for the evaluation of gender dysphoria."
Would you agree with that?
A I would agree that quality of life is an outcome that was determined in the study.
Q And then the next sentence, he says, "This paper does employ a variable as a measure for variability in gender dysphoria measured against surgical satisfaction; however, the author finds no statistical significance when doing this analysis."
Do you agree with that assessment of the van de Grift study?
A No. So in the van de Grift study they had looked at several components. So they had looked at people who there were only eight people in the study who

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were dissatisfied with the surgery and then they compared that with the larger group of people who were satisfied, which is a much larger group.
So there was no statistical difference between -- or reduction in gender dysphoria between those particular groups. But in terms of the numbers, I think that the -- if I'm remembering correctly, it was like the mean was 15 or something for the satisfied group. And in general when you look at the means for the population of people who haven't had surgery they're in the 50s.
Q Okay. I want to look at a couple of the publications either in your CV or cited in your bibliographies.
A Okay.
(Exhibit Nos. 11 through 16 marked for identification)
Q (Ms. Schmelzer): I'm going to hand you what's been marked as Exhibit 11.
A All right.
Q Do you recognize this exhibit?
A I do.
Q And is this a publication that was cited by you in one of your expert reports filed in this case?
A It is.

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Q I guess I want to look first at the very first page of the article. And the date of this is 2017; correct?
A It should be 2018.
Q Okay. 2018.
A That was when it was submitted. It's on the very top. It will say 2018.
Q Got it. I was looking at that little date under there. Okay. 2018.
Look at the second column there on the first page. The end of the Results paragraph where it says, "Nevertheless, standardized and validated SRS-specific questionnaires are lacking."
That means sex reassignment surgery; correct?
A That's correct.
Q "Standardized and validated SRS-specific questionnaires are lacking." Is that correct?
A That is what it says, yes.
Q Does that affect the outcome of studies that are looking at the effectiveness of surgery for treatment for gender dysphoria, the fact that there aren't standardized and validated surgery-specific questionnaires?
A So, in my opinion, I don't think that that invalidates any of the studies that have been done

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to date. For the most part when we do medical and psychological outcome research, a lot of the times we will be looking at outcomes that may not be as specific to the actual treatment.
So, for example, in psychotherapy, if you get dialectical behavioral therapy you won't be asked about the dialectical behavior therapy, you would be asked about what your symptoms are as you're done. So "do you have less depression," for example. It won't say, "Due to the DBT, do you experience less depression." Same thing as what happens here.
So you can still make conclusions related to the effectiveness of the treatments and they are still valid and it's considered how we are conducting the science as it is right now.
Q Does the fact that there aren't standardized and validated specific questionnaires for SRS, does that fact, I guess, affect where this study would be placed on the hierarchy of evidence that we talked about earlier?
A No. In terms of hierarchy of evidence, my understanding is that it is primarily focused on the actual way that the study is designed in terms of how it's planted or the experimental treatments and those types of things.

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And the hope is that you can have measures that are specified as possible, but also you have a -- you know, a standard that's related to how we look at the outcomes. And the outcomes aren't necessarily required to be so specific to the specific kind of treatment.
There could be some measures that might be improved by having the SRS-specific components included in them.
Q Can you turn to page 186, looks like -- yeah, of this article.
A Yes.
Q Under the "Conclusion" heading. Look at the second paragraph under "Conclusion," it says:
"Overall, it remains a challenge to evaluate surgical patient-reported outcomes purely based on short question sets. The broad variety of study designs, surgical approaches, methodological processes, and choices for questionnaires limits the reproducibility between different study groups. Creating validated SRS-specific standardized questionnaires is a goal for the near future to guarantee high-quality evidence in transgender research?"
Did I read that correctly?

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A Yes.
Q Do you agree with that conclusion?
A I agree that we should always be aiming to improve science. So in terms of finding more specific measures that we could continue to validate, and these studies I think seem like a great way for research to go.
However, it doesn't seem to me that -- you know, that this invalidates any of the research that has been done to date, and a lot of research has been very specific and has been evaluated in a very rigorous way.
Q The research on the effectiveness of surgery for gender dysphoria, do any of those studies rely on something different than short question sets?
A Yes. So several of the studies that we've talked about today have included validated measures for gender dysphoria which are not the short one-item pieces that perhaps they might be critiquing here.
So there have been, you know, pretty vast improvements over the last 20 years in terms of how we're measuring these outcomes.
But I would also say in my clinical experience, my clinical experience with all the patients who I've worked with who have been able to engage in

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these surgeries, it has been life changing for them.
So even if there are these little methodological pieces that are included in terms of how we can improve some of the research, you can't deny what the clinical outcomes are from to specifically what it's been like for me to work with in my patient population.
Q Of this patient population that you have worked with that have had surgery, do any of them no longer have gender dysphoria?
A Yes.
Q Approximately -- give me a percentage of how many no longer have gender dysphoria after surgery.
A So this is assuming -- I think part of it is you would have to take into account a patient who is able to have the medically-necessary care they need for themselves.
So for the people who have been able to say this is the kind of medical care that I need to be able to reduce gender dysphoria, if they are able to have those procedures, in my clinical experience, evidence that a reduction in gender dysphoria to the point where they wouldn't meet criteria anymore at all.
Q So everyone who has had that reduction in your

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experience?
A In my personal clinical population who I've worked with. But I'm saying that's for people who have had all the medically-necessary care that they have needed.
There are some people, of course, who maybe have one procedure and they need another and so they wouldn't have a complete decrease in gender dysphoria in that instance.
Q All right. I'm going to show you what's been marked as Exhibit 12, which you should recognize.
A Yes.
Q So this is one of your journal publications. Is that correct?
A That's correct.
Q And was this published in 2016. Am I correct with that?
A That's correct.
Q And then I'll have you look at page 963 of the document. Right at the first sentence on the top under (b) you note:
"There are methodological challenges in conducting research with trans populations."
You wrote that. What did you mean by that?
A So, what we mean by that is that there are pieces

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that are included in terms of, you know, how representative some of the literature is, are people including enough trans people of color in their samples, who is conducting research. You know, they are general critiques of the methodology of some of the literature.
Q So, some of these challenges in the literature that looks at the effectiveness of surgery for treating gender dysphoria?
A We were primarily talking about the overall research. So in the article that we cite here, the Tebbe & Budge, 2016, we discuss ways that researchers can, you know, basically conduct research in a sound and ethical way with the trans community.
So we provide a lot of recommendations that are related to that.
Q Do you believe there are methodological challenges in conducting research concerning the effectiveness of surgery for gender dysphoria?
A I think there are methodological challenges in every single research design. However, I think that for the majority of the research that we've talked about today, I think it's very sound and has been conducted in a really rigorous way.

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So there are going to be methodological challenges in any scientific study.
Q Later on in that page, the last paragraph starts:
"The relatively small number of publications found across these content analyses suggests the need for more scholarship about trans people and issues."
Is this one of the general statements you talked about above?
A Yes.
Q And do you think that there is a relatively small number of publications focused on the effectiveness of surgery for treating gender dysphoria?
A Relative to what?
Q Relative to the science supporting other forms of treatment for other kinds of medical disorders?
A Let's see, I'm not sure I still --
Q Sure. Relative to -- let me rephrase that.
Do you think that there is a relatively small number of publications found addressing the effectiveness of treatment -- of surgical treatment for gender dysphoria in the realm of scientific evidence used to support treatments for individuals?
A Actually, I think that out of all of the studies that have been done related to transgender people

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probably the most amount of research that has been done focuses on medical care and access to those kinds of treatments.

We talk more specifically in this content analysis about some of the areas in which there are -- you know, there hasn't been a lot of attention paid to certain pieces.

But I would say that relative to some of the other things that have been published about trans people there is a lot of research focusing on hormones in gender confirmation surgery.

Q Let's look at Exhibit 13: "Mental health and gender dysphoria: A review of the literature."

This publication is cited in one of your bibliographies?

A I believe it is.

Q I'm going to look at the abstract there, the second sentence, "Research has also provided conflicting psychiatric outcomes following gender-confirming medical interventions."

Did I read that correctly?

A Yes.

Q Do you agree with that statement?

A I agree that there have been some studies that have found differing findings related to

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gender-confirming interventions, and in my experience, that the more recent studies actually have less variability in their findings, because we have learned a lot more how to conduct research with trans people.

Q By more recent studies do you mean after publication of this article in 2016?

A No, but the statement that they make is research is providing conflicting psychiatric outcomes, so they're talking about research in general.

Q I want to turn to page 54 of that. I think it's the last page of it where all the references are.

Under "Quality of the studies" it says, "Almost all of the studies reviewed showed selection bias. Since most included only individuals attending transgender healthcare services, the results are not generalizable to the overall trans population. Many studies are also limited by the inclusion of trans people at different stages of treatment. Longitudinal studies are also limited by lost-to-follow-up data and short follow-up time; only registry-based studies do not have lost-to-follow-up data, but their cross-sectional design fails to measure improvement of psychopathology within the same individual following

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GCMI" -- meaning gender-confirming medical interventions; correct?

A Yes.

Q And "Furthermore, they are limited by the lack of matching according to known risk factors for psychiatric disorders and psychopathology within the general population."

Did I read that correctly?

A That's correct.

Q Do you agree that almost all the studies in this area have both limitations?

A I think that some of these limitations are true for the studies. There is going to be limitations in any study in any review that's given.

However, I would say that the whole reason why this case exists in the first place is by one of these limitations are discussed.

So usually in the United States transgender individuals who are seeking access to gender-confirming surgeries only have very few places to go to seek those services because their insurance does not cover their surgeries.

And so there is a limitation potentially in some of the those pieces, but I would say that the information that we received related to their

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satisfaction on what happens after surgery and if their gender dysphoria decreases, those kinds of things to me I don't think really generalize the actual outcome of the surgery because of the population we're seeking.

So there are some pieces in here that I think can be included as potential limitations of studies. But I'd also say -- so this publication was published in 2016 and there are some longitudinal studies that have a hundred percent follow-up, and I talk about those in Exhibit 5.

So on page 2, I cite two studies that have follow-up rates as high as a hundred percent. And those studies were published -- one was in 2014 but one was also in 2018.

So I would say that there are studies that definitely don't meet these limitations.

Q And in that second column under "Implications for future research," I'm looking at the second paragraph from the end right in the middle where it says:

"A robust measure is needed to relate the primary outcome for gender-confirming medical interventions to gender dysphoria. The variability of tools to measure gender and body dysphoria does

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not allow firm conclusions to be drawn, and this suggests the need for a stronger measurement tool."
Did I read that correctly?
A Yes.
Q So this is something that you talked about in other articles as well that you've cited?
A Uh-huh. That's correct. So I would say that there are two gender dysphoria measures that are widely used that are highly validated over and over again, and I had mentioned one of those prior, and the other one was the gender dysphoria scale. So there are validated gender dysphoria measures that are used.
And then in the Garcia and Karasic article. They create an entire new measure. So it's not like these measures don't exist.
Q So would you disagree with that statement then?
A I always think that we can improve upon the instrument that we have. So I would say if we can even create even better science out of what we have then I'm all for that. I'm a scientist, so I would hope that that would happen.
But I would say that we do have tools that we can use to measure this. We can always improve upon the things that we have.

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Q All right. Exhibit 14 I'm going to hand you here. Do you recognize Exhibit 14?
A Yes.
Q And this another publication that you cited in one of your expert reports?
A Yes.
Q I know it doesn't have a date that I could find on it, but 2007, does that --
A I need to look and see what the actual date was on this one. Okay. 2007.
Q So published in 2007?
A That's what I have.
Q So I'm going to have you turn to page 199, under the heading "The Effectiveness of SRS in Adults: A Commentary." The second paragraph starts:
"Methodologically, however, this conclusion should be carefully quantified. Not one of the reviewed outcome studies was a controlled one."
Did I read that correctly?
A You did.
Q This is sort of addressing what we talked about earlier in the your article about the methodological limitations on some of these studies?
A No. And this was published in 2007. There have been many controlled studies. All the controlled

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studies I think we have talked about, if not all, most them have been published beyond 2007.
Q Would you say then that publications before 2007 and studies before 2007 aren't reliable in assessing the effectiveness of surgery for gender dysphoria?
A No, I would say as a scientist that I feel like we have to rely on the body of work that has been done before the work that we complete.
We use all of the prior data and all of the prior analyses to help learn from what were some of the limitations of those studies, how was that study done, can I replicate it, what can you do better the next time. And that's how science is done.
And so for me, I'd say you don't ignore the studies that were completed before this time. You take into account what is the evidence, what is the trends, what are things that you can learn from.
Which I think you've seen a trend of that as I've talked about it, that there has been a lot of improvement, but I wouldn't ignore the data that showed trends toward -- you know, before 2007, the data that showed trends toward being effective treatment.
Just as it says here, they say, "Just as Green and Fleming concluded, SRS is an effective treatment

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for gender identity disorder in adults."
Q Later on in that paragraph it states: "In many studies, sound psychometric instruments were not used. Especially disturbing is that many researchers did not directly measure gender dysphoria as the main outcome variable but instead use derivative measures, for example, satisfaction with surgery, sexual and interpersonal relationships, occupational and global functioning, or quality of life in general. Although these outcome variables are important, in our view, gender dysphoria should be the main, although not the sole, outcome variable following SRS."
Do you agree with that?
A I personally think that studies should be using gender dysphoria as one of the outcome measures if that's one of the things that they are looking at.
I do think that you can gain a lot of information from the measures they are talking about. So sexual functioning, satisfaction with surgery, interpersonal relationships, quality of life, that those can contribute to a greater understanding of what we know of overall well being as an outcome.
But I wouldn't throw those pieces out. I would

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say that the trend has been measuring gender dysphoria as an outcome measure, and I think that is a good methodological way to look at these studies.
Q Okay. One more here. I'm going to show you what's been marked as Exhibit 15.
A Okay.
Q And is this a publication that you cited in one of your expert reports in this case?
A Yes.
Q If you go to the second page of this, 1099. So what's the date of this publication?
A 2016.
Q 2016. Okay. So the second -- first full paragraph, second sentence down where it starts, "Transgender medicine presents a particular challenge for the development of evidence-based guidelines. First and foremost, data on health outcomes in transgender medicine are currently limited to retrospective studies, case series, and individual case reports due to the lack of funding opportunities for research in this field as well as institutional stigmatization of the transgender community."
Do you agree with that statement?
A No, actually, I think we've talked a lot about how the studies have improved with time. And there are

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a lot of controlled studies, a lot of longitudinal studies that existed that aren't discussed in that sentence.
Q In the following paragraph it talks about the World Professional Organization for Transgender Health (WPATH) Standards of Care. Is that correct?
A In that first sentence?
Q Yeah. Under the following title: Current Guidelines for Transgender Medicine."
I guess midway through after the "15" number, it says, "Over the years, this document has evolved substantially, yet it remains largely based on lower-quality evidence (i.e., observational studies) and expert opinion."
Did I read that correctly?
A Yes.
Q Do you agree that the WPATH standards are largely based on lower quality evidence and expert opinion?
A Well, I would say the standards of care were -- the most recent version was published in 2012, and it meant that they were working on it several years beforehand.
So much of the evidence that they had cited in those standards of care was some of the old research we talked about that I still think a large body of

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data that the effectiveness of hormones in surgery.
However, since they wrote the document and since the document has been published there have been a lot of updates related to the information and the Standards of Care, Version 8, is in the process of being written.
Q Do you know what process is it -- what stage of the process it's at?
A They have identified individuals who are, you know, writing the different sections and they have an outline of what the sections will look like.
Q Have they identified you as someone who is writing any part of the standards?
A No, I decided it was not in my timeline to be able to do that at this time.
Q I'm going to look at your supplemental report, Exhibit 4. On page 12, it's the very last sentence before your declaration, you say:
"Based on this evidence, the consensus in the medical slash psychological community with respect to post-pubescent children and adults is that a person's gender identity cannot be changed."
Did I read that correctly?
A Yes.
Q Is that an opinion that you have?

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A Yes.
Q So what is gender fluidity?
A Gender fluidity is a concept where an individual will identify as gender-fluid, for example, and they will say today I am male, or more masculine, and tomorrow I may feel more female, or feminine.
So it's an identity that's recognized in the community as a legitimate gender identity.
Q And I think we can go back to that same article. I can't remember what exhibit number that was.
MR. DUPUIS: No. 6.
Q (Ms. Schmelzer): Exhibit 6, on page 660. So the first text page, second column, the last paragraph starts "Gender fluidity occurs with both cisgender and transgender individuals"; correct?
A That's correct.
Q So does that mean that individuals including transgender individuals can change their gender identity?
A No. So there is a difference between somebody who identifies as gender fluid versus gender fluidity.
So, for example, gender fluidity may mean like maybe my gender expression I was considered wearing a tie and pants today, so they'd be presenting a little more masculine. That may be considered from

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an expression-based perspective that you can have some fluidity in that.
That is not an identity-based -- what we considered gender identity.
You can have gender identity that's called gender fluid. That would be what I was just describing earlier. Somebody may experience themselves as both masculine and feminine at different times. But that gender identity itself as gender fluid would be fixed.
Q So somebody who is gender fluid will always be gender fluid?
A People can develop and change over time, but at least what we would say in terms of adulthood, when you reach adulthood that those gender identities tend to not be much of a variability. How that fluidity may manifest, and then it may look different as people age, get older and how they express their gender. We develop like that all the time.
But in terms of the actual gender fluid identity, that won't change.
Q Look at Exhibit 5, your second supplemental report. This is me just tying up loose ends at the end here.
On page 5 of your report, the first full

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paragraph, you say:
Mayer indicates that, quote, treatments aimed at aligning one's gender identity with their biological sex may be successful at ending, parens, i.e. treating, end of parens, gender dysphoria.
Where did you find that quote from Dr. Mayer?
A If my memory serves me correctly that would have been from the deposition.
Q Did you believe in reading that quote that Dr. Mayer was advocating for reparative therapy for transgender individuals?
A That is how I read that statement.
Q Do you think that Dr. Mayer is qualified to opine about the medical efficacy of surgery for treating gender dysphoria?
A I do not.
Q Why not?
A I think that Dr. Mayer has experience in research methods and research methodology. However, regarding any issues related to transgender identity and gender dysphoria, in my reading of his CV and his clinical experience, it appears that he has never done a research study with transgender individuals and he has not seen any transgender patients.

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So, to me, it doesn't seem like he has that clinical expertise or the research expertise to be able to opine on the topics.
Q So do you believe that a biostatistician or epidemiologist in order to opine about the effectiveness of treatments for transgendered individuals has to have some experience actually treating those individuals?
A I would think it would make him a much better witness if that is something that he had experience in.
I think he can talk about research design and that seems to be something that would potentially be in his fieldhouse.
But even when he talks about research design, he describes research studies that couldn't be done in the field for reasons that I described. He says that we need to these double-blind and single-blind studies and that's not possible.
So, for me, even if an epidemiologist could opine on these issues it doesn't seem like Dr. Mayer has a lot of experience with the data or with how to design research with transgender individuals.
Q Okay. I'm going hand you what's been marked as Exhibit 16. This is one of your publications;

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correct?
A That's correct.
Q And it's titled: "To Err Is Human: An Introduction to the Special Issue on Clinical Errors."
That was published 2016; right?
A 2016.
Q The very first sentence, "In the recent past, I was engaged in a therapeutic process that led to a clinical error."
What was that nature of that clinical error?
A I would like to talk about it in generalities to --
Q Yes, I don't want you to disclose any patient confidence.
A I was supervising a doctoral student who was working with a client and the doctoral student, for reasons I won't go into, could no longer engage in therapy with that client no longer. So I had helped that student terminate that treatment with her client perhaps too early.
Q And was this a transgendered client?
A No.
Q And in terminating the relationship too early, how did that lead to a clinical error?
A Clinical errors can be defined broadly. I just felt like it would have been a much smoother ending to

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their relationship if they hadn't ended so abruptly.
We did transfer the patient to another therapist in the field so the patient didn't have a lapse in treatment.
I just felt like there wasn't a natural way for them to say goodbye.
Q Do you think this clinical error resulted in some psychological harm to the client?
A I do not. I think that the client was upset that the relationship ended, but it also seemed like the client benefited with therapy -- with a therapist at the same clinic they got to see next.
Q Have you had any clinical errors in any of your counseling of transgender patients?
A Can you define the way that you're talking about clinical errors?
Q Something that affected their therapy or treatment.
MR. DUPUIS: Adversely?
MS. SCHMELZER: Adversely, yes, clinical error.
THE WITNESS: I think that one of the reasons why I published this special issue is that all therapists make clinical errors and some of them are smaller and some of them are larger.

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So I would say, of course, I've made some clinical errors with many of my client's and likely also with my transgender clients. There isn't one to date that I can think of where it resulted in something that was so harmful to the person that, you know, they told me that it was harmful to them or I could tell that it was extremely harmful to them. But I'm sure that I've made clinical errors along the way.
Q (Ms. Schmelzer): And you might not want to go into this, but do you know whether or not you ever made a clinical error in recommending medical treatment for someone with gender dysphoria?
A In my knowledge, I do not know that I have made a clinical error with a recommendation.
MS. SCHMELZER: That's all I have.
MR. DUPUIS: Can we talk real quick?
MS. SCHMELZER: Okay.
(Recess)
MR. DUPUIS: I actually don't have any questions, so if we're done --
MS. SCHMELZER: Okay.
(Discussion off the record)
MS. SCHMELZER: Are you going to

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reserve?
MR. DUPUIS: Yes. Read and sign.
(Adjourning at 2:51 p.m.)

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STATE OF WISCONSIN)
) SS:
COUNTY OF DANE)

I, Cheri Winter, a Certified Shorthand Reporter and Notary Public in and for the State of Wisconsin, do hereby certify that the foregoing deposition was taken before me on the 22nd day of August, 2018; that it was taken at the request of the Defendants, upon Notice; that it was taken in shorthand by me, a competent court reporter and disinterested person, approved by all parties in interest and thereafter converted to typewriting using computer-aided transcription; that said deposition is a true record of the deponent's testimony.

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 (X) was ( ) was not required.

That the deposition was taken pursuant to Notice; that said STEPHANIE BUDGE, PH.D. before examination was sworn by me to testify to the truth, the whole truth, and nothing but the truth relative to said cause.

Dated August 27, 2018.

CHERI WINTER NOTARY PUBLIC STATE OF WISCONSIN

Notary Public
In and for the State of Wisconsin

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