UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

CODY FLACK, SARA ANN MAKENZIE, MARIE KELLY, and COURTNEY SHERWIN Plaintiffs, v. WISCONSIN DEPARTMENT OF HEALTH SERVICES and LINDA SEEMEYER, in her official capacity as Secretary of the Wisconsin Department of Health Services, Defendants.	Case No. 3:18-cv-00309 Judge William Conley

SECOND SUPPLEMENTAL EXPERT WITNESS DECLARATION OF STEPHANIE L. BUDGE, PhD, LP

1. I have been retained by counsel for the Plaintiffs as an expert in the above-captioned lawsuit. I previously submitted an expert witness declaration [Dkt. No. 24] ("Budge Decl.") and supplemental expert witness declaration [Dkt. No. 60] in connection with Plaintiffs' motion for a preliminary injunction in this case. I submit this second supplemental declaration to respond to points raised in the declaration of Daniel Sutphin, M.D. ("Sutphin Decl."), which was submitted by Defendants in opposition to the plaintiffs' motion for modification of the preliminary injunction. I have personal knowledge of the matters stated in this supplemental declaration.

2. My background, qualifications, and compensation for my services in this case, and the basis for my opinions in this case are described in my original declaration and in my C.V. attached as an exhibit to that declaration. The additional sources I have consulted in

preparing this supplemental declaration are identified in Exhibit A. Since submitting my previous declarations in this case, I have testified as an expert witness at deposition and trial in *Boyden v. Conlin*, No. 17-cv-264-wmc (W.D. Wis.).

3. In his declaration, Dr. Sutphin implies that patient "regret" should be considered when taking surgical outcomes for gender-confirming surgeries into account. Sutphin Decl. ¶ 27. As a way of supporting his argument, he cites three non-scientific, popular media articles. *Id.*

4. Beyond popular media articles, Dr. Sutphin cites only one scholarly article by Djordjevic, *et al*. (2016) to support his scientific argument regarding regret, although that article actually concludes that the "vast majority" of individuals suffering from gender dysphoria are satisfied with their surgical treatments. In that article, the authors note the surgical outcomes for 7 patients who requested reversal surgery over a 4-year period. They indicate that all 7 patients were *misdiagnosed* prior to having gender confirmation surgery (p. 1000). The 7 patients "did not fulfill the complete diagnostic criteria for a gender identity disorder diagnosis" (p.1005) and all were "misdiagnosed" with gender identity disorder (now referred to as gender dysphoria) (p. 1000). The authors note in their conclusion that their article reports "on one of the largest series of regretful patients" at just *2 or less* individuals per year (p. 1006). The authors conclude their article by saying: "The vast majority of properly diagnosed transsexual patients are satisfied with their decision to undergo SRS, with only a few coming to regret it" (p. 1006).

5. There is no dispute that a very statistically small number of individuals will indicate that they are unsatisfied with surgery or indicate that they regret that gender confirming surgery occurred. However, in my professional opinion, these rare instances of regret do not call into question the overall efficacy of gender-confirming surgeries to treat gender dysphoria in

transgender individuals for whom those surgeries are deemed medically necessary by their treating providers.

6. There is significant nuance in how regret is discussed in the scientific literature. In Defendants' opposition brief ("Defs.' Br."), the State indicates that studies often indicate that it takes many years for regret "to surface" and they also cite a Swedish study focused on suicide rates. Defs.' Br. at 15, 16. In one of the largest studies focused on regret (Landen, *et al.* (1998), Swedish scientists analyzed data (N =218) over a 20 year period of time (from 1972-1992) and found that 3.8% of the patients (n = 8) in the study experienced regret over that period of time. All 8 of the patients who reported experiencing regret indicated that they experienced regret because they had a lack of family support for their gender identity or because they had not found a place in the transgender community.

7. In an additional study (Lawrence (2003)) that focused on 232 transgender women, data were analyzed for surgeries conducted over a 6-year period (1994-2000) and patients described their experiences at least 1 year post-surgery. In this study, zero patients reported "outright regret" and only 6% (15 participants) reported feeling "sometimes regretful." Of the 15 who reported some regret, 8 participants indicated that the regret was due to physical or functioning issues and 5 participants reported family/social support issues as being the source of the regret, such as being an outcast from family. The other 2 individuals presented with their gender assigned at birth for differing reasons (to play golf or to present to clients at work).

8. In a third study, Dhejne, *et al.* (2014) analyzed data regarding applications for legal and surgical gender confirmation over a 50-year period (1960-2010). There were a total of 767 applications over that 50-year period. There were 15 "regret applications"—5 (2%) trans men and 10 (2.3%) trans women over the 50 year period of time, with the majority occurring 30-

50 years ago and only 0.3% (*n* =1) (i.e., a *single* incident) occurring from 2001-2010. Although Defendants cite the Dhejne, *et al*. (2014) study in their brief as the primary source for their argument that supposed "deep regret" calls the efficacy of gender-confirming surgeries into question, it is clear from the data from that very study that the incidents of regret are statistically very low.

9. Dr. Sutphin quotes Dr. Charles L Ihlenfeld to support a conclusion that there should be cause for concern regarding medical treatment for gender dysphoria. Dr. Sutphin provides a quote that was cited as historical context in a book written by Dr. Jack Drescher. Upon reviewing the original citation (Ihlenfeld (2004)), Dr. Ihlenfeld is reflecting on an interview he provided in 1976 to Daniel Greene. In the 2004 article (nearly 30 years later), Dr. Ihlenfeld reflects on this being part of his thoughts "in the early years" (p. 151) and states: "I continue to this day to support hormonal and surgical reassignment when that seems appropriate…I know that through reassignment many patients have found happiness and a personal fulfillment that simply would not have been possible otherwise" (pp. 151-152). Dr. Sutphin closes his paragraph by indicating that he agrees with Dr. Ihlenfeld; however, it appears that Dr. Sutphin does not have a full or accurate understanding of Dr. Ihlenfeld's views.

10. Dr. Sutphin also suggests that "suicidal behavior and psychiatric morbidity remain elevated in the transsexual population monitored over a 30 year period" (p. 14). He cites the Dhejne, *et al*. (2011) article to support his claim. However, the weight of peer-reviewed research on the effects of gender-confirming care on suicidality clearly demonstrates a relationship between transgender individuals obtaining transition-related care (e.g., hormones and gender confirmation surgery [GCS]) and a reduction in suicidal ideation. In their recent study, Tucker, *et al*. (2018) found that transgender individuals who had undergone hormone

therapy and GCS reported lower suicidal ideation within the past year and past two weeks when compared to transgender individuals who had not received any medical treatments or only one medical treatment. Additional studies indicate that suicidal ideation is significantly lower for transgender individuals who receive hormone therapy versus those who do not. *See* Bauer *et al*. (2015); Wilson, *et al*. (2015).

11. Regarding surgeries, some studies have found that even though there is a decrease in the transgender sample's suicidal ideation, the suicidal ideation rates remain higher than the general population (for example, the Dhejne, *et al.* (2011) study cited by Dr. Sutphin). In response to these findings, Bauer, *et al.* (2015) conducted analyses to determine the relative risk reduction post-surgery, and found that there was a there is a 62% relative risk reduction post-surgery for the transgender sample in their study. Additionally, Wilson, *et al*. (2015) found transgender women who had breast augmentation reported lowered suicidal ideation than those who had not had surgery or hormones.

12. In conclusion, it is my professional opinion, consistent with the peer-reviewed research discussed above, that transgender individuals are not more likely to experience suicidal ideation or attempt/complete suicide after having gender confirming medical care, as Dr. Sutphin claims. To the contrary, they are *less* likely to experience suicidal ideation or attempt/complete suicide after receiving medically necessary surgical care for gender dysphoria. Thus, it is my professional opinion that the claims being made by the State and by Dr. Sutphin are incorrect and that the data actually provide an even stronger rationale for the medical necessity of hormones and surgeries to reduce gender dysphoria.

13. In addition, the State contends "subjective satisfaction with surgery is not the same as measuring the objective effects on the dysphoria." Defs.' Br. at 19. There are several

responses to this argument. First, there are a number of peer-reviewed studies that focus on the objective effects of gender dysphoria using validated gender dysphoria measures (*see* Garcia & Karasic (2018); Glynn, *et al.* (2016); Fisher, *et al*. (2016); Van de Grift, *et al*. (2018))—all of which have noted significant reductions in gender dysphoria post-surgery. Thus, the State's contention that "studies that use more objective assessments of mental health often show little to no benefit from surgery" is simply incorrect and unsupported by the relevant research. As reflected in these peer-reviewed studies, there is strong evidence that refutes the State's argument. In addition to improvement in gender dysphoria, recent peer-reviewed studies report significant improvement in mental health when using validated mental health measures. Examples from just this year include the following studies: Tucker, *et al*. (2018) reported that depression (measured with the PHQ-9) was lowest for the groups who had gender confirmation surgery and Owen-Smith et al. (2018) reported that depression and anxiety (measured by the Beck Anxiety Inventory and Center for Epidemiologic Studies Depression Scale) were significantly greater for individuals who had not had gender confirmation surgery.

14. However, even if there were not studies that examined the positive mental health outcomes from gender-confirming surgeries with respect to specific diagnoses (e.g., depression, anxiety), the studies that have focused on quality of life and satisfaction with surgery should not be discounted. These studies provide important information on life functioning and can also be proxy measures to what reductions in gender dysphoria can look like post-surgery for transgender individuals. Finally, the peer-reviewed research I have previously discussed (*see* Budge Decl. ¶¶ 25-33) makes clear that surgeries demonstrably reduce gender dysphoria, improve quality of life, increase life functioning, and improve overall satisfaction with life and happiness.

15. The conclusions of these studies are in alignment with my clinical experience treating transgender patients with gender dysphoria. In my years of clinical experience working with transgender individuals, quality of life and satisfaction measures most closely align with how clients discuss their outcomes in therapy. In addition, it is these factors that are often noted for clinical improvement when determining if a client's functioning or mental health seems to be improving.

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

Dated: 12/9/2018

Stephanie Budge

Stephanie L. Budge, PhD, LP

Exhibit A: References

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