**No. 21-2875**

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**UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT**

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DYLAN BRANDT, et al..,

*Plaintiff-Appellees,*

*vs.*

LESLIE RUTLEDGE, et al..,

*Defendant-Appellants.*

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On Appeal from the United States District Court
for the Eastern District of Arkansas, No. 2100450-JM
Before the Honorable Judge James M. Moody, Jr.

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# Brief of Amici Curiae for Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, and Carol Freitas as Amici Curiae in Support of Defendants, Supporting Reversal

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Ernest G. Trakas
EVANS & DIXON, LLC
211 N. Broadway, Suite 2500
St. Louis, Missouri 63102
(314) 621-7755
etrakas@evans-dixon.com
Counsel for Amici Curiae

## STATEMENT OF CORPORATE DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici curiae* Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds and Carol Freitas, by and through undersigned counsel, state that they are not publicly held corporations that issue stock, nor do they have parent corporations.

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## STATEMENT OF INTEREST

*Amici* Keira Bell, Laura Becker, Sinead Watson, KathyGrace Duncan, Laura Reynolds and Carol Freitas respectfully submit this brief in support of Defendants. All parties have consented to this filing.[1]

Amici, like Plaintiffs, experienced gender dysphoria when they were adolescents and young adults. Like Plaintiffs, Amici believed that "gender-affirming" care would resolve their gender dysphoria ("GD") and permit them to live healthy, well-adjusted lives. Amici learned that such treatments did not resolve the psychological issues underlying their GD, but only increased their distress as they realized they had irreversibly altered their bodies based upon ideology.

Amici respectfully submit this brief to provide this Court with a balanced perspective about the absence of any objective standard of care and the attendant absence of efficacy, safety, and scientific foundation for so-called gender-affirming treatments. Amici believe it is critical that this Court hear their stories as women who were once where the Plaintiffs are now and have experienced loss, physical harm, and increased emotional distress from treatments that were supposed to benefit them.

[1] *Amici* affirm that no counsel for a party authored this brief in whole or in part and no one other than *amici*, its members, or its counsel contributed any money to fund its preparation or submission.

## INTRODUCTION

Plaintiffs seek to vitiate the Arkansas Save Adolescents from Experimentation (SAFE) Act which prohibits healthcare providers from providing or referring anyone under the age of 18 for gender-affirming procedures. Amici believed that undergoing gender-affirming care would alleviate their GD and permit them to live healthy, well-adjusted lives. Like Plaintiffs, Amici were gender non-conforming from a young age, diagnosed with GD and subsequently began hormone therapy. Amici initially experienced some relief. However, they later realized that the changes to their bodies did not relieve their underlying distress. As they matured, they understood that puberty-blocking drugs, hormone treatments, and removing healthy breasts did not address the issues of their minds and hearts that were the actual causes of their distress.

Amici have returned to their female identities. However, they cannot regain the fully functional female bodies they had before they transitioned and must contend with the irreversible effects of cross-sex hormones. Most importantly, the gender-affirming care Amici received did not provide adequate and necessary diagnostic tools to assess the origins of their GD and transgender identities. They were consequently denied the ability to determine whether medical interventions were necessary. The treatments did not address the underlying psychological and sociological conditions underlying their desire to medically transition. Amici

continue to experience grief, remorse, and regret for what has been taken from them and want to help other young gender non-conforming people, including Plaintiffs, to avoid those experiences.

## LEGAL ARGUMENT

### I. The District Court Accepted and Applied an Inappropriate and Unethical Standard of Care.

Of profound concern is the District Court's erroneous acceptance and application of a non-existent Standard of Care ("SOC") based solely on Amici American Academy of Pediatrics' ("AAP") wholesale misrepresentation that the medical profession has adopted medically supportable and sound SOC. AAP's SOC supports the administration of gender-affirming care ("GAC") without cognitive therapy required to explore underlying causes for the GD or address contributing or complicating mental health issues. If allowed to stand, the lower Court's reliance on this false SOC authorizes medical professionals to diagnose and treat children based solely on the child's self-report of his/her attitudes and feelings regarding regressive cultural sex-role stereotypes.[2] Physicians and other healthcare providers are thus relieved of any legal or ethical accountability for misdiagnosis and resulting medical harms.

[2] See discussion of standards for diagnosis and "persistence," *infra*, Section I.A.

AAP claims that gender identity incongruity is a normal innate variation of human identity placing the child at risk of GD and, upon diagnosis of either, attendant GAC is necessary in all circumstances. *AAP Brief at. 5,7.* In other words, AAP places incongruent gender identity and GD in the same diagnostic category as birth defects and, as such, no medical intervention (to correct or address the defect) can be harmful. In turn, AAP asserts that the "robust consensus" of the medical community is that GAC is the "***only*** effective treatment", and that said treatment complies with appropriate, applicable, and accepted SOCs. AAP Brief at 7-12 (emphasis added).

AAP misled the District Court into accepting and applying "guidelines" issued by the Endocrine Society and WPATH (WPATH SOC). These guidelines (that are not SOC) are ideologically based, *i.e.*, biased. The AAP-promoted SOC based on these guidelines disregard and omit ethically required and independently confirmed evidence of a demonstrated, persistent presence of gender dysphoric symptoms. This SOC misrepresents the diagnostic requirements for treatments. In recounting the requirements to the District Court, AAP referred only to the adolescent having "demonstrated a long-lasting and intense pattern of gender dysphoria" and omitted that said pattern of intense distress may be either "suppressed or expressed."[3] *Id. at 10.* In other words, the dysphoria may be

[3] WPATH, *Standards of Care Volume 7*, 19 (2011).

unknown to anyone else, and, perhaps, even long suppressed by the adolescent without any independent confirmation. By omitting this requisite, AAP casts the SOC for diagnosis of GD as objective and all prescribed gender-affirming treatments as medically necessary and ethical, which is not true.

The SOC as expressed in the guidelines relies exclusively on the patient's subjective articulation of the prepubescent presence and persistence of dysphoric symptoms. Subsequent diagnosis is made without review and analysis by a qualified mental health professional to confirm intensity and persistence. The ethical requirement for diagnosis is shifted from the medical professional to the child. No other medical condition burdens the patient, let alone a child, with a decision regarding self-sterilization, while providing a pathway for medical professionals to avoid accountability.

AAP (mis)represented to the District Court that SOCs include cognitive therapies for mental health issues. *Id. at 11*. In fact, the only "coexisting psychological, medical, or social problems" that must be addressed prior to starting treatments are those that the clinician determines may "interfere with treatment."[4] The WPATH SOCs do not require assessment or exploration of whether any co-morbid neuro/psych condition may cause or contribute to the patient's GD or can be

[4] *Id.* Under the WPATH SOC, the role of mental health professionals is discretionary and mental health assessments need only "broadly conform" to the guidelines. *Id.* at 14-15.

adequately addressed to resolve the patient's distress without life-changing hormonal and surgical interventions.

The Court accepted and applied an erroneous SOC that unethically authorizes initiating gender-affirming treatment while ignoring and denying access to cognitive therapy that will identify the tools necessary to provide informed consent to medical intervention.

### A. WPATH And Endocrine Society Standards Are Not Authoritative Standards of Care Nor Even High Quality Clinical Practice Guidelines Upon Which Clinicians Should Base Treatment of Vulnerable Minors.

#### 1. WPATH SOC Are Tainted By Bias, Lack Methodological Rigor and Reliance On Low-Quality Primary Research.

Vulnerable children and adolescents experiencing GD deserve the highest quality evidence-based treatment available. They deserve scientifically sound holistic SOC that address not just their physical appearance, but the myriad of issues underlying their dysphoria. The WPATH SOC advanced by the AAP are self-evidently not SOC. "WPATH is not the typical professional organization that develops clinical practice guidelines. WPATH is a hybrid professional and activist organization, where activists have become voting members and have served as

president."[5] Since at least 2009, WPATH guidelines have incorporated the idea that gender is "a spectrum" of durable identities, abandoned the reality that sex is "binary;"[6] and favored medical and surgical interventions over psychotherapy directed at underlying causes.

WPATH's bias is further evidenced by the lack of methodological rigor and reliance on low-quality primary research in formulating the guidelines, as confirmed by the first systematic review to use a validated quality appraisal instrument to assess all international clinical practice guidelines ("CPGs") addressing gender minority/trans health. Researchers found that none had methodological rigor or evidentiary quality necessary to qualify as high-quality CPGs.[7] Further the study found that "many national and local guidelines are adaptations of, acknowledge being influenced by, or are intended to complement WPATH SOC v7, despite expressed reservations that WPATH SOC v7 is based on lower-quality primary research, the opinions of experts and lacks grading of evidence."[8] The study

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[5] Lin Fraser, *Psychotherapy in the World Professional Association for Transgender Health's Standards of Care: Background and Recommendations*, 11 INT'L J. OF TRANSGENDERISM 110, 113-14 (2009), https://doi.org/10.1080/15532730903008057.

[6] *Id.*

[7] S. Dahlen, D. Connolly, et. al. *International Clinical Practice Guidelines for gender minority/trans people: systematic review and quality assessment*, BMJ OPEN, 2, 6 (April 29, 2012).

[8] *Id.*

concluded that "WPATH SOCv7 **cannot be considered 'gold standard**.'" (Emphasis added).[9] [10]

Neither WPATH nor the Endocrine Society guidelines is endorsed by ECRI Guidelines Trust ("ECRI"), an independent non-profit patient safety organization that analyzes CPGs.[11] ECRI reported that neither Endocrine Society nor WPATH guidelines met inclusion criteria to be rated because "[o]nly a few of their recommendations were supported by the systematic review; the majority were not."[12] As such, neither WPATH nor the Endocrine Society guidelines remotely rises to high-quality practice guidelines that can be recommended for use by clinicians.

Finally, assertions that there is a "biological durability" to gender identity is clearly challenged, if not refuted, by the fact that most cases of GD in children naturally resolve by adulthood.[13] "It is precisely this lack of durability that should give pause to administering potentially harmful and often irreversible medical interventions to young patients with GD."[14]

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9 *Id.* at 8 (emphasis added).

10 *Id.* Table 2, p. 7.

11 *Id.*

12 *Id.*

13 William Malone, Paul Hruz, *et. al.*, *Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective*, THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM (June 14, 2021).

14 *Id.*

### 2. There Is A Dearth Of Evidence To Support The Claim That Hormones and Surgeries Are Safe And Effective

The medical and surgical interventions pushed by WPATH guidelines were developed when males were the predominant population seeking "transition," have not been examined for efficacy and safety for females, and have not demonstrated a long-term benefit for children and adolescents.[15] Furthermore, the Dutch research which was the sole basis for the "gender-affirmative" treatment of gender-dysphoric youth was limited to adolescents with early-onset GD who had received comprehensive screening. In other words,

> [t]he existing body of evidence regarding treatment outcomes for GD was not only graded as "low quality," but has been derived from a vastly different population than the one presenting with GD today. Currently, GD predominantly presents in adolescent females with no childhood history, in contrast to the prior predominantly male and childhood onset GD presentation. It is not yet known whether this novel patient segment, which remains poorly understood and largely unstudied, will benefit or be harmed by hormonal and surgical interventions.[16]

As Amici's experiences demonstrate, "the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret." [17]

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[15] Society for Evidence Based Medicine (SEGM), *Correction of a Key Study: No Evidence of "Gender-Affirming" Surgeries Improving Mental Health*, August 30, 2020 https://www.segm.org/ajp_correction_2020

[16] Malone, *supra*, n.13 at 1-2

[17] *Id.*

Furthermore, AAP's claim of effectiveness is at odds with a now-corrected population-based study that found no evidence that hormones or surgery improves long-term psychological well-being.[18]

Surgical interventions for adolescents received a D2 rating (very low-quality evidence for improving outcomes) from Hayes Directory Report, a medical research firm that analyzes medical treatments and devices worldwide for health insurers and providers.[19] Consequently, gender-affirming medical interventions to treat GD in teens are not proven safe and effective.

### 3. Current Practice Guidelines Do Not Protect The Adolescent Population Now Presenting With GD From Unnecessary Medical Harms.

The demographics of children who are now presenting with GD are very different from those who were treated and studied to determine whether they benefited from irreversible medical interventions impacting secondary sex characteristics and physical well-being.[20] In addition, the treatment protocols took

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[18] SEGM, *supra*, n. 16.*; Correction to Bränström and Pachankis*. 177 AM J PSYCHIATRY (8): 734 (2020).

[19] Hayes Directory, *Sex Reassignment Surgery for the Treatment of Gender Dysphoria*, August 2018, https://www.hayesinc.com/publications/evidence-analysis/health-technology-assessment/sex-reassignment-surgery-for-the-treatment-of-gender-dysphoria/dir-sex707/.

[20] When the WPATH guidelines were published in 2011, natal males were the primary group presenting to gender clinics in adolescence. Current ratios now have females presenting at some clinics 7 to 1. Kenneth J. Zucker, *Adolescents with gender dysphoria: reflections on some contemporary clinical and research issues* ARCHIVES OF SEXUAL BEHAVIOR, 1983–92 (2019).

clear and rigorous steps to prevent unnecessary medical harm. By comparison, current practice guidelines used in the U.S. are not designed to address the current presenting population and do not require adequate protocols to avoid unnecessary medical harm.

WPATH's SOC for treating GD in adolescents were drafted in 2011 using a Dutch model of care for medically treating the rare condition of early childhood onset GD (mostly in boys) that persisted into adolescence.[21] The Dutch disqualified adolescent-onset and mental health comorbidity cases and only provided medical interventions to a highly select group of well-adjusted adolescents whose early onset dysphoria was fully documented. Their strict protocols were designed to guard against "false positives" and protect minors from unnecessary medical harm. The ideologically-driven WPATH did not follow the strict requirements of the Dutch Model to assure ethically based care.

Historically, the vast majority of children presenting with early-onset GD desist. There are no objective biological markers by which GD can be diagnosed, its origins include imprecise psychological and social factors, and there never have been reliable diagnostic tools to determine which children's GD would desist or who

[21] As recently as 2013, the DSM-5 diagnostic criteria for GD estimated this condition occurs in 0.002%-0.014% adults, with females representing the lower band (2-3 per 100,000 adult females). American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders*, 454 (5th ed., 2013).

might benefit from medical transition. The only diagnostic rubric used to assess for medicalization is constancy and persistence of GD. For this reason, the Dutch Model included support for the child and family but not social transitioning which could cause premature reification of the child's incongruent gender identity. Where the child's GD persisted into puberty, a rigorous screening protocol was applied to determine if they were ethically eligible for puberty blockers, *i.e.*, the condition was not the result of mimicking co-morbid conditions or complicated by significant mental health issues. Importantly, in all cases, long-lasting demonstrable GD was well known to the child's family and documented in medical records, and all adolescents received extensive expert psychological support throughout treatment.

By contrast, the WPATH SOC provide medical treatment based only on an adolescent's subjective self-report of the presence and persistence of GD. No independent confirmation or differential neuro/psych assessment is required to determine causational or contributing factors, nor are mental health therapies required throughout the course of treatment. Further, there has been a dramatic, unprecedented change in the demographics of children and adolescents presenting with GD. Since the mid-2000s, pediatric gender clinicians have reported increasing numbers of referrals and changes in the types of cases presenting for care. Previously most cases were prepubescent boys, but newly presenting cases are overwhelmingly adolescent females, the majority of whom have significant mental health problems

and neurocognitive comorbidities, such as autism-spectrum disorder or ADHD.[22] It is not known which cases or how many from this novel patient population will persist as transgender-identified long-term and which will re-identify with their biological sex.[23] "Research on male adolescent clients cannot be generalized to females, an age-old fallacy in medicine."[24] Most importantly, there is no evidentiary basis for asserting that these females will benefit from medical transition.

Adolescents now present based upon a self-diagnosis derived from social media and fully scripted as to what to say and do to qualify for medical transition. Children and parents are being taught that attitudes about culturally sanctioned sex-role stereotypes are reliable indications of an innate (supposedly immutable) gender identity that should not be questioned but only, and always, affirmed. The epidemiology and treatment(s) in transgender care are rapidly changing, and WPATH's now more than decade-old guidelines are severely outdated and incapable

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[22] *See* Nastasja M. de Graaf and Polly Carmichael, *Reflections on Emerging Trends in Clinical Work with Gender Diverse Children and Adolescents*, 24 CLINICAL CHILD PSYCH AND PSYCHIATRY (2), 353–64 (Apr. 2019); John F. Strang *et al., Increased Gender Variance in Autism Spectrum Disorders and Attention Deficit Hyperactivity Disorder*, 43 ARCHIVES OF SEXUAL BEHAVIOR 8, 1529 (Nov 2014).

[23] Kenneth J. Zucker, *The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al (2018)*, 19 INT'L J. TRANSGENDERISM,(2) at 4, table 1 (2018).

[24] Lisa Mac Richards, *Bias, not evidence dominates WPATH transgender standard of care,* Canadian Gender Report, October 1, 2019.

of addressing the current presenting population. Consequently, the entire recommendation section for adolescent transgender care in the WPATH guidelines —the very section upon which Youth Plaintiffs' and Amici's treatments are based— are "dubious at best, irrelevant at worst"[25] and incapable of ethically addressing the current presenting population.

### B. WPATH Leadership Acknowledges That There Is No Medical Consensus Regarding Best Practices For Treating The Adolescent Population Now Presenting With Gender Dysphoria.

WPATH leadership recognizes the changes in adolescent demographics presenting with GD, the unknown origins and lack of consensus in the medical community about what SOCs should be applied to prevent unnecessary medical harm. Dr. Laura Edwards-Leeper, Chair of the WPATH committee charged with the revision of the SOCs, has acknowledged WPATH's ideological dilemma, and publicly questioned WPATH's position that immediate access to GAC is the only effective treatment. [26]

> We have gone to the other extreme which is moving people forward pretty quickly [into medicalization] without proper assessment and mental health support in place, a lot of times not involving the parents in the process, and the field has become very polarized which makes it difficult for any of us who are in the field

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25 *Id.*

26 *What Do We Mean By "Gender Affirming Care?" A Conversation with Dr. Laura Edwards-Leeper,* The Unspeakable Podcast with Megham Daum, October 3, 2021

> because we're not all on the same page and I think it makes it extremely difficult for parents to navigate because depending on who they talk to … they may be told very many different things in terms protocol and the process and even how people interpret the standards of care may differ from one place to another. It can be very confusing for families who are going through this these days.

Dr. Edwards-Leeper's concerns regarding WPATH and its embracement of immediate invasive medical treatment are based on increased complexity in GD diagnosis and treatment driven by the pervasive influence of social media on youth.[27]

Similarly, Dr. Erica Anderson, a psychologist, member of the WPATH Board and President of the USPATH Board, recently stated that it is not clear what the standards of care for the new cohort should be.

> I think that's a really important question to ask is are these different kids first and if they are, should we be treating them differently than the early presenters, the children who well before puberty asserted gender different than we thought they had? And I think it's an open question … Is there something going on with our teenage girls? And the answer I would give is yes. Do we know what it is precisely? No.[28]

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[27] *We Feel Like We're In The Wild West: Parents of Gender-Questioning Kids Ask Their Own Questions*, The Unspeakable Podcast with Megham Daum, October 5, 2021

[28] *Why Marci Matters* by Abigail Shrier, October 6, 2021 https://abigailshrier.substack.com/p/why-marci-matters

Importantly for young people with GD and mental health issues, the shift toward immediate medicalization, as Dr. Edwards-Leeper concedes, has led to elimination of psychotherapeutic safeguards. The first four versions of the WPATH standards required psychotherapy before referrals for hormones and surgery.[29] Adoption of the idea of a gender spectrum brought about a shift in the fifth version of the guidelines (1998), in which the pre-referral psychotherapy requirement was removed and replaced with a section on psychotherapy as only one part of "managing patients" with gender identity disorder.[30]

Practitioners have admonished that "exploratory psychotherapy" should be "the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures."[31] This is especially critical "when we are witnessing an exponential rise in the incidence of young people with GD who have diverse and complex mental health presentations and require careful assessment and treatment planning."[32]

## II. Amici's Lived Experiences Point To Harm, Not Medical Necessity.

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29 Fraser, *supra*, n. 5. at 111.

30 *Id.*

31 Roberto D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 ARCHIVES OF SEXUAL BEHAVIOR 7-16 (October 2020), https://doi.org/10.1007/s10508-020-01844-2.

32 *Id.* at 13-14.

As is true about Plaintiffs, Amici initially believed that medical transition would feel empowering, satisfying and lifesaving. However, they learned that hormones and surgeries did not resolve the underlying causes of their GD and did not enable them to live "healthy well-adjusted lives." What they had believed was true—that they were men trapped in women's bodies—was in fact a feeling brought about by trauma and other underlying issues. Changing their bodies to satisfy that feeling was ultimately ineffective and harmful.

Amici are a small sample of detransitioners now telling their stories.[33] Mental health clinicians and researchers around the world have taken notice and called for additional research into this poorly studied and underestimated population[34] and for rejection of the gender-affirming care model for minors.[35] A plethora of recent

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[33] Reddit's "detrans" forum (http://www.reddit.com/r/detrans/) has over 23,000 members. Seventy-five detransitioners tell their stories in Post Trans Booklet available at https://post- trans.com/Detransition-Booklet, and many more on https://sexchangeregret.com/ voices/ and https://www.detransvoices.org

[34] Entwistle, *Debate: Reality Check – Detransitioners Testimonies Require Us to Rethink Gender Dysphoria.* 26 CHILD AND ADOLESCENT MENTAL HEALTH (May 14, 2021)

[35] Notably, Finland - SEGM, *One Year Since Finland Broke with WPATH "Standards of Care"* (July 2, 2021); Sweden - SEGM, *Sweden's Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies* (May 5, 2021); Australia and New Zealand - SEGM, *First Mental Health Guideline to Explicitly Deviate from Gender Affirmation* (November 7, 2021); and the U.K. - *The Cass Review: Independent review of gender identity services for children and young people*.

research demonstrates that transition regret is not a rare inconsequential anomaly.[36] Two factors account for the increase - gender affirmation based solely on self-reports and lack of required comprehensive assessments and therapies to assess and treat underlying neuro/psych issues that cause or contribute to the patient's distress and self-perception prior to embarking on medical interventions.[37]

Amici's lived experiences tragically attest to the validity of these findings.

**Keira Bell, U.K.**

Keira Bell, 24, challenged the WPATH protocols used at the Tavistock Gender Identity Clinic, part of the U.K.'s National Health Service. *Bell v. The Tavistock and Portman NHS Foundation Trust,* [2020] EWHC 3274 (Admin). Her story of care under the WPATH guidelines convinced the High Court that the hormonal and surgical treatments were experimental and the guidelines did not appropriately safeguard adolescents. *Id.* (This case is on appeal).

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[36] Hall et al., *Access to care and frequency of detransition among short discharged by UK national adult gender identity clinic: retrospective case-note review*, BJPSYCH OPEN (Oct.1, 2021) showing based on review of 2017 medical records over 10% indicated patients detransitioned or withdrew prior to completing treatment.

[37] Lisa Littman, *Individuals Treated for Gender Dysphoria and Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, ARCHIVES OF SEXUAL BEHAVIOR (Oct. 5, 2021); Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, J. HOMOSEXUALITY (Apr. 30, 2021). See also Lisa Marchiano, *Gender detransition: a case study*, ANALYTICAL PSYCHOLOGY (Nov. 10, 2021) (listing research).

Keira was an athletic gender non-conforming child who felt more comfortable around boys. She became distressed about changes happening to her body as part of puberty. She wanted to continue fitting in with the boys and did not want to deal with what teenage girls had to deal with. She was severely depressed and suffered from anxiety beginning at about age 14. At age 15, she began binding her breasts and appearing as a boy in public. That year she went to a psychologist about gender transition and referred to Travistock where she was diagnosed her with GD based on her self-report but did not address her depression and anxiety. At 16, she was put on puberty blockers and at 17, began taking testosterone.

However, as her facial features, muscle mass and voice masculinized, she became more dysphoric about her breasts, and still felt isolated and depressed and decided she needed a mastectomy to better align her body with her feelings (her identity). She saw a surgeon once for a pro-forma pre-surgery consultation. Once Keira was diagnosed with GD each step in the medicalized transition pathway was simply viewed as the logical next step. The surgery went smoothly. Emotionally, however, it was anti-climactic, and not enough to resolve her depression and anxiety.

Keira was confused. She saw people speak about euphoria regarding taking testosterone and double mastectomies. She had wanted to transition very badly and had high expectations, but once it was done she did not experience the euphoria she had heard about. Even though she was passing well as a male, she realized she never

would actually be a man and that intimate relationships would not be any easier. She began to look introspectively and wonder if transition had actually benefitted her.

After a year she decided to transition back to her female identity but realized that she could never fully regain her female body. She is still processing the indescribable feeling of loss and regret. With the benefit of maturity, she now understands the hormones and surgery were all experimental and realizes that she had internalized misogynist messages about what it means to be a woman which allowed her to be experimented on.

**Laura Becker, Wisconsin.**

Laura Becker, 24, was a gender-nonconforming child who had an emotionally abusive childhood. She was diagnosed with depression and anxiety and being on the autism spectrum at age 11. Laura was hospitalized numerous times suffering from undiagnosed post-traumatic stress disorder and suicidal ideation, beginning at age 15. On Tumblr she found out about trans identities and a community of kids like herself who did not fit in with traditional cultural gender stereotypes; and began to wonder if she was transgender or agender.

At age 17, Laura started experiencing severe GD and began binding her breasts and wearing men's clothes. However, she had difficulty finding social acceptance as either a masculine girl or an effeminate boy. She saw a therapist who

diagnosed her with GD and affirmed her trans-identification but did not offer any psychotherapeutic alternatives for her significant mental health issues.

Believing that she could only be "happy" if she medically transitioned, Laura began taking testosterone at age 19 after a single visit to a clinic. The testosterone exacerbated her depression and anxiety, made her more aggressive, and caused her to engage in increased risky behaviors. After another hospitalization for suicidal ideation, Laura decided her only option was a mastectomy to fully transition and resolve her gender distress. Laura obtained the required letters of recommendation for the surgery from her general practitioner and psychiatrist, but neither questioned her about her mental health issues or how they may be contributing to her desire for gender-affirming medical treatments.

After the surgery, Laura initially felt "happy" and relieved. However, as with the testosterone, there was no improvement in her mental health, self-esteem, anxiety, or depression, and she was again hospitalized. She began to get therapy that started to get at the causes for her dysphoria and provided tools to begin to practice self-love. She received a psychiatric evaluation which diagnosed her as having PTSD resulting from childhood emotional abuse. Once she received the proper diagnosis, she improved and detransitioning began to happen.

With greater maturity and improved mental health, Laura realized the gravity of what she had done. She felt ashamed, sad, angry at herself, and angry at the mental

health professionals who failed her. She realized that she had undergone unnecessary medical treatments to address a mental health condition better treated with appropriate psychotherapy. Her health was compromised and her body disfigured based on false hopes that obscured powerful underlying causal issues. She cautions that the notion of allowing teens to obtain medical transition treatments is incredibly irresponsible, destructive, and unethical without providing these young people with the intensive psychotherapy necessary to overcome the underlying issues.

**Sinead Watson, Scotland**

Sinead Watson, 30, was a gender-nonconforming "tomboy" as a child. She started experiencing GD at about age 14 when she started developing large breasts and some men began sexually harassing her. At 16, a friend of the family sexually assaulted her, but she not was not provided any therapy to address the psychological trauma. By her late teens, she began to have romantic crushes on girls and to hate being a woman. Online she googled "I hate being a woman" and search results linked her to information about variations of gender identities.

Sinead started socially transitioning in 2013 by cutting her hair, binding her breasts, and wearing men's clothing. At age 20, she began intensive viewing of internet vlogs made by women who had transitioned to a male identity. These said that transition would alleviate dysphoria and that if you hate being a woman and having breasts then you must be a trans-man. She believed those messages and

fantasized that she could become a man who was stronger, less vulnerable as a way out of her depression and anxiety.

Sinead was hospitalized at age 21 after a suicide attempt and began to consider medically transitioning. She was placed on a year's long waiting list at a gender clinic. Once she was seen, she was diagnosed with GD and prescribed testosterone. Although her medical records indicated depression, inpatient psychiatric care and alcoholism, no mental health therapies were required or offered prior to beginning medicalization. Her mental health issues were considered secondary to her need to medically transition. A year later, she had a mastectomy at 26 and felt amazing because she had finally accomplished a long-term goal and was free of her breasts.

After about four months, the euphoria died down. Sinead still hated herself and found that medically transitioning had not helped her underlying issues with sexual abuse and depression. She began to understand that her fantasy to become a man was not the answer to her problems. She understood that she needed therapy to treat the issues and began to engage in self-care, talk about the sexual abuse with people who cared, and gain a new healthier perspective.

Sinead returned to her female identity but will never regain the healthy body parts that were removed. She is astounded that doctors prescribed testosterone and performed a double mastectomy on a physically healthy young woman without asking the basic question "Why do you hate being a girl?" Asking that question and

exploring the answer via talk therapy would have changed her life in a much more effective way than did medicine and surgery.

**KathyGrace Duncan, Oregon**

From a very young age, KathyGrace was gender nonconforming - preferred male attire, thought she was a "boy" and wanted to live as one. However, it was not until after she had medically transitioned and lived for many years as a man that she was able to reflect on the complex true origins and causes for her self-perception and GD. Growing up in a dysfunctional family in which her mother was often the victim of her father's emotional and verbal abuse, KathyGrace intuited the message that "my dad would love me if I were a boy." Sexual abuse by a family member between the ages of 10 and 12 further convinced her that being a girl meant being unsafe and unlovable.

In sixth grade, she learned about female to male transsexuals, that her distress was caused by not having the "right" body; and the only way to live a normal life was to medically transition and become a heterosexual male. At age 19, she began living as a man named Keith and went to a therapist who formally diagnosed her with GD. She began testosterone and a year later had a mastectomy. At the time, she believed it was necessary so that what she saw in the mirror matched what she felt on the inside. She never viewed her condition as touching on mental health issues, and neither did the therapist who diagnosed her. Whether her self-perception

and desire to transition was related to her mental health issues was never explored. After 11 years passing as a man and living a relatively "happy" and stable life (which included having a number of girlfriends), KathyGrace realized that she was living a lie built upon years of repressed pain and abuse -- hormones and surgery had not helped her resolve underlying issues of rejection, abuse, and sexual assault. Her desire to live as a man were symptoms of deeper unmet needs.

With the help of life coaches and a supportive community, KathyGrace returned to her female identity and began addressing the underlying issues that had been hidden in her attempt to live as a man. She experienced depression that she had repressed for years and grieved over the irreversible changes to her body. If someone had walked with her through her feelings instead of affirming her desire to transition, then she would have been able to address her issues more effectively and not spend so many years making and recovering from a grave mistake.

**Laura Reynolds, American living in Austria**

Laura Reynolds was a gender non-conforming child who was diagnosed with ADHD, depression, and anxiety. Later she learned she had undiagnosed autism. When she learned that ADHD was more common in boys, she began to think she had a "male brain." This accounted for why she did not fit in socially and wanted to have more freedom to be active like boys. When changes to her body brought sexual harassment, she experienced a sense of panic about her female body and she became

dysphoric. At 15, Laura learned about transitioning on the internet. She thought it was possible to change her sex, and she began binding her breasts and tried to socially transition.

At 18, Laura went to a gender clinic and was diagnosed with GD and started on testosterone. The psychologist never explored why she thought she had GD, wanted to transition or reviewed her neurological deficits. A year later, she scheduled a double mastectomy. At the time, she believed it was possible that she could become a man, that breast removal was necessary to be a "Transman," and that she would never want to have children.

Two rounds of breast removal surgery were traumatic and resulted in increased body dysphoria. She was left with large amounts of scar tissue and permanent disfigurement. She realized that she could not change her sex and that it would not be possible to actually live as a man. She decided to detransition and get off testosterone for health reasons, including painful vaginal atrophy.

At 34, Laura became a single parent. Laura had gestational diabetes while pregnant and was told her baby should breast feed in order to reduce his chances of becoming diabetic. This was rendered impossible because she had been affirmed along the pathway to medical transition and surgery while in her youth. Laura believes that due to her autism, she was neurologically immature as a youth, had a very limited sense of the world and of what it meant to live as a transgender person.

Also, there were many complex reasons for her long-lasting dysphoria which were never dealt with because the mental health professional she saw assumed it was simply because she was transgender.

**Carol Freitas, California**

Similarly, Carol Freitas would have been spared physical, psychological, and emotional losses if she had received a proper diagnosis and treatment for PTSD and depression before undergoing years of medical and surgical interventions. Carol's father died when she was 18 months old and her Mother remarried when she was four. As a youth, Carol was gender non-conforming but lived in a household where gender expression was strictly aligned with cultural stereotypes -- she was not allowed to wear boys' clothes or play boys' sports. At puberty she realized she was same-sex attracted with crushes on girls and became depressed and anxiety-ridden as she feared what "being Gay" might mean to how she lived her life and family relationships. She dropped out of school. At 20, she began to meet other LGBT youth and her life stabilized, but she also learned that many masculine females, like herself, felt that they were "born in the wrong body" and were transitioning. She went to a gender therapist who diagnosed her with GD and told her that transition was the only treatment that would alleviate her discomfort and anxiety. But at the time, "gatekeeping" required that she first live as man for 6 months which was not

possible because she had large breasts. At the time. Carol viewed herself as a male trapped in the "wrong body," but her mental health otherwise was stable.

However, a few years later, after she experienced successive losses of close relatives, old wounds and issues erupted - along with a sense of despair over being in the wrong body. By that time, the rules had changed and she could immediately get started on testosterone. Four months later, she made an appointment with a plastic surgeon and had her healthy breasts removed. At no time was there discussion of emotional and mental health issues or her feelings about being same-sex attracted.

Her anxiety and depression intensified when she was taking testosterone to the point that she could not leave her house. She saw a therapist specifically for depression and was provided with an anti-depressant that made a profound positive difference. Within a month, she realized she had not needed to transition; it was the biggest mistake she had ever made. Carol believes that healthcare providers did not ask about her mental health issues, or her attitudes about being a homosexual, because they believed that they were caused by GD and that transitioning would fix the problem. In fact, the opposite was true.

## CONCLUSION

Young vulnerable people with GD such as Plaintiffs and Amici deserve holistic compassionate care based on science, not a conveyor belt of chemicals and surgery which place the burden of the diagnosis on the adolescent, relieve the

medical provider of accountability and responsibility for misdiagnosis, and fail to treat contributory mental health conditions that, if addressed, would have resulted in avoiding medical harm.

Arkansas' Act 626 banning gender-affirming medical treatments for minors is necessary to safeguard underage patients, their parents, and the medical community from unethical medical practices and to prevent unnecessary medical harm.

For these reasons, the district court's Order should be vacated, the preliminary injunction lifted, and the case remanded to the District Court.

Dated: November 19, 2021.

/s/Ernest G. Trakas
Ernest G. Trakas (Counsel of Record)
Evans & Dixon, LLC.
211 N. Broadway, Suite 2500
St. Louis, Missouri 63102
(314) 552-4188
etrakas@evans-dixon.com
Attorneys for Amici Curiae

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**Signature** /s/ Ernest G. Trakas_____
Attorney for Amici Curiae.

**Date** _November 19, 2021

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Attorney for Amici Curiae.

**Date** _November 19, 2021

**United States Court of Appeals**
***For The Eighth Circuit***
Thomas F. Eagleton U.S. Courthouse
111 South 10th Street, Room 24.329
St. Louis, Missouri 63102

**Michael E. Gans**
***Clerk of Court***

**VOICE (314) 244-2400**
**FAX (314) 244-2780**
**www.ca8.uscourts.gov**

November 23, 2021

Mr. Ernest G. Trakas
EVANS & DIXON
Suite 2500
211 N. Broadway
Saint Louis, MO 63102

RE: 21-2875 Dylan Brandt, et al v. Leslie Rutledge, et al

Dear Counsel:

The amicus curiae brief of Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, and Carol Freitas, has been filed. If you have not already done so, please complete and file an Appearance form. You can access the Appearance Form at www.ca8.uscourts.gov/all-forms.

Please note that Federal Rule of Appellate Procedure 29(g) provides that an amicus may only present oral argument by leave of court. If you wish to present oral argument, you need to submit a motion. Please note that if permission to present oral argument is granted, the court's usual practice is that the time granted to the amicus will be deducted from the time allotted to the party the amicus supports. You may wish to discuss this with the other attorneys before you submit your motion.

Michael E. Gans
Clerk of Court

CRJ

Enclosure(s)

cc: Ms. Lauren R. Adams
Mr. Garrard R. Beeney
Mr. Nicholas J. Bronni
Vernadette R. Broyles
Mr. John J. Bursch
Mr. Michael A. Cantrell
Ms. Jennifer C. Chavez
Ms. Leslie Cooper
Ms. Sharon Elizabeth Echols
Mr. James D. Esseks
Ms. Sarah C. Everett

Ms. KaTina Hodge-Guest
Mr. Alexander S. Holland
Mr. Edmund G. LaCour Jr.
Mr. Duncan C. Simpson LaGoy
Mr. Peter Drake Mann
Ms. Mary Elizabeth McAlister
Mr. Gary McCaleb
Mr. Christopher Ernest Mills
Mr. Jonathan Joseph Ossip
Ms. Laura Kabler Oswell
Mr. Chase B. Strangio
Mr. Gary L. Sullivan
Joel H. Thornton
Mr. Christopher L. Travis
Mr. Vincent M. Wagner
Ms. Breean Walas

District Court/Agency Case Number(s): 4:21-cv-00450-JM