

No. 21-2875

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

DYLAN BRANDT ET AL.,
Plaintiffs-Appellees,
v.

LESLIE RUTLEDGE, ET AL.,
Defendants-Appellants

On Appeal from the United States District Court for the
Eastern District of Arkansas
Case No. 4:21-CV-00450-JM (Hon. James M. Moody Jr.)

**BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS
AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL
HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS-APPELLEES
AND AFFIRMANCE**

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, the undersigned counsel for the American Academy of Pediatrics (“AAP”), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry (“AACAP”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality (“GLMA”), the American College of Osteopathic Pediatricians (“ACOP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the American Psychiatric Association (“APA”), the Arkansas Chapter of the American Academy of Pediatrics (“ARAAP”), the Arkansas Council on Child and Adolescent Psychiatry (“ACCAP”), the Arkansas Medical Society (“AMS”), the Arkansas Psychiatric Society, the Association of Medical School Pediatric Department Chairs (“AMSPDC”), the Endocrine Society, the National Association of Pediatric Nurse Practitioners (“NAPNAP”), the Pediatric Endocrine Society (“PES”), the Society for Adolescent Health and Medicine (“SAHM”), the Society for Pediatric Research (“SPR”), the Society of Pediatric Nurses (“SPN”), the Societies for Pediatric Urology and the World Professional Association for Transgender Health (“WPATH”) certify that:

1. AAP, the Academic Pediatric Association, AACAP, GLMA, ACOP, AMA, APS, APA, ARAAP, ACCAP, AMS, the Arkansas Psychiatric Society,

AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, the Academic Pediatric Association, AACAP, GLMA, ACOP, AMA, APS, APA, ARAAP, ACCAP, AMS, the Arkansas Psychiatric Society, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU or WPATH.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics (“AAP”), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry (“AACAP”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality (“GLMA”), the American College of Osteopathic Pediatricians (“ACOP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the American Psychiatric Association (“APA”), the Arkansas Chapter of the American Academy of Pediatrics (“ARAAP”), the Arkansas Council on Child and Adolescent Psychiatry (“ACCAP”), the Arkansas Medical Society (“AMS”), the Arkansas Psychiatric Society, the Association of Medical School Pediatric Department Chairs (“AMSPDC”), the Endocrine Society, the National Association of Pediatric Nurse Practitioners (“NAPNAP”), the Pediatric Endocrine Society (“PES”), the Society for Adolescent Health and Medicine (“SAHM”), the Society for Pediatric Research (“SPR”), the Society of Pediatric Nurses (“SPN”), the Societies for Pediatric Urology (“SPU”) and the World Professional Association for Transgender Health (“WPATH”).¹

¹ The parties have consented to the filing of this brief. Fed. R. App. P. 29(a)(2). *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief. Fed. R. App. P. 29(a)(4)(E).

Amici are professional medical and mental health organizations seeking to ensure that all children and adolescents, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve to thrive both physically and emotionally. *Amici* include international, national, and state organizations and represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. *Amici* WPATH and the Endocrine Society also publish the most widely accepted and used medical guidelines for treating gender dysphoria, which the Appellants (the “State of Arkansas” or “State”) and several of its *amici* repeatedly mischaracterize. The Court should consider *amici*’s brief because it provides important expertise and addresses misstatements about gender-affirming care in the briefs filed by the State and the State’s *amici*.

INTRODUCTION

Act 626 (hereinafter, the “Healthcare Ban”) would prohibit Arkansas healthcare providers from providing or even referring patients under the age of 18 for critical, evidence-based treatments for gender dysphoria. As the district court recognized, this care is supported by scientific evidence, and denying it to adolescents who need it puts them at risk of significant harm to their mental health. On appeal, Arkansas and several of its *amici* mischaracterize the well-accepted medical guidelines for treating gender dysphoria in adolescents and the evidence supporting those guidelines. They also level factually inaccurate and unsupported attacks against *amici*. Below, *amici* provide the Court with an accurate description of these well-accepted treatment guidelines, summarize the scientific evidence supporting the medical interventions prohibited by the Healthcare Ban, and respond to the baseless attempts to discredit those guidelines and the evidence underlying them.

Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the patient’s gender identity (*i.e.*, the innate sense of oneself as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient’s life.² If not treated, or treated improperly, gender dysphoria can result in

² See R. Doc. 45-23 (AAP Policy Statement) at 2 tbl. 1, 3.

debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is “gender-affirming care.”³ Gender-affirming care is care that supports a child or adolescent as they explore their gender identity—in contrast with efforts to change the individual’s gender identity to match their sex assigned at birth, which are known to be ineffective and harmful. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical interventions, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall well-being of adolescents with gender dysphoria.

The Healthcare Ban, however, disregards this medical evidence by prohibiting healthcare providers from treating adolescent patients with gender dysphoria in accordance with the accepted standard of care. In addition, the Healthcare Ban prevents healthcare providers from utilizing their medical

³ *Id.* at 10.

education, training, and expertise in treating these adolescent patients, and profoundly intrudes on the patient-provider relationship by completely banning referrals for gender-affirming medical treatments.⁴ It is for these reasons, among others, that pediatricians, endocrinologists, psychiatrists, and other medical professionals practicing in Arkansas opposed the Healthcare Ban, expressing their concern that it would jeopardize their patients' health and well-being.⁵ Accordingly, *amici* urge this Court to affirm the district court's preliminary injunction.

ARGUMENT

This brief begins by providing background on gender identity and gender dysphoria. It then describes the well-accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that suggests the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying care to those who need it.

⁴ See R. Doc. 30-1 (Letter from Arkansas Chapter of American Academy of Pediatrics to A. Hutchinson (Mar. 30, 2021)).

⁵ See *id.*; R. Doc 30-2 (Letter from Arkansas Council on Child and Adolescent Psychiatry and American Academy of Child and Adolescent Psychiatry to A. Hutchinson (Mar. 31, 2021)).

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a particular gender.⁶ Most people have a gender identity that aligns with their sex assigned at birth.⁷ However, transgender people have a gender identity that does not align with their sex assigned at birth.⁸ In the United States, it is estimated that approximately 1.4 million individuals are transgender.⁹ Of these individuals, approximately 10 percent are teenagers aged 13 to 17.¹⁰ Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

The medical community's understanding of transgender people and gender identity has evolved considerably over the past two decades.¹¹ There is now a widely held recognition that simply being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."¹² The

⁶ R. Doc. 45-23 (AAP Policy Statement) at 2 tbl.1

⁷ See R. Doc. 45-22 (Am. Psychological Ass'n Guidelines) at 834.

⁸ See *id.* at 832.

⁹ See Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, Williams Inst., at 2 (Jan. 2017), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf>.

¹⁰ See *id.* at 3.

¹¹ See R. Doc. 45-22 (Am. Psychological Ass'n Guidelines) at 832.

¹² Jack Drescher et al., *Position Statement on Discrimination Against Transgender and Gender Diverse Individuals*, Am. Psychiatric Ass'n (APA), 1 (2018), <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf>.

general consensus of the medical and mental health communities is that transgender identities are “normal variations of human identity and expression.”¹³

While being transgender is a normal variation of human identity, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to “impairment in peer and/or family relationships, school performance, or other aspects of their life.”¹⁴ The American Psychiatric Association’s Diagnostic and Statistical Manual defines the diagnostic criteria for gender dysphoria as including (1) a marked incongruence between one’s experienced or expressed gender and assigned gender of at least 6 months’ duration, and (2) clinically significant distress or impairment in social, occupational, or other important areas of functioning.¹⁵

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.¹⁶ Research suggests the highly elevated rate of

¹³ James L. Madara, *AMA to states: Stop interfering in healthcare of transgender children*, Am. Med. Ass’n (Apr. 26, 2021), <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children>; *see also* Am. Psychological Ass’n, *APA Resolution on Gender Identity Change Efforts*, 4 (2021), <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>.

¹⁴ R. Doc. 45-23 (AAP Policy Statement) at 3.

¹⁵ *See* R. Doc. 45-24 (DSM-5) at 452-53.

¹⁶ *See* Brayden N. Kameg & Donna G. Nativio, *Gender dysphoria in youth: An overview for primary care providers*, 30(9) J. Am. Assoc. Nurse Pract. 493 (2018), <https://pubmed.ncbi.nlm.nih.gov/30095668/>.

suicidality among transgender people. Indeed, in one recent national survey, over 60 percent of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75 percent reported symptoms of generalized anxiety disorder in the preceding two weeks.¹⁷ Even more troubling, more than 50 percent of this population reported having seriously considered attempting suicide,¹⁸ and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.¹⁹

II. The Widely Accepted Guidelines for Treating Adolescents With Gender Dysphoria Provide for Medical Interventions When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, gender-affirming medical interventions are necessary.²⁰ This care greatly reduces the negative physical and mental health consequences that

¹⁷ See Amit Paley, *The Trevor Project 2020 National Survey*, at 1, <https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf>.

¹⁸ See *id.* at 2.

¹⁹ See Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, US Dep’t of Health and Human Servs., Centers for Disease Control & Prevention, 68(3) MMWR 67, 70 (Jan. 25, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf>.

²⁰ See, e.g., Endocrine Soc’y, *Transgender Health: An Endocrine Society Position Statement* (2020) (hereinafter “Endocrine Soc’y Position Statement”), <https://www.endocrine.org/advocacy/position-statements/transgender-health>.

result when gender dysphoria is untreated.²¹ The accepted guidelines for providing this care to adolescents were developed through a professional and transparent process and are supported by empirical research.

A. The Guidelines for Treating Gender Dysphoria Include Thorough Mental Health Assessments and, for Some Adolescents, Medical Interventions.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: specifically, (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (collectively, the “Guidelines”).²²

The Guidelines provide that youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified mental health professional (“MHP”). Further, the Guidelines provide that each patient who receives gender-affirming care receives only evidence-based, medically necessary, and appropriate interventions that are tailored to the patient’s individual needs.

²¹ *See id.*

²² R. Doc 45-21 (Endocrine Society Guidelines); R. Doc 45-19 (WPATH Guidelines).

1. Gender-Affirming Care Begins With a Robust Mental Health Assessment, Which Is Required Before Any Further Medical Interventions Are Provided.

According to the Guidelines, gender-affirming care begins with a thorough evaluation by a qualified mental health professional, who: (1) is trained in childhood and adolescent developmental psychopathology, (2) is competent in diagnosing and treating the ordinary problems of children and adolescents, and (3) meets the competency requirements that the Guidelines specify for MHPs working with adults.²³ These requirements include: (1) a master’s degree or its equivalent in a clinical behavioral science field, (2) competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes, (3) the ability to recognize and diagnose coexisting mental health concerns and distinguish them from gender dysphoria, (4) documented supervised training and competence in psychotherapy or counseling, (5) being knowledgeable about gender identities and expressions, and the assessment and treatment of gender dysphoria, and (6) continuing education in the assessment and treatment of gender dysphoria.²⁴

When evaluating a patient with gender dysphoria, the MHP must, among other things, assess the patient’s “gender identity and gender dysphoria, history and

²³ See R. Doc. 45-19 (WPATH Guidelines) at 13.

²⁴ See *id.* at 22.

development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers.”²⁵ The MHP also must screen the patient for coexisting mental health concerns.²⁶ Any coexisting mental health concerns “need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria.”²⁷ If gender dysphoria is diagnosed, the Guidelines provide that the MHP should discuss available treatment for gender dysphoria and any coexisting concerns, including potential benefits and risks.²⁸

2. The Guidelines Recommend Only Non-Physical Interventions for Prepubertal Children Suffering From Gender Dysphoria.

For prepubertal children suffering from gender dysphoria, the Guidelines provide for mental healthcare and support for the child and their family.²⁹ The Guidelines do *not* recommend that any physical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.³⁰

²⁵ *Id.* at 23-24.

²⁶ *Id.* at 24-25.

²⁷ *Id.* at 25.

²⁸ *Id.* at 24.

²⁹ *See id.* at 16-17; R. Doc. 45-21 (Endocrine Society Guidelines) at 3877.

³⁰ *See* R. Doc. 45-19 (WPATH Guidelines) at 17-18, R. Doc. 45-21 (Endocrine Society Guidelines) at 3871.

3. In Certain Circumstances, the Guidelines Provide For the Use of Medical Interventions To Treat Adolescents Suffering From Gender Dysphoria.

For patients whose gender dysphoria continues into adolescence—after the onset of puberty—the Guidelines provide that in addition to mental healthcare, medical interventions may also be indicated. Before an adolescent may receive any medical interventions for gender dysphoria, a qualified MHP must determine that: (1) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria, (2) the gender dysphoria emerged or worsened after the onset of puberty, (3) any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, and (4) the adolescent and the parents or guardians have given informed consent to the treatment.³¹ Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (5) agree with the indication for treatment, (6) confirm that the patient has started puberty, and (7) confirm that there are no medical contraindications.³²

If all of the above criteria are met, the Guidelines instruct that gonadotropin-releasing hormone (GnRH) analogues, or “puberty blockers,” may be offered

³¹ R. Doc. 45-19 (WPATH Guidelines) at 19.

³² R. Doc. 45-21 (Endocrine Society Guidelines) at 3878 tbl. 5.

beginning at the onset of puberty.³³ The purpose of puberty blockers is to delay irreversible pubertal development until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.³⁴ GnRH analogues have well-known efficacy and side-effect profiles.³⁵ In addition, their effects are generally reversible.³⁶ In fact, GnRH analogues have been used by pediatric endocrinologists for more than 30 years for the treatment of precocious puberty.³⁷ The risks of any serious adverse effects of these treatments are exceedingly rare when provided under clinical supervision.³⁸

Later in adolescence—and if the patient, their parents or guardians, and medical team all agree it is medically indicated—hormone therapy may be used to

³³ R. Doc. 45-19 (WPATH Guidelines) at 18; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579 (2021), <https://www.nejm.org/doi/full/10.1056/NEJMp2106314>.

³⁴ R. Doc. 45-19 (WPATH Guidelines) at 19.

³⁵ Martin, *supra* note 33 at 2.

³⁶ *See id.*

³⁷ *See id.*

³⁸ *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria*, 6 *Psychoneuroendocrinology* 190 (2015), <https://pubmed.ncbi.nlm.nih.gov/25837854/>, (no adverse impact on executive functioning); Ken C. Pang, et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) *Pediatrics* e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

initiate puberty consistent with the patient's gender identity.³⁹ Hormone therapy is only prescribed when a qualified MHP has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to assent to the treatment, and that any coexisting problems that could interfere with treatment have been addressed.⁴⁰ A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication for the treatment, the patient and their parents or guardians must be informed of the potential effects and side effects, and the patient and the patient's parents or guardians must give their informed consent.⁴¹ Hormone therapy involves using cross-sex hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.⁴² Although some of these changes become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.⁴³

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications

³⁹ Martin, *supra* note 33 at 2.

⁴⁰ R. Doc. 45-21 (Endocrine Society Guidelines) at 3878 tbl. 5.

⁴¹ *See id.*

⁴² *See* R. Doc 45-23 (AAP Policy Statement) at 6.

⁴³ *See id.* at 5-6.

and close surveillance to mitigate any potential risks.⁴⁴ Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental healthcare team. There is “no one-size-fits-all approach to this kind of care.”⁴⁵

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process.

1. The Guidelines for the Treatment of Gender Dysphoria Are the Product of the Same Scientific Rigor That Underpins Other Important Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other medical guidelines promulgated by *amici* and other professional medical organizations. These processes are specifically designed to ensure that treatment recommendations are based on the best available scientific evidence, and include subjecting the proposed guidelines to multiple rounds of scientific review.

For example, the Endocrine Society’s Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (CPG)

⁴⁴ See R. Doc. 45-21 (Endocrine Society Guidelines) at 3871, 3876.

⁴⁵ Martin, *supra* note 33, at 1.

was developed following a 26-step, 26-month drafting, comment, and review process.⁴⁶ The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized and methodologically sound Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.⁴⁷ That assessment of the evidence using GRADE is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of medical professionals. Reviewers are subject to strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.⁴⁸ Further, the Endocrine Society Clinical Guidelines Committee (CGC) continually surveils the portfolio of published clinical practice guidelines for potential updates to these and other guidelines. Recently, the CGC reviewed the Transgender CPG and determined the 2017 guideline continues to reflect the best, most up-to-date medical evidence.

The WPATH standards are the result of a drafting, comment, and review

⁴⁶ See R. Doc. 45-21 (Endocrine Society Guidelines) at 3872-73.

⁴⁷ See Gordon Guyatt et al., *GRADE guidelines: 1. Introduction - GRADE evidence profiles and summary of findings tables*, 64 *J. Clinical Epidemiology* 383 (2011), <https://www.who.int/alliance-hpsr/resources/publications/HSR-synthesis-Guyatt-2011.pdf>; Gordon H. Guyatt et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*, 336 *BMJ* 924 (2008), https://www.who.int/hiv/topics/treatment/grade_guyatt_2008.pdf.

⁴⁸ Endocrine Society, *Methodology*, <https://www.endocrine.org/clinical-practice-guidelines/methodology> (last visited Jan. 17, 2022).

process that took five years.⁴⁹ The draft guideline papers went through journal peer-review and were then publicly available for discussion and debate, including multiple additional rounds of feedback from experts in the field, as well as from transgender individuals.⁵⁰ They are periodically updated to account for new developments in the research and practice, and WPATH is currently in the process of its eighth revision.⁵¹

2. The Guidelines Are the Result of a Process Based in Science, Not Ideology.

The State’s *amici* attack the undersigned *amici*, and the medical profession more broadly, as being motivated by ideology rather than science. These attacks are baseless. There is no basis for the claim that the major medical and mental health professional groups in the United States—and within Arkansas—are acting based on ideology rather than their medical judgment about the best care for patients.

For example, in an attempt to brand the American Academy of Pediatrics as ideologically driven, the state’s *amici* assert that the AAP “disregarded the request of over 80 percent of its members for more discussion of ‘alternatives to the use of

⁴⁹ See R. Doc. 45-19 (WPATH Guidelines) at 109-10.

⁵⁰ See *id.*

⁵¹ WPATH, *Standards of Care 8: History and Purpose*, <https://www.wpath.org/soc8/history>.

hormone therapies” to treat gender dysphoria.⁵² This is inaccurate. In fact, one member suggested in an online forum that AAP should reconsider its support for gender-affirming care and submitted a resolution to that effect—a resolution that was not endorsed by any chapter, committee, council, section, or district.⁵³ Only 57 of the AAP’s 67,000 members commented in support of the resolution—0.08 percent of AAP’s members, not 80 percent.⁵⁴ Ultimately, the resolution was soundly defeated by the voting members at the AAP Leadership Conference.⁵⁵

The State’s *amici* also point to remarks made by Dr. Erica Anderson (past-president of WPATH’s regional affiliate, USPATH) reflecting concerns that some providers are not following these protocols to suggest that she opposes gender-affirming medical treatments banned by Act 626.⁵⁶ They similarly point to comments made by Dr. Marci Bowers (WPATH president-elect) about how care can be improved. But both Dr. Bowers and Dr. Anderson “stand behind the appropriate care of transgender and gender diverse youth, which includes, when

⁵² Brief of Family Research Council as Amicus Curiae Supporting Defendants-Appellants, *Brandt v Rutledge* (No. 21-2875), at 26 (hereinafter, “FRC Amicus Br.”) (citation omitted).

⁵³ See Alyson Sulaski Wyckoff, *AAP continues to support care of transgender youths as more states push restrictions*, AAP News, Jan. 6, 2022, <https://publications.aap.org/aapnews/news/19021>.

⁵⁴ See *id.*

⁵⁵ See *id.*

⁵⁶ See Amicus Brief of Quentin L. Van Meter, M.D. et al., *Brandt v Rutledge* (No. 21-2875), at 32; FRC Amicus Br. at 22-23.

indicated, the use of ‘puberty blockers’ ... [and] gender-affirming hormones” and “oppose[] any attempts to dictate or restrict, by statute, judiciary, or otherwise, access to such treatment when recommended according to accepted standards and guidelines.”⁵⁷

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

1. Multiple Studies Indicate the Effectiveness of Gender-Affirming Medical Interventions.

The results of multiple studies indicate that adolescents suffering from gender dysphoria who receive medical interventions as part of their gender-affirming care experience improvements in their overall well-being.⁵⁸ Eight studies have been published that investigated the use of puberty blockers on adolescents suffering from gender dysphoria,⁵⁹ and six studies have been published that investigated the use of hormone therapy to treat adolescents suffering from gender dysphoria.⁶⁰ These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including

⁵⁷ Joint Letter from USPATH and WPATH (Oct. 12, 2021), <https://www.wpath.org/media/cms/Documents/Public%20Policies/2021/Joint%20WPATH%20USPATH%20Letter%20Dated%20Oct%2012%202021.pdf>.

⁵⁸ See Martin, *supra* note 33, at 2.

⁵⁹ For a listing of these studies, see R. Doc. 51-1 ¶ 13.

⁶⁰ For a listing of these studies, see *id.* ¶ 14.

statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.⁶¹ The study found that those who received puberty blocking hormone treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.⁶² Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.⁶³ Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.⁶⁴

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 by de Vries et al. found that treatment with puberty blockers was associated with decreased depression and improved

⁶¹ See Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145(2) *Pediatrics* e20191725 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269/>.

⁶² See *id.*

⁶³ See *id.*

⁶⁴ See Luke R. Allen et al., *Well-being and suicidality among transgender youth after gender-affirming hormones*, 7(3) *Clinical Prac. Pediatric Psych.* 302 (2019), <https://psycnet.apa.org/record/2019-52280-009>.

overall functioning.⁶⁵ A prospective six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.⁶⁶ “Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population.”⁶⁷

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming treatments prohibited by the Healthcare Ban are effective for the treatment of gender dysphoria. For these reasons, and consistent with the clinical experience of healthcare providers, the use of the gender-affirming medical interventions specified in the Guidelines are “supported by all mainstream

⁶⁵ See Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) *J. Sexual Medicine* 2276 (2011), <https://pubmed.ncbi.nlm.nih.gov/20646177/>.

⁶⁶ Annelou L.C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) *Pediatrics* 696 (2014), <https://pubmed.ncbi.nlm.nih.gov/25201798/>.

⁶⁷ Stephen M. Rosenthal, *Challenges in the care of transgender and gender-diverse youth: an endocrinologist’s view*, 17 *Nature Rev. Endocrinology* 581 (Oct. 2021), <https://pubmed.ncbi.nlm.nih.gov/34376826/>.

pediatric organizations, representing thousands of physicians across multiple disciplines.”⁶⁸

2. The State Mischaracterizes the Evidence Supporting the Use and Efficacy of Gender-Affirming Medical Interventions.

Even though the available evidence indicates that adolescents suffering from gender dysphoria can benefit from gender-affirming medical interventions, the State and its *amici* assert that there is insufficient evidence to justify their use. That is not the case, as summarized above. In an attempt to discredit the scientific evidence that supports gender-affirming medical interventions, the State and its *amici* offer several criticisms of that evidence, none of which stand up to scrutiny.

For instance, the State claims that because there are no randomized controlled studies of puberty blockers or hormone therapy for the treatment of gender dysphoria in adolescents, the care is not supported by sufficient evidence of efficacy.⁶⁹ However, a randomized controlled trial of puberty blockers or hormone therapy in these circumstances is not feasible, in part because of ethical issues associated with randomizing patients into a control group where, as here, there is

⁶⁸ R. Doc 30-2 (Letter from Arkansas Council on Child and Adolescent Psychiatry and American Academy of Child and Adolescent Psychiatry to A. Hutchinson (Mar. 31, 2021)) at 1 (emphasis omitted).

⁶⁹ See, e.g., Appellants’ Br. at 14.

important evidence that the intervention offered to the treatment group is superior.⁷⁰ Nor could patients or clinicians be blinded to whether a patient was receiving the active drug or a placebo, given the visible effects of puberty blockers and hormone therapy on an adolescent's physical development.⁷¹ Pediatric patients and their parents or guardians often make decisions about medical care without the benefit of a randomized controlled trial due to challenges in conducting these trials for many different conditions affecting this patient population.⁷² For example, there are no randomized clinical trials for the use of puberty blockers to treat precocious puberty, but the treatment is widely accepted.⁷³

Additionally, the State and some of its *amici* criticize the Guidelines because the recommendations are supported by evidence rated as “low quality.” Such a rating can be explained by multiple factors including, for example, a lack of support by randomized controlled trials. However, as discussed above, that methodology has been deemed by many experts to be an unethical study approach

⁷⁰ See Simona Giordano & Soren Holm, *Is Puberty Delaying Treatment ‘Experimental Treatment’?*, 21(2) Int’l J. Transgender Health 113 (2020), <https://www.tandfonline.com/doi/full/10.1080/26895269.2020.1747768>.

⁷¹ See *id.*

⁷² See Carolina Martinez-Castaldi et al, *Child Versus Adult Research: The Gap in High-Quality Study Design*, 122(1) Pediatrics 52 (2008), https://www.researchgate.net/publication/5257344_Child_Versus_Adult_Research_The_Gap_in_High-Quality_Study_Design.

⁷³ See Giordano, *supra* note 70.

for the treatment of transgender adolescents with gender dysphoria.

Some of the State's *amici* criticize the WPATH guidelines as being based on a Dutch study that analyzed a population of transgender children that they say was different from the population of transgender minors today.⁷⁴ That is not correct. The WPATH guidelines are based on a body of research, including numerous studies spanning decades that encompass a wide variety of transgender individuals.⁷⁵ For transgender adolescents with gender dysphoria, there is a growing body of evidence that indicates the efficacy of gender-affirming medical care.⁷⁶

Finally, the State and its *amici* attempt to discredit the Endocrine Society Guidelines by noting that the Guidelines merely suggest, rather than recommend, the use of puberty blockers.⁷⁷ However, this reflects a fundamental misunderstanding of how medical guidelines are written. Medical guidelines using the word “suggest” are common and reflect an appropriate analysis of underlying evidence. For example, with respect to guidelines for the treatment of diabetes, Endocrine Society “suggestions” include: 1) that older patients eat diets rich in

⁷⁴ See, e.g., FRC Br. at 12-14; Bell Br. 9-10.

⁷⁵ For a listing of the studies on which it relies, see R. Doc. 45-19 (WPATH Guidelines), at 72-93.

⁷⁶ See e.g., R. Doc 45-23 (AAP Policy Statement) at 4.

⁷⁷ See, e.g., Family Res. Counsel Amicus Br., at 23-24.

protein to prevent malnutrition; 2) simplifying the treatment regimens for patients with dementia; 3) trying different cholesterol medication if one medication does not sufficiently lower a patient’s cholesterol; and 4) referring elderly patients with balance and gait problems to physical therapy to reduce the risk of fractures.⁷⁸

D. Contrary to the State’s Assertions, There Is No Accepted Protocol of “Watchful Waiting” for Adolescents With Gender Dysphoria.

1. Evidence Suggests That Transgender Individuals Who Have Reached the Earliest Stages of Puberty Rarely “Desist” Later in Life.

To support its argument that gender-affirming medical treatments are unnecessary, the State claims that many young people experiencing gender dysphoria will eventually “desist,” that is, come to identify with their sex assigned at birth, thus obviating the need for gender-affirming care.⁷⁹ In making this argument, the State ignores the important distinction between prepubertal children on the one hand and adolescents on the other.

While some *prepubertal children* who experience gender dysphoria may go on to identify with their sex assigned at birth by the time they reach puberty, there are *no* studies to support the proposition that *adolescents* with gender dysphoria

⁷⁸ Derek LeRoith et. al, *Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline*, 104(5) J. Clinical Endocrinology & Metabolism 1520 (2019), <https://academic.oup.com/jcem/article/104/5/1520/5413486>.

⁷⁹ See, e.g. Appellants’ Br. at 6.

will come to identify with their sex assigned at birth, whether they receive treatment or not.⁸⁰ On the contrary, “[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult.”⁸¹ The Guidelines only recommend the use of medical interventions where, in addition to meeting other criteria, a qualified MHP finds that the adolescent presents with “a long-lasting and intense pattern” of gender dysphoria that “emerged or worsened with the onset of puberty.”⁸²

2. Contrary to the State’s Assertions, the “Watchful Waiting” Approach Was Never Intended to Apply to Adolescents.

Relying on its assertion that many individuals with gender dysphoria will eventually “desist,” the State then argues that “watchful waiting” should be considered the “primary treatment model[] for gender dysphoria,” and gender-affirming medical interventions should not be provided.⁸³ Again, the State elides

⁸⁰ See, e.g., Stewart L. Adelson, *Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents*, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957, 964 (2020), <https://theinstitute.umaryland.edu/media/ssw/institute/sogie-center/Practice-Parameter-on-Gay-Lesbian-or-Bisexual-Sexual-Orientation.pdf>, (“In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood”).

⁸¹ Rosenthal, *supra* note 67.

⁸² R. Doc. 45-19 (WPATH Guidelines) at 19.

⁸³ Appellants’ Br. at 6.

the distinction between prepubertal children and adolescents. Some mental health practitioners use “watchful waiting” when treating prepubertal children, which involves waiting until the child begins puberty before considering social transition.⁸⁴ But “watchful waiting” is not recommended for the treatment of adolescents with gender dysphoria.⁸⁵

The State attempts to create the appearance of a dispute within the medical community by falsely suggesting that watchful waiting and gender-affirming medical treatments are competing alternatives, when in fact watchful waiting is applicable only to prepubertal children and, under the Guidelines, puberty blockers and hormone therapy are prescribed only after the onset of puberty for adolescents. Indeed, using the “watchful waiting” approach on gender-dysphoric adolescents could cause immense harm by denying them treatment that could alleviate their distress and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversed—if at all—only through surgery.

3. Claims About “Social Contagion” Do Not Provide a Basis to Deny Medical Interventions For Whom It Is Medically Indicated.

Several of the State’s *amici* argue that the number of adolescents who

⁸⁴ *E.g.*, R. Doc 45-23 (AAP Policy Statement) at 4.

⁸⁵ *Id.*

identify as transgender has been increasing due to “rapid onset gender dysphoria” that purportedly spreads through social exposure to transgender people.⁸⁶ Even assuming an adolescent were to seek gender-affirming care as a result of peer influence, they would not be provided medical interventions unless they met the rigorous criteria for such treatment under the Guidelines.

Further, there is no evidence to support the social contagion “theory.” The term “rapid onset gender dysphoria” was coined by the author of an anonymous survey of parents of transgender youth, recruited from websites that promote the belief that “social contagion” causes transgender identity.⁸⁷ The “study” suffered from numerous flaws, and the author published a correction, acknowledging that “[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis,” and that the “report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon.”⁸⁸

⁸⁶ See, e.g., Family Res. Counsel Amicus Br. at 12-13; Alabama et al. Amicus Br. at 4; Sheinfeld et al. Amicus Br. at 26-28; Women’s Liberation Front Amicus Br. at 22.

⁸⁷ Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*. 14(3) PLoS One e0214157 (Aug. 2018), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330>. The study states that survey participants were recruited from the websites YouthTransCriticalProfessionals.org, TransgenderTrend.com, and 4thWaveNow.com. See *id.*

⁸⁸ Lisa Littman, *Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*. 14(3) PLoS One e0214157 (March 2019), <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0214157>.

It is true that the number of referrals to gender clinics has increased in recent years. But this increase has coincided with a decrease in the stigma against transgender people, an increase in public awareness of the existence of gender dysphoria and the availability of gender-affirming care, and improvements in insurance coverage for those treatments, all of which likely would lead more people with gender identity issues to seek professional help. In any event, not all patients who seek care at gender clinics receive gender-affirming medical interventions. In fact, a 2018 study showed that the percentage of patients who presented to a gender clinic for evaluation and received gender-affirming medical interventions has actually *decreased* over time.⁸⁹

4. The Use of Puberty Blockers Is a Measured Approach to the Treatment of Gender Dysphoria.

For adolescents suffering from gender dysphoria, the onset of puberty often produces physical changes that can significantly increase their gender dysphoria and psychological distress.⁹⁰ The experience of full endogenous puberty is an “undesirable condition for [transgender] individual[s] and may seriously interfere with healthy psychological functioning and well-being.”⁹¹ Delaying puberty

⁸⁹ See Chantal M. Wiepjes et al., *The Amsterdam cohort of gender dysphoria study (1972-2015): trends in prevalence, treatment, and regrets*, 15(4) J. Sexual Med. 582, 582 (Feb. 2018), <https://pubmed.ncbi.nlm.nih.gov/29463477/>.

⁹⁰ See R. Doc. 45-23 (AAP Policy Statement) at 5.

⁹¹ R. Doc 45-21 (Endocrine Society Guidelines) at 3880.

through puberty blockers is a measured treatment because it delays the need for patients to make less-reversible decisions regarding their gender identity, and instead provides patients with time to understand their gender identity while preserving the widest spectrum of potential treatments and outcomes. Puberty blocking treatment consistent with the Guidelines also can make pursuing additional forms of transition later in life easier, because this treatment prevents irreversible physical changes such as protrusion of the Adam's apple or breast growth.⁹² Moreover, puberty blocking treatment is reversible; if the treatment is suspended, endogenous puberty will resume.⁹³

III. The Healthcare Ban Would Irreparably Harm Many Adolescents With Gender Dysphoria By Denying Them the Treatment They Need.

The Healthcare Ban denies adolescents with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and that the medical community has endorsed. The medical treatments prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health. As discussed above in Part II.C, research has shown that adolescents with gender dysphoria who received puberty blockers and/or hormone therapy experienced less depression, anxiety, and suicidal

⁹² See R. Doc. 45-23 (AAP Policy Statement) at 5.

⁹³ See *id.*

ideation. Several studies have found that hormone therapy consistent with the Guidelines is associated with reductions in the rate of suicide attempts and significant improvement in quality of life for transgender individuals.⁹⁴ In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, it is not surprising that psychiatrists have attested that, should the Healthcare Ban take effect, “the lives of some of our patients will be put at risk.”⁹⁵

In addition, the Healthcare Ban would increase the likelihood that adolescents with gender dysphoria will seek out dangerous, non-medically supervised treatments. When medically-supervised care is available, patients are less likely to seek out “harmful self-prescribed hormones, use of construction-grade silicone injections, and other interventions that have potential to cause adverse events.”⁹⁶ The use of hormones purchased on the street or online “may be significant health problems if used improperly.”⁹⁷ Even more commonplace tactics

⁹⁴ See M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 *Clinical Endocrinology* 214 (Feb. 2010), <https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x>; see also Turban et al., *supra* note 61.

⁹⁵ R. Doc 30-2 (Letter from Arkansas Council on Child and Adolescent Psychiatry and American Academy of Child and Adolescent Psychiatry to A. Hutchinson (Mar. 31, 2021)) at 2 (emphasis omitted).

⁹⁶ Am. Med. Ass’n, *supra* note 13.

⁹⁷ David A. Levine, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender*,

such as chest binding (which seeks to minimize physical characteristics incongruent with one's gender identity) can lead to chronic injury and pain.⁹⁸

CONCLUSION

For the foregoing reasons, the District Court's decision granting the preliminary injunction should be affirmed.

and Questioning Youth, 132(1) *Pediatrics* e297 (July 2013), <https://pediatrics.aappublications.org/content/132/1/e297>.

⁹⁸ See, e.g., Sarah M. Peitzmeier et al., *Time to First Onset of Chest Binding-Related Symptoms in Transgender Youth*, 147(3) *Pediatrics* e20200728 (2021), <https://publications.aap.org/pediatrics/article-abstract/147/3/e20200728/77086/Time-to-First-Onset-of-Chest-Binding-Related?redirectedFrom=fulltext>.

Dated: January 20, 2022

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Dated: January 20, 2022

/s William R. Isasi

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*Counsel for American Academy of
Pediatrics and Additional National and
State Medical and Mental Health
Organizations*

CERTIFICATE OF SERVICE

I hereby certify that on January 20, 2022, I electronically filed the foregoing **BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE** with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s William R. Isasi
William Isasi

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January 25, 2022

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

Dear Counsel:

The amicus curiae brief of the American Academy of Pediatrics and additional National and State Medical and Mental Health Organizations 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

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Ms. Vernadette R. Broyles
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Mr. Omar Gonzalez-Pagan
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Ms. Lindsay Harris
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Ms. KaTina Hodge-Guest
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Ms. Katelyn Kang
Mr. Andrew King
Mr. Caleb B. King
Mr. Edmund G. LaCour Jr.
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Mr. Jesse Ryan Loffler
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Mr. Gary McCaleb
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Ms. Alison Ann Tanner
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Mr. Ernest G. Trakas
Mr. Christopher L. Travis
Ms. Julie Veroff
Mr. Vincent M. Wagner
Ms. Breean Walas
Ms. Stephanie Yu
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