No. 21-15668

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

D.H., BY AND THROUGH HIS MOTHER, JANICE HENNESSY-WALLER; JOHN DOE, BY HIS GUARDIAN AND NEXT FRIEND, SUSAN DOE, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED

Plaintiffs-Appellants,

v.

JAMI SNYDER, DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, IN HER OFFICIAL CAPACITY,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Arizona, No. 20-cv-00335-SHR
Before the Honorable Judge Scott J. Rash

INTERNATIONAL BRIEF FOR PSYCHOTHERAPEUTIC EXPERTS IN THE FIELD OF TREATMENT OF TRANS-IDENTIFIED CHILDREN, AS AMICI CURIAE IN SUPPORT OF THE DEFENDANT-APPELLEE

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CORPORATE DISCLOSURE STATEMENT

The Amici Curiae, natural persons, are not required to file a corporate disclosure statement by Rule.

Date: July 7, 2021

/s/ Michael Garth Moore
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STATEMENT OF INTEREST AND SOURCE OF AUTHORITY[1]

Pursuant to Federal Rule of Appellate Procedure 29 and Ninth Circuit Local Rule 29-2, *Amici Curie* Professor Gene Feder (OBE), Susan Evans BPC, Marcus Evans BPC, Dr. Pål Suren, Dr. David Bell, and Professor Sophie Scott respectfully submit this brief in support of the Defendant-Appellee.

Professor Gene Feder[2] is a Professor of Primary Care at the Centre for Academic Primary care, Bristol Medical School (UK), and a salaried general practitioner (Montpelier Health Centre, Bristol, UK). A clinical and health services researcher with over 30 years' experience of conducting randomized controlled trials, cohort studies, surveys, systematic reviews and qualitative studies, Professor Feder co-developed the validated Appraisal of Guidelines for Research and Evaluation (AGREE) instrument, used globally to assess the quality of clinical guidelines and standards. He has chaired four NICE (national UK) and one World Health Organization (WHO) guidelines, and held the chair of Primary Care Research and Development at Barts and the London Medical

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[1] Pursuant to Fed.R.App.P. 29(a)(4)(E), *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no persons other than this amici curiae, its members, or its counsel have made any monetary contributions intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

[2] The views, information or opinions expressed by Professor Feder in this brief are his own. Professor Feder is not responsible and does not necessarily reflect or endorse the accuracy, or opinions of the other individuals contained in this brief.

College from 1999 to 2007. In 2017, Professor Feder was awarded an OBE (Order of the British Empire) for services to health care.

Susan Evans, BPC[3] is a practicing psychoanalytic psychotherapist. She initially trained as a State Registered Nurse and Registered Mental Health Nurse and then worked for nearly 40 years in a variety of mental health services in the National Health Service, including the national gender identity service for children. She was a senior clinical lecturer at the Tavistock and Portman NHS Foundation Trust and also devised and ran BSc degree courses for Middlesex University. She was a Senior Fellow, University East London. She is a member of the British Psychotherapy Foundation, the London Psychoanalytic Psychotherapy Service, and is registered with the British Psychoanalytic Council.

Marcus Evans is a psychoanalyst with the British Psychoanalytical Society. He trained as a RMN and worked in mental health services and as an adult psychotherapist in the NHS for 40 years. For several years he was Clinical Director of the Adult and Adolescent Departments at the Tavistock & Portman NHSFT. He was one of the founding members of the Fitzjohn's Service for the treatment of patients with severe and enduring mental health conditions and/or personality disorder. He is registered with the British Psychoanalytic Council. Susan Evans and Marcus Evans are co-authors of the recently published book

[3] British psychoanalytic council-registered

entitled "Gender Dysphoria – a therapeutic Model for working with children, adolescents and young adults."[4]

Dr Pål Surén is a researcher in Child Health and Development at the Norwegian Institute of Public Health. He is a specialist in paediatrics and has a PhD in epidemiology. Dr Surén is an expert in childhood neurodevelopmental disorders and has researched and authored peer-reviewed publications on autism spectrum disorders, epilepsy and ADHD in children.

Dr David Bell is Consultant Psychiatrist, Fellow of the Royal College of Psychiatrists and the former President of the British Psychoanalytic Society/Institute of Psychoanalysis. He was a Consultant Psychiatrist in Psychotherapy, Adult Department, at the Tavistock and Portman NHS Foundation Trust (1994- 2021) where he led as service for the most serious and complex disorders. He teaches a course on Gender and Sexuality at the Institute of Psychoanalysis and was a member of the Institute of Psychoanalysis Gender/Sexuality Study Group. In his role as Staff Governor representing academic and clinical staff, he prepared in 2018 a report on the Tavistock Gender Service for Children and Adolescents (GIDS). This report was part of the chain of events leading to the UK Judicial Review.[5]

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[4] Susan Evans. *Gender Dysphoria: a Therapeutic Model for Working with Children, Adolescents and Young Adults.* Phoenix Pub House (2021).

[5] *Bell v. The Tavistock and Portman NHS Foundation Trust,* [2020] EWHC 3274 (Admin)

Professor/Dr Sophie Scott is the Director of UCL's Institute of Cognitive Neuroscience. She has published over 130 peer reviewed scientific papers, including papers in Nature, Science, and the Proceedings of the Academy of Natural Sciences. She is a fellow of the Academy of Medical Sciences, and of the British Academy. Since 1994, she has been working in cognitive neuroscience, a scientific field that examines the relationships between human behaviour and the human brain, and how these can be affected by age, disease and individual differences.

INTRODUCTION

The Plaintiffs-Appellants' case is that there is robust consensus across the international medical community that surgery, including mastectomy, is an appropriate and medically necessary treatment for some adolescents with gender dysphoria. The Plaintiffs-Appellants' case rests on a plain denial of the concerns many eminent medical health experts have when it comes to treating adolescents with gender dysphoria. Many – indeed a growing number of highly respected medical professionals, some of whom are signatories to this brief – do not support the affirmation approach which draws on the World Professional Association for Transgender Health (WPATH) Standards of Care, according to

which sex reassignment surgery is alleged to be "effective and medically necessary" in order "to alleviate gender dysphoria". [6]

The WPATH Standards assert that for many transgender-identified minors "relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."[7] The assertion that the surgery affirmation approach set down in the WPATH protocols is supported across the international medical community is false. On the contrary, the consensus is moving away from the affirmation model.

Highly significant research on identifying and critically appraising all published international clinical practice guidelines relating to the healthcare of gender minority/trans people was published in the *British Medical Journal* (in April 2021)[8], to which our distinguished expert evaluator of the WPATH international guidelines, Professor Gene Feder refers in his statement. In that research it is found that while the WPATH Standards of Care Version 7 are

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[6] WPATH "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" 7th Version (2012), pp. 54-55. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341

[7] *Id*. WPATH

[8] Sara Dahlen, et al. *International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment*. Brit. Med. J. Open 11(4):e048943 (2021) https://bmjopen.bmj.com/content/11/4/e048943.long

currently acting as a benchmark in this field, "expressed reservations" exist that WPATH is based on "lower-quality primary research" and "lacks grading of evidence".[9]

While there is a lack of consensus among medical professionals that affirmative surgery is appropriate and medically necessary for adolescents with gender dysphoria – to which lack of consensus this brief attests – there is no debate among experts that surgery has irreversible effects.

The other European experts in this brief, Susan Evans, Marcus Evans, Doctor Pål Suren, Dr. David Bell and Professor Sophie Scott, are drawn from senior positions of excellence in the related fields of psychotherapy, psychoanalysis, pediatrics, psychiatry, child safeguarding and child neurological development. Along with Professor Feder, they unanimously reject the affirmation model presented in the WPATH protocols on the grounds that gender identity development in young people is a complex multi-faceted process affected by a variety of social, political and cultural factors, urging on the one hand for caution in the best interests of the child; and on the other hand, for more research which is badly needed as to the long-term effects – physical and psychological – of gender or sex reassignment medical treatments.

[9] *Id*. at 2.

I. A CRITICAL APPRAISAL OF THE "AFFIRMATIVE APPROACH"

A. There has been a sharp increase in referrals to Tavistock clinic and a flip in sex ratios

There has been a 3264% rise in referrals to the national gender identity service at the Tavistock and Portman NHS Trust in London over the past 10 years (from 77 in 2009–2010 to 2590 in 2018–2019).[10] The profile of gender dysphoric young people referred to the service has also undergone a major transformation: we have seen a reversal of the gender ratio from two-thirds male:female to two-thirds female:male, with a recently described clinical phenomenon of as yet uncertain diagnostic significance making up a substantial proportion. This gender dysphoria of recent onset among adolescents (sometimes termed 'recent-onset gender dysphoria' or ROGD, 'rapid-onset adolescent dysphoria'[11] or 'adolescent-onset transgender history'[12]) lacks an

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[10] *Referrals to the Gender Identity Development Service* (*GIDS*) *level off in 2018–19*. Tavistock and Portman NHS Foundation Trust (28 Jun 2019) (https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/).

[11] Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*. PLoS ONE e0202330 (2018) Google Scholar

[12] Annelou de Vries, *Challenges in timing puberty suppression for gender-nonconforming adolescents*. 146 PEDIATRICS (4) e2020010611 (2020).Google ScholarPubMed

agreed name or established diagnostic criteria, but its emergence has been documented by a number of gender clinics worldwide.[13]

Bernadette Wren, the then associate director of the Tavistock and Portman NHS Foundation Trust's Gender Identity Development Service (GIDS), gave evidence to a House of Commons select committee in which she summarized the GIDS intake in the following terms: "many of the young people, and increasing numbers of them, have had a gender-uncontentious childhood, if you like, and it is only when they come into puberty and post-puberty that they begin to question. That now represents a substantial proportion of our group."[14]

We have very little understanding of what underlies these changes. Indeed, the understanding of this whole area is extremely limited and it is thus particularly important to examine it from different perspectives.

B. The narrow "affirmation" approach for children overlooks complexity and the unknowns.

The gender-affirmative treatment approach, endorsed by the American Academy of Paediatrics (AAP) and several other American medical societies,

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[13] Ken Zucker, *Adolescents with gender dysphoria: reflections on some contemporary clinical and research issues*. 48 ARCHIVE OF SEXUAL BEHAVIOR 1983–92 (2019) .Google Scholar PubMed

[14] Women and Equalities Committee. *Oral Evidence: Transgender Equality Enquiry, HC390: Tuesday 15 September 2015*. House of Commons (2015) (http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/transgender-equality/oral/21638.html).

endorses the child's belief that they were born in the wrong body and practitioners are required to support the child's self-identification. This is despite research findings which strongly suggest that most of these cases would eventually desist if left untreated.[15]

The 'affirmation approach' (which includes the use of surgery such as mastectomies) looks narrowly at a problem in only one area of psychological functioning, as if one part of the individual could be isolated from other areas of the personality. This ignores the complex relationship between the overt symptomatic picture and trauma, social anxieties and even the relatively normal turbulence of adolescence.

C. Detransitioners highlight problems with surgical gender affirmation for youth

There is a growing number of detransitioners who underwent gender reassignment as adolescents or young people, but who subsequently realised that medical transition was a mistake. A recently published study of detransitioners for the *Journal of Homosexuality*, by Elie Vandenbussche (published in April 2021) highlights the possible reasons for detransitioning:

> Half of the sample (50%) later reported having decided to detransition due to the fact that their transition did not alleviate their gender dysphoria. Others (45%) reported having found alternative ways to deal with their gender dysphoria […] These

[15] Jiska Ristori, Thomas Steensma, *Gender dysphoria in childhood*. Int Rev Psychiatry, 28: 13–20 (2016) Google Scholar; and Steensma, TD, et al., *Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study*. 16 CLIN CHILD PSYCHOL PSYCHIATRY, 499–516 (2011) CrossRefGoogle ScholarPubMed

> results highlight the necessity to start looking into alternative solutions for treating gender dysphoria […] In addition to that, 70% of the sample reported having realized that their gender dysphoria was related to other issues.[16]

An increasing number of "regretters" or "detransitioners" are speaking out on social media and at conferences to argue they have been let down by mental health services that have failed to assess their psychological problems before prescribing medical treatments such as hormones and surgery as treatment for their gender dysphoria. A number of clinicians have called for research into desistance, detransition and regret among gender dysphoric adolescents.[17] [18] The US National Institutes of Health (NIH) Sexual & Gender Minority Research Office (SGMRO) recently named detransition in its report outlining scientific research gap areas in the field of sexual and gender minority health.[19]

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[16] E. Vandenbussche, E., *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, Journal of Homosexuality (2021), doi: 10.1080/00918369.2021.1919479.

[17] Expósito-Campos, Pablo. *A Typology of Gender Detransition and Its Implications for Healthcare Providers*. 47 JOURNAL OF SEX & MARITAL THERAPY, pp. 270–80. (2021) DOI:10.1080/0092623X.2020.1869126.

[18] Kirsty Entwistle,. *Debate: Reality Check – Detransitioner's Testimonies Require Us to Rethink Gender Dysphoria*. 26 CHILD AND ADOLESCENT MENTAL HEALTH, pp. 15–16. (2021) DOI:10.1111/camh.12380.

[19] *Sexual & Gender Minority Health Research: Listening Session October 22, 2019. Summary Document.* Sexual & Gender Minority Research Office. National Institutes of Health (2019) (https://dpcpsi.nih.gov/sites/default/files/SGM%20Health%20Research%20Listening%20Session%20Summary%20Document%20FINAL.pdf).Google Scholar

II. THE KEIRA BELL CASE HIGHLIGHTED INADEQUACIES IN GENDER-AFFIRMING MODEL OF CARE PROMOTED BY WPATH AND MINORS' GENERAL INABILITY TO CONSENT TO EXPERIMENTAL AND IRREVERSIBLE GENDER REASSIGNMENT INTERVENTIONS

Amici Susan and Marcus Evans, as psychotherapists with professional involvement in the therapeutic treatment of trans-identified individuals in the UK, have serious concerns about the transition of children before maturity.[20] They would like to emphasize that they are not taking a position with regard to an *adult's* decision to transition. Indeed, they understand that transition is, for some adults, the optimum way to lead their lives and present to the world.

A. Origin of the Keira Bell case

Between 2003 and 2007, Susan Evans worked for the Gender Identity Development Service (GIDS) at the Tavistock Clinic in London, a specialized facility for young people experiencing difficulties with gender identity. During this period, Ms. Evans became concerned that some of the children were being referred for gender affirmation treatments after a superficial assessment process. Ms. Evans raised her concerns to the clinic leadership, and eventually resigned.

In 2018, Marcus Evans was elected as a Tavistock Trust board governor. In this capacity, he became aware of two issues that touched on Ms. Evans' concerns. The first was described in a letter from a group of concerned parents

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[20] The material that follows is connected to a paper we presented at a multi-disciplinary conference on 23 January 2021, entitled *Do Not Adjust Your Set: Sex, Gender and Public Policy*.

regarding the quality of the treatment their children had received at the gender clinic. The second was a report authored by Dr David Bell, who, in his role as staff governor, had been approached by a group of ten GIDS professionals (about 20 percent of the total staff) expressing ethical concerns consistent with the issues raised by the parents. Marcus resigned in February 2019 because he did not observe that the Trust's leadership intended to deal with these concerns appropriately.

Around that time, in May 2019, the UK House of Lords held an event entitled "First Do No Harm: The ethics of transgender healthcare."[21] After the event, several of the participants (including Marcus Evans and Susan Evans) met informally, whereupon they discussed how to ensure that clinical safeguarding and ethical practices were respected. All agreed that one problems was that there was a serious reluctance among many professionals to speak out publicly, lest they be accused of transphobia.

Marcus Evans and Susan Evans were being contacted by parents and ex-patients, many with tales of upsetting (and sometimes harrowing) treatment experiences. One of the parents was Mrs. A (as identified in the judicial review), a mother who had a 15-year-old daughter on the GID's waiting list,

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[21] *First Do No Harm: The ethics of transgender healthcare* (May 2019) https://2d3aa506-25d9-4c0d-b140-7d13f9421f96.filesusr.com/ugd/1b54b4_32788a07d22f4fa59e2cab0dfc6971cf.pdf

who had been diagnosed with autism, was experiencing emotional difficulties, and had decided she was transgender. Mr. and Mrs. A were worried that their daughter would be started on hormone treatments without first receiving a thorough psychological assessment and treatment.

In October 2019, they decided to initiate a judicial review of the clinical practices at GIDs, and the High Court accepted our request. They then started gathering a multinational group of expert witnesses, one of whom was Keira Bell. Keira—now a 23-year-old detransitioner (i.e., someone who once presented as transgender, but no longer does so)—believed that her co-morbid psychological difficulties had not been sufficiently assessed or treated before she was started on medical gender reassignment at 15, before eventually undergoing mastectomy at 20.

It was never their goal to make it more difficult for gender dysphoric children and their families to obtain help and treatment. What they wanted was for these families to get the *right* treatment. It is very important to underscore the fact that there is currently no gold standard, long-term research in childhood medical transition.

B. The High Court Ruling Regarding Minor's Ability to Consent

The case of Keira (Quincy) Bell highlighted the issues regarding young people's ability to provide informed consent to irreversible interventions. In Keira's own words:

> [T]he further my transition went, the more I realized that I wasn't a man, and never would be. We are told these days that when someone presents with gender dysphoria, this reflects a person's "real" or "true" self, that the desire to change genders is set. But this was not the case for me. As I matured, I recognized that gender dysphoria was a symptom of my overall misery, not its cause.[22]

At 23, Keira felt that she should not have been able to embark on such a procedure, having regard to the maturity and understanding that she possessed at the time. Keira brought a judicial review in the UK High Court to challenge policies and practices based on unconditional "affirmation" and prescription of puberty blockers to children under 18 with gender dysphoria at the Gender Identity Development Service (GIDS), part of the Tavistock and Portman NHS Foundation Trust.

In December 2020, the High Court ruled that it is "doubtful" that 14- and 15-year-olds possess Gillick competence[23] to consent to the use of puberty blockers and "highly unlikely" that a child under 13 would be able to consent to such treatment. It found that 16-year-olds could consent to medical treatment,

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[22] K. Bell.: *My Story*, Persuasion (blog), 7 April 2021, https://www.persuasion.community/p/keira-bell-my-story.

[23] The test for assessing legal capacity in children under the age of 16, established in *Gillick v West Norfolk and Wisbech Area Health Authority* (1985) 2 A11 ER 402. The criteria for deciding competence was set out by Lord Fraser ("the Fraser Guidelines") whereby a child must be capable of demonstrating, in the absence of parental consent, sufficient understanding to appreciate the nature, purpose, and hazards of the proposed treatment.

but where "treatment is as yet innovative and experimental", judicial authorization should be sought.[24]

Following the judgment in *Bell*, the Family Division of the High Court ruled on 26 March 2021 that while parental consent may form a legal basis to prescribe puberty blockers to children under 16 years, there was a need for additional safeguards. Moreover, the finding in *Bell* that medical interventions to treat gender dysphoria in children should be considered experimental was accepted by the Family Division, due to the limited evidence of efficacy or long-term effects of the treatment.[25]

Mastectomies were not considered by the High Court as this is not a procedure offered through GIDS, nor are mastectomies commonly performed on minors in the UK. However, the fact that the High Court considered the earlier steps of the protocol experimental and recommnended additional safeguards suggests even greater concerns with a minor's ability to provide meaningful informed consent to irreversible gender-affirming surgeries such mastectomy.

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[24] *Bell v Tavistock and Portman NHS Trust* [2020] EWHC 3274(Admin), paras. 151-152.

[25] *AB v CD & Ors* [2021] EWHC 741 (Fam) (26 March 2021); reported by NHS England: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/update-following-recent-court-rulings-on-puberty-blockers-and-consent/

II. EUROPE IS SHIFTING TOWARD CAUTIONARY APPROACH TO TREATMENT OF YOUNG PEOPLE WITH GENDER DYSPHORIA.

A. United Kingdom

In the UK – post *Bell* – there is a palpable shift towards adopting more cautionary approaches to the treatment of young people with gender dysphoria. Evidence of this came in late 2020, when Dr. Hilary Cass was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people.

Dr. Cass is a former President of the Royal College of Paediatrics and Child Health and Chair of the British Academy of Childhood Disability. Her charge to lead the so-called "Cass Review" will focus on the improvement of care for children and young people, including key aspects of care such as how and when they are referred to specialist services, and clinical decisions around how doctors and healthcare professionals support and care for patients with gender dysphoria.

It will also set out workforce recommendations for specialist healthcare professionals and examine the recent rise in the number of children seeking treatment. Underpinning the raison d'etre of the Cass Review is the principle

that gender identity involves a "complex range of issues", which are simply not recognized in the WPATH guidelines.[26]

B. Nordic Countries

The shift towards caution over affirmation is also evidenced in the Nordic Countries, where there is a significant re-evaluation of the WPATH clinical practice guidelines underway.

In May 2021, the Karolinska University hospital in Stockholm, which contains Sweden's largest adolescent gender clinic, released new guidelines saying it would no longer prescribe blockers and hormones to children under 18 outside clinical trial settings[27] – in direct conflict with WPATH protocols

This follows earlier developments in Finland, where a Finnish psychiatrist, Dr. Riittakerttu Kaltiala-Heino, had conducted pioneering research in 2015 which found that more than 75% of adolescents applying for sex-reassignment surgery needed help for psychiatric problems other than gender dysphoria.[28] These findings were strongly corroborated in research papers

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[26] Cass Review, "*Independent review of gender identity services for children and young people*", https://cass.independent-review.uk/

[27] Society for Evidence Based Medicine, *Sweden's Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies*, (5 May 2021) https://segm.org/Sweden_ends_use_of_Dutch_protocol.

[28] Kaltiala-Heino Riittakerttu, et al. *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*. 9 CHILD AND ADOLESCENT PSYCHIATRY AND MENTAL HEALTH, 5. (2015) doi:10.1186/s13034-015-0042-y.

published this year (which found 89% needed such help).[29] As a result of these findings, in 2020 Finland adopted strict guidelines prioritising therapy over hormones and surgery.[30]

An endorsement of "affirmative surgery" for minors is therefore not tenable in the current international climate, since there is mounting evidence that clinical opinion is increasingly divided and that the approach advocated by WPATH is not considered to meet the prerequisite standard of care and is not endorsed by medical experts as a gold standard for clinical practice guidelines in relation to the treatment of transgender and gender dysphoric adolescents.

C. WPATH Standards of Care 7 Not Recommended for Use in Clinical Practice

To make a judgement about the quality of the WPATH Standards of Care 7, *Amicus* Professor Gene Feder applied the AGREE instrument, which generates a score and also prompts the assessor to rate the overall quality and give an opinion on whether they would recommend the guideline for clinical use. If the tool is being used to make an actual policy decision about implementation/adoption of a guideline in a clinical service, at least four people

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[29] Kasia Kozlowska, et al, *Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service*.1 HUMAN SYSTEMS: THERAPY, CULTURE AND ATTACHMENTS.11 (2021) doi:10.1177/26344041211010777.

[30] "Continental Europe Enters the Gender Wars", *The Economist* (12 June 2021), https://www.economist.com/europe/2021/06/12/continental-europe-enters-the-gender-wars

would need to apply it. In this instance, Professor Feder gives his opinion about the standards of care and uses the tool as a benchmark.

The AGREE instrument is divided into 6 independent domains: scope & purpose, rigour of development, clarity of presentation, applicability, and editorial independence. In the table below Professor Feder summarizes his scoring of these domains with respect to the WPATH standards.

DOMAIN	SCORE*	MAIN LIMITATIONS
scope & purpose	13/21	Broad non-specific aims, populations not clearly defined
stakeholder involvement	11/21	No details of revision committee, target patient population involvement is opaque
rigour of development,	20/56	No systematic search for evidence, no appraisal of evidence, no estimate of magnitude of effectiveness and adverse effects of treatment, no explicit linkage of evidence to recommendations/standards, no update specification
clarity of presentation	12/21	Many recommendations are non-specific, treatment options not linked to outcomes
applicability	13/28	No guidance on obstacles to implementation
editorial independence	3/14	No statement about competing interests of committee nor about funder having no influence on content

* over total possible score

Overall, there is little robust evidence for the effectiveness of the treatments recommended in the WPATH guidelines and what evidence there is from (mostly) retrospective cohort studies not appraised nor linked to the standards. There is a serious concern about the independence of the committee

that undertook this 2012 revision of the standards (original version, repeatedly revised and updated, from 1979). Overall, Professor Feder rates the quality of this guideline as 3/7 and would not recommend their use.

Since conducting his evaluation of the WPATH Standards of Care (SOC), an expert appraisal of the international clinical practice guidelines (or CPGs) for gender minority/trans people has been conducted, and the research findings published in the British Medical Journal.[31]

It is noted that WPATH SOCv7 contains no list of key recommendations nor auditable quality standards. What extracted recommendations are to be found within the WPATH guidelines are presented in an incoherent manner, containing "little consistency or agreement on what passages were selected".

The study's principal findings, with which Professor Feder concurs, are stated as follows:

> Variable quality international CPGs regarding gender minority/trans people's healthcare contain little, conflicting information on mortality and quality of life, no patient facing messages and inconsistent use of systematic reviews in generating recommendations…[] WPATH SOCv730 cannot be considered 'gold standard'.[32]

[31] Sarah Dahlen,, et al. *International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment*. BRIT. MED. J. Open 11(4):e048943 (29 Apr. 2021) https://bmjopen.bmj.com/content/11/4/e048943.long

[32] Dahlen p. 8., *supra*

III. NEUROSCIENCE DOES NOT SUPPORT THE NOTION THAT YOUNG PEOPLE CAN ADEQUATELY WEIGH AND APPRECIATE THE SIGNIFICANT CONSEQUENCES THAT WILL RESULT FROM THE DECISION TO UNDERGO MASTECTOMY TO TREAT GENDER DYSPHORIA

All cultures recognize the onset of adolescence as the start of the entry into the adult world: a journey that takes place over several years. Many limitations on the responsibility for teenagers for their own actions are in place to protect them from long-terms consequences (e.g. ages for driving, drinking alcohol, age of consent, getting a tattoo). Much of this reflects a lay understanding of what neuroscience is now confirming –teenage brains on the whole are structurally and functionally different from adult brains. This affects both their engaging with risky behavior, and their understanding of the implications of risky behavior. Thus, in 2005 the US Supreme Court, influenced partly by this emerging neuroscience research, increased the minimum age for capital punishment to be the same as that for voting and serving on juries.

The human brain is formed of approximately 89 billion brain cells, or neurones, most of which are grown during gestation.[33] Following birth, there is a further period of extended brain development, with the brain quadrupling in

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[33] S.A. Bayer, et al. *Timetables of neurogenesis in the human brain based on experimentally determined patterns in the rat*. 14 NEUROTOXICOLOGY (1):83–144 (1993). [PubMed] S. Rakic , & N. Zecevic, *Programmed cell death in the developing human telencephalon.* 12 THE EUROPEAN JOURNAL OF NEUROSCIENCE. 2721–2734, (12 Aug 2000). doi: 10.1046/j.1460-9568.2000.00153.x. [PubMed]

size between birth and age 6, when it is roughly 90% the size of an adult brain. However, the pattern of growth is underpinned by some complex changes that are occurring well into one's 20's. These are:

- Synaptic pruning
- Myelination of different brain networks
- Differential growth of specific functional and anatomical areas

A. Synaptic pruning

At birth and in early infancy, many connections exist and are created between neurones: this is known as synaptic exuberance. In the early years of life these are rapidly pruned, at first quickly, then more slowly. During adolescence a more adult profile of synaptic connections starts to appear: this appears most slowly in prefrontal fields compared to sensory and is still not established fully at age 18 years.[34] The relationship between synaptic exuberance and pruning and their implications are still being explored, but in terms of brain connectivity, the adult pattern is not yet established at 18.

B. Myelination

Myelination in the human brain begins before birth in visual brain and continues into the middle of the third decade incortical and subcortical systems. This has been expressly linked to the development of cognitive skills in children

[34] P.R. Huttenlocher, & A.S. Dabholkar, , *Regional differences in synaptogenesis in human cerebral cortex.* 387 THE JOURNAL OF COMPARATIVE NEUROLOGY,:167–178 (1997) doi: 10.1002/(SICI)1096-9861(19971020)387:2<167::AID-CNE1>3.0.CO;2-Z. [PubMed].

and adolescents, as myelination greatly improves the speed of condition of neurones, and hence their efficiency.

Myelination proceeds form back to front of the brain, with frontal and prefrontal fields continuing to be myelinated into the mid 20.[35] At 18yrs old, the connections to the frontal lobes are not myelinated like a mature adult brain, and this is likely to affect frontal lobe functions.

C. Differentiation

Throughout childhood, the brain grows and changes: this involves a non-linear pattern of change in the proportion of white and grey matter, which may partly involve changes in myelination and also the loss of cells through cell death. A recent study looking at this pattern into adolescence found that "First, we found evidence for continued development of both intracranial volume (ICV) and whole brain volume (WBV) through adolescence, albeit following distinct trajectories. Second, our results indicate that CGMV is at its highest in childhood, decreasing steadily through the second decade with deceleration in the third decade, while CWMV increases until mid-to-late adolescence before decelerating.[36] This indicates that considerable changes are still happening in

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[35] C. Lebel, C. Beaulieu *Longitudinal diffusion tensor imaging of healthy brain development in children.* Honolulu: ISMRM Annual Meeting (2009) [Google Scholar]

[36] K.L. Mills, et al., *Structural brain development between childhood and adulthood: Convergence across four longitudinal samples*, 141 NEUROIMAGE, 273–281 (2016). https://doi.org/10.1016/j.neuroimage.2016.07.044.

the structure of the adolescent brain. In terms of specific brain areas, while the cortex continues to thin through adolescence, the decreases are most marked in the parietal lobes and least marked (or growth is seen) in temporal and prefrontal fields.[37]

D. Implications

The pattern of maturation of the brain in adolescence suggests a particular issue with frontal lobe functions – the frontal and temporal lobes are the last to be fully myelinated. The frontal lobes are associated with complex cognitive control processes, so called 'meta-cognitive processes' that enable us to plan our behavior, control our responses, to be able to adapt our behavior to different contexts and requirements, and to anticipate the implications and consequences of behavior.

The absence of mature frontal lobe connectivity and functions has been linked to increased impulsivity and risk-taking in adolescence, and to their greater susceptibility to peer opinions and behavior. [38] Functional imaging studies have shown that while adults recruit frontal lobe networks during decision making tasks, teenagers are more likely to recruit 'limbic networks" i.e. sub cortical networks linked more to emotional processing and reward

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[37] C.K. Tamneset al., *Development of the Cerebral Cortex across Adolescence: A Multisample Study of Inter-Related Longitudinal Changes in Cortical Volume, Surface Area, and Thickness*, 37 JOURNAL OF NEUROSCIENCE, 3402-3412 (22 March 2017) https://pubmed.ncbi.nlm.nih.gov/28242797/.

[38] Sarah-Jayne, Blakemore, Trevor Robbins. Decision-Making in the Adolescent Brain 15 NATURE NEUROSCIENCE, pp.1184–91(2012)

processing. The implication is that the differential integrity of frontal lobe connectivity leads to teenagers making different, more risky decisions than adults, and relying on different brain networks to do so. This is backed up by behavioral studies showing that when decision making is 'hot' (i.e. more emotional), under 18-year-olds make less rational decisions than when the responses are being made in a colder, less emotional context.

The current treatment regime is exposing young people to significant risk of harm. The greater susceptibility to peer pressure among youth make them especially vulnerable to risk taking, and this may well be enhanced by social media, where actions can be encouraged without any responsibility for outcomes.

In some cases, medical interventions such as surgery may be effective in alleviating gender dysphoria, though we still do not know how to differentiate those who might be helped by this from those who will not. However, given the risks and irreversible effects that have life-long consequences, even if the risks are well explained, in the light of the scientific literature, it is unlikely for an adolescent to be unable to fully grasp the implications of treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behavior.

IV. Alternatives to Gender Affirmation of Minors

A. Gender conflicts can be a normal part of development

Adolescence is a time of experimentation that inevitably stirs up all sorts of conscious and unconscious confusions, doubts and conflicts. The process of growing up, with all its attendant anxieties relating to biological, emotional, and sociological changes, causes some children to fixate on the idea that transitioning will provide a way of regaining psychological equilibrium. The desire to transition often is related to a wish to control sexual development, and perhaps to defer it entirely.

B. The development of gender conflicts can be connected to other psychological factors

There is also a growing body of knowledge that connects the development of gender dysphoria with psychological factors.[39] A group of parents whose children were treated at the Tavistock and Portman NHS Foundation Trust's Gender Identity Development Service (GIDS) in London wrote to the trust's board. In their letter they express deep concern that children

[39] M. Bonfatto, & E. Crasnow, E., *Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service*. 44 J. CHILD PSYCHOTHERAPY, 44: 29–46 (2018) Google Scholar; M. Rustin, Clinical commentary by Margaret Rustin, child and adolescent psychotherapist. 44 J. CHILD PSYCHOTHERAPY 132–5 (2018) Google Scholar; T. Patterson, *Unconscious homophobia and the rise of the transgender movement*. 24 PSYCHODYN PRACT 56–9 (2018) Google Scholar; C. Dhejne, et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*. PLoS ONE 6(2): e16885 (2011) Google Scholar; S. Donym, *The New Homophobic Bridge to Nowhere: Child Transition*. Medium (2018) (https://medium.com/@sue.donym1984/the-new-homophobic-bridge-to-nowhere-child-transition-c621d6188d6e); D. Chew, et al., *Hormonal treatment in young people with gender dysphoria: a systematic review*. 141 Pediatrics (4): e20173742 (2018) Google Scholar.

with no long history of gender dysphoria, who were on the autism spectrum or suffered from social anxiety adjustment disorders were, with very insufficient investigation, diagnosed as transgender.

C. Treatment of gender dysphoria should not be exceptionalized

Professionals need to show both empathy and understanding, while also making objective assessments of patients' difficulties. At the very least, the ordinary ethical standards of good practice must be restored to this area, as our duty, first and foremost, must always be "do no harm".[40]

It's understandable that parents and professionals want to protect children from unnecessary pain and give them something that the child believes will make them feel more comfortable. However, the desire to reduce pain and anxiety by rushing into either social or medical transition needs to be resisted, as there are long-term costs that a child in a fixed state of mind is unable to imagine or understand.

It's worth re-emphasizing the importance of not separating gender dysphoria from other aspects of a person's mental functioning, since many of the young people who present with gender incongruence have co-morbid

[40] A version of this statement and the introduction to it included here was published on 4 February 2021 in *Quillette* magazine, see https://quillette.com/2021/02/04/first-do-no-harm-a-new-model-for-treating-trans-identified-children/

problems. All human beings are complicated. And our problems are usually multidimensional.

D. The risk-benefit of gender-affirming interventions including surgeries for youth is not known.

One needs to be very cautious about recommending medical and surgical interventions that place a lifelong burden of treatment on patients. We know little about their effectiveness (there have been no long-term follow-up studies). The Oxford University's Professor of Evidence-Based Medicine Carl Heneghan has gone as far as to describe medical interventions on children with gender dysphoria as live experiments. [41]

E. The Need for further research not impeded by political pressures

The extraordinary grip of powerful trans lobbies is having the effect of silencing clinicians who fear them. Television producers and journalists continually report that, although clinicians at GIDS are willing to speak in confidence to them about their reservations of treatment in these areas, they shy away from being named for fear of the consequences – being branded a transphobic bigot. This is not limited to the UK.

In Canada, Dr. Kenneth Zucker, a well-known researcher and clinical lead of the Child, Youth and Family Gender Identity Clinic in Toronto, was

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41 BMJ. "Gender-Affirming Hormone in Children and Adolescents." BMJ EBM Spotlight, 25 Feb. 2019, https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

sacked from his post after being accused of conducting 'conversion therapy'. The investigation subsequently completely exonerated Zucker.[42]

In 2018, Lisa Littman described the insights of parents whose adolescent children had recently adopted a transgender identity – a phenomenon she provisionally labelled 'rapid-onset gender dysphoria'.[43] Littman's paper prompted huge controversy. The paper was withdrawn under pressure from the activists, only to be subsequently republished with only very modest revisions, while a subsequent paper demonstrated that the methodology used by Littman was consistent with the use of methodologies in other areas of gender dysphoria research. [44]These are just some of many more examples of scientists whose careers were negatively impacted by the politicization of gender medicine. This politically driven culture interferes with the freedom of thought necessary to work with these very troubled children and adolescents.

CONCLUSIONS AND RECOMMENDATIONS

Medical and surgical interventions in those with gender dysphoria very often leave the underlying problems completely unaddressed. However, patients

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42 M. Kearns, *The exoneration of Dr. Kenneth Zucker*. NAT REV (11 Oct. 2018) Google Scholar

43 Lisa, Littman.*Rapid-onset gender dysphoria in adolescents and young adults.* PLoS ONE 13: e0202330 (2018) CrossRef

44 Lisa Littman, *The Use of Methodologies in Littman (2018) Is Consistent with the Use of Methodologies in Other Studies Contributing to the Field of Gender Dysphoria Research: Response to Restar* (2019). 49 ARCHIVES OF SEXUAL BEHAVIOR, pp. 67–77 Jan. 2020, doi:10.1007/s10508-020-01631-z.

often put enormous pressure on family, schools and clinical services to join with them in the belief that to transition to the 'ideal' body, i.e. to eradicate unwanted aspects of their body, is the only solution to their problems.

WPATH and its singular endorsement of medical gender affirmation does not represent medical consensus, and in fact, the consensus is moving away from invasive medical interventions for minors. There is a growing appreciation of the complexities of gender dysphoria presentation in youth, the inter-related nature of the gender dysphoria and other psychological and developmental factors, as well as the concerns over safeguarding of young people from irreversible and experimental gender-affirming interventions, which include mastectomy.

For the foregoing reasons, the judgment of the district court should not be reversed.

Respectfully submitted this 7th day of July, 2021,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Brief was filed electronically on July 7, 2021 and will, therefore, be served electronically upon all counsel.

/s/ Michael Garth Moore
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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rules of Appellate Procedure 29(a)(4) & (5) and 32(g), the undersigned counsel certifies:

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because this brief contains 6,550 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed.R.App.P. 32(a)(5) and (6) because this brief has been prepared using Microsoft Office Word and is set in Times New Roman font in a size equivalent to 14 points or larger.

/s/ Michael Garth Moore
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