

No. 21-2875

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

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DYLAN BRANDT, et al.,  
Plaintiffs-Appellees,

v.

LESLIE RUTLEDGE, in her official capacity  
as the Arkansas Attorney General, et al.,  
Defendants-Appellants.

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

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**BRIEF OF *AMICI CURIAE* MEDICAL AND MENTAL HEALTH  
PROFESSIONALS SUPPORTING DEFENDANTS-APPELLANTS  
AND URGING REVERSAL**

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## **AUTHORITY TO FILE**

This brief is authorized to be filed under Fed. R. App. P. 29(a)(2) as all parties have consented to its filing.

## **IDENTITY AND INTEREST OF AMICI CURIAE**

Amici Curiae are medical and mental health professionals who are experts in gender-identity theory. Amici opine that the Arkansas Save Adolescents From Experimentation Act (“SAFE Act”), Ark. Code Ann. §§ 20-9-1501-1504 is a rational response to the ethical and medical concerns created if minors are subjected to medical gender affirming treatments that are (at best) very weakly supported as to long term safety and efficacy.

Quentin L. Van Meter, M.D. is a board-certified Pediatric Endocrinologist in private practice in Atlanta, Georgia, with extensive training in issues of transgender health over 40 years. Dr. Van Meter is President of the American College of Pediatricians, fellow of the Endocrine Society, and member of the Pediatric Endocrine Society and of the American Association of Clinical Endocrinologists. He served as Associate Clinical/Adjunct Professor of Pediatrics at Emory University School of Medicine and the Morehouse Medical College.

Michael K. Laidlaw, M.D. is board-certified in Endocrinology, Diabetes, and Metabolism. Dr. Laidlaw earned his medical degree from the University of Southern California in 2001 and completed his residency in internal medicine and a fellowship in endocrinology, diabetes, and metabolism at Los Angeles County University of Southern California Medical Center. He works in private practice and is a contributing member of the Pediatric and Adolescent Gender Dysphoria Working Group ([www.gdworkinggroup.org](http://www.gdworkinggroup.org)) which works internationally on professional issues related to pediatric and adolescent gender dysphoria.

Andre Van Mol, M.D., is a board-certified Family Physician and Co-chair of the Committee on Adolescent Sexuality for the American College of Pediatricians. He works in coalition with other professionals on public policy matters regarding gender identity theory and has served as amicus curiae to several federal appellate courts and the United States Supreme Court. He advises legislators and advocacy organizations internationally on sexuality and gender identity.

Jeffery E. Hansen, Ph.D. is a Pediatric and Adolescent Psychologist in private practice and the founder and director of The

Center for Connected Living, LLC in Olympia, WA. He holds a B.A. in psychology from the University of California at Berkeley, and an M.A. in psychology and a Ph.D. in clinical psychology from the University of Arkansas. Dr. Hansen completed a post-doctoral fellowship in pediatric psychology at Madigan Army Medical Center in Tacoma, Washington where he now serves as a senior Pediatric Psychologist and lead for clinical training and education in the Child and Family Behavioral Health Service. With over 25 years of experience with pediatric and adolescent psychology, Dr. Hansen successfully treats gender dysphoric youth presenting with psychological comorbidities using the “wait and see” or the “therapeutic approach” (explained below) with positive results, including resolution of gender dysphoria in some patients.

Amici critically evaluate Plaintiffs-Appellees’ claim that a medical consensus supports pharmaceutical and surgical “gender affirming” treatments for youth who identify with a gender discordant from their sex. No such consensus exists. Instead, gaps and flaws in the science underlying gender affirmation for minors are driving an emerging international consensus to forego medical gender affirmation

treatments for youth in favor of using psychology as the first-line approach to this psychological condition.<sup>1</sup>

The Legislature enjoys broad discretion to discern and adopt sound evidentiary foundations before establishing public policy, particularly when an issue is debatable or there is evidence of an emerging consensus. *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Before the SAFE Act, trans-identifying youth in Arkansas were at risk of being deprived of natural sexual development through puberty and losing their fertility, sexual functioning, physiological development, and social relationships that would naturally develop if not supplanted by “gender affirmation.” The SAFE act eliminates those risks for Arkansas youth and dovetails with the international trend toward using psychology as the first-line approach to gender dysphoric youth.

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<sup>1</sup> We generally use “child” when referring to a pre-pubescent person; “adolescent” for a person undergoing puberty; and “youth” refers to both. But the reader must be attentive to context when “adolescence” is discussed, as it may be defined by chronological age (which often serves as a general but often inaccurate proxy for being in puberty); Tanner Scale (which describes five physiological stages); or by psychological maturation (a broader category driven by physiological and social maturing and typically used in the mental health fields).

## ARGUMENT

The SAFE Act regulates medical conduct to protect minors from risky, often irreversible medical procedures which gender-identity advocates insist on using despite having only the weakest research support, particularly as to their long-term safety and results.

**I. The Legislature correctly recognized serious gaps in the research underlying medical gender affirmation treatments for minors.**

The State specifically noted the lack of longitudinal, long-term safety and efficacy studies of cross-sex hormonal gender affirmation treatments. The potential long-term impacts are serious: a child or adolescent who is successfully “affirmed” in a sex-discordant gender will be denied the normative sexual maturation, functioning, and relations of their sex, so the State had a well-founded concern about this data gap.

Even leading gender identity advocates acknowledge how weak the science is: “Parents will say to us, ‘What do you really know about the long-term effects of puberty blockers? Who has really studied the children for 20 years?’ said Diane Ehrensaft, a clinical psychologist and the UCSF clinic’s mental health director. ‘And we say, That’s what we

plan to do.” Helen Santoro, *Big gaps in transgender research: A team at USCF is working to change that*, The Mercury News, Mar. 3, 2019, [https://bit.ly/MercuryNews\\_Research\\_Gaps](https://bit.ly/MercuryNews_Research_Gaps).

Nonetheless, Plaintiffs-Appellants forcefully rejected the State’s position, relying on Dr. Antommaria’s Declaration. Pls.’ Mem. Supp. Mot. Prelim. Inj. 40, R. Doc. 12 (citing Antommaria Decl. ¶ 3, R. Doc. 11-12). Dr. Antommaria testified that the Legislature inaccurately claimed that there was “a lack of ‘long-term longitudinal studies’” supporting medical gender affirmation. Antommaria Decl. 1-2, R. Doc. 11-12. In support of his views, Dr. Antommaria listed articles he had read and might rely on, including Johanna Olson-Kennedy, et al. *Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study*, 8 JMIR Rsch. Protocols (2019), doi: 10.2196/14434. Antommaria Decl. 2, 47.

But Olson-Kennedy et al. contradict Dr. Antommaria’s declaration: “Transgender children and adolescents are a poorly understood and a distinctly understudied population in the United States.” Olson-Kennedy, et al. *supra*. Specifically, “there is minimal available data examining the long-term physiologic and metabolic

consequences of gender-affirming hormone treatment in youth. *This represents a critical gap in knowledge that has significant implications for clinical practice across the United States.*” *Id.* (emphasis added).

Olson-Kennedy, et al. squarely support the Legislature’s observation that long term research into the safety and efficacy of medical gender affirmation treatment is seriously lacking.

This profound data gap is independently confirmed by the Hayes Corporation, which regularly reviews the evidentiary support for many medical procedures. Hayes is authoritative, as companies and hospitals that cover 83% of insured Americans rely on it when deciding on health-insurance coverage. Hayes, Inc., *The Hayes Difference*, <https://www.hayesinc.com/about-hayes/>.

When Hayes evaluated 10 peer-reviewed articles and 11 other studies involving cross-sex hormone administration for adolescent gender dysphoria in 2014, it gave it the lowest “D2” rating: the research findings were “too sparse” and “too limited” to even *suggest* conclusions. Hayes, Inc., *Hormone Therapy for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2014). And Hayes very recently examined the evidence for gender reassignment surgery (including



breast/chest operations) for adolescents, concluding it also merited only the lowest “D2” rating, reflecting a “paucity of data” contained in the three studies available for review. Hayes, Inc., *Sex Reassignment Surgery for the Treatment of Gender Dysphoria*, Hayes Medical Technology Directory (2018). This “D2” rating means that there “is insufficient published evidence to assess the safety and/or impact on health outcomes or patient management.” Hayes, Inc., *The Hayes Rating*, <https://www.hayesinc.com/about-hayes/>.

There is also a serious question over whether a youth can grasp all that they lose by affirming perceived gender against the fact of sex. Youth lack fully developed capacity to assess the severity of these risks or weigh the claimed benefits of gender affirmance against its many harms. Amanda C. Pustilnika & Leslie Meltzer Henry, *Adolescent Medical Decision Making and the Law of the Horse*, 15 J. Health Care L. & Pol’y 1 (2012); see Stephen B. Levine, *Informed Consent for Transgendered Patients*, 45 J. Sex & Marital Therapy 218-229 (2018), DOI: 10.1080/0092623X.2018.1518885 (assessing challenges to obtaining informed consent to provide gender affirmation treatment upon demand).

Neurologically, the youthful brain is immature and lacks an adult capacity for risk assessment before the early to mid-20s. Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 *J. of Am. Physicians & Surgeons* 52 (2016). And extant research cannot assure them that the procedures will prove safe or effective. “There are a large number of unanswered questions that include the age at start, reversibility[,] adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. . . . The current evidence base does not support informed decision making and safe practice in children.” Carl Henneghan, *Gender-Affirming Hormone in Children and Adolescents*, *BMJ EBM Spotlight* (Feb. 25, 2019), [https://bit.ly/BMJ\\_GEIDHormoneConsent](https://bit.ly/BMJ_GEIDHormoneConsent).

With that data gap and unanswered ethical questions, the SAFE Act is a prudent, rational measure that defers risks of medical gender affirmation procedures until adulthood and protects Arkansas youth of from those substantial risks.

**II. The immutability of sex versus the malleability of gender supports the State’s view of suspect classes under the 14th Amendment.**

The State correctly argues that the SAFE Act merits only rational basis review under the 14th Amendment in part because trans-identifying people “do not exhibit obvious, immutable, or distinguishing characteristics that define them as a discrete group” which are key factors defining a suspect class for Equal Protection Clause analysis. *Lyng v. Castillo*, 477 U.S. 635, 638 (1986); see Appellants’ Op. Br. 33 (explaining that gender identity is not a suspect class for Equal Protection purposes).

**A. Sex is immutable, binary, objectively known and established by human sexual physiology.**

Sex is immutable, binary, and objectively provable. Humans reproduce sexually, so the definitive distinction for the two sexes is the reproductive roles of males and females. Lawrence S. Mayer & Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, 50 *New Atlantis* 89-90 (2016).

An organism is male or female if it is biologically and physiologically designed to perform one of the two roles in sexual reproduction. Am. Psychiatric Ass’n, *Diagnostic & Statistical Manual of*

*Mental Disorders* 829 (5th ed. 2013) (“DSM-5”). Genetic sex coding directs the development of male or female gonads and other primary sexual traits, and the coded chromosome pairs “XY” or “XX” are established at conception. Deborah Bartz, et al. *Clinical Advances in Sex- and Gender-Informed Medicine to Improve the Health of All: A Review*, JAMA Internal Med. (2020). That sex coding is written in every nucleated cell in that person’s body. Sex is therefore not “assigned” at birth but is established at conception and “declares itself anatomically in utero and is acknowledged at birth.” Cretella, *supra* 51. Subjective, unprovable perceptions of where one falls on a gender continuum do not alter one’s sex.

**B. Gender is a malleable, subjectively perceived continuum which cannot be objectively proven.**

Gender, as used here, means “the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women,” which “influence the ways people act, interact, and feel about themselves.” Am. Psych. Ass’n, *Answers to Your Questions About Transgender People, Gender Identity and Gender Expression* 1 (2014), [https://bit.ly/APA\\_GEID\\_Answers](https://bit.ly/APA_GEID_Answers) (“APA Gender Answers”). Gender reflects the extent to which a person

conforms to, departs from, or simply rejects socially normative behavior for males or females. Gender is an expressly nonbinary, malleable continuum ranging from masculine to feminine to something else altogether:

Other categories of transgender people include androgynous, multigendered, gender nonconforming, third gender, and two-spirit people. *Exact definitions of these terms vary from person to person and may change over time but often include a sense of blending or alternating genders.*

*APA Gender Answers 2* (emphasis added). Gender is not binary but “can be conceptualized as a continuum, a mobius, or patchwork.” Randi Ettner, et al., *Principles of Transgender Medicine and Surgery* 43 (Routledge 2nd ed. 2016) (internal citations omitted). But logically, a patchwork, mobius, or continuum of subjective perceptions cannot define the objective binary taxonomy of sex.<sup>2</sup>

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<sup>2</sup> Plaintiffs-Appellees’ experts try to fuzz the sex binary by discussing intersex conditions, which are rare, objectively diagnosable disorders of sexual development, unlike subjective gender identity perceptions. See Leonard Sax, *How common is Intersex? A response to Anne Fausto-Sterling*, 39 J. of Sex Rsch. (2002) DOI: 10.1080/00224490209552139 (finding about 0.018% incidence). Intersex conditions do not invalidate the objective taxonomy of humans being male or female and treating them is exempted from the SAFE Act under Ark. Code Ann. § 20-9-1502(c)(1).

Cultural manifestations of gender are malleable. For example, whether men should wear earrings has seesawed at least since King Tut's time. Robert Traynor, *The Culture of Earrings for Men*, Hearing Health & Tech. Matters (Feb. 9, 2016), [https://bit.ly/Men\\_earrings](https://bit.ly/Men_earrings). And children change as they develop. A “tomboy” girl may gravitate toward dolls and dresses as she ages, while a boy who might play with dolls may later seek out rugged adventure sports or hunting.

So, “gender is neither the causal result of sex nor as seemingly fixed as sex,” but is “a free-floating artifice, with the consequence that *man* and *masculine* might just as easily signify a female body as a male one, and *woman* and *feminine* a male body as easily as a female one.” Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* 10 (Routledge 1st ed. 1990). Thus, the “hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex—that a person might be ‘a man trapped in a woman’s body’ or ‘a woman trapped in a man’s body’—is not supported by scientific evidence.” Mayer, *supra* 8. The State is on sound scientific and constitutional grounds when it recognizes that sex is immutable, but gender is not.

**III. Dr. Turban fails to establish the supposed consensus that subjecting youth to pharmaceutical or surgical gender affirmation treatments is safe and effective in the long term.**

If there were a “medical consensus” that subjecting youth to medical gender affirmation treatments is safe and effective, it would have to conform to the prime directive of medicine: First, do no harm:

The physician must be able to tell the antecedents, know the present, and foretell the future—must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm.

Hippocrates, *Of the Epidemics*, Internet Classics Archive, <https://bit.ly/MedPrimeDirective>.

But such a consensus does not exist. The field of gender affirming treatment “suffers from a vexing problem: There are no randomized controlled trials (RCT) of different treatment approaches, so the front-line clinician has to rely on lower-order levels of evidence in deciding on what the optimal approach to treatment might be.” Kenneth J. Zucker, *Debate: Different strokes for different folks*, 25 *Child and Adolescent Mental Health* 36-37 (2020), *accord*, Paul W. Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, 87

Linacre Q. 34–42 (2019) (cataloging shortcomings in gender-identity research).

Nonetheless, Plaintiffs-Appellees claimed a supportive consensus exists when briefing the preliminary injunction in district court. The state countered with able experts, to which Plaintiffs-Appellees replied with supplemental declarations from its experts. Notable among those was the initial declaration from Dr. Jack Turban in support of their medical consensus argument. Turban Decl., R. Doc. 51-1. But examining Dr. Turban’s declaration exposes the exceptionally weak research underlying gender affirmation treatments in youth, and thus rebuts Plaintiffs-Appellees’ consensus theory.

**A. Dr. Turban’s *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation* article does not establish causation between pubertal blockade and decreased suicidality**

Dr. Turban relies in part on his article, Jack L. Turban, Dana King, Jeremi M. Carswell and Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 *Pediatrics* (2020) to claim that that “gender-affirming medical care is linked to favorable mental health outcomes.” Turban Decl. 5-6, R. Doc.



51-1. Yet he admits that this 2020 *Pubertal Suppression* article has been “rigorously criticized,” *Id.* at 9.

And rightly so: “linked” only admits to a correlation, which does not prove causation. That admission is necessary because the study design was cross-sectional, and such a study design cannot establish causal relationships. *Handbook of Survey Methodology for the Social Sciences* 66 (Lior Gideon ed., Springer 2012).

Dr. Turban also overlooked that study participants treated with puberty blockade *and* those who were not had alarmingly high rates of suicidal ideation (50% or higher) within the last year, rates strikingly similar to those reported for transgender adults in Noah Adams, Maaya Hitomi, and Cherie Moody, *Varied Reports of Adult Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature*, 2 *Transgender Health*, 69 Fig. 2 (2017) (reporting suicide ideation for trans-identified adults at 51.7% for males and 45.4% for female).

Nor did Dr. Turban discuss the more robust measure of suicide risk: what happens when a person has the idea *and* plans suicide? For that factor, there was no significant difference between the study groups, and those who received puberty blockers were hospitalized more

often for suicide attempts than those who did not receive that medication.

This suggests that suicide risk may be driven more by co-occurring psychological issues than from gender dysphoria itself—which is plausible given that 96% of U.S. adolescents attempting suicide suffer from at least one mental illness. Matthew K. Nock et al., *Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement*, 70 JAMA Psychiatry 303 (2013).

Even more concerning, when puberty blockers are used “on label” for the uncontroversial treatment of central precocious puberty, there is evidence of increased depression and “rare reports of suicidal ideation and attempt....” *Lupron Highlights of Prescribing Information* (2020), <https://bit.ly/LupronRxGuide>. This raises a question of whether puberty blockers play a causal role in suicidality, and that question should be answered before the Legislature allows broader use of them to supplant normal pubertal development of trans-identifying children.

There are also serious concerns about the long-term efficacy of puberty blockade. “[T]rans-identification and its associated medical

treatment can constitute an attempt to evade experiences of psychological distress” which “puts young trans people at risk of receiving potentially damaging medical treatment they may later seek to reverse or come to regret, while their underlying psychological issues remain unaddressed.” Robert Withers, *Transgender medicalization and the attempt to evade psychological distress*, 65 J. Analytical Psych. 865–889, 865 (2020) <https://doi.org/10.1111/1468-5922.12641>.

Yet there is one thing that puberty blockade seems almost 100% effective in doing: directing a pre-pubertal trans-identifying child to subsequent cross-sex hormone treatments and potentially surgical treatments. In a study of 70 puberty-blocked children, *every child* proceeded to cross-sex hormone treatments—the next step toward full gender reassignment. Annelou L. C. de Vries, Thomas D. Steensma, Theo A. H. Doreleijers, Peggy T. Cohen-Kettenis, *Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study*, 8 J. Sexual Med. 2276-2283 (2011); see Tessa Brik, Lieke J.J.J. Vrouenraets, Marine C. de Vries, Sabine E. Hannema, *Trajectories of adolescents treated with gonadotropin releasing hormone*

*analogues for gender dysphoria*, 49 Arch. Sex Behav. 2611–2618 (2020), (finding only 3.5% termination of use).

This one-way route to cross-sex hormone treatment is very concerning when 61% to 98 % of children *desist* from their discordant gender identity and realign with their sex as normal puberty ensues. Jiska Ristori & Thomas D. Steensma, *Gender dysphoria in childhood*, 28 Int'l Rev. of Psychiatry 13-20 (2016). The 100 percent *persistence* of gender identity reported by de Vries, *supra*, strongly suggests that some of the patients were driven toward affirming their perceived sex-discordant gender when, but for puberty blockade, they would have aligned with their sex.

This is highly problematic—no one can predict which dysphoric youth may desist and which will not, and pubertal blockade interrupts crucial physiological and social development. That uncertainty and the ethical questions arising from affirming youth who would otherwise realign their identity to their sex support the SAFE Act delaying these treatments for minors.

**B. Dr. Turban’s *Association between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults* article does not support his claim of mental health benefits from gender affirmation.**

Dr. Turban states that his team had “found that, after adjusting for a range of potentially confounding variables, exposure to gender identity conversion efforts was associated with greater odds of attempting suicide.” Turban Decl. 37 n.61, R. Doc. 51-1 (citing Jack L. Turban, N. Beckwith, S. L. Reisner & A. S. Keuroghlian, *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*, 77 JAMA Psychiatry 68-76 (2020)). But the *Recalled Exposure* article is too flawed to support his claim.

Several prominent scientists recently challenged *Recalled Exposure’s* “problematic analysis” and “flawed conclusions” by which it advanced “the misguided notion that anything other than ‘affirmative’ psychotherapy for gender dysphoria (GD) is harmful and should be banned.” Roberto D’Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behav. 7 (2021).

*Recalled Exposure* drew its data from the flawed 2015 U.S. Transgender Study, a particularly weak online convenience survey obtained by recruiting participants “through transgender advocacy organizations and subjects were asked to ‘pledge’ to promote the survey among friends and family.”<sup>3</sup> *Id.* at 8. This recruiting method yielded a large but highly skewed sample.” *Id.* Such retrospective studies depend heavily on the participants’ unreliable memories, and “you cannot make statistical generalizations from research that relies on convenience sampling.” Gideon, *supra* 66.

The survey is rife with data irregularities. Nearly 40% of the survey participants had not transitioned medically or socially, and a significant number reported that they did not plan to transition. Many respondents claimed that puberty blockers were begun *after* they turned 18 years old, which is highly improbable as gender affirming puberty blockade must precede puberty, not come years after it. And the survey results had to be specially weighted due to an unusually high

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<sup>3</sup> S.E. James, J.L. Herman, S. Rankin, M. Keisling, L. Mottet & M. Anafi, Nat’l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* (2016), <https://bit.ly/2015TransgenderSurveyRpt>.

proportion of respondents reporting their age as exactly 18 years.

D'Angelo, *supra* 8.

*Recalled Exposure* also conflated interactions with mental health practitioners with interactions involving counselors, religious advisors, and other professionals; it did not distinguish between voluntary or coerced encounters; it did not differentiate between diagnostic encounters versus specific therapeutic interventions; there was no information on whether gender dysphoria was the focus of the supposed conversion session or secondary to other health issues; and it did not determine whether unethical actions were taken during the supposed “conversion” session. *Id.* at 7-8.

In sum, its “conversion” question is flawed because its raw binary division of gender affirming treatments is a “blunt classification [that] overlooks a wide range of ethical and essential forms of agenda-free psychotherapy that do not fit into such a binary; at worst, it effectively mis-categorizes ethical psychotherapies that do not fit the ‘affirmation’ descriptor as conversion therapies.” *Id.* at 7. And stigmatizing all non-affirming psychotherapy for gender dysphoria risks reducing “access to

treatment alternatives for patients seeking non-biomedical solutions to their distress.” *Id.*

Remarkably, in proposing that gender identity conversion efforts (“GICE”) lead to poor mental health and suicide attempts, *Recalled Exposure* failed “to control for the individual’s pre-GICE-exposure mental health status.” *Id.* at 10. This is crucial, as a patient may present with comorbidities that would readily merit conventional psycho-therapy—what gender-identity advocates would characterize as “non-affirming” treatment. Then, if such a patient would attempt suicide, *Recalled Exposure* would assume that the attempt was due to “conversion therapy” even if appropriately treating a comorbid condition (unrelated to gender dysphoria) was the true cause of the attempt. *Id.*

“In fact,” the *One Size* authors conclude, “failure to control for the subjects’ baseline mental health makes it impossible to determine whether the mental health or the suicidality of subjects worsened, stayed the same, or potentially even improved after the non-affirming encounter.” *Id.* Accordingly, “[g]iven the high rate of co-occurring mental illness in transgender-identifying patients, failure to control for



prior mental health status is a serious methodological flaw.” *Id.*  
(citation omitted).

Ultimately, *Recalled Exposure’s* “[p]resenting a highly confounded association as causation is a serious error, given its potential to dangerously misinform and mislead clinicians, policymakers, and the public at large about this important issue.” *Id.* at 11.

**C. A key study Dr. Turban cited to claim that gender affirmation surgery leads to improved mental health outcomes had to withdraw its central statistically significant finding.**

Dr. Turban tries to bolster his arguments by dismissing Richard Bränström and John E. Pachankis, *Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study*, 177 *Am. J. of Psychiatry* 727-734 (2019), as “not particularly relevant” because the “majority” of such surgeries are not currently offered to minors. Turban Decl. 24, R. Doc. 55-1. But gender affirming mastectomies were among the most common surgeries in the study, a fact he omits. *Bränström, supra* 730.

Moreover, the Bränström, et al. article exemplifies poor quality research. Dr. Turban soft-pedaled the swift, intense criticism challenging the article’s finding of “a statistically significant

relationship between time since surgery and mental health status” based on the researchers observing “that as of 2015, patients who had surgeries further in the past had better mental health than patients whose surgeries were more recent.” Soc’y for Evidence Based Gender Med., *Correction of a Key Study: No Evidence of “Gender-Affirming” Surgeries Improving Mental Health* (Aug. 30, 2020), [https://www.segm.org/ajp\\_correction\\_2020](https://www.segm.org/ajp_correction_2020). Defendants-Appellants’ expert Dr. Michael Laidlaw and Amici Dr. Andre Van Mol coauthored one of the critiques: Andre Van Mol, Michael K. Laidlaw, Miriam Grossman, & Paul R. McHugh, *Gender-affirmation surgery conclusion lacks evidence*, 177 Am. J. of Psychiatry 765–766 (2020). See Richard Bränström & John E. Pachankis, *Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals’ Mental Health: Response to Letters*, 177 Am. J. of Psychiatry 769-772 (2020) (acknowledging critics’ role in correcting the article).

The criticism led to correcting the article to eliminate the claimed statistically significant relationship between gender affirmation surgery and later-improved mental health (while leaving intact the study’s

finding of that hormone treatment alone did not significantly affect subsequent mental healthcare treatment). Specifically, “the results [of the reanalysis] demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts.” *Correction to Bränström and Pachankis*, 177 Am. J. of Psychiatry 727-734 (2020).

Ironically, Dr. Turban marginalizes the State experts (whose views Amici generally share) as “outliers” in medicine, Turban Decl. 3-4, R. Doc. 51-1, yet “outliers” were the ones who challenged the Bränström article. If the State’s experts are indeed “outliers,” then “outliers” should be understood as referring to professionals willing to improve science by engaging in the hard debates.

**IV. The risks of medical gender affirmation treatments for minors are driving an emerging consensus toward psychotherapy as the first-line treatment for gender dysphoria in youth.**

There is a global shift away from using gender affirmation as the first-line response to gender dysphoric youth.

First, there is no consensus supporting pubertal blockade. Instead, “almost all clinics and professional associations in the world use what’s called the *watchful waiting* approach to helping [gender dysphoric]

children....” James M. Cantor, *American Academy of Pediatrics policy and trans-kids: Fact-checking*, Pediatric and Adolescent Gender Dysphoria Working Group (2019), [https://bit.ly/AAP\\_Policy\\_Factcheck](https://bit.ly/AAP_Policy_Factcheck).

Indeed, the American Psychological Association Handbook on Sexuality and Psychology cautions *against* a rush to affirm that “runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist.” Walter Bockting, *Ch. 24: Transgender Identity Development*, 1 Am. Psych. Ass’n Handbook of Sexuality and Psychology 744, 750 (D. Tolman & L. Diamond eds., 2014).

There are also risks to gender affirmation in adolescents, particularly when cross-sex hormone treatment suppresses the normal development of some secondary sex characteristics and foster the development of secondary opposite-sex characteristics. For example, in females the course of cross-sex hormones means unusually high doses of testosterone that atrophies and chemically degrades the sex organs leading to sexual dysfunction and eventual sterility. Michael K. Laidlaw, *The Gender Identity Phantom*, [gdworkinggroup.org](http://gdworkinggroup.org) (Oct. 24,

2018), <http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/>. And “transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone,” that may also lead to polycythemia (an excess of red blood cells), which is associated with “a significantly increased risk of cardiovascular disease, coronary heart disease, and death due to both” for younger females. Michael K. Laidlaw et al., *Letter to the Editor from Laidlaw et al.: “Erythrocytosis in a Large Cohort of Transgender Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years,”* J. Clinical Endo. & Metab. (July 23, 2021), doi: 10.1210/clinem/dgab514.

Plaintiffs-Appellees also argue that the SAFE Act discriminates on transgender status when it allows the use of puberty blockers for central precocious puberty but prohibits using puberty blockers to affirm perceived gender.

But these are medically different treatments: treating precocious puberty involves blocking abnormally early pubertal development in a disease state (for example a child of age 4 who enters Tanner stage 2) which is maintained until allowing puberty to resume at a more typical

age, say 11 years. Puberty then continues through its normal stages until reaching Tanner stage 5 (full adult sexual maturity).

In contrast, gender affirmation puberty blockade is administered to youth with no physical disease relevant to puberty, at an age when puberty normally begins, and when they are “in the earliest stages of pubertal development (Tanner stages 2-3).” In this instance, puberty blockers “suppress endogenous puberty and avoid the development of undesired secondary sex characteristics.” Olson-Kennedy, et al., *supra*.

This is highly significant, because “[c]ontinued suppression of the pituitary gonadal axis by [puberty blocking agents] will maintain a state of immaturity of the male and female gonads. As a result, though the child will likely continue to grow in stature, the gonads and entire pelvic genitalia will remain stunted” in early pubertal development.

Michael Laidlaw, Michelle Cretella & Kevin Donovan, *The Right to Best Care for Children Does Not Include the Right to Medical Transition*, 19 Am. J. Bioethics 75-77 (2019). Subsequent dosing with “cross sex hormones will not change this condition. As a result, the patient will be infertile as an adult.” *Id.* For the same reason, the patient will also be sexually dysfunctional.

Concerns like these and the extremely weak science have long been known. See David Batty, *Mistaken Identity*, The Guardian, July 30, 2004, <http://bit.ly/2EGBEYO>. (reporting assessment of over 100 follow-up studies on post-operative transsexuals; none proved that sex reassignment is beneficial for patients). And the concerns persist: in a very recent, short-term study, researchers “found no evidence of change in psychological function with [puberty blockade] treatment as indicated by parent report (CBCL) or self-report (YSR) of overall problems, internalising or externalising problems or self-harm.” Polly Carmichael, Gary Butler, et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, PLOS ONE (2021), doi: 10.1371/journal.pone.0243894.

Gender medicine practitioners around the globe—including from countries that have been at the forefront of developing gender-identity theory—are abandoning the gender affirmation model in favor of conventional exploratory psychological approaches.

Finland in 2020 recognized that “[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited,” and

recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation. Council for Choices in Healthcare in Finland, *Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation*, June 11, 2020, [https://bit.ly/Cohere\\_Finland\\_GDAinMinorsRx](https://bit.ly/Cohere_Finland_GDAinMinorsRx).

In 2021, Sweden’s largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials. Soc’y for Evidence Based Gender Med., *Sweden’s Karolinska Ends All Use of Puberty Blockers and Cross-Sex Hormones for Minors Outside of Clinical Studies* (May 5, 2021), [https://bit.ly/SEGM\\_SwedenStopsHormones](https://bit.ly/SEGM_SwedenStopsHormones).

In the United Kingdom, litigation against the Tavistock gender clinic led the appellate court to observe that the “treatment of children for gender dysphoria is controversial. Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood. The question raises not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense



professional and public debate.” *Bell v. Tavistock & Portman NHS Found. Trust*, [2021] EWCA (Civ) 1363.<sup>4</sup>

This shift was dramatically publicized in the United States when two prominent gender affirming doctors “blew the whistle” on sloppy gender affirmation care. Dr. Marci Bowers is a “world-renowned vaginoplasty specialist who operated on reality-television star Jazz Jennings,” and Erica Anderson is a clinical psychologist at the University of California San Francisco’s Child and Adolescent Gender Clinic. Abigail Shrier, *Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care*, Common Sense with Bari Weiss (October 4, 2021), <https://bit.ly/TransDocsBlowWhistle>. Both doctors are natal males who transitioned to female identities; both are World Professional Association for Transgender Health board members, and both say that this “new [gender affirmation] orthodoxy has gone too far,” with Dr. Anderson even saying that “many transgender healthcare providers were treating kids recklessly.” *Id.*

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<sup>4</sup> Available at <https://www.judiciary.uk/wp-content/uploads/2021/09/Bell-v-Tavistock-judgment-170921.pdf>.

*Blow the Whistle* recapped the history of treating gender dysphoria, noting that until about 10 years ago, “psychologists treated it with ‘watchful waiting’ — that is, a method of psychotherapy that seeks to understand the source of a child’s gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body.” *Id.* But watchful waiting was replaced with “affirmative care,” where doctors are urged to “corroborate their patients’ belief that they are trapped in the wrong body” while families are pressured to help the child transition to the claimed identity—with activists sometimes telling parents that the choice is transition or suicide. *Id.* Dr. Bowers’ retrospective on the young patients treated with gender affirming surgeries comes close to damning: “But honestly, I can’t sit here and tell you that they have better—or even as good—results.” *Id.*

When even the foremost practitioners of gender affirmation found “reckless” gender affirmation treatment occurring and doubt the efficacy of the procedures, it is fair to say that the Legislature acted rationally to protect the State’s youth from those procedures, especially when conventional psychotherapy and watchful waiting provide a safe, effective alternative to the pharmaceutical-surgical approaches.

**V. Conventional psychology may safely and effectively guide a dysphoric youth to stability while deferring decisions on risky, poorly researched, and often irreversible medical gender affirming treatments until adulthood.**

More and more mental health professionals endorse safe alternatives to fast-tracking youths to medically transition, including the “wait and see approach” and the “therapeutic approach.”

The “wait-and-see” approach developed by respected gender identity researchers in the Netherlands, does not try to direct cross-gender expression, but also doesn’t encourage early transitioning in most cases. Erin Anderssen, *Gender identity debate swirls over CAMH psychologist, transgender program*, The Globe and Mail, Feb. 14, 2016, [https://bit.ly/GlobeMail\\_CAMH\\_Controversy](https://bit.ly/GlobeMail_CAMH_Controversy). Sasha Ayad, a leading international transgender expert suggests that parents consider refraining from early affirmation of a child/adolescent gender identity, instead supporting their child’s identity exploration without necessarily taking on the identity. Abigail Schrier, *Irreversible Damage: The Transgender Craze Seducing out Daughters* (2020).

Dr. Zucker has argued in published research and previous interviews that therapy should be guided by the age of the patient and based on best evidence, including the important longitudinal studies

which reveal that gender identity is malleable or changeable in young children, and that the vast majority will, if not early-affirmed, outgrow their cross-gender identity by the time they are teenagers, and most, in fact, will often grow up quite possibly to be gay adults. Anderssen, *supra*. Zucker reported that in a 25-year period, not one patient who started seeing him by age 6 has switched gender. Hanna Rosin, *A Boy's Life*, The Atlantic, Nov. 2008, [https://bit.ly/Atlantic\\_BoysLife](https://bit.ly/Atlantic_BoysLife).

Research sexologist Dr. Deborah Soh explains that the therapeutic approach allows for youth to explore the parameters of their gender while being open to the potential of growing comfortable in their sex. In this approach the therapist seeks to understand relevant factors of the youth's development to include adverse childhood experiences, trauma, and other psychopathology, or other factors in the patient's life that might be moving the youth to feel this way. Debra Soh, *The End of Gender* (2020).

The therapeutic counseling approach has empirical support for its effectiveness in resolving gender dysphoria: "In conclusion, the adolescents included in this review met criteria for GD and initially requested medical interventions to resolve their difficulties. Over the

course of the psychosocial assessment, they came to understand their distress and its alleviation (at that particular point in time) differently and eventually chose not to take a medical (hormonal) pathway and/or identified their gender identity as broadly aligned with their biological sex. Of course, this is not the case for many other young people presenting to the service and it is important to hold onto the multiplicity of possible outcomes.” Anna Churcher Clarke & Anastassis Spiliadis, *‘Taking the lid off the box’: The value of extended clinical assessment for adolescents presenting with gender identity difficulties*, 24 *Clinical Child Psych. and Psychiatry* 338-353 (2019).

Churcher and Spiliadis take a very open approach to the gender identity question, recognizing that there may be a multiplicity of outcomes but also demonstrating that psychology may resolve dysphoria without resort to risky and often irreversible medical treatments. This aligns with the purposes of the SAFE Act which says “not yet” rather than “never” to dysphoric youth. And that is a prudent, rational legislative choice given the risk, the lifelong impacts, the irreversibility of many treatments, and the dearth of evidence to show long-term safety and efficacy of gender affirmation treatments.

## CONCLUSION

The Arkansas legislature acted prudently and rationally to protect Arkansas youth from ill-founded medical treatments through the SAFE Act. The lower court decision should be reversed.

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Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

Under Fed. R. App. P. 32(g), the undersigned certifies that this brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5). Exclusive of the sections exempted by Fed. R. App. P. 32(f), the brief contains 6,428 words, according to the word count feature of the software (Microsoft Word 365) used to prepare the brief. The brief has been prepared in proportionately spaced typeface using Century Schoolbook 14 point.

/s/ John J. Bursch  
John J. Bursch

## CERTIFICATE OF SERVICE

I hereby certify that I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the Appellate CM/ECF system on November 19, 2021. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the Appellate CM/ECF system.

*/s/ John J. Bursch*  
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