
UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

DYLAN BRANDT, by and through his mother, Joanna Brandt; JOANNA BRANDT, *et al.*

Plaintiffs-Appellees,

v.

LESLIE RUTLEDGE, in her official capacity as the Arkansas Attorney General, *et. al.*

Defendants-Appellants.

On Appeal from the United States District Court for the Eastern District of Arkansas, No. 4:21-cv-00450, Before the Honorable Judge James M. Moody

Brief for Yaacov Sheinfeld, Jeanne Crowley, Ted Hudacko, Lauren W., Martha S., Kellie C., Kristine W., Bri Miller, Helen S. and Barbara F., as Amici Curiae in Support of Defendants-Appellants, Supporting Reversal

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STATEMENT OF CORPORATE DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici curiae* by and through undersigned counsel, state that they are not publicly held corporations that issue stock, nor do they have parent corporations.

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STATEMENT OF INTEREST

Pursuant to Fed. R App P. 29, *Amici Curiae* respectfully submit this brief in support of Defendants-Appellants. All parties have consented to this filing.¹

Amici are Yaacov Sheinfeld, Jeanne Crowley (pseudonym)², Ted Hudacko, Lauren W. (pseudonym), Martha S. (pseudonym), Kellie C. (pseudonym), Kristine W. (pseudonym), Bri Miller, Helen S. (pseudonym) and Barbara F. (pseudonym). They are parents of children who said they were transgender and wanted medical interventions to change their bodies to conform to their believed discordant gender identity.

Because there was no protective legislation in place such as Arkansas' SAFE Act, Amici were subjected to misinformation, coercion, and threats from health care providers, and even at times from their children, trying to convince them to consent to the interventions. In some cases, the children received puberty-suppressing drugs and/or high doses of wrong-sex hormones (testosterone for girls and estrogen for boys) designed to trick their bodies into developing characteristics of the opposite sex. Even in those families in which the children did not obtain the medical interventions, the availability and promotion of the interventions sowed dissension

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

² Some of the amici are using pseudonyms in order to protect the identity of their children and/or other family members.

between parents and their children and created distrust in the medical profession. Parents did not receive the information necessary to give informed consent. The children's underlying mental health and trauma issues were not addressed.

Amici respectfully submit this brief to provide this Court with their first-hand knowledge of the dangers posed by these interventions that the Arkansas Legislature has wisely determined should not be provided to children.

INTRODUCTION

The Save Adolescents from Experimentation (SAFE) Act sends the message that Arkansas' vulnerable children will be protected from experimental medical and surgical interventions that will irreversibly change their bodies, create unknown future harm, and take away their right to decide whether to have children. It is a message that Amici wish that their children could have heard and heeded before embarking on a journey that tore apart their families, ravaged their bodies, left mental illness untreated, and in one instance, ended their life. Arkansas has acted to protect its most vulnerable citizens by prohibiting "gender-transition" medical and surgical interventions designed to divert a child's body from its natural development to an altered state mimicking the opposite sex.

The SAFE Act protects children's well-being and safeguards parents' rights to make medical and mental health decisions for their children unfettered by misinformation and manipulation. Prohibiting these interventions for children means

that health care providers can focus on root causes of children’s distress instead of placing them on a conveyor belt of “gender transition” that will perpetuate harm.

LEGAL ARGUMENT

I. The SAFE Act Strengthens Arkansas’ Established Protection of Children From Harmful Experimental Medical Interventions.

The SAFE Act further strengthens Arkansas’ protection of vulnerable children previously accorded by its restrictions on sterilization and genital mutilation of minors, in keeping with its compelling state interest in “protecting powerless children.” *Bohn v. County of Dakota*, 772 F.2d 1433, 1439 (8th Cir. 1985). The SAFE Act also furthers the state’s compelling interest in preserving family integrity by prohibiting medical and surgical interventions that are toxic to family relationships.

A. The SAFE Act Protects Children From Sterilization in Keeping With The Constitution and Arkansas Statutes.

Emerging research and Amici’s lived experiences demonstrate that the interventions prohibited under the SAFE Act are not safe and effective for children. Practitioners in Europe, who pioneers in “gender-transition” interventions, have significantly restricted or even halted the procedures.³ Even practitioners who are

³ See e.g., National Institute for Health and Care Excellence (NICE) NHS, *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria, & Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* April 1, 2021, <https://www.evidence.nhs.uk/document?id=2334889&returnUrl=search%3ffrom%3d2021-03-10%26q%3dEvidence%2bReview%26to%3d2021-04-01;>

part of the World Professional Association for Transgender Health (WPATH) are questioning whether children and adolescents should be given puberty blockers and wrong-sex hormones.⁴ Among the concerns practitioners raise is that puberty blockers, which are almost universally followed up with wrong-sex hormones, result in infertility and sexual dysfunction.⁵ In other words, these medical interventions effectively sterilize children before they are developmentally mature enough to understand the ramifications of being forever foreclosed from having children or experiencing sexual pleasure.

As the Supreme Court said in *Skinner v. Oklahoma*, 316 U.S. 535, 541-42 (1942), “[t]he power to sterilize, if exercised, may have subtle, far-reaching and devastating effects.” The person who is sterilized is “forever deprived of a basic

<https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtr%3f%3dDate>; Society for Evidence-Based Gender Medicine (SEGM) *Karolinska Institute Halts Puberty Blockers, Cross-Sex Hormones for < 16*; May 5, 2021, https://segm.org/Sweden_ends_use_of_Dutch_protocol; Glen Owen, *NHS quietly U-turns on its guidelines for controversial puberty-blocking drugs for transgender teens which could have long-term effects on brains, bones and mental health*, UK DAILY MAIL, June 20, 2020, https://www.dailymail.co.uk/news/article-8418463/NHS-U-turns-controversial-puberty-blocking-drugs-transgender-teens.html?ns_mchannel=rss&ns_campaign=1490&ito=1490; SEGM, *One Year Since Finland Broke with WPATH "Standards of Care" Finland prioritizes psychotherapy over hormones, and rejects surgeries for gender-dysphoric minors*, July 2, 2021, https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors.

⁴ Abigail Shrier, *Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care*, Common Sense, October 4, 2021, <https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle>.

⁵ *Id.*

liberty,” *i.e.*, the decision of whether to procreate, which is “one of the basic civil rights of man...fundamental to the very existence and survival of the race” *Id.* As this Court said in *Vaughn v. Ruoff*, 253 F.3d 1124, 1128-29 (8th Cir. 2001), all persons possess the liberty interest in preserving the right to create children of their own in the future.

In keeping with this essential human right, Arkansas enacted Ark. Code §§ 20-49-201 *et seq* to protect vulnerable children from involuntary sterilization. Parents seeking involuntary sterilization of their children who are deemed mentally incompetent must first obtain a court order following an evidentiary hearing in which the parents must provide testimony from at least two experts and the child is represented by counsel. Ark. Code § 20-49-204. Parents cannot simply consent to sterilization of their mentally compromised children and deprive them of their right to be able to decide whether to procreate upon reaching adulthood.

Similarly, under the SAFE Act, parents cannot simply consent to the sterilization of their children for purposes of conforming their bodies to fit their perception of a discordant gender identity. All of Arkansas’ children have the right to preserve the ability to make the important decision of whether to have children. *Vaughn*, 253 F.3d at 1128-29. The SAFE Act ensures that children experiencing gender dysphoria also have that right.

B. The SAFE Act Strengthens Arkansas' Protection of Vulnerable Girls From Genital Mutilation.

Likewise, the SAFE Act ensures that all of Arkansas' minor girls are protected from surgical interventions that result in genital mutilation. Ark. Code § 5-14-136 prohibits female genital mutilation on minors, even with parental consent. Prior to passage of the SAFE Act, minors could consent to genital mutilation as part of a "sex reassignment" procedure. Section 5-14-136(e)(2). That created a loophole that weakens the protections for girls. Unscrupulous practitioners could claim that the procedure was performed for "sex reassignment" purposes and escape liability for genital mutilation of minor girls.

The SAFE Act closes the loophole in the existing law. "Sex reassignment" can no longer be a permitted reason for seeking surgery that mutilates a minor girl's genitalia. All Arkansas girls are protected against such surgeries, regardless of purported reasons, until they reach adulthood.

II. The SAFE Act Safeguards Parents' Fundamental Rights To Make Medical Decisions And Prevents The Disruption of Families Caused By "Gender-Transition" Interventions.

A. "Gender-Transition" Medical Interventions Are Not Supported By Traditional Medical Safeguards Necessary For Parents To Make Sound Decisions.

Parents are presumed to act in the best interests of their children to make sound medical and mental health decisions that children are incapable of making. *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Making sound medical decisions requires

consulting trained specialists using the “traditional tools of medical science.” *Id.* at 609. “The decision should represent an independent judgment of what the child requires and ... all sources of information that are traditionally relied on by physicians and behavioral specialists should be consulted.” *Id.* at 608. In the case of “gender-transition” hormonal and surgical interventions for children, parents are foreclosed from making sound medical decisions because the procedures are not based on traditional tools of medical science, including independent judgments based on scientifically credible clinical research establishing the safety and efficacy of such interventions.⁶

The WPATH “standards” practitioners cite as evidence that medical and surgical interventions are safe and effective do no such thing and lack the scientific rigor required for informed medical decision-making.⁷ The Grading of Recommendations Assessment, Development and Evaluation (GRADE) system, the accepted standard for reviewing clinical practice guidelines (“CPGs”), found that nearly all of the WPATH recommendations are based upon “low” or “very low” quality evidence.⁸ Published studies in transgender medicine are limited by, *inter alia*, small sample sizes, recruitment bias, high numbers of patients lost to follow-

⁶ Paul W. Hruz. M.D., Ph.D. *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, 87 THE LINACRE QUARTERLY 34 (2020).

⁷ *Id.* at 37.

⁸ *Id.*

up, and frequent reliance on “expert opinion” alone.⁹ A recent systematic review using a validated quality appraisal instrument to assess the international CPGs addressing transgender health found that none of the transition-based guidelines had methodological rigor or evidentiary quality necessary to qualify as high-quality CPGs.¹⁰ Under traditional medical protocols, practitioners would not “advance a single treatment approach over other potential interventions” based upon such low-quality evidence.¹¹

Amici’s experiences demonstrate that is precisely what “gender-transition” practitioners are doing, *i.e.*, presenting parents with a single treatment approach, medical intervention, that is based on low or very low-quality evidence. Parents are not informed about the lack of evidence supporting the safety of the single option. Neither are they provided with evidence-based information on short-term and long-term risks, lack of FDA approval of the proposed use of these drugs or the fact that the vast majority of children with gender dysphoria will desist after puberty if they are not subjected to interventions.¹² Practitioners strip parents of their ability to discern safe and effective care for their children by failing to disclose information

⁹ *Id.*

¹⁰ S. Dahlen, D. Connolly, et. al. *International Clinical Practice Guidelines for gender minority/trans people: systematic review and quality assessment*, *BMJ Open*, at 2, April 29, 2021; 11:e048943. doi:10.1136/bmjopen-2021-048943.

¹¹ Hruz, *supra* n. 6, at 37.

¹² *Id.* at 36.

necessary to exercise informed consent and then coerce and threaten parents who refuse to consent. Parents are placed in an impossible position of not having the information necessary to make a sound decision and being coerced with the threat of their children committing suicide if they do not consent. Parents furthermore have to contend with internet-fueled demands of their children.

Arkansas' SAFE Act prevents parents from being placed in that untenable position. Acting in accordance with its compelling interest in the protection of minor children, *Myers v. Morris*, 810 F.2d 1437, 1462 (8th Cir. 1987), the Legislature has appropriately made the choice of protecting minor children from such medical "gender-transition" interventions until they reach adulthood.

B. Amici's Experiences Demonstrate The Compelling Need For The SAFE Act.

Amici are parents who come from various walks of life and diverse belief systems and cultural backgrounds but share the experience of having a child who professed to having a gender identity that did not correspond to his or her sex. Medical interventions were promoted as the only viable option for their children, supplanting psychotherapy which would have better addressed the children's underlying mental health issues. The often-coercive promotion of "gender-transition" medical interventions created dissensions in and dissolution of families, alienation, exacerbation of existing trauma and adverse physical consequences for children who received the interventions. Amici are sharing their experiences to

demonstrate why this Court should uphold the Arkansas Legislature's efforts to protect Arkansas families from similar experiences.

Yaacov Sheinfeld.

Yaacov Sheinfeld was shocked when his wife told him that their 17-year-old daughter had announced she was transgender. Their daughter, S., had been in counseling for depression since she was 15 but never said anything about gender dysphoria. Yaacov learned that five of his daughter's friends had also announced that they were transgender. Being transgender provided S. with acceptance she had not previously experienced in high school.

When S. went to college she began taking testosterone. When Yaacov and his wife met with S., Yaacov observed that S. was very depressed. She announced that she was going to get a double mastectomy. Yaacov objected. The social worker who facilitated S. getting the surgery called Yaacov a chauvinist who did not love his daughter enough. She told Yaacov that he had to get on board with the decision. The social worker assured the parents that everything would be fine. S. thereafter refused to talk to her father and began threatening that she would kill herself if she did not get the surgery she wanted. S. had a double mastectomy at age 19.

Yaacov witnessed distressing physical changes in S., so distressing that he even considered suicide at one time. S. gained and lost lots of weight, had pain all over her body, mood swings, could not concentrate, and was briefly hospitalized in

a psychiatric hospital. S. was deeply depressed and taking a significant number of medications along with testosterone. Yaacov kept assuring his daughter he would do whatever he could to help her. S.'s pain became so intense that she began taking Fentanyl.

S. was found dead on August 6, 2021 with Fentanyl and alcohol in her system. She was 28.

Yaacov supports banning medical interventions for minors because children, especially children with mental health issues such as his daughter, cannot make clear decisions about their future, particularly when neither they nor their parents are provided with information about the effects of these interventions. He contends these interventions that were supposed to relieve her problems killed his daughter.

Jeanne Crowley

Jeanne Crowley and her husband were repeatedly told that the puberty blockers their pre-teen daughter, M., was clamoring for were the answer for her anxiety and distress about her changing body. They were advised that children like her had high rates of suicide and self-harm and puberty blockers would help by stopping the development of secondary sex characteristics that cause children distress and “give the children time to explore their identity.”

Gender-affirming mental health and medical professionals assured the parents that acceding to their daughter's demand for puberty blockers was necessary for her

mental health. The parents were repeatedly assured that the puberty blockers were nothing more than a “pause button” and completely reversible. Based on these assurances the parents consented to M. receiving a long-lasting puberty-blocking implant. Once the implant was in place, there was no follow up. Jeanne had to initiate contact with the clinic to replace the implant and get necessary lab work. M. previously had psychological evaluations that revealed depression, Autism Spectrum Disorder (ASD) with sensory issues, dyslexia, and dysgraphia. M. had also experienced social trauma. However, none of these issues was addressed by health care professionals once they determined M. had gender dysphoria. Nor did they offer any other treatment options.

Jeanne learned through her own research that puberty blockers were shown to cause loss of bone density and diminished cognitive development. Healthcare professionals did not inform her of those harms. When the parents raised the issue, the doctors responded that they have been prescribing the blockers for many years to treat precocious puberty and the reported bone loss was “nothing to worry about.”

A bone density scan has revealed that M. has an 11 percent loss of bone density in one hip, 14 percent loss in the other, and a 7 percent loss in the lumbar region. She has developed osteopenia at a time in her life when her bone density should have been increasing (an important protection against osteoporosis in adulthood). When M.’s parents confronted the physician to have the blocker

removed, the doctor recommended that M. continue on to cross-sex hormones, *i.e.*, testosterone. The parents were not informed this would likely sterilize their child. Jeanne declined, pointing out that it is estrogen, not testosterone, that improves bone density.

Throughout the time that M. was on puberty blockers, her parents had difficulty finding a therapist to explore M.'s underlying mental health issues. Therapists were unwilling to address anything other than affirming M. as transgender. M. is improving working with a psychotherapist the parents were finally able to find. However, the availability of these medical interventions for a pre-teen girl distressed by changes in her body meant that neither she nor her healthcare providers would consider other alternatives.

Ted Hudacko.

Ted Hudacko's relationship with his now-17-year-old son, S., abruptly and effectively ended on August 17, 2019 when his wife announced that S. was transgender and that she, S., and their other son were leaving the family home. Except for a brief visit with a psychologist and viewing him from afar at school events, Ted has not been allowed to see or talk to his son since then. His attempts to participate in supervised visitations and family reunification therapy have been rebuffed. His ex-wife states that there is no basis for Ted to talk to S. if Ted will not endorse S.'s proclaimed female identity. Ted learned that S. had convinced his

mother to divorce Ted so that S. could pursue “gender-transition” medical interventions.

Ted only learned that his son was undertaking “gender-affirming” medical interventions when he received a statement from his health insurance provider showing a payment of \$209,820.34 to an endocrinologist at a child and adolescent gender clinic. Ted asked his ex-wife about the charge and she emailed that their son had been given an implant of Supprelin (used to suppress testosterone) and was receiving estradiol (estrogen) pills. Ted has learned that this combination is a form of “chemical castration.”

Ted previously contacted his son’s endocrinologist asking for information about the safety and efficacy of these interventions, their impacts on cognition and memory in children, and whether it’s possible for a parent to consent to experimental treatments. He received no response. Ted sent questions and provided information to his son’s psychologist. He received back a copy of the “Genderbread Person” worksheet used in elementary schools to introduce gender identity to children. None of S.’s providers have contacted Ted to obtain a medical history. None of them has responded to Ted’s questions about a differential diagnosis for his son, *i.e.*, underlying mental health issues. Ted is concerned about the perverse financial incentives of pharmaceutical companies as children are being sterilized.

The availability of “gender-affirming” medical interventions for vulnerable children experiencing distress about changes in their bodies meant the end of a father-son relationship, a marriage and reasoned holistic medical analysis and treatment of S’s distress. The SAFE Act will save Arkansas families from similar devastation.

Lauren W.

Lauren W.’s son, B., experienced trauma, including a physical assault, in middle school and attempted suicide twice. B.’s therapist said that he had body dysmorphia, self-hate and anxiety, but not gender dysphoria. B. was emotionally volatile and was diagnosed with ADHD, oppositional defiance disorder, and anxiety. In October 2020, B. sent a text saying he did not feel like a girl but felt more like a girl than a boy, wanted to go by she/her pronouns, and that anyone who did not agree with his message would be “written out” of his life.

The family’s pediatrician referred the parents to a gender clinic. B., age 14, began demanding puberty blockers after one virtual visit with a clinician at the gender clinic. B. became increasingly unstable and his parents consulted the social worker at the gender clinic about B.’s demand for puberty blockers. They were given information that said puberty blockers were reversible, safe, a “pause button,” and had no negative health effects other than concerns for bone density after a year or

two. The social worker said puberty blockers would stabilize B., painting a picture of puberty blockers as a safe, good solution.

The endocrinologist met with B. alone after which B. received the puberty blockers. According to B., the endocrinologist told him that they needed to get his parents “on board” with his receiving estrogen once the puberty blockers started. Within a week of receiving puberty blockers, B. began angrily demanding cross-sex hormones, *i.e.*, estrogen.

Lauren began questioning and researching the safety of these medical interventions. When she asked clinicians about their safety and sent critical research articles, they responded, “We follow WPATH standards.” Lauren asked about the protocols the clinicians used to determine when to prescribe puberty blockers or hormones. The gender clinic director said they have no criteria to determine who will benefit from blockers and hormones – they “get kind of a sense of” who will benefit. The director said she thought “transition is beautiful” and was not troubled about the fact that children who go on to on cross-sex hormones are sterilized.

At a meeting with clinic staff, the clinic had a pediatric gynecologist attend the meeting about her son. The gynecologist told Lauren that B. would commit suicide if she did not agree with his demand for hormones. Lauren asked about B.’s mental health issues and the clinic’s social worker recommended a psychological

evaluation. The evaluator attributed all of B.'s behavior problems to B. being transgender.

B. became increasingly unstable and continued to demand hormones. He began writing profanity-laden emails to the gender clinic demanding that they prescribe hormones over his mom's objection. The clinician responded that they supported B.'s efforts to "medically transition" but could not prescribe hormones without his mom's consent, driving a further wedge between B. and his parent.

Puberty blockers have done nothing to help B., but have only increased his instability, placing him on a conveyor belt to sterilizing cross-sex hormones. Lauren believes that the medical community has failed children like B. by permitting them to self-diagnose and then placing them on a one-way street of medicalization and surgery. Prohibiting medical and surgical interventions on children, as the SAFE Act does, will help protect these vulnerable children.

Martha S.

At age 16, Martha S.'s son, M., began acting out after suffering two traumatic events. When his behavior improved after receiving antibiotics for a sinus infection, M. was diagnosed with Pediatric Auto-immune Neuropsychological Disorder Associated with Strep (PANDAS), a condition that his older sister had. PANDAS causes the same kind of psychiatric symptoms that are seen in trans-identified children, *e.g.*, severe anxiety, ADHD, schizophrenia, OCD, and eating disorders.

M., who is Caucasian, blonde-haired and blue-eyed, identified as African-American for a semester in high school. Later that year M. told his mother that he was transgender. When he was home from school he was depressed and spent a lot of time on the internet asking questions about why he felt so miserable. He was told by sources on Reddit that he was transgender.

The family's pediatrician referred the parents to a gender clinic with the expectation that the "experts" at the clinic would help them sort out the issues. The gender clinic told Martha that M. needed to be seen by a gender therapist to get a diagnosis of gender dysphoria. M. had three visits with a gender therapist who did not do any testing and did not address any underlying issues. After the third visit, the therapist prepared a pro forma letter for the clinic that contained inaccurate history and stated that M. was suffering from gender dysphoria and was ready for medical interventions.

M and his parents saw a psychologist at the gender clinic who after one visit with M and filling out some questionnaires said that she would recommend that M. see the endocrinologist to be prescribed hormones. She said M. would be put on puberty blockers to suppress his testosterone and on estrogen. Martha questioned why M. would be recommended for hormone therapy when he did not have a history of gender dysphoria until after he was diagnosed with PANDAS and suffered trauma. The psychologist said, "You have to honor your young person." Martha

replied, “He is not our young person -- he is our child.” She and her husband asked to speak to the endocrinologist first to find out about side effects. The therapist said that they could not see the endocrinologist unless they were ready to get prescriptions for hormones. Martha and her husband said they needed more information.

A neuropsychologist evaluated the whole family and diagnosed M. with bipolar or possibly dissociative disorder, but not with gender dysphoria. She recommended psychiatric treatment rather than hormonal treatment without first addressing the other disorders. M., however, kept demanding hormones because he had been convinced this was what he needed. Martha and her husband did not follow through on that demand. After M turned 18 and went away to college, he found a practitioner who prescribed a testosterone suppressor and an estrogen patch. He soon stopped the suppressor because he did not like the effects. He returned home for online learning in the spring, went on antibiotics and his health improved. He then discontinued the estrogen patch and is now critical of the pharmaceutical industry.

Martha said that the availability of medical and surgical interventions for minors puts parents in a terrible bind. Parents are put in a difficult position when they have a mentally and physically ill child who is convinced that he needs an intervention recommended by a physician which is not based on sound science. This experience has damaged both the parents’ and M.’s trust in the medical community. If physicians are legally prevented from recommending those interventions, then

parents will not be not put at cross purposes with their child and the medical community.

Kellie C.

Kellie C. has not seen or spoken to her almost 18-year-old daughter, D., since 2018 when D.'s father told D. that her mother was "toxic" because she would not affirm D.'s identity as a fictional male character. D. became involved in fan fiction at age 11, when she began puberty, and by age 13 had diagnosed herself with gender dysphoria and began identifying as a 17-year-old male character from Harry Potter. Every year since then, D. has celebrated the birthday of the fictional character, and is now identifying as a 23-year-old male.

A psychiatric evaluation found that D. is delusional and incapable of taking care of herself, on the autism spectrum, has OCD and possibly ADHD, but is not psychotic. While they admit that D. is identifying as a 23-year-old man and proclaiming that she has Dissociative Identity ("multiple personality") Disorder, the evaluation team does not believe she has DID. Instead, they believe that D. has researched DID and is using it as a maladaptive coping tool for working through childhood trauma. Kellie just recently learned that D. was sexually assaulted at age 13 or 14.

D. is in a residential treatment center. The treatment team has not engaged in therapy with D. to address her underlying issues. Instead, they have embraced her

delusion that she is a 23-year-old fictional male character as a transgender identity. The therapists reiterate that they want D. to feel “safe” so they will not address underlying issues unless D. wants to. They say that D. is ready for “gender-affirming” medical interventions. D. has asked for puberty blockers and testosterone. The therapists and D.’s father have told her the only thing standing in the way of her getting these interventions is mom’s refusal to consent. The therapists and psychologists have told Kellie that she should do her own research, but if she does not agree then she will have a dead daughter instead of a “live son.”

Kellie views the SAFE Act as an important step in preventing harm to vulnerable children. Making the medical interventions unavailable to children will prevent the harms of these interventions on the children and the harms inflicted on parents fighting to protect their mentally disturbed children from irresponsible health care providers.

Barbara F.

After enduring ridicule from her father for laughing like her mother and witnessing her brother getting preferential treatment, Barbara F.’s 11-year-old daughter, B. said she identified as a boy and wanted to be referred to by an alternate male name. B.’s father fully embraced the new identity and began harassing Barbara for not affirming it. He accused Barbara of emotional abuse and called child protection services against her. He convinced B. to not participate in visitations with

her mother unless her mother affirmed the new identity. Although the parents have shared decision-making authority, B.'s father has made unilateral decisions regarding S.'s education and health care, including enrolling her in school as a boy.

Acting on the advice of their family physician, Barbara took B. to a gender clinic, believing that she would have an opportunity to seek psychology counseling for B. and discuss her sudden identification as a boy. However, the clinic indicated that they do not have time to provide counseling but would only discuss puberty blockers and hormone therapy to affirm B.'s belief that she is a boy. Barbara stated that she did not consent to further consultations regarding medical intervention due to her concerns for their unproven safety and efficacy. Clinic staff ignored Barbara's directions. Without telling Barbara, an endocrinologist met with B., then age 12, privately and with her father to discuss beginning puberty blockers. The endocrinologist then met with Barbara and her daughter. When Barbara raised concerns about the puberty blockers, the endocrinologist said that there are "no studies that show the drugs aren't safe." She also told Barbara in front of her daughter "to get on board if she doesn't want her daughter to commit suicide."

Barbara has notified clinic staff that she does not consent to their treating her daughter. Nevertheless, the clinic and B.'s father have continued with regular consultations. Clinic staff said that they plan to convince Barbara to consent to the medical interventions. Barbara does not know whether B. has received any medical

interventions to affirm her assertion that she is a boy. She has been able to visit with her daughter, but their relationship remains strained by the fact that Barbara will not approve these medical interventions.

The availability and promotion of medical interventions for this now 13-year-old girl has been used to drive a wedge between B. and her mother and to prevent B. from receiving counseling for underlying mental health issues and unhealthy divorce dynamics. The SAFE Act prevents such coercive manipulation against Arkansas' vulnerable children.

Bri Miller

Bri Miller's daughter, L., began experiencing gender confusion at age 13 after being involved in a toxic manipulative relationship with an older boy. L. went from being a confident happy girl comfortable in her body to a disheveled teen who wanted to hide her body with oversized sweatshirts. L. began identifying as a boy with a friend who was also identifying as a boy. It took Bri six months to find her daughter a counselor who would address L.'s underlying trauma without immediately affirming her gender confusion. L. became disenchanted with the counselor when she would not talk about hormone treatments. L. said she believed she might have ADHD.

In the course of gathering information for the ADHD evaluation, Bri learned that, without notifying Bri, L.'s school had been affirming L. as a boy with a male

name. When they met with L's pediatrician, the doctor asked whether they were going to use he/him pronouns. Bri said "no we are going to stay in reality." The pediatrician scolded Bri and asked whether L. had seen a gender therapist. The doctor met with L. alone, after which L. was hysterical and crying. The doctor told Bri that L. had called the suicide hotline and, with L. present, that "if you do not get her the help she needs and she kills herself you will feel awfully guilty." L. later told her mother she felt badly for the doctor making her feel like she did not care for L.

L. kept saying she wanted testosterone, that she wanted a male-looking body and to hear how her voice was going to sound. She believed her voice would sound great because a lot of "YouTube influencers" love how their voices sounded after they took testosterone. Seven of L's friends at school had identified as trans and four were on testosterone. Bri is seeing evidence that L. is desisting from her belief that she is a boy and becoming more comfortable in her female body.

"Gender-affirming" medical interventions for children are dangerous and should be banned because, "in no other sphere do we encourage children to change their bodies or take dangerous off-label prescriptions because they are uncomfortable with their body." Parents are being told these treatments are safe and well-studied, when they are not, and one-page marketing materials gloss over the harms. Bri further noted that neither children nor their parents can consent to the unknown risks and to the future ramifications of these treatments.

Kristine W.

Kristine W's daughter, S., had been diagnosed with OCD, Tourette's Syndrome and bulimia when she began intensive outpatient psychiatric treatment for suicidal ideation. She had spent copious amounts of time online during the pandemic lockdown and was influenced by the transgender ideology. She suddenly declared, in a manner which sounded scripted, that she believed she was a boy and wanted to use a male name. When Kristine spoke to her daughter's caregivers, they focused on S. wanting to go by a male name and pronouns. Kristine asked them to address S.'s self-harm, anxiety and bulimia, but they refused. Instead, they told Kristine that she needed to ask, "How can we help you with your gender identity?" The staff told Kristine that "transgender identity is very trendy in the hospital setting right now." Despite this they continued an affirmative confirmation of her obsessive thoughts. During one visit, with S. present, the caregivers stated that transpeople are more likely to commit suicide if not affirmed. In another instance, staff at the hospital said, "You must affirm or she will kill herself. Do you want live son or dead daughter?" The school counselor made similar statements.

Following the psychiatric treatment, S. returned to seeing psychiatrists and counselors that she had previously been seeing. Her medication was adjusted, she stopped self-harming and her tics were better controlled. After doing more research and believing it important to ground their child in reality, her parents no longer used

the preferred male name and pronouns at home. Kristine told S. that she could change her name if she desired when she was an adult but until then she did not get to choose her name. S asked why her own parents would not use her new name but everyone else did. She felt that her parents cared more about the name than her feelings of suicide because of the comments made by doctors about how fragile trans kids are. Kristine explained that no one loved her as much and cared about her mental health more than do her parents, who wanted to do what was best for her in the long run, which was to hold reality for her. S. had asked for testosterone, but Kristine resisted, hoping to delay such decisions until adulthood. S. has since announced “I’m not a boy – boys are awful” and is dressing on and off as a girl. Her mental health is improving.

S. has a few separate friend groups across three different schools. Of 10-15 children, only one identifies as her natal sex. Kristine notes these numbers mimic known social contagions such as anorexia and cutting behavior. It is statistically impossible and improbable that all these children will continue to identify as another gender into adulthood. To allow the medical establishment to push children into irreversible treatments and to pit objecting parents against their children is a great tragedy. Families are being ruined. For these reasons, Kristine believes “gender-affirming” medical interventions should not be available for children.

Helen S.

An encounter with an online sexual predator at age 12 and time at a gender-affirming youth center led Helen S.'s daughter, E. to question her gender identity at age 14. Helen stopped counting after 35 kids in their community had announced a trans identity. E., who is exceptionally bright and musically gifted, was seeing a therapist for issues related to diagnoses of ADHD, ASD, anxiety, depression, and social struggles when she said that she was questioning her gender identity. When E. told her doctor about wanting to use different names, he suggested that she go to a gender clinic. Helen believed that the clinic would be a place to ask questions and get information and options to help E. deal with the distress she was feeling about her body.

When Helen and E. met with the endocrinologist at the gender clinic, the only information she received was to start E. on "gender-transition" medical interventions. There was no psychological evaluation, no medical criteria for a diagnosis of gender dysphoria. The only prerequisite for beginning medical interventions was the child's self-diagnosis and one parent's consent. Helen was told that E. should be prescribed puberty blockers at her next appointment and when she turned 16 could start taking testosterone. Helen and E. were told that puberty blockers were just "a pause button to buy you some time to think," a perfectly safe, reversible, benign intervention. Helen was not comfortable with the

recommendation. The doctor replied in front of E. that “You have to be aware of the suicide risk. She may consider suicide if you don’t do this.” When Helen questioned there might a social contagion aspect, the doctor dismissed this concern. She then said “I love helping trans kids. It is the favorite part of my job helping kids be who they are.”

E. continued to ask for puberty blockers, saying some of her friends were on them. Helen said that it was a family decision and that their insurance would not cover the blockers. E. continued to have mental health issues and spent some time in a psychiatric hospital at age 16 after a friend died and E. began self-harming. Helen found a therapist who began to focus on E.’s cognitive mental health issues, and E.’s gender identity confusion desisted just before her 18th birthday.

Helen believes “gender-affirming” medical interventions for children should be banned because the medical community is not acting in the patient’s best interest and outside the norms of ethical medical care. Parents should not be pressured by threats of suicide into acceding the wishes of their children facilitated by activist doctors.

CONCLUSION

Arkansas’ SAFE Act banning medical and surgical interventions aimed at changing children’s bodies to affirm a discordant gender identity is necessary to

protect Arkansas' children and police the medical community to safeguard parents' medical decision-making in the best interest of their children.

For these reasons, the district court's decision should be reversed.

Dated: November 19, 2021.

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Attorney for Amici Curiae.

Date November 19, 2021

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I hereby certify that on November 19, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. On November 23, 2021 I resubmitted the brief having corrected a deficiency.

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s/ Mary E. McAlister
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