No. 21-15668

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

D.H., by and Through, Janice Hennessy-Waller; John Doe, by 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

Brief for Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, Carol Freitas, and Detransvoices.org as Amici Curiae in Support of Defendant-Appellee, Supporting Affirmance

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STATEMENT OF CORPORATE DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici curiae* Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, Carol Freitas, and Detransvoices.org, 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 Federal Rule of Appellate Procedure 29, *Amici Curiae* Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, Carol Freitas, and Detransvoices.org, respectfully submit this brief in support of Defendant-Appellee. All parties have consented to this filing.[1]

Amici are women who, like Appellants, experienced gender dysphoria when they were adolescents and young adults. Amicus Detransvoices.org is an organization founded by Amicus Carol Freitas as a community resource created for people who have detransitioned from transgender self-identification. Like Appellants, Amici believed that removing their healthy breasts would resolve their gender dysphoria and permit them to live healthy, well-adjusted lives. Amici learned that surgery did not resolve the psychological issues underlying their gender dysphoria, but only increased their distress as they realized they had irreversibly altered their bodies based upon ideology.

Amici respectfully submit this brief to provide this Court with a balanced perspective on the question of the lack of efficacy, safety, and scientific foundation for these surgeries. Amici further believe it is critical that this Court hear their stories as women who were once where Appellants are now and who have experienced loss,

[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.

physical harm, and increased emotional distress from treatments that were supposed to help. Amici believe this Court's analysis should be based on a balanced presentation of evidence regarding these surgeries and an understanding of the human toll exacted by them.

INTRODUCTION

Appellants are two teenage females who are asking Arizona taxpayers to pay for them to have their healthy breasts surgically removed. Both have been diagnosed with gender dysphoria and have other co-morbidities.

Appellant D.H. developed significant psychological distress at an early age, including severe anxiety and suicidal ideation, and was placed in intensive psychiatric care at ages eleven and thirteen. (Excerpts of Record, "ER" 453, lines 8-11). Upon entering puberty D.H. began to hate her[2] body, especially her breasts, and began binding them to provide the appearance of a flat chest. (ER 453, lines 22-28). D.H. is taking testosterone to appear male. (ER 454, lines 1-5). D.H. believes that surgically removing her healthy breasts will resolve the psychological distress and asks that Arizona taxpayers pay for the double mastectomy. (ER 455, lines 1-11).

Appellant John Doe is a 16-year-old female with a history of depression, anxiety, and self-harm. (ER 458, lines 10-14). John Doe has also been diagnosed with chronic PTSD stemming from early-life attachment trauma. (ER 458, lines 15-20). A therapist testified that John's mental health is "particularly fragile." (*Id.*). John has been undergoing therapy, taking testosterone, and binding her chest, but is still experiencing extreme distress, depression, and panic attacks, engaging in self-

[2] Female pronouns are used for clarity and consistency, as Plaintiffs are biological females seeking removal of female breast tissue.

harm, and having suicidal ideations. (ER 458, line 26 to 459, line 6); ER 469, line 23 to 470, line 22). John also believes that surgically removing her healthy breasts will alleviate her psychological and emotional distress. (ER 471, lines 3-10).

Amici similarly believed that removing their healthy breasts would alleviate their gender dysphoria and permit them to live healthy, well-adjusted lives. Like Appellants, Amici had histories of mental illness, hospitalizations, trauma, PTSD, and severe distress surrounding puberty. Like Appellants, Amici were diagnosed with gender dysphoria and began testosterone regimens, which did not relieve their dysphoria. Like Appellants, Amici bound their chests and were convinced that removing their healthy breasts would bring the relief they were seeking. Amici initially experienced some relief. However, they later realized that the changes to their bodies did not relieve their underlying distress. As they gained maturity, they understood that removing healthy breasts did not address the issues of their minds and hearts that were the actual causes of their distress.

Amici have returned to their female identities. However, they are unable to regain the fully functional female bodies they had before they transitioned. Their healthy breasts were removed. They have been scarred and disfigured and lost the ability to breastfeed children, which in the case of one Amicus, has health consequences for her child. Amici are now receiving effective support for their underlying issues, but continue to experience grief, remorse, and regret for what has

been taken from them. Amici want to help other young women, including Appellants, to avoid those experiences.

LEGAL ARGUMENT

I. Young Women Experiencing Gender Dysphoria Are Denied Evidence-Based Holistic Medical Interventions And Guided Into Irreversible Surgery Based on Advocacy-Driven Guidelines

Vulnerable young women experiencing gender dysphoria deserve the highest quality evidence-based treatment available. They deserve scientifically sound holistic interventions that address not just their physical appearance, but the myriad of issues underlying their dysphoria so that they can experience long-term healthy and well-adjusted lives.

That is not what these vulnerable young women are receiving in the interventions being undertaken under current practices, particularly under the most frequently cited guidelines, the WPATH "Standards of Care"[3] version 7 and Endocrine Society Clinical Practice Guidelines.[4] These guidelines are widely

[3] Eli Coleman, Walter Bockting, *et. al.*, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, 7th Ed., The World Professional Association for Transgender Health (WPATH) (2012), www.wpath.org.

[4] Wylie C. Hembree, Peggy T. Cohen-Kettenis, *et. al*., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,* 102 J. CLIN. ENDOCRINOL. METAB., 3869–3903 (November 2017), https://academic.oup.com/jcem.

regarded as authoritative and evidence-based by professional organizations, practitioners, and courts. In reality, they are neither.

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

WPATH uses the term "standards of care" interchangeably with "practice guidelines."[5] However, the terms are not interchangeable. "Standards of care" are "authoritative, unbiased consensus positions designed to produce optimal outcomes."[6] By contrast, "practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased."[7] The WPATH document is entitled "Standards of Care," but its own authors acknowledge that they are rather "practice guidelines," stating: "As in all previous versions of the SOC, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria **are clinical guidelines**; individual health professionals and

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5 Coleman, *supra* n.3, at 2.

6 William Malone, Paul Hruz, *et. al.*, *Proper Care of Transgender and Gender-diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective*, THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM p. 1 (June 14, 2021). https://academic.oup.com/jcem/advance-article/doi/10.1210/clinem/dgab205/6190133

7 *Id.* at 1.

programs may modify them."[8] The Endocrine Society more accurately calls their recommendations "clinical practice guidelines."[9]

However, neither WPATH nor the Endocrine Society guidelines rises to the level of high-quality practice guidelines that can be recommended for use by clinicians. Vulnerable young women experiencing gender dysphoria, such as Appellants and Amici, who need and deserve high quality, compassionate care are instead being subjected to regimens built on ideology instead of science.[10, 11]

1. WPATH and Other Transition-Based Clinical Practice Guidelines Lack Methodological Rigor and Rely On Low-Quality Primary Research.

In the first systematic review to use a validated quality appraisal instrument to assess all international clinical practice guidelines ("CPGs") addressing gender minority/trans health, researchers found that none of transition-based guidelines had methodological rigor or evidentiary quality necessary to qualify as high-quality CPGs.[12] "High-quality CPGs support high-quality healthcare delivery. They can

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8 Coleman, *supra n.3*, at 2 (emphasis added).

9 Hembree, *supra* n. 4.

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, citing Institute of Medicine. *Clinical practice guidelines we can trust*, The National Academies Press, 2011.

11 Lisa Mac Richards, *Bias, not evidence dominates WPATH transgender standard of care*, Canadian Gender Report, October 1, 2019. http://genderreport.ca/bias-not-evidence-dominate-transgender-standard-of-care/

12 Dahlen, *supra* n. 10, at 2, 6.

guide clinicians and policymakers to improve care, reduce variation in clinical practice, thereby affecting patient safety and outcomes."[13] Vulnerable young women with gender dysphoria like Appellants and Amici deserve treatments based on such guidelines.

However, as the study found, that is not what they are receiving. "Globally, many national and local guidelines are adaptations of, acknowledge being influenced by, or are intended to complement WPATH SOC v7, despite expressed reservations that WPATH SOC v7 is based on lower-quality primary research, the opinions of experts and lacks grading of evidence."[14] The study concluded that "WPATH SOCv7 **cannot be considered 'gold standard**.'"[15] No reviewers could recommend WPATH and only one could recommend the Endocrine Society guidelines.[16]

Although WPATH's stated overall goal is '"to provide clinical guidance for health professionals,' it contains no list of key recommendations nor auditable quality standards, yet is widely used to compare procedures covered by U.S. providers."[17] Neither WPATH nor any of the other CPGs focusing on gender transition had independent review of their recommendations.[18] By contrast, CPGs

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13 *Id.*
14 *Id.*
15 *Id.* at 8 (emphasis added).
16 *Id.* Table 2, p. 7.
17 *Id.* at 6.
18 *Id.* at 8.

which addressed HIV prevention and treatment for transgender patients had independent external reviews and strong evidence bases.[19] "Although HIV prevention and transition are important, it is puzzling to have found so little else, maybe suggesting CPGs for gender minority/trans people have been driven by provider-interests rather than healthcare needs."[20] In other words, vulnerable young women with gender dysphoria such as Appellants and Amici have been and are being subjected to medical interventions driven by special interests instead of evidence.

2. Current Practice Guidelines Are Tainted By Lack Of Systemic Review, Conflicts Of Interest, Ideological Bias, And Lack of Mental Health Safeguards.

The ideological, instead of evidentiary, basis of the WPATH guidelines is confirmed by the organization's membership base, public statements, and contents of their guidelines.[21]

> WPATH is not the typical professional organization that develops clinical practice guidelines. WPATH is a hybrid professional and activist organization, where activists have become voting members and have served as president. In fact, it can be argued that WPATH is activist-led rather than evidence-led, as witnessed at their conferences.[22]

"At the 2017 USPATH/WPATH conference, activists protested and shut down a session with Dr. Kenneth Zucker, who endorsed a cautious approach to treating

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19 *Id.*
20 *Id.*
21 Richards, *supra* n. 11.
22 *Id.* at 8.

children with gender dysphoria."[23] "WPATH is allowed to discuss only topics and engage with presenters that are approved by activists, which is the antithesis to a professional organization, or evidence-based inquiry."[24]

WPATH did not perform any systematic review to draw conclusions for its recommendations in its guidelines and the Endocrine Society performed only scant systematic reviews.[25] Consequently, neither WPATH nor the Endocrine Society's guidelines are endorsed by ECRI Guidelines Trust ("ECRI"), an independent non-profit patient safety organization that analyzes clinical practice guidelines.[26] ECRI reported that the Endocrine Society guidelines did not meet inclusion criteria to be rated because "[o]nly a few of their recommendations were supported by the systematic review; the majority were not." [27] WPATH was not included "because the guidelines were more than five years old, and did not use a systematic review to process."[28]

Epidemiology and treatments in transgender care are rapidly changing, so, WPATH's now nine-year-old guidelines are severely outdated.[29] For example, "when the WPATH guidelines were published in 2011, natal males were the primary

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23 *Id.*
24 *Id.*
25 *Id.* at 4-5
26 *Id.*
27 *Id.*
28 *Id.*
29 *Id.* at 5.

group presenting to gender clinics in adolescence, but now males have been eclipsed by natal females 3 to 1."[30] "Research on male adolescent clients cannot be generalized to females, an age-old fallacy in medicine."[31] This makes the entire recommendation section for adolescent transgender care in the WPATH guidelines —the very section upon which Appellants and Amici's treatments are based— "dubious at best, irrelevant at worst."[32]

WPATH's guidelines are also tainted by significant conflicts of interest. Institute of Medicine[33] guidelines stipulate that committee chairmen for developing practice guidelines must be completely free of conflicts of interest.[34] That is not the case with Eli Coleman, the committee chair for WPATH guidelines.[35] Coleman's position at the University of Minnesota is funded by Jennifer Pritzker, a trans person and head of Tawani, a transgender advocacy organization.[36] Six of the members of the committee drafting the standards work at the University of Minnesota's Program in Sexuality, which received more than $6 million from Tawani.[37] The advocacy organization also funded the development of the WPATH guidelines.[38]

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30 *Id.*
31 *Id.*
32 *Id.*
33 *Id.* at 4.
34 *Id.* at 6-7.
35 *Id.* at 7.
36 *Id.*
37 *Id.*
38 *Id.*

Beyond the conflicts of interest, the contents of the WPATH guidelines exhibit bias in favor of medical and surgical interventions as opposed to psychotherapy directed at underlying causes. Since at least 2009, WPATH guidelines have incorporated the idea that gender is "a spectrum" and abandoned the reality that sex is "binary."[39] Importantly for Appellants, Amici, and other young women with gender dysphoria and mental health issues, that shift led to the elimination of psychotherapeutic safeguards. The first four versions of the WPATH standards required psychotherapy before referrals could be made for hormones and surgery.[40] The adoption of the idea of a gender spectrum brought about a shift in the fifth version of the guidelines (1998), in which the pre-referral psychotherapy requirement was removed and replaced with a section on psychotherapy as only one part of "managing patients" with gender identity disorder.[41] As Amici's experiences demonstrate, *infra*, that means that young women can have their bodies altered surgically and permanently without the mental health issues underlying the desire to alter their bodies even being addressed.

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

40 *Id.* at 111.

41 *Id.* at 111.

However, practitioners have admonished that "exploratory psychotherapy" should be "the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures."[42] This is especially critical "when we are witnessing an exponential rise in the incidence of young people with GD who have diverse and complex mental health presentations and require careful assessment and treatment planning."[43]

B. There Is A Dearth Of Evidence To Support The Claim That Surgical Interventions Are Safe And Effective.

The medical and surgical interventions pushed by WPATH and other advocacy organizations have not been proven safe and effective, further demonstrating that they are based on ideology, not science. Appellants, Amici, and other young women experiencing gender dysphoria are being exploited for profit and culture change, not being provided safe and effective medical and mental health care. Adding insult to injury, the guidelines being applied to them were developed when males were the predominant population seeking "transition" and have not been examined for efficacy and safety for females.[44]

> The existing body of evidence regarding treatment outcomes for GD [gender dysphoria] was not only graded as "low quality," but has been derived from a vastly different population than the one presenting with

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42 Roberto D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, Archives of Sexual Behavior 50:7-16, 13 (October 2020), https://doi.org/10.1007/s10508-020-01844-2.

43 *Id*. at 13-14.

44 Malone, *supra* n. 6, at 1-2.

> GD today. Currently, GD predominantly presents in adolescent females with no childhood history, in contrast to the prior predominantly male and childhood onset GD presentation. It is not yet known whether this novel patient segment, which remains poorly understood and largely unstudied, will benefit or be harmed by hormonal and surgical interventions.[45]

As Amici's experiences demonstrate, "the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret."[46] Furthermore, the Endocrine Society's claim of effectiveness is at odds with a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being.[47] After anomalies in the study methodology were brought to their attention, the authors acknowledged in a published correction that "the results demonstrated *no advantage of surgery"* in relation to mental health improvements.[48]

Furthermore, the Endocrine Society's guidelines' assertions that there is a "biological durability" to gender identity is challenged by the fact that most cases of

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45 *Id.*

46 *Id.*

47 *Id.*, citing Correction to Bränström and Pachankis. *Am J Psychiatry*. 2020;177(8):734.

48 *Id.* (emphasis added). *See also*, Society for Evidence Based Medicine *Correction of a Key Study: No Evidence of "Gender-Affirming" Surgeries Improving Mental Health*, August 30, 2020 https://www.segm.org/ajp_correction_2020; Andre Van Mol et al, *Correction, Transgender Surgery Provides No Benefit*, Public Discourse (September 13, 2020) https://www.thepublicdiscourse.com/2020/09/71296/.

GD in children naturally resolve by adulthood.[49] "It is precisely this lack of durability that should give pause to administering potentially harmful and often irreversible medical interventions to young patients with GD,"[50] such as Appellants and Amici.

The quality of evidence of efficacy and safety of surgical interventions has also led the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services ("CMS") to refuse to issue a national coverage decision for surgical interventions for Medicare patients.[51] Obama Administration HHS officials concluded: "There is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[52] CMS also would not endorse the use of WPATH guidelines.[53]

Surgical interventions for adolescents received a D2 rating from Hayes Directory Report, a medical research firm that provides analyses of medical

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49 Malone, *supra* n. 6, at 1.

50 *Id.*

51 Centers for Medicare and Medicaid Services, *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* (CAG-00446N) August 30, 2016, http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

52 *Id.* at 48.

53 *Id.* at 41.

treatments and devices for health insurers and providers.[54] That rating means that there is a paucity of evidence to show effectiveness in improving patient outcomes or safety in adolescents.[55] The Hayes report examined studies concerning surgical interventions from all over the world and found a very low quality of evidence.[56]

Consequently, surgical interventions to remove healthy breasts to treat gender dysphoria in teens are not proven safe and effective. Vulnerable young females, such as Appellants and Amici, deserve better than poor to very poor evidence that irreversible procedures they are undertaking will do what they are promised to do. As Amici learned firsthand, that is exactly what they received, *i.e.*, treatments based on poor evidence. Poor long-term outcomes are the tragic result.

II. The Lived Experiences Of Women Subjected To Surgical Interventions Point To Harm, Not Medical Necessity.

As is true about Appellants, Amici initially believed that having their healthy breasts surgically removed would feel empowering, satisfying and lifesaving. However, they learned that the mastectomies did not resolve the underlying causes of their gender dysphoria and did not enable them to live "healthy well-adjusted lives." What they had believed was true—that they were men trapped in women's

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

55 *Id.*

56 *Id.*

bodies—was in fact a feeling brought about by trauma and other underlying issues. Changing their bodies in order to satisfy that feeling was ultimately ineffective and harmful.

These women's stories portray the real human cost of these experimental, unproven surgeries. They show that, far from being medically necessary and life-saving, they are harmful, irreversible treatments that adversely affect not only the women, but their children as well.

Grace Lidnisky-Smith is one of the women featured on a recent CBS News 60 Minutes story[57] about problems with the treatment of young people who express that they are transgender. She described her experience with transgender medicine in *Newsweek*.[58]

> I became depressed and gender dysphoric after years of obsessing over identity issues. Finally, I thought I saw my route forward: the total transformation of medical transition, to live as a man.
>
> I had the most supportive possible environment for transitioning: easy access to hormones, an affirming community and insurance coverage. What I didn't have was a therapist who could help me scrutinize the underlying issues I had before I undertook serious medical decisions. Instead, I was diagnosed with gender dysphoria and given the green light to start transition by my doctor on the first visit.

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[57] CBS News, *Health Care Challenges for Transgender Youth,* May 23, 2021, https://www.cbsnews.com/video/transgender-health-care-60-minutes-video-2021-05-23/

[58] Grace Lidinsky-Smith, *There's No Standard for Care When it Comes to Trans Medicine*, NEWSWEEK, JUNE 25, 2021, https://www.newsweek.com/theres-no-standard-care-when-it-comes-trans-medicine-opinion-1603450.

> I started my transformation with cross-sex hormones injections. Four months later, I had my breasts removed in the masculinizing surgical procedure known as "top surgery." The day I got my first testosterone shot, I wept with joy. I thought I had discovered my path to self-actualization as a transgender man.
>
> One year later, I would be curled in my bed, clutching my double-mastectomy scars and sobbing with regret. I wondered desperately how I could have been so wrong about something so important....
>
> My gender dysphoria, which I had taken as proof that I was truly meant to live as male, turned out to stem from other mental health issues. My change had been a brutal mistake, and I would have to live with the consequences—numb scars, no breasts, a deepened voice—for the rest of my life.[59]

Amici's lived experiences, which follow, are tragically similar.

Keira Bell, United Kingdom

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

Keira was an athletic gender non-conforming child who felt more comfortable around boys. She became distressed about the changes happening to her body as part of puberty. She wanted to continue fitting in with the boys and did not want to deal with what teenage girls had to deal with. She was severely depressed and suffered

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59 *Id.*

from anxiety beginning at about age 14. At age 15 she began binding her breasts and appearing as a boy in public.

Keira wanted to explore gender transition and began seeing a psychologist for an assessment prior to going to Tavistock, the gender clinic for youth in England. Tavistock incorporated the WPATH guidelines into their practice. She saw the psychologist for about a year, but the psychologist did not address her depression and anxiety. After her 16th birthday, she began taking puberty blockers. At age 17, she began taking testosterone. She still felt isolated and depressed and began thinking about surgery.

At the time, at age 20, Keira very much believed she needed surgery because it would improve her life and relieve her of the pain of binding and her unwanted breasts. She felt strongly it was the right decision because it would align her body with her feelings (her identity). She was not offered psychotherapy as an alternative for addressing her gender dysphoria, depression, and anxiety. The surgery would be paid for by the government so she did not need to weigh the financial costs. In retrospect she laments that had there been "roadblocks" along the way she may have reconsidered.

She saw a surgeon once for a pro forma pre-surgery consultation. Providers agreed that since she had been taking hormones and was of legal age that surgery was the logical next step. The surgery went smoothly and she had no immediate

physical complications. Emotionally, however, it was anti-climactic. Online she had heard some say they felt euphoric. She had wanted the surgery very badly and had high expectations, but once it was done she did not experience the euphoria she had heard about.

Keira was confused. She didn't experience stigma or discrimination, and was passing well as a male. She believed that life and relationships would be better after the surgery. Upon further consideration, however, she realized that intimate relationships would not be any easier. She began to look introspectively and wonder if the surgery actually benefitted her. As much as she felt like a man, she began feeling that she was portraying a level of deception to the rest of the world. Keira felt like she had been had and realized that it should have been obvious that she could not change her sex.

Within a year she stopped taking testosterone and began to transition back to her female identity, but realized that she could never fully regain her female body. Even at age 20, she had not understood how important her breasts were and what removing them would mean to her and to her future intimate relationships. In recent months complications have started to appear – tingling and itchiness in the chest and possible complications with lymph nodes. She now understands the hormones and surgery were all experimental. She is still processing the indescribable feeling of loss and regret. With the benefit of greater maturity, Ms. Bell is beginning to

appreciate the beauty of being a woman as she realizes that she had internalized misogynist messages about what it means to be a woman, and that those messages allowed her to be experimented on.

Laura Becker, Wisconsin, U.S.A.

Laura Becker, 24, was also a gender-nonconforming child who had a troubled childhood. She was diagnosed with depression and anxiety and being on the autism spectrum at age 11. Similar to Appellant D.H., Laura was hospitalized numerous times, including for suicide ideation and undiagnosed post-traumatic stress disorder, beginning at age 15. She was eccentric and had difficulty making friends until she began interacting with quirky boys in theater at the high school. After finding out about trans identities on Tumblr she began to wonder if she was transgender or agender.

After some personal betrayals landed her in the psychiatric hospital again, Laura started experiencing severe gender dysphoria at age 17 and began binding her breasts and wearing men's clothes. She began thinking she was too feminine to be accepted and loved by gay men, but too masculine to be accepted by straight men. She saw two gender therapists who supported her trans-identification but did not offer any psychotherapeutic alternatives for her significant mental health issues.

Laura began taking testosterone at age 19, when she learned that it was easy to obtain and would not cost anything. She received testosterone after a single visit

to a clinic. The testosterone exacerbated her depression and anxiety, made her more aggressive, and caused her to engage in increased risky behaviors. After another hospitalization for suicidal ideation, Laura decided to pursue a mastectomy, which she had been pondering for two years. At the time she was determined to have the surgery, felt certain it was the right decision, and firmly believed it was necessary to save her life and that misery or suicide were the only other alternatives. Her parents did not question her decision and agreed to pay for it.

The surgeon followed the WPATH guidelines. He required Laura to have two letters of recommendation for the surgery. She was not questioned about her mental health issues or how they may be contributing to her desire for surgery.

After the surgery Laura felt happy and relieved. She liked the appearance of having a flat chest. However, there was no improvement in her mental health, self-esteem, anxiety, or depression, and she was again hospitalized. She began to get therapy that started to get at the causes for her dysphoria and provided tools to gain control over her thoughts and to begin to practice self-love. She received a psychiatric evaluation which diagnosed her as having PTSD resulting from childhood emotional abuse. This made sense to her and she began to improve. Once she received the proper diagnosis, detransitioning began to happen.

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

angry at the mental health professionals who failed her. She realized that she had undergone cosmetic surgery to treat a mental health condition that could have been treated with appropriate psychotherapy. She laments that if therapists would have thoroughly examined her mental and emotional state over prolonged periods of time, she would have been able to receive effective cognitive treatment and would not have proceeded with removing her healthy breasts. Instead she experienced unnecessary disfigurement and scarring from completely unnecessary surgery.

Laura asserts that the surgery gives false hope that vulnerable young women can actually improve their life, love themselves and become a different person, when in reality it just creates a temporary placebo effect for powerful underlying causal issues. She cautions that the notion of allowing teens to obtain this surgery is incredibly irresponsible, destructive and unethical without providing these young vulnerable women the intensive psychotherapeutic attention necessary to overcome the underlying issues.

Sinead Watson, Scotland

Sinead Watson, 30, started experiencing gender dysphoria at about age 14 when she began suffering sexual harassment as her body changed. She became a magnet for the wrong type of attention from men. Some men whom she had known since childhood began acting inappropriately toward her, and her older male boss began sexually harassing her. A friend of the family sexually assaulted her at age

16. She came to hate being a woman as she internalized the message that being a woman meant being the object of predatory sexual attention from men.

Sinead started socially transitioning in 2013 by cutting her hair, binding her breasts, and wearing men's clothing. At age 20, she began viewing vlogs on the internet made by women who had transitioned to a male identity. These said that transition would alleviate dysphoria and that if you hate being a woman and having breasts then you must be a trans-man. She believed those messages and thought that she could become the man named "Sean" she had fantasized about who was stronger, less vulnerable.

Sinead was hospitalized at age 21 after a suicide attempt. She was also experiencing depression and alcohol abuse. She began considering medically transitioning and was seen at a gender clinic at age 24. She began testosterone later that year and had a mastectomy at 26. At the time she felt that hormones and surgery were necessary to save her life. Immediately after the mastectomy she felt euphoria. She felt amazing because she had finally accomplished a long-term goal and was free of her breasts. There were no immediate complications from the surgery, but there was some asymmetry and scarring.

After about four months, the euphoria died down. Sinead still hated herself and found that her underlying issues with sexual abuse and depression had not been helped by testosterone and surgery. She began thinking that perhaps she should

pursue more surgery, but then considered that if testosterone and "top surgery" had not improved her life, would further surgery do so? She began to understand that her fantasy that she could become a man named "Sean" and that "Sinead" would disappear did not and would not happen. She understood that she needed therapy to treat the issues in her mind, not doctors to irreversibly change her body. She began to engage in self-care, talk about the sexual abuse with people who cared, and gained a new healthier perspective.

Sinead returned to her female identity but will never regain the healthy body parts that were removed. She had a complete loss of sensation of her chest for two years, which began to come back only last year. The sight of her chest is distressing. She is astounded that doctors prescribed testosterone and performed a double mastectomy on a physically healthy young woman without asking the basic question "Why do you hate being a girl?" Asking that question and exploring the answer via talk therapy would have changed her life in a much more effective way than did medicine and surgery.

KathyGrace Duncan, Oregon, USA

No one asked KathyGrace Duncan why she hated being a girl either. Growing up in a dysfunctional family in which her mother was often the victim of her father's emotional and verbal abuse, KathyGrace intuited the message that "my dad would love me if I were a boy" and began to develop a secret desire to be a boy at a very

young age. Sexual abuse by a family member between the ages of 10 and 12 further convinced her that being a girl meant being unsafe. Ms. Duncan internalized three lies about women, *i.e.*, that women were weak, women were vulnerable, and women were not lovable. She did not want to be that, and decided she would be the man that her dad was not.

She left home at age 19 and began living as a man named Keith. She began testosterone and had a mastectomy at age 20. At the time, she believed it was necessary so that what she saw in the mirror matched what she felt on the inside and so that she could escape being female. After 11 years living as a man relatively "happy" and stable (which included having a number of girlfriends) KathyGrace realized that she was living a lie built upon years of repressed pain and abuse. She realized that hormones and surgery had not helped her resolve the underlying issues of rejection, abuse, and sexual assault. Her desire to live as a man and remove her breasts were symptoms of deeper unmet needs.

With the help of life coaches and a supportive community, KathyGrace returned to her female identity and began addressing the underlying issues that had been hidden in her attempt to live as a man. She experienced the depression that she had repressed for years and grieved over the loss of her healthy breasts. She realized that even at age 20, she had no idea of the long-term consequences of having her breasts removed, including being unable to breast feed children. She has restored her

appearance somewhat through implants, but cannot recover the natural feel or functionality. If someone had walked with her through her feelings instead of affirming her desire for transition and surgery, then she would have been able to address her issues more effectively and not spent 11 years to discover this was a grave mistake and many more to recover from it.

Laura Reynolds, U.S. Citizen living in Austria

Laura Reynolds was a gender non-conforming child who was diagnosed with ADHD, autism, depression, and anxiety. She learned that ADHD was more common in boys and began to think she would have more freedom to be active if she were a boy. When changes to her body brought sexual harassment, she experienced a sense of panic about her body and she became dysphoric. At age 15 Laura learned about transitioning on the internet. She thought it was possible to change her sex, and she began binding her breasts and tried to socially transition.

At age 18, Laura was diagnosed with Gender Dysphoria and started on testosterone. Binding her breasts posed sensory problems for Laura due to her autism and was uncomfortable, so she scheduled a double mastectomy when she was 19. At the time, she believed it was possible that she could become a man, that breast removal was something trans-men did, and that she would never want to have children. She was certain she would never detransition.

Two rounds of breast removal surgery were traumatic and resulted in increased body dysphoria. They left her with large amounts of scar tissue and permanent disfigurement. She decided to detransition and get off testosterone for health reasons, including painful vaginal atrophy.

At age 34, Laura became a single parent. Laura had gestational diabetes while pregnant and was told her baby should breast feed in order to reduce his chances of becoming diabetic. This was rendered impossible because she had been affirmed along the pathway to medical transition and surgery while in her youth instead of receiving holistic mental health care that would have revealed the internalized misogyny and negative view of pregnancy and reproduction that led to her gender dysphoria.

Carol Freitas, California U.S.A., co-founder of Detransvoices.org

Similarly, Carol Freitas would have been spared physical, psychological, and emotional losses if she had received a proper diagnosis and treatment for depression before undergoing years of medical and surgical interventions. Carol suffered a series of traumatic personal losses that, coupled with undiagnosed PTSD from childhood abuse and neglect, caused her to spiral downward. She had earlier considered transitioning, but decided against it because of gatekeeping requirements. As she felt herself spiraling out of control and did not want to consider suicide because she had a young son, she reconsidered transitioning as a way of resolving

the effects of the trauma. By that time, the rules had changed and she could immediately get started on testosterone. There was no discussion of mental or emotional health issues, or of side effects of taking testosterone. Four months later, she made an appointment with a plastic surgeon and had her healthy breasts removed, again with no discussion of underlying issues or long-term consequences.

Her anxiety and panic attacks increased when she was taking testosterone. The panic attacks intensified to the point that she could not leave her house. She saw a therapist specifically for depression symptoms and was provided with an anti-depressant that made a profound difference. She felt better than she ever had. Within a month, she realized she had not needed to transition; that it was the biggest mistake she had ever made. She did not detransition for about a year because she could not believe that it was so easy, *i.e.*, that the right anti-depressant addressed her problems. She realized that healthcare providers did not ask about her mental health issues because they believed that they were caused by gender dysphoria and that transitioning would fix the problem. In fact, the opposite was true.

Carol co-founded Detransvoices.org shortly after detransitioning in order to provide a clearinghouse of resources, including therapists, doctors, social groups, articles, and a voice for detransitioners. Amici are not isolated examples of post-transition regret. Thousands of detransitioners are speaking out on Reddit's "detrans" forum (http://www.reddit.com/r/detrans/). Seventy-five detransitioners

tell their stories in Post Trans Booklet available on line (https://post-trans.com/Detransition-Booklet) and many more on https://sexchangeregret.com/voices/.

CONCLUSION

Amici represent a cross-section of women around the world who have realized that medical and surgical interventions they were told would relieve them of their gender dysphoria and result in a happy, well-adjusted life in fact created irreversible harmful changes that profoundly affect them and their loved ones. Of grave concern is that these promises of surgical relief are based on practice guidelines that are ideologically driven opinions bereft of scientific evidence.

Young vulnerable women with gender dysphoria deserve holistic, compassionate care based on science, not a conveyor belt of chemicals and surgery. Arizona's regulation banning surgical procedures aimed at removing young women's healthy body parts for purposes of affirming a discordant gender identity is eminently reasonable and protective of these women and girls.

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

Dated: July 7, 2021.

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UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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I am the attorney or self-represented party.

This brief contains 6,497 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

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FOR THE NINTH CIRCUIT

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Brief for Keira Bell, Laura Becker, Sinead Watson, Kathy Grace Duncan, Laura Reynolds, Carol Freitas, and Detransvoices.org as Amici Curiae in Support of Defendant-Appellee, Supporting Affirmance

Signature _/s/ Mary E. McAlister_____ **Date** _July 7, 2021