IN THE SUPREME COURT OF VIRGINIA
Record No. 211061

PETER VLAMING,

Plaintiff- Petitioner

v.

WEST POINT SCHOOL BOARD; et. al.

Defendants-Respondents

BRIEF *AMICI CURIAE* OF QUENTIN VAN METER, M.D., BILL SHAW, M.D., DANIEL SWARTZ, M.D., JAMES ANDERSON, M.D., PAUL ROCKSWOLD, M.D., M.P.H., CAROLYN SUE SEEPE, M.D., M.P.H., SCOTT ARMISTEAD, M.D., and KURTIS S. ELWARD, M.D., M.P.H., IN SUPPORT OF PETITIONER

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American Psychiatric Association. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS. 451-459 (5th ed, 2013). 12

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. SEX. MED. 2276-2283 (2011). 9

Declaration of Allan M. Josephson, M.D., *United States of America v. North Carolina*, No. 1:16-cv-00425 (M.D. N.C. 2016) 12

Declaration of Quentin Van Meter at 10, *United States of America v. North Carolina*, No. 1:16-cv-00425 (M.D. N.C. 2016) 10

Dirk C. Strauss & J. Meirion Thomas, *Letter to the Editor: What does the Medical Profession Mean by "Standard of Care?"* 27 J CLIN ONCOLOGY, e192-193 (2009).....11

Eli Coleman *et. al., Standards of Care for the Health of Transsexual, Transgender, and Gender-Non-conforming People*, version 7, 13 INTERNATIONAL JOURNAL OF TRANSGENDERISM 165-232 (2012). 13

Human Rights Campaign, Interactive Map: Clinical Care Programs for Gender-Expansive Children and Adolescents https://www.hrc.org/resources/interactive-map-clinical-care-programs-for-gender-nonconforming-children.....12

Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS (4), e20182162 (October 2018).....11

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Kenneth Zucker, Hayley Wood, Devita Singh, & Susan Bradley, *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*. 59 JOURNAL OF HOMOSEXUALITY, 369-97 (2012). 8

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Kristina R. Olson, *et. al.*, *Gender Identity 5 years after Social Transition*, PEDIATRICS (Pre-Publication Release May 4, 2022). https://doi.org/10.1542/peds.2021-056082.....18

Peter Moffett & Gregory Moore, *The Standard of Care: Legal history and Definitions: the Bad and Good News*, 12 WEST J OF EMERGENCY MED, 109-112 (2011).....11

Rachel Gilgoff *et. al.*, *Adverse Childhood Experiences, Outcomes and Interventions*, 67 PEDIATR CLIN NORTH AM 259-273 (2020).....14

Walt Heyer, GENDER, LIES, AND SUICIDE, (2013).....15

Wylie C. Hembree *et al*, *Endocrine Treatment of Gender-dysphoric/Gender-incongruent Persons: an Endocrine Society Clinical Practice Guideline*, 102 J. OF CLINICAL ENDO. METAB. 3869-3903 (2017) 13

Wylie C. Hembree, *et al*, *Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical Practice Guideline*, 94 J. CLIN. ENDO. METAB. 3132-3154 (2009).....10

Ximena Lopez, Maya Marinkovic, *et. al. Pediatric Endocrine Society Transgender Health Special Interest Group, Statement On Gender- Affirmative Approach To Care From The Pediatric Endocrine Society*, 29 CURR. OPIN. PEDIATR. (4) 475-480 11

INTEREST OF AMICI[1]

Amici Quentin Van Meter, M.D., Bill Shaw, M.D., Daniel Swartz, M.D., James Anderson, M.D., Paul Rockswold, M.D., M.P.H., Carolyn Sue Seepe, M.D., M.P.H., Scott Armistead, M.D., and Kurtis S. Elward, M.D., M.P.H. ("Amici Physicians") are physicians who treat children and adolescents and who have studied the research regarding so-called "gender-affirmation" efforts, including social transition with the use of discordant names and pronouns, aimed at affirming a child's assertion that he or she identifies as something other than their natal sex. As medical professionals, Amici Physicians are troubled by the actions of Respondents (the "District") taken in response to a policy that compels District students and staff to unquestionably accede to a student's demand that he or she be treated as a member of the opposite sex. The District's policy, like others in place throughout the Commonwealth and the country, is based on ideologically driven premises lacking sound scientific evidence and contrary to the best interests of children.

Amici Physicians believe it is critically important for this Court to have information regarding the experimental nature of "gender-affirming" efforts, including socially transitioning a child with the use of "preferred pronouns" and opposite-sex names, when considering the actions taken by the District. In adopting

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[1] No counsel for a party authored this brief in whole or in part, and no party, party's counsel, or any person other than *amicus curiae* or their counsel contributed money intended to fund preparation or submission of this brief.

a policy requiring that staff accede to the wishes of children regarding "preferred pronouns" or face termination, the District is taking sides and forcing employees like Mr. Vlaming to take sides in an ongoing scientific and cultural debate regarding the efficacy and safety of "gender affirming" protocols.

As well as violating the free speech and free exercise rights of employees, the District's adoption of the pro-affirmation protocols places the imprimatur of the state on unproven and flawed protocols that do not benefit and actually harm children. The District has put itself in the position of compelling staff like Mr. Vlaming to engage in conduct that is not in the best interest of their students in order to conform to an ideological agenda.

Amici Physicians wish to provide the Court with evidence of the flaws and dangers in the "gender affirmation" approach adopted by the District, and therefore the error in the actions taken against Mr. Vlaming.

STATEMENT OF FACTS

Amici Physicians adopt and incorporate by reference the Nature of the Case and Material Proceedings Below and Statement of Facts in Petitioner's opening brief to the Supreme Court of Virginia. For purposes of this Brief, Amici Physicians emphasize the following facts as most relevant to Amici's arguments.

Mr. Vlaming believes both as a matter of human anatomy and religious conviction that each person's sex is biologically fixed and cannot be changed

regardless of a person's feelings or desires. (Complaint, ¶80). Accordingly, Mr. Vlaming believes that if he uses male pronouns to refer to a female student, as the District demanded that he do, he would be lying by "express[ing] the message that [the] person is, or [that he as] the speaker believes them to be, male." (Complaint, ¶¶ 83, 89).

The District demanded that Mr. Vlaming express ideas that he believes to be false (and that are empirically false), *i.e.*, that "gender identity, rather than biological reality, fundamentally shapes and defines who we truly are as humans, that our sex can change, and that a woman who identifies as a man really is a man." (Complaint, ¶6). Mr. Vlaming's conscience and religious practice prohibit him from lying, so he cannot use male pronouns to refer to a female student without violating his religious beliefs. (Complaint, ¶¶ 83, 89). As Amici Physicians will explain, Mr. Vlaming's conscientious beliefs comport with biological reality and with what is in the best interest of children like his student.

ASSIGNMENTS OF ERROR

1. The trial court erred by dismissing Vlaming's state constitutional and statutory free-exercise claims (Claims 4 and 5) because he sufficiently alleged the School Defendants violated his free-exercise rights when they fired him for declining to violate his religious beliefs, and because federal cases limiting federal free-exercise rights do not limit Virginia's free-exercise protections. [Compl. 25, 31–33; Pl.'s Resp. to Dem. 25–38; 6/7/21 Tr. 76–80, 87–90; Final Order 4.]

2. The trial court erred by dismissing Vlaming's state constitutional free-speech claims (Claims 1–3) because he sufficiently alleged the School Defendants fired him

for declining to express a viewpoint he disagreed with on an issue of public concern. [Compl. 24–31; Pl.'s Resp. to Dem. 7–25; 6/7/21 Tr. 68–76, 86–90; Final Order 4.]

3. The trial court erred by dismissing Vlaming's state due-process claim (Claim 6) because he sufficiently alleged the School Defendants exercised unbridled discretion when they fired him for allegedly violating an unconstitutionally vague policy. [Compl. 33–34; Pl.'s Resp. to Dem. 38–40; 6/7/21 Tr. 81–82; Final Order 4.]

4. The trial court erred by dismissing a portion of Vlaming's breach-of-contract claim (Claim 9) because he sufficiently alleged the School Board breached its contract with him because it violated Virginia's Constitution and state statutes when it fired him. [Compl. 36–37; Pl.'s Resp. to Dem. 41–43; 6/7/21 Tr. 84–86; Final Order 4.]

SUMMARY OF ARGUMENT

Policies like the District's that compel staff like Mr. Vlaming and students to socially affirm gender-dysphoric children are not harmless rules of conduct. Nor are they reflective of sound scientific and medical evidence. Instead, they are part of a larger ideologically driven phenomenon that mandates a singular response to the complex question of how to respond when a child claims to have questions about his or her identity. While claiming to be following sound scientific and medical evidence, the District is in fact doing neither. Instead it is taking sides in an ideological debate. The District is siding with, and compelling their employees like Mr. Vlaming, to side with those who deny biological reality and objective truth and embrace experimental social constructs.

Through its policy, the District claims that acceding to a confused child's request to affirm a discordant gender identity is acting in his or her best interest. However, as Amici will demonstrate, the opposite is true. Affirming a child's

assertion of a discordant gender identity actually exacerbates the psychological and emotional distress that underlie the assertion. In refusing to deny biological reality by acceding to his student's demands, it was Mr. Vlaming who was acting in her best interest. Rather than being terminated, Mr. Vlaming should be celebrated.

School gender-affirming policies such as the District's endorse the message to a gender dysphoric child that his or her natural biological development is a source of distress. Children who are unquestionably affirmed, even celebrated, by peers and adults will come to believe that changing their bodies through medical and surgical interventions is acceptable, even desirable. As physicians, Amici understand the irreversible effects of the medical and surgical interventions and the harms they pose to developing bodies—harms that are not yet fully known and are not communicated to children or their parents. Amici ask this Court to thoughtfully consider the historical and scientific information provided in this Brief and to overrule the lower court.

ARGUMENT

A. The Experimental, Non-Scientific Roots Of The Transgender Movement That Drives The District's Policy

In order to understand the concept of using pronouns that are not congruent with one's biological sex, it is important to understand the transgender movement from its original roots to the current state of demand for civil rights protections. Contrary to representations made by advocates, "social affirmation" and other

"gender-affirming" interventions are not grounded in science, but in social experimentation.

Before the 1970s the term "gender" referred to the nouns and pronouns used in some of the world's languages. It was Professor John Money of Johns Hopkins University Medical Center who rebranded "gender" to indicate what he called "the inner sexed self."[2] Prior to Dr. Money, "gender" had not been applied to human beings, and to this day the term cannot be found in any medical text published prior to Dr. Money's tenure. Dr. Money experimented on infants, toddlers, and adults to manipulate the social environment of select patients to see if they could live life as if they were born in the opposite sex.[3] His experiments, which today would be grounds for conviction of sexual abuse, failed miserably. The failure is most notably seen in the death of twin brothers who were subjects of his experiments by drug overdose and suicide in young adulthood.[4] Dr. Money's era of sexual

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[2] John Money and Anke Ehrhardt, MAN & WOMAN, BOY & GIRL: DIFFERENTIATION AND DIMORPHISM OF GENDER IDENTITY FROM CONCEPTION TO MATURITY (1973).

[3] Amicus Dr. Van Meter worked with Dr. Money at Johns Hopkins and so has first-hand knowledge of his work.

[4] John Colapinto, AS NATURE MADE HIM: THE BOY WHO WAS RAISED AS A GIRL (2000). The Reimer twins became patients of Dr. Money after one of them had to have his penis removed following a botched circumcision. Dr. Money used the tragedy to experiment with having the injured twin raised as a girl and his brother raised as a boy. The experiment led to both boys becoming emotionally troubled young men whose lives ended early at their own hands. *Id.*

experimentation at Johns Hopkins was ended when Professor Paul McHugh came on board and closed the gender clinic.

Dr. Money's colleagues who wanted to continue the experiments turned to the Harry Benjamin Society to disseminate their message that adults who wished to "turn into" the opposite sex (which is medically impossible) could change their appearance. The Society had an international network of physicians and surgeons who willingly worked on the bodies of adults who felt they were born in the body of the wrong sex.

Dr. Kenneth Zucker, a clinical psychologist from Toronto, looked at this phenomenon and named it Gender Identity Disorder (GID). He was, for decades, regarded as the world's expert on the subject. His clinic focused mainly on children. In his work at the clinic, he was able to discern that there was underlying psychological trauma that led children to fear growing up in the role of their biological sex. Over a 30-year period, Dr. Zucker studied 560 children whose parents came to him with a concern about their child's incongruent gender identity. He designed a healing process that realigned the child's perception of his or her gender identity with his or her sex by the time he or she passed through puberty to young

adulthood.[5] The small group of young adults that remained incongruent required ongoing counseling to reduce the likelihood of taking their own lives. Dr. Zucker's published bibliography was extensive, such that his name appeared numerous times in the list of references at the end of most papers published on the subject.

The Harry Benjamin Society did not agree with Dr. Zucker's approach. As an alternative it began to create what it called "Standards of Care" under the aegis of its new name, the World Professional Association of Transgender Health (WPATH).

Before 2000, medical and surgical interventions for gender incongruent individuals who wished to live as a new persona of the opposite sex was limited to adults. There were no protocols generated based on clinical research. Instead, treatments were offered in the experimental manner of John Money: "let's do something and see what happens."

Then, in the Netherlands, several of the doctors in the WPATH network decided to treat children with GID who had not yet entered puberty. The adult patients they had treated complained about how difficult it was for mature biologic males to feminize their appearance because their innate puberty had masculinized their body structures giving them broad shoulders, deep voices, extensive facial and

[5] Kenneth Zucker, Hayley Wood, Devita Singh, & Susan Bradley, *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*. 59 JOURNAL OF HOMOSEXUALITY, 369-97 (2012).

body hair, and thinning scalp hair. With that in mind, WPATH doctors developed a protocol for treating children, now referred to as the "Dutch protocol." That protocol included blocking natural puberty once it started, followed by the introduction of opposite-sex hormones to create changes in line with the incongruent gender identity.[6]

In 2007, after a mini-sabbatical in the Netherlands, Norman Spack, a pediatric endocrinologist in Boston, opened the first official transgender clinic in the United States. He used a version of the Dutch protocol to affirm the incongruent gender identities of his patients. Dr. Spack presented his concepts to a joint meeting of the Pediatric Endocrine Society and the European Endocrine Society in New York City in 2009. Dr. Van Meter attended that meeting and listened to Dr. Spack present his opinions. Dr. Van Meter was deeply bothered because he believed that this represented a regression back to the crude experimentation of John Money.

B. Ideology, Not Science, Drove Development Of So-called "Standards of Care," Which Include Social Affirmation Of Children As Incorporated Into Defendants' Policy.

Dr. Spack was instrumental in putting together the Endocrine Society's Guidelines for the Care of Transgendered Persons with a secret committee of

[6] 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. SEX. MED. 2276-2283 (2011).

WPATH members, published in 2009.[7] The guidelines were touted as representing the opinion of the vast majority of Endocrine Society members, when, in truth, they were the opinion of nine people, half from Europe and half adult medicine specialists. The guidelines were copied from the WPATH guidelines. The guidelines clearly stated that there was **little or no scientific validity** for all but three of their recommendations.[8] Also, the guidelines expressed concern that there needed to be clinical studies to verify safety and effectiveness in children.

The WPATH and Endocrine Society guidelines are often referred to as "standards of care" by those advocating for "gender affirming" protocols such as the District's policy. Advocates place the "standards of care" label on the guidelines in order to portray them as authoritative, especially to school boards and courts. However, "standards of care," by definition, imply that a large group of practitioners representing all sides of the issue have convened, weighed the evidence, and come to a consensus to create standards that are devoid of politics or ideology. Guidelines are a large step down from standards of care and often represent a mix of ideology

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[7] Wylie C. Hembree, *et al*, *Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical Practice Guideline,* 94 J. CLIN. ENDO. METAB. 3132-3154 (2009).

[8] Declaration of Quentin Van Meter at 10, *United States of America v. North Carolina,* No. 1:16-cv-00425 (M.D. N.C. 2016)

and science.[9,10] The WPATH and Endocrine Society protocols are guidelines, not "standards of care," regardless of whatever label is slapped on them. There is no broad consensus on the recommendations in those two sets of guidelines. Similarly, statements by the Pediatric Endocrine Society,[11] the American Academy of Pediatrics,[12] and the American Medical Association, also touted as consensus "standards of care" are just "me too" documents with no broad support from the general membership of those professional societies. In other words, they do not represent authoritative, scientifically sound standards of care upon which courts should base decisions or school boards should fashion policies. In particular, these non-authoritative guidelines should not be the basis for compulsory policies that carry the threat of termination for non-compliance, as is the case here.

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[9] Dirk C. Strauss & J. Meirion Thomas, *Letter to the Editor: What does the Medical Profession Mean by "Standard of Care?"* 27 J CLIN ONCOLOGY, e192-193 (2009).

[10] Peter Moffett & Gregory Moore, *The Standard of Care: Legal history and Definitions: the Bad and Good News*, 12 WEST J OF EMERGENCY MED, 109-112 (2011).

[11] Ximena Lopez, Maya Marinkovic, *et. al. Pediatric Endocrine Society Transgender Health Special Interest Group, Statement On Gender- Affirmative Approach To Care From The Pediatric Endocrine Society*, 29 CURR. OPIN. PEDIATR. (4) 475-480.

[12] Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS (4), e20182162 (October 2018).

Armed with these faux authoritative guidelines and with the help of internet influencers, transgender health industry activists worked to proliferate the ideology. As a result, the number of university-based transgender clinics burgeoned from one in 2007 to over 65 in 2021.[13] The incidence of gender incongruity in males jumped 500 percent. Before 2010, the number of females presenting with gender identity disorder (GID) was half the incidence in males. The incidence of GID in females is now double that of males. Intent on removing any vestiges of reticence association with a discordant "gender identity," activists pressured Dr. Zucker to remove GID from the DSM-V as a "disorder" to be instead considered a normal variant of healthy behavior.[14] In 2013, GID was replaced with the term Gender Dysphoria, under which believing that one has an incongruent gender identity is only a problem if it is causing mental anguish.[15]

As has been true from the outset of the transgender movement, the creation of practice guidelines and recategorization of GID to "gender dysphoria" was driven by ideology, not science. Amici Physicians view this as a troubling and dangerous

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13 *See, e.g.* Human Rights Campaign, Interactive Map: Clinical Care Programs for Gender-Expansive Children and Adolescents https://www.hrc.org/resources/interactive-map-clinical-care-programs-for-gender-nonconforming-children.

14 *See* Declaration of Allan M. Josephson, M.D., *United States of America v. North Carolina,* No. 1:16-cv-00425 (M.D. N.C. 2016)

15 American Psychiatric Association. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS. 451-459 (5th ed, 2013).

foundation upon which to make decisions about the physical, mental, and emotional health of children.

C. Social Affirmation Is An Ideologically Driven Concept That Harms Children.

The scientifically deficient, ideologically driven pedigree of the transgender movement should inform the Court's consideration of the District's actions in terminating Mr. Vlaming's employment for failing to abide by a policy requiring that school staff unquestionably affirm students who demand to be affirmed in a discordant gender identity. This demand for "social affirmation," *i.e.* changing outward appearance, adopting a gender discordant name and using incongruent pronouns based on nothing more than the request of a student is a harmful proposition with far-reaching consequences.

The call for immediate unquestioned social affirmation goes beyond even the recommendations of WPATH[16] and the Endocrine Society,[17] which are purportedly the source for the policy requiring immediate affirmation. WPATH and Endocrine Society guidelines recommend that when a child asserts a discordant gender identity the very first step is to have a thorough, independent psychological evaluation of

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[16] Eli Coleman *et. al.*, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Non-conforming People*, version 7, 13 INTERNATIONAL JOURNAL OF TRANSGENDERISM 165-232 (2012).

[17] Wylie C. Hembree *et al*, *Endocrine Treatment of Gender-dysphoric/Gender-incongruent Persons: an Endocrine Society Clinical Practice Guideline*, 102 J. OF CLINICAL ENDO. METAB. 3869-3903 (2017).

the gender incongruent child and family (their parents, step-parents, grandparents, full siblings, step- and half-siblings and any non-relative that has lived with the child) to unearth any Adverse Childhood Experiences (ACEs)[18] that might be the root cause of the child's discomfort living in the perceived role of their biologic sex. Some of the more common ACEs are death of a parent or sibling, presence of drug or alcohol abuse in the home, incarceration of a parent, physical, emotional, or sexual abuse, often within the family, and frequent moves to new and unfamiliar locations.[19] ACEs create a fearful, unreliable environment in which the child struggles to live.[20]

To children suffering from ACEs and struggling to live in their environment, the idea of creating a new persona through which they can shed their identity can be what looks like the perfect answer to their deepest wishes. However, if these issues exist, as they do in most cases of children asserting a discordant gender identity, living a pretense of being the opposite sex will not resolve the pain, but bury it deeper, waiting for an eruption in adulthood. At most transgender health clinics mental health staffers do not address these deep wounds. Instead, they reassure the child that the new persona is indeed the answer. Parents are also told that following

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[18] Rachel Gilgoff *et. al., Adverse Childhood Experiences, Outcomes and Interventions*, 67 PEDIATR CLIN NORTH AM 259-273 (2020).

[19] *Id.*

[20] *Id.*

the "gender affirmation" path is the only answer, and reluctant parents are often bullied into believing their child will commit suicide if they do not acquiesce.[21]

School policies, like the District's, of unquestioned affirmation of a child's assertion that he or she identifies as another sex, similarly exacerbates instead of relieving underlying ACEs or other issues that lie at the root of the asserted gender incongruity, especially when transgender messages are ubiquitous. For example, a young child, carrying the internal wounds of ACEs attends school where the curriculum is sprinkled with sexuality education, including the "Gender Unicorn" theory that tells the child he or she can be any sexual identity they please. Books in their school library celebrate imaginary heroes who find true happiness once they jettison their biologic sex and ride off into the sunset of a glitter world where all problems were solved simply by rejecting their sex. Add to this internet sites in which the suffering child is embraced by "glitter families" who promise to support him or her if his or her parents will not and encourage him or her to embrace a new identity.

Bombarded by these messages, a troubled, unhappy, lonely child sees happiness as just a name change and a hair cut away. The child is miserable and is overcome with the desire to become someone who is not miserable. He or she has

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[21] Walt Heyer, GENDER, LIES, AND SUICIDE, (2013)"

been convinced that he or she is born with the brain of the opposite sex, can change his or her sex and solve his or her problems, none of which is true.

Fully convinced of that delusion, buoyed by internet influencers, "glitter" families and other advocates, the confused child declares that he or she is the opposite sex. He or she then instructs the adults that he or she must be addressed by a new chosen name and incongruent pronouns. Without question and perhaps without notifying parents, the adults at school comply with the demand. When the school has in place a policy like the District's, adults are required to entertain the delusion. Any attempt to ask about underlying issues or, as in Mr. Vlaming's case, to depart from the denial of biological reality is met with threats and/or termination of employment.

Unquestionably acquiescing to a child's demands for social affirmation has wide-ranging consequences which many of the Amici Physicians have witnessed while caring for families and children. Social affirmation is not a harmless foray into fantasy which can be reversed by just returning to the original name, hair style and clothing. Amici have witnessed that once a child claims that he or she is the opposite sex there is a rent in the fabric of the family that cannot be mended without residual scarring. Parents often take sides against one another. Playmates, particularly younger ones, are fearful that they, too might turn into the opposite sex. Peers'

parents often forbid social interaction with the transitioning child. All of this can further overwhelm an already troubled and frightened child.

In other cases, the troubled child who has been convinced that the change will solve his or her problems may become emboldened and manipulate non-supportive parents by threatening to kill themselves if they do not get what they want. School staff further embolden the child by celebrating their "bravery" and, as is the case here, punishing any adult who fails to acquiesce to the child's demands.

Other children in the social environment are also adversely affected. Dr. Van Meter was asked to give a professional opinion on behalf of a family whose two boys were deeply traumatized by the sudden change in gender identity of a six-year-old boy in their private school. The adverse environment caused by the forced social affirmation of a classmate led to the children being pulled out of the school to protect them from further trauma.

In the words of Dr. Zucker, social affirmation is a mistake that does more harm than good.[22] He was aware of the wide-ranging negative consequences from social affirmation at school and tailored his protocols to alleviate those consequences by not allowing social affirmation to extend beyond the walls of home initially, and

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[22] Kenneth Zucker, *Debate: Different strokes for different folks*. JOURNAL OF CHILD ADOLESC MENT HEALTH 1-2 (2019) doi:10.1111/camh.12330

then to allow the child to live happily in their own sex as they matured through puberty.

Attempts to disprove Dr. Zucker's conclusion have fallen short. Kristina Olsen and her colleagues in Seattle published the results of a one-year study[23] and more recently a five-year study,[24] both of which purported to show that social affirmation is beneficial. However, the studies are marred by having no control group, using convenience sampling for study participants, and other flaws. More particularly, in the 2016 study, 50 percent of the individuals, controls, and siblings had depression, and more than 50 percent had anxiety. The authors did not report the data collection timeframe, but it is unlikely that in approximately one-half of all kids 3-12 years old were depressed and one-half were not anxious. It is not likely that the authors had enough follow-up time to make conclusions regarding 3 to 6 year olds. Furthermore, the authors did not use an independent observer, but parents to judge short term and long-term happiness.

Such studies are so scientifically deficient that they would normally never get by an editor and find their way into print. However, because transgender protocols are driven by ideology instead of science, articles purporting to "prove" that social,

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[23] Kristina R. Olson *et al, Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 PEDIATRICS e201 (2016).

[24] Kristina R. Olson, *et. al.*, *Gender Identity 5 years after Social Transition*, PEDIATRICS (Pre-Publication Release May 4, 2022). https://doi.org/10.1542/peds.2021-056082.

medical, or surgical interventions are profoundly beneficial are regularly included in medical literature despite failing to satisfy scientific publishing standards.

CONCLUSION

Mr. Vlaming clearly understands that a boy cannot become a girl and a girl cannot become a boy and refused to ignore that truth when teaching his students. Social affirmation, including the use of gender incongruent pronouns, is window dressing that allows a troubled child to hide from painful reality. In refusing to participate in such a harmful deception, Mr. Vlaming was acting in the best interest of his students. For that, he should be celebrated, not terminated.

For the foregoing reasons, Amici Physicians respectfully request that this Court rule in favor of Petitioner and overturn the Circuit Court's order.

Dated: May 23, 2022

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 5:26

The undersigned certifies that this brief complies with the type-volume limitations of Rule 5:26 of the Rules of the Supreme Court of Virginia. Exclusive of the sections exempted by Rule 5:26(b) the brief contains 4,991 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 Times New Roman 14 point.

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I certify that this 23rd day of May, 2022, electronic copies of the foregoing were served by electronic mail on:

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I further certify that I have filed an electronic PDF version of the foregoing with the Clerk via the Virginia Appellate Courts eBriefs System.

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