No. 24-539

In The

Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF REGULATORY AGENCIES, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF THE CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS AND ALLIANCE FOR HIPPOCRATIC MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

Kristine L. Brown
8700 E. Jefferson Avenue
Denver, CO 80237
(720) 285-9552
kristi@kristiburtonbrown.com

LEGAL PRINTERS LLC ● Washington, DC ● 202-747-2400 ● legalprinters.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes

Other Authorities

INTEREST OF *AMICI CURIAE*[1]

Amicus curiae The Christian Medical and Dental Associations (CMDA) is a national nonprofit, professional organization whose members are Christian physicians and allied healthcare professionals. CMDA has approximately 13,000 members and 365 chapters nationally. CMDA's mission is to educate, encourage, and equip Christian healthcare professionals to glorify God. CMDA believes that Christian healthcare professionals glorify God by following Christ, serving with excellence and compassion, caring for all people, and advancing Biblical principles of healthcare within the Church and throughout the world. CMDA members' practice of healthcare is founded on, compelled by, and central to, their Christian religious beliefs.

Amicus curiae Alliance for Hippocratic Medicine is a nonprofit alliance of membership organizations that uphold and promote the fundamental principles of Hippocratic medicine: protecting the vulnerable at the beginning and end of life; seeking the ultimate good for the patient with compassion and moral integrity; and providing health care with the highest standards of excellence based on medical science. Alliance for Hippocratic Medicine organizational members include the American Association of Pro-Life Obstetricians and Gynecologists, the American

---

[1] Rule 37 Statement: No attorney for any party authored any part of this brief, and no one apart from *Amici* and its counsel made any financial contribution toward the preparation or submission of this brief.

College of Pediatricians, the Coptic Medical Association, the Catholic Medical Association, the Christian Medical and Dental Associations, the Canadian Physicians for Life, the American College of Family Medicine, the Euthanasia Prevention Coalition, the National Association of Pro-Life Nurses, and the Hippocratic Registry, together representing over 30,000 medical professionals who uphold and promote the fundamental principles of Hippocratic medicine, which includes first doing no harm.

As the incidence of gender dysphoria among minors spikes in the U.S. and around the world, those responsible for treating these minors are ethically bound to provide the most scientifically sound information available. Unfortunately, the clinical evidence motivating the practice of youth medical gender transitions is methodologically flawed. It cannot justify the invasive, permanent, and experimental gender transition procedures being pushed by supporters of Colorado's Speech Censorship Law at issue in this case.[2] What is more, as critical reviews of these flawed studies mount, waves of detransitioners, i.e., those who were "transitioned" as minors but have since recognized their gender conforms with their biological sex, are coming forward lamenting the irreversible consequences of these gender transition procedures.

---

[2] *See* E. Abbruzzese, et al., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed*, 49(6) J. Sex & Marital Therapy, 673-699 (2023).

Amici believes counselors and doctors have an ethical duty to fully discuss the best available evidence regarding social transitioning and gender transition procedures with their minor clients and parents. The Colorado law in question wrongly assumes all clients experiencing gender dysphoria want to embrace it and that the condition is never unwanted. Many patients seen by doctors first see a counselor and, in Colorado, the counselor is banned from giving clients full and accurate advice about how to avoid gender transition procedures, even where the patient wants a choice other than transition and even where the advice would aid minors in avoiding behaviors associated with increased risk for mental illness and suicidal thoughts and behavior. *Amici* thus has a direct interest in the outcome of this case because it will affect the legal fulfillment of their duties and obligations to their clients and whether their clients are being given the full scope of information about a permanently life-altering procedure.

SUMMARY OF ARGUMENT

Gender transition procedures (GTPs) endanger already at-risk gender dysphoric minors with experimental, unproven hormonal and surgical procedures. These procedures physically change a child's or teen's body prematurely and permanently. Speech bans on comprehensive counseling prior to or during GTPs contradict the spirit of science, the ethics of medicine, and the value of ongoing research as they run squarely against evidence-based healthcare, client autonomy, free speech, and the counselor-client relationship. Colorado law,

including Colo. Rev. Stat. § 12-245-224, § 12-245-202(3.5)(a), and § 12- 245-202(3.5)(b)(II), requires counselors to treat a minor's professed gender identity as permanent, even where the minor wishes to return to his or her biological gender. While, in a best case scenario, the law may potentially allow for some information about the negative effects of GTPs to be shared, it bans a full discussion about these effects since the counselor may not, under any circumstances, attempt to advise the minor to alter his or her behavior or gender expression – even where the sharing of such information would be in the minor's best interest and even where the minor has requested full information on how to resist the path of gender transition.

The mounting tide of evidence shows that two Dutch studies[3] relied on by defenders of GTPs are seriously flawed, and that advocates in the field routinely exaggerate known benefits and hide or downplay known risks and unknown consequences. *See* Abbruzzese *supra* and Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence,* 49(4) J. Sex & Marital Therapy, 348-368 (2022). In reality, the science shows that the irreversible, invasive, and harmful consequences of GTPs are medically unnecessary, as gender dysphoria in minors will resolve in the vast majority of cases. An intensive review from the U.S.

[3] *See* Annelou L C de Vries, et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. Sexual Med. 2276 (2011); Annelou L C de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

Department of Health and Human Services, released in May 2025, stated: "For social transition, the certainty of benefits and harms is very low…" and continued, "Specific to medication transition…there remains substantial uncertainty about their psychological and long-term health impacts." U.S. Dep't of Health and Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence & Best Practices* 89 (2025). This research and conclusions drawn from it could not be shared under Colorado law, as it could be considered a speech practice aimed at altering behavior or changing gender expression. Even if that is a client's stated goal, the counselor may not have this aim and share information that aids in this aim. If a minor is aware that, based on the medical evidence, he or she may not experience gender dysphoria in the future even if no action is taken and especially if no transition is experienced, this could lead that minor to change his or her gender expression and is therefore off limits for counselors' speech in Colorado.

On top of the fact that gender dysphoria is often resolved in minors without GTPs, these procedures often fail to deliver on their promise to resolve gender dysphoria, as the growing, public community of detransitioners shows. This collective, growing body of medical evidence and real-life experience has led many governments and medical institutions around the world to push back against gender transition procedures, particularly for minors, preferring instead psychological evaluation and mental health support. U.S. counselors and

physicians should be allowed to fully discuss this evidence with their clients – who seek out their services voluntarily – including the real risks and irreversible changes effected by GTPs, connected to advice on what action could be taken to avoid GTPs, even if this information leads to changes in a minor's behavior and gender expression.

ARGUMENT

I. Counselors and Other Medical Professionals Should Be Allowed to Fully Discuss the Dangers That Experimental, Unproven Medical Procedures Pose to Their Clients.

Gender dysphoria is a persistent state of distress that stems from the feeling that one's gender identity—one's personal sense of being a man or a woman—does not align with their physical, biological sex. *See* American Psychiatric Association: DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.), American Psychiatric Publishing, Inc. A person experiencing gender dysphoria desires to live and be accepted as a member of the opposite sex.[4]

Gender transition procedures (GTPs) attempt through psychosocial, hormonal, and surgical interventions to psychologically and physically alter in the patient the phenotypical appearance of secondary

---

[4] *See* Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE 1 (2011).

sex characteristics to become similar to the physical sex which aligns with the patient's personal gender identity (but not his biological sex) and thereby reduce gender dysphoria.[5] GTPs consist of four main parts: (1) social transition; (2) blocking normal puberty or menstruation; (3) high dose opposite-sex hormones; and (4) surgical removal of body parts to make external sexual characteristics resemble those of the opposite sex (also known as "sex-reassignment" and "gender affirming" surgery). Many results from GTPs are irreversible, and it is clear that social transition is the first step in the process that often leads to the more permanent medical steps. "Gender social transition of prepubertal children will increase dramatically the rate of gender dysphoria persistence when compared to follow-up studies of children with gender dysphoria who did not receive this type of psychosocial intervention and, oddly enough, might be characterized as iatrogenic." K.J. Zucker, *Debate: Different Strokes for Different Folks*, 25(1) Child Adolesc. Ment. Health 36-37 (2020). Counselors in Colorado are required to either affirm or silently stand by while their clients engage in social transition, even if the client desires to align their identity with their sex and the counselor believes he or she is ethically obligated to inform the patient that transition is not the best course of action, based on current information. This, despite the advice of the American Psychological Association: "Premature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role,…) should

---

[5] *See Feminizing Hormone Therapy*, Mayo Clinic, (found at: https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096) (last accessed June 10, 2025).

be approached with caution to avoid foreclosing this stage of (trans)gender identity development." W. Bockting, *Ch. 24: Transgender Identity Development*, 1 American Psychological Association Handbook on Sexuality and Psychology, 744, D. Tolman & L. Diamond eds. (2014).

In fact, Colorado's ban also violates the patient's need for self-determination – which cannot exist where there is a lack of complete and accurate information or a full discussion of options available or where a client is prohibited from receiving the type of counseling he or she is seeking. As a 2021 study explains, "continued warnings by the American Psychological Association and other mental health associations against clients using SAFE-T [Sexual Attraction Fluidity Exploration in Therapy] are misinformed, unprofessional, and even unethical in terms of meeting the legitimate self-determination needs of clients." Pela, C. & Sutton, P. *Sexual Attraction Fluidity and Well-being in Men: A Therapeutic Outcome Study*. 12 J. Human Sexuality, 61, 78 (2021).

Additionally, the Colorado law prohibits a counselor from adequately respecting some clients' religious views and moral values and aiding such a patient in finding a way out of gender dysphoria. "The contention that a desire to modify same-sex attractions and behaviors can only be an expression of self-stigma reflects a serious disregard for and misunderstanding of conservative religious and moral values." S.L. Jones, et al., *A Scientific, Conceptual, and Ethical Critique of the Report of the*

APA Task Force on Sexual Orientation. 45 (2) The General Psychologist, 7-18 (2010).

Until recently, gender dysphoria has been a relatively rare condition in children and adolescents. Lately, however, there have been very significant increases in referrals for this condition noted around the globe. For example, "In 2021, about 42,000 children and teens across the United States received a diagnosis of gender dysphoria, nearly triple the number in 2017..." Robin Respaut & Chad Terhune, *Putting Numbers of the Rise in Children Seeking Gender Care*, REUTERS INVESTIGATES, (Oct. 6, 2022), https://www.reuters.com/investigates/special-report/usa-transyouth-data/.

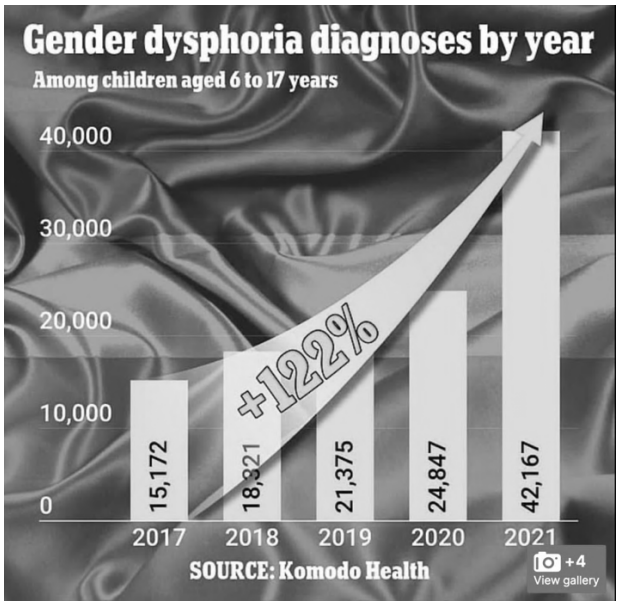

Photo 1: Research shows the spike in gender dysphoria diagnoses for children and teens.

Data evidence demonstrates that gender dysphoria has risen at the same time that other mental health issues have increased in children and teens.

> Analysts at LexisNexis Risk Solutions — which has a dataset of more than 300 million patients — found the number of insurance claims for gender identity care among under-18s spiked 133 percent from 2019 to 2023. It is part of a wider sharp increase in mental health issues among children. Claims for care relating to eating disorders surged 108 percent in the same time, while anxiety-related claims rose 61 percent. Overall, the report found that claims for any kind of mental health care surged 83 percent among under-18s over the period studied.

Peter Garbow, *Daily Mail: Gender Dysphoria Diagnoses Among Children Have Spiked 133% Since 2019,* CENTER FOR ARIZONA POLICY (June 13, 2024), https://www.azpolicy.org/2024/06/13/daily-mail-gender-dysphoria-diagnoses-among-children-have-spiked-133-since-2019/. There is evidence that this increase in gender dysphoria specifically may be due in part to social influences and fueled by social media and internet use. *See* Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 13(8) PLOS ONE e0202330 (2018). Social media and internet use increased among minors during the COVID lockdowns, which covered a good portion of

the time when the spike in mental health conditions, including gender dysphoria, occurred.

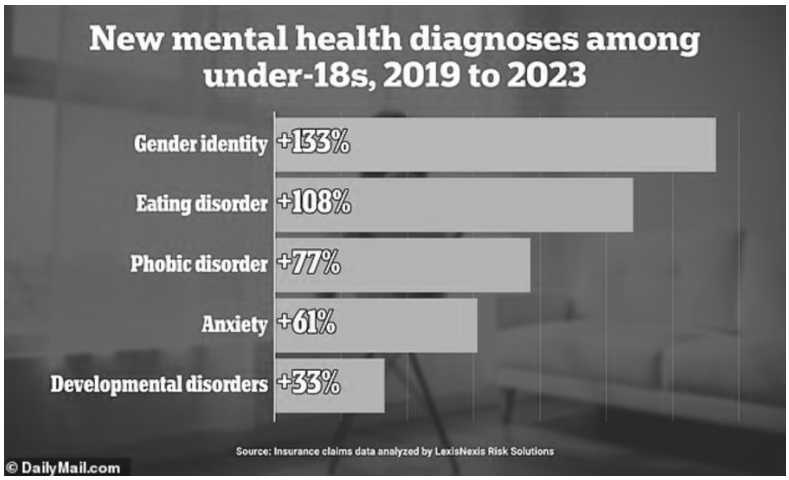

Photo 2: Research shows the dramatic increase of mental health diagnoses among minors.

As the incidence of gender dysphoria has skyrocketed, so, too, has the number of detransitioners (individuals returning to their biological sex).[6] The irreversible and experimental nature of many GTPs as well as the large numbers of detransitioners who were subjected to GTPs as minors but then changed their gender identity back

---

[6] *See* Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50(8) Arch. Sex. Behav. 3353-3369 (2021); *see also* Kirsty Entwistle, *Reality Check – Detransitioner's testimonies require us to rethink gender dysphoria*, 26(1) Child Adolesc. Ment. Health 15-16 (2020).

to that of their biological sex, caution against the widespread acceptance of these procedures.

Despite the irreversible physical changes from GTPs and the number of people detransitioning, Colorado law limits what counselors may say about detransitioning and bans the counselor from recommending steps of action to mitigate gender dysphoria rather than encouraging it. In so doing, Colorado law bans counselors from having a full discussion with their minor clients who profess a cross-sex identity or from advising them on a best course of action to avoid the dangers of GTPs, based on current scientific research and medical evidence. At present, Colorado's Speech Censorship Law applies to licensed counselors. Psychiatrists are banned from similar speech under Colo. Rev. Stat. § 12-240-121(1)(ee). Without a reversal of Colorado law as unconstitutional, the state is encouraged to expand its censorship of speech to all doctors. Both the current version of the law and any expansion are devastating to ethical and science-based medical practice, where doctors and counselors fully discuss the dangers of medications and medical procedures – especially experimental ones – with their clients.

A. Desistance is the Norm for the Overwhelming Majority of Children with Gender Dysphoria.

Over 80% of minors experiencing gender confusion desist—that is, they naturally align their

minds with their bodies if left to themselves.[7] This means that, if allowed to work through any psychological, mental, or emotional issues—often caused by trauma—children, adolescents, and adults, will often re-identify with their biological sex, given time. Numerous studies have considered whether gender dysphoria persists throughout childhood. As stated above, on average, 80% of children chose not to continue into adulthood as transgender.[8] The largest sample to date of boys who were clinic-referred for gender dysphoria, published in 2021, confirms that gender dysphoria does not persist in most children past puberty if they are not pushed into GTPs by medical professionals: "Of the 139 participants, 17 (12.2%) were classified as persisters and the remaining 122 (87.8%) were classified as desisters." Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psychiatry 632784 (2021).[9]

---

[7] *See APA Handbook on Sexuality and Psychology*, American Psychological Association, W. Bockting, *Ch. 24: Transgender Identity Development* at 744; *see also* James M. Cantor, *Do Trans Kids Stay Trans When They Grow Up?*, Sexology Today! (Jan. 11, 2016), http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html).

[8] *See* Thomas D. Steensma, et al., *Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) J. AACAP 582-590 (2013).

[9] *See also* Kenneth J. Zucker, *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies and 'Desistance' Theories About Transgender and Nonconforming Children" by Temple Newhook, et al.*, 19 International Journal of Transgenderism, 231-245 (2018).

Because the rate of desistance is so high, GTPs will necessarily cause serious and irreversible harm to many children and adolescents who would naturally outgrow the condition if not "affirmed." Moreover, evidence suggests that minors who are pushed further into their gender confusion by trusted adults (such as parents and medical professionals) will continue down that path. For example, one study of adolescent males with gender dysphoria found that "98% elected to start cross-sex hormones" after six months on puberty blockers. Polly Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People With Persistent Gender Dysphoria in the UK*, 16(2) PLOS ONE e0243894 (2021) [hereinafter Carmichael, et al.]. Studies have consistently confirmed this detrimental result.[10] Therefore, GTPs may irreparably box in thousands of children who are still in the process of discovering their true feelings and beliefs about their own identity and are nowhere near ready to make an irreversible decision about their physical bodies.

Under Colorado law, since counselors are banned from helping a child act against gender dysphoria, the counselor is not legally permitted to share the

---

[10] *See* CM Wiepjes, et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets*, 15(4) J. Sex. Med. 582-590 (2018); T. Brik, et al., *Trajectories of Adolescents Treated With Gonadotropinreleasing Hormone Analogues for Gender Dysphoria* 49 (7) Arch. Sex. Behav. 2611-2618 (2020); L.E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) Pediatrics e20193006 (2020); and Carmichael, et al.

studies above or the stories of detransitioners if the client has asserted a desire to change his or her current behavior or to return to his or her biological gender. Thus, minor clients in Colorado no longer have access to a full range of perspectives in therapy, and evidence-based practice is stunted by current law. Colorado's Speech Censorship Law is unconstitutional, as counselors and medical professionals alike should retain the right under the law to discuss the full implications of gender transitioning in order to help their clients seek lasting and effective treatment for gender dysphoria instead of being forced to encourage them in social transitioning and GTPs. It is not only unnecessary, but also unethical, to permanently medicalize a child for a condition that, statistically, usually goes away if the condition is not encouraged. Colorado law allows only encouragement of this transitory condition while banning all spoken discouragement of it – in effect, prohibiting counselors from using the best medical evidence and its implications in their discussions with clients.

B. Puberty Blockers and Cross-Sex Hormones Are Known to Cause Severe Adverse Medical Effects, Including Sterilization.

Several studies have shown the likely adverse health effects of hormonal interventions, effects of which are not fully reversible. Many of these studies were evaluated in the comprehensive review done by the U.S. Department of Health and Human Services just last month as well as two indepth reviews published in 2024 in the Archives of Disease in

Childhood. *See* U.S. Dep't of Health and Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence & Best Practices* (2025); Jo Taylor et al., *Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, 109 Arch. Dis. Child. s48-s56 (2024); Jo Taylor et al., *Interventions to Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review* 109 Arch. Dis. Child. s33-s47 (2024). Current medical research suggests that youth treated with puberty blockers and/or cross-sex hormones develop problems with bone density (bone mineral density compromise at its period of greatest growth, which can lead to osteopenia/-porosis), insulin resistance, elevated blood pressure, elevated triglycerides, damaged liver function, thromboembolic disease (blood clots) cerebrovascular disease (strokes), breast and uterine cancers, mental health deterioration, and cardiovascular disease.[11] In addition, taking puberty

---

[11] *See* D. Klink, et al., *Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents With Gender Dysphoria*, 100(2) J. Clin. Endocrinol. Metab. E270-E275 (2015); N.J. Nokoff, et al., *Body Composition and Markers of Cardiometabolic Health in Transgender Youth on Gonadotropin-Releasing Hormone Agonists*, 6(2) Transgender Health, 111-119 (2021); J. Olson-Kennedy, et al., *Physiologic Response to Gender-Affirming Hormones Among Transgender Youth*, 62(4) J. Adolesc. Health 397-401 (2018); D.R. Jacobs, Jr., et al., *Childhood Cardiovascular Risk Factors and Adult Cardiovascular Events*, 386(20) New Eng. J. Med. 1877-188 (2022); Asa Radix & Andrew M. Davis, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 318(15) JAMA 1491-1492 (2017); Michael Laidlaw, et al., *The Right to*

blockers increases the risk of infertility by blocking the maturation of sperm and eggs.[12] Following puberty blockers with cross-sex hormones assures sterility.[13] Contrary to the narrative pushed by supporters of gender transition procedures, rates of self-harm do not improve while on puberty blockers, puberty blockers are not proven to be fully reversible, and long-term complications are known.[14] An expert report by Dr. James Cantor detailed the risks to neurodevelopment and cognitive development associated with puberty blockers:

> It is well known that pubertal hormone levels drive important stages of neural development and resulting capabilities, although the mechanisms are not yet well understood. Dr. John Strang (Research Director of the Gender Development Program at Children's National Hospital in Washington, D.C.) (Terhune 2022),

---

Best Care for Children Does Not Include the Right to Medical Transition, 19(2) Am. J. Bioeth. 75-77 (2019); Michael Biggs, *The Tavistock's Experiment wih Puberty Blockers* (2019), https://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf.; and Carmichael, et al.

[12] *See* Michael K. Laidlaw, et al., *Letter to the Editor: Endocrine Treatment of Gender-Dsyphoria/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 104 J. Clin. Endocrinol. Metab. 686-687 (2019).

[13] *See* Howard E. Kulin, et al., *The Onset of Sperm Production in Pubertal Boys. Relationship to Gonadotropin Excretion*, 143(2) JAMA Pediatrics, 190-192 (1989).

[14] *See* Carmichael, et al. *See also* Jenny Sadler Gallagher, et al., *Long-Term Effects of Gonadotropin-Releasing Hormone Agonist and Add-Back in Adolescent Endometriosis*, 31(2) J. Pediatr. Adolesc. Gynecol. 190 (2018).

> the Cass Review from England, and the systematic review from Finland all reiterated the central importance and unknown effects of GnRH-agonists on windows, or "sensitive periods," in brain development, notably including adolescence.

Declaration of James M. Cantor Ph.D at 126-127, *McComb Children's Clinic, Ltd., v. Becerra*, 5:24CV48-LG-ASH (S.D. Miss. filed May 13, 2024).

The Cass Review went into explicit detail on the concerns presented to minors' brain development when they are infused with puberty blockers:

> A further concern, already shared with NHS England (July 2022) (Appendix 6), is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences.

Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, 178 (2024) [hereinafter The Cass Review].

Cross-sex hormones also bring a host of risks and adverse health effects. For example, when introduced into a healthy biological male, estrogen significantly increases the risks of blood clots, heart attacks, strokes, breast cancer, insulin resistance, and more—and these risks increase with length of use.[15] Similarly, testosterone use in females significantly increases the risks of heart attacks, strokes, breast and uterine cancer, hypertension, severe acne, and more. Moreover, a 2019 international panel of endocrinologists concluded that without exception, the only evidence-based indication for testosterone therapy in women is its short-term use for the treatment of hypoactive sexual desire disorder in postmenopausal women. The panel further noted that "[t]he safety of long-term testosterone therapy has not been established." Susan R. Davis, et al., *Global Consensus Position Statement on the Use of Testosterone Therapy for Women*, 104(10) J. Clin. Endocrinol. Metab. 4660, 4665 (2019). Mental health issues increase significantly as well, and even the Lupron [a puberty blocker and hormone suppressor] package insert warns that it can cause mood swings, depression, suicidal ideation, and attempts.[16] If counselors want to preserve their license in Colorado, they may conclude that they must be silent about the medical risks of puberty blockers and cross-sex hormones because Colorado law prohibits them from any effort

---

[15] *See* Nash R. Getahun, et al., *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, 169(4) Ann. Intern. Med. 205-213 (2018) and *ibid* note 11.

[16] *See* Carmichael, et al., and Biggs, *supra* note 11.

– including speaking – that may "change behaviors or gender expressions" related to gender identity. Colo. Rev. Stat. § 12-245-202(3.5). It is medically dangerous for Colorado to limit the discussion counselors can have with their clients on these topics.

C. The Claim That Medical Transitions Reduce the Likelihood of Suicide is a Myth, and Mental Health Treatment Reduces It Instead.

GTP advocates often claim that "gender affirming" care is required to prevent suicides. Parents of children and adolescents experiencing gender dysphoria are told that they have a choice between a "dead daughter" or a "living son" or between planning a transition or a funeral and therefore are pressured to agree to transition. Jared Eckert & Makenna McCoy, *New Documentary Highlights the Harm of "Gender Affirming" Health Care Model on Children*, THE HERITAGE FOUNDATION (June 22, 2021), https://www.heritage.org/gender/commentary/new-documentary-highlights-the-harm-gender-affirming-health-care-model-children). There is no compelling evidence, however, that gender transition procedures reduce the likelihood of suicide for gender dysphoric children. *See* The Cass Review at 33. Indeed, among individuals who undergo full transition, the suicide rate significantly increases—not decreases. *See* Dhejne, et al., *supra* note 4.

To be sure, children with gender dysphoria suffer from a high rate of suicidal ideation. Rather than minimizing this danger, transitioning and divorcing one's gender identity from one's biological sex actually *increases* the risk, particularly because of the permanent effects of medication and surgery. For example, a 2011 Swedish long-term study of 324 sex-reassigned persons showed that ten years later, the sex-reassigned group had *nineteen times* the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care compared to the general population of Sweden. *Id.* And a 2020 Swedish study, claiming to be the first total population study of 9.7 million Swedish residents, ultimately showed neither "gender-affirming hormone treatment" nor "gender-affirming surgery" improved the mental health benchmarks. *See* Richard Bränström & John E. Pachankis, *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*, 177(8) Am. J. Psychiatry 727 (2020). In response to scientific criticisms that the data in the 2020 study did not support the authors' conclusions, the AJP editor requested an independent statistical review of the data, which led to a reanalysis of the data and an official correction. When gender dysphoric clients who received surgeries were compared to those who did not have surgeries, there was no statistically significant difference in their mental health utilization. *See Correction to Bränström and Pachankis*, 177(8) Am. J. Psychiatry 734 (2020). *See also* Ned. H. Kalin, *Reassessing Mental Health Treatment Utilization Reduction in*

Transgender Individuals After GenderAffirming Surgeries: A Comment by the Editor on the Process 177(8) Am. J. Psychiatry 764 (2020).

A Finnish study of gender-referred adolescents and young adults from 1996-2019 concluded: "Clinical gender dysphoria does not appear to be predictive of all-cause nor suicide mortality when psychiatric treatment history is accounted for." Sami-Matti Ruuska et al., *All-Cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study*, 27 BMJ Ment Health 1 (2024). This study pointed out the "utmost importance" of "identify[ing] and appropriately treat[ing] mental disorders in adolescents experiencing gender dysphoria to prevent suicide." *Id.* Rather than recommending GTPs, the study found a need for mental health treatment to preserve the lives of these minor clients. Further, it found a need for health policies "to ensure that accurate information is provided to professionals along these lines." *Id.*

Colorado law prohibits licensed counselors from sharing recommendations based on this researched information with their clients when those clients seek advice on how to change. As medical professionals, *amici* advocate for ethical treatment of the whole person – including adequate mental health solutions – rather than rushing to permanent and damaging medication and surgeries simply because that lines up with the ideology of the state. It is a medical tragedy that Colorado pushes

counselors into encouraging treatment that is associated with a higher suicide risk instead of allowing a full-spectrum discussion when a minor patient is experiencing the mental health condition of gender dysphoria.

D. The Growing Number of Detransitioners Blame the Medical Profession for Not Disclosing the Risks and Irreversible Dangers Inherent in Medical Transitioning.

Thousands of individual transitioners regret their transition and are now attempting to de-transition. For example, in late 2017, the subreddit r/detrans (r/detrans, 2020) was revitalized, and in four years, grew from 100 members to more than 46,000 members. *See* Littman (2021) *supra* note 6. Many of these men and women who transitioned as children are speaking out publicly about the irreversible harm GTPs caused them, demonstrating that some effects of GTPs are permanent.[17] Many claim they lacked information on transition procedures' known risks and available alternatives and that these procedures were pushed on them as the only realistic treatment for gender dysphoria.[18] Colorado law forces this dangerous lack of information on future clients, banning any

---

[17] *See, e.g.*, *Masculinizing Surgery*, Mayo Clinic, https://www.mayoclinic.org/tests- procedures/masculinizing-surgery/about/pac-20385105 (accessed June 10, 2025).

[18] *See r/detrans | Detransition Subreddit*, (created Nov. 14, 2017), https://www.reddit.com/r/detrans/.

encouragement from counselors for clients to pursue an alternative.

There are studies claiming to show low rates of regret among transitioned persons.[19] But these studies consistently show high rates of participant loss to follow up (even ranging from 20–60%) and set unreasonably strict definitions for regret by, for example, failing to explore the relationship between regret and high rates of post-transition suicide.[20] By playing with the numbers, those in favor of medical transitions are stacking the deck in favor of their preferred ideology and, once again, refusing to address the hard evidence contradicting the ideology promoted by the state of Colorado.

E. "Gender Transition" Surgery is Irreversibly Damaging, Especially to Children.

There is a focused effort by some in the medical community to push a minor's parents to allow him or her to undergo "gender transition" surgery as soon as possible. Often, this surgery is strongly pushed before mental health treatment has been offered, adequate counseling has been provided, and without full, informed exploration of the permanent and irreversible damage that may be caused to the

---

[19] *See, e.g.*, T. C. van de Grift, et al., *Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-Up Study*, 44(2) J. Sex & Marital Ther. 138-148 (2017).

[20] *See* Robert D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Arch. Sex. Behav. 7-16 (2021).

patient's body and natural functions. Colorado law prohibits licensed counselors from advising any client of these significant risks if, in so doing, the counselor would be attempting to change the gender behavior or expression of the minor. This is true even if the client *wants* to change his or her current behaviors or gender expression and wants the counselor's advice to do so. Counselors are prohibited from encouraging a minor patient to wait on or avoid gender transition and, in fact, may only *encourage* transition, even though encouraging social transition often leads to the more physically dangerous medication- and surgery-based transitions.

Not only do some of these surgeries – orchiectomy and oophorectomy in particular – make the patient sterile – for minors, well before they have been able to make a fully informed decision as to whether they might one day change their minds and desire to have children naturally – but they also unalterably change a child's physical development. The American College of Pediatricians writes that "physically healthy transgender-believing girls are being given double mastectomies at 13 and hysterectomies at 16, while their male counterparts are referred for surgical castration and penectomies at 16 and 17, respectively, and it becomes clear that affirming transition in children is about mutilating and sterilizing emotionally troubled youth." ACPeds, *Transgender Interventions Harm Children*, (June 2022) https://tinyurl.com586zp6wh (last visited Oct. 6, 2024). In addition to affecting a patient's reproductive organs and abilities in

obvious ways, these surgies also remove tissue from other parts of the body, such as the forearm or thigh, in order to make faux body parts for the patient. Other surgeries can affect the chest, neck, face, skin, hair, or vocal cords.

Complication rates for transgender surgery are extremely high and fall far outside normal ranges. They often affect multiple body systems. A 13-year review of surgical outcomes found "a great number of adverse events,' including complications in the "genital region, urinary tract, gastrointestinal events, wound healing disorders" and more. *See* R. Rossi Neto, et al., *Gender Reassignment Surgery – A 13 Year Review of Surgical Outcomes*, 38(1) Int. Braz. J. Urol. 97-107 (2012). Even a 2021 study supportive of gender transition surgery admitted that "the rate of complications following penile inversion vaginoplasty range from 20% to 70%." Rayisa Hontscharuk et al., *Penile Inversion Vaginoplasty Outcomes: Complications and Satisfaction*, 9(6) Andrology 1732, 1733 (2021). These complications included rectal injury in up to 6.7% of patients, infection in up to 27%, tissue necrosis in up to 24.6%, excessive post-operative bleeding in up to 12%, divergent urinary stream in up to 33%, incontinence in up to 16%, rectoneovaginal fistulas in up to 17%, and venous thromboemboisms in up to 6%. Secondary operations were required in 20-54.2% of patients for "cosmetic revision," demonstrating that the surgeries are often unsuccessful even for the purpose for which they are sought. *Id* at 1738.

According to a 2023 study, gender transition surgery complications for biological females occur at an even higher rate of 76.5%. Bashar Hassan et al., *Predictors of Major and Minor Complications following Phalloplasty*, 9(1) J. Reconstr. Microsurg. Open e34-e42 (2024). In addition to disfiguring the patient's forearm or thigh, bleeding requiring transfusion occured in 7.9% of the cases and, the longer the surgery took to finish, the more likely the patient would have the complication of sepsis. *Id.* These patients experience a urethral fistula (leaking urine) rate of 27-50% and seek a repeat surgery at a rate of 73%, again proving that, in addition to being physically and medically dangerous, the surgeries are failing to achieve the sought after purpose. H. Veerman et al., *Functional Outcomes and Urologic Complications After Genital Gender Affirming Surgery With Urethral Lengthening In Transgender Men*, 204 J. Urology 104, 107 (2020). This is especially true for minor patients.

F. The Consensus Among Non-U.S. Medical Bodies is Caution, Appropriate Mental Health Care, and Counseling Rather Than Immediate Affirmation and Transition.

Governments, medical organizations, and academic institutions in the United Kingdom, Sweden, Denmark, Finland, and Norway have recently rejected automatically prioritizing gender transition, and now emphasize extended mental

health evaluation and support.[21] For example, the UK closed the world's largest pediatric gender clinic, NHS's Tavistock Gender Identity Development Service, per findings in The Cass Review. [22] The Cass Review is one of several systematic reviews done by governments around the world to determine the safety and effectiveness of gender transition medication in minors. "They *unanimously* concluded the evidence on medicalized transition in minors to be of poor quality." Declaration of James M. Cantor Ph.D at 40, *McComb Children's Clinic, Ltd., v. Becerra*, 5:24CV48-LG-ASH (S.D. Miss. filed May 13, 2024). Additionally, "There have been 18 cohort studies of puberty blockers and cross-sex hormones

---

[21] *See, e.g.*, *Public Consultation: Interim service specification for specialist gender dysphoria services for children and young people*, NHS England (Oct. 20, 2022), https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria-services-for-children-and-young-people-22.pdf; *Care of Children and Adolescents with Gender Dysphoria*: *Summary of National Guidelines*, Socialsyrelsen (Dec. 2022), https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf; *Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation*, COHERE Finland (June 16, 2020), https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abedfae46f2e/Summary_minors_en.pdf; Jennifer Block, *Norway's Government is "in Dialogue" With Health Services About Gender Treatments*, 382 BMJ 1572 (2023).

[22] *See* Jasmine Andersson & Andre Rhoden-Paul, *NHS to close Tavistock child gender identity clinic*, BBC NEWS (July 28, 2022), https://www.bbc.com/news/uk-62335665.

in minors. They provide no reliable evidence of effectiveness for improving mental health relative to mental health treatments that lack medical risk." *Id*. at 108.

The Journal of the Danish Medical Association, Ugeskrift for Laeger, explained why the medical professionals in Denmark now provide counseling and support to gender dysphoric minors instead of medications and surgery. After an 8700% increase in gender dysphoria cases between 2014 and 2022 (70% of the cases among girls ages 11-18) and a 65% rate of medically transitioning minors in 2018, studies revealed that "a key assumption [was] now in question…the permanence of transgender identity in youth with longstanding gender dysphoria that intensified in puberty." *Denmark Joins the List of Countries That Have Sharply Restricted Youth Gender Transitions*, Society for Evidence Based Gender Medicine (Aug. 17, 2023), https://segm.org/Denmark-sharply-restricts-youth-gender-transitions. The study also revealed that "there is a much greater proportion of gender dysphoric youth with comorbid mental illness (e.g., 75% in Finland.) These conditions include depression, anxiety, suicidal thoughts/self-harm, autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)" and acknowledged their concern with the "growing rates of detransition among those who initiated transition in youth and a lack of research into the detransition phenomenon." *Id*.

Many medical organizations in the United States have used their clout to protect and expand the

(lucrative) practice of pediatric "gender affirmative" care and degrade any efforts by counselors or medical professionals to provide alternative options to their clients.[23] In response to recent lawsuits and legal challenges, these groups stubbornly insist that the science is settled. *Id.* Support for Colorado's misguided Speech Censorship Law only underscores why gender transitions for minors has wrongly become a political issue rather than a scientific and medical issue.

Some U.S.-based medical organizations are joining their European counterparts and speaking out on the side of caution, science and evidence-based medicine. In February 2024, the American College of Pediatricians published a position statement, explaining that "social transition, puberty blockers and cross-sex hormones have no demonstrable, long-term benefit on the psychosocial well-being of adolescents with gender dysphoria," with the lead author of the statement, Dr. Jane Anderson, writing that "[a] review of at least 60 research papers demonstrates no benefit to social affirmation, puberty blockers, cross-sex hormones or surgical interventions for these youth." Melissa Rudy, *'Gender-affirming' treatments don't benefit youth, says pediatricians group: 'Irreversible consequences,'* FOX NEWS (Feb. 8, 2024), https://www.foxnews.com/health/gender-affirming-

---

[23] *See, e.g.*, *AMA Reinforces Opposition to Restrictions on Transgender Medical Care*, American Medical Association (June 15, 2021), https://www.ama-assn.org/press-center/press-releases/ama-reinforces-opposition-restrictions-transgender-medical-care).

treatments-dont-benefit-youth-pediatricians-group-irreversible-consequences. The Association of American Physicians and Surgeons described "an explosive increase in persons who identify with the construct of gender different from sex, at an age where identity is easily malleable and brain development is not fully concluded," and put out a position statement explaining that GTPs "commit a patient to a lifelong need for medical, surgical, and psychological care," thus making it "medically and ethically contraindicated." *AAPS Statement on "Gender-Affirming Care" for Minor Children*, AAPS (Feb. 20, 2023), https://aapsonline.org/aaps-statement-on-gender-affirming-care-for-minor-children/.

Despite the worldwide recommendations for fully-informed counseling, therapy, and mental health care instead of gender transitioning for minors, Colorado law would force counselors to either vocally support or silently affirm actions that medical professionals agree have "no benefit" for minors. Not only is this unconstitutional; but it is also permanently harmful to an entire generation of children and teenagers who may become permanently physically damaged if Colorado is allowed to control the speech of counselors.

CONCLUSION

The known facts contraindicating medical gender transitions, combined with the growing number of detransitioners, counsels against the speech censorship at issue in this case. Ethical practice – for

licensed counselors, physicians, and other medical professionals – must remain true to the Hippocratic Oath and their duty to "do no harm." They must be free to fully inform and advise all clients of the risks and dangers of gender transition, instead of being forced into silence by a state government whose current law and preferred ideology bars counselors from making evidence-based recommendations, pushes minors into social transitioning, and leads to medications and surgeries which will permanently damage countless minor clients. The Colorado law particularly assumes that no young person experiencing gender dysphoria could ever freely choose to seek counseling to aid him or her in rejecting gender dysphoria. This is patently false, and neither these clients nor any others should be denied the exercise of informed, free speech from their counselors.

Respectfully submitted,

KRISTINE L. BROWN
Counsel of Record
8700 E. JEFFERSON AVE. #370953
DENVER, CO 80237
(720) 285-9552
KRISTI@KRISTIBURTONBROWN.COM

June 13, 2025