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 AMERICAN UNITY FUND AND ETHICS & PUBLIC POLICY CENTER AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE[1]

Amici may not be obvious companions in a case like this. *Amicus* American Unity Fund is a nonprofit organization committed to making the conservative case for the rights and interests of LGBT Americans while advancing the religious liberty and free speech rights of all Americans. *Amicus* Ethics & Public Policy Center is a nonprofit research institution that applies the Judeo-Christian moral tradition to critical issues of policy, law, and culture. These perspectives mean that the undersigned *amici*'s viewpoints sometimes diverge on important issues, including the topic of homosexuality.

But both *amici* agree that minors suffering from gender dysphoria should be entitled to pursue counseling with the licensed, professional counselor of their choice and should not be limited to the solely "affirming" interventions that Colorado law essentially mandates. Accordingly, AUF and EPPC join together to submit this brief informing the Court about the scientific evidence associated with counseling for minors suffering from gender dysphoria. EPPC advocates the availability of this counseling because it has a strong interest in promoting the Judeo-Christian vision of the human person, upholding rights of free speech and religious liberty, and responding to the challenges of gender ideology—issues directly related to this case. AUF advocates for the availability of this counseling

[1] Pursuant to SUP. CT. R. 37.6, amicus certifies that no counsel for any party authored this brief in whole or in part, no party or party's counsel made a monetary contribution to fund its preparation or submission, and no person other than amici or their counsel made such a monetary contribution.

because freedom for all Americans—including the LGBT community—includes the freedom for minors with gender dysphoria to seek out professional counseling with the recipient's counselor of choice.

SUMMARY OF THE ARGUMENT

Through its ban on so-called "conversion therapy," Colorado has outlawed counseling to help resolve gender dysphoria in minors, which is actually the *appropriate* treatment for such minors. In enacting this Counseling Ban, Colorado has elevated adolescents' transient feelings about gender to the status of an immutable characteristic when there are serious uncertainties regarding the etiology of gender dysphoria. For example, it is currently unknown why gender dysphoria is more prevalent among adolescent females, individuals with autism spectrum disorders, and minors who face serious mental-health issues or have experienced troubled childhoods. And the fact that detransitioners exist—individuals who altered their bodies to conform to a concept of gender identity that *later changed*—shows that an adolescent's present "gender identity" is not necessarily a stable concept.

The effect of Colorado's Counseling Ban will likely harm the very people it is supposed to help. By essentially prohibiting counseling to help minors overcome gender dysphoria, Colorado is foreclosing a wholly appropriate intervention for minors. And driving kids down a path of "affirmation" as Colorado now does will likely increase the number of minors who take puberty blockers and cross-sex hormones, causing life-altering physical changes (including a risk of infertility) for no proven benefit. *Amici* submit this

brief to explain why minors should be permitted to obtain the counseling they desire to help them deal with the indisputably serious distress that results from gender dysphoria. The Court should reverse.

ARGUMENT

I. Gender Dysphoria Is A Poorly Understood Psychiatric Diagnosis.

In recent years, we have witnessed an explosion in the number of minors diagnosed with gender dysphoria. This dramatic increase has disproportionately affected adolescent girls. In addition, individuals with autism spectrum disorders or mental-health issues, such as depression and anxiety, are more likely to be diagnosed with gender dysphoria. Currently, no one has any explanation for these phenomena. But whatever the explanation, they show how misguided Colorado's Counseling Ban is.

A. "Gender Identity" Is An Inherently Unstable Concept That Cannot Be Objectively Verified.

"Gender dysphoria" is a psychiatric diagnosis defined by diagnostic criteria set out in the AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION (5th ed. 2022) ("DSM-5-TR"). Although the criteria for gender dysphoria vary slightly for children, adolescents, and adults, the primary indication of the diagnosis is a strong and lasting desire to be the opposite sex and "clinically significant distress or impairment" resulting from that desire. DSM-5-TR at 512-13. An individual's "desire" regarding his or her "sex" is often described as the individual's "gender identity." *See*

Independent Review of Gender Identity Services for Children and Young People: Final Report, NAT'L HEALTH SERV. ENG. 241 (Apr. 2024) ("Cass Review"). And thus, when an individual's present "gender identity" is purportedly different from his "sex," the individual is said to be "transgender." *Id.*

But the concept of "gender identity" is far from well-defined. A researcher cited by Colorado's expert took to the pages of the New York Times last year to explain that "gender identity" is a "feeling." Jack Turban, *I'm a Psychiatrist. Here's How I Talk to Transgender Youth and Their Families About Gender Identity*, N.Y. TIMES (July 8, 2024), https://nyti.ms/3LJRMcv. Dr. Turban explained that there is a "transcendent sense of gender," which "goes beyond language." *Id.* Instead, "people often just *feel* male or female, and some more strongly than others." *Id.* (emphasis in original).

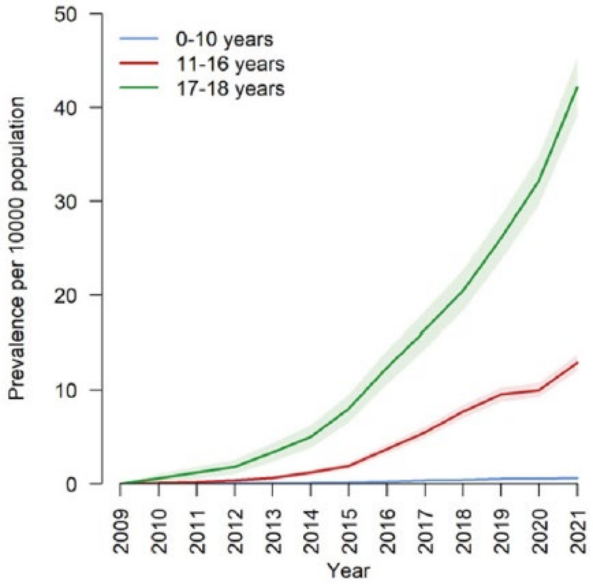
Dr. Turban was right about one thing: It is hard to put the concept of "gender identity" into language. And that is a problem for people drafting laws or making medical decisions. As the United States Department of Health & Human Services recently acknowledged in an exhaustive analysis regarding the treatment of minors with gender dysphoria, "a person's gender identity is subjective"; it is "undetectable by blood tests or neuroimaging"; and it is "otherwise beyond the reach of science." *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, U.S. DEP'T OF HEALTH & HUM. SERVS. 34 & n.24 (May 1, 2025), https://perma.cc/8VS4-M83Z ("HHS Report"); *id.* at 10 (The "diagnosis of gender dysphoria is based entirely on subjective self-reports and

behavioral observations, without any objective physical, imaging, or laboratory markers."); *id.* at 21 ("[T]here are no verifiable physiological or biochemical markers—such as abnormal imaging, lab, or clinical findings—to confirm the [Gender Dysphoria] diagnosis."). This is apparently no concern for Dr. Turban, who said that, although "it's hard to describe this transcendent feeling in words," minors can express their feeling in other ways—for example, "young patients draw themselves as a certain gender and have a 'wow, this is me' feeling." Turban, *supra*. The amorphousness of "gender identity" in minors demonstrates the misguided regime adopted through Colorado's Counseling ban. Here, Colorado is, quite literally, legislating based on the way minors think about their *feelings* surrounding gender. HHS Report at 10 ("The diagnosis [of gender dysphoria] centers on attitudes, feelings, and behaviors that are known to fluctuate during adolescence.").

B. The Unexplained Explosion Of Gender Dysphoria In Particular Patient Populations Undercuts The Basis For Colorado's Counseling Ban.

It is undisputed that the number of minors diagnosed with gender dysphoria has skyrocketed in recent years. "Over the past decade, the increase in patients has been described as exponential." HHS Report at 65; *see also* Cass Review at 26 (noting "the exponential change in referrals [for gender dysphoria] over a particularly short five-year timeframe"). The following chart displays the increased prevalence of gender dysphoria among minors in the United

Kingdom based on patient data from general practices across the UK:

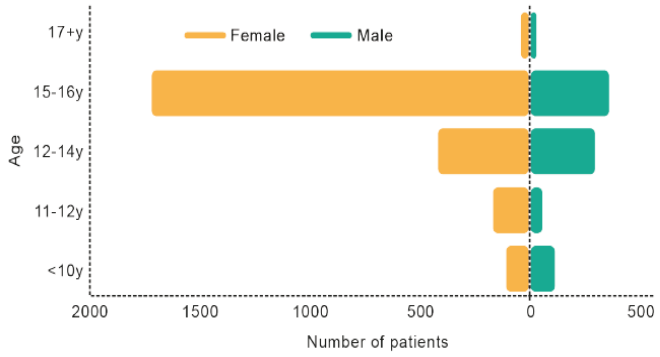


Cass Review at 87. As the chart shows, there have been massive increases in the percentage of minors aged 11-18 who have been diagnosed with gender dysphoria—with a particularly striking increase among minors aged 17-18. And even among minors, three particular patient groups are more likely to be diagnosed with gender dysphoria: (1) adolescent females, (2) individuals with Autism Spectrum Disorders, and (3) individuals with serious mental-health issues or troubled childhoods.

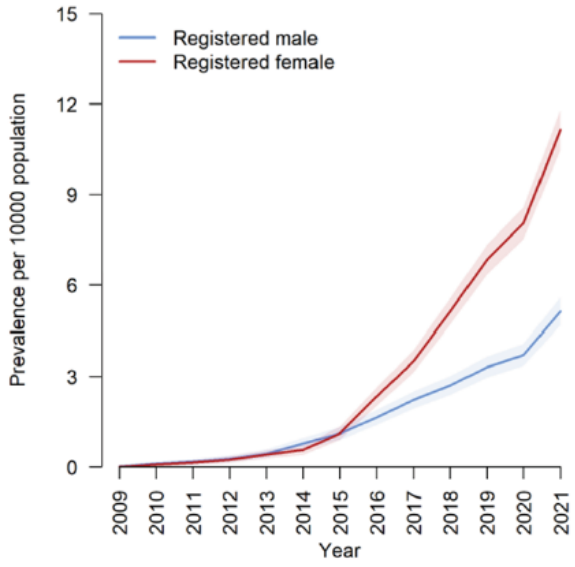
Adolescent Females. "One striking characteristic of the surge of adolescents presenting with a wish to undergo medical transition is the disproportionate number of female adolescents[.]" HHS Report at 60; *see also* Cass Review at 26 (describing the how the

"increase has disproportionately been seen in birth registered females presenting in adolescence"). The following charts display two features of this development.

Figure 12: Distribution of patient's age on referral and birth-registered gender on referral to GIDS, 1 April 2018 to 31 December 2022



Cass Review at 86.



Id. at 87. The top chart displays the breakdown between adolescent males and females for gender dysphoria in the UK—showing that the number of females with gender dysphoria dwarfs the number of males. Based on the same data, the bottom chart reflects the increase in prevalence of gender dysphoria among male and female minors in the UK. These two charts thus show not only that adolescent females are significantly more likely to be diagnosed with gender dysphoria, but also that the *increase* in diagnoses for gender dysphoria disproportionately affects adolescent females. There is no explanation for these dramatic distinctions between boys and girls.

Autism Spectrum Disorders. Another unexplained phenomenon is the overrepresentation of individuals with autism spectrum disorders (ASD) among those who have been diagnosed with gender dysphoria. "The high prevalence of ASD among youth presenting with [gender dysphoria] has been recognized for some time." HHS Report at 65. "Some research studies have suggested that transgender and gender-diverse individuals are three to six times more likely to be autistic than cisgender individuals[.]" Cass Review at 93. In addition, the increase of gender dysphoria in adolescent females overlaps with the increase in gender dysphoria among individuals with autism spectrum disorders because autism "is often missed in adolescent girls." *Id.*

Mental Health Issues & Troubled Childhoods. Another feature of the new patient population is extensive mental-health problems. "The current patient population has a high rate (relative to the general population) of comorbid mental health problems,

including depression, anxiety, suicidality, self-harm, and eating disorders[.]" HHS Report at 65. Research conducted with the national healthcare database in Finland "found that 75% of patients presenting to [pediatric gender medicine] clinics in the mid-2010s had severe mental health problems that appeared to have *predated* the emergence of [gender dysphoria.]" *Id.* And research regarding the UK's major gender clinic revealed that "rates of depression, anxiety, and eating disorders were higher in the gender clinic referred population than in the general population." Cass Review at 91.

In addition, minors with gender dysphoria disproportionately experienced troubling childhoods. UK Researchers conducted a systematic review of all studies documenting patient characteristics. *See* Jo Taylor et al., *Characteristics of Children and Adolescents Referred to Specialist Gender Services: A Systematic Review*, ARCHIVES DISEASE CHILDHOOD (2024), https://perma.cc/QKH2-UM24. This review found that studies reporting on adverse childhood experiences "demonstrated high rates amongst children and young people" referred to the UK's gender clinic. Cass Review at 94. Those rates included high-end estimates of the minors who had faced tragic childhood experiences, including the following data: up to 67% had faced "combined neglect or abuse," up to 19% had faced "sexual abuse," nearly 50% had experienced "mental illness or substance abuse" by their mother, and nearly 25% had been "expos[ed] to domestic violence." *Id.*

C. Detransitioners Show That Minors Should Have Access To Counseling That Does More Than Merely Affirm Their Present Gender Identity.

"Some adolescents transition and later detransition, reverting to living as their sex[.]" HHS Report at 30. Unfortunately, we do not have refined data analyzing the experience of detransitioners "due to the lack of long-term follow up studies[.]" Cass Review 33. But the data we do have is startling. Indeed, "[r]esearch into experiences of detransition" has "suggested social influence or pressure have played a role in the transient transgender identifications of some patients." HHS Report 67. Online surveys for self-identified detransitioners have revealed that the *leading* reason for detransitioning is that the individual "[r]ealised that my gender dysphoria was related to other issues." Cass Review at 189. A review of detransitioners at the UK's gender clinic demonstrated "[c]ommon presenting features and risk factors such as high levels of adverse childhood experiences, alexithymia (inability to recognize and express their emotions) and problems with interoception (making sense of what is going on in their bodies)." *Id.*

The fact that detransitioners exist should be a serious concern for proponents of Colorado's law. A similar concern should be minors who identify as "gender fluid"—*i.e.*, they "see themselves as being anywhere on a spectrum from gender non-conforming through to binary trans," and their identity along that spectrum may change. *Id.* at 108 (noting that young people who identify this way may "remain fluid in their gender identity for an extended period"). These concepts—

which demonstrate that an adolescent's gender identity can and does change—cut against the proposition that adolescents should only be able to obtain counseling that affirms their present gender identity.

* * *

In sum, "the nature and causes of gender dysphoria/incongruence are complex and poorly understood, and there is very limited understanding of the currently presenting population of predominantly birth-registered adolescent females." *Id*. at 193. Despite this poor understanding and the inherent instability in the concept of "gender identity," Colorado has essentially banned counseling that seeks to help minors suffering from gender dysphoria—which is a wholly appropriate approach for helping those young people deal with and overcome gender dysphoria.

II. Counseling Is An Entirely Appropriate Treatment For Minors With Gender Dysphoria.

The treatment of gender dysphoria in minors consists of two radically different approaches. One approach consists of providing psychotherapeutic support (including counseling) to children and adolescents to help them deal with the psychological distress they are experiencing. Another approach, so-called "gender-affirming care," primarily consists of changing the patient's body through the use of puberty blockers, cross-sex hormones, and surgeries to satisfy the patient's conception of what his or her body *should* look like—*i.e.*, to "transition" the patient's body to align with the patient's present "gender identity." But researchers and health authorities around the world

have recognized that there is no reliable evidence that medicalized and surgical gender transitions help resolve gender dysphoria.

A. Scientists And Health Authorities Around The Globe Agree That The Severe Risks Of Transitioning Outweigh Any Purported Benefit.

The practice of medicine turns on a relationship between the risk and benefit of a particular treatment. "[C]linicians must ensure, insofar as reasonably possible, that any interventions they offer to patients have clinically favorable risk/benefit profiles relative to the set of available alternatives[.]" HHS Report at 217. This analysis turns on evidence. But not all medical evidence is created equal, and researchers have spent decades developing the practice of "evidence-based medicine" to help clinicians make informed decisions. *See* GORDON GUYATT ET AL., USERS' GUIDES TO THE MEDICAL LITERATURE: ESSENTIALS OF EVIDENCE-BASED CLINICAL PRACTICE, JAMAEVIDENCE 10 (3d ed. 2015), https://perma.cc/H46Z-NKEC ("Evidence-Based Medicine User Guide"). Following the principles of evidence-based medicine, researchers and health authorities around the world have concluded that no reliable evidence justifies the use of gender-affirming care over counseling and other forms of psychotherapy in minors.[2]

[2] The terms "counseling" and "psychotherapy" are often used interchangeably and both refer, at least in part, to forms of talk therapy, in which a patient converses with a professional about psychological, emotional, and social challenges. Both

1. There Is No Reliable Evidence That "Transitioning" A Minor's Body Resolves Gender Dysphoria.

The highest form of medical evidence is a "systematic review," which is "a summary of research that addresses a focused clinical question in a systematic, reproducible manner." *Id.* at 272. Essentially, researchers conducting a systematic review begin by formulating the relevant question they are investigating and specify selection criteria for studies that will help answer that question. *Id.* at 274-75. "Having specified their selection criteria, reviewers will conduct a comprehensive search of the literature in all relevant medical databases, which typically yields a large number of potentially relevant titles and abstracts." *Id.* "They then apply the selection criteria to the titles and abstracts, arriving at a smaller number of articles that they retrieve." *Id.* at 275. "Having completed the culling process, the reviewers assess the risk of bias of the individual studies and abstract data from each study." *Id.* This part of the process—assessing the risk of bias of the individual studies—helps explain why systematic reviews are the best form of medical evidence: They pool all the research and then assess *the reliability* of the existing research to determine the *quality* of the evidence for a particular question.

Numerous systematic reviews have been performed to assess the benefit of "gender-affirming care" for minors; all of them have concluded the evidence is

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terms are used throughout this brief to refer to this kind of talk therapy, which Colorado's Counseling Ban forbids as treatment for gender dysphoria.

weak. First, Finland's health authority (the Council for Choices in Healthcare or COHERE) conducted a systematic review in 2020. HHS Report at 142. "Finnish authorities concluded that the body of evidence supporting puberty blockers and cross-sex hormones for youth is inconclusive." *Id.* Second, in 2022, researchers at McMaster University—a leader in evidence-based medicine—completed a systematic review at the request of the Florida Agency for Health Care Administration. *See* Romina Brignardello-Petersen & Wojtek Wiercioch, *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence* (May 16, 2022), https://perma.cc/S4A3-NKDY. "Due to the important limitations in the body of evidence," they concluded, "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria." *Id.* at 5. Third, Swedish researchers published a systematic review that was commissioned by Sweden's Agency for Health Technology and Assessment of Social Services in 2023. *See* Jonas F. Ludvigsson et al., *A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research*, 112 ACTA PAEDIATRICA 2279 (2023), https://perma.cc/E7S9-7CLB. This review concluded that the "[e]vidence to assess the effects of hormone treatment" on (among other things) "mental health" in minors "with gender dysphoria is insufficient." *Id.* at 2280.

Last year, researchers from York University published a series of systematic reviews as part of the Cass Review—which is an independent review commissioned by the United Kingdom's National Health

Service and that has provided an in-depth analysis of the concerns regarding the treatment of gender dysphoria in minors using data from the UK's health system. *See* Jo Taylor et al., *Interventions To Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, ARCHIVES DISEASE CHILDHOOD (2024), https://perma.cc/J3BT-93CK ("Taylor – Puberty Blockers"); Jo Taylor et al., *Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, ARCHIVES DISEASE CHILDHOOD (2024), https://perma.cc/J3BT-93CK ("Taylor – Cross-Sex Hormones"). In their review of puberty blockers, the researchers concluded that their "findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the effects of puberty suppression on gender dysphoria, body satisfaction, psychological and psychosocial health, cognitive development, cardiometabolic risk and fertility." Taylor – Puberty Blockers at 12. Similarly, in their review for cross-sex hormones, the researchers concluded that their "findings add to other systematic reviews in concluding there is insufficient and/or inconsistent evidence about the risks and benefits of hormone interventions in this population." Taylor – Cross-Sex Hormones at 6.

In May 2025, the United States Department of Health and Human Services published "an overview of systematic reviews—also known as an 'umbrella review.'" HHS Report at 13. This review "found that the overall quality of evidence concerning the effects of any intervention on psychological outcomes, quality of life, regret, or long-term health, is very low." *Id.* This finding "indicates that the beneficial effects reported

in the literature are likely to differ substantially from the true effects of the interventions." *Id.* "In other words, the best available evidence indicates that PBs [puberty blockers], CSH [cross-sex hormones], and surgery have not been shown to improve mental health outcomes." *Id.* at 218.

In sum, every systematic review on this topic has concluded the same thing: There is no reliable evidence to justify the use of puberty blockers, cross-sex hormones, and surgeries as a treatment for gender dysphoria in minors.

2. The Harms Of Medically And Surgically Transitioning Minors Vastly Outweigh Any Harm Associated With Counseling.

As mentioned above, medical decisions turn on a balancing of risks and benefits. And while there is no evidence that "gender-affirming care" improves mental-health outcomes, "there is increasing recognition of the risks and harms associated with [it]." HHS Report at 218. This list of harms includes "impaired cognitive function, greater susceptibility to hormone-sensitive cancers, cardiac disease, reduced bone density, sexual dysfunction, infection, and infertility." *Id.*

Moreover, any proposed intervention must be compared to the risk-benefit profile of *alternative* interventions. *See id.* at 218-19. In this context, "a relevant alternative is some combination of psychotherapeutic interventions." *Id.* at 219. And "a systematic review of the evidence found no evidence of negative or adverse effects in any of the studies examined" for determining potential harms of these interventions. *Id.*

(citing Claire Heathcote et al., *Psychosocial Support Interventions for Children and Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, 109 ARCHIVES DISEASE CHILDHOOD S19 (2024), https://perma.cc/9SR9-WFNF). Therefore, on one side (medicalized and surgical transition) we have almost no evidence of benefit and the risk of dramatic harms, including infertility, cancer, and decrease in cognitive function; on the other side (counseling) there is similar evidence of benefit but there are essentially *no* harms. Thus, counseling should clearly be the preferred approach.

This relationship explains why health authorities around the world have determined that counseling and psychotherapy should be the primary treatment for minors with gender dysphoria. In Sweden, Finland, and the UK, "[p]sychotherapy is now the recommended first-line treatment[.]" HHS Report at 246.

- "Per England's National Health Service (NHS): The primary intervention for children and young people… is psychosocial (including psychoeducation) and psychological support and intervention[.]'" *Id* at 246-247. (citation omitted).

- "Per Finland's Council for Choices in Health Care in Finland (COHERE): The first-line treatment for gender dysphoria is psychosocial support and, as necessary, psychotherapy and treatment of possible comorbid psychiatric disorders." *Id* at 247. (citation omitted).

- "Per Sweden's National Guidelines": "'Psychosocial support that helps adolescents deal with natal puberty without medication needs to be the first option when choosing care measures.'" *Id.* (citation omitted).

In sum, health authorities following the principles of evidence-based medicine have concluded that counseling or psychotherapy as a treatment for gender dysphoria—the very practice that Colorado is prohibiting here—should be the *primary* treatment for minors.

B. Several Evidence-Based Methods Of Counseling Can Be Adapted To Treat Gender Dysphoria In Minors.

There have been limited studies tailored exclusively to measuring the benefit of counseling as a treatment for gender dysphoria. The impulse behind laws like Colorado's are at least partially to blame. As HHS has explained, the "evidence gap" between the effect of counseling and other forms of psychotherapy on nearly every other mental-health condition and its effect on gender dysphoria "may be due to a conflation of psychotherapy with 'conversion therapy.'" HHS Report at 88. The Cass Review likewise noted that the "role of psychological therapies in supporting children and young people with gender incongruence or distress has been overshadowed by an unhelpfully polarised debate around conversion practices." Cass Review at 150.

Specifically, "[p]ublic and academic debates over what constitutes 'conversion' in the context of youth

with [gender dysphoria] have been hindered by the politicization of the issue." HHS Report at 253. The primary problem is that the concept of "conversion therapy" does not map onto counseling related to gender identity. "'Conversion therapy'—sometimes called 'reparative therapy'—originally referred to efforts to change the sexual orientation" of an individual. *Id.* at 252. That is nothing like what is happening with respect to counseling for gender dysphoria. Indeed, some assert that medical and surgical gender transitions are the *real* conversion therapy in this context because "altering a person's body in response to distress rooted in internalized social disapproval" with respect to the person's present gender identity "is no more appropriate than attempting to change someone's sexual orientation for similar reasons." *Id.* at 253. And "[d]iscussions about the role of psychotherapy in the treatment of youth with [gender dysphoria] suffer from internal inconsistencies in the field of gender medicine, whereby psychotherapy is both recognized as an important tool but is also stigmatized if its aim is the resolution of [gender dysphoria]." *Id.* at 88. Colorado's Counseling Ban plays directly into this inconsistency by permitting counseling with respect to an adolescent's gender dysphoria but only in one direction—to affirm the adolescent's present gender identity.

Thus, "there has been a failure to systematically consider how psychosocial interventions should be used and to research their efficacy." *Id.* at 89. But counseling and other forms of psychotherapy as a treatment for psychological disorders is both commonplace and common sense. "Psychotherapy is the least invasive intervention for addressing psychological distress, regardless of its etiology, and it has been

recognized as the international standard of care for a wide range of mental health diagnoses." *Id.* at 247. For example, "psychotherapy as an effective intervention for depression, the most common mood disorder, has been studied extensively and is supported by high-quality evidence." *Id.* at 248.

As HHS recently explained, psychotherapy "is a well-suited intervention" for minors with gender dysphoria. *Id.* at 257. It "is intended to help patients develop self-understanding, engage with emotional vulnerability, and build practical strategies for managing distress." *Id.* HHS has outlined three types of psychotherapy that can potentially be used to help resolve a minor's gender dysphoria:

Behavioral Therapy: Two types of behavioral therapy—cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT)—can be adapted to treat gender dysphoria. Both "approaches are performed according to manualized instructions that provide structure and standardization" (and are thus sometimes referred to as "manualized approaches"). *Id.* at 258. These approaches "are evidence-based treatment for mental health problems that co-occur with GD [gender dysphoria], such as depression, anxiety, and eating disorders." *Id.* As HHS explains, CBT and DBT "can help patients identify thoughts and feelings related to sex-based distress, including cognitive distortions." *Id.* And therapists "can help patients develop healthy coping skills for managing this specific type of distress[.]" *Id.*

Psychodynamic Therapy: A "psychoanalytic approach that involves exploration of ego defenses and

unconscious motivations" is referred to as "psychodynamic psychotherapy." *Id.* at 259. "This approach is evidence-based for mental health conditions that co-occur with GD [gender dysphoria]." *Id.* Specifically, it "can help patients gain deeper understanding of their personal identity, including any external factors that may contribute to their cross-sex identification and desire for medical/surgical interventions." *Id.* "Additionally, psychodynamic work around the theme of cross-sex identification or sex-related distress can facilitate exploration of patients' early childhood experiences, family of origin, beliefs/values system, and interpersonal patterns in familial and romantic relationships as well as in school/work environments." *Id.*

Family Therapy: "This approach identifies problems affecting the patient and the family unit and aims to strengthen familial bonds and improve communication skills, by supporting work around attachment ruptures, communication, and understanding different family members' perspectives." *Id.* "Family therapy is an evidence-based approach to treating adolescent eating disorders, where familial distress and embodied distress are heightened, as in GD [gender dysphoria]." *Id.*

All of these approaches to resolving gender dysphoria in minors are banned (or, at the very least, chilled) by Colorado's Counseling Ban.

III. Colorado's Counseling Ban Will Likely Drive Minors Toward Harmful Medical And Surgical Gender Transitions.

Through its Counseling Ban, Colorado has effectively outlawed the most responsible treatment for

gender dysphoria in minors and the best alternative to "gender affirming care." The result is that, for minors suffering from gender dysphoria in Colorado who are seeking treatment or counseling, a pathway of "affirmation" is the only option. This will have devastating effects because it will steer minors toward medical and surgical gender transitions.

Specifically, evidence suggests that "affirming" an adolescent's gender incongruence increases the likelihood of that adolescent continuing down the medical and surgical treatment pathway. Often the process starts with "social transition," which "involves changing one or more aspects of one's presentation or expression, such as name, appearance, or behavior, with the goal of being perceived and treated as a member of the other sex, or to avoid being perceived and treated as a member of one's own sex." HHS Report at 84. Although some may think of social transition as benign, the Cass Review explains that "it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning and longer-term outcomes." Cass Review at 158. It is not difficult to understand that a male adolescent showing up to school in a dress could have a psychological effect on the boy. It is thus likely that this process of social transition will *worsen* a minor's understanding of his or her body and thus increase the likelihood of continuing to medicalized transition through puberty blockers. Indeed, some "studies suggest that early social transition is associated with a high rate of persistence of GD [gender dysphoria]" and a greater than 90% likelihood of continuing to puberty blockers and cross-sex hormones. HHS Report at 89. Thus, the process

from social transition to puberty blockers may no longer be "seen as a reversible 'pause button'" and may instead be "more like a 'gas pedal' that accelerates medical transition." *See id.* at 71.

By sending minors down this path through the Counseling Ban, Colorado is potentially increasing the likelihood of minors being subjected to *medicalized* transition with puberty blockers and cross-sex hormones. The CounselingBan cannot plausibly be defended as either "evidence based" or beneficial to the health of minors.

CONCLUSION

For these reasons, the Court should reverse the judgment below.

Respectfully submitted,

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