No. 23-477

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

v.

JONATHAN THOMAS SKRMETTI, Attorney General and Reporter for Tennessee, *et al.*,

Respondents.

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

BRIEF OF *AMICI CURIAE* ISABELLE AYALA, JILL DOE, SOREN ALDACO, AND JANE SMITH IN SUPPORT OF RESPONDENTS

JOSHUA K. PAYNE
Counsel of Record
JORDAN CAMPBELL
RONALD MILLER
DANIEL SEPULVEDA
CAMPBELL MILLER PAYNE, PLLC
5955 Alpha Rd #1491
Dallas, Texas 75240
(214) 316-7156
josh@cmppllc.com

Counsel for Amici Curiae

October 15, 2024

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D.C. 20002

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	2
I. *Amici* Know from Personal Experience That Youthful Gender Transition Is Harmful	2
II. Scientific Evidence Demonstrates That Youthful Gender Transition Is Harmful	23
A. Encouraging Children to Transition Changes Outcomes by Preventing Natural Desistance	23
B. Detransitioning Is on the Rise, and Also Shows That Young People Become Comfortable with Their Sex over Time.	25
C. Evidence Is Lacking for Benefits That Would Outweigh the Clear Harms of Transitioning to Minors.	27
CONCLUSION	29

TABLE OF AUTHORITIES

CASES Page(s)

L. W. by & through Williams v. Skrmetti, 83 F.4th 460 (6th Cir. 2023) 27

COURT FILINGS

Expert Report of James M. Cantor, PhD, *Poe v. Labrador,* No. 1:23-cv-00269 (D. Idaho), ECF 56-4 23

OTHER AUTHORITIES

Aaron Sibarium, *The Hijacking of Pediatric Medicine*, The Free Press, Dec. 7, 2022, https://www.thefp.com/p/the-hijacking-of-pediatric-medicine 5-6

Azeen Ghorayshi, *Medical Group Backs Youth Gender Treatments, but Calls for Research Review*, N.Y. Times, Aug. 3, 2023, https://tinyurl.com/bdckjfsj 6

Carly Guss, et al., *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, 27(4) Curr. Opin. Pediatr. 421-426 (2015) 24

Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69(9) J. Homosex. 1602-1620 (2022), Epub Apr. 30, 2021 25

TABLE OF AUTHORITIES—Continued

Page(s)

Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, The Cass Review (April 2024), https://tinyurl.com/3st6ftkh 27, 28

Isabel Boyd, et al., *Care of Transgender Patients: A General Practice Quality Improvement Approach*, 10(1) Healthcare 121 (2022).. 26

J. Straub, et al., *Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery*, 16(4):e57472 Cureus 1-9 (2024). 28

James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46(4) J. of Sex & Marital Therapy 307-313 (2020), Epub Dec. 14, 2019 5

Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 (4) Pediatrics (2018)........................... 5

Laura Edwards-Leeper & Erica Anderson, *The Mental Health Establishment Is Failing Trans Kids*, Wash. Post, Nov. 24, 2021, https://tinyurl.com/52ktuhyy.......... 26

Lindsay Kornick, *Detransitioner sues American Academy of Pediatrics, accuses it of pressuring gender change on youths*, Fox News, Oct. 26, 2023, https://tinyurl.com/56ryvxtw 8

TABLE OF AUTHORITIES—Continued

Page(s)

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) 25-27

Lisa Marchiano, *Gender Detransition: A Case Study*, 66(4) J. of Anal. Psychol. 813-832 (2021) 26

Pamela Paul, *As Kids, They Thought They Were Trans. They No Longer Do.*, N.Y. Times, Feb. 2, 2024, https://tinyurl.com/2jv8md99 27

Pamela Paul, *Why Is the U.S. Still Pretending We Know Gender-Affirming Care Works?*, N.Y. Times, July 12, 2024, https://tinyurl.com/43t7u29z 28

Pien Rawee, et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Arch. Sex. Behav. 1813-1825 (2024) 23

R. Hall, et al., *Access to Care and Frequency of Detransition Among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review*, 7(6):e184 BJPsych Open. 1-8 (2021) 26

Sex Matters, *Dispelling the suicide myth*, May 10, 2024, https://tinyurl.com/2mcwr6cy 7

TABLE OF AUTHORITIES—Continued

Page(s)

Thomas D. Steensma, et al., *Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) J. Am. Aca. Child Adolesc. Psychiatry 582-590 (2013).. 24

Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. of Clinic. Endocrin. & Metab. 3869-3903 (2017).. 24

INTEREST OF *AMICI CURIAE*

Amici Curiae Isabelle Ayala, Jill Doe, Soren Aldaco, and Jane Smith respectfully submit this brief in support of Respondents.[1] *Amici* experienced gender dysphoria when they were children and adolescents. They were led to believe that "affirming" perceptions of themselves as members of the opposite sex for the purpose of "gender transition" would resolve their gender dysphoria and permit them to live healthy, well-adjusted lives.

Sadly, *Amici* learned through their experiences that such affirmation did not resolve their mental health issues or gender dysphoria. Instead, the pathway they were led down, which included social transitioning and medical interventions such as puberty blockers, cross-sex hormones, and surgeries, only caused physical harm and increased their distress as they realized their bodies had been irreversibly altered based upon a false promise.

Amici respectfully submit this brief to provide this Court with an understanding of the experiences of detransitioners, the evidence showing that gender transition is harmful, and the evidence showing that gender dysphoria often resolves when children are allowed to grow up naturally without being steered into a path of medical or social transition.

---

[1] A pseudonym is being used to protect the identity of *Amici* Jill Doe and Jane Smith and their family members. No counsel for a party authored this brief in whole or in part, and no person other than *Amici* or their counsel made a monetary contribution intended to fund the preparation or submission of the brief.

SUMMARY OF ARGUMENT

Isabelle Ayala, Jill Doe, Soren Aldaco, and Jane Smith are living proof that "affirming" a young person to identify as the opposite sex is deeply harmful. These individuals experienced gender dysphoria when they were children and adolescents. They were led to believe that social and medical gender transition, including puberty blockers, cross-sex hormones, and surgical procedures, would resolve their gender dysphoria and permit them to live healthy, well-adjusted lives.

Sadly, *Amici* learned through their experiences that transitioning did not resolve their mental health issues or gender dysphoria, but only caused physical harm and increased their distress as they realized their bodies had been irreversibly altered based upon a false promise.

Consistent with the experiences of the *Amici*, available evidence shows that gender dysphoria usually resolves on its own or through counseling a young person to cope with the reality of their natural sex. Social and medical transition is thus unnecessary and often harmful. Furthermore, evidence is lacking for benefits that would outweigh the clear harms of transitioning to minors.

ARGUMENT

I. *Amici* Know from Personal Experience That Youthful Gender Transition Is Harmful

Isabelle Ayala

Isabelle struggled with her mental health from a very early age. Such issues ran in her family, including

anxiety disorder, bipolar disorder, depression, and post- traumatic stress disorder. At the age of seven, while living with her parents and two half-brothers, Isabelle was sexually assaulted. The following year, at the age of eight, Isabelle experienced early-onset puberty, all too often a consequence for sexual assault victims.

Isabelle felt uncomfortable with the changes to her body elicited by early-onset puberty, and her discomfort was exacerbated by the sexual trauma she endured. Puberty, and the changes that came with it, "just didn't feel right at all" in Isabelle's view. The sexual trauma haunted her and contributed to a profound insecurity that pushed Isabelle to begin looking for help.

Around age 11, as her body continued conforming to that of a woman and her apparent body dysmorphia persisted, Isabelle began cutting herself, often doing so multiple times a day. The relief she found in harming herself in this way was fleeting, lasting only minutes. Even so, as a sign of her desperation and the growing severity of her depression and anxiety, she would continue harming herself in this way for many years.

It was also around the age of 11 that Isabelle—still in her profound state of desperation and with growing depression and anxiety—engaged substantively in social media interactions for the first time, creating profiles on Instagram, Kik, and Tumblr, among others. These social media interactions introduced Isabelle to the concept of being "trans," an idea that immediately gained traction in her mind since Isabelle's life experiences to that point taught her that to be a woman is to be vulnerable. Within months, to distance herself from the trauma she endured as a young girl,

Isabelle began to identify as a boy within her group of close friends.

The following summer, at the age of 12, Isabelle came out to her mom, explaining to her that she wanted to be a boy. Isabelle recalls that "it did not go well." Amidst "a lot of crying and screaming," Isabelle's mother explained that Isabelle "would regret it," and that it "was just a phase" because Isabelle "did not show signs [of being transgender] when she was really little."

The following 12 months were especially turbulent for Isabelle. In her vulnerable mental state, she was convinced—by social media influences and the depth of her pain and despair as a sexual assault victim—that the solution to her mental anguish was to transition from what she viewed as a weak, vulnerable, 13-year-old girl to a strong, confident, independent boy. Her mother, on the other hand, remained certain that Isabelle's interest in transitioning was simply a phase and her mother was adamant that proper counseling, not rushing into a purported gender transition, would help resolve Isabelle's distress. Isabelle's mental health continued to decline, however, so much so that she began to eat demonstrably less out of a phobia of getting pregnant despite not being sexually active at all.

Isabelle's determination to pursue the path of medicalization grew to the point that she was ready to do or say whatever she needed to get what she thought would help her. Acting on this self-diagnosis, Isabelle bought a chest binder from a vendor on the internet. Without the guidance or direction of a medical practitioner, but only on the advice of the influence she found on the internet, she began to bind her chest to pacify her discomfort with her female figure. She also

engaged in "speech exercises" she found online to strain her voice, attempting to force it into a masculine pitch range.

Her mother continued to insist that this was the wrong path and would only make things worse. After realizing that she would not be able to talk her daughter out of these thoughts easily, Isabelle's mother encouraged Isabelle to at least wait until she was an adult before allowing anyone to provide her with irreversible medical interventions. Isabelle's father, on the other hand, was content to help Isabelle pursue whatever made her happy in the short term.

It was during this tumultuous time that Isabelle's parents separated, compounding Isabelle's grief. When Isabelle was 13 years old, she moved from Florida to Rhode Island with her father and half-brother, leaving behind her mother and her friends. Isabelle and her father had begun to discuss the possibility of seeing a gender therapist as a next step.

Shortly after turning 14, in February 2017, Isabelle was hospitalized for suicidal ideation. During her week-long inpatient stay at the pediatric psychiatric ward, the medical providers referred Isabelle to a resident physician, Dr. Jason Rafferty, who, unbeknownst to Isabelle, would author the American Academy of Pediatrics' gender policy statement published the following year.[2] During Isabelle's initial

[2] The AAP policy statement was published in October 2018. *See* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 (4) Pediatrics (2018). The policy statement has been criticized as unsupported by adequate evidence and riddled with errors. *See* James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46(4) J. of Sex & Marital Therapy 307-313 (2020), Epub Dec. 14, 2019; Aaron

visit with Dr. Rafferty, she—in her deeply compromised mental state—told him that her growing suicidality was related to her level of discomfort with her natal sex and her inability to transition due primarily to her mother's refusal. She was convinced that getting rid of her secondary sex characteristics, dissociating herself from the vulnerable female she was when she was attacked at seven years old, and becoming a boy was the only way to treat her mental health struggles.

At that same meeting, however, Isabelle also shared with Dr. Rafferty a major hesitation regarding her desire to medically transition, namely, "that [she] might want to have a biological child."[3] She further explained, "[g]iving birth really fascinates me and I think it is a beautiful thing," reflecting the fact that even at 14 years old she could sense the unique bond between a mother and a child.

Even so, in a matter of minutes and based substantially, if not exclusively, on the endorsements of Isabelle set forth above, Dr. Rafferty concluded that Isabelle "would benefit [from] and meets criteria to consider hormonal transition," noting only a single

---

Sibarium, *The Hijacking of Pediatric Medicine*, The Free Press, Dec. 7, 2022, https://www.thefp.com/p/the-hijacking-of-pediatric-medicine. In August 2023, the AAP recognized the need for additional study, but reaffirmed the policy statement anyway, "'very clearly putting the cart before the horse.'" Azeen Ghorayshi, *Medical Group Backs Youth Gender Treatments, but Calls for Research Review*, N.Y. Times, Aug. 3, 2023, https://tinyurl.com/bdckjfsj (quoting Dr. Gordon Guyatt, a clinical public health researcher at McMaster University who helped develop the field of evidence-based medicine).

[3] Isabelle was able to overcome her prior phobia of pregnancy through therapy in the intervening months.

"concern," namely "parental (maternal) refusal." Dr. Rafferty formed these conclusions in spite of the fact that Isabelle had just undergone inpatient mental health evaluation and treatment, and the fact that Isabelle had expressed the desire to give birth to a child someday.

Soon after, Dr. Rafferty convinced Isabelle and her parents that putting Isabelle on testosterone was the only viable treatment for her mental health struggles. Dr. Rafferty did not disclose the absence of scientific evidence supporting this type of medical intervention, or the fact that he was working on the AAP policy statement promoting it. In effect, Isabelle was being experimented on without her or her parents' knowledge or consent. Additionally, Isabelle's parents were subjected to "emotional blackmail" by being told if they did not consent to cross-sex hormone treatment, Isabelle would kill herself.[4]

The testosterone Dr. Rafferty prescribed did not cure Isabelle's mental health problems. In fact, her depression and anxiety worsened, culminating in her attempting suicide for the first time later that year. Dr. Rafferty did not stop Isabelle's testosterone prescription in response. Instead, he encouraged Isabelle to extend her medical transition as the solution to her problems and pursue surgery.

Isabelle eventually returned to Florida and continued taking testosterone before deciding to quit "cold turkey." Off the cross-sex hormones, she gradually

---

[4] This pressure technique—asking parents if they would "prefer to have a dead daughter or a living son"—has become so common in "gender-affirming" care for minors that it is known as "the suicide myth." *See* Sex Matters, *Dispelling the suicide myth*, May 10, 2024, https://tinyurl.com/2mcwr6cy.

grew out of her gender dysphoria and began to become more comfortable with her female body, altered as it was from taking testosterone. She realized she was not a boy and never could have been one. Instead, she realized that her mental health issues and discomfort in her body were likely the result of her childhood trauma and other mental health comorbidities, and she detransitioned.

In addition to her psychological and emotional injuries, Isabelle's body underwent irreversible physical changes and suffered permanent damage. She has experienced significant vaginal atrophy; her voice has been permanently altered; she has to deal with excess facial and body hair and the accompanying stress and mental anguish that brings; she struggles with compromised bone structure; she is unsure whether her fertility has been irreversibly compromised; and she developed Hashimoto's disease, an autoimmune disease that only the males in her family have a history of, from taking testosterone. She still deals with episodes of anxiety and depression, complicated by the regret of feeling like she had made a mistake in choosing to transition, even though she knows that she was actually just a vulnerable young girl who was taken advantage of by people whom she trusted would take care of her.[5]

[5] Isabelle filed a lawsuit against Dr. Rafferty and the American Academy of Pediatrics for conspiring to publish a fraudulent policy statement on medical intervention and experimenting on her without her consent. *See* Lindsay Kornick, *Detransitioner sues American Academy of Pediatrics, accuses it of pressuring gender change on youths*, Fox News, Oct. 26, 2023, https://tinyurl.com/56ryvxtw.

Jill Doe

As a young child, Jill was what most would consider a stereotypical young girl. She never felt like or identified as a boy but rather was always what many would consider a "girly-girl." She enjoyed choir, dance, theater, and loved to collect dolls.

Around the ages of six and seven, Jill endured prolonged sexual abuse. Understandably, as her childhood progressed, she began to suffer from a complex array of mental health issues. Jill's mental health struggles included, among others: anxiety, depression, undiagnosed post-traumatic stress disorder (PTSD), and potentially bipolarism and autism, which certain of her mental health providers had suggested.

When Jill turned 11, around the onset of puberty, she began struggling with the thought of developing into a woman, not surprising given the sexual abuse she had suffered, which at that time had still never been addressed or asked about by anyone. It was around this time that Jill started meeting with a school counselor to discuss issues related to her deteriorating mental health. In some of these sessions, Jill expressed that she believed life would be so much easier if she were a boy—again, a fully understandable feeling given the unaddressed trauma of the sexual abuse she endured. Nevertheless, the counselor called Jill's parents and told them she believed Jill was transgender.

Jill's parents, completely surprised by this and at a loss for how to handle this supposed diagnosis, turned to "the experts," which led them to one of the largest pediatric gender clinics in the country (which was conveniently located not far from their residence). Jill

was placed under the care of the director of the clinic. Jill was just 12 years old.

One of the first actions her doctor took was to separate Jill from her parents. Alone in the room with the doctor, Jill described her surface-level understanding of gender, stating things like, "I mostly have boy friends," and "I like boy things." Based on such statements, the doctor immediately diagnosed Jill with gender dysphoria and told her that she was "trans," which the doctor also described as "all very normal." This all took place within minutes during Jill's very first visit. Her doctor—again, the director of one of the largest pediatric gender clinics in the country—did not perform a mental health assessment, she did not ask about things like past trauma, abuse or mental health struggles, she did not explore Jill's medical history or other diagnoses, and she did not involve any other medical or mental health providers in diagnosing Jill with gender dysphoria. Instead, her doctor simply took a handful of platitudinal statements from a scared, confused, and traumatized barely-12-year-old girl and assigned her a life-altering diagnosis.

The doctor recommended Jill promptly be put on puberty blockers to prevent her body from going through the "wrong puberty" and undergoing changes she deemed "irreversible." The doctor utterly mischaracterized puberty blockers as "fully reversible" and falsely stated there would be "no consequences." Indeed, she described puberty blockers as a "great option" that would simply "pause puberty" to give Jill time to figure herself out. Ultimately, the doctor had a Lupron blocker implanted in Jill. Lupron is a drug historically used to chemically castrate sex offenders and treat advanced male prostate cancer – its use to

treat gender dysphoria in children is off-label, as it has not been approved by the FDA for such use.

Jill continued seeing this doctor and others at the clinic for years. After being on Lupron for about a year, the lead doctor asked Jill if boys in her class were going through puberty. When Jill confirmed that they were, the doctor suggested that to "keep [her] on track," Jill should start taking testosterone. Jill was unsure and expressed doubts about taking cross-sex hormones, but the doctor assured her that doing so early on would ensure that later in life Jill would be more likely to fully "pass" as a "cis male." Her doctor further stated that if Jill got on cross-sex hormones faster, it "would be easier on [her] body." Jill hesitantly agreed.

Jill's parents, on the other hand, remained very much against Jill being put on testosterone. To convince them to agree to the cross-sex hormone therapy, her doctor again separated Jill from her parents, this time to address her parents. The doctor told Jill's parents that Jill was suicidal. This was a lie. At the time, Jill had never had any thoughts of suicide, and she certainly never expressed anything along those lines to her doctor. But the doctor went even further. She lied again when she told Jill's parents that if they did not agree to cross-sex hormone therapy for her, Jill would commit suicide. In tears, Jill's parents "consented" to allowing the doctor and her team to inject their confused, suffering child with life-altering testosterone, and Jill took her first injection at age 14.

Jill began experiencing significant adverse effects from the testosterone injections, including bad acne. She requested a change to topical testosterone gel, and the switch was made. But shortly thereafter, her labs came back showing that her testosterone levels were

"too low" for a boy, so she was switched back to testosterone injections. After being on cross-sex hormones on one form or another for about a year, Jill had very little breast development. While Jill was still just 14 years old, the lead doctor recommended she get a double mastectomy.

Just as she had misled and coerced Jill and her parents into starting testosterone, the doctor again misled them by emphasizing the supposed importance of removing Jill's healthy breasts sooner rather than later. She told them that having the surgery done at an early age made the healing process easier, and that if Jill waited any longer it would be impossible to do it right – that is, if she wanted a "natural," "cis-male-looking chest," they had to do it now (again, at age 14).

Notably, for much of the time that Jill was seeing this doctor, she was also seeing a therapist whom the doctor had recommended she see. Jill trusted that the care she was receiving was adequate and that her medical and mental health providers were seeking her best interest, but every time she discussed feelings of discomfort with her body or feelings about gender, the therapist minimized Jill's concerns, dismissing them as perfectly normal for someone who is trans. With the benefit of hindsight, Jill now recognizes these concerns were largely rooted in her past sexual trauma, but not once, ever, was she asked if she had any history of trauma or sexual abuse. The therapist simply attributed everything to Jill's purported gender identity journey.

Jill's therapist joined the doctor in encouraging Jill to surgically remove her healthy breasts. The doctor recommended a plastic surgeon, whose only requirement before agreeing to perform the surgery was getting a letter of recommendation from a primary

care physician and a mental health provider indicating that Jill was a good candidate for a "gender-affirming" double mastectomy. The doctor and the therapist she recommended for Jill provided these letters, which were fraught with misrepresentations.

Nevertheless, the plastic surgeon agreed to perform the surgery, and it was scheduled after only a perfunctory virtual meeting between Jill and someone on the surgeon's staff. In fact, the surgeon did not meet with Jill until the day of her surgery. The surgeon rubber-stamped Jill's fitness for the surgery (largely, if not exclusively, on the basis of the recommendation letters he received), had her mother sign a generic consent form, and within an hour of their first in-person meeting the procedure was performed.

Between the Lupron implant, the testosterone injections and gel, and now the surgical removal of her healthy breasts, Jill's mental health began to spiral. For the first time in her life, she began self-harming. She began suffering from symptoms of psychosis for the first time. She started hallucinating and hearing voices. She grew to hate her body even more, leading to severe body image issues. She began obsessively working out and adopted a low-calorie diet. When she brought up these feelings with her therapist or doctor, her concerns were again dismissed as the product of Jill's jealousy of "cis men," and feelings of seclusion because she was trans. All these symptoms began after Jill started taking testosterone and had her healthy breasts surgically removed, and yet not once did her doctor or therapist consider the propriety of continuing to medicalize Jill.

On the contrary, they each continued to push her down the path of transition, despite her obvious decline and growing skepticism in the ensuing years.

In fact, years later, when Jill was 17, the doctor told Jill that because she had been on testosterone for nearly five years at that point, she should get a hysterectomy. Jill was shocked to hear this, and it prompted her to realize that she likely wanted to have children of her own one day. Her doctor insisted that she get the hysterectomy, however, telling Jill that having children was probably not possible for her due to her having been on Lupron and testosterone for so long.

Shortly thereafter, Jill connected with a dialectical behavior therapy specialist and for the first time began to realize that many of her mental health struggles were a byproduct of unresolved trauma from being sexually abused, multiple times, over her childhood and adolescence. She began to realize she may not even be "trans," but rather had been suffering from PTSD and other issues related to her unresolved trauma. Consequently, she began to scale back her testosterone dosage and frequency. As she did so, her mental health issues began to resolve. By early 2024 she stopped taking testosterone altogether and her mental health improved even further. She began to have a healthy view of her body, and she began to truly heal. She now realizes she was never "trans."

Soren Aldaco

Soren struggled with her identity from an early age. Due to a troubled family life, the sudden loss of a beloved grandmother, peer ridicule, and a host of other stressors and troubles plaguing her early years, Soren's psychological health was poor from the start. Making matters worse, Soren experienced an early puberty resulting in the development of her breasts beyond what was typical among her pre-teen peers.

This early development invited even more ridicule and, influenced by the "female" body images she saw on her social media, caused her to deeply dislike her physical appearance. Because of this dislike for her female physical appearance, coupled with her general propensity to enjoy activities usually enjoyed by boys and the influence from some transgender online friends, Soren began wondering if maybe she was transgender too.

Over the course of eighth and ninth grade, Soren flirted with identifying as a boy with a small group of close friends and a couple of trusted teachers. Eventually, Soren's flirtation with and fluctuation between gender identities began to stagnate, as she had become comfortable taking on a balanced gender identity that reflected the gender-nonconforming nature to which she felt most attuned. Gender identity aside, during this time, Soren's psychological troubles only worsened.

By the tenth grade, Soren's depression and anxiety had become crippling. Once a straight-A student, Soren now found herself falling behind both academically and socially. In addition to depression, anxiety, and the social disorders she would later discover with the help of competent counseling, Soren experienced the added psychological stress of meeting her biological father for the first time in December of 2017. The next month, as a 15-year-old, these stresses and issues coalesced and manifested into a manic episode that resulted in an in-patient stay at a psychiatric hospital in Texas.

As a result of her manic episode, Soren's mother checked her into the hospital in January 2018, where she was treated by a psychiatrist for three days. During that time, and against Soren's expressed

wishes not to discuss her gender identity, the psychiatrist relentlessly pressed her on the topic by prompting her with trans-related questions and affirmations. The psychiatrist pressed so hard on the issue that Soren felt as though the only way to cease the discussion was to agree with him and tell him that she did identify as transgender. At the age of 15, this coerced "confession" from Soren would mark the first notable time she had ever discussed her gender identity offline with anyone outside her close group of friends and trusted confidants and the first time ever speaking about it with a medical professional.

Notably, the psychiatrist did not do any meaningful or comprehensive psychobehavioral examination, did not explore Soren's existing mental and psychological issues, and did not discuss or attempt to address her glaring comorbidities. Instead, he appeared to simply jump to—and indeed encourage—the conclusion that the sole explanation for Soren's psychotic break was her needing to embrace a transgender identity, after only knowing her for mere minutes.

The psychiatrist's persistence caused Soren to feel like she was being pressured or coerced off the comfortable balance she had struck concerning her gender-nonconforming identity. Consequently, Soren began to wonder anew whether she was, in fact, transgender. The psychiatrist related to Soren's parents that Soren's gender identity issues were, in fact, the source of Soren's mental health struggles, which in turn further confused Soren's parents and left them torn on how they could help her.

As a result of this pressure, Soren began to explore what it would be like to actually live as a medicalized transgender "boy" by researching the various procedures and expanding the group of people with whom

she would adopt that persona and identity. A few months after her manic episode and hospitalization, Soren began treatment with another therapist and psychologist who helped her discover that in addition to her Major Depressive Disorder, ADHD, and other diagnoses, Soren was also diagnosed with autism. Soren's autism was never discussed or even considered by the psychiatrist at the hospital.

It was not until several years later that Soren had enough maturity and awareness to look back on these events with the psychiatrist at the hospital and realize that his coercion was undue and improper. The psychiatrist's influence caused an incessant pressure on Soren to travel down the path of harmful changes to her body, which compounded her mental health struggles instead of curing them.

In January 2020, when Soren was 17 years old, a nurse practitioner prescribed her testosterone. Soren first met the nurse practitioner at a transgender "support group," which hosted meetings for transgender young people and their supporters. The group was run by transgender "elders." The group existed to help guide the children and adolescent attendees on their "gender journey." The nurse practitioner attended the meetings, although he was not himself transgender. The nurse practitioner apparently used the meetings to build up a list of patients and was the cross-sex hormone provider for many of the children and adolescents who frequented the group. Upon Soren's first casual encounter with the nurse practitioner at a group meeting, he immediately confirmed to her that, as with the other young girls and boys in the group, he could and would prescribe Soren with the testosterone she wanted if and when she visited his office.

At Soren's first ever appointment—a visit lasting only approximately 30 minutes—the nurse practitioner wrote Soren a prescription for her first round of anastrozole (an estrogen blocker) and testosterone cypionate at a very large dosage. The nurse practitioner gave Soren instructions on how to inject herself with the drugs and sent her on her way. He failed to discuss with Soren the full extent of the risks posed by the cross-sex hormones and the irreversible consequences that use of the cross-sex hormones would cause. He also failed to discuss any potential alternatives to the cross-sex hormones, instead deferring to Soren's wishes to take testosterone like the other kids in the support group. He also failed to discuss or address any of Soren's numerous mental health issues and existing comorbidities and conducted no psychobehavioral mental health analysis.

Even though Soren was only 17 years old, the nurse practitioner never sought or obtained any written consent from Soren's parents to guide her down this destructive path.

The cross-sex hormones caused severe complications in Soren's body. Rather than reduce her dosage or take her off the cross-sex hormones completely, the nurse practitioner simply referred Soren out to various medical specialists who could treat the specific symptoms that arose while continuing to prescribe and administer the cross-sex hormones. Believing that the cross-sex hormone regimen was helping her, Soren continued taking the cross-sex hormones for nearly two years.

As with many young people put on a path of medical transition, Soren eventually turned to surgery as the next step. A therapist treating Soren for relationship and co-dependency issues wrote a letter recommend-

ing her for transition "top surgery" (i.e., a double mastectomy) when Soren was 18. The therapist did so without properly evaluating Soren as a candidate for such surgery.

The therapist's treatment focused almost exclusively on the co-dependence and relationship issues Soren was experiencing with her partner; their sessions never focused on or attempted to fully assess or resolve the question of Soren's gender identity. To the extent that the topic did come up, Soren explained that she was still exploring her gender expression and becoming more comfortable with a non-masculine (or non-conforming) expression.

Notably, over the entire course of Soren's treatment with the therapist, COVID-19 restrictions were in place, and Soren had little to no normal social experiences. Even her high school experience was entirely online and by video during this time. Therefore, not even Soren was aware, nor could she have been aware, of what it would be like to live a full social life as a transgender male.

Despite Soren's lack of awareness, the therapist's failure to properly assess her as a candidate for an irreversible medical transition procedure, and Soren's history of mental health struggles, surgeons agreed to perform the double mastectomy on her. Shortly after Soren turned 19, she went under the knife. The surgery left Soren in significant pain and in need of urgent, emergency medical attention as complications arose during her recovery.

Soren experienced pools of blood forming subcutaneously within her torso and her nipples were literally peeling off her chest. The staff at the surgery center where Soren's double mastectomy was performed

dismissed her concerns, and Soren was left to seek assistance elsewhere. She drove to an emergency room to get the urgent care she knew she needed, and after spending all night in the hospital waiting, the breast oncology team finally treated her the next day, observing that Soren had "massive bilateral hematomas" (16cm on the left flank, and 17cm on the right). They re-opened the original incisions and stitched in drains (which should have been included in the original surgery) and drained significant amounts of accrued blood and other bodily fluids. In addition to undergoing the pain and suffering this caused, Soren was then forced to continue draining blood and fluids from her chest cavity for the following week.

Following that horrific experience, Soren began to realize that neither the testosterone nor the double mastectomy had helped her feel entirely comfortable in her body. Discouraged by this realization, Soren began looking for and discovered a successful alternative to resolve the issues with her gender identity through the simple practice of meditation and mindfulness. Through this practice, Soren learned that her body was not the problem at all; the problem was with her perception and expectation of her body that society and social media had all but forced upon her.

Jane Smith

Jane grew up in a deeply traumatic family setting. Her parents were hoarders, so she grew up surrounded by filth. Horrifically, she was sexually abused by her father, an alcoholic, for years growing up. Undoubtedly related to her traumatic upbringing, Jane suffered from post-traumatic stress disorder, night terrors, severe depression and anxiety, and she developed an eating disorder. Jane even became suicidal and at

one point was hospitalized when she became delirious and threatened to kill herself.

Since the age of 16, Jane had gone to therapy to try to help treat her mental health issues. Around this time, Jane also began to be heavily influenced online by sites and groups on Tumblr and other social media platforms that promoted transgenderism as a panacea for people struggling with mental health issues, like depression and anxiety. During her treatment with her first therapist, as this online influence started to sink in, Jane asked the therapist whether he thought she might be transgender. Despite admitting that he did not have much familiarity with the subject matter, the therapist said that he thought she might be since she was "so logical and analytical" (evidently, the therapist thought of logic and analysis as male-typical traits), but he did not account for the trauma Jane faced every day. Since the therapist did not know much about transgender issues, he referred Jane to a second therapist, who passed her along to the purported experts at one of the most prominent gender clinics in the Midwest.

Jane decided to go to the aforementioned gender clinic. She was entirely open about and shared her highly troubled past and her existing, profound mental health struggles. She relayed that she was not sure she was transgender. Despite all of this, on her first visit, the staff at the clinic began referring to her with male pronouns and offered to prescribe her cross-sex hormones. Jane declined the initial invitation since, again, she was not even sure she felt she was transgender. However, she continued to return to the clinic. After a number of additional visits—at each one she again was offered cross-sex hormone prescriptions—she decided that she wanted to try to become a boy.

The clinic underplayed the known side-effects, simply reading a list of outcomes and describing them as some minor things that "might" happen. Instead, Jane was told that she would finally get to "experience male puberty."

She did not experience male puberty. She stayed on testosterone and other "gender-affirming" medications for almost six years. And it wrecked her body. Within the past few years, Jane decided to detransition and identify as her natural female self. She realized she could never become a man; instead, she can now appreciate that she was just young, confused, and vulnerable, and had been seduced and deceived to buy into an idea she could never actually attain.

Life has become exceedingly difficult given the permanent effects of the cross-sex hormones. Her voice has permanently changed—she was a soprano but is now a baritone—and she feels that she does not recognize the voice coming out of her own body, a deeply disturbing reality for her. Others are also taken aback when they see her returning feminine appearance but then "hear a man's voice" when she talks; she suspects she has lost out on three job opportunities because of it. She grew facial hair and now has to shave to try to stave off the male appearance it brings. She struggles with eating disorders. She has joint issues, general fatigue, and increased vascularity. She randomly gets extremely nauseous. Jane has vaginal atrophy and other adverse effects in her genitals. And she feels that her brain has been severely compromised.

Once a very successful student who graduated high school early with multiple scholarship offers, Jane now struggles to hold a job. And she is angry. Angry at the doctors who did this to her. Angry that someone

with her extreme mental health comorbidities could have been offered life-altering cross-sex hormones after a single visit by the purported experts at a prestigious gender clinic. And she is angry that due to a harsh statute of limitations in her home state of Ohio, she has no recourse in the courts, as she did not realize the harm and abuse that was inflicted upon her until it was too late under existing Ohio law.

II. Scientific Evidence Demonstrates That Youthful Gender Transition Is Harmful

A. Encouraging Children to Transition Changes Outcomes by Preventing Natural Desistance.

Over the last 50 years, numerous scientific studies have shown that gender dysphoria in children is not fixed. Instead, the vast majority of prepubertal children with gender dysphoria *who do not socially or medically transition* will stop feeling dysphoric by the time they reach adulthood. Eleven peer-reviewed studies published between 1972 and 2021 investigated the persistence of childhood-onset gender dysphoria, and all reached the same conclusion: "among pre-pubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61-88% desistance across the large, prospective studies." Expert Report of James M. Cantor, PhD, *Poe v. Labrador,* No. 1:23-cv-00269 (D. Idaho), ECF 56-4 at 57-58 (listing studies); *see also* Pien Rawee, et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Arch. Sex. Behav. 1813-1825, 1813 (2024) ("Gender non-contentedness, while being relatively common during early adolescence, in general decreases with age and appears to be associated with a poorer self-concept and mental

health throughout development.”). No published study has shown otherwise.

Given this evidence, the Endocrine Society’s Clinical Practice Guidelines acknowledge “the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence.” Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. of Clinic. Endocrin. & Metab. 3869-3903, 3879 (2017).

Yet among children *who are affirmed in a transgender identity*, multiple studies have found that few or none grow into comfort with their biological sex: “The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood.” Carly Guss, et al., *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Consideration*s, 27(4) Curr. Opin. Pediatr. 421-426, 421 (2015); *see also* Thomas D. Steensma, et al., *Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) J. Am. Aca. Child Adolesc. Psychiatry 582-590, 588-89 (2013) (childhood social transitions are “important predictors of persistence”).

Available evidence, then, suggests that affirming a transgender identity in children changes outcomes and prevents natural desistance in many children. Because, as the Endocrine Society recognizes, “we cannot predict the psychosexual outcome for any specific child,” Hembree, et al. at 3876, protecting children from harmful medical interventions and not “affirming” a child’s transgender identity preserves

children's ability to desist naturally, with their natal bodies and functions intact.

B. Detransitioning Is on the Rise, and Also Shows That Young People Become Comfortable with Their Sex over Time.

Consistent with these studies and the experiences of *Amici*, research shows that an increasing number of youth and adults are detransitioning, indicating harm and lack of efficacy of the interventions. Vandenbussche 2021, for example, is a survey of 237 detransitioners with 70% reporting that they detransitioned after realizing their gender dysphoria was related to other issues. Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69(9) J. Homosex. 1602-1620, 1606 (2022), Epub Apr. 30, 2021. And Littman 2021 is a survey of 100 detransitioners where 60% reported their decision to detransition was motivated by the fact that they "became comfortable identifying with their natal sex." 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, 3361 (2021).

In her study, Dr. Littman found that, as is true of *Amici*, a majority of the study subjects felt that they had been rushed into "gender-affirmative" interventions with irreversible effects without the benefit of adequate psychologic evaluation. *Id.* at 3364-3366. Dr. Littman also found that several of the participants in her study felt pressured to transition from their doctors or therapists. *Id.* at 3366. Thirty-eight percent of participants in Dr. Littman's study said that their gender dysphoria was caused by trauma or mental health issues, and more than half said that transition-

ing delayed or prevented them from getting treatment for their trauma or mental health issues. *Id.* at 3361-3362.

In addition, many clinicians have commented on the rising numbers of detransitioners they are seeing. *See, e.g.,* Laura Edwards-Leeper & Erica Anderson, *The Mental Health Establishment Is Failing Trans Kids*, Wash. Post, Nov. 24, 2021, https://tinyurl.com/52ktuhyy (noting "rising number of detransitioners that clinicians report seeing," which is typically "youth who experienced gender dysphoria and other complex mental health issues, rushed to medicalize their bodies and regretted it"); Lisa Marchiano, *Gender Detransition: A Case Study*, 66(4) J. of Anal. Psychol. 813-832, 814 (2021) ("[T]he number of young people detransitioning (reaffirming their natal sex) … appears to be increasing. Detransitioners are now sharing their stories online and entering therapy."); *see also* R. Hall, et al., *Access to Care and Frequency of Detransition Among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review*, 7(6):e184 BJPsych Open. 1-8, 1 (2021) ("Detransitioning might be more frequent than previously reported."); Isabel Boyd, et al., *Care of Transgender Patients: A General Practice Quality Improvement Approach*, 10(1) Healthcare 121 (2022) ("[T]he detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields.").

Dr. Littman observed that her research into detransitioners "adds to the existing evidence that gender dysphoria can be temporary." Littman 2021 at 3365. She concluded that "intervening too soon to medicalize gender dysphoric youth risks iatrogenically derailing

the development of youth who would otherwise grow up to be LGB nontransgender adults." *Id.*[6]

C. Evidence Is Lacking for Benefits That Would Outweigh the Clear Harms of Transitioning to Minors.

Earlier this year, the *New York Times* published accounts of detransitioners, which demonstrate the negative effects of "unproven treatments for children." Pamela Paul, *As Kids, They Thought They Were Trans. They No Longer Do.*, N.Y. Times, Feb. 2, 2024, https://tinyurl.com/2jv8md99. As one detransitioner, who is also a psychotherapist, put it: "'You're made to believe these slogans . . . . Evidence-based, lifesaving care, safe and effective, medically necessary, the science is settled — and none of that is evidence based.'" *Id.* (quoting Paul Garcia-Ryan).

In what is widely regarded as the most comprehensive review of available evidence, Dr. Hilary Cass, a renowned pediatrician in the United Kingdom, found adequate evidence lacking to support transition in children and young people. *See Independent Review of Gender Identity Services for Children and Young People: Final Report*, The Cass Review (April 2024), https://tinyurl.com/3st6ftkh. Dr. Cass emphasized that social transition should be thought of as an "active intervention because it may have significant effects on the child or young person in terms of their

---

[6] As the court of appeals observed in this case, the experiences of detransitioners also show that "transgender identity" is not "definitively ascertainable at the moment of birth" or "necessarily immutable." *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 487 (6th Cir. 2023) (internal quotation marks and citations omitted).

psychological functioning and longer-term outcomes." *Id.* at 158.

As the *New York Times* summarized, Dr. Cass's four-year review "found no definitive proof that gender dysphoria in children or teenagers was resolved or alleviated by what advocates call gender-affirming care, in which a young person's declared 'gender identity' is affirmed and supported with social transition, puberty blockers and/or cross-sex hormones." Pamela Paul, *Why Is the U.S. Still Pretending We Know Gender-Affirming Care Works?*, N.Y. Times, July 12, 2024, https://tinyurl.com/43t7u29z. Dr. Cass also noted the lack of "clear evidence that transitioning kids decreases the likelihood that gender dysphoric youths will turn to suicide, as adherents of gender-affirming care claim." *Id.*

That finding is consistent with another recent study, which found that patients who had undergone sex-modification surgery had "a 12.12 times greater risk of suicide attempts" than patients who had not undergone such surgery. J. Straub, et al., *Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery*, 16(4):e57472 Cureus 1-9, 3 (2024). Patients who had undergone surgery also had "a 7.76 times higher risk of PTSD." *Id.*

Scientific evidence, as well as the experiences of *Amici* and other detransitioners, shows gender transition is harmful and supports Respondents' reasonable and tailored measures to protect children from those harms.

CONCLUSION

Amici respectfully submit that this Court should affirm the judgment of the court of appeals.

Respectfully submitted,

JOSHUA K. PAYNE
Counsel of Record
JORDAN CAMPBELL
RONALD MILLER
DANIEL SEPULVEDA
CAMPBELL MILLER PAYNE, PLLC
5955 Alpha Rd #1491
Dallas, Texas 75240
(214) 316-7156
josh@cmppllc.com

Counsel for Amici Curiae

October 15, 2024