No. 25-77

IN THE

Supreme Court of the United States

STEPHEN FOOTE, individually and as Guardian and next friend of B.F. and G.F., minors; Marissa Silvestri, individually and as Guardian and next friend of B.F. and G.F., minors, JONATHAN FELICIANO; SANDRA SALMERON,
Petitioners,

v.

LUDLOW SCHOOL COMMITTEE, TODD GAZDA, former Superintendent; LISA NEMETH, Interim Superintendent; STACY MONETTE, PRINCIPAL, Baird Middle School; MARIE-CLAIRE FOLEY, school counselor, Baird Middle School; JORDAN FUNKE, former librarian, Baird Middle School; TOWN OF LUDLOW,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

BRIEF OF *AMICI CURIAE* CLEMENTINE BREEN AND SOREN ALDACO IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

INTEREST OF *AMICI CURIAE*

Amici Curiae Clementine Breen and Soren Aldaco respectfully submit this brief in support of Petitioners.[1] *Amici* experienced gender dysphoria when they were children and adolescents. They were led to believe that "affirming" their self-identified genders and transitioning 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, social transitioning and medical interventions—such as puberty blockers, cross-sex hormones, and surgeries—caused *Amici* physical harm and exacerbated 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.

SUMMARY OF ARGUMENT

Clementine Breen and Soren Aldaco are living proof that "affirming" a young person's declared gender is deeply harmful. These individuals experienced gender dysphoria when they were children and adolescents.

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[1] Counsel of record received timely notice of the intent to file this brief under Supreme Court Rule 37.2. 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 this brief.

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.

Clementine Breen

As a young child, Clementine was what most would consider a stereotypical young girl. She enjoyed choir, dance, and theater, loved to collect dolls, and never felt like or identified as a boy.

Around the ages of six and seven, Clementine endured prolonged sexual abuse. Understandably, as her childhood progressed, she began to suffer from a complex array of mental health issues, including, 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 Clementine 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 Clementine started meeting with a school counselor to discuss issues related to her deteriorating mental health. In some of these sessions, Clementine 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. The counselor did not question Clementine's experiences of gender incongruence, nor did the counselor investigate Clementine's underlying mental comorbidities. Rather, the counselor affirmed Clementine's gender identity by calling Clementine's parents and telling them she believed Clementine was transgender.

Clementine's parents, completely surprised by this and unsure of 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 close to their residence). Clementine was placed under the care of the director of the clinic. Clementine was just 12 years old.

One of the first actions her doctor took was to separate Clementine from her parents. Alone in the room with the doctor, Clementine described her surface-level understanding of gender, stating things like, "I mostly have boyfriends," and "I like boy things." Based on such statements, the doctor immediately diagnosed Clementine 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 Clementine'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 Clementine's medical history or other diagnoses, and she did not involve any other medical or mental health providers in diagnosing Clementine 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 Clementine 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 Clementine time to figure herself out. Ultimately, the doctor had a Lupron blocker implanted in Clementine. 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.

Clementine continued seeing this doctor and others at the clinic for years. After about a year on Lupron, the lead doctor asked Clementine if boys in her class were going through puberty. Clementine confirmed that they were, and the doctor suggested that Clementine take testosterone to "keep [her] on track."

Clementine expressed doubts about taking cross-sex hormones, but the doctor assured her that doing so early on would ensure that later in life Clementine would be more likely to fully "pass" as a "cis male." Her doctor further stated that if Clementine got on cross-sex hormones faster, it "would be easier on [her] body." Clementine hesitantly agreed.

Clementine's parents, on the other hand, remained very much against Clementine being put on testosterone. To convince them to agree to the cross-sex hormone therapy, her doctor again separated Clementine from her parents, this time to address her parents. The doctor told Clementine's parents that Clementine was suicidal. This was a lie. At the time, Clementine 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 Clementine's parents that if they did not agree to cross-sex hormone therapy for her, Clementine would commit suicide. In tears, Clementine's parents "consented" to allowing the doctor and her team to inject their confused, suffering child with life-altering testosterone, and Clementine took her first injection at age 14.

Clementine 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 various forms of cross-sex hormones for about a year, Clementine had very little breast development. While Clementine was still just 14 years old, the lead doctor recommended she get a double mastectomy.

Just as Clementine and her parents were misled and coerced into starting testosterone, the doctor again misled them by emphasizing the supposed importance of removing Clementine'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 Clementine 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 Clementine was seeing this doctor, she was also seeing a therapist whom the doctor had recommended she see. Clementine 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 Clementine's concerns, dismissing them as perfectly normal for someone who is trans. With the benefit of hindsight, Clementine 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 Clementine's purported gender identity journey.

Clementine's therapist joined the doctor in encouraging Clementine 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 Clementine was a good candidate for a "gender affirming" double mastectomy.

The doctor and the therapist 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 Clementine and someone on the surgeon's staff. In fact, the surgeon did not meet with Clementine until the day of her surgery. The surgeon rubber-stamped Clementine's fitness for the surgery (largely, if not exclusively, informed by 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, Clementine'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 Clementine's jealousy of "cis men," and feelings of seclusion because she was trans. All these symptoms began after Clementine 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 Clementine.

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 Clementine was 17, the doctor told Clementine that because she had been on

testosterone for nearly five years at that point, she should get a hysterectomy. Clementine 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 Clementine that having children was probably not possible for her due to her having been on Lupron and testosterone for so long.

Shortly thereafter, Clementine 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 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 she disliked her female physical appearance, enjoyed activities usually enjoyed by boys, and was influenced by 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 psychiatric episode that resulted in an in-patient stay at a psychiatric hospital in Texas.

As a result of her psychiatric 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. Under this coercion, Soren shared her positive experiences from a summer camp she had attended for a three-week period each of the prior three years. Her time there represented a welcome departure from what was otherwise a tense home environment. She enjoyed being around other smart, quirky adolescents and her needs were taken care of daily in a way that was more restful than at home.

As the psychiatrist pressed Soren further, he learned that the gender fluidity that Soren had experimented with was "affirmed" at this summer camp—that administrative staff at the camp used Soren's preferred name and pronouns and otherwise facilitated any lies that Soren requested to hide her then-current gender identity from others, including her parents back home. The psychiatrist latched onto this anecdote, concluding that Soren's depression and anxiety, culminating in her psychiatric episode, must have been caused by the failure of those in her life to "affirm" her gender identity. Eager to end the conversation, Soren finally decided to just agree with his conclusion 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 mental breakdown

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 exploring what it would be like to actually live as a medicalized transgender "boy" by researching procedures and expanding her social circle. A few months after her psychiatric 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" run by elders that hosted meetings for transgender young people and their supporters to help guide the children and adolescent attendees on their "gender journey." Though the nurse practitioner was not himself transgender, he attended 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 and irreversible consequences posed by the cross-sex hormones. 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 recommending 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 performed the double mastectomy shortly after Soren turned 19. 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.

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 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 all concluded that "among prepubescent 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) (explaining that gender non-contentedness generally "decreases with age and appears to be associated with a poorer self-concept and mental health throughout development."). No published study has shown otherwise.

The Endocrine Society's Clinical Practice Guidelines also 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 multiple studies found that among children *who are affirmed in a transgender identity*, few or none grow into comfort with their biological sex by the time they reach adulthood. Carly Guss, et al., *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, 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. 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. Two recent surveys displayed this lack of efficacy for medical interventions. The first survey showed that 70% of detransitioners reported they had detransitioned after realizing their gender dysphoria was related to other issues, while 60% of the second survey's detransitioners reported their decision to detransition was motivated by the fact that they "became comfortable identifying

with their natal sex." Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69(9) J. Homosex. 1602–1620, 1606 (2022), Epub Apr. 30, 2021; 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 this second survey, Dr. Littman found that, as is true of *Amici*, a majority of the study subjects felt that they were 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 transitioning 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.").

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

Last 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* Hillary Cass, *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 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.* There was also no clear evidence that social transitions had a positive or negative effect on mental health. Cass, *supra* 31. Rather, Dr. Cass found that children who socially transitioned "were more likely to proceed to a medical pathway." *Id.*

Despite growing research showing that individuals are detransitioning in increasing numbers, children are being affirmed by those around them and by the medical professionals who are prescribing puberty blockers, cross-sex hormones, and performing irreversible, life-altering surgeries that carry significant risks.

There is no doubt that puberty is "a major developmental process;" however, there is limited understanding of the effects of puberty blockers on children. Diane Chen, et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental*

Effects of Pubertal Suppression in Transgender Youth, 5(4) Mary Ann Liebert, Inc. 246, 254 (2020). Nevertheless, researchers have found that delaying pubertal growth can substantially decrease a child's peak bone mass. Vicente Gilsanz, et al., *Age at Onset of Puberty Predicts Bone Mass in Young Adulthood*, 158(1) J. Pediatrics 100-105.e2 (2011).

Cross-sex hormones, such as estrogen and testosterone, are associated with a number of complications, such as type 2 diabetes, stroke, increased risk of breast cancer, heart attacks, depression, and thoughts of suicide. *Feminizing Hormone Therapy*, Mayo Clinic (July 12, 2024), https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096; *Testosterone Injection*, Cleveland Clinic, https://my.clevelandclinic.org/health/drugs/18031-testosterone-injection (last visited Aug. 20, 2025).

In addition to the above-mentioned complications, a recent study found that patients who had undergone sex modification surgery had "a 12.12 times greater risk of suicide attempts," "a 9.88 times higher risk of self-harm or suicide," and "a 7.76 times higher risk of PTSD" than patients who had not undergone such surgery. John J. Straub, et al., *Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery*, 16(4):e57472 Cureus 1–9, 3 (2024).

While doctors and surgeons are providing "gender-affirming care," their patients' underlying mental issues remain unaddressed, as the evidence and the *Amici*'s stories indicated above show, which carries grave consequences as well. Untreated mental illness can lead to social isolation, decreased academic performance, self-harm, harm to others, a weakened immune system, heart disease, and other medical conditions. *Mental Illness*, Mayo Clinic (Dec. 13, 2022), https://

www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968.

Scientific evidence, as well as the experiences of *Amici* and other detransitioners, shows gender transition is harmful and supports Petitioners and other parents' ability and responsibility to protect children from those harms.

III. Massachusetts' Asserted Interest in Promoting a Child's Gender Identity Is Not Compelling.

Amici's unique perspective and the scientific evidence reinforces that the government's basis for enforcing the Commonwealth of Massachusetts' Department of Elementary and Secondary Education's Guidance ("DESE Guidance") and the Ludlow School Committee's protocol ("the Protocol"), and the government's asserted interest in authorizing public schools to acknowledge a minor's self-identified gender, even if parents object, is not compelling. Under either the Free Exercise Clause or the Free Speech Clause, the compelling interest requirement is extremely rigorous. "A government policy can survive strict scrutiny only if it advances interests of the highest order and is narrowly tailored to achieve those interests." *Fulton v. City of Philadelphia*, 593 U.S. 522, 541 (2021) (internal quotation marks and citation omitted). The government cannot "rely on broadly formulated interests," and general interests, such as nondiscrimination, are not sufficient to carry this burden. *Id.* at 541–42.

Here, Ludlow argued that it had a compelling interest in "cultivating a safe [and] inclusive . . . environment for students," especially for transgender minors. *Foote v. Ludlow Sch. Comm.*, 128 F.4th 336,

356-57 (1st Cir. 2025). The First Circuit held that the Protocol creates a safe environment for transgender children because it removes psychological barriers and results in "better mental health outcomes." *Id.* at 357. (quoting *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 597 (4th Cir. 2020)). As part of this reasoning, the State categorically ignored the Plaintiffs' rights in bringing up their children in the way that they deem fit. *Id. Amici*'s experiences as detransitioners and developing scientific research provide a different perspective and demonstrate that "affirming" a child's asserted gender identity can lead to significant physical and psychological harm. Additionally, children do not possess the "experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them." *Bellotti v. Baird*, 443 U.S. 622, 635 (1979) (citing *Ginsberg v. New York*, 390 U.S. 629, 649–650 (1968) (Stewart, J., concurring)). As a result, the State's alleged interest in affirming a child's self-identified gender is not a compelling interest.

In fact, *Amici*'s experiences show that the State would actually discharge its obligation to protect the "physical and psychological well-being of minors" by allowing the Plaintiffs and others like them to direct the upbringing of their children. *Foote*, 128 F.4th at 356-57 (quoting *Sable Commc'ns of Cal., Inc. v. FCC*, 492 U.S. 115, 126 (1989)).

Children who face the same challenges *Amici* faced deserve to grow up in truly supportive environments. These children need parents who recognize the dangers of social and medical transitioning and who will provide them with the right resources to help address whatever challenges they may be experiencing.

CONCLUSION

Amici respectfully submit that this Court should grant a writ of certiorari.

Respectfully submitted,

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