No. 25-840

In the Supreme Court of the United States

INTERNATIONAL PARTNERS FOR ETHICAL CARE, INC., et al.,
Petitioners,
v.
BOB FERGUSON, GOVERNOR OF WASHINGTON, IN HIS OFFICIAL CAPACITY, et al.,
Respondents.

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

BRIEF OF DETRANSITIONERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae are three detransitioners—that is, individuals who have previously been through so-called "gender-affirming" medical interventions intended to help them live as the opposite sex but later desisted in their transgender identity. *Amici* are women who underwent masculinizing medical interventions as minors and, now as adults, continue to suffer harm related to the ill-conceived care they received. All three *amici* are engaged in litigation against the medical providers who irreparably harmed them.

Amicus Chloe Brockman, a/k/a Chloe Cole, is a 22-year-old California resident. Ms. Brockman received puberty blockers and testosterone at age 13, followed by a double mastectomy at age 15. At age 16, Ms. Brockman detransitioned and resumed living as a girl.

Amicus Luka Hein is a twenty-four-year-old Nebraska resident. Ms. Hein received a double mastectomy followed by testosterone, both at age 16. The following year, Ms. Hein's doctor recommended that Ms. Hein undergo a partial hysterectomy as the next stage in her "transition." Fortunately, Ms. Hein did not undergo this procedure. At age 20, Ms. Hein detransitioned and resumed living as a woman.

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[1] In accordance with Supreme Court Rule 37, no counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici curiae or their counsel made such a monetary contribution.

Amicus Kaya Clementine Breen is a 22-year-old California resident. Ms. Breen received puberty blockers at age 12, testosterone at age 13, and a double mastectomy at age 14. At age 17, Ms. Breen's doctor recommended that she receive a hysterectomy. Fortunately, Ms. Breen did not undergo this procedure. When Ms. Breen was 19, she detransitioned and resumed living as a woman.

All three *amici* were permanently maimed by their health care providers who placed them on the fast-moving "gender-affirming care" pipeline—immediate social affirmation and mental-health treatment directed toward affirming their asserted transgender identity, followed by puberty blockers or cross-sex hormones and surgery. In each of their cases, providers failed to address serious underlying psychological problems before recommending irreversible interventions. *Amici* have an interest in ensuring that courts understand what may follow when vulnerable minors are placed on that pathway without the meaningful involvement of parents who know their children and can insist on caution, comprehensive evaluation, and care that does not scar them for life.

SUMMARY OF THE ARGUMENT

By enacting SHB1406 and SB5599 (the "FRA Amendments"), Washington has singled out runaway minors who seek "gender-affirming treatment" for a statutory process that removes parents' decision-making authority at the very moment parents are needed most. As Petitioners explain, under the FRA Amendments, a shelter may route runaway children to the Department of Children, Youth, and Families

("DYCF" or the "Department") instead of notifying the parents, and the Department must offer referrals for behavioral-health services. Pet. Br. at 9–12. Respondents insisted at the certiorari stage that the referrals are voluntary and that the challenged statutes do not authorize the Department to administer hormones or surgery. Br. in Opp. 9. But that limitation does not undermine Petitioners' showing of harm. Indeed, a referral to affirming behavioral-health services can be the first consequential step on a pathway toward medical intervention, particularly for a distressed runaway child who has already rejected parental guidance.

Amici have firsthand experience with that pathway. Each endured adolescence with serious emotional, psychological, or traumatic issues. Each began to believe that her distress could be resolved by becoming male. And each was "treated" by providers as though their belief was the answer rather than as a symptom requiring careful exploration. Chloe received puberty blockers and testosterone at 13 and had her healthy breasts removed at 15. Luka had her healthy breasts removed at 16, began testosterone months later, and was then advised to undergo a hysterectomy. Clementine received puberty blockers at 12, testosterone at 13, and a double mastectomy at 14 before being advised to undergo a hysterectomy. Each later detransitioned. None can undo the surgeries or all the physical changes that followed from hormones.

This Court has recognized the substantial uncertainty surrounding pediatric sex-transition medicine. *United States v. Skrmetti*, 605 U.S. 495 (2025). In *Skrmetti*, this Court noted that current standards of care recognize potential effects on fertility and the

possibility of later detransition; that data on long-term physical, psychological, and neurodevelopmental outcomes remain limited; and that health authorities abroad have concluded that the evidence supporting puberty blockers and hormones for gender-dysphoric minors is low-quality, insufficient, or inconclusive. *Id.* at 501–03. The Court ultimately held that Tennessee could respond to that uncertainty by restricting the use of puberty blockers and hormones for minors. *Id.* at 523–24.

This case does not require the Court to decide whether every form of gender-affirming treatment is always harmful, or whether every child who receives it will regret doing so. Article III does not demand that showing. But the nature of the threatened injury matters when assessing whether parents have alleged a cognizable constitutional injury from a legal regime designed to reduce their ability to prevent it. The consequences here can be irreversible. A female's breasts cannot be restored after mastectomy. Some hormonal changes do not disappear when treatment stops. Fertility can be permanently impaired. And the decision whether a troubled adolescent should begin down that path is exactly the sort of grave medical judgment this Court has long recognized as requiring parental involvement. *See Parham v. J.R.*, 442 U.S. 584, 602–04 (1979).

The Ninth Circuit's standing rule forces parents to wait until the feared sequence has advanced far enough that the harm may no longer be preventable. *Amici*'s stories show why that is no answer. Once an adolescent is referred into an affirming treatment pathway, a later judicial victory cannot restore what

was lost. Petitioners should not have to wait for that injury before they may challenge a law deliberately structured to diminish their role in preventing it.

ARGUMENT

I. CHLOE BROCKMAN

Chloe Brockman's childhood in California's Central Valley was marked by significant emotional and psychological challenges. Beginning at a young age, Chloe struggled with anxiety, depression, ADHD, and frequent social isolation. Around age six, Chloe developed an interest in male clothing, but it was not until age nine that she confronted the growing disconnect she felt between her biological sex and her social identity as a female.

Chloe believed—due in part to her exposure to television, the internet, social media, and pornography—that her body needed to conform to various aesthetic standards to be regarded as genuinely female. The women she saw online had bodies unlike her own. Still a child, she internalized the belief that she was and would remain unworthy of social acceptance as a female. As her body matured, she focused intensely on the difficulties she associated with becoming a woman: menstrual cycles, pregnancy and childbirth, and the possibility of sexual harassment or violence. Her unresolved mental-health challenges and fears about womanhood further isolated her from her peers.

This isolation led Chloe to seek out online forums where she could discuss her feelings and connect with people who had similar stories. She spent hours reading posts by LGBT activist groups and transgender

influencers who praised other transgender individuals, particularly those who underwent surgical transitions. To a girl with minimal social connections, the acceptance and praise were powerful. Chloe began to view transition as a way both to escape what she feared about womanhood and to obtain social approval.

In May 2017, at age 12, Chloe told her parents about her desire to be called "Kai" and treated as a boy. Her parents were hesitant and sought professional advice. Within a month, Chloe met with a child psychologist who affirmed Chloe's belief that she was a boy without meaningfully exploring why she had developed that belief. Over the next several years, Chloe had similar experiences with other providers. Although she reported anxiety, depression, and other mental-health problems alongside her gender distress, the providers did not meaningfully investigate whether those problems were driving her beliefs about gender. Instead, Chloe experienced immediate and consistent affirmation in which her providers encouraged breast binding and told her that puberty blockers and testosterone could be necessary to resolve her distress.

Those encounters culminated in Chloe's referral to an endocrinologist at age 13. She received puberty blockers intended to stop her normal puberty, followed by testosterone intended to produce outwardly male characteristics. According to Chloe, the providers did not adequately evaluate her mental-health symptoms and did not adequately explain the possibility that she might later re-identify with her biological sex. Nor did Chloe understand the fertility and

sexual-function consequences that could follow from the treatment. At 13, those future consequences carried little weight compared with her immediate desire to feel comfortable and accepted.

But Chloe did not experience the results she had expected with the medical interventions she underwent. Her mental health and social circumstances did not materially improve. Then a boy at school sexually assaulted her by groping her breast in front of classmates. The incident intensified Chloe's discomfort with being female and led her to conclude that removing her breasts would protect her from further unwanted sexual attention. When Chloe told her endocrinologist that she wanted a double mastectomy, the doctor approved the request rather than treating it as a reason to pause and explore the trauma that had precipitated it.

At a gender clinic, Chloe and her parents met with a "gender specialist" who approved her for surgery after a two-hour meeting. The specialist told Chloe that she would be unable to breastfeed, but at 14 years old she did not meaningfully appreciate that consequence. Chloe was not informed that surgery might not resolve her underlying mental-health problems or that she might later regret permanently removing healthy breasts. On June 4, 2020, at age 15, after only one additional presurgical consultation conducted virtually, Chloe underwent a double mastectomy.

The surgery did little to alleviate Chloe's underlying struggles. She became distressed by the scars and grafts on her chest. Her anxiety and depression worsened, she developed suicidal ideation, and she began

to regret her decision as she grappled with the possibility that the course of treatment had impaired her future ability to bear and care for a child. In May 2021, Chloe began detransitioning.

Detransition did not give Chloe the body she had before treatment. Years of testosterone had produced a deeper voice and other masculinizing changes. She experienced physical problems after stopping hormones and complications from her mastectomy, including loss of erogenous sensation in her chest. Psychologically, she struggled with severe depression and suicidality and had difficulty reintegrating socially as a young woman.

Chloe now speaks publicly about the harms of "gender-affirming care." Her experience is a concrete example of why a referral into such care can matter long before a later prescription or surgery takes place.

II. LUKA HEIN

In 2015, Luka Hein's life began to fracture. At 13 years old, her parents divorced, and the instability that followed pushed her into a period of deep uncertainty and confusion. Splitting her time between two homes in Nebraska, Luka struggled with a growing sense of isolation and began to question who she was. Within one year of the divorce, her academic performance deteriorated, she developed unhealthy eating habits, and she experienced severe anxiety and panic attacks. Luka's psychological struggles soon manifested externally—she became easily angered, and she began cutting herself and experiencing suicidal thoughts. Although Luka eventually received counseling, psychiatric care, and medication for depression

and generalized anxiety, her mental health continued to deteriorate.

In early 2017, Luka's mental health deteriorated to the point that she was placed in a partial psychiatric care program. After Luka left the program, she was exposed to an older man online, who coerced her into sending him sexually explicit images. When Luka eventually refused to send the man more photos, he threatened her. The trauma Luka experienced from this event caused Luka's psychiatrist to return her to the intensive partial psychiatric care program in May 2017. Luka's treatment became more rigorous, and her medications were increased.

Unfortunately, Luka's increased treatment did little to stem the tide of her worsening psychological health. Luka had entered puberty, and she became deeply uncomfortable with her developing body, especially her breasts—a feeling exacerbated by the exploitation she had experienced online. Hoping to alleviate her distress, Luka turned to online forums, where she discovered transgender influencers who extolled the virtues of hormone therapy and surgery, claiming that taking such steps could ease Luka's suffering. Motivated by the views of these commentators, Luka began binding her breasts, transferred from an all-girls school, changed her name, and told her mental health providers and her parents that she was transgender and wanted to receive "top surgery"—the permanent surgical removal of her breasts.

The gender clinic providers worked in tandem to accelerate Luka's "gender-affirming" treatment. After a mere fifty-five-minute session with one provider,

Luka was diagnosed with gender identity disorder, and the providers began steering her toward surgery. Throughout 2017, Luka continued to experience significant familial and academic turmoil, and her mental health condition worsened. Rather than help Luka process the physical changes she was experiencing as a result of puberty and treat her underlying mental health problems, Luka's mental health providers encouraged Luka to seek support from LGBT support groups, discussed chest-binding, and ultimately referred Luka, then 15 years old, to a gender clinic for "top surgery."

In January 2018, Luka met with a plastic surgeon for the first time. Despite having never met Luka before, the surgeon diagnosed Luka with gender identity disorder and began planning for a double mastectomy. Although the surgeon acknowledged that the ordinary approach would be to wait until Luka was older, Luka's providers warned that delaying surgery could increase psychological harm and invoked suicide risk even though Luka had not expressed suicidal thoughts for nearly a year. Trusting the providers' claimed expertise, Luka's parents consented.

During the preoperative process in July 2018, Luka was warned about ordinary surgical risks such as infection, bleeding, scarring, and an undesirable aesthetic result. But she was not meaningfully prepared for the possibility that she might later regret removing healthy breasts, which could not be restored. On July 26, 2018, when Luka was 16 years old, her breasts were surgically removed.

Luka's providers were not content with the removal of her breasts, viewing her "transition" as incomplete. Her providers started Luka on testosterone, even though the prescribing physician failed to inform Luka of the profound effects testosterone would have on her physiologically and psychologically. Within a year, the same physician also recommended that Luka have a partial hysterectomy as the next step in her transition. Luka's parents objected, and she did not undergo the procedure. She continued taking testosterone for several years, during which she experienced heart irregularities, aching joints, and pelvic pain. In late 2022, she stopped testosterone because of those symptoms.

In early 2023, Luka told one of her providers that she no longer identified as male. She explained that she was in significant pain because of the long-term use of testosterone and now understood that, at age 16, she was unable to appreciate what consenting to permanent surgery would mean for the rest of her life. In response, the provider did little more than tell Luka that this was just another step on her gender journey and that she should seek further mental health counseling, the very thing that should have been done from the start.

Luka's experience illustrates the particular danger in treating an adolescent's insistence as the end of a clinical inquiry. The State characterizes the referrals contemplated by Washington's law as merely "voluntary." But a vulnerable minor can voluntarily accept a referral and still lack the perspective necessary to understand where the referral may lead. That is why parental involvement is not an incidental

procedural preference. It is one of the principal safeguards against irreversible decisions made during a period of crisis.

III. CLEMENTINE BREEN

As a young child in Southern California, Clementine Breen never expressed any feelings of confusion about her gender or indicated in any way that she felt like a boy. As she matured, however, serious mental-health challenges surfaced. She suffered from anxiety, depression, presumed autism, and undiagnosed post-traumatic stress disorder. Her childhood included repeated sexual abuse, the difficulties of living with a severely autistic and sometimes violent sibling, and the loss of both grandmothers and a beloved pet in a short period. Together, these events created an emotionally disturbing home environment for Clementine that exacerbated her underlying psychological conditions—conditions that demanded compassionate, patient, and mindful professional care.

Unfortunately, Clementine did not receive such care. When Clementine entered puberty around age 11, she began meeting with a school counselor. During one meeting, she said that she thought life would be easier if she were a boy. Rather than explore how that statement related to her history of abuse, puberty, or other mental-health problems, the counselor concluded that Clementine was transgender and informed her parents.

Unsure how to proceed, Clementine's parents sought guidance from a youth gender-medicine center. Clementine first met with the center's providers in December 2016, shortly after turning 12 years old.

Within minutes—and without a formal psychological evaluation, consultation with her other doctors, or meaningful exploration of her underlying mental-health problems—a physician diagnosed Clementine with gender dysphoria and told her she was "trans." The physician immediately recommended puberty blockers to prevent her from going through what was described as the "wrong puberty" and to prevent the "irreversible" changes of female puberty. The doctor recommended that Clementine have a puberty blocker surgically implanted in her arm and ordered the implant that same day. On March 6, 2017—less than three months after Clementine's first visit—Clementine received the puberty blocker implant.

From there, Clementine was rushed along the "gender-affirming care" pipeline with little regard for whether these treatments were in any way indicated for her. In September 2017, a gender-center physician recommended testosterone to keep her transition "on track." While Clementine was initially uncertain, her doctor convinced her it was necessary if Clementine ever wanted to "pass" as a biological male. Clementine's parents opposed the treatment. To persuade them, the physician falsely told them that Clementine was suicidal and framed the choice in catastrophic terms: accept a living son or risk a dead daughter. Believing that refusal could lead Clementine to take her own life, her parents consented. Clementine began testosterone in January 2018, at age 13 and only thirteen months after her first visit to the gender center.

The effects of the testosterone were quick. Clementine developed acne, grew more body hair, spoke in a lower register, and had a substantially increased

libido. Her physician then recommended a double mastectomy, emphasizing that early surgery would make her chest more closely resemble that of a biological male. To obtain surgery, Clementine needed recommendation letters from a physician and mental-health professional. Both were hurriedly provided.

Clementine's surgeon did not meet her in person until the morning before surgery and, even then, did not thoroughly discuss the risks of the surgery with her. Her mother did not receive the consent form until roughly an hour before the procedure. In May 2019, at age 14, both of Clementine's healthy breasts were removed.

Her mental health worsened after surgery. Clementine developed depression, intense anger, suicidal thoughts, self-harm, an eating disorder, and auditory and visual hallucinations. Psychiatrists prescribed antidepressant and anti-anxiety medication. Yet the gender center continued to advise further transition, including a higher testosterone dosage and a recommendation for hysterectomy.

Eventually Clementine and her family began to doubt the competency of the gender center's care and decided to go a different route, including dialectical behavior therapy. Through that treatment, Clementine began to understand her mental-health struggles as connected to unresolved trauma rather than to an immutable need to become male. She reduced and then stopped testosterone in early 2024. Her mental health improved as she did so and as she resumed identifying as female.

But much of the damage cannot be undone. Clementine's voice and body are permanently masculinized by testosterone. Her breasts cannot be restored. She may face impaired fertility. She also continues to navigate the social consequences of having spent formative years living as a boy. Her story demonstrates why the government cannot treat the difference between immediate medical treatment and a referral for "affirming" behavioral health services as though the latter were harmless. In Clementine's experience, affirmation was not the endpoint. It was the entry point.

IV. *AMICI'S* EXPERIENCES SHOW WHY THE FRA AMENDMENTS THREATEN GRAVE AND IRREVERSIBLE HARM

Respondents emphasized at the certiorari stage that the FRA Amendments do not authorize DYCF to administer puberty blockers, hormones, or surgery, but instead require the Department to offer referrals for behavioral-health services. Br. in Opp. 6–9. But *amici's* experiences demonstrate why this fact provides little comfort to parents. None of the *amici* began with surgery. Each began with counseling or other mental-health treatment in which providers affirmed her asserted gender identity. That affirmation naturally led to referrals to a gender clinic, the referrals led to puberty blockers or testosterone, and those interventions eventually led to double mastectomies and recommendations for still more surgery. Not every child referred for behavioral-health services will follow that path. But *amici* did. And their experiences illustrate why parents may reasonably regard the beginning of that process as consequential rather than benign.

The consequences can also be permanent. Chloe received puberty blockers and testosterone at 13 years old and underwent a double mastectomy at 15. Luka underwent a double mastectomy and began testosterone at 16 years old. Clementine received puberty blockers at 12 years old, testosterone at 13, and a double mastectomy at 14. All three later detransitioned. Yet detransition could not restore what had been removed or reverse every physical effect of the treatments they received. Their experiences include permanent masculinization, loss of breast tissue and sensation, postoperative complications, physical pain, and concerns regarding fertility.

This Court's decision in *United States v. Skrmetti*, 605 U.S. 495 (2025), confirms that the risk of harm at issue here is not speculative. In describing the medical landscape surrounding these treatments, the Court noted that "current standards recognize known risks associated with the provision of sex transition treatments to adolescents, including potential adverse effects on fertility and the possibility that an adolescent will later wish to detransition." *Id.* at 504. The Court also observed that data remain limited concerning the "long-term physical, psychological, and neurodevelopmental outcomes in youth," and that understanding of gender-identity development during adolescence continues to evolve. *Id.* (citation omitted). And it recognized that health authorities in several European countries have responded to evidentiary uncertainty by substantially restricting the availability of these interventions for minors. *Id.* at 505. Of course, *Skrmetti* did not purport to resolve every medical dispute surrounding pediatric gender medicine. But it left no doubt that the treatments at issue

implicate serious risks, give rise to potentially irreversible consequences, and are fraught with genuine scientific uncertainty.

Those realities make parental involvement especially important. This Court has long recognized that "children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment." *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Instead, "[p]arents can and must make those judgments." *Id.* And a child's disagreement with a parent's medical judgment does not itself transfer that authority to the State. *Id.* at 604. These principles have particular force here, where the decision may permanently alter the child's body, fertility, or sexual function.

The injury Petitioners seek to prevent therefore cannot sensibly be evaluated only from the end of the treatment pathway. By the time a child has received hormones or undergone surgery, the threatened harm is no longer merely imminent; it is irreversible. *Amici* know that firsthand. Each was certain as an adolescent that transition was the answer to her distress. Each later concluded otherwise. But it was too late by then—their bodies could never go back to what they were.

That is why Petitioners should not have to wait for the feared treatment to occur before they may challenge a legal regime that diminishes their ability to prevent it. Washington has placed runaway minors seeking "gender-affirming treatment" into a special notification-and-referral process that Petitioners allege can delay meaningful parental involvement while

the State offers affirming behavioral-health services. Pet. Br. 5–15. *Amici's* experiences provide concrete examples of the injury Petitioners allege. The FRA Amendments authorize referrals for "affirming" services without parental involvement while also delaying or limiting the parents' ability to learn what is happening with their child. Pet. Br. 9–15. For a child already seeking "gender-affirming treatment," that exclusion can prevent parents from intervening before counseling and affirmation set the child down the pathway to medical treatment with permanent consequences. Once those consequences occur, no later lawsuit—and no later change of mind—can undo them.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge the Court to reverse the judgment of the Ninth Circuit and hold that Petitioners have Article III standing to challenge Washington's statutory scheme.

Respectfully submitted,

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