

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

and

L.W., BY AND THROUGH HER PARENTS AND NEXT
FRIENDS, SAMANTHA WILLIAMS AND BRIAN WILLIAMS, ET
AL., RESPONDENTS IN SUPPORT OF PETITIONER

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT
OF APPEALS FOR THE SIXTH CIRCUIT

**BRIEF OF MAX LAZZARA AS *AMICUS CURIAE*
IN SUPPORT OF RESPONDENTS**

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INTEREST OF *AMICUS CURIAE*¹

Amicus curiae Max Lazzara is an individual who experienced the kind of medicalized pediatric gender-affirming care prohibited by Tennessee Senate Bill 1. She experienced medical transition as a minor, including commencing testosterone and undergoing a double mastectomy, both at age 16. Yet, after six years of living as a male her gender dysphoria began to fade, and eight years after transition she realized she had made a mistake and detransitioned back to her original female identity. Max attempted suicide several times both before and after medical transition.

In the United States, pediatric gender-affirming care protocols justify medical transition as a purported solution to the risk of suicide. Max seeks to show the Court—through her own story and medical studies—that pediatric medical transition in fact does not reduce the risk of suicide and fails to properly address the patient’s mental health. Indeed, countries outside the United States have modified their protocols, restricting medical transitions for minors. Yet, in the United States the medical transition of minors continues based on ideology rather than evidence, with practitioners using the fear of suicide to manipulate patients and parents in order to obtain consent to medical transition. Max’s story illustrates how medical transition is offered in gender-affirming care as the only solution to distress, and hence directs patients into extended periods of living as transgender persons, regardless of whether or not such is a permanent identity of the individual.

¹ No party or counsel for a party authored this brief in whole or in part. No one other than *amicus* or her counsel made a monetary contribution to preparing or submitting this brief.

To fully convey Max Lazzara’s story, this statement of interest includes her personal statement. Max Lazzara is willing to share this personal information with the Court, in a context where much of her story was already publicized in a Reuters’ Special Report on “*Why detransitioners are crucial to the science of gender care.*”² The rest of the brief will build upon the issues raised by her story with objective information pertaining to the issue of suicide and the care of persons experiencing gender dysphoria/discordance.

Here is Max’s story in her own words:

I began identifying as female to male (FTM) transgender in March of 2011 when I was 14 years old. As a child, I had some history of gender incongruence (including 6 months of insisting on a male identity and different name when I was 5 years old), alienation and ostracization from other girls & from female gender norms, confusion over sexual orientation, and discomfort with my female physical characteristics, which intensified as I started puberty at age 11. I was tomboyish in some ways, but generally just thought of myself as a girl until I discovered the definition of FTM transgender online and immediately took that identity on. This was only a month after my first hospitalization for mental health issues; I had previously overdosed on household medications three times (at ages 11, 13, and 14) with the intent of suicide, but only became sick, and was not hospitalized.

² Robin Respaut, et al., *Why detransitioners are crucial to the science of gender care*, REUTERS, (Dec. 22, 2022), <https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/>.

I began to come out to people close to me as trans, was in both inpatient and outpatient hospitalization during the summer of 2011, and came out publicly in October, during my freshman year of high school. After disclosing this, I moved out of state to live with my aunt and began socially transitioning at a new school. After four months, I moved back home to Minnesota and started at another new school, continuing my social transition. I was sexually assaulted while using the boys' bathroom and attempted suicide, this time with it being life-threatening, and spent a few weeks in inpatient hospitalization. It was after this incident that I first visited the University of Minnesota's Center for Sexual Health, where I would begin the process of medical transition.

My care team at the Center for Sexual Health was made fully aware of my psychiatric history, and I was diagnosed with Gender Identity Disorder (GID) over two intake appointments in May 2012. At this time I was also diagnosed with "Adjustment disorder with mixed disturbance of emotions and conduct," indicating that I was in a heightened state of emotion after an intense event, but this did not deter my therapist from diagnosing me with GID. I had previously received diagnoses for major depressive disorder, generalized anxiety disorder, (provisional) bipolar disorder, and OCD during my first hospitalization the prior year.

I began to see my therapist twice monthly, and in the fall of 2012 began attending a group for trans-identified teenagers and our parents. We met in a large group with clinicians from the

Center for Sexual Health, as well as breaking off into teen-only and parent-only group discussion with clinicians. It was during these group sessions that the threat of impending suicide was presented most heavily to me and especially to my mother. I do recall hearing “you’d rather have a live son than a dead daughter, right?” as a hypothetical, and my mother reports that these sentiments were a constant refrain in the parent-only group. Any parent who expressed doubts (even if only about medicalization, not identity) was reassured that this was truly who their child was, and that failure to align with the desires of the child was putting them at risk of death. The group functioned as a support group, but it also served to assure us teenagers that our desires were paramount, that what we imagined for our bodies was not to be challenged, and that our distress could be managed, but not solved - except with medical measures that would change our physical characteristics. The distress was validated as being rational, rather than being challenged, as it would be with any other sort of disorder related to body dysmorphia, such as anorexia.

It only took five months for me to begin taking testosterone (October 2012, age 16), despite my therapist indicating in my records that I was still experiencing significant psychiatric & emotional disturbance and difficulty functioning socially and in public. The idea was that the hormones would be what finally gave me confidence, finally allowed me to function normally. It truly does seem that my doctors saw medical measures as an eventual solution to my

distress, and not as something that could potentially complicate existing mental health concerns. Ten months later, still age 16, I had a double mastectomy at a private plastic surgery clinic. Despite the medicalization - and the fact that I was now passing as a boy and most of my peers had no idea of my birth sex - in January 2014, I once again attempted suicide and was hospitalized, this time not staying in inpatient. My final visit to my gender therapist was in February 2014. She notes that I was “hospitalized after a negative peer-related event,” neglecting to mention that it was for a suicide attempt. This visit was also the first and only time I saw her after my mastectomy.

I continued hormones but ceased seeing trans-specific health providers entirely, determined to move on with my life. I had relationships, friendships, got a job, got an apartment, graduated high school, and in some ways things seemed to be going quite well. However, I still struggled with mental health, and increasingly with addiction and disordered eating. I once again attempted suicide in May 2017, when I was 20 years old, and was hospitalized inpatient.

Additionally, I lived and was treated at a residential treatment center for 7 months in 2018. My eating disorder and addictions more or less took center stage, my gender dysphoria began to fade, and after a few years of mounting confusion I finally realized I had made a mistake in early 2020, and decided to detransition in October 2020, coming out as a lesbian and seeing myself as an adult woman for the first time.

My clinicians assured me and my family that medicalizing - in particular, medicalizing so fast and so young - was the most important thing we could do in order to prevent me from attempting suicide again. In reality, all my existing issues continued, new issues (such as addiction or disordered eating) were not addressed, and I became incredibly adept at compartmentalizing and minimizing my mental health concerns. I cannot say whether medicalization furthered my mental health issues or simply allowed them to continue, but I was certainly not told I had other options. Being diagnosed with GID at 15 - being told by medical professionals I was correct that I was “actually male” or “had a male brain” - gave my dysphoria a real sense of permanence, and no clinician ever suggested to me that I could be using this identity to cope with trauma, low self-esteem, or peer alienation, despite knowing those were my main struggles.

By validating the distress rather than validating me, the distress was given undue power and allowed to run rampant. Medical transition did not, in any way, prevent or reduce my risk of suicidal ideation and suicide attempts.

SUMMARY OF ARGUMENT

Children and adolescents experiencing gender dysphoria/discordance and gender diverse youth are highly vulnerable.³ They deserve treatment protocols that reflect evidence-based medical care, based upon soundly constructed research studies, appropriate weighing of risks and benefits, and implementing the basic bioethical principles of “first, do no harm.”⁴

Unfortunately, the practice of pediatric gender-affirming care in the United States implements contentious ideological premises that consider it unnecessary and inappropriate to take the time to properly assess patients prior to implementing medical transition.⁵ The ideology of gender-affirming care considers it “anti-trans” not to offer and encourage medical transition for minors, regardless of uncertainties about long-term impacts. Researching those who desist or detransition is considered a distraction or even betrayal, rather than as necessary and useful to the construction of sound protocols of care. Those who speak of detransitioning or desisting are considered traitors to a cause to be silenced and shamed, rather than persons in need of care and understanding.⁶

This ideological agenda has used the topic of suicide and suicidality to shut down concerns about the long-term impacts of pediatric transgender interventions, whether by parents, patients, physicians, the

³ J.A. 301.

⁴ J.A. 343–44.

⁵ Emily Bazelon, *The Battle Over Gender Therapy*, NY TIMES, <https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html> (last updated June 24, 2022); Respaut, *supra* note 2.

⁶ Respaut, *supra* note 2.

medical community, or the general public. Parents are told that “[i]t’s better to have a live son than a dead daughter”⁷ or asked, “[w]ould you rather have a dead daughter or a live son?”⁸ Those who raise concerns about these pediatric medical interventions are accused of being responsible for dead children.⁹ Even in this case, the implication is raised that if this Court upholds the Tennessee law at issue, the result will be an increase in suicides.¹⁰

This fear-mongering around the risk of suicide is not supported by the evidence. Indeed, the weight of evidence and logic suggests that Tennessee’s prohibition of pediatric medical interventions would save lives.

Tennessee’s prohibition of pediatric medical transition is consistent with the watchful waiting approach that used to be predominant in the care of pediatric gender dysphoria patients. Watchful waiting is *not* the equivalent of conversion therapy. It is based on data (discussed below) that most cases of gender dysphoria in children, in the process of the child’s development, resolve by adulthood.¹¹ Watchful waiting was an accepted method of treatment in the field of pediatric transgender medicine in the United States and Canada until ten to fifteen years ago.¹² Variations of

⁷ Bazelon, *supra* note 5.

⁸ J.A. 905.

⁹ Bazelon, *supra* note 5.

¹⁰ Brief for the Petitioner at 3, *United States v. Skrmetti*, (No. 23-477); Reply Brief for the Petitioner at 7, *United States v. Skrmetti*, (No. 23-477).

¹¹ J.A. 504-06, 620-23, 668-70.

¹² Bazelon, *supra* note 5.

watchful waiting are once again becoming the predominant form of treatment of pediatric gender dysphoria in Western Europe, where nations reviewing pediatric protocols have determined that the medical interventions at issue in this case are experimental in pediatric care and should only be employed in exceptional circumstances.¹³ Given the structure of European health care systems, these new European restrictions are the functional equivalents of Tennessee's prohibition, at least for purposes of the facial constitutional challenge involved in this case.

There are reasons to believe that, as to the risk of suicide, attempted suicide, and serious suicidal ideation, over the lifetime of the patient, watchful waiting protocols for children and adolescents experiencing gender dysphoria are superior to, and would save more lives as compared with, the aggressive practice of pediatric medical interventions found in the current practices of pediatric gender-affirming care.

First, there is agreement that transgender adults experience very high rates, far above the general population, of suicide, attempted suicide, and serious suicidal ideation.¹⁴ Adult transgender life in itself, therefore, includes very heightened risks related to suicide.¹⁵

Second, there is substantial evidence that most gender dysphoria beginning in either childhood or

¹³ J.A. 332–42, 356–70, 504–06, 582–92

¹⁴ See *infra* Section II.

¹⁵ *Id.*

adolescence will resolve.¹⁶ The resolution does not come through “conversion therapy” but through the course of the person’s development.¹⁷

Third, there is substantial evidence that pediatric medical transition, combined with the ideological pre-suppositions propagated in the process of gender-affirming care, direct patients into a longer-term pathway of transgender identity, from which it is difficult to detransition or desist.¹⁸ Thus, pediatric gender-affirming care, and especially medically transition, extends gender dysphoria, rather than merely providing a means of transition.

Fourth, this suggests that children treated under the protocols of gender-affirming care will, statistically, spend much more of their lives as transgender persons with the corollary very high rates of suicide, attempted suicide, and suicidal ideation.¹⁹ The stark statistical differences—a 3.5 times higher rate of suicide for transgender adults according to one study, and much higher in others—means that avoiding adult life years lived as a transgender individual would itself

¹⁶ J.A. 650–55; James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. OF SEX & MARITAL THERAPY 307, 307–13 (2020); Jiska Ristori & Thomas D. Steensma, *Gender dysphoria in childhood*, 28 INT’L REV. OF PSYCHIATRY 13, 18–22 (2016); Kenneth J. Zucker, *The myth of persistence: Response to “A critical commentary on follow-up studies and ‘desistance’ theories about transgender and non-conforming children” by Temple Newhook et al.*, 19 INT’L J. OF TRANSGENDERISM 231, 231–45 (2018).

¹⁷ J.A. 650–55.

¹⁸ J.A. 635–41.

¹⁹ J.A. 443–45, 504.

avoid suicide.²⁰ This is not a justification for conversion therapy, nor is it a denigration of those who live full lives as transgender persons. But it is a corrective to pediatric gender-affirming care protocols that use the fear of suicide to justify pediatric medical transition, thereby manipulating patients, parents, and society.

Fifth, for some, the very process of medical transition may be a causative factor for suicide and attempted suicide. Both an early Dutch study concerning adults undergoing surgical transition and a recent American study concerning pediatric medical transition have found an unusually high rate of attempted suicide and/or suicide as adverse events related to medical transition.²¹

Sixth, there is no specific evidence of a significantly lower suicide rate for those who have received puberty blockers and/or cross-sex hormones, as compared to those who have not received these medical

²⁰ Annette Erlangsen, et al., *Transgender Identity and Suicide Attempts and Morality in Denmark*, JAMA 2145, 2145–2153 (2023).

²¹ Bram Kuiper & Peggy T Cohen-Kettenis, *Sex reassignment surgery: A study of 141 Dutch transsexuals*, ARCHIVES OF SEXUAL BEHAVIOR 17, no. 5 (1988); Diane Chen, et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388 N. ENGL. J. MED. 240, 240 (2023). See also Highlights of Prescribing Information, Food and Drug Association (Apr. 2022), https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/019732s045,020517s043lbl.pdf (depression, suicidal ideation and attempt reported as adverse events in postmarketing experience); Chad Terhune, et al., *As more transgender children seek medical care, families confront many unknowns*, REUTERS (Oct. 6, 2022), <https://www.reuters.com/investigates/special-report/usa-transyouth-care/> (discussing concern with prescribing puberty blockers for transgender children already at higher risk for mental health issues).

interventions. Such claims are inferences that go far beyond the actual evidence and thus are based on an ideological preference for gender-affirming pediatric care.²²

Seventh, the standard-setting process in the United States has been undermined by an ideological commitment to pediatric gender-affirming care. This has systemically distorted all stages of evidence-based medicine. These ideological commitments create incentives for researchers to affirm gender-affirming care, shape the design and interpretation of studies, determine how results are presented, and justify intense advocacy against research that produces results contrary to the orthodoxies of gender-affirming care. Ideological commitments incentivize American researchers and clinicians to ignore and explain away the findings of systematic European reviews finding a lack of evidence to support the practice of pediatric medical transition.²³

The standard-setting process is particularly resistant to consideration of those who detransition, desist, or regret, as well as those whose gender dysphoria would have naturally resolved without the protocols of gender-affirming care. Such individuals are rendered virtually invisible and insignificant, apparently because the very existence of such persons is a challenge to pediatric gender-affirming care protocols. For example, according to the most recent version of WPATH's Standards of Care (SOC-8), "no clinical cohort studies have reported on profiles of adolescents who regret

²² J.A. 398–400, 664–72; *see also* Section VIII, *infra*.

²³ Bazelon, *supra* note 5; J.A. 531, 582–92.

their initial decision of detransition after irreversible affirming treatment.”²⁴

Rather than seeking to fill in this gap, proponents of pediatric gender-affirming care discourage such studies as irrelevant or dangerous, leaving academics and clinicians “terrified to do this research.”²⁵ Almost all studies track patients for far too short a period of time to capture patients who detransition or desist, relying on and extrapolating from the tendency of those who transition to continue in that pathway for a significant period of time. In the meantime, patients who detransition and desist receive online abuse “telling them to ‘shut up’ or even sending death threats,” and the physicians who medically transitioned them may be of no help in the pathway back.²⁶

²⁴ WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* S47 (8th ed. 2022) [hereinafter SOC-8] (emphasis added).

²⁵ Respaut, *supra* note 2.

²⁶ *Id.*

ARGUMENT

I. Watchful waiting versus gender-affirming care

Much of current pediatric gender-affirming medicine in the United States is focused on giving patients what they want as quickly as possible, and much of the passion of proponents presumably comes from seeing immediate benefits as to happiness and mental health in at least a significant number of patients. This leads to mantras such as “children know who they are.”²⁷ However, giving children what they want now is not a rational basis for medical interventions with potentially permanent, and certainly long-term, impacts.

Tennessee’s prohibition of pediatric medical transition is consistent with the watchful waiting approach that used to be predominant in the care of pediatric gender dysphoria patients. Watchful waiting is not the equivalent of conversion therapy; rather, it involves supportive counseling.²⁸ It is based on data that most cases of gender dysphoria in children and adolescents, in the process of the child’s development, resolve by adulthood.²⁹ Watchful waiting was an accepted method of treatment in the field of pediatric transgender medicine in the United States and Canada until ten to fifteen years ago.³⁰ Variations of

²⁷ Ed Yong, *Young Trans Children Know Who They Are*, THE ATLANTIC (Jan. 15, 2019) <https://www.theatlantic.com/science/archive/2019/01/young-trans-children-know-who-they-are/580366/>.

²⁸ J.A. 443–45, 504.

²⁹ *Id.*

³⁰ Bazelon, *supra* note 5; WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th ed. 2012).

watchful waiting are once again the predominant form of treatment of pediatric gender dysphoria in much of Western Europe, as those countries have determined that the more aggressive medical interventions at issue in this case are experimental and should only be employed in exceptional circumstances.³¹

SOC-8 affirms that “prepubescent children are not eligible for medical intervention” and that “gender trajectories in prepubescent children cannot be predicted and may evolve over time.”³² Hence, even current gender-affirming standards employ something like watchful waiting for prepubescent children.

II. Studies of transgender adults in the United States and Europe find alarmingly high rates of both suicidal ideation and suicide, and the evidence does not demonstrate that pediatric medical transition reduces those rates.

Numerous studies in the United States and Europe over decades have found that transgender adults have

³¹ J.A. 332–43, 582–92; *Children and young people’s gender services: implementing the Cass Review recommendations*, NHS ENGLAND, <https://www.england.nhs.uk/long-read/children-and-young-peoples-gender-services-implementing-the-cass-review-recommendations/> (last updated Aug. 29, 2024); *Care of Children and Adolescents with Gender Dysphoria: Summary*, SOCIALSTYRELSEN (Swedish National Board of Health and Welfare) (Dec. 2022); <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>; Azeen Ghorayshi, *Youth Gender Medications Limited in England, Part of Big Shift in Europe*, NY TIMES (Apr. 9, 2024) <https://www.nytimes.com/2024/04/09/health/europe-transgender-youth-hormone-treatments.html>.

³² SOC-8, *supra* note 24, at S67.

very high rates of suicidal ideation and suicide, even in the most accepting societies.³³

Further, the available evidence does *not* demonstrate that pediatric medical transition reduces suicide rates, either before or after adulthood.³⁴

The earliest studies of suicide come from the Netherlands. In a 1988 study of 141 patients who had undergone sex reassignment surgery, three patients committed suicide post-transition, and sixteen attempted suicide within two to five years of starting transition.³⁵ By contrast, the Dutch suicide rate has varied from a high of around 14.4 per 100,000 annual suicides in the early 1980s to around 11 per 100,000 in more recent years. Thus, the three suicides out of 141 patients over a maximum of five years is exceptionally high, with an equivalent rate of at least 425 suicides per 100,000.³⁶

A Swedish population-based matched cohort study covering the period from 1973 to 2003 of those who had undergone sex reassignment surgery found “considerably higher risks for mortality, suicidal behavior and psychiatric morbidity than the general population.”³⁷ “[M]ortality from suicide was much higher in sex-

³³ See J.A. 398–400.

³⁴ J.A. 398–400, 664–72.

³⁵ Bram Kuiper & Peggy T Cohen-Kettenis, *Sex reassignment surgery: A study of 141 Dutch transsexuals*, Archives of Sexual Behavior 17, no. 5 (1988).

³⁶ *1,894 suicides in 2016*, CENTRAAL BUREAU VOOR DE STATISTIEK (June 28, 2017) <https://www.cbs.nl/en-gb/news/2017/26/1-894-suicides-in-2016>.

³⁷ Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE 1, 1 (2011).

reassigned persons, compared to the matched controls.”³⁸ The raw data shows 10 deaths by suicide among the 324 sex-reassigned persons, whereas there were 5 deaths by suicide for 3240 matched controls: a rate about twenty times higher.³⁹

More recently, a large-scale Danish study following nearly seven million people over four decades of health and legal records found that transgender individuals had 7.7 times the rate of suicide attempts, and 3.5 times the rate of deaths of suicide, as compared with the rest of the population.⁴⁰ Further, the risk of death by causes other than suicide was nearly double that for the non-transgender population.⁴¹ As to mental health concerns, nearly 43% of the transgender population had a psychiatric diagnosis, compared with 7% of the general population.⁴²

A study examining Veterans Health Administration electronic medical records from 2000 to 2011 through official “gender identity disorder” codes found “the rate of suicide-related events” among transgender VHA veterans “more than 20 times higher than were rates for the general VHA population.”⁴³

³⁸ *Id.* at 5.

³⁹ *Id.*

⁴⁰ Erlangsen, *supra* note 20.

⁴¹ *Id.*

⁴² *Id.*

⁴³ John R. Blosnich, et al., *Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care*, 103 AM. J. PUBLIC HEALTH e27, e27.

More recently, the Williams Institute at UCLA Law School in 2019 published the results from the 2015 US Transgender Survey, touted as the “largest survey of transgender people in the US to date”⁴⁴ This was an online survey of adults (18 and older) which produced 27,715 respondents; like any online survey, it reflects the limitations of such self-selected, online survey results.⁴⁵ In many respects the sample was not representative of the US population, being much younger and better educated, and with a higher proportion of white respondents.⁴⁶ Obviously, as a survey of the living, it could not identify completed suicides. Nonetheless, it is striking that “transgender adults have a prevalence of past-year ideation that is about twelve times higher, and a prevalence of past-year suicide attempts that is about eighteen times higher, than the US general population.”⁴⁷ Indeed, 81.7% “reported ever seriously thinking about suicide in their lifetimes, while 48.3% had done so in the past year. In regard to suicide attempts, 40.4% reported attempting suicide at some point in their lifetimes, and 7.3% reported attempting suicide in the past year.”⁴⁸

Given the overwhelming evidence, SOC-8 acknowledges that “[s]ome studies have shown a higher prevalence of depression, anxiety, and suicidality than in the general population, *particularly in those requiring*

⁴⁴ Jody L. Herman, et al., *Suicide Thoughts and Attempts Among Transgender Adults*, UCLA SCHOOL OF LAW WILLIAMS INSTITUTE 1 (Sept. 2019), <https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/>.

⁴⁵ *Id.* at 5.

⁴⁶ *Id.* at 10–11.

⁴⁷ *Id.* at 1.

⁴⁸ *Id.*

medically necessary gender-affirming medical treatment."⁴⁹ SOC-8 and others hypothesize that these much higher rates of suicidality stem from discrimination and minority stress.⁵⁰

But evidence shows that neither discrimination nor minority stress is, in general, associated with completed suicides.⁵¹ For example, as to race, the suicide rate for Black males in the United States was considerably lower in 1950, under the conditions of state-approved segregation, than it was in 2018: (7.5 versus 11.6 per 100,000).⁵² The rates of suicide for white males from 1950 to 2018 have been two to three times higher than for Black males.⁵³ The rates of suicide for males are consistently more than three times higher than for females from 1950 to the latest statistics.⁵⁴ Thus, as to completed suicides, white males, often considered the privileged majority, have had, under very different social conditions as to race and gender as have existed from 1950 to the present, far higher rates of suicide than groups living under minority stress and even state-approved forms of discrimination.

Hence, suicide rates do not correlate with minority status or a lived experience of discrimination. Indeed, the Danish study of very high rates of suicides and attempted suicide comes from one of the most LGBTQ +

⁴⁹ SOC-8, *supra* note 24, at S171 (emphasis added).

⁵⁰ *Id.*; see also Herman, *supra* note 44, at 2.

⁵¹ J.A. 396–97.

⁵² *National Center for Health Statistics, CDC* (2019), <https://www.cdc.gov/nchs/hus/data-finder.htm?year=2019&table=Table%20009>.

⁵³ *Id.*

⁵⁴ *Id.*

friendly nations in Europe and, indeed, the world.⁵⁵ This is not to say that no discrimination exists, but rather to emphasize that discrimination may not be the most important factor as to suicide rates.

Thus, while anti-discrimination efforts are valuable in themselves, they cannot resolve the much higher rates of suicide and suicidality for transgender adults.

The very high rates of suicide and suicidality for adult transgender persons suggests that the representation, to pediatric patients and their parents, that medical transition will permanently resolve mental health issues and distress, and save those patients from suicide and suicidality, are false.

Further, the claims that these very rates can be alleviated by pediatric medical transition lack an evidentiary basis and are inconsistent with recent research.⁵⁶ Indeed, the British experience is that a prohibition of pediatric medical transition did *not* cause a surge in suicides.⁵⁷

⁵⁵ Erlangsen, *supra* note 20; see also *Denmark – a very LGBT+ friendly country*, DENMARK, <https://denmark.dk/society-and-business/denmark-a-very-lgbt-friendly-country>.

⁵⁶ J.A, 398-400, 664–72.

⁵⁷ Louise Appleby, *Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust: independent report* (July 2024), <https://www.gov.uk/government/publications/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust-independent-report>.

III. Research on suicide attempts and especially on suicidal ideation cannot predict actual suicide rates and may overstate the risks of actual suicide.

Advocates of pediatric gender-affirming care use studies of attempts and ideation to frighten patients and parents into commencing medical transition. But suicide is rare even among those who attempt suicide and suicidality does not predict actual suicide rates. In the United States, in 2022, about 49,000 people died by suicide, 1.6 million attempted suicide, 3.8 million made a plan for suicide, and 13.2 million seriously considered suicide.⁵⁸ Thus, about 3% of those who attempt suicide die, and the proportions are much lower for other categories of suicidality.⁵⁹

Further, groups differ on the percentage of attempts that lead to death or actual suicide; thus, females attempt suicide at substantially higher rates than males, even though males have a much higher suicide rate.⁶⁰

Suicide attempts and suicidal ideation indicate substantial distress and are, of course, of substantial concern. However, the huge and varied gap between suicide itself and the varied forms of suicidality *demonstrates that research on those steps short of actual suicide cannot necessarily predict suicide rates.* This is particularly important because of the many

⁵⁸ *Suicide Data and Statistics*, CDC (July 18, 2024), <https://www.cdc.gov/nchs/hsr/data-finder.htm?year=2019&table=Table%20009>.

⁵⁹ *Id.*

⁶⁰ *Id.*

ways in which the purported risk of a “dead child” are used in a manipulative way.

IV. Abundant evidence supports high rates of desistance and resolution of gender dysphoria.

Given the extremely high rates of suicide and suicidality in the adult transgender population, the possibility of desistance of gender dysphoria is particularly significant. Those who through the course of childhood and adolescence resolve gender dysphoria may avoid a lifetime of very high rates of suicide, attempted suicide, and suicidal ideation.

Early treatment protocols for gender dysphoria were statistically focused primarily on early-onset gender dysphoria, beginning as early as the toddler years, and most often involving biological males with a female gender identity.⁶¹ The experience with this population is that the dysphoria for most resolves by puberty in the context of a supportive “watchful waiting” protocol.⁶² SOC-8 acknowledges that gender trajectories in prepubescent children cannot be predicted and evolve over time.⁶³

In more recent years there has been a very sharp increase in minors presenting with gender dysphoria.⁶⁴ Unlike the past dominant cohort, most have been biological females, and most have been presenting near, at, or after puberty rather than early in childhood. This is not controversial: SOC-8 refers to “the

⁶¹ *Supra* note 16.

⁶² *Id.*

⁶³ SOC-8, *supra* note 24, at S67.

⁶⁴ *Id.* at S43.

exponential growth in adolescent referral rates” and notes that “adolescents assigned female at birth ... initiating care 2.5-7.1 times more frequently as compared to adolescents who are assigned male at birth.”⁶⁵ SOC-8 also acknowledged a “phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed, (or experienced and expressed) gender diversity during their childhood years.”⁶⁶ Many have pre-existing mental illness.⁶⁷

Recent studies of this apparently late-onset group have also found very high rates of desistance. A German study published in 2024 noted: “The diagnostic persistence over the 5-year follow-up period of less than 50% in all age groups is in line with the literature and presumably reflects the fluidity of the concept of gender identity in childhood and adolescence”⁶⁸ A secondary analysis of records from the US Military Healthcare System found a four year gender-affirming hormone continuation rate of 70.2%, meaning that nearly 30% had discontinued.⁶⁹ A Dutch study of gender non-contentedness in adolescence and early

⁶⁵ *Id.*

⁶⁶ *Id.* at S44–45.

⁶⁷ Rittakerttu Kaltiala-Heino, et al., *Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development*, 9 CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 1, 5 (2015).

⁶⁸ Christian J Bachmann, et al., *Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013-2022*, 121 DTSCH ARZTEBL INT 370, 370–71 (2024).

⁶⁹ Christina M. Roberts, et al., *Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults*, 107 J. OF CLINICAL ENDOCRINOLOGY & METABOLISM e3937, e3939 (2022).

adulthood concluded: “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.”⁷⁰ These studies are consistent with other research indicating a high rate of desistance.⁷¹

On the other hand, there is evidence that social and medical pediatric gender-affirming care may extend the period of gender dysphoria.⁷² As these mostly do not involve long-term studies, there remains uncertainty as to how long.

V. Many US practitioners of pediatric gender-affirming care do not carry out comprehensive assessments prior to commencing medical transition.

Many who practice pediatric gender-affirming care do not even attempt to assess or predict long-term gender identity and do not regularly conduct comprehensive psychosocial assessments, as these are perceived as needless barriers to care. The goal instead is to proceed as rapidly as possible with medical intervention, based on the view that “any delay in treatment prolongs a child’s distress and puts them at risk of self-harm.”⁷³

⁷⁰ Pien Rawee, et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 ARCHIVES OF SEXUAL BEHAVIOR 1813, 1813 (2024).

⁷¹ J.A. 652–55.

⁷² J.A. 635–41.

⁷³ Respaut, *supra* note 2.

For example, Dr. Colt St. Amand, a listed co-author of SOC-8, and a WPATH-certified practitioner and mentor, was quoted as follows by the New York Times in June 2022:

St. Amand thinks the purpose of assessment is not to determine the basis of a kid's gender identity. "That just reeks of some old kind of conversion-therapy-type things I think what we've seen historically in trans care is an overfocus on assessing identity People are who they say they are, and they may develop and change, and all are normal and OK. So I am less concerned with certainty around identity, and more concerned with hearing the person's embodiment goals. Do they want to have a deep voice? Do you want to have breasts? You know, what do you want for your body?"⁷⁴

Thus, St. Amand does not attempt to "shield teenagers from taking medication with effects they might later decide they didn't want If the drugs don't suit them ... they can simply stop."⁷⁵

Another prominent advocate of gender-affirming care negatively characterized assessments of long-term gender identity as "singling out trans kids, and specifically with a mental-health provider; not medical staff, to interrogate, to go down this comprehensive inquisition of their gender."⁷⁶

Thus, the provision of professional mental health assessment is characterized as a barrier and burden

⁷⁴ Bazelon, *supra* note 5.

⁷⁵ *Id.*

⁷⁶ *Id.*

rather than a positive provision of care. Other critics called such limits “abusive” and “unethical” and as undermining patient autonomy.⁷⁷

These negative views of assessment were elicited in response to an earlier draft of SOC-8, which for pediatric patients recommended “several years” of persistently identifying with another gender and a requirement of a comprehensive diagnostic assessment prior to commencing medical transition.⁷⁸ These requirements are minimized in the final draft; for example, gender incongruence should be “marked and sustained” prior to commencing gender-affirming medical care, but no particular period of time is indicated.⁷⁹ Thus, the SOC-8 final standards were significantly influenced by advocacy and ideology.

VI. According to SOC-8 commencing medical transition without comprehensive assessments amounts to practice without empirical support and may not be in the long-term best interests of the patient.

The final SOC-8 standards did adhere to the recommendation of a “comprehensive biopsychosocial assessment of adolescents,” despite the pushback against assessment as a “harmful assertion of psychogatekeeping.”⁸⁰ SOC-8 warned:

There are no studies of the long-term outcomes of gender-related medical treatment for youth who have not undergone a comprehensive

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ SOC-8, *supra* note 24, at S32, S48.

⁸⁰ *Id.* at S48; Bazelon, *supra* note 5.

assessment. Treatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.⁸¹

SOC-8 further noted that findings of “low regret can only currently be applied to youth who have demonstrated sustained gender incongruence and gender-related needs over time as established through a comprehensive and iterative assessment.”⁸²

SOC-8 relies entirely on Dutch studies and protocols as an evidentiary basis for gender-affirming care in adolescence. Yet, even those American clinics that conduct interdisciplinary assessments generally do not follow the much more extensive Dutch protocols. Thus, Reuters interviewed staff at 18 gender clinics across the United States and found that “[n]one described anything like the months-long assessments [Dutch clinicians] adopted in their research.”⁸³ Indeed, seven of the eighteen clinics “are comfortable prescribing puberty blockers or hormones based on the first visit, depending on the age of the child.”⁸⁴

Further, nothing prevents practitioners who disagree with the need to conduct a “comprehensive biopsychosocial assessment” (or who simply lack the resources to carry out such an assessment) from ignoring

⁸¹ SOC-8, *supra* note 24, at S51.

⁸² *Id.* at S61.

⁸³ Terhune, *supra* note 21.

⁸⁴ *Id.*

the SOC-8 recommendations. Those recommendations have no binding authority.

Thus, even according to the assessment of that evidence by SOC-8, many practitioners in the United States lack an evidence-based medical justification for their protocols with minors. These clinics are prescribing medical interventions with life-long consequences on a highly vulnerable pediatric population without an evidentiary basis for their protocols.

The lack of an evidentiary basis for the actual practice of pediatric medical gender transition in the United States has important implications for the intertwined issues of mental health, suicidality, and suicide. Without reliable long-term data about the psychological impact of pediatric gender transition, there is no way to justify the claim that such care reduces suicide, suicidality, or even assists mental health, on a long-term basis.

VII. The SOC-8 Claims that the Dutch Protocols provide an evidentiary basis for pediatric medical transition are undermined by more recent reviews of the evidence.

Recent international systemic reviews of the medical evidence for pediatric medical transition in Finland, Norway, Sweden, and the United Kingdom have caused those nations to retreat from the systemic practice of pediatric medical gender-affirming care, with the result that the pediatric use of hormones (puberty blockers and cross-sex hormones) and surgeries has been limited to exceptional circumstances and/or on an experimental basis.⁸⁵ The general conclusion has been that the more aggressive pediatric medical transitions

⁸⁵ J.A. 332–42, 356–70, 504–06, 582–92.

are based on low to very low-quality evidence, which is insufficient to justify them as a general practice, given the risks.⁸⁶

The Dutch studies lacked a control group, were based on a very small final sample of 55 cases, involved selection of only the most successful cases at each treatment stage, and used a flawed measure of resolution of gender dysphoria.⁸⁷ Most significantly, the Dutch studies excluded patients with a post-pubertal onset of gender dysphoria and those with significant mental illness, and thereby are inapplicable to a large subset of patients currently seen at gender clinics.⁸⁸

Thus, the Dutch studies lack an evidentiary basis to assert psychological benefit, including reduction of suicide and suicidality, for pediatric medical transition, particularly as such is practiced currently in the United States.

⁸⁶ J.A. 364–70.

⁸⁷ E. Abbruzzese, *The Myth of “Reliable Research” in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed*, 49 J. OF SEX & MARITAL THERAPY 673, 677 (2023).

⁸⁸ *Id.*; see also Marijn Arnoldussen, *Demographics and gender-related measures in younger and older adolescents presenting to a gender service*, 32 EUROPEAN CHILD & ADOLESCENT PSYCHIATRY 2537, 2544 (2023) (“The conclusion of a previous study that gender-affirming treatment earlier in life may have benefits is not necessarily founded for everyone.”).

VIII. Proponents of gender-affirming care in this case have relied on studies for broad claims about the benefits of pediatric medical transition that are not supported by the data in those studies.

Advocacy masquerading as science is rampant in the studies relied on by the proponents of pediatric gender affirmation in this case. One example is the study by Turban, et. al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*. The study claims that “pubertal suppression for transgender adolescents who want this treatment is associated with favorable mental health outcomes,” including “lower odds of lifetime suicidal ideation.”⁸⁹ The study expressly claims that the study “strengthens recommendations by ... WPATH for this treatment to be made available for transgender adolescents...”⁹⁰

The study itself is based entirely on the 2015 survey of transgender adults in the United States, discussed above, which showed very high rates of suicidality among transgender adults.⁹¹ To reach the study’s gerrymandered conclusions on lifetime odds of suicidal ideation, the study extracted a group of 89 survey respondents who indicated they had received pubertal suppression, compared to a group of 3405 who had not.⁹² The extracted survey answers were indicated in Table 3:

⁸⁹ Jack L. Turban, et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS 1, 1 (2020).

⁹⁰ *Id.* at 7.

⁹¹ Herman, *supra* note 44, at 9.

⁹² Turban, *supra* note 89, at 5.

TABLE 3⁹³

Raw Frequencies of Outcome Variables

Have You Ever Had [Pubertal Suppression] for Your Gender Identity or Gender Transition?

	Yes (n = 89; 2.5%)	No (n = 3405; 97.5%)
Suicidality (past 12 months)		
Ideation	45 (50.6%)	2204 (64.8%)
Ideation with plan	25 (55.6%)	1281 (58.2%)
Ideation with plan and attempt	11 (24.4%)	473 (21.5%)
Attempt resulting in inpatient care	5 (45.5%)	108 (22.8%)
Suicidality (lifetime)		
Ideation	67 (75.3%)	3062 (90.2%)
Attempts	37 (41.6%)	1738 (51.2%)
Mental health and substance use		
Past-month severe psychological distress (K6 \geq 13)	32 (37.2%)	1847 (55.1%)
Past-month binge drinking	26 (29.2%)	825 (24.3%)
Lifetime illicit drug use	24 (27.3%)	850 (25.3%)

As this table reveals, this claimed finding of lower lifetime suicidal ideation fails to note that, as to the

⁹³ *Id.* at 15. The percentages were calculated based on the number of respondents who answered the particular question.

most serious forms of suicidality—“with plan and attempt” and “attempt resulting in inpatient care”—the results are actually worse for those who received puberty blockers.⁹⁴ Indeed, the most serious category, “attempt resulting in inpatient care” is twice as high for those who received puberty blockers: 45.5% versus 22.8%.⁹⁵ *Thus, one could rationally surmise that as to the actual risk of death by suicide, the risk is far higher for those who received puberty blockers.* Either way, the risks of suicidality remained very high in the treatment group; even under the flawed methodology of the study, the prediction was for a 75.3% lifetime risk of suicidality and a 41.6% risk of attempt for those receiving puberty blockers, hardly a mental health success.⁹⁶

Similarly, as to mental health, in two of the three categories (binge drinking and illicit drug use), the statistics are worse for those who received puberty blockers.⁹⁷

In terms of reliability, the study notes that “[p]ercentages were calculated from the total of nonmissing values.”⁹⁸ This reflects that many did not respond to all of the questions, which also indicates the risks of trying to build too much out of the uncertainties of survey data. The group receiving puberty blockers were

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

not matched with those not receiving puberty blockers in age and other significant factors.⁹⁹

These flaws, and others, were pointed out in published comments and are also a part of the record in this case.¹⁰⁰ Yet, despite its flaws, this study is given prominence in this litigation. The study is cited twice in Dr. Turban’s Declaration,¹⁰¹ and the Federal District Court relies on Dr. Turban’s Declaration (although not this study specifically) on the critical issue of whether “the medical procedures banned by SB 1 are harmful to minors.”¹⁰² Some of the most significant *amici* in support of Petitioners rely on the study. Thus, the American Psychological Society relies on the study for the proposition that “[m]any scientifically rigorous studies have demonstrated improvements in mental health for transgender youth who received gender-affirming care.”¹⁰³ The APA further relies on the study for the proposition that “[t]here is substantial research that supports the efficacy of gender-affirming care in improving positive mental health outcomes for

⁹⁹ *Id.* at 13.

¹⁰⁰ Scott S. Field, MD, UAB School of Medicine, Comment, *RE: Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS (March 3, 2020); Michael Biggs, University of Oxford, Comment, *RE: Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS (Jan. 30, 2020); Paul W. Hruz, Washington University School of Medicine, Comment, *Suicidality in Gender Dysphoria Youth Offered Pubertal Blockade Remains Alarmingly High*, PEDIATRICS (Jan. 26, 2020); J.A. 111, 563-66.

¹⁰¹ J.A. 143-44, notes 5 & 6.

¹⁰² *L.W. v. Skrametti*, 679 F. Supp. 3d 668, 709, 711 (M.D. Tenn. 2023).

¹⁰³ Br. *Amici Curiae* American Psychological Association, et al., *United States v. Skrametti*, (No. 23-477), at n. 48.

transgender youth who are able to access that care.”¹⁰⁴ The amicus brief of the American Academic of Pediatrics cites the study multiple times, most significantly for its claim that “those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it.”¹⁰⁵ The Brief of Amici Curiae Clinical Practice Guideline Experts cite SOC-8’s reliance on this study to support *amici’s* overall claim that clinical practice guidelines—like SOC-8—“are reliable and evidence-based.”¹⁰⁶

The extensive reliance on this study in this litigation demonstrates that ideology has overtaken evidence. The medical organizations relied on by the District Court cannot be trusted by this Court, and the comprehensive reviews carried out in recent years in Europe are much more reliable.

Further, the ideological blinders of American practitioners indicate why Tennessee’s prohibition is necessary, as any European-style limited exceptions would most likely be abused in our decentralized healthcare system.

CONCLUSION

As experienced by this amicus and many others, the messages of pediatric gender-affirming care are simplistic: If you are experiencing gender dysphoria/discordance, you are permanently transgender. You will experience great distress, and be in serious

¹⁰⁴ Br. *Amici Curiae* American Academy of Pediatrics, et al., *United States v. Skrametti*, (No. 23-477), at n. 37.

¹⁰⁵ *Id.* 19 & n. 61.

¹⁰⁶ Br. *Amici Curiae* Clinical Practice Guideline Experts, *United States v. Skrametti*, (No. 23-477), at 4, 16.

risk of suicide, until and unless you undergo medical transition. Your mental health issues will be resolved, or at least significantly alleviated, only when you medically transition. These messages claim to be based on listening to pediatric patients but are actually a recruitment into an ideology. These messages claim to be based on evidence, but in actuality, most of the claims lack the kind of quality evidence generally required in medical care.

By contrast, watchful waiting protocols may affirm the reality of the *experience of gender dysphoria/discordance* but do not immediately ascribe a permanent transgender identity to that experience. Patients and parents can be told that the child or adolescent may be transgender but also that there are other possibilities, given the diverse possibilities as to gender identity and sexual orientation. Hence, the goal of treatment would be to accompany the patient and build resilience through what may be a journey of many years as to gender identity and sexual orientation. Mental health issues and diagnoses are to be treated as issues of their own and are not assumed to be resolvable through medical transition. Medical interventions that risk physical health complications and infertility, and may prematurely cement gender identity, are deferred to avoid unnecessary suffering.

Tennessee and the Sixth Circuit are correct that Tennessee Senate Bill No. 1 does not discriminate against any protected class. Instead, Tennessee is ensuring that pediatric patients experiencing gender dysphoria/discordance have the opportunity to receive evidence-based medical care. Tennessee is protecting minors against the harms wrought by ideologically driven forms of medical intervention. While rational basis review is the most appropriate standard,

Tennessee Senate Bill 1 survives any standard of constitutional review because it is narrowly tailored to effectuate compelling interests.

This Court should not be intimidated or manipulated by the claim that pediatric medical transition generally saves children and adolescents from suicide, and the accompanying implication that upholding Tennessee Bill 1 would lead to increased deaths. To the contrary, the best available medical evidence indicates that watchful waiting protocols consistent with Tennessee Bill 1 are most likely to reduce the risks of suicide and suicidality and save lives.

Respectfully submitted.

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OCTOBER 2024