No. 23-477

IN THE
SUPREME COURT OF THE UNITED STATES

UNITED STATES,
Petitioner,
v.
JONATHAN SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, ET AL.,
Respondents.

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

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BRIEF OF AMICI CURIAE PARTNERS FOR ETHICAL CARE, KEVIN AND CHARMAGNE COX, JOY FLORES, ANDREA SNOW, MARTHA S., KRISTINE W., BRI MILLER, LIZ AND CHRIS DOE, YAACOV SHEINFELD, HELEN S., AS AMICI CURIAE IN SUPPORT OF RESPONDENTS, SUPPORTING AFFIRMANCE

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IDENTITY AND INTEREST OF AMICI[1]

Pursuant to Supreme Court Rule 37, Amici Curiae Partners for Ethical Care ("PEC"), Kevin and Charmagne Cox, Liz and Chris Doe, Yaacov Sheinfeld, Joy Flores, Andrea Snow, Martha S., Kristine W., Bri Miller, and Helen S.[2] (collectively "Parent Amici"), respectfully submit this brief in support of Respondents.

PEC is a secular, non-partisan, grassroots nonprofit organization of people from around the world. PEC's mission is to raise awareness and support efforts to stop unethical treatment of children under the banner of "gender identity affirmation." PEC believes that no child is "born in the wrong body" and that laws such as Tennessee's and Kentucky's prohibition of body modification procedures on minors are critical to protecting children and their families from harms caused by such practices.

Parent Amici are parents of children who believed they were transgender and wanted medical interventions to change their bodies to conform to an identity that was inconsistent with their sex. Amici

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[1] 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 the amici curiae or their counsel made a monetary contribution to its preparation or submission.

[2] Some Amici are using pseudonyms to protect their identity and the identity of their children. The true identities of Amici are known to counsel.

were subjected to misinformation and coercion from health care providers attempting to convince them to consent to the interventions. Their children's underlying mental health issues were not addressed. Even where the children did not obtain the medical interventions, the availability and promotion of these interventions sowed dissension between the parents and their children that harmed the family and created distrust for the medical profession.

Amici respectfully submit this brief to provide this Court with their first-hand knowledge of the dangers posed by these interventions to which the Tennessee and Kentucky Legislatures have wisely determined minor children should not be exposed.

SUMMARY OF ARGUMENT

Tennessee and Kentucky have acted to protect minors by prohibiting medical interventions designed to divert a child's body from its natural development to an altered state mimicking the opposite sex. Tenn. Code Ann. §§ 68-33-101, et. seq., ("TN Act") and Ky. Rev. Stat. Ann. § 311.372 ("KY Act") properly balance the states' compelling interest in protecting children's health and basic human rights with the rights of parents to direct medical care, particularly when the exercise of that right is influenced by manipulation and misinformation. These laws send the message that Tennessee's and Kentucky's children will be protected from experimental medical and surgical interventions that will irreversibly change their

bodies, create future harm, and take away their right to an "open future" (to rights that must be protected so that they can be exercised in the future).[3] It is a message that Parent Amici wish their children could have heard and heeded.

LEGAL ARGUMENT

The Sixth Circuit correctly concluded that "the unsettled, developing, in truth, still experimental, nature of treatments" prohibited by the Acts provide "[p]lenty of rational bases" for the laws and "'persuasive evidence' that Kentucky and Tennessee could choose fair-minded caution and their own approach to child welfare." *L.W. v. Skrmetti*, 83 F.4th 460, 488-89 (6th Cir. 2023). Extending heightened scrutiny protection to these laws that do not use sex-based classifications to apply unequal treatment to males and females and do not violate the rights of a suspect class cannot be justified by this Court's precedents, including *Bostock v. Clayton County,* 140 S. Ct. 1731 (2020); *Skrmetti,* 83 F. 4th at 484, 486, 488.

The crumbling consensus of medical support for the treatments prohibited by the Acts, uncertainties that make true informed consent impossible, and interference with parents' fundamental right to direct children's medical care

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[3] Sarah C. J. Jorgensen, et al., *Puberty Suppression for Pediatric Gender Dysphoria and the Child's Right to an Open Future*, 53 ARCHIVES SEXUAL BEHAV. 1941, 1941 (2024) (citing J. FEINBERG,FREEDOM AND FULFILLMENT: PHILOSOPHICAL ESSAYS 76 (1980)), https://doi.org/10.1007/s10508-024-02850-4.

that is in the best interests of their children further demonstrate the wisdom of the Sixth Circuit's decision. Parent Amici's stories about coercion, deception, rending of family units, and lifelong injuries powerfully illustrate the wisdom of Tennessee's and Kentucky's decision to prohibit the treatments for minors.

I. The Acts Further The States' Compelling Interests In Protecting The Health And Welfare Of Their Children.

Since "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens," states have a compelling interest in "safeguarding the physical and psychological well-being of a minor." *New York v. Ferber*, 458 U.S. 747, 756-57 (1982) (citing *Prince v. Massachusetts*, 321 U.S. 158, 168 (1944)). Tennessee and Kentucky have acted to safeguard minor children by prohibiting harmful and unproven medical treatments aimed at denying biological reality.

The "persuasive evidence" cited by the Sixth Circuit included "considerable evidence about the risks of these treatments and the flaws in existing research." *Skrmetti,* 83 F.4th at 489.

> Administering puberty blockers to prevent pubertal development can cause diminished bone density, infertility, and sexual dysfunction. Introducing high doses of testosterone to female minors increases the risk of

> erythrocytosis, myocardial infarction, liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast and uterine cancer. And giving young males high amounts of estrogen can cause sexual dysfunction and increases the risk of macroprolactinoma, coronary artery disease, cerebrovascular disease, cholelithiasis, and hypertriglyceridemia.

Id.

A. Risks and Adverse Effects of Prohibited Treatments Prompt European Nations to Curtail or Ban Them.

Evidence describing the risks, flaws, and adverse effects of the medical interventions prompted European practitioners who pioneered the medical interventions to significantly curtail or even halt the procedures for minors. Several international systematic evidentiary reviews concluded that the practice of pediatric gender transition rests on *low to very low quality evidence*—meaning that the benefits reported by the existing studies are unlikely to be true due to profound problems in the study designs.[4] Following those

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[4] E. Abbruzzese, et al., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed*, 49 J. SEX & MARITAL THERAPY 673, 676 (2023) (emphasis in original), doi:10.1080/0092623X.2022.2150346 (citing

reviews, Sweden, Finland, and the United Kingdom adopted new treatment guidelines for gender dysphoric youth that prioritize noninvasive psychosocial interventions and sharply restrict hormones and surgery. [5]

National Institute for Health and Care Excellence ("NICE"), *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (2020), https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf. ; NICE, *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria* (2020), https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf (2020); I. Pasternack, et al., *Medical approaches to treatment of dysphoria related to gender variations. A systematic review* 106 (2019), https://app.box.com/s/y9u791np8v9gsunwgpr2kqn8swd9vdtx; SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services), *Hormone therapy for gender dysphoria—Children and young people* (2022), https://www.sbu.se/contentassets/ea4e698fa0c4449aaae964c5197cf940/hormonbehandling-vid-konsdysfori_barn-och-unga.pdf)

[5] *Id.* (citing COHERE (Council for Choices in Health Care), *Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* (2020), https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors; National Health Service (NHS), *Interim service specification for specialist gender dysphoria services for children and young people—Public consultation* (2022). https://www.engage.england.nhs.uk/

The United Kingdom's National Health Service ("NHS") commissioned an independent review of gender identity services for children and young people.[6] The final report, known as the "Cass Review," was released in April 2024. It confirmed and expanded upon the findings of the earlier systematic evidence reviews.[7] The report found that the guidelines published by the World Professional Association of Transgender Healthcare (WPATH), which have been primary sources for medical interventions, lack developmental rigor.[8] Investigators found no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes. There was insufficient or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial well-being, cognitive development, cardio-metabolic risk or fertility but

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specialised-commissioning/gender-dysphoria-services/; NHS, *Regional model for gender care announced for children and young people* (July 28, 2022), http://tavistockandportman.nhs.uk/about-us/news/stories/regional-model-for-gender-care-announced-for-children-and-young-people/; Socialstyrelsen (National Board of Health and Welfare), *Care of children and adolescents with gender dysphoria – Summary* (2022), https://www.socialstyrelsen.se/ globalassets/sharepoint-dokument/ artikelkatalog/kunskapsstod/2022-3-7799.pdf

[6] Hilary Cass, *Independent review of gender identity services for children and young people: Final report* (2024), https://cass.independent-review.uk/home/%20publications/final-report/.

[7] *Id.*

[8] *Id.* at 28.

positive evidence of compromised bone density and decreased psychological functioning.[9]

> There is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health.[10]

As a result of the Cass Review, the NHS decommissioned the use of puberty blockers for gender dysphoria and is in the process of restructuring its health care system to prioritize noninvasive interventions.[11]

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9 *Id.* at 32, 179.

10 *Id.* at 184.

11 NHS, *Children and Young People's Gender Services: Implementing the Cass Review recommendations*, NHS ENGLAND (Aug. 29, 2024), https://www.england.nhs.uk/long-read/children-and-young-peoples-gender-services-implementing-the-cass-review-recommendations/

B. U.S. Practitioners Continue to Promote Treatments Despite Low and Very Low Quality Evidentiary Support.

Despite this crumbling medical consensus regarding the efficacy and safety of medical interventions, practitioners in the United States continue to follow the guidelines based on the low quality and very low quality evidence as revealed in the European studies. American practitioners purport to continue to follow what is known as the "Dutch protocols."[12] The Dutch studies upon which the protocols are based found that medical interventions could successfully change phenotypical appearance.[13] However, they did not show that the physical changes yielded psychological improvements significant enough to justify the adverse effects of the treatment—including the certainty of sterility.[14] The studies are riddled with flaws that make them "unfit for clinical or policy decision-making."[15] The most concerning of the flaws include multiple sources of bias which undermine confidence into the reported "benefits,"

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[12] Abbruzzese, *supra* n.4, at 676 (citing A.L.C. de Vries, et al., *Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study*, 8 J. SEXUAL MED.2276 (2011), doi:10.1111/j.1743-6109.2010.01943.x; A.L.C. de Vries, et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134 PEDIATRICS 696 (2014), doi:10.1542/peds.2013-2958).

[13] *Id.*

[14] *Id.*

[15] *Id.* at 677.

incomplete evidence regarding health risks, and poor applicability to current cases.[16]

Most children and adolescents seeking the interventions today "suffer from post-pubertal onset of gender dysphoria and significant mental illness—two clinical presentations the Dutch explicitly disqualified from their studies. As such, **none of the Dutch findings are applicable to most of the youth seeking treatment today**."[17] The Dutch findings are also inapposite because psychotherapy, which is dismissed or even banned as "conversion therapy" by U.S. gender specialists, was a core part of the Dutch protocol.[18] Dutch researchers acknowledged that psychotherapy "may have contributed to the psychological well-being of these gender dysphoric adolescents."[19] In fact, psychotherapy was the only treatment permitted for "adolescents… whose wish for sex reassignment seems to originate from factors other than a genuine and complete cross-gender identity," *e.g.,* "non-binary" or other non-female or non-male identities.[20]

The fact that "gender-affirming" interventions are now provided to "the very segment that was explicitly excluded from the

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16 *Id.*

17 *Id.* (emphasis added).

18 *Id.* at 683.

19 *Id.*

20 *Id.* at 686 (citing A.L.C. de Vries, et al., *Clinical Management of gender dysphoria in adolescents*, 9 INT'L J. TRANSGENDERISM 83, 87-88 (2006), doi:10.1300/J485v09n03_04.

eligibility in the foundational studies is alarming."[21] Prohibiting such alarming interventions founded on low or very low quality evidence, flawed research, and known risks of adverse consequences was not merely reasonable, but required to protect the health and well-being of the children of Tennessee and Kentucky.

II. The Acts Strengthen Parents' Fundamental Rights To Make Sound Medical Decisions.

Parents are presumed to act in the best interests of their children to make sound medical decisions that children are incapable of making. *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Making sound medical decisions requires consulting medical professionals using the "traditional tools of medical science." *Id.* at 609. The peculiarities of the body modification interventions mean that parents are not provided with the necessary tools. Therefore, they are foreclosed from making the sound decisions necessary to protect their children's health. Prohibiting these treatments, as Tennessee and Kentucky have done, actually preserves parents' fundamental rights, and in turn, their children's health and safety.

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[21] *Id.*

A. The Body Modification Interventions Are Not Based on Credible Clinical Evidence.

"Traditional tools of medical science,"[22] include credible clinical evidence that proves the safety and efficacy of the interventions.[23] As discussed *supra,* in the case of body modification interventions there is no such credible clinical evidence. The body modification interventions also violate the cardinal rule that practitioners do not advance a single treatment approach over other safer interventions based upon low-quality evidence.[24]

Parent Amici's experiences described *infra* demonstrate that "gender specialists" do not inform parents about the lack of evidence supporting the safety and efficacy of the single option. Neither do they provide parents with evidence-based information on short-term and long-term risks, lack of FDA approval of the proposed use of the drugs and hormones, or the fact that the majority of children with gender dysphoria will desist after puberty if they are not subjected to such interventions.[25]

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[22] *Parham,* 442 U.S.at 609.

[23] Paul W. Hruz, *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, 87 LINACRE Q. 34 (2020).

[24] *Id.* at 37.

[25] *Id.* at 36.

B. Parents Cannot Exercise Informed Consent Under The Modified Concept Adopted By Body Modification Practitioners.

Unprecedented increases in children claiming a transgender identity have placed increasing pressure on practitioners to rapidly evaluate and recommend treatment.[26] As a result, practitioners have developed a perfunctory "informed consent" model that in fact contradicts true informed consent.[27]

Informed consent requires: 1) Disclosure of information about the nature of the condition, the proposed treatment and its alternatives; 2) Assessment of patient and caregiver understanding of the information and capacity for medical decision-making; and 3) Obtaining signatures.[28] Practitioners are required to thoroughly inform their patients about the benefits, risks, and uncertainties of a particular treatment, as well as about alternatives.[29]

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[26] Stephen B. Levine, et al., *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, 48 J. SEX & MARITAL THERAPY 706, 708 (2022), doi:10.1080/ 0092623X.2022.2046221.

[27] *Id.*

[28] *Id.* at 707.

[29] *Id.*

Under the modified model adopted by body modification practitioners, mental health evaluations are not required, and hormones can be provided after just one visit following the patient's or guardian's "consent" signature.[30] This is the antithesis of true informed consent. It does not provide the accurate understanding of risks, benefits, and alternatives that is required for true patient autonomy.[31] As a result, the patient, or in this case, the parents tasked with decision-making, are told that the interventions are "safe and effective," but not informed that evidence of the benefits of interventions is of very low certainty.[32] Parents are also not told that the purported benefits of the interventions must be carefully weighed against the health risks to fertility, bone, sexual and cardiovascular health, of which the parents are also not informed.[33]

Instead of fulfilling their obligation to benefit and not harm the patient, practitioners assume that children know best and work to validate the child's fervent wishes for hormones and surgery.[34] As Parent Amici attest, *infra,* the zeal to validate the child can include coercing parents to consent under threat that the child will commit suicide. Under these circumstances, "informed consent" is impossible. By prohibiting the procedures, the Acts

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30 *Id.* at 708.
31 *Id.*
32 *Id.*
33 *Id.*
34 *Id.*

stop the charade of "informed consent" as revised by body modification practitioners.

III. The Acts Protect Children's Well-Being By Helping Parents Preserve Children's Futures.

Prohibiting these body modification procedures for minors also protects children's right to an "open future" that includes the ability to make decisions regarding family creation and intimate relationships when they are mature enough to understand and appreciate the ramifications of those decisions and experience their benefits.[35] Body modification practitioners emphasize the child's immediate self-fulfillment and self-determination to the detriment of their long-term future.[36]

> Although proponents of gender affirmation recognize that gender identity development is dynamic and can undergo multiple shifts throughout childhood and into adulthood, they contend that the role of adults is not to question the child's gender identity nor explore causative factors for their dysphoria, but instead to affirm their gendered self-image and facilitate achievement of their "gender embodiment goals," through medical intervention, if desired.[37]

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35 Jorgensen, *supra,* n.3.

36 *Id.* at 1943-1947.

37 *Id.* at 1943.

By emphasizing a child's immediate self-fulfillment and re-orienting parents away from their protective instinct to restrict children's freedom of choice, body modification practitioners overlook important aspects of child development, particularly the child's right to an "open future."[38] The "open future" principle refers to rights that children do not have the capacity to exercise as minors but must be protected so children can exercise them when they reach maturity.[39] Examples include the right to decide whether to have children, get married or enter into other intimate sexual relations. Before children are mature enough to make these decisions the rights are held "in trust," *i.e.* "saved for the child until he is an adult."[40] If not properly protected, these rights can be violated "in advance" before the child is in a position to maturely appreciate or exercise them.[41] Violating the rights in advance "[g]uarantees now that when the child is an autonomous adult, certain options will already be closed to him. His right while still a child is to have these future options kept open until he is a fully formed self-determining adult capable of deciding among them."[42]

Parents are presumed to act in the best interest of their children, *Parham,* 442 U.S. at 603,

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38 *Id.*

39 *Id.* at 1942 (citing J. FEINBERG, FREEDOM AND FULFILLMENT: PHILOSOPHICAL ESSAYS 76-78 (1980)).

40 *Id.*

41 *Id.*

42 *Id.*

and therefore to protect their children's right to an open future. However, when subjected to coercive pressure from body modification practitioners, parents might accede to their child's wishes and violate the child's right to an open future. By prohibiting the body modification interventions, the Acts remove the opportunity for practitioners to exert coercive pressure. Parents will be better able to exercise their fundamental right to make decisions that are in the best interest of their children, both in the present and future.

IV. Parent Amici's Experiences Demonstrate The Compelling Need For The Act.

Parent Amici come from various walks of life but share the experience of having a child who professed to having an identity that did not correspond to his or her sex. Medical interventions were promoted as the only viable option for their children, supplanting psychotherapy which would have better addressed the children's underlying mental health issues. The promotion of these medical interventions with the ubiquitous threat of suicide created dissensions in families, exacerbation of existing trauma and adverse physical consequences for children who received the interventions. Amici are sharing their experiences to demonstrate why this Court should affirm the Sixth Circuit.

Kevin and Charmagne Cox

Kevin and Charmagne Cox are the Kentucky parents of 21-year-old triplets and 14-year-old H. Kevin is a retired Air Force Colonel and works in the health field. Charmagne works at home full-time. Their family has lived through multiple deployments, Hurricane Katrina, and a grandparent being killed by a drunk driver, but the turmoil they experienced during their daughter H's struggles with her sexual identity was the hardest thing their family has ever endured.

During the pandemic, H. was isolated and fell into depression with symptoms of self-harm and cutting. At 12, H. announced that she was pansexual. Following COVID, Charmagne rejoined a home-schooling co-op thinking the socializing would help H. She made friends with a girl who was changing names and using different pronouns. H. started wearing androgynous clothing and ordered a chest binder. After a short time, Charmagne and Kevin discontinued H.'s use of the binder because H. has asthma, and they were concerned about her breathing.

The parents later discovered that H. had been socially transitioned to a male identity at the gym and at a co-op school. Charmagne volunteered at the co-op and was friends with the director. H. was close friends with the director's daughter. Charmagne learned the school was deliberately deceiving her and her husband by referring to H. as a female and using her legal name when Charmagne was present,

but otherwise referring to H. as a male with a made-up name in order to conceal the social transitioning occurring at school. The director's daughter was identifying as non-binary. Charmagne removed H. from the school.

At 13 H. announced that she was going to have her breasts cut off and start taking testosterone when she turned 18. Hearing of accounts in which teens were supplied with hormones without their parents' knowledge, Charmagne and Kevin had H. tested for the presence of puberty blockers or elevated testosterone. The tests came back negative.

H. began desisting at age 14. The Coxes found a counselor who worked with H. to reconnect with her sex. They shut off communications with people who were negative influences. The Coxes found that turning off the internet for a time was the most effective response. The parents are still monitoring her environment closely. After almost three years of gender turmoil H. is now wearing make-up and earrings, growing her hair out, and telling her sisters that she feels more like a girl. Her mental state is much improved.

Kevin and Charmagne are deeply grateful their state of Kentucky has passed a child protective statute similar to Tennessee's Act. The Coxes believe that administering drugs that interfere with healthy pubertal development, hormones that are physically appropriate for the opposite sex, and surgeries that remove healthy body parts is a form of abuse being

perpetuated by a sliver of the medical community. These statutes will help families by ensuring their children cannot undergo treatments that will cause lasting harm and will spare other parents with gender dysphoric children what their family has endured.

Joy Flores

Joy Flores' daughter, D., was an academically advanced student who never quite fit in with her peers. She was socially isolated and dealing with substantial personal losses by age 10 when she was diagnosed with Polycystic Ovary Syndrome and began puberty. The syndrome made the outset of puberty more difficult, with heavy menstrual flow and excessive hair growth. She was not emotionally ready for the changes and combined with the losses and isolation affiliated with COVID, D. was overwhelmed.

D began reading Tumblr and watching YouTube videos that promoted transgender identities. She also discovered pornography, which led her at age 11 to find what she believed was the reason for her discomfort, *i.e.,* that she was transgender. As she spent more time on the internet her gender dysphoria worsened. When D. told her mother that she was trans, her parents took her to a gender therapist. The therapist met privately with D. and refused to tell her parents what was discussed during the sessions.

Joy later learned that the therapist did not explore the root of her problems, but just "affirmed"

her trans identity. Within a couple of months, the therapist guided D. to "come out" at school, where she was applauded and told she was brave. Joy and her husband were not told that D. had "come out" at school and was being treated as a male. When Joy found out, she spoke to the school counselor who said they were following guidelines that parents were not to be told about their children's gender identity at school.

The family's pediatrician referred them to a pediatric gender clinic. The intake therapist met with then 13-year-old D. without D.'s parents present. The parents were not informed about what was said. The therapist met with the parents. The therapist informed them that they have a transgender child and that the clinic could prescribe testosterone for D. that afternoon. No one did a psychological or physical evaluation of D. or recommended psychological counseling before considering testosterone.

Joy and her husband later saw a physician who was not an endocrinologist. The physician again pushed testosterone, but the parents declined. The doctor then recommended Depo Provera, which would stop D.'s menstrual cycle. The parents agreed to that intervention. D. continued to meet with the doctor in private sessions. At each session, the doctor offered D. testosterone and told her that gender dysphoria was the reason for D.'s depression, anxiety, and sadness. Joy asked the doctor "with no long-term studies you are giving young females an adult male hormone, how do you sleep with yourself

at night?" The doctor replied, "It makes them SO HAPPY." D. never saw a psychologist or psychiatrist at the gender clinic.

All of the therapists Joy visited told her she must accept and affirm D. as a boy. They offered no other options. Just before D. turned 18 the family found a holistic health coach who worked with D. and the family. She discovered that D. had Lyme disease, which helped explain some of D.'s dysphoria. The coach helped D. feel comfortable in her body and the dysphoria has lessened.

While D's dysphoria has diminished, the effects of the gender doctor's persistent promotion of testosterone, which drove a wedge between D. and her parents, remains. Joy believes that these medical interventions must be banned. It does not matter if a parent consents to the pressure from the providers. Children can change their minds, and no one knows when a child will desist from gender dysphoria as D. has. Laws such as the Acts help parents because if these interventions are not permitted for minors, then the pressure from providers (and their children) to go against their best judgment will be alleviated.

Andrea Snow

Andrea's son, B., experienced trauma, including a physical assault, in middle school and attempted suicide twice. B.'s therapist said that he had body dysmorphia, self-hate and anxiety, but not gender dysphoria. B. was emotionally volatile and was diagnosed with ADHD, oppositional defiance

disorder, and anxiety. In October 2020, B. sent a text saying he did not feel like a girl but felt more like a girl than a boy, wanted to go by she/her pronouns, and that anyone who did not agree with his message would be "written out" of his life.

The family's pediatrician referred the family, who live in California, to a gender clinic. B., age 14, began demanding puberty blockers after one virtual visit with a clinician at the gender clinic. B. became increasingly unstable, and his parents consulted the social worker at the gender clinic about B.'s demand for puberty blockers. They were given information that said puberty blockers were reversible, safe, a "pause button," and had no negative health effects other than concerns for bone density after a year or two. The social worker painted a picture of puberty blockers as a safe, good solution.

B. received puberty blockers after a single visit with an endocrinologist who met with B. without his parents present. According to B., the endocrinologist told him that they needed to get his parents "on board" with his receiving estrogen once the puberty blockers started. Within a week of receiving puberty blockers, B. began angrily demanding cross-sex hormones, *i.e.,* estrogen.

Andrea began questioning and researching the safety of these medical interventions. When she asked clinicians about their safety and sent them critical research articles, they responded, "We follow WPATH standards." Andrea asked about the protocols the clinicians used to determine when to

prescribe puberty blockers or hormones. The gender clinic director said they have no set criteria to determine who will benefit from blockers and hormones – they "get kind of a sense of" who will benefit." The director said she thought "transition is beautiful" and was not troubled about the fact that children who go on to on cross-sex hormones are sterilized.

At a meeting with clinic staff, the clinic had a pediatric gynecologist attend the meeting about her son. The gynecologist told Andrea that B. would commit suicide if she did not agree with his demand for hormones. Andrea asked about B.'s mental health issues and the clinic's social worker recommended a psychological evaluation. The evaluator attributed all of B.'s behavior problems to B. being transgender.

B. became increasingly unstable and continued to demand hormones. He began writing profanity-laden emails to the gender clinic demanding that they prescribe hormones over his mom's objection. The clinician responded that they supported B.'s efforts to "medically transition" but could not prescribe hormones without his mom's consent, driving a further wedge between B. and his parent.

Puberty blockers have done nothing to help B., but have only increased his instability, placing him on a conveyor belt to sterilizing cross-sex hormones. Andrea believes that the medical community has failed children like B. by permitting

them to self-diagnose and then placing them on a one-way street of medicalization and surgery. Prohibiting medical and surgical interventions on children will help protect these vulnerable children.

Martha S.

At age 16, M., son of Martha S. (of Texas), began acting out after suffering two traumatic events. When his behavior improved after receiving antibiotics for a sinus infection, M. was diagnosed with Pediatric Auto-immune Neuropsychological Disorder Associated with Strep (PANDAS), a condition that his older sister had. PANDAS causes the same kind of psychiatric symptoms that are seen in trans-identified children, *e.g.*, severe anxiety, ADHD, schizophrenia, OCD, and eating disorders.

M., who is Caucasian, blonde-haired and blue-eyed, identified as African-American for a semester in high school. Later that year M. told his mother that he was transgender. When he was home from school he was depressed and spent a lot of time on the internet asking questions about why he felt so miserable. He was told by sources on Reddit that he was transgender.

The family's pediatrician referred the parents to a gender clinic with the expectation that the "experts" at the clinic would help them sort out the issues. The gender clinic told Martha that M. needed to be seen by a gender therapist to get a diagnosis of gender dysphoria. M. had three visits with a gender therapist who did not do any testing and did not address or attempt to treat any underlying issues.

After the third visit, the therapist prepared a pro forma letter for the clinic that contained inaccurate history and stated that M. was suffering from gender dysphoria and was ready for medical interventions.

M. and his parents saw a psychologist at the gender clinic who after one visit with M. and filling out some questionnaires said that she would recommend that M. see the endocrinologist to be prescribed hormones. She said M. would be put on puberty blockers to suppress his testosterone and on estrogen. Martha questioned why M. would be recommended for hormone therapy when he did not have a history of gender dysphoria until after he was diagnosed with PANDAS and suffered trauma. The psychologist said, "You have to honor your young person." Martha replied, "He is not our young person -- he is our child." She and her husband asked to speak to the endocrinologist first to find out about side effects. The therapist said that they could not see the endocrinologist unless they were ready to get prescriptions for hormones. Martha and her husband said they needed more information.

A neuropsychologist evaluated the whole family and diagnosed M. with bipolar or possibly dissociative disorder, but not with gender dysphoria. She recommended psychiatric treatment rather than hormonal treatment without first addressing the other disorders. M., however, kept demanding hormones because he had been convinced this was what he needed. Martha and her husband did not follow through on that demand. After M. turned 18 and went away to college, he found a practitioner

who prescribed a testosterone suppressor and an estrogen patch. He soon stopped the suppressor, however, because he did not like the effects. He returned home for online learning in the spring, went on antibiotics and his health improved. He then discontinued the estrogen patch and is now critical of the pharmaceutical industry.

Martha said that the availability of medical and surgical interventions for minors puts parents in a terrible bind. Parents are put in a difficult position when they have a mentally and physically ill child who is convinced that he needs an intervention recommended by a physician which is not based on sound science. This experience has damaged both the parents' and M.'s trust in the medical community. If physicians are legally prevented from recommending those interventions, then parents will not be put at terrible cross purposes with their child and the medical community.

Bri Miller

Bri Miller's daughter, L., began experiencing gender confusion at age 13 after being involved in a toxic manipulative relationship with an older boy. L. went from being a confident happy girl comfortable in her body to a disheveled teen who wanted to hide her body with oversized sweatshirts. L. began identifying as a boy with a friend who was also identifying as a boy. It took Bri (of Maryland) six months to find her daughter a counselor who would address L.'s underlying trauma without

immediately affirming her gender confusion. L. became disenchanted with the counselor when she would not talk about hormone treatments. L. said she believed she might have ADHD.

In the course of gathering information for the ADHD evaluation, Bri learned that, without notifying Bri, L.'s school had been affirming L. as a boy with a male name. When they met with L's pediatrician, the doctor asked whether they were going to use he/him pronouns. Bri said "no we are going to stay in reality." The pediatrician scolded Bri and asked whether L. had seen a gender therapist. The doctor met with L. alone, after which L. was hysterical and crying. The doctor told Bri that L. had called the suicide hotline and, with L. present, that "if you do not get her the help she needs and she kills herself you will feel awfully guilty." L. later told her mother she felt badly for the doctor making her feel like she did not care for L.

L. kept saying she wanted testosterone, that she wanted a male-looking body and to hear how her voice was going to sound. She believed her voice would sound great because a lot of "YouTube influencers" love how their voices sounded after they took testosterone. Seven of L's friends at school had identified as trans and four were on testosterone. Bri is seeing evidence that L. is desisting from her belief that she is a boy and becoming more comfortable in her female body.

"Gender-affirming" medical interventions for children are dangerous and should be banned

because, as Bri points out, "in no other sphere do we encourage children to change their bodies or take dangerous off-label prescriptions because they are uncomfortable with their body." Parents are being told these treatments are safe and well-studied, when they are not, and one-page marketing materials gloss over the harms. Bri further noted that neither children nor their parents can consent to the unknown risks and to the future ramifications of these treatments.

Kristine W.

Kristine W's daughter, S., had been diagnosed with OCD, Tourette's Syndrome and bulimia when she began intensive outpatient psychiatric treatment for suicidal ideation. She had spent copious amounts of time online during the pandemic lockdown and was influenced by transgender beliefs. She suddenly declared that she believed she was a boy and wanted to use a male name. When Kristine (a Virginia resident) spoke to her daughter's providers, they focused on S. wanting to go by a male name and pronouns. Kristine asked them to address S.'s self-harm, anxiety and bulimia. Instead, they told Kristine that she needed to ask, "How can we help you with your gender identity?" The staff told Kristine that "transgender identity is very trendy in the hospital setting right now." Despite this they continued an affirmative confirmation of her obsessive thoughts.

During one visit, with S. present, the provider stated that trans people are more likely to commit

suicide if not affirmed. In another instance, staff at the hospital said, "You must affirm or she will kill herself. Do you want a live son or a dead daughter?" The school counselor made similar statements to Kristine.

Following the psychiatric treatment, S. returned to seeing psychiatrists and counselors that she had previously been seeing. Her medication was adjusted, she stopped self-harming and her tics were better controlled. After doing more research and believing it important to ground their child in reality, Kristine and her husband stopped using the preferred male name and pronouns at home. Kristine told S. that she could change her name if she desired when she was an adult but until then she did not get to choose her name. S asked why her own parents would not use her new name but everyone else did. She felt that her parents cared more about the name than her feelings of suicide because of the comments made by doctors about how fragile trans kids are. Kristine explained that no one loved her as much and cared about her mental health more than her parents, who wanted to do what was best for her in the long run, which was to hold reality for her. S. had asked for testosterone, but Kristine resisted, hoping to delay such decisions until adulthood.

S. has since announced "I'm not a boy – boys are awful" and is dressing on and off as a girl. Her mental health is improving.

S. has several friend groups across three different schools. Of 10 to 15 children, only one identifies as her natal sex. Kristine notes these numbers mimic known social contagions, such as anorexia and cutting behavior. It is statistically highly improbable (if not impossible) that all these children will continue to identify as another sex into adulthood. To allow the medical establishment to push children into irreversible treatments and to pit objecting parents against their children is a great tragedy. Families are being ruined. For these reasons, Kristine believes "gender-affirming" medical interventions should not be available for minor children.

Helen S.

An encounter with an online sexual predator at age 12 and time at a gender-affirming youth center led Helen S.'s daughter, E. to question her gender identity at age 14. Helen stopped counting after 35 kids in their Iowa community had announced a trans identity. E., who is exceptionally bright and musically gifted, was seeing a therapist for issues related to diagnoses of ADHD, ASD, anxiety, depression, and social struggles when she said that she was questioning her sexual identity. When E. told her doctor about wanting to use different names, he suggested that she go to a gender clinic. Helen believed that the clinic would be a place to ask questions and get information and options to help E. deal with the distress she was feeling about her body.

When Helen and E. met with the endocrinologist at the gender clinic, the only information she received was to start E. on "gender-transition" medical interventions. There was no psychological evaluation, no medical criteria for a diagnosis of gender dysphoria. The only prerequisite for beginning medical interventions was the child's self-diagnosis and one parent's consent. Helen was told that E. should be prescribed puberty blockers at her next appointment and when she turned 16 could start taking testosterone. Helen and E. were told that puberty blockers were just "a pause button to buy you some time to think," a "perfectly safe, reversible, benign intervention." Helen was not comfortable with the recommendation. The doctor replied *in front of E.* that "You have to be aware of the suicide risk. She may consider suicide if you don't do this." When Helen questioned there might a social contagion aspect, the doctor dismissed this concern. She then said "I love helping trans kids. It is the favorite part of my job helping kids be who they are."

E. continued to ask for puberty blockers, saying some of her friends were on them. Helen said that it was a family decision and that their insurance would not cover the blockers. E. continued to have mental health issues and spent some time in a psychiatric hospital at age 16 after a friend died and E. began self-harming. Helen found a therapist who began to focus on E.'s cognitive mental health issues, and E.'s gender identity confusion desisted just before her 18th birthday.

Helen believes "gender-affirming" medical interventions for children should be banned because the medical community is not acting in the patient's best interest and outside the norms of ethical medical care. Parents should not be pressured by threats of suicide into acceding to the wishes of their children facilitated by activist doctors.

Liz and Chris Doe

Liz and Chris Doe were depending on medical professionals to help them understand what was happening to their daughter who suddenly proclaimed a trans identity and to advise them what to do. Now they no longer know whom they can trust for sound advice. As a Tennessee family with a gender dysphoric teen, the Act is critical to protecting their child.

The Does' daughter, A., had been a "girly-girl" throughout her younger years. So, when she declared she was "trans" after starting puberty it made no sense. A. had been diagnosed at age 8 with dyslexia and ADHD and had been seeing a psychiatrist who prescribed medication. At 13, A. was diagnosed with anxiety and depression and started seeing a therapist.

A. attended a small middle school for kids with dyslexia. She was in a class with all boys and liked how boys hung out together. A. started to only want to wear boys' clothes, which the parents supported. A. struggled to find a place to fit in. She and her friends got heavily into Anime, which has many gender-bending characters. A friend began

circulating information about sexuality and gender. During the pandemic, A. announced that she was "trans." A. had also been on Tik Tok and discussing transitioning on social media. Liz found the algorithms on A's social media heavily weighted with trans-promoting materials and influencers. A. has six kids in her friend group who are identifying as non-binary or trans.

A. had also began accessing pornography online. A. said she was trying to figure out her sexuality, then said she's "pansexual", then "asexual." A. got into Manga and other books that influenced her to see herself as a gay "boy" and that led her to believe she could actually be a boy. During this time, A. went from being a bright and winsome child, a "spontaneous light in the room," to a child with frequent dark and sullen moods.

A. socially transitioned at 13 when she moved to public school. The Does felt pressured to affirm the new identity from all sides. Feeling like they had little choice, they agreed to the school using "they" as a pronoun and a preferred androgynous name. The psychiatrist managing A.'s meds saw her alone. When mom came in, the psychiatrist informed Liz that they had decided A. was going to use her new name and pronouns at summer camp. Taken aback, Liz informed the psychiatrist it was a girls' camp. The psychiatrist told Liz "they know how to handle these situations."

A. began to refuse to go to the therapist she had been seeing. The Does were referred to a gender

therapist, who said he could help A. socially transition and figure out the "next steps," which the parents understood to mean puberty blockers and opposite-sex hormones. The gender therapist gave no other options.

Every gender-affirming professional talked about suicide, saying they had to affirm the trans identity or A. is more likely to kill "themself." Although they have taken down Tik-Tok, changed the algorithms, and monitored the internet more closely, they were hesitant to take away A.'s phone and computer because "everything is perceived as transphobic."

A. wears a chest binder, which forces her to be sedentary. A. cannot ride a bike because she cannot breathe well enough. This is causing A. to gain unhealthy weight. Yet, when Liz asked a nurse practitioner from Vanderbilt about the binder, she simply said "it fits A. fine." Recently A. said that she desires to transition surgically and that she can't wait to have her breasts removed and to start testosterone.

The Does are striving to protect their daughter from these medical interventions. A. at times refuses to talk with her parents because they will not grant her demands. They feel their parental authority has been taken out of their hands. They already had a stubborn child, but once others are allowed to question their authority, it has made matters so much worse as more friends join the transgender social trend.

The Does state the Act that makes these irreversible treatments out of reach for minor children is absolutely necessary to protect vulnerable kids like their daughter. Parents of gender confused kids are depending on medical professionals to advise them. Activist professionals have undermined their parental authority and damaged their ability to trust the medical profession.

Children do not grasp the long-term consequences of these treatments or what it means to lose one's healthy breasts. Their growing bodies are not made to be altered or constricted. The advice parents are receiving from gender specialists is allowing children to demand these body alterations as a coping mechanism for other issues, rather than finding healthier coping options. Without this law, it will lead to irreversible harm to their daughter and to other children like her.

Yaacov Sheinfeld

Yaacov Sheinfeld was shocked when his wife told him that their 17-year-old daughter had announced she was "transgender." Their daughter, S., had been in counseling for depression since she was 15 but never appeared distressed over her sex. Yaacov learned that five of his daughter's friends had also announced that they were transgender. Identifying as transgender provided S. with acceptance she had not previously experienced in high school.

When S. went to college she began taking testosterone. When Yaacov and his wife, New Jersey residents, met with S., Yaacov observed that S. was very depressed. She announced that she was going to get a double mastectomy. Yaacov objected. The social worker who facilitated S. getting the surgery called Yaacov a chauvinist who did not love his daughter enough. She told Yaacov that he had to get on board with the decision. The social worker assured the parents that everything would be fine. S. thereafter refused to talk to her father and began threatening that she would kill herself if she did not get the surgery she wanted. S. had a double mastectomy at age 19.

Yaacov witnessed distressing physical changes in S., so distressing that he even considered suicide at one time. S. gained and lost lots of weight, had pain all over her body, mood swings, could not concentrate, and was briefly hospitalized in a psychiatric hospital. S. was deeply depressed and taking a significant number of medications along with testosterone. Yaacov kept assuring his daughter he would do whatever he could to help her. S.'s pain became so intense that she began taking Fentanyl. S. was found dead on August 6, 2021 with Fentanyl and alcohol in her system. She was 28.

Yaacov urges banning medical interventions for minors because young people, especially those with mental health issues such as his daughter, cannot make clear decisions about their future, particularly when neither they nor their parents are provided with information about the full effects of

these interventions. He contends these interventions that were supposed to relieve her problems killed his daughter.

CONCLUSION

The Acts are necessary to protect Tennessee's and Kentucky's minors and police the medical community to safeguard patients and their parents' medical decision-making in the best interest of their children. For these reasons, the Sixth Circuit's decision should be affirmed.

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