No. 22-942

In The
Supreme Court of the United States

BRIAN TINGLEY,

Petitioner,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for State of Washington; UMAIR A. SHAH, in his official capacity as Secretary of Health for State of Washington; and SASHA DE LEON, in her official capacity as Assistant Secretary of the Health Systems Quality Assurance Division of the Washington State Department of Health,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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BRIEF OF *AMICUS CURIAE* ETHICS AND PUBLIC POLICY CENTER IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

In a pre-enforcement challenge, the Ninth Circuit held that Washington's "Conversion Law," Wash. Rev. Code § 18.130.020(4), was congruent with the Free Speech Clause of the First Amendment despite its viewpoint-based prohibitions on how licensed counselors may discuss gender identity with their clients. In so doing, the Ninth Circuit held that "lesser scrutiny" applied because of a national tradition permitting the censorship of medical speech. Acknowledging such a tradition is particularly dangerous because the emerging medical consensus directly contradicts the policy behind the censorship law.

The questions presented are:

1. Whether a law that censors conversations between counselors and clients as "unprofessional conduct" violates the Free Speech Clause.

2. Whether a law that primarily burdens religious speech is neutral and generally applicable, and if so, whether the Court should overrule *Employment Division* v. *Smith*, 494 U.S. 872 (1990).

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INTEREST OF *AMICUS CURIAE*[1]

The Ethics and Public Policy Center ("EPPC") is a nonprofit research institution dedicated to applying the Judeo-Christian moral tradition to critical issues of public policy, law, culture, and politics. EPPC's Programs cover a wide range of issues, including bioethics and human flourishing, governmental and judicial restraint, personhood and identity, and religious liberty. EPPC has a strong interest in promoting the Judeo-Christian vision of the human person and responding to the challenges of gender ideology.

Gender ideology has permeated the culture with stunning speed, influencing medicine, media, government, and education. Because it sows confusion and undermines personal well-being, its rise has created an urgent need for clarity, education, and compassionate guidance. This brief was written by Mary Hasson, J.D., the Kate O'Beirne Fellow at EPPC and the Director of EPPC's Person and Identity Project, and Ryan T. Anderson, Ph.D., the President of EPPC.

SUMMARY OF ARGUMENT

The ethics of the Washington "Conversion Law" ("the Law") cannot be considered apart from the

[1] *Amicus* provided 10 days advance notice of this brief to all parties. Per Rule 37.6, counsel affirms that no counsel for any party authored any portion of this brief and that nobody other than *amicus* or counsel made a monetary contribution to fund this brief.

gender-affirming approach that underlies it. Gender affirmation provides the theoretical basis for the Law and similar state statutes that presume a minor who declares him or herself "transgender" is presumptively correct in that judgment, so clinicians must affirm the minor's asserted identity. This brief presents ethical concerns regarding gender-affirmation as a prescriptive response to a minor's identity distress and regarding the Law itself, which denies effective psychotherapy to minors seeking to explore alternative pathways, including the possibility of desisting from a "transgender" gender identity.

Across the globe, gender specialists and whistleblowers have raised alarm over the scant evidence supporting gender-affirming protocols and the mounting evidence that gender affirmation causes harm to minors. In the wake of extensive evidence reviews, several leading European gender clinics recently ended or curtailed gender-affirming interventions for minors. Extensive psychotherapy, open to exploring alternative diagnoses and non-invasive ways of managing gender dysphoria, is emerging as the first-line response to adolescent identity distress.

In the United States, influential gender therapists admit that gender identity "conversion therapy" laws have exerted a chilling effect on therapists, preventing them from offering minors the careful psychological assessments and counseling they need. These transgender-affirming psychologists warn that, without in-depth psychological care to address psychological co-morbidities and to explore the roots of their

dysphoria, some minors will pursue body modifications that they will end up regretting. Research on "de-transitioners" confirms that regret is real, and likely to increase in a clinical environment where minors bear the weight of self-diagnosis, and professionals must rely on adolescent claims of certainty.

We urge the Court to consider the serious ethical concerns surrounding the Law, which effectively mandates a "gender-affirmation-only" approach and denies effective psychotherapy to minors seeking psychological help to explore alternative pathways, including the possibility of desisting from a transgender identity.

ARGUMENT

I. The challenged Washington law presumes that "gender affirmation" is the only ethical way to treat gender dysphoria.

The ethics of the Law cannot be considered apart from the gender-affirming approach that underlies it. Gender affirmation provides the theoretical basis for the Law, which bars exploration of the full range of the minor's feelings and bodily experiences, and instead presumes that a minor's experience of "gender dysphoria," or disharmony between self-perceived "gender identity" and the physical body, is immutable and that

a minor's judgment as to their "transgender" status is always correct.[2]

The number of children and adolescents diagnosed with gender dysphoria or identifying as "transgender" has risen dramatically over the past decade, becoming "an international phenomenon."[3] The typical patient profile also has changed: until recently, gender dysphoria patients were usually either adult males or young children, mostly boys. Today, the typical patient is an adolescent, usually female.[4] Alongside the explosion in gender-dysphoric or transgender-identified minors, psychology and medicine witnessed a sea change in the dominant clinical approach towards these issues, raising serious ethical questions.[5]

For years, gender dysphoria in children was addressed through "watchful waiting" or psychotherapy for the child and family. In most of these situations (up

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[2] "Gender dysphoria" is a diagnosis listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, text revision (DSM-5-TR). "Gender dysphoria . . . refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity." *What is Gender Dysphoria?*, AM. PSYCH. ASS'N (Jack Turban Phys. Rev.; Aug. 2022), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

[3] Kenneth J. Zucker, *Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues*, 48 ARCH. SEX. BEHAV. 1983 (1992), https://doi.org/10.1007/s10508-019-01518-8.

[4] *Id.*

[5] Lucy Griffin, et al., *Sex, gender and gender identity: a re-evaluation of the evidence*, 45 BJPSYCH BULL. 291 (2021), https://doi.org/10.1192/bjb.2020.73.

to 88%), the gender dysphoria (identity distress) would resolve by puberty.[6] In contrast, nearly all minors who begin gender-affirming social and medical transitions today persist in transgender identification.[7] Based on the belief that "gender variations are not disorders, gender may be fluid and not binary," the gender-affirming approach insists that minors who identify as transgender should be permitted "to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection."[8]

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[6] Devita Singh, et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 FRONT. PSYCH. 632784 (2021), https://doi.org/10.3389/fpsyt.2021.632784; Thomas D. Steensma, et al., *Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study*, 16 CLIN. CHILD. PSYCHOL. PSYCH. 499 (2011), https://doi.org/10.1177/1359104510378303; Thomas D. Steensma, et al., *Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study*, 52 J. AM. ACAD. CHILD. ADOLESC. PSYCH. 582 (2013), https://doi.org/10.1016/j.jaac.2013.03.016.

[7] See, for example, this study from the Tavistock and Portman NHS Gender Identity Development Service (UK), which found 98% of adolescents who underwent puberty suppression continued on to cross- sex hormones. Polly Carmichael, et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16 PLOS ONE e0243894 (2021), https://doi.org/10.1371/journal.pone.0243894.

[8] Laura Edwards-Leeper, et al., *Affirmative practice with transgender and gender nonconforming youth: Expanding the model*, 3 PSYCHOL. SEX. ORIENTATION & GENDER DIVERSITY 165, 166 (2016), https://doi.org/10.1037/sgd0000167 (citing Marco A. Hidalgo, et al., *The Gender Affirmative Model: What We Know and*

Consequently, according to a leading gender therapist, "the gender identity and related experiences asserted by a child, an adolescent, and/or family members" should be accepted as "true" and "the clinician's role in providing affirming care to that family is to empathetically support such assertions."[9] The gender-affirming model rejects "therapeutic approaches that encourage individuals to accept their given body and assigned gender," and contends that alternative approaches "may inadvertently cause psychological harm."[10] Thus, the Law, which prohibits "counseling or psychotherapies" that "seek to change an individual's . . . gender identity," effectively requires psychotherapists to use the gender-affirming approach—and only the gender-affirming approach—with gender-dysphoric minor clients.[11]

Despite the "absence of empirical data," the gender-affirming model and its medical and surgical interventions are heavily promoted by transgender activists, allied clinicians, and establishment medical organizations.[12] Even so, the rapid swing from the

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What We Aim to Learn, 56 HUM. DEV. 285, 286 (2013), http://dx.doi.org/10.1159/000355235).

[9] Edwards-Leeper, *supra* n.8, at 165.

[10] *Id*. at 166 (citing ENDING CONVERSION THERAPY: SUPPORTING AND AFFIRMING LGBTQ YOUTH, SUBST. ABUSE & MENTAL HEALTH SERV. ADMIN. (2015), https://store.samhsa.gov/product/Ending-Conversion-Therapy-Supporting-and-Affirming-LGBTQ-Youth/SMA15-4928.

[11] Wash. Rev. Code § 18.130.020(4)(a).

[12] Edwards-Leeper, *supra* n.8; Am. Acad. of Pediatrics, *Policy Statement: Ensuring Comprehensive Care and Support for*

"watchful waiting" therapeutic paradigm to a "gender-affirmative" protocol is unprecedented. So too is the number of transgender-identified adolescents seeking irreversible "transgender" protocols—drastic measures that some come to regret.[13]

II. Gender affirmation is an unethical therapeutic approach based on faulty anthropology.

Generally accepted standards of medical ethics require clinicians to treat patients with "honesty, beneficence [doing good], nonmaleficience [doing no harm], justice, and respect for patient autonomy."[14] Gender affirmation, along with the resulting bodily modifications that come with this approach, fails these

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Transgender and Gender-Diverse Children and Adolescents, 142 PEDIATR. e20182162 (2018), https://doi.org/10.1542/peds.2018-2162.

[13] Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 ARCH. SEX. BEHAV. 3353 (2021), https://doi.org/10.1007/s10508-021-02163-w.

[14] Stephen B. Levine, *Informed Consent for Transgendered Patients*, 45 J. SEX & MARITAL THER. 218 (2019), https://doi.org/10.1080/0092623X.2018.1518885. Good medicine facilitates human flourishing, where mind and body are well-functioning, and various bodily systems achieve their ends. A person's thoughts and feelings achieve their ends by being in contact with reality. Any medical intervention intended to affirm someone's false beliefs is inherently misguided. Identifying as female or "as a woman" does not make a male a female where such an "identity" doesn't correspond to reality.

standards and is thus ethically indefensible as a prescriptive response to identity distress.

The human sexual binary *is* reality. According to the National Academy of Science's Committee on Understanding the Biology of Sex and Gender Differences, sex is "the classification of living things . . . as male or female according to their reproductive organs and functions assigned by the chromosomal complement."[15] A person's sex is imprinted in every cell of the person's body and cannot change.[16]

If an adolescent seeks validation for an identity that does not correspond to reality, a therapist has an ethical duty to speak the truth, not to validate a false self-perception. It is profoundly unethical, for example, to reinforce a male child's belief that he is not a boy, or that he "is" or can "become" a female. It is similarly unethical for a therapist to tell a male patient that his self-perception (or gender identity) that he "is" a girl overrides the reality of his male-sexed body. No one can change sex. And it is physically and emotionally damaging to introduce cross-sex hormones, destroy fertility, or remove genitals or reproductive organs to "help make the body look and feel less masculine and more feminine" (for males who identify as a "girl") or "less

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[15] Institute of Medicine, Exploring the Biological Contributions to Human Health: Does Sex Matter? 1 n.1 (2001), https://doi.org/10.17226/10028.

[16] *Id*. at 28-44 (Chapter 2: "Every Cell has a Sex").

feminine and more masculine" (for females who identify as a "boy")."[17]

III. Gender affirmation leads to poor outcomes and irreversible harm.

Clinical concerns over the outcomes of gender affirmation for minors have escalated.[18] Gender affirmation has a domino effect, beginning with psycho-social transition.[19] Although it is not physically invasive, once begun, psycho-social transition is psychologically difficult to reverse. Children who socially transition

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[17] *Transgender resources for patients*, RANDALL CHILDREN'S HOSPITAL LEGACY HEALTH T-CLINIC (last visited Mar. 29, 2023), https://www.legacyhealth.org/children/health-services/transgender/kids-faq (links for "Estrogen" and "Testosterone" under "Gender-affirming medical care resources"). This resource is listed on the website of Dr. Laura Edwards-Leeper. *See Resources*, DR. LAURA EDWARDS-LEEPER, PH.D. (last visited Mar. 29, 2023), http://www.drlauraedwardsleeper.com/resources (link for "Legacy Health T-Clinic" under "Portland, OR Area Resources").

[18] *See, e.g.*, Alison Clayton, *Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect – The Implications for Research and Clinical Practice*, 52 ARCH. SEX. BEHAV. 483 (2023), https://doi.org/10.1007/s10508-022-02472-8; William Malone, et al., *Puberty blockers for gender dysphoria: the science is far from settled*, 5 LANCET CHILD & ADOLESC. HEALTH e33 (2021), https://doi.org/10.1016/S2352-4642(21)00235-2; Griffin, *supra* n.5; Kirsty Entwistle, *Debate: Reality check–Detransitioner's testimonies require us to rethink gender dysphoria*, 26 CHILD & ADOLESC. MENTAL HEALTH 15 (2020), https://doi.org/10.1111/camh.12380.

[19] When a minor's desired identity is affirmed, the minor initiates external "social" changes to express the desired identity (name, pronouns, hair, clothing, etc.).

are more likely to persist in a transgender-identification than children who do not. This raises serious ethical questions.[20] The Dutch gender-affirming protocol never supported social transition for pre-pubertal children over concerns that it would bias outcomes toward persistence in transgender identification.[21]

Social transition sets the child on a path toward medical transition before the child is mature enough to appreciate its long-term consequences. In pre-pubertal children, social transition creates an impetus for use of puberty blockers. A pre-pubertal child who presents as a member of the opposite sex views puberty with extreme anxiety, fearing the appearance of secondary sex characteristics will reveal the child's true sexual identity. Puberty blockers can preserve the child's secret, for a time, by interrupting the child's natural development.

However, puberty is a whole-body developmental process. Preventing its normal course has unknown long-term consequences beyond "pausing" development of secondary sex characteristics: puberty blockers suspend a child's social and cognitive maturation

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[20] Kenneth J. Zucker, *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children" by Temple Newhook, et al.*, 19 INT'L J. TRANSGENDERISM 231 (2018), https://doi.org/10.1080/15532739.2018.1468293.

[21] Annelou L.C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, 59 J. HOMOSEXUALITY 301 (2012), https://doi.org/10.1080/ 00918369.2012.653300.

along with other developmentally necessary growth, including bone mineralization. Stopping puberty blockers allows the patient's body to resume the development of secondary sex characteristics, but the time lost from the unnatural delay in biological maturation cannot be recaptured.

No longer described as "fully reversible," puberty blockers have negative effects on bone density, emotional maturation, and other developmental aspects.[22] Further, puberty blockers generally fail to lessen the child's gender dysphoria and produces mixed results on mental health; the long-term effects remain unknown (no long-term studies exist on the safety and outcomes of puberty blockade in dysphoric children for an extended time).[23]

Multiple studies show that almost all children who begin puberty blockers go on to receive cross-sex hormones, with life-altering consequences.[24] Blocking

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[22] Nat'l Inst. 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; Michael Biggs, *Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria*, 34 J. PEDIATR. ENDOCRIN. & METAB. 937 (2021), https://doi.org/10.1515/jpem-2021-0180.

[23] Carmichael, *supra* n.7; Clayton, *supra* n.18; Annelou L.C. de Vries, et al., *Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study*, 8 J. SEX. MED. 2276 (2011), https://doi.org/10.1111/j.1743-6109.2010.01943.x.

[24] Carmichael, *supra* n.7; Stephen B. Levine, *Ethical Concerns About Emerging Treatment Paradigms for Gender*

the maturation of genitals and reproductive organs and then introducing cross-sex hormones causes permanent sterility.[25] Gender clinicians also admit that puberty blocking may impair the child's later adult sexual function.[26] These losses cannot be fully comprehended by a child, thus precluding the possibility of informed consent.

Cross-sex hormones also carry numerous health risks, including genital and vaginal atrophy, hair loss (or gain), voice changes, and infertility; they increase cardiovascular risks and cause liver and metabolic changes.[27] The flood of high-dose, opposite-sex hormones causes emotional and psychological changes. Females who take testosterone experience an increase in gender dysphoria, particularly regarding their breasts, creating heightened demand for double

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Dysphoria, 44 J. SEX & MARITAL THER. 29 (2018), https://doi.org/10.1080/0092623X.2017.1309482.

[25] Diane Ehrensaft, a leading proponent of gender-affirming care, notes that a "child who begins puberty blockers at Tanner Stage 2 and proceeds directly to cross-sex hormones will be rendered infertile." Diane Ehrensaft, *Gender nonconforming youth: current perspectives*, 8 ADOLESC. HEALTH MED. THER. 57 (2017), https://doi.org/10.2147/AHMT.S110859.

[26] Abigail Shrier, *Top Trans Doctors Blow the Whistle on 'Sloppy' Care*, FREE PRESS (Oct. 4, 2021), https://www.thefp.com/p/top-trans-doctors-blow-the-whistle.

[27] Carl Heneghan & Tom Jefferson, *Gender-affirming hormone in children and adolescents*, BMJ EBM SPOTLIGHT (Feb. 25, 2019), https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

mastectomies as young as 13.[28] The gender-affirming model recommends treating this emotional discontent with mastectomies performed on adolescent girls. This is an unethical practice described by psychotherapist Alison Clayton as "dangerous medicine."[29]

The gender-affirming approach continues to push ethical boundaries. The World Professional Association for Transgender Health (WPATH) "Standards of Care Version 8" initially lowered the recommended ages for minors to receive cross-sex hormones and surgeries but, within hours of its release, withdrew the age minimums entirely.[30] This amounts to unethical human experimentation—on *children*. A Swedish teen who underwent medical transition and then de-transitioned after suffering substantial bodily harm describes the "gender-affirming" medical protocol this

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[28] Johanna Olson-Kennedy, et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts*, 172 JAMA PEDIATR. 431 (2018), https://doi.org/10.1001/jamapediatrics.2017.5440.

[29] Alison Clayton, *The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?*, 51 ARCH. SEX. BEHAV. 691 (2021), https://doi.org/10.1007/s10508-021-02232-0.

[30] Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH, S1 (2022), https://doi.org/10.1080/26895269.2022.2100644; Eli Coleman, et al., *Correction: Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH, S259 (2022), https://doi.org/10.1080/26895269.2022.2125695.

way: "They're experimenting on young people . . . we're guinea pigs."[31]

IV. Other countries are increasingly aware of the unethical nature of gender affirmation.

The unethical nature of these interventions has drawn global attention, including in nations that had initially embraced gender-transition interventions.[32] The leading gender clinic in Sweden has stopped using puberty blockers for minors.[33] Finland has likewise reversed course, issuing new guidelines that prioritize psychotherapy as the first-line treatment for gender dysphoric minors.[34] In the United Kingdom,

[31] *Uppdrag granskning: Transbarnen* (SVT television broadcast Nov. 26, 2021) [*Mission Investigate: Trans Children*], https://www.svtplay.se/video/33358590/uppdrag-granskning/mission-investigate-trans-children-avsnitt-1.

[32] Becky McCall & Lisa Nainggolan, *Transgender Teens: Is the Tide Starting to Turn?*, MEDSCAPE (Apr. 26, 2021), https://www.medscape.com/viewarticle/949842; Chad Terhune, et al., *A Reuters Special Report: 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/; Megan Twohey & Christina Jewett, *They paused puberty, but is there a cost?*, NEW YORK TIMES (Nov. 14, 2022), https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html.

[33] Lisa Nainggolan, *Hormonal Tx of Youth With Gender Dysphoria Stops in Sweden*, MEDSCAPE (May 12, 2021), https://www.medscape.com/viewarticle/950964.

[34] Summary of a recommendation by COHERE 16.6.2020 Finland. COHERE website: https://palveluvalikoima.fi. The Council for Choices in Health Care in Finland (COHERE Finland)

whistleblower complaints exposed the National Health Service's (NHS) gender clinic's inadequate psychological care for gender dysphoric minors.[35] A landmark case against the NHS brought by a detransitioner found that minors lacked capacity to consent to treatments that cause sterility and impair sexual function, causing the NHS to suspend the use of puberty blockers and institute new procedures for better psychological care.[36] (The decision was reversed on procedural grounds, with further appeal denied.) The UK's National Institute for Health and Care Excellence (NICE) also reviewed the evidence and found little benefit and substantial risk of harm from gender-affirming treatment in minors.[37] An NHS-commissioned review deemed the UK's national gender clinic for minors "unsafe," resulting in its closure.[38] Psychotherapists in Australia and New Zealand issued a policy statement stressing the importance of assessing the

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works in conjunction with the Ministry of Social Affairs and Health, www.palveluvalikoima.fi.

[35] David Connett, *NHS gender identity clinic whistleblower wins damages*, GUARDIAN (Sep. 4, 2021), https://www.theguardian.com/society/2021/sep/04/gender-identity-clinic-whistleblower-wins-damages.

[36] Becky McCall, *NHS Makes Child Gender Identity Service Changes After High Court Ruling*, MEDSCAPE (Dec. 4, 2020), https://www.medscape.com/viewarticle/941781.

[37] Nat'l Inst. for Health and Care Excellence (NICE), *supra* n.22.

[38] Hilary Cass, The Cass Review: Independent Review of Gender Identity Services for Children and Young People: Interim Report (2022), https://cass.independent-review.uk/publications/interim-report/.

"psychological state and context in which gender dysphoria has arisen," before making treatment decisions.[39]

Most recently, in March 2023, The Norwegian Healthcare Investigation Board (NHIB/UKOM) restricted the use of puberty blockers for gender affirmation to research settings, deeming their use "experimental" and lacking in evidence-based support.[40]

V. Many states are likewise expressing caution about the gender-affirmation model.

Here in America, many states are paying attention to these international developments. A growing number of states have passed laws prohibiting gender-transition interventions on minors on the basis that this radical approach is experimental and unethical.[41]

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[39] Becky McCall, *Psychiatrists Shift Stance on Gender Dysphoria, Recommend Therapy*, MEDSCAPE (Oct. 7, 2021), https://www.medscape.com/viewarticle/960390.

[40] Society for Evidence-based Gender Medicine (@segm_ebm), TWITTER (Mar. 9, 2023), https://twitter.com/segm_ebm/status/1634032333618819073 (citing UKOM, PASIENTSIKKERHET FOR BARN OG UNGE MED KJØNNSINKONGRUENS (2023) [THE NORWEGIAN HEALTHCARE INVESTIGATION BOARD, PATIENT SAFETY FOR CHILDREN AND YOUNG PEOPLE WITH GENDER INCONGRUENCE], https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag.)

[41] *See* Ala. S.B.184 (2022); Ariz. S.B.1138 (2022); Ark. H.B.1570 (2021); Ark. S.B.199 (2023); Ga. S.B.140 (2023); Idaho H.71 (2023); Ind. S.B.34 (2023); Iowa S.F.538 (2023); Ky. S.B.150 (2023); Miss. H.B.1125 (2023); S.D. H.B.1080 (2023); Tenn.

In February 2022, for example, the Texas Attorney General issued an opinion letter stating that sterilizing treatments and other permanent "sex-change procedures," including puberty suppression, cross-sex hormones, and various surgeries, "can constitute child abuse when performed on minor children."[42] Texas's governor subsequently directed the Texas Department of Family and Protective Services to "conduct a prompt and thorough investigation of any reported instances of these abusive procedures in the State of Texas."[43]

Florida has taken multiple actions to restrict the provision of gender-transition interventions. In February 2023, the Florida Board of Medicine and Florida Board of Osteopathic Medicine finalized rules prohibiting the provision of gender-transition interventions for minors, eliminating an earlier exception for research.[44] Responding to an HHS document promoting

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H.B.0578 (2021); Tenn. S.B.126 (2021); Tenn. H.B.0001 (2023); Utah S.B.16 (2023); W. Va. H.B.2007 (2023).

[42] Tex. Att'y Gen. Op. Letter No. KP-0401, from Ken Paxton, Attorney General, to Matt Krause, Chair, House Committee on General Investigating 1-2 (Feb. 18, 2022), https://www.texasattorneygeneral.gov/sites/default/files/opinion-files/opinion/2022/kp-0401.pdf.

[43] Letter from Greg Abbott, Governor, State of Texas, to Jaime Masters, Commissioner, Texas Department of Family and Protective Services (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.

[44] AP, *Puberty Blockers and Hormone Replacement Therapy Will Be Banned for Minors, Even During Clinical Trials*, WUSF PUBLIC MEDIA (Feb. 10, 2023), https://wusfnews.wusf.usf.edu/health-news-florida/2023-02-10/florida-boards-of-medicine-confirm-ban-on-gender-affirming-care-for-transgender-youth.

"gender-affirming care" for young people, the Florida Department of Health issued guidelines in 2022 that clarified that treatment of gender dysphoria for children and adolescents should *not* include social gender transition, puberty blockers, cross-sex hormones, or transitioning surgeries because of "the lack of conclusive evidence, and the potential for long-term, irreversible effects."[45] Florida's Agency for Health Care Administration issued rules in August 2022 eliminating state Medicaid coverage of gender-transition interventions.[46] The rules responded to a request from the Agency's secretary seeking a determination whether gender-transition interventions were "consistent with generally accepted professional medical standards."[47] The agency review, published June 2022, found that gender-transition interventions "are not consistent with widely accepted professional medical standards

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[45] Press Release, Office of the State Surgeon Gen., Fla. Dep't of Health, Treatment of Gender Dysphoria for Children and Adolescents (Apr. 20, 2022), https://www.floridahealth.gov/_documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf; *cf. Setting the Record Straight*, Florida Agency for Health Care Administration (2022), https://ahca.myflorida.com/LetKidsBeKids/page3.shtml ("detailing the lack of conclusive evidence in recent directives and 'fact sheets' issued by [HHS] for the coverage of 'gender affirming' care, for children and adolescents").

[46] Brooke Migdon, *Florida Publishes Rule Barring Medicaid Coverage for Gender-Affirming Health Care*, THE HILL (Aug. 12, 2022), https://thehill.com/changing-america/respect/equality/3598274-florida-publishes-rule-barring-medicaid-coverage-for-gender-affirming-health-care/.

[47] Florida Medicaid Report, *supra* note 45, at 2.

and are experimental and investigational with the potential for harmful long term affects [sic].”[48]

VI. Washington’s Law forecloses the most ethical treatment: client-responsive psychotherapy.

Treating youth struggling with gender dysphoria is difficult and complex. “There is no common underlying meaning to gender dysphoria,” writes psychologist David Schwartz.[49] The circumstances giving rise to discontent with the body or confusion about identity are as varied as the individuals themselves.

Although the specific causes of gender dysphoria are often unclear, it is well-documented that minors experiencing it generally present with multiple comorbidities, such as depression or anxiety.[50] Many have also suffered traumatic childhood events. A recent study of children and adolescents seeking care for

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[48] *Report Overview*, Florida Agency for Health Care Administration (2022), https://ahca.myflorida.com/letkidsbekids/.

[49] David Schwartz, *Clinical and Ethical Considerations in the Treatment of Gender Dysphoric Children and Adolescents: When Doing Less Is Helping More*, 20 J. INFANT, CHILD, & ADOLESC. PSYCHOTHER. 439 (2021), https://doi.org/10.1080/15289168.2021.1997344.

[50] A recent study reported that 87.7% of children and adolescents diagnosed with gender dysphoria had comorbid psychiatric diagnoses, and many had a “history of self-harm, suicidal ideation, or symptoms of distress.” Kasia Kozlowska, et al., *Attachment Patterns in Children and Adolescents With Gender Dysphoria*, 11 FRONT. PSYCHOL. 582688 (2021), https://doi.org/10.3389/fpsyg.2020.582688.

gender dysphoria found that "[akin] to children with other forms of psychological distress, children with gender dysphoria" have "multiple interacting risk factors that include at-risk attachment, unresolved loss/trauma, family conflict and loss of family cohesion, and exposure to multiple [adverse childhood experiences]."[51] In light of these complicated histories, the minimum level of adequate psychotherapy ought to explore "factors that could be misinterpreted as non-temporary gender dysphoria as well as factors that could be underlying causes for gender dysphoria."[52]

The gender-affirming protocol, however, sidelines all of this social science. It does not look for "reasons why" an adolescent feels alienated from the body, because gender affirmation incorporates an "essentialist" view of gender—presuming that a person's "transgender" identity is innate.[53] Gender identity is perceived as a "soul-like quality or 'essence,'" which means that "questioning the . . . existence of gender identity becomes equated with questioning that person's entire sense of being."[54]

The recent sharp rise in gender dysphoria among adolescents, particularly females, challenges this view. Colloquially described as "rapid onset gender dysphoria," this new presentation is linked to "predisposing psychosocial factors," undermining the claim that an

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[51] *Id.*

[52] Littman, *supra* n.13.

[53] Zucker, *supra* n.3.

[54] Griffin, *supra* n.5.

adolescent's asserted identity should be uncritically accepted, and weighing strongly against medical and surgical interventions.[55]

The complexity of these situations underscores the need for therapeutic goals to meet the client's (not others') needs and wishes. The therapeutic goal of "desisting," or re-integrating one's sense of identity with the reality of the sexed body, should never be precluded. As Dr. Schwartz writes, "Remember what desisting is: the child becomes *comfortable* in his or her skin. The child stops insisting that he or she *is* really another gender. . . . The child is at relative peace with the body he or she has. By what logic could the child's acquisition of peace and comfort not be a desirable outcome?"[56]

Nearly 85% of gender dysphoric minors *do* become "comfortable in their own skin" *if* they receive psychotherapy or are simply left alone. In contrast, nearly all gender dysphoric minors who receive gender affirmation will *persist* in transgender identities and experience poor long-term outcomes. Based on his experience treating such minors, Dr. Schwartz concludes "desistance, when it happens, is desirable. . . . [W]e should

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[55] Zucker, *supra* n.3 (referencing the research of Dr. Lisa Littman. *See* Lisa Littman, *Parent reports of adolescents perceived to show signs of a rapid onset of gender dysphoria*, 13 PLoS ONE e0202330 (2018), https://doi.org/10.1371/journal.pone.0202330; Lisa Litman, *Correction: Parent reports of adolescents and young adults perceived to shown signs of a rapid onset of gender dysphoria*, 14 PLoS ONE e0214157 (2019), https://doi.org/10.1371/journal.pone.0214157).

[56] Schwartz, *supra* n.49.

think of every trans aspiring child as a potential desister."[57] The gender-affirming approach maintains otherwise, treating desistance as unethical, while reifying a minor's identity desires and treating them as fact. Under the Law, gender dysphoric minors must be "affirmed"—and deprived of the psychotherapy needed to find healing. Presuming that a minor's dissociative feelings are indicative of an emergent, fixed identity leads clinicians to ignore other possible causes, such as autistic-spectrum disorders, mental health issues, traumatic histories, or same-sex attraction.

A new book, *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, by veteran BBC journalist Hannah Barnes, reports that Tavistock clinicians routinely failed to explore alternative diagnoses and treated nearly all children as presumptively "transgender."[58] This approach, observed former Tavistock clinician Anna Hutchinson, meant that "If the service was getting this wrong, it was getting it wrong with some of the most vulnerable children and young people."[59] Two leading U.S. gender

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[57] *Id.*

[58] Gaby Hinsliff, *Time to Think by Hannah Barnes Review—inside Britain's only clinic for trans children*, GUARDIAN (Mar. 10, 2023), https://www.theguardian.com/books/2023/mar/10/time-to-think-by-hannah-barnes-review-inside-britains-only-clinic-for-trans-children.

[59] Christina Buttons, *U.K.'s Largest Pediatric Gender Clinic Ignored Autism Connection In Teens Seeking Sex Changes, New Book Claims*, DAILY WIRE (Feb. 15, 2023), https://www.dailywire.com/news/u-k-s-largest-pediatric-gender-clinic-ignored-autism-connection-in-teens-seeking-sex-changes-new-book-claims.

clinicians say that clinicians increasingly fail to provide comprehensive assessments and therapy because they fear "being cast as transphobic bigots by their local colleagues and referral sources if they engage in gender exploring therapy with patients, as some have equated this with conversion therapy."[60] Clinicians fear running afoul of "conversion therapy" laws, like the one at issue here.

VII. The Law forces every adolescent down the gender-affirming pathway, towards irreversible medical harm.

Despite all of the evidence above, Washington State now gives gender dysphoric adolescents little choice but to travel the gender-affirming path, as the Law prohibits open-ended psychotherapy and alternative pathways. The long-term outcomes are not promising. Adults who identify as transgender have high rates of reported suicidality and those who have had genital surgery are nineteen times more likely than the general population to commit suicide.[61] Other recent studies of adults found similar results after

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[60] Laura Edwards-Leeper & Erica Anderson, *The mental health establishment is failing trans kids*, WASH. POST (Nov. 24, 2021), https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/.

[61] Cecilia Dhejne, et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE e16885 (2011), https://doi.org/10.1371/journal.pone.0016885.

gender-affirming surgeries: suicide risks and mental health issues remain high.[62]

Gender therapists Laura Edwards-Leeper and Erica Anderson warn that transgender-identified minors are receiving "sloppy, dangerous," and "substandard" care from mental health professionals who practice "gender-affirmative care," because "gender-affirming" providers "affirm without question" an adolescent's asserted identity and "assume that a person with gender dysphoria who declares they are transgender is transgender and needs medical interventions immediately."[63]

A recent study of 100 detransitioners proves those assumptions wrong: "38 percent reported that they believed their original dysphoria had been caused by 'something specific, such as trauma, abuse, or a mental health condition'" and "fifty-five percent said they 'did not receive an adequate evaluation from a doctor or mental health professional before starting transition.'"[64]

Three adult detransitioners—Walt Heyer, Ted Halley, and Billy Burleigh—offered similar testimony

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[62] Roberto D'Angelo, *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 ARCH. SEX. BEHAV. 7 (2021), https://doi.org/ 10.1007/s10508-020-01844-2; Chantal M. Wiepjes, et al., *Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017)*, 141 ACTA PSYCHIATR. SCAND. 486 (2020), https://doi.org/10.1111/ acps.13164.

[63] Shrier, *supra* n.26.

[64] Littman, *supra* n.13.

in an *amicus curiae* brief in a lawsuit challenging Florida's restriction on Medicaid reimbursements for gender-affirmation care. At one point, all three men "were excited when doctors they trusted told them that a gender transition was the silver bullet solution to their dysphoria." "But after years of fully committing to their gender transitions, [all three] came to see that gender transition interventions were not the answer to their problems. Thankfully, they found others who gave them different advice. Walt, Ted, and Billy worked through their childhood trauma and their gender dysphoria resolved, and today they are today happier and healthier than they ever were when they were presenting as women."[65]

"The bedrock principle of all clinical practice" is "[f]irst, do no harm."[66] "Gender affirmation" for minors is ethically indefensible as a treatment pathway and as a basis for restricting counseling and psychotherapy under the Law.

We urge the Court to consider the serious ethical issues surrounding this Law, which effectively mandates "gender-affirmation-only" and denies effective psychotherapy to minors seeking psychological help

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[65] Brief for Walt Heyer, Ted Halley, and Billy Burleigh as *Amici Curiae* Supporting Defendants at 5, *Dekker v. Weida*, 4:33-cv-325 (N.D. Fl. Apr. 7, 2023), available at https://eppc.org/wp-content/uploads/2023/04/140-1-Detransitioners-Amicus-Brief.pdf.

[66] Schwartz, *supra* n.49.

for their gender dysphoria, including the possibility of harmonizing identity and the physical body.

CONCLUSION

For the foregoing reasons, this Court should grant the Petition and reverse the Ninth Circuit's ruling.

Respectfully submitted,

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April 2023