No. 24-539

IN THE

Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF REGULATORY AGENCIES, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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

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INTEREST OF *AMICUS CURIAE*[1]

The Ethics and Public Policy Center (EPPC) is a nonprofit research institution that applies the Judeo-Christian moral tradition to critical issues of public policy, law, culture, and politics.

Gender ideology has permeated American culture, spurring an unprecedented rise in youth "transgender" identification and demands for irreversible body modifications. These developments raise crucial questions of medical ethics, informed consent, patient safety, and healthcare regulation. They also present serious challenges to religious liberty, free speech, and parental rights.

EPPC files this *amicus* brief because it has a strong interest in promoting the Judeo-Christian vision of the human person, upholding rights of free speech and religious liberty, and responding to the challenges of gender ideology—issues directly related to this case.

Ryan T. Anderson, Ph.D., the President of EPPC, and Mary Rice Hasson, J.D., the Kate O'Beirne Senior Fellow at EPPC and Director of EPPC's Person and Identity Project, contributed to this brief.

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1. Counsel of record received timely notice of *Amicus*' intent to file this brief under Supreme Court Rule 37.2. No counsel for any party authored this brief in whole or in part, nor did any such counsel or party make any monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

Colorado's law at issue in this case forbids "conversion therapy" for minors, defined as "any practice or treatment . . . that attempts to or purports to change an individual's sexual orientation or gender identity." But the law specifically exempts *gender affirming* therapy, which facilitates "identity exploration and development" and assists in "a person undergoing gender transition." Colo. Rev. Stat. §§ 12-245-224, 12-245-202. The ethics of Colorado's counseling restriction cannot be considered apart from the "gender affirming" viewpoint underlying it.

This brief presents legal and ethical concerns regarding gender affirmation as the prescriptive response to a minor's identity distress. It also considers how the counseling restriction acts as a legal barrier to the expression of alternative viewpoints. Rather than permitting clients to hear a range of views, Colorado's law restricts counselors' speech, permitting only messages that reflect the state-favored viewpoint—gender affirmation—while fencing out alternative views and probing questions.

For nearly a decade, physicians, parents, and policy makers have watched with concern as gender affirmative guidelines, reframed under a "rights-based approach, removed previous safeguards and increased availability of [gender-affirming] medical interventions for children and adolescents."[2] The numbers of minors identifying

2. Kasia Kozlowska, et al., *Evolving National Guidelines for the Treatment of Children and Adolescents with Gender Dysphoria: International Perspectives*, Hum. Sys., Nov. 2024, at 3.

as transgender and seeking hormonal and surgical body modifications has increased exponentially. The increasing numbers eventually triggered a long overdue scrutiny of the evidence base for gender affirmative interventions. Rigorous evidence reviews, the emergence of de-transitioners (formerly transgender-identified youth harmed by gender transitions), and whistleblowers have exposed the substandard evidence base of gender affirmative interventions and focused a spotlight on the medical scandal surrounding gender transitions for minors.

Since 2020, multiple European countries have limited or banned gender transition interventions in minors, citing the low-quality evidence base and undeniable harms (including sterility and sexual dysfunction) of gender affirmative practices.[3]

In April 2024, the Cass Review, a four-year research initiative commissioned by the UK National Health Service (NHS), delivered "the most extensive review of gender medicine ever undertaken."[4] The Cass Review concluded that the evidence base for gender-affirming interventions in minors is "remarkably weak,"[5] rests on

3. *Id.*

4. Roberto D'Angelo, *Do We Want to Know?*, Int'l J. of Psychoanalysis, Sept. 2024, at 8.

5. Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report 13 (2024) [hereinafter "Cass Review"].

"shaky foundations,"[6] and offers "no good evidence on the long-term outcomes."[7]

Global concerns about gender affirmation are echoed by U.S. clinicians, families, and lawmakers. Since 2021, 26 states have examined the evidence for youth gender affirmation and responded by passing laws restricting or banning most gender transition interventions for minors.[8]

Gender affirmation theories and activist-driven "conversion therapy" bans assert that gender identity is immutable. But science and experience prove otherwise. Research confirms that "change" in sex-incongruent gender identity is not unexpected, is often desired, and has positive mental health outcomes. Desistence rates in children are consistently high, while longitudinal studies show that identity-related discontent in adolescents declines significantly as they mature.[9] Psychological measures of gender identity increasingly incorporate

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6. Hilary Cass, *Gender Medicine for Children and Young People is Built on Shaky Foundations. Here is How We Strengthen Services*, *BMJ*, April 10, 2024.

7. Cass Review, note 5, *supra*, at 13.

8. Lindsey Dawson & Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, Kaiser Family Foundation (last updated Nov. 26, 2024), https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/.

9. Devita Singh, et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers Psych. 632784 (2021); Pien Rawee, et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Arch. Sex. Behav. 1813 (2024).

the concept of "change" into psychological assessments.[10] Indeed, a 2024 study found that 18.2% of sexual and gender minority youth reported "a different gender identity over time."[11] De-transitioners are living witnesses to the harm resulting from gender affirmation and foreclosed options.

Because gender identity, unlike sex, *can* change, counselors *should* consider and respond to a client's goals, including a client's desire to explore change. In contrast, counseling restrictions exert a chilling effect on therapists, discouraging the careful psychological assessments and counseling that minors need.[12] Gender identity "conversion therapy" laws effectively impose the gender affirmative viewpoint—and the novel and faulty anthropology on which it is based—on all counselors and their clients.

We urge the Court to consider the serious ethical concerns raised by Colorado's counseling restriction. The law effectively mandates a gender-affirmation-only approach and denies effective talk therapy to minors seeking psychological help for identity-related distress and who desire to explore becoming more comfortable with their bodies. For these reasons, *Amicus* urges this Court to grant the petition for a writ of certiorari.

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10. Penelope Strauss, et al., *A Critical Discussion of Pediatric Gender Measures to Clarify the Utility and Purpose of "Measuring" Gender*, Int'l J. Transgender Health, Aug. 2024.

11. Andre Gonzales Real, et al., *Trajectories of Gender Identity and Depressive Symptoms in Youths*, 7 JAMA Open Network e2411322 (2024).

12. Kozlowska, et al., note 2, *supra*, at 6.

ARGUMENT

I. Colorado's counseling restriction is inextricably linked to gender affirmation.

Colorado's counseling restriction cannot be considered apart from the gender-affirming viewpoint that underlies it. See Colo. Rev. Stat. §§ 12-245-224, 12-245-202. Gender affirmation presumes that a minor's self-identification as "transgender" is correct and should be affirmed, and identity exploration should be oriented only towards gender transition.

As psychologist Laura Edwards-Leeper explains, gender affirming clinicians treat "the gender identity and related experiences asserted by a child, an adolescent, and/or family members [as] true," so "the clinician's role . . . is to empathetically support such assertions."[13] Because "young trans children know who they are,"[14] the narrative goes, adults should neither doubt nor probe the child's asserted identity.

Gender-affirming clinicians are leading voices in the campaigns for counseling restrictions; they have a vested interest in expanding the lucrative market for gender affirming interventions. Consider Dr. Norman Spack, who opened the first U.S. pediatric gender clinic in 2007 at Boston Children's Hospital, using the Dutch

13. Laura Edwards-Leeper, et al., *Affirmative Practice with Transgender and Gender Nonconforming Youth: Expanding the Model.* 3 Psych. Sex. Orient. Gender Diversity 165 (2016).

14. Ed Yong, *Young Trans Children Know Who They Are*, *The Atlantic*, Jan. 15, 2019.

Protocol—experimental use of hormones in identity-distressed minors.[15] He soon relaxed the eligibility criteria and accelerated the intervention protocols, despite little evidence of benefit.[16] Patient demand surged. Six years later, Spack and several colleagues published the first description of the "gender affirmative model."[17] In it, they cautioned *against* psychotherapy, stoking fears that encouraging bodily acceptance would cause a "cascade of psychosocial adversities," including depression, incarceration, and suicidality.[18]

Five years later, in 2018, the American Academy of Pediatrics (AAP) endorsed gender affirmation as the

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15. Dutch clinicians began using hormonal interventions in the 1990s to alter the bodies of adolescents labeled as "juvenile transsexuals," in hopes that earlier interventions meant better cosmetic outcomes. Critics denounced the gender program as "reckless" and an "abuse of medicine," and the Dutch clinicians were portrayed as "Nazis experimenting with children." The Dutch persisted, boasting of success to international colleagues, despite the thin evidence supporting their claims. See Alex Bakker, The Dutch Approach: Fifty Years of Transgender Health Care at the VU Amsterdam Gender Clinic 116 (2021).

16. For example, Spack used puberty blockers in nine-year-olds. Beth Schwartzapfel, *How Norman Spack transformed the way we treat transgender children*, *Bos. Phoenix*, Aug. 10, 2012.

17. The gender affirmative model is the American application of the Dutch protocol, with an accelerated timetable, less screening, and more aggressive interventions. Marco A. Hidalgo, et al., *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 Hum. Dev. 285 (2013).

18. *Id.* at 286.

only ethical intervention for identity-distressed minors.[19] It marked an astounding shift. Gender affirmation rose to prominence in U.S. and European medical circles at lightning speed, with little vetting of the research behind it. Demand surged, driven by social media, activist clinicians, and progressive institutions. The AAP's policy, though written by a medical resident backed by a small committee, put an authoritative stamp on the gender affirmative approach, despite its weak evidence base.

The AAP policy, however, has drawn scathing criticism for overstating the supportive evidence for gender affirmation, while minimizing the potential harm to a minor's brain, bones, sexual function, and fertility.[20] The AAP misrepresented long-standing psychological approaches to gender distress, falsely characterizing them as "conversion therapy," harmful, and "outside the mainstream."[21] As sexologist James Cantor noted in an exhaustive critique of the AAP policy, "*there are no studies of conversion therapy for gender identity*" in children (emphasis in original), and it "makes no sense to refer to externally induced 'conversion'" because most children naturally desist and become comfortable with their bodies "regardless of any attempt to change them."[22]

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19. Jason Rafferty, et al., Am. Acad. Pediatrics Comm. on Psych. Aspects of Child & Fam. Health, Comm. on Adolescence, Section on LGBT Health & Wellness, *Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents* 142 Pediatrics e20182162 (2018).

20. James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. Sex. & Marital Therapy, Dec. 2019.

21. See Rafferty, note 19, *supra*.

22. Cantor, note 20, *supra*, at 2.

The link between gender affirmation and restrictive counseling laws persists. In 2022, U.S. Assistant Secretary for Health Rachel Levine promoted gender affirming interventions for minors as "lifesaving," while President Biden launched a "crack down" on counseling ("conversion therapy"), using executive orders and federal regulatory power.[23]

The Cass Review warns that it is "harmful to equate" talk therapy that seeks to "explore [youth] concerns and experiences and help alleviate their distress" with conversion therapy.[24] In contrast, activists see "conversion therapy" in nearly *all* counseling *except* gender-affirming approaches. A 2023 report by the Trevor Project, an "LGBTQ+" activist group, warns against "services that promote therapies using terms such as 'conversion,' 'reparative,' 'reintegrative,' 'unwanted same-sex attraction,' 'sexual attraction fluidity exploration,' and 'rapid-onset gender dysphoria.'"[25]

At bottom, non-affirming talk therapy threatens the gender industry. Asking "*why*" a person experiences

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23. Press Release, The White House, *Fact Sheet: President Biden To Sign Historic Executive Order Advancing LGTBQI+ Equality During Pride Month* (June 15, 2022); see also Chad Terhune, et al., *As More Transgender Children Seek Medical Care, Families Confront Many Unknown*, *Reuters*, Oct. 6, 2022.

24. Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report 150 (2024) [hereinafter "Cass Review"].

25. The Trevor Project, It's Still Happening: A Report on Practitioners of So-Called Conversion "Therapy" in the U.S. (2023).

identity distress or seeks transition is perceived as a denial of the gender-affirming narrative that says it is perfectly normal, healthy, and good to deny the reality of one's sex, to desire amputation of hated breasts or genitals, and to seek construction of non-functioning facsimile genitals of the opposite sex.

II. Gender affirmation is unethical and based on a faulty anthropology

The gender affirmative approach, like the earlier Dutch Protocol, is a novel theory based on a faulty anthropology.[26] Gender affirmation denies human nature and the significance of sexual difference. It rejects objective truth and views human flourishing as a function of autonomy.[27] It claims the individual has the power to self-define an identity based on feelings, regardless of sex, and recognizes an "infinite variety of authentic gender selves."[28] Gender affirmation, in short, contravenes common sense, basic biology, and medical ethics.[29]

Medical ethics obliges clinicians to treat patients with "honesty, beneficence [(do good)], nonmaleficence [(do no harm)], justice, and respect for patient autonomy."[30] Good

26. Theresa Farnan, *Our World Has Lost the Catholic Understanding of Human Anthropology*, *Our Sunday Visitor*, June 2, 2023.

27. Ryan Anderson, When Harry Became Sally: Responding to the Transgender Moment (2019).

28. Hidalgo, note 17, *supra*, at 288.

29. See Farnan, note 26, *supra*.

30. Stephen B. Levine, *Informed Consent for Transgendered Patients*, 45 J. Sex. & Marital Therapy 218 (2019).

medicine facilitates human flourishing, where mind and body function as designed.

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."[31] Sex is binary, determined at conception, and immutable. A person's sex is imprinted in every cell of the person's body and cannot change.[32] Feelings cannot override or erase this truth.

When an adolescent seeks affirmation of an identity at odds with reality, the therapist has an ethical duty to speak the truth, not to validate the minor's 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 female patient that her self-perception that she "is" a boy overrides the reality of her female-sexed body.

Because no one can change sex, it is physically and emotionally damaging to introduce cross-sex hormones in a healthy person, disrupting healthy bodily functions and impairing fertility. It is also damaging to remove genitals and reproductive organs to (in the words of one gender clinic) "help make the body look and feel less masculine

31. Inst. of Med., Exploring the Biological Contributions to Human Health: Does Sex Matter? 1 n.2 (2001), https://www.ncbi.nlm.nih.gov/books/NBK222294/.

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

and more feminine" for males identifying as "girls" or "less feminine and more masculine" for females identifying as "boys."[33]

III. Sex cannot change, but gender identity can.

Gender affirmation and laws restricting counseling rest on the same faulty premise—that "sexual orientation and gender identity are immutable traits" that must be affirmed, at any age, while any "attempts to change these characteristics" are harmful.[34] In other words, when the mind and body are incongruent, the body should change, not the mind.

By design, gender affirmation promotes persistent transgender identification.[35] Counseling restrictions aim at the same result. The restrictions are defensive maneuvers

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33. Randall Child. Hosp. Legacy Health, *Transgender resources for patients*, https://www.legacyhealth.org/Children/health-services/transgender/kids-faq (PDF links for "Estrogen" and "Testosterone" under "Gender-affirming medical care resources").

34. Movement Advancement Project, LGBTQ Policy Spotlight: Conversion Therapy Bans (2017), https://www.lgbtmap.org/policy-and-issue-analysis/policy-spotlight-conversion-therapy-bans.

35. Kristina R. Olson, et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics e2021056082 (2022) (stating 97.5% of socially transitioned children *persist* in transgender identification); 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) (stating 98-100% of puberty-suppressed minors proceed to cross-sex hormones).

that fence out alternative ideas and ensure the gender affirmative viewpoint dominates. This viewpoint, in turn, maximizes the likelihood that transgender identification will persist and gender transition will result.

In real life, however, self-perception (gender identity) can and does change. Decades of research show that nearly all (88%) children who express a transgender identity or exhibit identity distress typically "desist," resolving those feelings before puberty.[36] Recent studies show similar patterns. For example, a Dutch long-term study characterized gender "discontent" as common in adolescence but naturally dissipating over time.[37] Among German adolescents, less than half of gender dysphoria diagnoses persisted over five years.[38]

Exposure to alternative ideas and exploratory conversations may be exactly what identity-distressed minors need. Research on de-transitioners, for instance, shows that new information and new insights, including becoming "more comfortable identifying as my natal sex" or realizing their gender dysphoria arose from trauma or other factors, helped align the body and mind and spur

36. Devita Singh, et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers Psych. 632784 (2021); Pien Rawee, et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Arch. Sex. Behav. 1813 (2024).

37. Rawee, et al., note 36, *supra*.

38. Christian J. Bachmann, et al., *Gender Identity Disorders Among Young People In Germany: Prevalence and Trends 2013–2022*, 121 Deutsches Arzteblatt Int'l 370 (2024).

detransition.[39] Psychological exploration and openness to change *before* transitioning likely would have saved many de-transitioners from lifelong regret and irreversible physical harm.

Among sexual and gender minority youth more generally, a 2024 study found that 18.2% "reported a different gender identity over time," indicating that "gender identity can evolve."[40] Data from UK endocrine clinics found that 8.2% of adolescents pursuing gender transition experienced an identity re-alignment (2.9% after simply *receiving information* about transition, and 5.3% after beginning either puberty suppression or cross-sex hormones).[41]

Psychological measures of gender identity also recognize possibilities for change. For example, the Perth Gender Picture is a tool that helps adolescents think about "their current gender identity, how it was in the past, and how they hope or wish it will be in five

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39. 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).

40. Andre Gonzales Real, et al., *Trajectories of Gender Identity and Depressive Symptoms in Youths*, 7 JAMA Open Network e2411322 (2024).

41. Gary Butler, et al., *Discharge Outcome Analysis of 1089 Transgender Young People Referred to Paediatric Endocrine Clinics in England 2008-2021*, 107 Arch. Disease Childhood 1018 (2022).

or ten years in the future."[42] The Genderqueer Identity Scale measures identity throughout transition, and asks whether "[i]n the future, I think my gender will be fluid or change over time."[43] The Gender Preoccupation and Stability Questionnaire probes the client's experience of gender dysphoria, asking: "Over the past two weeks how often has your sense of what gender you identify with changed at all?"[44]

Good medicine and common sense suggest that a change in identity feelings towards alignment of body and mind is a *positive* development. As Psychotherapist David 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?"[45] Dr. Schwartz concludes "desistance, when it happens, is desirable. [W]e should think of every trans aspiring child as a potential desister."[46]

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42. Penelope Strauss, et al., *A Critical Discussion of Pediatric Gender Measures to Clarify the Utility and Purpose of "Measuring" Gender*, Int'l J. Transgender Health, Aug. 2024, at 13.

43. *Id*. at 12.

44. *Ibid.*

45. 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 & Adol. Psych. 1 (2021).

46. *Ibid.*

IV. Gender affirmation is a medical scandal causing irreversible harm to minors.

The international tide has turned rapidly away from the gender affirmative approach.[47] The approach's poor evidence base has come under scrutiny, amid shocking evidence of harm to minors. Since 2020, multiple European countries have limited or banned gender transition interventions in minors, citing unexplained changes in patient demographics, sharp increases in youth transgender identification, concerns about low-quality evidence, harmful outcomes (including sterility and sexual dysfunction), and the growing ranks of de-transitioners.[48]

The leading gender clinic in Sweden has stopped using puberty blockers for minors.[49] Finland likewise reversed course, issuing new guidelines that prioritize psychotherapy as the first-line treatment for gender dysphoric minors.[50] Denmark, which initiated pediatric gender transition in 2016, recently followed Sweden and Finland and drastically limited puberty blockers

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47. Kasia Kozlowska, et al., *Evolving National Guidelines for the Treatment of Children and Adolescents with Gender Dysphoria: International Perspectives*, Hum. Sys., Nov. 2024.

48. Sarah C. J. Jorgensen, et al., *Puberty Suppression for Pediatric Gender Dysphoria and the Child's Right to an Open Future*, 53 Arch. Sex. Behav. 1941 (2024).

49. Lisa Nainggolan, *Hormonal Tx of Youth With Gender Dysphoria Stops in Sweden*, *Medscape*, May 12, 2021.

50. PALKO/COHERE Finland, Recommendation of the Council for Choices in Health Care in Finland: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors (2020).

and hormones in minors.[51] The Norwegian Healthcare Investigation Board (NHIB/UKOM) restricted puberty blockers for gender affirmation to research settings, deeming them "experimental" and lacking evidence-based support.[52]

In the United Kingdom, whistleblower complaints, a landmark lawsuit, and two substantive evidence reviews by the British National Institute for Clinical Excellence (NICE) led to a multi-year, NHS-commissioned substantive evidence review (the Cass Review).[53] In April 2024, the Cass Review delivered "the most extensive review of gender medicine ever undertaken,"[54] concluding that the evidence base for gender-affirming interventions in minors is "remarkably weak,"[55] rests on "shaky foundations,"[56] and offers "no good evidence on the long-term outcomes of interventions to manage gender-related distress."[57] In response, the UK government banned

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51. Soc'y for Evidence-based Gender Med., *Denmark joins the list of countries that have sharply restricted youth gender transitions*, Aug. 17, 2023.

52. Ukom, Patient Safety for Children & Adolescents with Gender Incongruence (2023).

53. Cass Review, note 24, *supra*, at 13.

54. Roberto D'Angelo, *Do We Want to Know?*, Int'l J. of Psychoanalysis, Sept. 2024.

55. Cass Review, note 24, *supra*, at 13.

56. Hilary Cass, *Gender Medicine for Children and Young People is Built on Shaky Foundations. Here is How We Strengthen Services*, *BMJ*, April 10, 2024.

57. Cass Review, note 24, *supra*, at 13.

puberty suppression for identity-distressed minors, except for clinical trials.[58]

The French Medical Academy and psychotherapists in Australia and New Zealand have urged caution towards medical gender transition interventions while prioritizing psychotherapy.[59] In November 2024, Chile ended federal funding for minors' gender transitions amid growing outcry over the practice.[60] Even the Dutch are re-assessing youth gender transitions. Responding to the Dutch Parliament's request, the Dutch Health Council will conduct a research review in 2025 of hormonal use in identity-distressed minors.[61]

Global concerns about gender affirmation are shared by many U.S. clinicians, families, and lawmakers. Since 2021, 26 U.S. states have passed laws restricting or banning most gender transition interventions in minors.[62]

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58. *Puberty Blockers Ban Is Lawful, Says High Court*, *BBC*, July 29, 2024.

59. Press Release, Fr. Nat'l Acad. of Med., *Medicine and Gender Transidentity in Children and Adolescents* (Feb. 25, 2022); Becky McCall, *Psychiatrists Shift Stance on Gender Dysphoria, Recommend Therapy*, *Medscape*, Oct. 7, 2021.

60. Bernard Lane, *No Hormones on Chile's Public Purse*, *Gender Clinic News*, Nov. 24, 2024.

61. Bernard Lane, *Hide the Data*, *Gender Clinic News*, Oct. 31, 2024.

62. Lindsey Dawson & Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, Kaiser Family Foundation (last updated Nov. 26, 2024), https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/.

Even so, 23 states, including Colorado, have enacted restrictive counseling laws, foreclosing sound therapeutic options, such as talk therapy, *if* the viewpoint presented is not gender affirmative.[63]

The U.S. gender industry is at the center of a growing "medical scandal," writes journalist Lisa Selin Davis.[64] Evidence of suppressed research, political manipulation, misleading the public, and unethical experimentation on minors has surfaced in recent months, partly in the context of litigation. As these developments make clear, a counselor's ability to speak freely, provide information, and respond to her client's wishes is an ethical priority.

V. Colorado's counseling restriction 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.[65] The circumstances giving rise to body-related discontent or identity confusion will vary. The specific causes of gender dysphoria are often unclear, but it is well-documented that minors experiencing it generally present with multiple comorbidities, such as depression

63. Movement Advancement Project, *Equality Maps: Conversion "Therapy,"* (last updated Dec. 5, 2024), https://www.lgbtmap.org/equality-maps/conversion_therapy.

64. Lisa Selin Davis, *Legal Challenges to Red-State Bans on Youth Gender Care Have Illuminated a Cover-Up*, *Globe Ideas*, Dec. 3, 2024.

65. Schwartz, note 45, *supra*, at 8.

or anxiety, or suffer from histories of trauma and adverse childhood experiences.[66] In light of these complicated histories, adequate psychotherapy ought to explore, at a minimum, "factors that could be misinterpreted as non-temporary gender dysphoria as well as factors that could be underlying causes for gender dysphoria."[67]

"Comprehensive treatment of gender dysphoria relies on in-depth individual and family interviews including exploration of childhood adversity and trauma and comprehensive formulation with differential diagnosis and treatment options," explains Australian psychiatrist Andrew Amos. However, the gender affirming paradigm prevents effective counseling by sidelining these important considerations, never asking "why" the adolescent feels alienated from the body, despises his or her anatomy, or dreads the prospect of growing up. Further, "by treating a minor's transgender identification as "a fixed or stable entity, rather than a state of mind with multiple causative factors," the gender affirming clinician "closes down opportunities for doctors and patients to explore the meaning of any discomfort."[68]

Colorado's viewpoint preference for gender affirmation turns a blind eye to the reality of change and the benefits of psychological exploration. The counseling restriction

66. Kozlowska, et al., note 47, *supra* (explaining 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").

67. See Littman, note 39, *supra.*

68. Lucy Griffin, et al., *Sex, Gender and Gender Identity: A Re-evaluation of the Evidence*, 45 British J. Psych. Bull. 291 (2021).

creates an unresolvable ethical dilemma for therapists who aim to respond to their clients' goals and desires but feel "unsure whether addressing psychological and social antecedents will lead to accusations of conversion therapy."[69] Gender therapists acknowledge that gender identity "conversion therapy" laws exert a chilling effect, causing some therapists to avoid offering minors the careful psychological assessments and counseling they need.[70] A clinical environment where professionals must rely on adolescent self-diagnosis and false claims of certainty, and where counselors are prevented from engaging in in-depth counseling to address psychological comorbidities and explore the roots of identity distress increases the likelihood that some minors will pursue body modifications that they will later regret.

Despite the evidence above, Colorado sends gender dysphoric adolescents down the gender-affirming path, as the state's counseling restriction prohibits open-ended psychotherapy and alternative pathways.

"The bedrock principle of all clinical practice" is "first, do no harm."[71] *Amicus* urges the Court to consider the serious ethical issues surrounding Colorado's law, which effectively mandates gender-affirmation-only and denies effective psychotherapy to minors seeking psychological help for their gender dysphoria, including the possibility of harmonizing identity and the physical body.

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69. Griffin, et al., note 68, *supra*.

70. Cass Review, note 24, *supra*, at 150.

71. See Schwartz, note 45, *supra*.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for a writ of certiorari.

Respectfully submitted,

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