Docket Nos. 21-35815 & 21-35856

In the

United States Court of Appeals for the Ninth Circuit

BRIAN TINGLEY,
Plaintiff-Appellant,

v.

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

Defendants-Appellees,

EQUAL RIGHTS WASHINGTON,
Intervenor-Defendant-Appellee.

Appeal from a Decision of the United States District Court for the Western District of Washington, Tacoma, Case No. 3:21-cv-5359-RJB Honorable Robert J. Bryan, District Judge

BRIEF OF AMICUS CURIAE ETHICS AND PUBLIC POLICY CENTER IN SUPPORT OF PLAINTIFF-APPELLANT AND IN SUPPORT OF REVERSAL

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INTERESTS 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 specifically bioethics and human flourishing, governmental and judicial restraint, and personhood and identity. 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, business, media, entertainment, government, and education. Because it is sowing confusion and undermining personal well-being, the rise of gender ideology has created an urgent need for clarity, education, and compassionate guidance. This brief was written by Mary Hasson, JD, the Kate O'Beirne Fellow at EPPC and the Director

[1] All parties have consented to this filing. No party's counsel authored this brief in whole or in part, and no person or entity other than amicus curiae or their counsel made a monetary contribution intended to fund the brief's preparation or submission.

of EPPC's Person and Identity Project, and Ryan T. Anderson, PhD, the President of EPPC.

SUMMARY OF ARGUMENT

The ethics of the Washington "Conversion Law" ("the Law") cannot be considered apart from the 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 "probing the contribution of the environment on gender identity development is … clinically irrelevant."[2] 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

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[2] WPATH Standards of Care, Version 8, Draft for Public Comment, December 2021, "Adolescent" Chapter, p. 3. https://www.wpath.org/soc8.

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

1. Gender affirmation and the Law: inextricably linked

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

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, observed all across North America, Europe, Scandinavia, and elsewhere."[3] The typical patient profile also has changed markedly: until recently, patients

[3] Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior,* 48(7), 1983–1992. https://link.springer.com/article/10.1007%2Fs10508-019-01518-8.

seeking treatment for gender dysphoria were usually either adult males or very young children, mostly boys. Today, the typical patient is an adolescent, usually female.[4] Alongside the explosive growth in gender-dysphoric or transgender-identified children and adolescents, the worlds of psychology and medicine have witnessed a sea change in the dominant clinical approach towards these issues—changes which raise serious ethical questions.[5]

For years, gender dysphoria in children was addressed through "watchful waiting" or with psychotherapy for the child and family. In most (up to 88%) of these situations, the child's gender dysphoria (identity distress) would resolve by puberty.[6] In contrast, nearly all

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[4] Zucker, K.J., *supra* n.3.

[5] Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2021). Sex, gender and gender identity: A re-evaluation of the evidence. *BJPsych Bulletin*, 45(5), 291-299. https://pubmed.ncbi.nlm.nih.gov/32690121/.

[6] Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. *Frontiers in psychiatry*, 12:632784. https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full; Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry*. 2011 Oct;16(4):499-516. doi: 10.1177/1359104510378303. Epub 2011 Jan 7. PMID: 21216800; Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis

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 children and adolescents who identify as transgender should be permitted "to live in the gender that

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PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2013 Jun;52(6):582-90. doi: 10.1016/j.jaac.2013.03 .016. Epub 2013 May 3. PMID: 23702447.

[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. Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. (2021). 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. *PloS one*, 16(2), e0243894. https://doi.org/10.1371/journal.pone .0243894. Similarly, Dutch researchers found nearly 97% of adolescents who received puberty blockers proceeded to cross-sex hormones. Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE. Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Arch Sex Behav*. 2020 Oct;49(7):2611-2618. doi: 10.1007/s10508-020-01660-8. Epub 2020 Mar 9. PMID: 32152785; PMCID: PMC7497424.

feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection."[8]

According to gender therapist Laura Edwards-Leeper, gender affirmation means "the gender identity and related experienced 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] Consequently, 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"

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[8] Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*, 3(2), 165–172. https://doi.org/10.1037/sgd0000167, citing Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development,* 56, 285–290, at 286. http://dx.doi.org/10.1159/000355235.

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

[10] Edwards-Leeper, L., et al., *supra* n.8, at 166, citing Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth, Substance Abuse and Mental Health Services Administration (2015). https://store.samhsa.gov/

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" to support them, the gender affirming model and gender affirming medical and surgical interventions have been heavily promoted by transgender activists, allied clinicians, and several establishment medical organizations.[12] Even so, the rapid swing from the "watchful waiting" therapeutic paradigm to a "gender affirmative" protocol that validates all asserted "gender identities" and puts adolescents on a path towards "gender-affirming" medical interventions is unprecedented. So too is the number of transgender-identified adolescents seeking irreversible "transgender" body modifications—drastic measures that some come to regret.[13]

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product/Ending-Conversion-Therapy-Supporting-and-Affirming-LGBTQ-Youth/SMA15-4928.

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

[12] Edwards-Leeper, L., et al., *supra* n.8.

[13] Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A

2. Gender affirmation: An unethical approach based on a faulty anthropology

Gender affirmation and the body modifications that inevitably result are ethically indefensible as a prescriptive response to a minor's identity distress. "Gender affirming" protocols are based on a faulty philosophical anthropology and a misguided understanding of the purpose of medicine. Medical ethics requires clinicians to treat patients with "honesty, beneficence [doing good], nonmaleficience [doing no harm], justice, and respect for patient autonomy."[14] Good medicine facilitates human flourishing, where the person's mind and body are well-functioning, and various bodily systems achieve their ends. A person's thoughts and feelings achieve their ends by bringing the person into contact with reality. Any medical intervention intended to affirm someone's false beliefs is inherently misguided. Identifying as female or

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Survey of 100 Detransitioners. *Arch Sex Behav* 50, 3353–3369. https://doi.org/10.1007/s10508-021-02163-w. https://link.springer.com/article/10.1007/s10508-021-02163-w.

[14] Levine, S.B. (2019). Informed Consent for Transgendered Patients, *Journal of Sex & Marital Therapy*, 45:3, 218-229. DOI: 10.1080/0092623X.2018.1518885.

"as a woman" does not make a male a female or a woman—such an "identity" doesn't correspond to reality.

The human sexual binary *is* reality. Sex is defined as "male or female according to their reproductive organs and functions assigned by the chromosomal complement."[15] Put differently, what makes someone female or male is being a human being who is organized for sexual reproduction in a certain way, with either testes to produce sperm or ovaries that produce ova (eggs). 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, then a therapist has an ethical duty to speak the truth, not to validate the person'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 to suggest that his self-perception (or gender identity) that he "is" a girl

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[15] Institute of Medicine 2001. *Exploring the Biological Contributions to Human Health: Does Sex Matter?*. Washington, DC: The National Academies Press, at p. 1. https://doi.org/10.17226/10028.

[16] Institute of Medicine 2001, *supra* n.15.

overrides the reality of his male-sexed body. So too for a female child who falsely perceives a male identity. No one can change sex. And it is physically and emotionally damaging to introduce cross-sex hormones, destroy fertility, or remove healthy breasts, genitals, or reproductive organs in an adolescent to "help make the body look and feel less masculine and more feminine" (for males who identify as a "girl") or "less feminine and more masculine" (for females who identify as a "boy")."[17]

3. Gender affirmation: Poor outcomes, irreversible harm

Clinical concerns over the outcomes of gender affirmation have escalated.[18] Gender affirmation has a domino effect, beginning with

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[17] "Feminizing Hormones," and "Masculinizing Hormone Side Effects: A Brief List," Randall Children's Hospital Legacy Health T-Clinic, Portland OR, https://www.legacyhealth.org/children/health-services/transgender/kids-faq, resource listed by Dr. Laura Edwards-Leeper. http://www.drlauraedwardsleeper.com/resources.

[18] For example, see the following recent publications: Malone, W., D'Angelo, R., Beck, S., Mason, J., & Evans, M. (2021). Puberty blockers for gender dysphoria: the science is far from settled. *The Lancet Child & Adolescent Health*, 5(9), e33–e34. https://doi.org/10.1016/S2352-4642(21)00235-2; Griffin, L., et al., *supra* n.5; Entwistle, K. (2020). Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria. *Child and Adolescent Mental Health*, camh.12380, https://doi.org/10.1111/camh.12380; Hruz, P. W. (2020). Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *The Linacre Quarterly*, 87(1), 34–42. https://doi.org/10.1177/

psycho-social transition.[19] Although it is not physically invasive, once begun, psycho-social transition is psychologically difficult to walk back. Children who socially transition are more likely to persist in a transgender-identification than children who do not socially transition. This raises serious ethical questions.[20] The Dutch gender-affirming protocol never supported social transition for pre-pubertal children, over concerns that it would tip the scales towards persistence in transgender

0024363919873762; Levine, S.B. (2021). Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender. *Arch Sex Behav* 50, 3527–3536, https://doi.org/10.1007/s10508-021-02142-1. Levine SB. Correction to: Reflections on the Clinicians Role with Individuals Who Self-identify as Transgender. *Archives of Sexual Behavior*. 2021 Nov;50(8):3537. DOI: 10.1007/s10508-021-02195-2. PMID: 34725753.

[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.).

[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.*, 19:2 INT'L J. OF TRANSGENDERISM 231 (2018) ("I would argue that parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment that will increase the odds of long-term persistence."), available at https://www.researchgate.net/publication/325443416.

identification.[21] Social transition sets the child on a path toward medical transition before the child is mature enough to appreciate the long-term physical and psychological consequences.

For pre-pubertal children, social transition also creates an impetus for the next step in gender affirming care: puberty blockers. A pre-pubertal child who presents as a member of the opposite sex views puberty with extreme anxiety, as the growth of secondary sex characteristics will reveal the child's true sexual identity. Puberty blockers interrupt the child's natural development and preserve the child's secret, if only for a time.

Puberty is a whole-body developmental process. Preventing its normal course, for an indeterminate time, has unknown long-term consequences beyond the "pause" in development of secondary sex characteristics: The child's social and cognitive maturation (including advances in executive functioning and other brain functions) is suspended along with other developmentally appropriate growth,

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[21] de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. *Journal of Homosexuality*, 59(3), 301–320. https://doi.org/10.1080/00918369.2012.653300.

including bone growth. Stopping the puberty blockers will allow the development of secondary sex characteristics to resume, 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, social and emotional maturation, and other aspects of development.[22] Further, puberty blockers generally fail to lessen the child's gender dysphoria and results are mixed in terms of effects on mental health.[23] Long-term effects remain unknown.[24]

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[22] National Institute for Health and Care Excellence (NICE), Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, NHS England, 11 March 2021. https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3fq%3dtransgender%26s%3dDate. Puberty blockers have significant effects on bone density, during a time of important bone growth. Biggs, Michael. "Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria" *Journal of Pediatric Endocrinology and Metabolism*, vol. 34, no. 7, 2021, pp. 937-939. https://doi.org/10.1515/jpem-2021-0180.

[23] Carmichael, P., et al., *supra* n.7; de Vries ALC, Steensma TD, Doreleijers TAH, and Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med* 2011;8:2276–2283. https://www.jsm.jsexmed.org/article/S1743-6095(15)33617-1/pdf.

[24] There are no long-term, rigorous studies on the safety and outcomes of using puberty blockers to disrupt natural puberty in healthy but dysphoric children for an extended time.

Multiple studies show that the vast majority of children who begin puberty blockers go on to receive cross-sex hormones, the next step in gender-affirming care, with life-altering consequences.[25] Blocking a child's natural puberty (preventing maturation of genitals and reproductive organs) and then introducing cross-sex hormones renders the child permanently sterile.[26] Gender clinicians now admit that puberty blocking may impair the child's later sexual functioning as an adult as well.[27] These losses cannot be fully comprehended by a child, precluding the possibility of informed consent.

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[25] Singh, D., et al., *supra* n.6; Steensma TD, Biemond R, et al., *supra* n.6; Steensma TD, McGuire JK, et al., *supra* n.6; Kreukels BP, et al., *supra* n.6.

[26] Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria. *J Sex Marital Ther*. 2018 Jan 2;44(1):29-44. doi: 10.1080/0092623X.2017.1309482. Epub 2017 Apr 19. PMID: 28332936. https://pubmed.ncbi.nlm.nih.gov/28332936/.

[27] Abigail Shrier, "Top Trans Doctors Blow the Whistle on 'Sloppy Care,'" Common Sense, October 4, 2021. https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle; *Bell v. Tavistock and Portman Trust*, High Court of Justice, Royal Courts of Justice, January 12, 2020. https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf.

Cross-sex hormones carry numerous health risks and cause many irreversible changes in adolescents' bodies, including genital or vaginal atrophy, hair loss (or gain), voice changes, and impaired fertility. They also increase cardiovascular risks and cause liver and metabolic changes.[28] The flood of opposite sex hormones has variable emotional and psychological effects as well. Females who take testosterone experience an increase in gender dysphoria, particularly regarding their breasts, creating heightened demand for double mastectomies on teens as young as 13.[29] The gender affirming model recommends performing mastectomies on the healthy breasts of adolescent girls in order to address emotional discontent. This is an unethical practice described by

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[28] Blog, "Gender-affirming hormone in children and adolescents," BMJ EBM Spotlight. February 25, 2019. https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

[29] Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatr*. 2018 May 1;172(5):431-436. doi: 10.1001/jamapediatrics.2017.5440. PMID: 29507933; PMCID: PMC5875384.

psychotherapist Alison Clayton as nothing less than "dangerous medicine."[30]

The gender-affirming approach continues to push ethical boundaries. The World Professional Association for Transgender Health (WPATH) recently released its proposed "Standards of Care Version 8," which lower the recommended ages for adolescents to receive cross-sex hormones to age 14, double mastectomy ("chest masculinization") to age 15, male breast augmentation and facial surgery to age 16, and removal of testes, vagina, or uterus to age 17, with flexibility to provide these gender affirming interventions at even younger ages.[31] This is unethical human experimentation—on *children*. A Swedish teen who underwent medical transition and then de-transitioned after suffering substantial

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[30] Clayton, A. The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?. *Arch Sex Behav* (2021). https://doi.org/10.1007/s10508-021-02232-0.

[31] WPATH Standards of Care, *supra* n.2, at p.9.

bodily harm describes the "gender affirming" medical protocol this way: "They're experimenting on young people … we're guinea pigs."[32]

The unethical nature of these interventions has drawn global attention.[33] The leading gender clinic in Sweden has ended the use of puberty blockers in minors.[34] Finland likewise has reversed course, after extensive evidence reviews, issuing new guidelines that prioritize psychotherapy as the first-line treatment for gender dysphoric minors.[35] In the United Kingdom, whistleblower complaints exposed the National Health Service's (NHS) gender clinic's inadequate psychological care for

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[32] Mission: Investigate. Trans Children ("Trans Train 4"), November 26, 2021. https://www.svtplay.se/video/33358590/uppdrag-granskning/mission-investigate-trans-children-avsnitt-1.

[33] Becky McCall and Lisa Nainggolan, Transgender Teens: Is the Tide Starting to Turn? Medscape. April 26, 2021. https://www.medscape.com/viewarticle/949842.

[34] Lisa Nainggolan, Hormonal Tx of Youth With Gender Dysphoria Stops in Sweden, Medscape. May 12, 2021. https://www.medscape.com/viewarticle/950964.

[35] Summary of a recommendation by COHERE 16.6.2020 Finland. COHERE website: https://palveluvalikoima.fi/en/frontpage. The Council for Choices in Health Care in Finland (COHERE Finland) works in conjunction with the Ministry of Social Affairs and Health, www.palveluvalikoima.fi.

gender dysphoric minors.[36] A landmark case against the NHS in 2020 by "detransitioner" Keira Bell found that minors lacked capacity to consent to gender affirming treatments that cause sterility and impair sexual function, causing the NHS to suspend the use of puberty blockers and institute new procedures to ensure better psychological care.[37] (The decision was later reversed on procedural grounds, and is currently on further appeal).

A separate evidence review in the UK, by the National Institute for Health and Care Excellence (NICE), found little evidence of benefit and substantial risk of harm from gender affirming treatment in minors, and the NHS has commissioned additional evidence reviews.[38]

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[36] Sonia Appleby, "NHS gender identity clinic whistleblower wins damages," The Guardian, Sept. 4, 2021. https://www.theguardian.com/society/2021/sep/04/gender-identity-clinic-whistleblower-wins-damages. Lauren Lewis, "NHS's only gender service for children believes all girls who don't like 'pink ribbons and dollies' must be transgender, whistleblower claims," The Daily Mail. November 22, 2021. https://www.dailymail.co.uk/news/article-10231507/NHSs-gender-service-children-believes-girls-dont-like-pink-transgender.html.

[37] Becky McCall, NHS Makes Child Gender Identity Service Changes After High Court Ruling. Medscape. December 4, 2020. https://www.medscape.com/viewarticle/941781.

[38] National Institute for Health and Care Excellence (NICE), *supra* n.22.

Psychotherapists in Australia and New Zealand recently issued a new policy statement emphasizing mental health treatment for gender dysphoric minors, rather than gender affirmation, and stressing the importance of assessing the "psychological state and context in which gender dysphoria has arisen," before any treatment decisions are made.[39]

4. Client-responsive psychotherapy is needed—but foreclosed by the Law

These situations are complex. "There is no common underlying meaning to gender dysphoria," writes psychologist David Schwartz. The circumstances giving rise to a child or adolescent's discontent with the body or confusion about identity are as varied as the individuals themselves. As a result, writes psychiatrist Dr. Stephen Levine, it is an essential "principle of good clinical management for any new symptom" to ask "[w]hy is this occurring now?"[40] However, Dr. Levine observes, "Many affirmative therapists find this question to be irrelevant and unethical because of the greater need to respect patient autonomy. They

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[39] Becky McCall, Psychiatrists Shift Stance on Gender Dysphoria, Recommend Therapy. Medscape. October 7, 2021. https://www.medscape.com/viewarticle/960390.

[40] Levine, S.B., *supra* n.18.

may offer the idea that a trans person, at any age, knows best what is needed. It is worth recalling that today's passion can be tomorrow's regret. Making a diagnosis of gender dysphoria is easy. Thinking about what it is a response to is not."[41]

Although the specific causes of gender dysphoria are often unclear, it is well-documented that children and adolescents experiencing gender dysphoria generally present with multiple co-morbidities, such as depression or anxiety.[42] Many also have suffered from adversity or traumatic childhood events. A recent study of children and adolescents seeking care for gender dysphoria found that "[akin] to children with

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[41] Levine, S.B., *supra* n.18.

[42] A recent study, for example, 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." Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents With Gender Dysphoria. *Front Psychol*. 2021 Jan 12;11:582688. doi: 10.3389/fpsyg.2020.582688. PMID: 33510668; PMCID: PMC7835132. *See also*, Newcomb, M.E., Hill, R., Buehler, K., *et al.*, High Burden of Mental Health Problems, Substance Use, Violence, and Related Psychosocial Factors in Transgender, Non-Binary, and Gender Diverse Youth and Young Adults. *Arch Sex Behav* 49, 645–659 (2020). https://doi.org/10.1007/s10508-019-01533-9. https://link.springer.com/article/10.1007/s10508-019-01533-9.

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 ACEs [adverse childhood experiences]."[43] In light of the complicated histories of transgender-identified persons, writes Dr. Lisa Littman, 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."[44]

Gender affirmation does not look for "reasons why" an adolescent feels alienated from his or her sexed body, because gender affirmation incorporates an "essentialist" view of gender—the belief that a person's "transgender" identity is innate.[45] Gender identity is viewed as a "soul-like quality or 'essence,'" which means that "questioning the … existence of gender identity becomes equated with questioning that person's entire

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[43] Kozlowska, K, et al., *supra* n.42.

[44] Littman, L., *supra* n.13.

[45] Zucker, K. J., *supra* n.3.

sense of being."[46] The recent sharp rise in gender dysphoria among adolescents, particularly females, challenges this view. Colloquially described as "rapid onset gender dysphoria," this theory rejects the claim that an adolescent's asserted identity should be uncritically accepted. (After all, "gender identity" cannot be verified or proven.) It attributes the sudden spike in transgender identification among adolescents to the possibility of "predisposing psychosocial factors," a view that strongly weighs against medical and surgical interventions.[47]

The complexity of these situations also underscores the need for therapeutic goals to meet the client's (not others') needs and wishes. The

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[46] Griffin, L., et al., *supra* n.5.

[47] Zucker, K. J., *supra* n.3 (referencing the research of Dr. Lisa Littman. Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE,* 13(8), e0202330. https://doi.org/10.1371/journ al.pone.0202330. Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to shown signs of a rapid onset of gender dysphoria. *PLoS ONE*. https://doi.org/10.1371/journal.pone.0214157.) According to Littman, "parents describe that the onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity."

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, or that she or he cannot be happy unless she or he is in the body of 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?"[48]

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 minors with gender dysphoria, Dr. Schwartz concludes "desistance, when it happens, is desirable … we should think of every trans aspiring child as a potential

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[48] David Schwartz (2021): Clinical and Ethical Considerations in the Treatment of Gender Dysphoric Children and Adolescents: When Doing Less Is Helping More, *Journal of Infant, Child, and Adolescent Psychotherapy*, DOI: 10.1080/15289168.2021.1997344.

desister."[49] 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 effective psychotherapy needed to find healing and wholeness. Presuming that a minor's dissociative feelings are healthy or indicative of a newly emergent, fixed identity is "dangerous," according to Anna Hutchinson, a veteran NHS gender clinician. It ignores other possible causes, including "autistic-spectrum disorders, depression, trauma or a history of sexual abuse." Foreclosing psychotherapy that explores alternative explanations "goes against what therapy is," says Dr. Hutchinson.[50]

Why would a clinician fail to provide the mental health assessment and therapy a minor needs? For fear of running afoul of "conversion therapy" laws, like the one at issue in this case. In a recent *Washington*

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[49] David Schwartz, *supra* n.48.

[50] Missing the Mark, "A proposed bill on conversion therapy could do more harm than good," *The Economist*, December 4, 2021. https://www.economist.com/britain/2021/12/04/a-proposed-bill-on-conversion-therapy-could-do-more-harm-than-good.

Post article, two prominent gender therapists, Dr. Laura Edwards-Leeper and Dr. Erica Anderson (who identifies as a transgender woman), acknowledged that therapists may 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."[51]

5. The Law forces every adolescent down the gender affirming pathway towards irreversible medical harm

In Washington, gender dysphoric adolescents have little choice but to travel the gender affirming path, as the Law prohibits open-ended psychotherapy and forecloses alternative pathways. And the long-term outcomes are not promising. Forty-one percent of all adults who identify as transgender attempt suicide at some point in their lives, and those who have had genital surgery are nineteen times more likely than the general population to die by suicide.[52] Other recent studies of adults

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[51] Laura Edwards-Leeper and Erica Anderson, "The mental health establishment is failing trans kids," *The Washington Post*, November 24, 2021. https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/.

[52] Dhejne, C, Lichtenstein, P, Boman, M, Johansson, ALV, Långström, N, Landén, M. Long-term follow-up of transsexual persons undergoing sex

found similar results after gender affirming surgeries: suicide risks and mental health issues remain high.[53]

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reassignment surgery: cohort study in Sweden. Scott J, editor. *PLoS ONE* 2011; 6(2): e16885.

[53] D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2020). One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria. *Archives of Sexual Behavior*. https://doi.org/10.1007/s10508-020-01844-2. Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C., Coumou, B., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). *Acta psychiatrica Scandinavica*, 141(6), 486–491. https://doi.org/10.1111/acps.13164; Correction to Bränström and Pachankis, *Am J Psychiatry*. 2020 Aug 1;177(8):734. doi: 10.1176/appi.ajp.2020.1778correction.PMID: 32741280, citing Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *Am J Psychiatry*. 2020 Aug 1;177(8):727-734. doi: 10.1176/appi.ajp.2019.19010080. Epub 2019 Oct 4. Erratum in: *Am J Psychiatry*. 2020 Aug 1;177(8):734. PMID: 31581798, and noting: "the authors reanalyzed the data to compare outcomes between individuals diagnosed with gender incongruence who had received gender-affirming surgical treatments and those diagnosed with gender incongruence who had not. While this comparison was performed retrospectively and was not part of the original research question given that several other factors may differ between the groups, the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts in that comparison."

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."[54]

A recent study of "de-transitioners" proves those assumptions wrong, admit Edwards-Leeper and Anderson. "In a recent study of 100 detransitioners … 38 percent reported that they believed their original dysphoria had been caused by 'something specific, such as trauma, abuse, or a mental health condition.'"[55] These young people believed at one time that being "transgender" was their "true" identity, but "fifty-five percent said they 'did not receive an adequate evaluation from a doctor or mental

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[54] Abigail Shrier, *supra* n.27.

[55] Littman, L., *supra* n.13.

health professional before starting transition.'"[56] In fact, their distress was due to other causes. They experienced deep regret over their gender affirming treatments, and the failure of therapists to explore possible alternative explanations.

"The bedrock principle of all clinical practice," writes psychologist David Schwartz, is "[f]irst, do no harm."[57] "Gender affirmation" for minors is ethically indefensible, both 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 for their gender dysphoria, including the possibility of desisting from a transgender identity.

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[56] Littman, L., *supra* n.13.

[57] David Schwartz, *supra* n.48. Harm includes "physical or mental damage" including "a diminishing of known functionality.

CONCLUSION

For the foregoing reasons, Amicus Curiae Ethics and Public Policy Center respectfully requests that this Court reverse the district court, with instructions to deny the Defendants' motion to dismiss and to grant the Plaintiff's motion for a preliminary injunction.

Respectfully submitted,

Dated: December 13, 2021

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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I hereby certify that on December 13, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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