

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for American Academy of Pediatrics (“AAP”), the Academic Pediatric Association (“APA”), the American Academy of Child & Adolescent Psychiatry (“AACAP”), the American Academy of Family Physicians (“AAFP”), the American Academy of Nursing (“AAN”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality (“GLMA”), the American College of Obstetricians and Gynecologists (“ACOG”), the American College of Osteopathic Pediatricians (“ACOP”), the American College of Physicians (“ACP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the Association of American Medical Colleges (“AAMC”), Association of Medical School Pediatric Department Chairs, Inc. (“AMSPDC”), the Endocrine Society (“ES”), the Kentucky Chapter of the American Academy of Pediatrics (“KCAAP”), the National Association of Pediatric Nurse Practitioners (“NAPNAP”), the Pediatric Endocrine Society (“PES”), the Societies for Pediatric Urology (“SPU”), the Society for Adolescent Health and Medicine (“SAHM”), the Society for Pediatric Research (“SPR”), the Society of Pediatric Nurses (“SPN”), and the World Professional Association for Transgender Health (“WPATH”) certify that:

1. AAP, APA, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP,

AMA, APS, AAMC, AMSPDC, ES, KCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, APA, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, AAMC, AMSPDC, ES, KCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH.

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici curiae are the American Academy of Pediatrics, the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Pediatricians, the American College of Physicians, the American Medical Association, the American Pediatric Society, the Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Inc., the Endocrine Society, the Kentucky Chapter of the American Academy of Pediatrics, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Societies for Pediatric Urology, the Society for Adolescent Health and Medicine, the Society for Pediatric Research, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health (collectively, “*amici*”).¹

Amici are professional medical and mental health organizations seeking to ensure that all adolescents, including those with gender dysphoria, receive the

¹ *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

optimal medical and mental health care they need and deserve. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment of transgender adolescents.

INTRODUCTION

On March 29, 2023, the Kentucky Legislature voted to override Governor Beshear’s veto on S.B. 150 (the “Healthcare Ban”), enacting a law that effectively bans healthcare providers from providing patients under 18 with critical, medically necessary, evidence-based treatments for gender dysphoria.² Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the medical interventions for adolescents prohibited by the Healthcare Ban.³

Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the patient’s gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient’s life.⁴ If not treated, or treated improperly, gender dysphoria can result in

debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is “gender-affirming care.”⁵ Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual’s gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.⁶ For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical interventions provided to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in

e20182162, at 2–3, tbl.1 (2018) (hereinafter, “AAP Policy Statement”), <https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for>.

⁵ *Id.* at 10.

⁶ *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf>.

the mental health and overall well-being of adolescents with gender dysphoria.⁷

The Healthcare Ban disregards this medical evidence by precluding healthcare providers from providing adolescent patients with treatments for gender dysphoria in accordance with the accepted standard of care. Accordingly, *amici* urge this Court to

assigned at birth.⁹ However, transgender people have a gender identity that does not align with their sex assigned at birth.¹⁰ In the United States, it is estimated that approximately 1.4 million individuals are transgender.¹¹ Of these individuals, approximately 10% are teenagers aged 13 to 17.¹² Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing understanding that being transgender is a normal variation of human identity.¹³ However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to “impairment in peer and/or family relationships, school performance, or other aspects of their life.”¹⁴ Gender dysphoria is a formal

⁹ See Am. Psychological Ass’n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 862 (2015), <https://www.apa.org/practice/guidelines/transgender.pdf>.

¹⁰ See *id.* at 863.

¹¹ See Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, Williams Inst., at 2 (Jan. 2017), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf>.

¹² See *id.* at 3.

¹³

diagnosis under the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-5-TR).¹⁵

Adolescents with gender dysphoria are not expected to identify later as their sex assigned at birth.¹⁶ Instead, “[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult.”¹⁷

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.¹⁸ Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the

¹⁵ See Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5 – TR*, at 512–13 (2022).

¹⁶ See, e.g., Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), <https://pubmed.ncbi.nlm.nih.gov/22917211> (“In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood”).

¹⁷ Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist’s View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 585 (Oct. 2021), <https://pubmed.ncbi.nlm.nih.gov/34376826>.

¹⁸ See Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*. 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), <https://pubmed.ncbi.nlm.nih.gov/30095668>.

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Medical Interventions.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (together, the “Guidelines”).²⁴ The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional (“HCP”). Further, the Guidelines provide that each patient who receives gender-affirming care should receive only evidence-based, medically.

According to the Guidelines, gender-

with the patient and their caregiver(s).

emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.³¹ Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.³²

If all of the above criteria are met, the Guidelines instruct that gonadotropin-

Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam’s apple or breast growth.³⁵ Puberty blockers have well-known efficacy and side-effect profiles,³⁶ and their effects are generally reversible.³⁷ In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.³⁸ The risks of any serious adverse effects from these treatments are exceedingly rare when provided under clinical supervision.³⁹

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient’s gender identity.⁴⁰ Hormone therapy involves using gender-affirming hormones to allow adolescents to

³⁵ See AAP Policy Statement, *supra* note 4, at 5.

³⁶ See Martin, *supra* note 7, at 2.

³⁷ See *id.*

³⁸ See F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEW ENG. J. MED. 1546 (1981).

³⁹ See, e.g.

develop secondary sex characteristics consistent with their gender identity.⁴¹ Hormone therapy is only prescribed when a qualified mental health professional has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to assent to the treatment, and that any coexisting problems have been addressed.⁴² A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with

again by multiple, independent groups of professionals.⁴⁹ Reviewers are subject to strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.⁵⁰ Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.⁵¹ The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.⁵² 119 authors were ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.⁵³

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive

⁴⁹ Endocrine Soc’y, *Methodology*, <https://www.endocrine.org/clinical-practice-guidelines/methodology>.

⁵⁰ *See id.*

⁵¹ *See* WPATH Guidelines, *supra* note 24, at S247–51.

⁵² *See id.*

⁵³ *See id.*

gender-affirming medical care experience improvements in their overall well-being.⁵⁴ Nine studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,⁵⁵ and nine

blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.⁵⁹ Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.⁶⁰ Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.⁶¹ A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.⁶²

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.⁶³ A six-year follow-up study of 55 individuals from the 2011 study found that

associated with a statistically significant decrease in depression and anxiety.⁶⁴

“Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population.”⁶⁵

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming treatments prohibited by the Healthcare Ban are effective for the treatment of gender dysphoria. As the U.S. Court of Appeals for the Eighth Circuit recently recognized in affirming an order preliminarily enjoining enforcement of a similar Arkansas law, “there is substantial evidence ... that the [Arkansas] Act prohibits medical treatment that conforms with the recognized standard of care.”⁶⁶

⁶⁴ Vries, *Young Adult Psychological outcome After Puberty Suppression and gender Reassignment*,

III. The Healthcare Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Denying Them the Treatment They Need.

The Healthcare Ban denies adolescents with gender dysphoria in Kentucky access to medical interventions that are designed to improve health outcomes and alleviate suffering and that are grounded in science and endorsed by the medical community. The medical treatments prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.⁶⁷ In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a preliminary injunction

⁶⁷ See M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), <https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x>; see also Turban, *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, *supra* note 55.

should be granted.

CERTIFICATE OF SERVICE

I hereby certify that foregoing Brief was served by electronic service upon counsel of record on May 22, 2023.

/s/ Amy D. Cabbage
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