No. 23-5600

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

L. W., by and through her parents and next friends, Samantha Williams and Brian Williams; SAMANTHA WILLIAMS; *et al.*

Plaintiffs – Appellees,

v.

JONATHAN THOMAS SKRMETTI, in his official capacity as the Tennessee Attorney General and Reporter, et al.

Defendants – Appellants,

UNITED STATES OF AMERICA

Intervenor – Appellee.

On Appeal from the United States District Court for the Middle District of Tennessee at Nashville. No. 3:23-cv-00376
Before the Honorable Eli J. Richardson, District Judge.

Brief for Liz and Chris Doe, Kevin and Charmagne Cox, Joy Flores, Yaacov Sheinfeld, Jeanne Crowley, Ellie Swimmer, Martha S., Kristine W., Bri Miller, and Helen S., as Amici Curiae in Support of Defendants-Appellants, Supporting Reversal

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STATEMENT OF CORPORATE DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici curiae* by and through undersigned counsel, state that they are not publicly held corporations that issue stock, nor do they have parent corporations.

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STATEMENT OF INTEREST

Pursuant to Fed. R. App. P. 29, *Amici Curiae* respectfully submit this brief in support of Defendants-Appellants. All parties have consented to this filing.[1]

Amici are Liz and Chris Doe (pseudonyms)[2], Kevin and Charmagne Cox, Joy Flores (pseudonym), Yaacov Sheinfeld, Jeanne Crowley (pseudonym), Ellie Swimmer (pseudonym), Martha S., Kristine W., Bri Miller, and Helen S. They are parents of children who believed they were transgender and wanted medical interventions to change their bodies to conform to an identity that was inconsistent with their sex.

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

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[1] *Amici* affirm that no counsel for a party authored this brief in whole or in part and no one other than *amici*, its members, or its counsel contributed any money to fund its preparation or submission.

[2] Some of the amici are using pseudonyms in order to protect the identity of their children and/or other family members.

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

INTRODUCTION

Tennessee has acted to protect its children by prohibiting medical interventions designed to divert a child's body from its natural development to an altered state mimicking the opposite sex. Tenn. Code Ann. §§ 68-33-101, et. seq., (the "Act") properly balances Tennessee's compelling state interest in protecting children's health and basic human rights with the rights of parents to direct medical care, particularly when the exercise of that right is influenced by manipulation and misinformation. It sends the message that Tennessee's children will be protected from experimental medical and surgical interventions that will irreversibly change their bodies, create future harm, and take away their right to decide as adults whether to have children. It is a message that Amici wish their children could have heard and heeded.

LEGAL ARGUMENT

I. The Act Properly Balances Parental Rights With Tennessee's Compelling State Interest To Protect Children's Health.

The Act furthers Tennessee's compelling state interest in protecting the health and welfare of its children. *See Kanuszewski v. Mich. Dep't of Health & Human Servs*., 927 F.3d 396, 419 (6th Cir. 2019). The Legislature has acted to protect minor

children from medical treatments that are harmful and unproven, even if parents approve. The Act further strengthens Tennessee's existing statutory protection of minors against sterilization, in Tenn. Code Ann. §68-34-108, and female genital mutilation, in Tenn. Code Ann. §39-13-110.

Emerging reviews of medical evidence and Amici's lived experiences demonstrate that the interventions prohibited under the Act are not proven safe and effective for children. European practitioners, who were pioneers in "gender-transition" interventions, have significantly restricted or even halted the procedures.[3] Among the concerns raised is that the interventions can effectively sterilize children before they are developmentally mature enough to understand what that means.[4]

As the Supreme Court said in *Skinner v. Oklahoma,* 316 U.S. 535, 541-42 (1942), "[t]he power to sterilize, if exercised, may have subtle, far-reaching and devastating effects." The person who is sterilized is "forever deprived of a basic liberty," *i.e.,* the decision of whether to procreate, which is "one of the basic civil

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[3] *See e.g.*, National Institute for Health and Care Excellence, *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (2021) https://arms.nice.org.uk/resources/hub/1070905/attachment; Society for Evidence-Based Gender Medicine (SEGM) *Karolinska Institute Halts Puberty Blockers, Cross-Sex Hormones for < 16*; May 5, 2021, https://segm.org/Sweden_ends_use_of_Dutch_protocol; SEGM, *One Year Since Finland Broke with WPATH "Standards of Care" Finland prioritizes psychotherapy over hormones, and rejects surgeries for gender-dysphoric minors*, July 2, 2021, https://segm.org/Finland_deviates_from_WPATH.

[4] *Id.*

rights of man...fundamental to the very existence and survival of the race" *Id.* As this Court said in *Sullivan v. Benningfield*, 920 F.3d 401, 408 (6th Cir. 2019), the liberty interest in preserving the right to create children of one's own is recognized as fundamental. The Act ensures that all children, including those with gender dysphoria, retain their fundamental right to make the important decision of whether to have children in the future, *See Sullivan*, 920 F.3d at 408, and the right to not suffer female genital mutilation even under the guise of "sex reassignment."

II. The Act Strengthens Parents' Rights To Make Sound Medical Decisions And Prevents Disruption of Families.

A. Medical Interventions That Disrupt Children's Sexual Function Are Not Supported By Traditional Medical Safeguards Necessary For Parents To Make Sound Decisions.

Parents are presumed to act in the best interests of their children to make sound medical decisions that children are incapable of making. *Parham v. J.R.*, 442 U.S. 584, 603 (1979). Making sound medical decisions requires consulting medical professionals using the "traditional tools of medical science." *Id.* at 609. In the case of "gender-transition" hormonal and surgical interventions for children, parents are foreclosed from making sound medical decisions because the procedures are not based on traditional tools of medical science, including credible clinical evidence that prove the safety and efficacy of such interventions.[5]

[5] Paul W. Hruz. M.D., Ph.D. *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, 87 THE LINACRE QUARTERLY 34 (2020).

Under traditional medical protocols, practitioners would not advance a single treatment approach over other safer interventions based upon low-quality evidence.[6] Amici's experiences demonstrate that is precisely what "gender specialists" are doing. Parents are not informed about the lack of evidence supporting the safety and efficacy of the single option. Neither are they provided with evidence-based information on short-term and long-term risks, lack of FDA approval of the proposed use of these drugs or the fact that the majority of children with gender dysphoria will desist after puberty if they are not subjected to such interventions.[7]

Parents are placed in an impossible position of not having the information necessary to make a sound decision, being coerced with the threat of their children committing suicide if they do not consent and contending with internet-fueled demands of their children. The Act prevents parents from being placed in that untenable position. The Act is a necessary tool to preserve family integrity by prohibiting medical and surgical interventions that undermine parental authority and are toxic to family relationships.

B. Amici's Experiences Demonstrate The Compelling Need For The Act.

Amici are parents who come from various walks of life but share the experience of having a child who professed to having an identity that did not

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6 *Id.* at 37.

7 *Id.* at 36.

correspond to his or her sex. Medical interventions were promoted as the only viable option for their children, supplanting psychotherapy which would have better addressed the children's underlying mental health issues. The promotion of these medical interventions with the ubiquitous threat of suicide created dissensions in families, exacerbation of existing trauma and adverse physical consequences for children who received the interventions. Amici are sharing their experiences to demonstrate why this Court should uphold the Tennessee Legislature's efforts to protect Tennessee minors and families from similar experiences.

Liz and Chris Doe

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

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

A. attended a small middle school for kids with dyslexia. She was in a class with all boys and liked how boys hung out together. A. started to only want to wear boys' clothes, which the parents supported. A. struggled to find a place to fit in. She and her friends got heavily into Anime, which has many gender-bending characters. A friend began circulating information about sexuality and gender. During the pandemic, A. announced that she was "trans." A. had also been on Tik Tok and discussing transitioning on social media. Liz found the algorithms on A's social media heavily weighted with trans-promoting materials and influencers. A. has six kids in her friend group who are identifying as non-binary or trans.

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

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

and pronouns at summer camp. Taken aback, Liz informed the psychiatrist it was a girls' camp. The psychiatrist told Liz "they know how to handle these situations."

A. began to refuse to go to the therapist she had been seeing. The Does were referred to a gender therapist, who said he could help A. socially transition and figure out the "next steps," which the parents understood to mean puberty blockers and opposite-sex hormones. The gender therapist gave no other options.

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

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

The Does are striving to protect their daughter from these medical interventions. A. at times refuses to talk with her parents because they will not grant her demands. They feel their parental authority has been taken out of their hands. They already had a stubborn child, but once others are allowed to question their

authority, it has made matters so much worse as more friends join the transgender social trend.

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

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

Kevin and Charmagne Cox

Kevin and Charmagne Cox are the Kentucky parents of 21-year-old triplets and 14-year-old H. Kevin is a retired Air Force Colonel and works in the health field. Charmagne works at home full-time. Both consider themselves politically moderate. Their family has lived through multiple deployments, Hurricane Katrina, and a grandparent being killed by a drunk driver, but the turmoil they experienced

during their daughter H's struggles with her sexual identity was the hardest thing their family has ever endured.

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

Shortly thereafter, the parents discovered H. had been socially transitioned to a male identity at the gym and at the co-op school. Charmagne volunteered at the co-op and was friends with the director. H. was close friends with the director's daughter. Charmagne learned the school was deliberately deceiving them by referring to H. as a female and using her legal name when Charmagne was present, but otherwise referring to H. as a male with a made-up name in order to conceal the social transitioning occurring at school. The director's daughter was also identifying as non-binary. Charmagne removed H. from the school.

At 13, H. announced that when she turns 18 she was going to have her breasts cut off and start taking testosterone. This was devastating to the entire family. Hearing of accounts in which teens were supplied with hormones without their

parents' knowledge, Charmagne and Kevin had H. tested for the presence of puberty blockers or elevated testosterone. Fortunately, the tests came back negative.

H. is desisting now at age 14. They found a counselor who worked with H. to reconnect with her sex. They cut off individuals that were negative influences. But the biggest key, they found, was to turn off the internet completely for a time. The parents are still monitoring her environment closely. But after almost three years of gender turmoil, H. is now wearing make-up and earrings, is growing her hair out, and telling her sisters that she feels more like a girl. Her mental state is much improved.

Kevin and Charmagne are deeply grateful their state of Kentucky has passed a similar child protective statute to Tennessee's Act. Research shows a young person's brain is not fully developed till their mid-20s. They believe that administering drugs that interfere with healthy pubertal development, hormones that are physically appropriate to the opposite sex, and surgeries that remove healthy body parts is form of abuse that is being perpetuated by a sliver of the medical community. There are many things that parents cannot do for the sake of their child's protection – riding without a car seat, giving them numerous drugs, or letting them drive without their license. These statutes will help family by ensuring their child cannot undergo treatments that will cause lasting harm and will spare other parents with gender dysphoric children what their family has endured.

Joy Flores

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

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

Joy later learned that the therapist did not explore the root of her problems, but just affirmed her trans identity. Within a couple of months, the therapist guided D. to "come out" at school, where she was applauded and told she was brave. Joy and her husband were not told that D. had "come out" at school and was being treated as a male. When Joy found out, she spoke to the school counselor who said they

were following guidelines that parents were not to be told about their children's gender identity at school.

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

Joy and husband later saw a physician who was not an endocrinologist. The physician again pushed testosterone, but the parents declined. The doctor then recommended Depo Provera, which would stop D.'s menstrual cycle. The parents agreed to that intervention. D. continued to meet with the doctor in private sessions. At each session, the doctor offered D. testosterone and told her that gender dysphoria was the reason for D.'s depression, anxiety, and sadness. Joy asked the doctor "with no long-term studies you are giving young females an adult male hormone, how do you sleep with yourself at night?" The doctor replied, "It makes them SO HAPPY." D. never saw a psychologist or psychiatrist at the gender clinic.

Joy sought advice from therapists but was told by them they must accept and affirm D. as a boy. They offered no other options. Just before D. turned 18 the family found a holistic health coach who worked with D. and the family. She discovered

that D. had Lyme disease, which helped explain some of D.'s dysphoria. The coach helped D. feel comfortable in her body and the dysphoria has lessened.

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

Yaacov Sheinfeld

Yaacov Sheinfeld was shocked when his wife told him that their 17-year-old daughter had announced she was transgender. Their daughter, S., had been in counseling for depression since she was 15 but never said anything about gender dysphoria. Yaacov learned that five of his daughter's friends had also announced that they were transgender. Being transgender provided S. with acceptance she had not previously experienced in high school.

When S. went to college she began taking testosterone. When Yaacov and his wife, New Jersey residents, met with S., Yaacov observed that S. was very depressed. She announced that she was going to get a double mastectomy. Yaacov

objected. The social worker who facilitated S. getting the surgery called Yaacov a chauvinist who did not love his daughter enough. She told Yaacov that he had to get on board with the decision. The social worker assured the parents that everything would be fine. S. thereafter refused to talk to her father and began threatening that she would kill herself if she did not get the surgery she wanted. S. had a double mastectomy at age 19.

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

S. was found dead on August 6, 2021 with Fentanyl and alcohol in her system. She was 28.

Yaacov supports banning medical interventions for minors because young people, especially those with mental health issues such as his daughter, cannot make clear decisions about their future, particularly when neither they nor their parents are provided with information about the full effects of these interventions. He contends these interventions that were supposed to relieve her problems killed his daughter.

Jeanne Crowley

Jeanne Crowley and her husband were repeatedly told that the puberty blockers their pre-teen daughter, M., was clamoring for were the answer for her anxiety and distress about her changing body. They were advised that children like her had high rates of suicide and self-harm and puberty blockers would help by stopping the development of secondary sex characteristics that cause children distress and "give the children time to explore their identity."

Gender-affirming mental health and medical professionals assured these New York parents that acceding to their daughter's demand for puberty blockers was necessary for her mental health. The parents were repeatedly assured that the puberty blockers were nothing more than a "pause button" and completely reversible. Based on these assurances the parents consented to M. receiving a long-lasting puberty-blocking implant. M. previously had psychological evaluations that revealed depression, Autism Spectrum Disorder (ASD) with sensory issues, dyslexia, and dysgraphia. M. had also experienced social trauma. However, none of these issues was addressed by health care professionals once they determined M. had gender dysphoria. Nor did they offer any other treatment options.

Jeanne learned through her own research that puberty blockers were shown to cause loss of bone density and diminished cognitive development. Healthcare professionals did not inform her of those harms. When the parents raised the issue,

the doctors responded that they have been prescribing the blockers for many years to treat precocious puberty and the reported bone loss was "nothing to worry about."

A bone density scan has revealed that M. has an 11 percent loss of bone density in one hip, 14 percent loss in the other, and a 7 percent loss in the lumbar region. She has developed osteopenia at a time in her life when her bone density should have been increasing (an important protection against osteoporosis in adulthood). When M.'s parents confronted the physician to have the blocker removed, the doctor recommended that M. continue on to cross-sex hormones, *i.e.*, testosterone. The parents were not informed this would likely sterilize their child.

Throughout the time that M. was on puberty blockers, her parents had difficulty finding a therapist to explore M.'s underlying mental health issues. Therapists were unwilling to address anything other than affirming M. as transgender. M. is improving working with a psychotherapist the parents were finally able to find. However, the availability of these medical interventions for a pre-teen girl distressed by changes in her body meant that neither she nor her healthcare providers would consider other alternatives.

Ellie Swimmer

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

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

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

The endocrinologist met with B. alone after which B. received the puberty blockers. According to B., the endocrinologist told him that they needed to get his parents "on board" with his receiving estrogen once the puberty blockers started. Within a week of receiving puberty blockers, B. began angrily demanding cross-sex hormones, *i.e.*, estrogen.

Ellie began questioning and researching the safety of these medical interventions. When she asked clinicians about their safety and sent critical research articles, they responded, "We follow WPATH standards." Ellie asked about the

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

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

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

Puberty blockers have done nothing to help B., but have only increased his instability, placing him on a conveyor belt to sterilizing cross-sex hormones. Ellie believes that the medical community has failed children like B. by permitting them to self-diagnose and then placing them on a one-way street of medicalization and

surgery. Prohibiting medical and surgical interventions on children will help protect these vulnerable children.

Martha S.

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

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

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

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

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

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

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

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

Bri Miller

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

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

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

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

"Gender-affirming" medical interventions for children are dangerous and should be banned because, as Bri points out, "in no other sphere do we encourage

children to change their bodies or take dangerous off-label prescriptions because they are uncomfortable with their body." Parents are being told these treatments are safe and well-studied, when they are not, and one-page marketing materials gloss over the harms. Bri further noted that neither children nor their parents can consent to the unknown risks and to the future ramifications of these treatments.

Kristine W.

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

During one visit, with S. present, the provider stated that trans people are more likely to commit suicide if not affirmed. In another instance, staff at the hospital said,

"You must affirm or she will kill herself. Do you want live son or dead daughter?" The school counselor made similar statements to Kristine.

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

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

S. has several friend groups across three different schools. Of 10 to 15 children, only one identifies as her natal sex. Kristine notes these numbers mimic known social contagions, such as anorexia and cutting behavior. It is statistically

highly improbable (if not impossible) that all these children will continue to identify as another gender into adulthood. To allow the medical establishment to push children into irreversible treatments and to pit objecting parents against their children is a great tragedy. Families are being ruined. For these reasons, Kristine believes "gender-affirming" medical interventions should not be available for minor children.

Helen S.

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

When Helen and E. met with the endocrinologist at the gender clinic, the only information she received was to start E. on "gender-transition" medical interventions. There was no psychological evaluation, no medical criteria for a

diagnosis of gender dysphoria. The only prerequisite for beginning medical interventions was the child's self-diagnosis and one parent's consent. Helen was told that E. should be prescribed puberty blockers at her next appointment and when she turned 16 could start taking testosterone. Helen and E. were told that puberty blockers were just "a pause button to buy you some time to think," a perfectly safe, reversible, benign intervention. Helen was not comfortable with the recommendation. The doctor replied *in front of E.* that "You have to be aware of the suicide risk. She may consider suicide if you don't do this." When Helen questioned there might a social contagion aspect, the doctor dismissed this concern. She then said "I love helping trans kids. It is the favorite part of my job helping kids be who they are."

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

Helen believes "gender-affirming" medical interventions for children should be banned because the medical community is not acting in the patient's best interest and outside the norms of ethical medical care. Parents should not be pressured by

threats of suicide into acceding the wishes of their children facilitated by activist doctors.

CONCLUSION

The Act is necessary to protect Tennessee's minors and police the medical community to safeguard patients and their parents' medical decision-making in the best interest of their children. For these reasons, the district court's decision should be reversed.

Dated: July 24, 2023.

/s/*Mary E. McAlister*
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Signature */s/ Mary E. McAlister*
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