No. 25-2566

**UNITED STATES COURT OF APPEALS**
**FOR THE EIGHTH CIRCUIT**

WYATT BURY, LLC; BALLPARK INVESTMENTS, LLC, doing business as Hope & Healing Counseling; WYATT BURY; PAMELA EISENREICH,

*Plaintiffs-Appellants*,

STATE OF MISSOURI ex rel. MISSOURI ATTORNEY GENERAL CATHERINE L. HANAWAY,

*Plaintiff,*

*v.*

*CITY OF KANSAS CITY, MISSOURI; JACKSON COUNTY, MISSOURI*

*Defendants-Appellees.*

On Appeal from the United States District Court
for the Western District of Missouri
Case No. 4:25-cv-00084-RK

# BRIEF OF THE INTERNATIONAL FOUNDATION FOR THERAPEUTIC AND COUNSELLING CHOICE AND DR. LAURA HAYNES AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS AND FOR REVERSAL

William Bock III
KROGER, GARDIS & REGAS, LLP
111 Monument Circle, Suite 900
Indianapolis, IN 46204
(317) 692-9000
wbock@kgrlaw.com

*Counsel for Amicus Curiae*

## CORPORATE DISCLOSURE STATEMENT

The undersigned counsel confirms that neither the International Foundation for Therapeutic and Counselling Choice (IFTCC), nor any of its members has a parent corporation and no publicly held corporation owns 10% or more of the stock of IFTCC of any of its members.

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## INTEREST OF AMICUS CURIAE[1]

The International Foundation for Therapeutic and Counselling Choice (IFTCC) is a multi-disciplinary organization with members providing support and counseling services in 35 countries to individuals seeking change in unwanted relational, sexual, and gender identity behaviors, feelings, and patterns. Dr. Laura Haynes, Ph.D., is Chair of the IFTCC Science and Research Council, an IFTCC Executive Board Member, and representative of the United States on the IFTCC Board. Amici are IFTCC and Dr. Haynes.[2]

Dr. Haynes has served as an expert to members in seven Parliaments and numerous other governmental bodies. She submitted an amicus brief to the Supreme Court of Bulgaria that was quoted multiple times in the favorable decision of the Court.

*Amicus* offer background on counseling's importance in relieving gender distress.

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[1] App.R. 29 statement: The parties consented to filing of this brief. No party's counsel authored any of the brief; *amicus* alone funded its preparation and submission.

[2] Dr. Haynes' Curriculum Vitae is provided as **Addendum B**.

## SUMMARY OF ARGUMENT

At the time Kansas City and Jackson County (the "governmental units") banned counselors from speaking to children and adolescents about feelings of distress or conflict regarding their natal sex to help resolve these feelings even researchers who opposed such counseling acknowledged there was no research evidence establishing that counseling directed at becoming comfortable with one's sex causes harm.

Furthermore, major medical and mental health organizations concede gender discordance or dysphoria is not caused by having the brain of the opposite sex. Studies have unanimously found that most children resolve discordant gender identity and gender dysphoria (unhappiness about their sex) by adolescence or early adulthood, and emerging research reflects counseling helps them do so.

Regrettably, the Kansas City and Jackson County ordinances deprive gender dysphoric patients who could benefit from counseling conversations to help them overcome their dysphoria and become comfortable with their own bodies, removing a potential option to avoiding costly and life altering physical (i.e., surgical and chemical) interventions with known deleterious side effects. Studies rated as high

quality by a systematic research review for the National Health Service-England (NHS-England) have found gender discordant or dysphoric children and adolescents have markedly high rates of severe mental health problems, identity problems in general, developmental disabilities, trauma from bullying for reasons other than gender presentation or gender or sexual identity, and suicidality, generally beginning before onset of discordant gender identity or dysphoria, seldom after. A counseling approach to resolving gender distress cannot possibly have caused these pre-existing problems, but it may well help to address, manage, decrease, or resolve them.

There is no published research whatsoever that meets scientific standards that suggests medical gender interventions resolve mental health problems or suicidality in minors. The "affirmative" or "medicalized" approach of treating gender dysphoria with puberty blockers, cross-sex hormones and ultimately irreversible, body-altering, surgery disregards that mental health problems and suicidality may in fact create or compound gender discordance or dysphoria.

Moreover, no reliable scientific research indicates that counseling conversations to assist gender dysphoric children and adolescents become

more comfortable with their own bodies is harmful. In fact, the few papers relied on to oppose such counseling are not credible. Researchers identifying as counseling-approach-opposed have (1) recruited survey participants who were not representative of gender discordant or dysphoric young people, (2) acknowledged they asked unclear questions, and as a result they themselves do not know what they studied, and (3) acknowledged they have not established that counseling for resolving gender discordance or distress causes harm, then inferred it anyway and called for therapy bans.

National health authorities in the U.S., U.K., Finland, and Sweden, and increasingly professional organizations outside the U.S., recommend the counseling approach for resolving gender distress and the mental health problems and suicidality that so often accompany it. American professional organizations favoring medicalized intervention and eschewing counseling are outliers.

## ARGUMENT

### I. Gender Dysphoria and Discordant Gender Identity Are Recognized Psychological Conditions Long Addressed Through Consensual Counseling

Some people experience a persisting, marked conflict between their subjectively experienced, perceived, or expressed sex ("gender identity")

and the inborn sex of their body, a condition referred to as "gender discordance" or diagnosed as "gender incongruence." *See* World Health Organization, *International Classification of Diseases, Eleventh Revision* HA60, HA61 (2022). Some of these experience clinically significant distress over this conflict that may be diagnosed as "gender dysphoria," meaning "gender distress" or unhappiness about one's sex. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* 512-513 (2022).

Rather than enforce gender role stereotypes, counseling challenges them. It challenges a view, for example, that if a male minor experiences some traits more stereotypically associated with females and desires to be a female, it means he is not a male and must be a female in a male's body. Counselors may explore the context in which the discordant gender identity arose and its meaning to the minor and also address any co-occurring mental health problems and explore any contribution these may be making to the gender distress. Resolution of gender-sex conflict or distress occurs through non-aversive, non-invasive, counseling conversations. Such counseling generally does not focus directly on changing gender identity. Although counseling bans refer to such

counseling as "gender identity change efforts" ("GICE") or "conversion therapy," these are political terms counselors do not use. Such counseling is better described as "counseling for resolving gender-sex-conflict or gender-distress."

A counseling approach can simply be exploratory for the purpose of resolving gender distress. Some gender distressed minors do not know what they want from counseling, while some have a preferred outcome. In most contexts considering a parent or child's desired outcome for care is considered foundational to an appropriate and ethical counseling relationship. However, the challenged ordinances forbid considering the counselee's wishes.

The most comprehensive-ever study of care for gender dysphoria concluded the counselor and the minor should "collaboratively" agree upon an individualized care plan "based both on the best available evidence" and "the client's characteristics, preferences, values and beliefs." *See* Hillary Cass, *The Cass review: Independent Review of Gender Identity Services for Children and Young People: Final Report* at 146 (2024) (hereafter, "*Cass Final Report*").

Some minors may want to become adults who enjoy what their

natural sexual body has to offer them if they know this counseling path exists. *See* Marcus Evans & Susan Evans, *Gender Dysphoria: A Therapeutic Model for Working With Children, Adolescents and Young Adults*, 7-8 (Bicester, Oxfordshire, UK: Phoenix Press, 2021). Some, due to religious convictions, are hesitant about medical body alteration and prefer to make peace with their body and want a counseling alternative to the medical path. In other cases, minors need or want non-invasive counseling to resolve their gender distress because medical considerations rule out medical interventions for them, or they have physical appearance features that would hinder being able to pass as the other sex. *See* Kenneth J. Zucker, et al., *Gender Dysphoria in Adults*, 12 Annual Review Clinical Psychology 237 (2016); *see also* Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69 Journal Homosexuality 7, 14 (2021) (hereafter, "Vandenbussche, *Detransition-Related Needs*").

Others who stopped taking puberty blockers or opposite-sex hormones need and want counseling to help them feel content with their sex because body-harming medicalized interventions did not resolve their gender pain or mental health problems. They wish they had been offered

a counseling option to resolve their gender dysphoria first. Vandenbussche, *Detransition-Related Needs* at 7, 11; *see also* Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition who Subsequently Detransitioned: A Survey of 100 Detransitioners* 50 Archives Sexual Behavior 3353, 3364 (2021).

### A. Gender Dysphoria and Discordant Gender Identity are Not Immutable Conditions

Proponents of counseling bans may find it difficult to accept evidence people resolve gender dysphoria through counseling because they hold to an assumption that a gender identity that conflicts with a person's sex is a biological trait, inborn and fixed. Were that true, counseling to help gender distressed people feel comfortable with their sex would be destined to fail. However, it is accepted by researchers around the world that this assumption is false. The viewpoint that discordant gender identity is biologically determined or caused by having the brain of the opposite sex has never been scientifically established and never had professional consensus in support of it.

The American Psychiatric Association accepts the findings of 11 out of 11 studies that children diagnosed in gender clinics overwhelmingly resolved gender dysphoria by adolescence or adulthood. *See* American

Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* at 455 (2013) (hereafter, "*APA Diagnostic Manual-2013*"); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* at 516 (2022) (hereafter, "*APA Diagnostic Manual-2022 Text Revision*"); Zucker, *The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies and 'Desistance' Theories About Transgender and Gender Non-Conforming Children" by Temple Newhook et al.*, online, International Journal Transgenderism 2-3 (2018) (hereafter, "Zucker, *The Myth of Persistence*"). In these studies, about two-thirds (67%) of those who met, and close to all (93%) of those who nearly met, diagnostic criteria for gender dysphoria resolved it. Zucker, *The Myth of Persistence* at 4. Some studies included information that the children received counseling.

In follow-up interviews, the children told researchers what helped them accept their sex was going through puberty and experiencing feelings of sexual attraction—experiencing what their natural sexual bodies have to offer. Thomas D. Steensma, et al., *Desisting and Persisting Gender Dysphoria After Childhood: A Qualitative Follow-Up*

*Study*, 16 Clinical Child Psychology and Psychiatry 499 (2010). The counseling approach to resolving gender conflict and distress, that Kansas City and Jackson County ban, supports children going through puberty, while the medicalized approach the governmental units promote prevents children from going through a full puberty, denying them this opportunity for natural gender dysphoria resolution.

Researchers accept that discordant gender identity and gender dysphoria are not biologically determined or an intersex condition of the brain. The American Psychological Association stated this understanding of *transgender identity* in its *APA Handbook of Sexuality and Psychology* in 2014. *See* Walter Bockting, Chapter 24: Transgender Identity Development, in *APA Handbook of Sexuality and Psychology, Volume* 743, (Deborah L. Tolman & Lisa M. Diamond eds-in-chief, American Psychological Association 2014).

A highly regarded global consensus statement on intersex disorders by several endocrine societies stated this view of *gender identity*, explaining that intersex conditions are biologically determined, but gender identity develops from a complex interplay of biological, psychological, and social influences. (It is "biopsychosocial.") They said

there is no consistent evidence that brains of gender discordant people are different from the brains of people who identify with their sex. Further, no biological marker has been found for gender identity, meaning one's "gender identity" cannot be diagnosed by conducting a biological test or looking at a person's brain. *See* Peter A. Lee, et al., *Consensus Statement: Global Disorders of Sex Development Update Since 2006: Perceptions, Approach and Care*, 85 Hormone Research Pediatrics 168 (2016). These endocrine societies included the European Society for Paediatric Endocrinology, the Paediatric Endocrine Society, the Asian Pacific Paediatric Endocrine Society, the Japanese Society of Paediatric Endocrinology, the Sociedad Latino-Americana de Endocrinologia Paediatrica, and the Chinese Society of Paediatric Endocrinology and Metabolism. *Id.* at 159.

Not only is it known that *children* resolve gender dysphoria, but rigorous research from Germany showed that 90% of *adolescents* resolve "gender non-contentedness" by early adulthood. Gender non-contentedness, however, increased in 10% of gender non-contented minors who had more mental health problems throughout their development and required more mental health services. Pien Rawee,

*Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives Sexual Behavior 1813, 1821 (2024) (hereafter, "Rawee, *Development of Gender Non-Contentedness*").

Most recently, the NHS-England most comprehensive-ever study of medicalized gender affirming treatment confirmed there is wide acceptance of the "biopsychosocial" view of development of gender dysphoria. *Cass Final Report* at 121.

### B. Gender Dysphoria and Discordant Gender Identity Can Be Effectively Addressed Through Counseling

#### 1. The mental health link to gender dysphoria

Studies across many countries demonstrate individuals experiencing gender dysphoria also experience higher rates of mental health problems. This correlation is not controversial. It was substantiated in an NHS-England commissioned systematic research review that evaluated 146 studies in 17 countries. *See* Jo Taylor, et al., *Characteristics of Children and Adolescents Referred to Specialist Gender Services: A Systematic Review*, 109, Archives Disease Childhood s3, s8 (2024). Most studies of this co-occurrence do not explain which came first—mental health conditions or gender dysphoria—but some do, and those have found that mental health conditions came first.

Rigorous studies have found that mental health problems and suicidality often pre-exist the onset of discordant gender identity or gender dysphoria and therefore may (at least in some cases) be causal for them. It may be expected that mental health counseling approaches for mental health conditions that may predispose to, precipitate, or perpetuate gender dysphoria may decrease or resolve gender dysphoria.

A study of gender nonconforming children and adolescents in the Kaiser Permanente health maintenance organization in California and Georgia found that about a third (~ 33%) of children (ages 3 to 9) experienced mental health problems prior to non-conforming gender identity. *See* Tracy A. Becerra-Culqui, et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared with Their Peers,* 141 Pediatrics 4 (2018) (hereafter, "Becerra-Culqui, *Mental Health of Transgender and Gender Nonconforming Youth*"). Among adolescents (ages 10 to 17), about three-quarters (71% of males and 75% of females) had pre-existing mental health problems. These conditions were largely present during the 6-months prior to first medical record evidence of gender nonconforming identity. *Id*. at 5. By comparison, about 3% to 6% of matched children and adolescents who identified with their sex had

had such conditions in their lifetime. *Id*. at 4-5. Pre-existing mental health problems found at high rates in *children* included anxiety disorders, attention deficit disorders, autism spectrum disorders, conduct and/or disruptive disorders, depressive disorders, and eating disorders. *Id*. at 4. Pre-existing mental health problems found at high rates in *adolescents* included anxiety disorders, attention deficit disorders, autism spectrum disorders, bipolar disorders, conduct and/or disruptive disorders, depressive disorders, eating disorders, psychoses, personality disorders, schizophrenia spectrum disorders, self-inflicted injuries, substance use disorders, and suicidal ideation. *Id*. at 5. An NHS-England commissioned research review rated the methodological quality of this study and a study in Finland in the "highest quality" category. *See* Lucy Thompson, et al., *A PRISMA Systematic Review of Adolescent Gender Dysphoria Literature: 2) Mental Health,* 2 PLOS Global Public Health 14 (2022).

The Finnish study, conducted at one of Finland's two university gender clinics, found that three-quarters (75%) of the clinic's adolescents had mental health problems—often severe, usually beginning prior to gender dysphoria and seldom after. *See* Riittakerttu Kaltiala-Heino, et

al., *Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development*, 9 Child Adolescent Psychiatry and Mental Health 1, 5, 6 (2015) (hereafter, "Kaltiala-Heino, *Gender Identity Service for Minors*"). Over half (57%) of the adolescents had suffered intensive and persistent bullying, in most cases beginning before thoughts about gender identity—usually for reasons unrelated to gender presentation or sexuality—but more often for this in boys, *id*. at 4, 6—and commonly accompanied by peer isolation and suicidal thoughts. These adolescents had "very high expectations that [sex reassignment] would solve their problems in social, academic, occupational and mental health domains." *Id*. at 5 at Table 2 "e group," 4, 6. The researchers appear to suggest severe mental disorders, *general* identity confusion—not only confusion about gender identity, neurodevelopmental disabilities—especially for those diagnosed with autism spectrum disorder, *id*. at 7, and/or bullying may have caused gender dysphoria or transgender identity.

Finland's care recommendation in 2020 said, "[i]n adolescents, psychiatric disorder and developmental difficulties may predispose a young person to the onset of gender dysphoria." Correspondingly, it

recommended that "first line" care for gender dysphoria be counseling for mental health problems and developmental difficulties. Of the medicalized approach it said, "Since reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions, it is not a valid justification for gender reassignment." *See* Council for Choices in Health Care in Finland, *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors*, 8, 7 (2020) (hereafter, "*PALKO/COHERE Finland*").

Findings similar to those in the U.S. and Finnish studies were reached in another systematic review commissioned by NHS-England that found 70% of gender cases had 5 or more associated clinical features, not just 1 or 2, and rarely none. *See* Domenico Di Ceglie, et al., *Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics*, 6 International Journal Transgenderism 3, 21 (2002). The Cass Final Report said mental health problems may impact on gender distress *Cass Final Report* at 155, ¶ 11.36, and recommended research on how "specific therapeutic modalities may help the core gender dysphoria." *Id.* at ¶

11.37.

In Canada, researchers reported 78% of adolescents in a gender clinic had previous mental health counseling, 60% had "a prior diagnosis" other than a gender diagnosis, and over half had suicidal ideation. The researchers explained how a gender affirming course of intervention had ignored a history of mental health problems and was followed by attempted suicide. *See* Melanie Bechard, et al., *Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A "Proof of Principle" Study*, 43 Journal Sex and Marital Therapy 681, 684-685 (2017) (hereafter, "Bechard, *Psychosocial and Psychological Vulnerability*").

* * *

Kansas City and Jackson County have ignored the contribution of mental health problems to the onset of gender distress and forbid counseling to resolve the distress at serious risk to minors.

**2. Counseling is effective in treating gender dysphoria**

The best available research on the counseling approach indicates that gender conflict and distress of children can be resolved through counseling. In 2013 Canadian-American psychologist Dr. Kenneth

Zucker, chaired the work group for the American Psychiatric Association's internationally recognized diagnostic manual chapter on gender dysphoria diagnosis. *See APA Diagnostic Manual-2013* at 451. Before and since, Dr. Zucker published over 300 peer reviewed articles and book chapters regarding gender dysphoria and resolving it through counseling. *See* Zucker, Full C.V., Publications (2020) *available at* https://www.kenzuckerphd.com/research.

Dr. Zucker communicated his counseling approach for gender dysphoria to psychiatrists and other mental health professionals in leading APA publications such as: *DSM-IV-TR Casebook, Volume 2: Experts Tell How They Treated Their Own Patients* Robert L. Spitzer et al. (Eds.) American Psychiatric Publishing (2006) at 321-334 reprinting Zucker, *I'm Half-Boy, Half-Girl": Play Psychotherapy and Parent Counseling for Gender Identity Disorder; The American Psychiatric Publishing Textbook of Child and Adolescent Psychiatry, 3rd Edition,* Eds. J. M. Wiener & M.K. Dulcan, APA Publishing (2005) at 813 reprinting Zucker et al., *Gender Identity and Psychosexual Disorders*, 3 Focus 598 (2004). Dr. Zucker also taught in universities that were among the highest ranked in Canada and the world. *See* Zucker, Full C.V.,

Academic and Hospital Appointments, Teaching Experience (2020) *available at*: https://www.kenzuckerphd.com/research. For decades Dr. Zucker taught mental health professionals and researched and advocated for counseling that had the goal of helping gender dysphoric children to "feel more comfortable in their own skin," that is, to reduce the child's "desire to be of the other gender." Zucker, *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 Journal Homosexuality (2012) at 388, 383 (hereafter, "Zucker, *A Developmental, Biopsychosocial Model*"). Dr. Zucker also advocated for adults requesting "help in trying to make their gender identity and gender expression more congruent with their assigned sex." Zucker, et al., *Gender Dysphoria in Adults*, 12 *Annual Review Clinical Psychology* 237 (2016).

Zucker and colleagues published the largest and methodologically best study to date on boys who resolved discordant gender identity by young adulthood. The boys were referred to the gender clinic Zucker headed for many years at Canada's largest mental health center, and, if they received counseling, the vast majority received his approach to care and not a "social affirmation" approach to live as the opposite sex with

opposite sex clothes, name, and pronouns. The outcome was that the vast majority came to identify with their natal sex by young adulthood (86% who met full criteria for gender dysphoria diagnosis and 90% who virtually met all criteria). *See* Devita Singh, et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, 12 Frontiers Psychiatry 8 (2021) (hereafter, "Singh, *A Follow-Up Study*"). Zucker and colleagues took the approach that a child's gender-atypical temperament, immature understanding of the concept of gender, parent permissiveness toward cross dressing, co-occurring mental health problems or trauma, or conflict that gets transferred from a parent to a child may contribute to the development of cross-sex identity expression. Counseling for the child and for the family can address these and parents can be taught to see the cross-sex identity as a symptom to be understood. Zucker, *A Developmental, Biopsychosocial Model* at 375-382, 389.

### 3. The political attack on the use of counseling to address gender dysphoria in minors

However, "gender affirming care" activists attacked the work of Zucker and his colleagues. In 2015, with the aid of what proved to be false allegations and an apparently sham investigation, they got him fired and his gender clinic closed. Accusations that ordinary counseling for

resolving gender distress is harmful and stigmatizing it with the political label "conversion therapy" has ruined the reputations and careers of professionals and clinics and chilled speech by licensed counselors for resolving gender distress. *See* Jesse Singal, *Culture Wars: How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired* (2016). Zucker sued for defamation and wrongful dismissal, and the health center that fired him apologized without reservation and settled with him for over a half-million dollars. *See CAMH Reaches Settlement with Former Head of Gender Identity Clinic: Mental Health and Addiction Teaching Hospital to Pay Him $586,000 in Damages, Legal Fees, Interest.* 1-2 (Canadian Press, 7 Oct. 2018).

### C. There is No Scientific Evidence of Harm Resulting from Counseling for Gender Dysphoria and/or Discordant Gender Identity

Claims of counseling ban advocates that counseling minors to become comfortable with their sex *can cause harm* has not been scientifically proven. Researchers associated with Harvard and its hospitals pre-published online a research article in the journal of the American Medical Association stating, "[t]he association of GICE [gender identity change efforts] with mental health outcomes, however, remains

largely unknown." *See* Jack L. Turban, et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, Online, JAMA Psychiatry E1 (2019) (hereafter, "Turban, *Association Between*"). The Harvard researchers said, "[t]o our knowledge, there have been no studies evaluating the associations between exposure to GICE during either childhood or adulthood and adult mental health outcomes." *Id.* at E2.

The dramatic harms of the medicalized approach—intentionally suppressing or destroying reproductive health, inducing potentially permanent loss of fertility, sexual function, and sexual pleasure, increasing risk of fatal diseases, *see* Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8,* 23(sup1) International Journal Transgender Health, S102, S119, S167 (2022); Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* 112-128 (2025) (hereafter, "DHHS, *Treatment for Pediatric Gender Dysphoria*"), and amputating healthy breasts—are self-evident. In contrast, counseling is the least invasive care for resolving gender

distress or conflict.

The argument against the counseling approach, that minors are capable of initiating body harming, sterilizing medicalized interventions but incapable of initiating consensual counseling conversations to reconnect with their sexual self is inconsistent and irrational.

### D. There is No Evidence Medical Interventions are More Successful than Counseling for Treating Gender Dysphoria and/or Discordant Gender Identity

There is no well-founded scientific research supporting restricting the topics that can be discussed in counseling. In fact, the Cass Interim Report recommended the same counseling approach for gender dysphoria as is used for other mental health problems in children and adolescents. *See* Hillary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People: Interim Report* at 69, ¶ 6.8 (2022) (hereafter, "*Cass Interim Report*").

The original Dutch studies that became the international protocol for medicalized gender interventions permit a comparison of the medicalized and counseling approaches. Adolescents excluded from medicalized interventions because of greater mental health problems were still given counseling. At a four-year follow-up evaluation, these

adolescents had become significantly less gender dysphoric, and the vast majority had no regret they did not undergo body-altering interventions. Quality of life scores were not significantly different for the medically treated and untreated groups. *See* Yolanda L.S. Smith, et al., *Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study* 40 Journal American Academy Child Adolescent Psychiatry 477, 478 (2001).

Also, at the largest child gender clinic in the world, the U. K. Gender Identity Development Service, a study of children eligible to receive puberty blockers found no significant difference in mental health functioning improvement between those who only received counseling and those who received both counseling and puberty blockers. *See* Rosalia Costa, et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 Journal Sexual Medicine 2212 (2015).

Advocates for the medicalized approach claim children have better mental health if they receive parental support for gender identity transition. However, parent and peer support for a child, but *not* support for living as the opposite sex, was found to account for improved mental

health of children in a German university gender clinic. Consequently, the clinic provided individual and family counseling. This study was among the two highest rated studies on treating gender dysphoria in children in a systematic research review conducted for NHS-England. *See* Elisabeth D.C. Sievert, et al., *Not Social Transition Status, But Peer Relations and Family Functioning Predict Psychological Functioning in a German Clinical Sample of Children with Gender Dysphoria*, 26 Clinical Child Psychology Psychiatry 79, 90 (2021).[3] The same clinic had similar findings for adolescents. *See* Naina Levitan, et al., *Risk Factors for Psychological Functioning in German Adolescents with Gender Dysphoria: Poor Peer Relations and General Family Functioning* 28 European Child Adolescent Psychiatry 1487, 1494 (2019).

The comprehensive, gold standard, NHS-England review concluded that there are "well proven" counseling interventions for mental health problems associated with gender dysphoria, that they might also help "core gender dysphoria," and that research should look at this. *See Cass Final Report* at 155, ¶ 11:36-37. It called for a return to the normal counseling approach used for addressing other child and adolescent

[3] Study rated in *Cass Final Report* at 161.

mental health problems. *Cass Interim Report* at 69. More government health authorities, based on research, are prioritizing counseling, including Sweden's National Board of Health and Welfare, *see* Society for Evidence Based Gender Medicine, *SEGM Summary of Key Recommendations from the Swedish National Board of Health and Welfare Feb. 2022 update*, at 1, 2 (2022), the Council for Choices in Health Care in Finland, *see PALKO/COHERE Finland* at 7-8, and the U.S. Department of Health and Human Services. *See* DHHS, *Treatment for Pediatric Gender Dysphoria, at* 15-16.

Notably, organizations prioritizing counseling over medicalized interventions include the Academy of Royal Medical Colleges (23 medical societies and faculties from the U.K. and Ireland) that supports the NHS-England Cass Report. *See* Academy of Royal Medical Colleges (U.K.) (n.d.). Academy statement: Implementation of the Cass Review. **Addendum A** contains a list of additional organizations concerned with the medicalized approach and supporting the counseling approach.

## II. The Papers Attacking Counseling Are Methodologically Flawed

### A. Bias in Selecting Participants

Surveys that claim counseling for resolving gender distress or

conflict is harmful have tended to recruit only gender-discordant participants from transgender advocacy organizations, resulting in serious bias. For example, medicalization-aligned researchers have recruited participants through advocacy organizations such as the Trevor Project, *see, e.g.*, Amy E. Green, et al., *Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults*, 110 American Journal Public Health, Open-Themes Research at 1222 (2020) (hereafter, "Green, *Self-Reported Conversion Efforts*"), or the U.S. 2015 Transgender Survey data set. *See, e.g.*, Travis Campbell & Yana van der Meulen Rodgers, *Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the U.S.,* 89 Journal Health Economics 3, 4 (2023) (hereafter, "Campbell, *Conversion Therapy*"); Katie Heiden-Rootes et al., *The Effects of Gender Identity Change Efforts on Black, Latinx, and White Transgender and Gender Nonbinary Adults: Implications for Ethical Clinical Practice*, 48 Journal Marital and Family Therapy 930 (2021) (hereafter, "Heiden-Rootes, *The Effects of Gender Identity Change Efforts*"); Tural Mammadli, et al., *Understanding Harms Associated with Gender Identity Conversion Efforts Among Transgender and Nonbinary Individuals: The Role of Preexisting Mental Well-Being*,

26 International Journal Transgender Health, 162 (2025) (hereafter, "Mammadli, *Understanding Harms*"); Turban, *Association Between*, at E1, E2. This method produces non-representative, low quality data. Demographic research has shown participants in the most-commonly-used U.S. 2015 Transgender Survey data set, for example, despite being large in number, are not representative of incongruent gender identified people in the U.S. *See* Roberto D'Angelo, et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behavior 2, 3 at Table 1 (2020). The researchers systematically excluded not politically active individuals or those who were traditionally religious and therefore may have had different needs, preferences, values, or beliefs regarding gender dysphoria.

By including only currently, not formerly discordant-gender-identified people, researchers excluded by research design the vast majority who resolved their gender conflict by adolescence or early adulthood as seen in population representative research, *see* Rawee, *Development of Gender Non-Contentedness* at 1821, and gender clinic studies, *see, e.g.*, Zucker at 2-3, *The Myth of Persistence;* Singh, *A Follow-Up Study* at 8. Most crucially, they exclude all who successfully embraced

their sex through counseling. Singh, *A Follow-Up Study* at 14. Further, tragically, they exclude all who sought counseling to resolve gender dysphoria after medicalized affirmation did not resolve it and they felt medical communities and transgender communities had abandoned them. *See* Vandenbussche, *Detransition-Related Needs at* 14-15. The researchers' recruitment methods preselected participants highly likely to bias the outcome.

### B. Counseling-Opposed Researchers Acknowledge Methodological Errors

Some counseling-opposed researchers have used obscure and biased questions that simply assume coercion. For example, Trevor Project researchers said, "questions examining attempts to convince young people to change their sexual orientation and gender identity were endorsed by two-thirds of respondents; however, these questions were too broad to be operationalized as formal SOGICE [sexual orientation and gender identity change efforts]." They also said many participants who experienced change efforts would not endorse use of the language "reparative therapy or conversion therapy." Green, *Self-Reported Conversion Efforts* at 1225 (2020). The researchers threw out 105 respondents who said they experienced "conversion or reparative

therapy" but not someone trying to "convince" them to change, hence potentially respondents who experienced consensual counseling conversations. *Id*. Most surveys asked the U.S. 2015 Transgender Survey question, "Did any professional (such as a psychologist, counselor, religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?" Researchers acknowledged the survey question was broad enough to include experiences that were not "conversion counseling." *See, e.g.*, Campbell, *Conversion Therapy* at 4. In a recent survey using these same questions, researchers said, "…we did not disaggregate GICE exposure based on the setting in which it was administered (i.e. religious vs. non-religious). Future studies should examine whether the administration of GICE in religious vs. non-religious settings is associated with differing outcomes." Mammadli, *Understanding Harms* at 175. Other researchers who used these questions said, "We also lack data regarding the degree to which GICE [gender identity change efforts] occurred (eg, duration, frequency, and forcefulness of GICE, as well as what specific modalities were used." Turban, *Association Between* at E8.

Due to these methodological weaknesses these surveys are not

useful sources of information about young-person-led consensual counseling conversations that are the target of counseling bans.

### C. Counseling-Opposed Researchers Acknowledge Their Inability to Prove "Change Efforts" Cause Harm

Survey researchers who identify as counseling-opposed report they find an *association* between a reported experience of "change efforts" and a reported experience of mental health problems and suicidality. However, correlation does not equal causation. Association between two things does not demonstrate that one was caused by the other. It is likely that people who go to any mental health counseling—whether gender conflict resolving or any other type of counseling—may be associated with higher rates of mental health problems than people who do not go to mental health counseling, just as people who go to cardiologists are associated with more heart problems than people who do not go to cardiologists.

To prove harm resulted from counseling, a study would need to document the mental health of a representative sample *both before and after* counseling by licensed mental health counselors that are open to a goal of gender conflict resolution to shed light upon whether participants' mental health became better than it was before, became worse, or stayed

the same. A survey that assesses participants at only one point in time, i.e., a "cross-sectional" survey, that attempts to infer causation is fatally flawed and cannot prove an intervention caused benefit or harm.

In one of the most often cited surveys that claims harm from counseling, the researchers acknowledged their survey's, "[l]imitations include its cross-sectional study design, which precludes determination of causation." Turban, *Association Between* at E8. Other studies relying on the same 2015 U.S. Transgender Survey data set as this survey have also acknowledged they did not prove harm. See, *e.g.*, Heiden-Rootes, *The Effects of Gender Identity Change Efforts* at 940; Mammadli, *Understanding Harms* at 175. Researchers for another survey attempted unsuccessfully to create before and after comparison groups from the data set but acknowledged their method of "heaping is an issue." Campbell, *Conversion Therapy* at 11. They also acknowledged being "constrained by some formidable data and methodology limitations." *Id.* at 14. Another often-cited survey using a Trevor Project data set acknowledged, "[f]or example, our data were cross sectional; thus, temporality cannot be determined." Green, *Self-Reported Conversion Efforts* at 1225. These counseling-opposed researchers admit their

surveys do not establish that "change efforts" (whatever that means) were harmful. They provide no scientific justification for banning counseling.

### D. Counseling-Opposed Researchers Have Not Addressed Evidence That Mental Health Problems for Which There Are Proven Counseling Interventions May Cause Both Gender Distress/Discordance and Suicidality

A critical additional difficulty for the surveys of counseling-opposed researchers is that, as previously discussed, studies recognized by systematic research reviews as high quality have found that people who were diagnosed with gender incongruence or dysphoria were also diagnosed at high rates with serious mental health problems, suicidal thoughts and attempts, and difficulties with accomplishments and functioning *before onset of gender discordance and dysphoria, seldom after, therefore before counseling to resolve gender conflict and distress occurs*. *See, e.g.*, Becerra-Culqui, , *Mental Health of Transgender and Gender Nonconforming Youth* at 1; Bechard, *Psychosocial and Psychological Vulnerability* at 681; Kaltiala-Heino, *Two Years of Gender Identity Service* at 6. Counseling to resolve gender conflict and distress cannot have caused these pre-existing mental health problems and

impacts, and counseling-opposed surveys have ignored this or only addressed it unsuccessfully. *See, e.g.*, Campbell, *Conversion Therapy*, at 11.

It has long been known that mental health problems are themselves a leading cause of suicides. More than thirty years ago the U.S. Centers for Disease Control recognized, "psychopathological problems are almost always involved in suicide." Patrick W. O'Carroll & Lloyd B. Potter, *Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop*, 43 MMWR 4-5 (1994). Indeed, a global mental health autopsy systematic research review found that, worldwide, 90% of people who committed suicide had unresolved mental health problems. The researchers' number one recommendation for preventing suicides was care for mental health problems. J.T.O. Cavanagh, et al., *Psychological Autopsy Studies of Suicide: A Systematic Review*, 33, Psychological Medicine 395 (2003).

Among adolescents, a U.S. nationally representative study found 96% who experienced suicidal thoughts, plans, or attempts had at least one mental health problem. Matthew K. Nock, et al., *Prevalence, Correlates and Treatment of Lifetime Suicidal Behavior Among*

*Adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement*, 70 *JAMA Psychiatry,* 305 (2013).

A large mental health autopsy study in the U.S. found that one-third of LGBT-identified adolescents and young adults who committed suicide were in some kind of professional care for mental health problems. Geoffrey L. Ream, et al., *What's Unique About Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth and Young Adult Suicides? Findings from the National Violent Death Reporting System*, 64 Journal Adolescent Health 607 (2019).

Notably, over the course of 30 years of increased transgender acceptance in the cities of Toronto, Amsterdam, and London, suicides of transgender adolescents did not change and remained strongly associated with mental health problems. *See* Nastasja M. de Graaf, et al., *Suicidality in Clinic-Referred Transgender Adolescents*, 50 European Child Adolescent Psychiatry 67, 77-78 (2020).

The NHS-England report said, "[t]ragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender affirmative treatments reduce this. Such evidence as is available suggests that these deaths are related to a range

of other complex psychosocial factors and to mental illness." *Cass Final Report* at 195, ¶ 16.22.

A systematic review of 17 systematic research reviews by the U.S. Department of Health and Human Services similarly found that mental health problems that commonly co-occur with gender dysphoria in children and adolescents are by themselves associated with suicidal thoughts and behavior, but gender dysphoria by itself is not. It also found there is no evidence that medicalized gender interventions reduce suicide in minors, which, it said, fortunately remains very low. DHHS, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* at 16.

Counseling bans unscientifically deny or overlook that mental health problems cause both gender conflict or distress and suicidality or suicides. The most serious risk of the governmental units' unscientific approach of banning counseling is that it may leave minors with a combination of harmed bodies and physical health and protracted suffering from unresolved mental health problems, resulting even in some cases in completed suicides. The refusal to allow counselors to speak with their patients about this topic not only impacts the counselor, but it

also denies the patient access to important information about the scientifically valid, non-intrusive, and frequently curative option of counseling.

## CONCLUSION

Increasing numbers of government health authorities and professional organizations are moving away from the medicalized approach to resolving gender dysphoria and gender incongruity in minors that Kansas City and Jackson County enthusiastically favor. Yet the governmental units take their unbalanced fervor for medicalization even a step further, unconstitutionally banning conversation with a trusted counselor as an option for minors facing gender dysphoria or gender incongruity. The District Court's denial of a preliminary injunction should be reversed.

Dated: October 28, 2025

Respectfully submitted,

*/s/ William Bock III*

William Bock III
KROGER, GARDIS & REGAS, LLP
111 Monument Circle, Suite 900
Indianapolis, IN 46204
(317) 692-9000
wbock@kgrlaw.com

*Counsel for Amicus Curiae*

## CERTIFICATE OF COMPLIANCE

This brief complies with the word limit of Fed. R. App. P. 27(d)(2)(A) because it contains 6,498 words, excluding parts exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in Word 365 using a proportionally spaced typeface, 14-point Century Schoolbook.

Dated: October 24, 2025

*/s/ William Bock III*
William Bock III
*Counsel for Amicus Curiae*

## CERTIFICATE OF SERVICE

I hereby certify that on October 28, 2025, I electronically filed the foregoing *Brief of the International Foundation for Therapeutic and Counselling Choice and Dr. Laura Haynes as Amicus Curiae in Support of Plaintiffs-Appellants and for Reversal* with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users, and that service will be accomplished by that system. This brief has been scanned for viruses and the brief is virus-free.

*/s/ William Bock III*
William Bock III
*Counsel for Amicus Curiae*